Running Head: ASSESSING PATTERNS OF FAMILY FUNCTIONING AND STRENGTHS

Assessing Patterns of Family Functioning and Family Strengths in the Families of Preschoolers with Developmental Delays, Behaviour Problems, and Both

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Abstract

Theories of family functioning, which identify important processes or components of family structure and interactions, have a common flaw of bipolarity, with 'functioning well' at one end of the spectrum and 'dysfunctional' at the other end. This results in the loss of important information about the positive characteristics of families, family strengths. Prior research has indicated that families of preschool aged children with behaviour problems or developmental delays demonstrate distinct patterns of family functioning characteristics. Though little research has explored family strengths, there is some indication that patterns of family strengths differ between families facing different challenges. The present study attempted to clarify and explore the distinct characteristics of family functioning and family strengths that occur in the families of preschool aged children with behaviour problems, developmental delays, and both. Participants were 34 primary caregivers of 3 to 6 year old children recruited through the public school system and two clinical agencies. Participants completed the Family Assessment Measure (FAM-III), the Family Functioning Style Scale (FFSS), and the Child Behavior Checklist (CBCL), to assess family functioning, family strengths, and behavioural problems respectively. Results of this study suggest that both severity of behavioural problems and presence of developmental delay are significantly related to the overall level and specific characteristics of family functioning and family strengths in the preschool population.

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Assessing Patterns of Family Functioning and Family Strengths in the Families of Preschoolers with Developmental Delays, Behaviour Problems, and Both

The family provides an important context for child development, particularly in the early years of life. Thus, it is not surprising that many researchers have incorporated family variables into the study of early childhood. There are, however, some inconsistencies in both the specific family variables included in such studies and the underlying theoretical framework that is used. In some studies, family factors are treated as demographic characteristics (Baker, Blacher, Crnic, & Edelbrock, 2002; Baker, Blacher, & Olsson, 2005; Baker, McIntyre, Blacher, Crnic, Edelbrock, & Low, 2003; Campbell, March, Pierce, Ewing, & Szumowski, 1991; Donenberg & Baker, 1993; Eisenhower, Baker, & Blacher, 2005; Hastings, Allen, McDermott, & Still, 2002; Keown & Woodward, 2002). That is, family related variables, such as parenting practices, coping strategies, parental psychopathology, and quality of marital relationship, are selected for study without reference to a unifying theory of how these variables may interact or to indicate why these variables are pertinent. Thus, these variables describe characteristics of the family that may be related to family functioning, but which do not cohesively describe family functioning. Alternatively, in other studies a theoretical framework of family functioning dictates the chosen variables and subsequent interpretation (Allison, Stacey, Dadds, Roeger, Wood, & Martin, 2003; Cunningham & Boyle, 2002; Dyson, 1991; Failla & Jones, 1991; Halpern, 2004; Judge, 1998; Kinsman, Wildman, & Smucker, 1999; Paterson & Sanson, 1999; Pirila, Van Der Meere, Seppänen, Ojala, Jaakkola, Korpela, & Nieminen, 2005; Reddon, McDonald, & Kysela, 1992; Schoppe, Frosch, & Magelsdorf, 2001; Trute & Hauch, 1988; Tschann, Kaiser, Chesney, Alkon, & Boyce, 1996; Weinger, 1999). This is primarily

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accomplished through the selection of an instrument based on one of the many theories of family functioning.

Indeed, many different theoretical frameworks are used throughout the literature. These have included the McMaster Approach to Families (Allison et al., 2003; Cunningham & Boyle, 2002; Kinsman et al., 1999; Weinger, 1999), the Process Model of Family Functioning (Trute & Hauch, 1988), the Circumplex Model of Marital and Family Systems (Paterson & Sanson, 1999), the T-Double ABCX Model of Family Adaptation (Reddon et al., 1992), the Social Climate framework (Dyson, 1991; Halpern, 2004; Tschann et al., 1996), the Family Functioning Style model (Pirila et al., 2005), and the Family Hardiness model (Failla & Jones, 1991; Judge, 1998). Each of the above models promotes a unique perspective on family functioning with an associated self-report measure which can be used in family research. Despite the large number of possible theoretical viewpoints and measures, these theories tend to capture the dynamic and interactional influence of the family on the child. The alternative, a demographic perspective, assumes that the family is a stable and unidirectional influence on the child. Thus, it is beneficial to study the family with reference to a family functioning framework since this perspective captures the dynamic and interactional nature of the family.

However, one limitation of most family functioning theories is the tendency towards bipolarity, with 'functioning well' at one end and 'dysfunctional' at the other end. In this perspective, 'functioning well' is, by necessity, defined as the absence of dysfunction in the family. For example, an absence of dysfunction in the area communication would be considered to indicate that the family is functioning well in this area. However, a lack of communication problems does not necessarily indicate that the family is communicating in an especially positive manner. Thus, the positive characteristics of families, referred to as family strengths, are often

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lost in the interpretation of results based on measures of family functioning. Though there has been a trend in the past few decades towards a more strengths-based approach to families in research, the important area of family strengths remains understudied (Dunst, Humphries, & Trivette, 2002; Helff & Glidden, 1998). Notably, the Family Functioning Style model provides a perspective that focuses only on the strengths of the family (Trivette, Dunst, Deal, Hamby, & Sexton, 1994). This model proposes that all families have unique combinations of strengths, which form the family functioning style (Trivette, Dunst, Deal, Hamer, & Propst, 1990). In this context, strengths are defined as the positive qualities of the family that are used to manage stressors and promote the well-being of both individual members and the family unit (Trivette et al., 1990). Though this model has been infrequently used in the past, increased use of this model may allow for a better and more complete understanding of families. Thus, this study will focus on understanding both family functioning as a whole and in particular the concept of family strengths.

These concepts of both family functioning and family strengths can be understood as influential factors throughout the transitions of a child's development. One critical period of transition that is influenced by family functioning is the entrance of a child into full-time schooling (Cowan & Cowan, 2003). In addition, this period is a significant part of the formative years of early childhood, in which the family's influence on the child's development is strong. Thus, it is imperative that family functioning and family strengths are understood in families with preschool-aged children, especially between the ages of 3 and 6 years old.

Family functioning and family strengths may be of particular importance when there are additional challenges faced by the family. An understanding of these family factors may be highly influential in providing optimal services for families who seek professional mental health

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services. Common challenges faced by families of children in this age group include serious behavioural problems (Campbell et al., 1991; Cunningham & Boyle, 2002; Donenberg & Baker, 1993; Halpern, 2004; Keown & Woodward, 2002; Paterson & Sanson, 1999; Schoppe et al., 2001; Tschann et al., 1996), developmental delays (Dyson, 1991; Failla & Jones, 1991; Judge, 1998; Weinger, 1999), and a combination of behavioural problems and developmental delays (Baker et al., 2002; Baker et al., 2003; Baker et al., 2005; Eisenhower et al., 2005; Merrell & Holland, 1997). Particular patterns in both functioning and strengths may be noted in each group. The purpose of this study is to compare the patterns of functioning and strengths in these different groups of families. Thus, in this Introduction, the theories of both family functioning and family strengths will be discussed to develop a more detailed understanding of the variables important to this study. This theoretical knowledge will then be placed in the context of the populations of interest, through discussion of the existing research on patterns of family functioning and family strengths in families of preschool aged children: (1) who do not have clinically significant behavioural problems or developmental delays; (2) with behavioural problems; (3) with developmental delays; and (4) with both behavioural problems and developmental delays.

Family Functioning

In order to study patterns of family functioning, it is imperative to select an appropriate theoretical perspective with an adequate associated measure of family functioning from the list mentioned above. Each theory of family functioning identifies different important processes or components of family structure and interactions which are thought to reflect the positive and dysfunctional characteristics of the unit. One of the most commonly used theoretical frameworks is the McMaster Approach to Families (Miller, Ryan, Keitner, Bishop, & Epstein,

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2000a), as is seen throughout the literature in the frequency of the citations of its associated self-report measure, the Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983). This model, based in systems theory, focuses on the interconnected and interactional nature of the family, with a strong focus on the structure and organizational influence of the family on its members (Epstein et al., 1983; Miller et al., 2000a). It identifies six dimensions of family functioning to guide family therapy practice: (1) problem solving; (2) communication; (3) roles, which are defined as patterns of behaviour through which daily tasks are accomplished; (4) affective responsiveness, including the quantity and quality of emotional responses; (5) affective involvement, that is the interest shown in other family members; and (6) behavioural control, which includes management of dangerous situations, meeting needs, and socialization (Epstein et al., 1983; Miller et al., 2000a). The McMaster model also makes note of "dysfunctional transactional patterns", which refer to impairment on any of the six dimensions (Miller et al., 2000a). Therefore, this model allows for the clear inspection of specific patterns of functioning in the family across the six dimensions, including both positive and dysfunctional characteristics, but with a heavier focus on dysfunctions. The McMaster model is a strong theory, but, due to its focus on structure, it does not fully capture the more dynamic interactional aspects of family functioning (Skinner, Steinhauer, & Sitarenios, 2000). In addition, while the FAD has been noted to be psychometrically sound (Epstein et al., 1983; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; Miller, Epstein, Bishop, & Keitner, 1985), some problems have been noted with the behavioural control subscale (Miller et al., 1985; Ridenour, Daley, & Reich, 1999), there has been debate over the uniqueness of the subscales (Miller, Ryan, Keitner, Bishop, & Epstein, 2000b; Ridenour et al., 1999; Ridenour, Daley, & Reich, 2000), and it has not been validated for use with the specific preschool populations that are the focus of this study. These concerns

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suggest that the McMaster model and the FAD, while popular, are not ideal for the purposes of this research.

An alternative model of family functioning that may be better suited to this study is the Process Model of Family Functioning (Skinner et al., 2000) which is closely related to the McMaster model (Skinner et al., 2000; Tutty, 1995). The Process model differs as it goes beyond listing the major factors that influence the family to discuss how these factors interact at three different levels, intrapsychic, interpersonal, and family systems, instead of just at the family systems level, and it also places the family in a larger social context through the inclusion of norms and values (Skinner et al., 2000). However, the seven dimensions considered by the Process model are very similar to those in the McMaster model, including: (1) task accomplishment, which involves identifying and addressing problems; (2) role performance, which involves the clear designation and acceptance of roles for each family member; (3) communication, including both the expression and reception of messages; (4) affective expression, which involves the content, intensity, and timing of emotional expression; (5) involvement, which is the degree and quality of relationships between members; (6) control, which involves the adaptability or flexibility of the family structure; and (7) values and norms, a unique subscale that determines if the family's values are consistent with the cultural context (Skinner et al., 2000). The Process model claims that task accomplishment is the primary goal of the family which can be obtained through role performance, communication, affective expression, involvement, and control in the context of the family's values and norms (Skinner et al., 2000). The Process model emphasizes both the positive and the dysfunctional characteristics of the family on bipolar continua for each dimension discussed above (Skinner et al., 2000). Thus, positive characteristics exist when the family is functioning well on a given dimension and

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dysfunctional characteristics exist when the family is functioning at the opposite, dysfunctional end of the dimension.

Positive characteristics and dysfunctions on each of the seven dimensions of family functioning are measured through the Family Assessment Measure (FAM-III; Skinner, Steinhauer, & Santa-Barbara, 1995). The FAM-III has been shown to demonstrate good reliability with an overall internal consistency rating of .93 for the general scale format (Skinner et al., 1995). The FAM-III has also demonstrated good validity through its ability to distinguish patterns of functioning for different populations and through correlations with other established measures of family functioning (Skinner et al., 1995). However, factor analysis has produced some concern that the FAM-III subscales actually measure only one underlying common factor, related to affective evaluations of family members (Gondoli & Jacob, 1993). The test creators have also acknowledged that the high correlations amongst the subscales suggests an underlying general functioning factor, but have maintained that the individual subscales provide some "reliable and unique variance", justifying the division (Skinner et al., 1995). In addition, the FAM-III manual provides data from a sample of families with developmentally delayed preschool-aged children (Skinner et al., 1995; Trute & Hauch, 1988), which demonstrates the applicability of the measure for use with this study's target population. Therefore, the Process model is a strong theoretical model which improves on the popular McMaster model and which has a theoretically and psychometrically strong associated self-report assessment measure, the FAM-III. In addition, the focus on patterns of positive and dysfunctional characteristics across a variety of dimensions provides an ideal perspective on family functioning.

Two other popular models of family functioning have also been considered in reviews of family functioning assessment measures but have been found to be lacking. It has been argued

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that the Social Climate model with its Family Environment Scale (FES) does not use relevant dimensions of family functioning and that there is limited evidence for the validity of the FES (Forman, Aronson, & Combs, 2003; Gondoli & Jacob, 1993; Halvorsen, 1991; Skinner, 1987; Tutty, 1995). The main complaint against the Circumplex Model of Marital and Family Systems with its Family Cohesiveness and Adaptability Evaluation Scales (FACES-III) has been a great debate between the proposed curvilinearity and the demonstrated linearity of the dimensions of family functioning (Forman et al., 2003; Gondoli & Jacob, 1993; Halvorsen, 1991; Skinner, 1987; Tutty, 1995). In contrast, these reviews tended to support the use of the FAM-III because of its ease of use, validity, grounding in a comprehensive model, and clearly defined dimensions (Forman et al., 2003; Halvorsen, 1991; Skinner, 1987; Tutty, 1995). Thus, when compared to other models of family functioning, the Process model and FAM-III clearly become the best choice for the study of family functioning patterns. However, in theories of family functioning, including the Process model, there tends to be a predominant focus on pathology and dysfunction. Positive characteristics and dysfunctions are typically conceptualized as opposites, with the positive characteristics being the absence of dysfunction on each dimension. Thus, positive aspects of family functioning, in the area of family strengths, are often overlooked or relegated a minor role when studying families.

Family Strengths

The positive qualities of families, referred to as family strengths, have been defined in a number of ways. The narrowest definition equates family strengths to a family form of resilience, such that strengths are conceptualized as resources for coping adequately with crises or adversity (Greef & LeRoux, 1999). This narrow definition is reflected in assessment measures and the interpretation of results in a high proportion of the family strengths literature.

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The Family Hardiness model and its measure the Family Hardiness Index (FHI) is a clear example of this focus on coping as each of the subscales measure a different aspect of the family's response to stressors (McCubbin, McCubbin, & Thompson, 1986). Although its theoretical basis is restricted to coping mechanisms, the FHI has been used to measure strengths in families (Failla & Jones, 1991; Judge, 1998). However, a broader conceptualization of family strengths is more appropriate to capture multiple aspects of family functioning. A good definition was provided by Trivette and colleagues (1990), identifying family strengths as:

> The competencies and capabilities of both various individual family members and the family unit that are used in response to crisis and stress, to meet needs, and to promote, enhance, and strengthen the functioning of the family system (p.18).

Thus, strengths are an integral part of family functioning, both in coping with the negative or problematic aspects of life and in optimizing well-being at all times, regardless of the presence of stressors.

There is a need for models that exclusively focus on family functioning from a strengths-based perspective, viewing strengths not as opposites of dysfunctions in the family system, but as positive characteristics of the family that are separate from dysfunctions, congruent with the broad definition provided above. There is converging evidence for this broad definition of family strengths, demonstrated by the high degree of similarity of models constructed across the decades (Giblin, 1996). These models go beyond defining family strengths in general, to list specific strength characteristics that may be possessed by families.

Otto (1962) conducted the first study on family strengths with the intent of moving away from a focus on "problem families" to learn about what constitutes a "strong family". This study was intended to clarify what strengths a family can have, so that they can be identified,

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developed, and utilized by the family. Through group discussions, married couples identified twelve specific strengths: (1) the ability to provide for physical, emotional, and spiritual needs of the family; (2) the ability to be sensitive to the needs of family members; (3) the ability to communicate effectively; (4) the ability to provide support, security, and encouragement; (5) the ability to initiate and maintain growth-producing relationships and experiences within and outside the family; (6) the capacity to maintain and create constructive and responsible community relationships; (7) the ability to grow with and through children; (8) the ability for self-help and to accept help when appropriate; (9) the ability to perform family roles flexibly; (10) mutual respect for the individuality of family members; (11) the ability to use a crisis or seemingly injurious experience as a means of growth; and (12) concern for family unity, loyalty, and interfamily cooperation (Otto, 1962). These strengths were not seen as separate and permanent entities, but rather as dynamic and interacting components of the overall family system (Otto, 1962/1963). Thus, patterns of strengths should reflect the present but changeable state of the family. Notably, this model includes all the critical definitional criteria of the response to stress or crisis, meeting various needs, and enhancement of the family for the broad definition of family strengths.

Another set of strengths has been identified though the research of Stinnett and colleagues (Schumm, 1985; Stinnett & DeFrain, 1985). Stinnett (1980) defined family strengths as:

> Those relationship patterns, interpersonal skills and competencies, and social and psychological characteristics which create a sense of positive family identity, promote satisfying and fulfilling interaction among family members, encourage the development of

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> the potential of the family group and individual family members, and contribute to the family's ability to deal effectively with stress and crises (p.2).

Again, the similarity to the broad definition of family strengths provided above is quite clear. This perspective on family strengths identified six key strengths: (1) the expression of appreciation; (2) commitment to the family; (3) positive communication; (4) enjoyable time spent together; (5) a high degree of religious orientation or spiritual well-being; and (6) the ability to manage stress and crises in a positive way (DeFrain, Cook, & Gonzalez-Kruger, 2005; Schumm, 1985; Stinnett & DeFrain, 1985). As in Otto's (1962/1963) model, these six factors are highly interrelated (Schumm, 1985). Thus, there is consistency between the models in the underlying definitional components and in the recognition of patterns between the strengths.

The characteristics identified by Otto and by Stinnett and colleagues were integrated to form the qualities of strong families that are the focus of the Family Functioning Style model (Dunst, Trivette, & Deal, 1988). This model lists twelve non-mutually exclusive qualities: (1) commitment to promoting the well-being and growth of members and the family; (2) appreciation for family members; (3) time spent together; (4) an underlying sense of purpose; (5) congruence amongst members towards meeting needs; (6) positive communication; (7) clear rules, values, and beliefs; (8) positive coping strategies to manage life events; (9) problem-solving abilities; (10) optimism, even in crises; (11) flexibility and adaptability in roles; and (12) balance between the use of internal and external family resources (Dunst et al., 1988; Trivette et al., 1990). These twelve strength qualities are combined uniquely by each family into a pattern, creating a family functioning style (Dunst et al., 1988; Trivette et al., 1990) with the unique combination being influenced by culture, beliefs, and socio-economic status (Trivette et al., 1994). These patterns are assessed using the Family Functioning Style Scales, a brief self-report

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measure (FFSS; Deal, Trivette, & Dunst, 1988; Trivette et al., 1990; Trivette et al., 1994). The FFSS has demonstrated adequate reliability and validity in families of preschool aged children with and without developmental disabilities or who were "at risk for poor outcomes" (Deal et al., 1988; Trivette et al., 1990; Trivette et al., 1994). Internal consistency ratings of the FFSS have been reported at a coefficient alpha of .92 (Deal et al., 1988; Trivette et al., 1990; Trivette et al., 1994). Factor analysis has produced five factors which demonstrate the multidimensional nature of family strengths: interactional patterns, family values, coping strategies, family commitment, and resource mobilization (Deal et al., 1988; Trivette et al., 1994). The validity of the FFSS has been established through significant correlations with the Family Hardiness Index and other measures of individual and family well-being (Deal et al., 1988; Trivette et al., 1990; Trivette et al., 1994). Thus, the Family Functioning Style model is strong model of patterns of family strengths that can be easily assessed using the FFSS.

It is important to note that defining the aforementioned qualities as strengths does not imply that they lie on continua with weakness or dysfunction at the opposite end (Dunst et al., 1988). In this critical way, the Family Functioning Style model is different from the models of family functioning discussed above, though the dimensions are somewhat similar. Thus, there are no right or wrong functioning styles, only ones that are more or less effective (Dunst et al., 1988). Indeed, all families can be said to have strengths (Dunst et al., 1988; Trivette et al., 1994). This perspective implies that the clinician is working to enhance the family and not to change or fix them through treatment. By recognizing and building on a family's strengths the clinician can help to make the family stronger and more capable of managing typical and atypical life events (Dunst et al., 1988; Trivette et al., 1994). The Family Functioning Style model integrates prior research to provide the clearest conceptualization of family strengths, as

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positive characteristic that form patterns of functioning in all families. Therefore, it is most relevant to the exploration and comparison of family patterns.

Family Functioning and Strengths in Families with Preschool Children

Patterns of family functioning and strengths may differentiate between specific groups of individuals. In order to explore these differences, it is important to have a reference group of "normal functioning". However, little research has compared this "normal" functioning across different stages of the family life cycle. Thus, it is nearly impossible to determine for certain what "normal" family functioning and strengths are in families of preschool aged children. The Process and McMaster theories of family functioning have proposed that there is a linear relationship such that healthy families tend to score in the average to highly functional ranges on dimensions of family functioning (Akister & Stevenson-Hinde, 1991; Miller et al., 1985; Skinner et al., 1995; Skinner et al., 2000). This relationship tends to be supported by the normative data on the associated self-report measures that combine age groups (Akister & Stevenson-Hinde, 1991; Miller et al., 1985; Skinner et al., 1995). The Family Functioning Style theory of strengths also follows this pattern, with healthy families of preschoolers proposed to score higher across all strengths dimensions (Trivette et al., 1994). Thus, there is a general trend proposed such that "normal" families should score in the average to high ranges of family functioning and family strengths.

The families of "normal" preschoolers are often used for comparison when patterns of functioning are explored in families of children with clinical problems. One study explored the families of children entering kindergarten who adjust well to this transition, as measured by good academic achievement and low rates of both internalizing and externalizing behavioural problems (Cowan & Cowan, 2003). The results of this study suggested that children adjusted

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better when an authoritative parenting style, characterized by a balance of warm responsiveness and limit setting, was used, when the quality of the parents' marital relationship was high, with low rates of negative interaction and fighting, when parents perceived fewer stressors, and when parental psychopathology was absent (Cowan & Cowan, 2003). Other studies focusing on children with behavioural problems have shown that families of preschoolers without such problems tend to experience less stress (Campbell et al., 1991; Donenberg & Baker, 1993) and have overall higher general functioning (Cunningham & Boyle, 2002). Overall, these families tend to be characterized by higher emotional expression and are more cohesive (Halpern, 2004). In addition, these "normal" families have mothers who are less controlling and negative (Campbell et al., 1991). These preschoolers tend to have parents who experience less negative and more positive feelings towards parenting (Donenberg & Baker, 1993) and feel more competent as parents (Cunningham & Boyle, 2002). These parents also tend to use higher levels of supportive coparenting and lower levels of undermining coparenting strategies (Schoppe et al., 2001). However, it is important to remember that these characteristics may not be the only dimensions in which families of "normal" preschoolers are functioning well; they are simply the dimensions that differentiate between families of children with and without behavioural problems. Therefore, the exact pattern of functioning and strengths in this "normal" group of families is uncertain, though it is theorized that average or high levels should be demonstrated across all dimensions.

Behaviour Problems in Preschool Children

Patterns of family functioning and family strengths are also important in families with a member experiencing clinical problems. The first population of interest in this study are the families of preschool aged children with behavioural problems. Though behaviour problems is

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of broadly inclusive term, it is externalizing behavioural problems that are of primary interest. The occurrence of psychopathology in preschool aged children is clearly manifested in the population of children referred to early childhood mental health clinics. One study exploring the clinical presentation of preschoolers, 95% of whom were aged 4 to 6 years, in a clinical setting reported that 93% of referred preschoolers met criteria for one or more major psychopathological condition, with 68% demonstrating comorbidity (Wilens, Biederman, Brown, Monuteaux, Prince, & Spencer, 2002). Attention deficit hyperactivity disorder (ADHD) was the most common diagnosis at 86%, followed by oppositional defiant disorder at 59% (Wilens et al., 2002). Conduct disorder was diagnosed in 21% of the sample. Other common diagnoses in this population included major depression (37%), separation anxiety disorder (34%), and bipolar disorder (23%; Wilens et al., 2002). Overall, the children were rated as having moderately severe functional impairment as well as mild to moderate social dysfunction (Wilens et al., 2002). Thus, the presence of psychopathology, and especially of behavioural disorders, is an important concern in preschool children. Indeed, the seriousness of behavioural problems in early childhood is clearly noted in the community prevalence rates that generally range from 10% to 15% of preschool-aged children (Campbell, 1995).

Nevertheless, there has been some concern about the validity of behavioural disorder diagnoses in preschool-aged children, with the suggestion that behavioural concerns such as temper tantrums and lack of attention are normative at this developmental stage (Campbell, 1995; Keenan & Wakschlag, 2002; Keenan & Wakschlag, 2004). However, there is evidence that behavioural problems in preschool children, aged 2.5 to 5.5 years, referred to clinics are significantly different from that of children in the community (Keenan & Wakschlag, 2004). In one study looking at symptom presentation, it was found that the rate of oppositional defiant

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disorder symptoms ranged from none to 8% in the community sample and from 31.6% to 72.2% in a matched clinic-referred sample, with only one child (out of 50) from the community and 47 (out of 79) from the clinical population meeting diagnostic criteria (Keenan & Wakschlag, 2004). In the same study, it was also found that eight out of twelve symptoms of conduct disorder significantly differentiated between the two groups, with rates of endorsement for these eight symptoms ranging from 20% to 44.9% in the clinical sample and from 2% to 4% in the community sample (Keenan & Wakschlag, 2004). In total, only one child from the community sample met diagnostic criteria for conduct disorder, compared to 33 in the clinical sample (Keenan & Wakschlag, 2004). Items that did not differentiate between the groups appear to have been highly developmentally inappropriate, for example, forced sexual activity or breaking and entering. Therefore, it is clear that diagnoses for disruptive behavioural disorders are valid in preschool aged children, discriminating between clinically referred and non-referred community populations (Keenan & Wakschlag, 2004). Similar results were found in another study comparing clinical and community samples of preschool-aged children, ranging from 3 to 6 years old (Gadow, Sprafkin, & Nolan, 2001). From parental ratings, the clinical sample was found to have higher rates of ADHD (44.2-53.3%), oppositional defiant disorder (37.3-38.5%), and conduct disorder (15.4-17.8%), compared to the community sample, which had rates of 3.9% to 8.1%, 5.8% to 7.0%, and 0.4% to 3.3% for each disorder respectively (Gadow et al., 2001). Symptom severity was also significantly greater for the clinical group (Gadow et al., 2001). These two studies clearly indicate that children presenting with behavioural problems in clinical settings are experiencing symptoms beyond what is developmentally expected.

These serious behavioural problems present in early childhood become even more concerning when the evidence, that disorders diagnosed in the preschool years often persist into

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later childhood (Keenan & Wakschlag, 2002; Kim-Cohen, Arseneault, Caspi, Tomás, Taylor, & Moffitt, 2005) and even into adolescence (Campbell, 1995), is considered. For example, in a comparison between five-year-old children with conduct disorder and non-disordered controls, the children with conduct disorder had significantly higher levels of ADHD symptoms, aggression, delinquency, and educational problems at age seven (Kim-Cohen et al., 2005). In fact, the conduct disordered children were 20.6 times more likely to have a conduct disorder at age seven than were the controls, especially if the conduct disorder was rated as moderate or severe at age five, and even those who "remitted" continued to experience behavioural and educational difficulties (Kim-Cohen et al., 2005). Thus, it is important to identify and treat behavioural problems at this early age to work towards minimizing future negative outcomes. It is also important to identify risk factors that may influence the development of these behaviour problems in preschoolers.

Behaviour Problems and Family Functioning

Family risk factors or predictors for the development of behavioural problems in preschool aged children have been identified which may be relevant for treatment of these problems. These family characteristics are generally considered to be indicators of family functioning. Overall, family functioning has been reported as low or towards the dysfunctional end of the spectrum when behavioural concerns are present (Cunningham & Boyle, 2002; Kinsman et al., 1999). In one clinical sample, mothers of 4-year-old children with oppositional defiant disorder and ADHD or oppositional defiant disorder alone rated their families as functioning poorer overall compared to the mothers of non-disordered children (Cunningham & Boyle, 2002). Poorer family functioning was also associated with greater levels of problem behaviours in children, aged 4 to 17, using services in a community mental health centre (Allison

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et al., 2003). These results were supported by the results of a community medical study of children, aged 2 to 16 years, which found that increasing behavioural concerns in the child were significantly related to increased distress in both the parents and the whole family (Kinsman et al., 1999). However, in another preschool community sample of children, aged 2 to 5 years, overall family functioning was not related to externalizing behaviours (Tschann et al., 1996). This inconsistency may be due to the limited range of severity of behavioural problems found in the community sample, as the behavioural problems reported were minimal (Tschann et al., 1996), so that the overall impact on family functioning was limited. In addition, the inconsistency could be related to the measure used, as the first three studies used the General Functioning subscale of the FAD and the latter used the FES, which has demonstrated poor psychometric properties (Loveland-Cherry, Youngblut, & Leidy, 1989; Waldron, Sabatelli, & Anderson, 1990). Thus, there appears to be an overall lower level of functioning in the families of preschool children with behavioural problems.

Specific aspects of family functioning that differ in the families of preschool children with behavioural problems have also been studied. Family demographic risk factors that have been identified include low SES (Campbell, 1995; Kim-Cohen et al., 2005; Stormont, 2001) family history of psychopathology, especially depression and antisocial behaviour (Campbell, 1995; Campbell et al., 1991; Cunningham & Boyle, 2002; Kim-Cohen et al., 2005), and single parent status (Tschann et al., 1996). These families have also been characterized by high levels of parent-child conflict (Campbell, 1995; Stormont, 2001), marital conflict (Campbell, 1995; Kim-Cohen et al., 2005; Stormont, 2001), or general family conflict (Halpern, 2004; Tschann et al., 1996), though the effects of this conflict may be moderated by the child's coping efforts (Halpern, 2004) and temperament (Tschann et al., 1996). In addition, high undermining

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coparenting, indicative of marital conflict, predicted more externalizing problem behaviours in preschool aged children (Schoppe et al., 2001).

Parenting factors may also be associated with behaviour problems. Generally, mothers of children with oppositional defiant disorder have been found to feel less competent (Cunningham & Boyle, 2002). In addition, high maternal control is typically found in studies of preschool children with behavioural problems (Campbell, 1995; Campbell et al., 1991; Stormont, 2001). However, one study found that mothers of children with oppositional defiant disorder used fewer controlling responses (Cunningham & Boyle, 2002). This discrepancy is further complicated by the results of another study which found that hyperactive preschool boys' parents used more of both lax and over-reactive parenting strategies (Keown & Woodward, 2002). Thus, it is possible that parents may inconsistently use control in managing their children with behavioural problems, which could reinforce the behaviours. Alternatively, it is possible that different child behaviours (e.g. hyperactivity, aggression, etc.) elicit different control responses from parents. Interestingly, a further study found that a punitive parenting style (interacting with inflexible temperament) and poorer 'fit' of the child to the family were related to presence of behavioural problems (Paterson & Sanson, 1999). Thus, it is not clear how parenting practices are related to the child's behavioural problems. It may be that it is not specific parenting practices or the level of control used that is a characteristic of families of children with behavioural problems, but instead the interaction of the practices used with different children in different situations that is the important element in family functioning.

The affective environment of the family is another important aspect of family functioning. General maternal negativity (Campbell et al., 1991; Kim-Cohen et al., 2005), less positive and more negative feelings toward parenting (Donenberg & Baker, 1993), lower familial

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emotional expressiveness (Halpern, 2004), and greater negative affect in the family (Allison et al., 2003; Schoppe et al., 2001) have all been related to the presence of externalizing behavioural problems in preschool children. However, one study found that children with more difficult temperaments were more aggressive when the family was highly expressive whereas children with easy temperaments showed lower aggressiveness in these family conditions (Tschann et al., 1996). It is possible that this interaction accounts for Halpern's (2004) report of lower familial emotional expressiveness, such that it is a reaction to the increased behavioural problems when expressiveness is high, highlighting an interactional approach to family functioning.

Inflexibility is another characteristic of these families, as a less adaptive family structure has predicted more externalizing behaviours in preschool children (Schoppe et al., 2001). Poorer coping abilities in general have also been reported by parents of hyperactive boys (Keown & Woodward, 2002) and difficulties in planning, decision making, and problem solving have been demonstrated (Allison et al., 2003; Cunningham & Boyle, 2002). The parents of hyperactive boys have also reported poorer parent-child communication and mother-child interactional synchrony, which is indicated by high levels of responsiveness, reciprocity, shared focus and shared affect (Keown & Woodward, 2002). Overall, low levels of family cohesion have been reported for preschool children with behavioural problems (Halpern, 2004). Thus, there appears to be a pattern emerging in the family functioning literature, which suggests poorer functioning in families of preschool children with behavioural problems that spans many dimensions of family functioning.

However, this picture of family functioning is complicated by interactions between family factors. In one study it was found that more supportive coparenting, indicative of a positive marital relationship, served as a buffer against children's externalizing problems in

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families with low levels of positive affect (Schoppe et al., 2001). However, where there were high levels of negative affect or low adaptability, undermining coparenting was a risk factor (Schoppe et al., 2001). Due to the interactions of some family variables that influence children's behavioural problems (Schoppe et al., 2001), it is important that multiple aspects of family functioning are considered together with respect to patterns of functioning rather than considering each component on its own. In addition, Paterson and Sanson's (1999) study of child and family characteristics highlighted the importance of using "narrower band" dimensions and considering interactions when considering the full picture of family functioning to gain an optimal amount of information. These are important considerations when selecting a model of family functioning to use as a framework for understanding families, going beyond measures of general functioning to include a variety of family dimensions as the Process model does. Furthermore, while identifying risk factors and areas of dysfunction in a family is important, other factors, particularly strengths, should also be considered. However, the literature is notably lacking in reports of positive family characteristics or strengths that could be cultivated to improve child outcomes in preschool aged children with behavioural problems.

Behaviour Problems and Family Strengths

Unfortunately, there has been very little research done exploring family strengths in families with a child experiencing behavioural problems. Only one study included strengths in the analysis which was an exploration of 416 Australian families of children aged 4 to 17 years seeking help in child and adolescent mental health services (Allison et al., 2003). The results of this study indicated that most parents viewed their family as functioning well, despite the indication that, as psychopathology scores increased, family and parent-child relationships were reported as poorer in quality (Allison et al., 2003). These families of children with clinically

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significant problems demonstrated a pattern of specific strengths, especially with regard to accepting family members, expressing feelings, and having hopefulness for the future (Allison et al., 2003). These are some of the strengths that will be assessed with the FFSS in this study to develop a more complete understanding of family strength patterns. It is clear that both strengths and dysfunction can coexist in the same family and are likely to be interrelated. It appears that there are patterns of family functioning and family strengths that reflect the challenges faced by families of children with behavioural problems. However, it is necessary to further investigate the strengths that exist in these families. In doing so, the constellation of specific strengths, shaped by the challenges characteristic of these families' experiences, should be uncovered. As behavioural problems are so concerning in preschool aged children, there is a great need for research aimed at discovering the strengths characteristics of their families for potential use to improve treatment outcomes.

Developmental Delays in Preschool Children

The second population of interest in the study of family functioning and strengths is children with developmental delays. Developmental delay is a vague term used frequently in the literature that can be used interchangeably with terms such as developmental disability (Failla & Jones, 1991), developmental handicap (Dyson, 1991), intellectual disability (Hastings et al., 2002), and mentally retarded (Weinger, 1999). Though clear definitions are seldom presented in the literature, a legal definition used in the United States indicates a severe and chronic disability present from childhood that is attributed to mental and/or physical impairment that limits the individual's ability to function (Association of University Centers on Disabilities, 2005). Diagnoses and problems that have been considered under the term of developmental disabilities for preschool aged children include mental retardation (Dyson, 1991; Weinger, 1999), physical

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or sensory impairments (Dyson, 1991; Judge, 1998), speech or language delays (Dyson, 1991; Judge, 1998), cerebral palsy (Judge, 1998), and learning disabilities (Dyson, 1991). Due to the severity and chronicity of developmental delays and the impact they may have on an individual's ability to function, it is logical that a family would be influenced by the presence of a young child with developmental disabilities.

Developmental Delays and Family Functioning

Unfortunately, very little research has been accumulated on family functioning in the families of preschool aged children with developmental delays. One study of the families of preschool children, aged 21 to 62 months, with developmental disabilities found that these families were functioning in the healthy range overall, as rated by both mothers and fathers on the FAM-III (Reddon et al., 1992). However, some mothers indicated problems related to role performance and affective expression and some fathers indicated problems in the areas of role performance and task accomplishment (Reddon et al., 1992). Similar results were found in another study comparing families of preschool aged children with and without developmental delays, such that the families did not differ on family functioning overall, despite higher reported family stress in the families where delays were present (Dyson, 1991). However, a distinct style of functioning emerged for families of children with delays such that they demonstrated higher achievement orientation, moral-religious emphasis, and control (Dyson, 1991). One further study also found that 95% of parents of preschool children with developmental delays rated their families as functioning without any weaknesses (Trute & Hauch, 1988). However, this study also found that affective expression, affective involvement, and consistency of family values and norms were strengths in these families (Trute & Hauch, 1988). Notably, there is a discrepancy as to whether or not affective expression is a strength or weakness of these families. Thus,

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further examination is necessary to confirm the specific pattern of family functioning that exists in families of young children with developmental delays. However, there appears to be a distinct pattern of family functioning in families of children with developmental delays that differs from that of families of children with behavioural problems.

Developmental Delays and Family Strengths

In addition to family functioning, family strengths have also been considered in the families of preschool children with developmental delays. One study compared boys aged 3 to 7 years with functional motor limitations and cognitive delays based on the severity of motor and cognitive problems and found that, overall, the presence of family strengths was consistent in these families, with only those experiencing the most severe functional motor limitations and cognitive delays showing lower levels of strengths (Pirila et al., 2005). Thus, the overall level of strengths is consistent across levels of severity when physical and cognitive disabilities are present. This is in accord with the family functioning findings discussed above. However, it is necessary to go beyond this overall view to explore specific patterns of strengths in the family.

Indeed, patterns of strengths have been related to developmental delays in a number of studies, particularly with regard to coping mechanisms (Failla & Jones, 1991; Hastings et al., 2002; Judge 1998). Family hardiness, a concept of functioning measured through coping abilities, has been found to be associated with high levels of coherence, functional support, and satisfaction with family functioning in the families of preschool aged children with developmental delays, especially for coping strategies related to positive appraisals of stressors (Failla & Jones, 1991). These results are supported by another study examining the positive impact of having a child with developmental delays which found that mothers of children with intellectual disabilities, aged 4 to 19 years old, who used reframing coping strategies, which

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involve positive reframing of events, perceived their children as a sources of happiness and fulfilment, family strength and closeness, and personal growth and maturity (Hastings et al., 2002). Some frequently used coping strategies in families of young children, from birth to 5 years, with developmental delays include concentrating on the next step, increased efforts to make things work, and creating positive meanings from the experience (Judge, 1998). The use of both formal and informal social supports is also critical to family functioning (Reddon et al., 1992). Therefore, there are many strengths related to coping mechanisms that are present in these families.

However, coping strategies have the potential to be both effective and ineffective. As Judge (1998) commented, not all coping strategies build strengths. In a study comparing family strengths and a variety of coping mechanisms used by families of preschool-aged children with developmental delays, a pattern was found. High family confidence strengths, including the ability to plan ahead, endure hardships, find meaningfulness in life, and appreciate individual members, were related to coping by seeking both informational and emotional support (Judge, 1998). High commitment strengths, including a sense of internal strength, a commitment to work together, and the ability to rely upon each other, were related to high use of social support and low levels of coping via controlling one's own feelings and actions, detaching from the situation, and acknowledgement of one's role in the problem (Judge, 1998). High challenge strengths, including efforts to be active, innovative, and to learn and experience new things, were related to coping by acquiring social support (Judge, 1998). Finally, high control strengths, including an internal locus of control, were related negatively to coping that involved self-blame and trying to escape or avoid the situation (Judge, 1998). Thus, methods of coping that involve seeking support and actively working towards solutions are considered to be strength-building.

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The high use of these effective coping strategies to manage stress produces a pattern of strengths in families of children with developmental delays. However, strategies for coping with stressors and crises are only one important set of family strength characteristics. Unfortunately, the patterns of other important strengths remain understudied. A comprehensive examination of family strengths patterns that adheres to a broader definition of strengths is necessary and can be accomplished using the Family Functioning Style model.

Developmental Delays and Behaviour Problems in Preschool Children

In addition to the two populations discussed above, a third population of preschoolers, those with both developmental delays and behavioural problems, will also be considered. Behavioural problems have been found to be associated with cognitive and language delays in preschool-aged children (Campbell, 1995; Plomin, Price, Eley, Dale, & Stevenson, 2002; Stormont, 2001). Other researchers have also found this link in early childhood by looking at the association between developmental delays and behavioural problems (Baker, et al., 2002; Baker et al., 2005; Baker et al., 2003; Eisenhower et al., 1997). Termed "dual diagnosis", behavioural problems in children with developmental delays, aged 3 to 5 years, are present at rates 3 to 4 times the overall presence of problems in typically developing peers (Baker et al., 2002; Baker et al., 2003; Eisenhower et al., 2005). The largest differences between the two groups were found for problems of social withdrawal and attention (Baker et al., 2002; Baker et al., 2003). Similar findings were reported by Merrell and Holland (1997), indicating that preschool-aged children, from 3 to 6 years old, with developmental delays demonstrated significantly lower levels of social skills and higher levels of behavioural problems than did their non-delayed peers. However, there appears to be differences in the presence of behavioural problems between specific syndromes that fall into the category of developmental delay, with higher rates being

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found for children with autism and cerebral palsy, rates equivalent to the non-delayed group for Down syndrome, and rates in between for children with developmental delays not specific to these other diagnoses (Eisenhower et al., 2005). Overall, there is strong evidence for the co-occurrence of behavioural problems and developmental delays, though the broadness of the concept of developmental delay may mask relationships more specific to particular diagnoses.

Developmental Delays, Behaviour Problems, Family Functioning, and Family Strengths

Family functioning has also been considered in the comparison of children with and without developmental delays in the context of behavioural problems. Interestingly, although families of 3-year-old children with developmental delays have reported a greater negative impact of the child on family functioning compared to families of non-delayed children, no differences were found in ratings of the child's positive impact on family functioning (Baker et al., 2002). However, this child related stress was more strongly associated with the presence of behavioural problems than with the developmental delay itself (Baker et al., 2002). In addition, when assessed one year later, any changes in the child's problem behaviour were related to increased stress or negative functioning, despite overall stability in behavioural problems and ratings of both positive and negative functioning (Baker et al., 2003). Ratings of negative impact also differed depending on the specific diagnosis of the developmentally delayed child, whereas positive ratings were equivalent for all subgroups (Eisenhower et al., 2005). Thus, there is an overall indication that, despite the significant stress associated with raising a child with a developmental delay, these families are able to maintain the same level of positive outlook on their family's functioning as do families who are not facing these stresses. This non-specific positive outlook may reflect significant underlying strengths in the family. In fact, one study found that parental optimism, which is an important strength characteristic, acted as a buffer

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between child behavioural problems and parental well-being, which influences the ability to cope with stress, for both delayed and non-delayed groups of children (Baker et al., 2005). Thus, a positive outlook or optimism appears to be a strength in families of preschool children with developmental delays that also moderates the effect of their behavioural problems on the well-being of the parents, which could be reflected in the overall family functioning. Other specific aspects of family functioning that have been reported in this dually diagnosed group of preschoolers include higher rates of parental depression and poorer marital adjustment (Baker et al., 2005). Thus, the current literature is clearly limited in understanding family functioning when both developmental delays and behavioural problems are present. Other aspects of family functioning, and especially family strengths, should also be compared in the families of these dually diagnosed children to seek detailed patterns in functioning within an appropriate theoretical framework, such as the Process and Family Functioning Style models.

Hypotheses

In each of the aforementioned populations, family functioning and family strengths were assessed for the purposes of this study within the context of the Process and Family Functioning Style models. Overall family functioning was predicted to be poorer in families of children with higher levels of behaviour problems and behaviour problems plus developmental delays compared to families of children with developmental delays and control families with minimal levels of behavioural concerns. In general, it was expected that higher levels of behavioural problems would coincide with poorer overall family functioning and fewer family strengths. However, the presence or absence of a developmental delay was not expected to significantly influence the overall level of family functioning or family strengths.

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In addition, it was expected that there would be group differences with distinct patterns of family functioning and strengths in each population. Due to the limited nature of previous existing research and the diversity of theoretical perspectives used, it was difficult to predict the exact patterns of functioning and strengths that should be expected. However, probable patterns of family functioning were predicted based on the integration of existing data. Thus, it was expected that families of children with behavioural problems would demonstrate dysfunctions in the areas of communication, task accomplishment, control, affective expression, and involvement. Families of children with developmental delays were expected to demonstrate a pattern of dysfunctions in role performance as well as positive characteristics in involvement, task accomplishment, values and norms, and control. Due to the lack of prior research, no specific pattern was predicted for the families of children with both behavioural problems and developmental delays. Furthermore, the patterns of strengths based in the Family Functioning Style model for each group were not predicted due to the lack of prior research. Thus, this study was intended to be exploratory and descriptive in nature so as to discern the patterns of family strengths in each population.

Methods

Participants

Families were initially recruited from several sources based on the presence of a child between the ages of 3 and 6 years. The primary caregiver from each family was invited to participate in this study. Though over 400 letters were sent out to families, only 38 completed research packages were returned. Of the 38 research packages returned, 4 were determined to be invalid based upon extremely elevated scores (T-score of 62 or higher) on one or both of the response style scales of the FAM-III. These scores indicated response styles that were excessive

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with regard to social desirability or defensiveness. Thus, only 34 families were included in the final analyses.

Families of children with clinical concerns related to behavioural problems and/or developmental delays were recruited from an early intervention program at a children's mental health centre and through a community organization providing support to children in local daycares. The families of eight boys and two girls, aged 3 to 6 years, were recruited from these sources. Additional families were recruited through junior and senior kindergarten classes at five elementary schools in the public school system. The families of 12 girls and 12 boys, aged 3 to 6 years, were recruited through the schools.

Measures

Behaviour problems. The Child Behavior Checklist for ages 1½ - 5 (CBCL; Achenbach & Rescorla, 2000) was used to assess the presence and severity of the children's behavioural problems. The CBCL/1½-5 is a 100 item parent-report measure of preschool aged children's behavioural and emotional problems. Parents are required to select whether each statement is 'not true', 'somewhat or sometimes true', or 'very true or often true' of their child. Items on the CBCL are summed into a variety of subscale scores. The Total Problems, Externalizing Problems, and Internalizing Problems scores were used in this study as indicators of behavioural problems. On each of these three scales, a T-score of 60 or higher represents the cut-off for the borderline and clinical ranges based on the normative data. The use of this cut-off has been recommended for the division of a sample population into a dichotomy of the presence versus absence of clinically significant concerns (Achenbach & Rescorla, 2000). The Total Problems, Externalizing Problems, and Internalizing Problems scales have demonstrated good reliability, with internal consistency coefficients of .95, .92, and .89 respectively and test-retest reliability

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reported at .90, .87, and .90 after eight days and at .76, .66, and .76 after one year. The validity of these three scales have been demonstrated through their ability to distinguish between clinically referred and non-referred samples of preschool-aged children, through correlations with interview-based diagnoses, and through the prediction of problem scores later in childhood at age nine.

Family functioning. The General Scale of the Family Assessment Measure (FAM-III; Skinner et al., 1995) was used to assess family functioning. The General Scale is a 50 item self-report measure. This form of the FAM-III is completed by one family member with reference to the functioning of the family as a unit. For each item the respondent must select whether they strongly agree, agree, disagree, or strongly disagree with a statement about their family. Responses are tallied to produce seven content scores, reflecting each of the seven dimensions of the Process model. Two response style scores, social desirability and defensiveness, are also included in the General Scale form. As per the guidelines for interpretation provided in the FAM-III manual, standardized scores of 40 or lower are considered to reflect positive characteristics and standardized scores of 60 or higher are considered to reflect weaknesses in the family (Skinner et al., 1995). The FAM-III has demonstrated excellent reliability, with an internal consistency coefficient of .93 on the General Scale. The validity of the FAM-III has been demonstrated through its ability to discriminate between different types of families and through substantial correlations with other established measures of family characteristics.

Family strengths. The Family Functioning Style Scales (FFSS; Deal et al., 1988; Trivette et al., 1994) was used to assess family strengths. The FFSS is a 26 item self-report measure, which requires the individual to select a response on a five point likert-style scale ranging from 'not at all like my family' to 'almost always like my family'. Each item is a statement reflecting

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one of the twelve potential strength characteristics of the family unit proposed by the Family Functioning Style model. Items that are endorsed as 'usually-' or 'almost always like my family' are considered to reflect a strength of the family (Deal et al., 1988; Trivette et al., 1994). The FFSS has demonstrated good reliability with the overall internal consistency coefficient reported at .92 (Deal et al., 1988; Trivette et al., 1994; Trivette et al., 1990) and split-half reliability reported at .92 (Trivette et al., 1990) and .85 (Deal et al., 1988; Trivette et al., 1994). The validity of the FFSS has also been established through significant correlation with the Family Hardiness Index and predictive ability for scores on measures of both individual and family well-being (Deal et al., 1988; Trivette et al., 1994; Trivette et al., 1990). Factor analysis of the FFSS has produced five significant factors: interactional patterns, family values, coping strategies, family commitment, and resource mobilization (Deal et al., 1988; Trivette et al., 1994). These factors may be used as subscales for the FFSS (C. Trivette, personal communication, May 29, 2006).

Procedure

Families recruited from the children's mental health centre and community daycare support service were selected for participation in the study by the respective agency staff through a review of the records of children who were currently receiving or had recently received services. Within these records, selection was based on a report of behavioural problems or developmental delay as a significant presenting concern for the child at the children's mental health centre. Statistical service provision records were used to identify prospective participants through the community daycare support service. Indication for selection related to developmental delays was considered based on evidence of a speech/language delay, developmental delay, or developmental disability in the child's records. The agency staff

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indicated the clinical concern which was their reason for selecting each child, following the provision of written consent by the caregiver.

The primary caregivers recruited through the children's mental health centre and community daycare support service were sent a letter describing the study and inviting them to participate through the agency staff. The primary caregivers recruited through the school board were sent a letter describing the study and inviting them to participate through their child's kindergarten teacher. All interested primary caregivers of eligible children received a package containing the three questionnaires, a consent form, and a brief description of the study. The primary caregivers were instructed to complete all of the questionnaires independently and to promptly return the completed questionnaires and consent forms. Participants were compensated with gift certificates to a fast food chain as well as by inclusion in a draw for larger gift certificates. All returned questionnaires were scored by hand by the primary researcher.

Results

Participants and Group Placement

Of the 34 families included in this study, 4 (11.8%) were referred to the study due to the presence of a preschool aged child with a clinically recognized developmental delay or developmental disability. The other 30 families (88.2%) did not report clinically significant developmental delays in the identified preschool aged child.

Clinically significant behavioural problems, as identified using the CBCL, were only reported for children in 3 of the 34 families and for only 1 out of the 6 children referred to the study by clinicians for behavioural concerns. For the purposes of analyzing patterns of family characteristics across groups, all participants were divided into either low, moderate, or high behavioural problems groups based upon their child's score on the CBCL. The low behavioural

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problems group consisted of 11 families (32.4%) with a CBCL Total Problems T-score of 40 or less. The moderate behavioural problems group consisted on 11 families (32.4%) with a CBCL Total Problems T-score at or between 40 and 50. The high behavioural problems group consisted of 12 families (35.3%) with a CBCL Total Problems T-score of 50 or more. It is important to note that the lack of clinical significance at these group cut-off points may heavily influence the meaningfulness of any differences found between the groups.

Furthermore, the combination of these two group placement variables created six cells with largely unequal group sizes. Of the four children with identified developmental delays, three fell into the high behaviour problems group and the remaining one scored in the low behaviour problems group. Of the children who were not identified as having a developmental delay, 10 scored in the low behaviour problems group, 11 in the moderate behaviour problems, and 9 in the high behaviour problems group. This was clearly not ideal with respect to conducting any statistical analyses and the validity of the results of those analyses.

Family Functioning and Family Strengths

The means, standard deviations, minimum and maximum scores from the total sample ($N = 34$) are reported for each subscale of the FAM-III and FFSS in Tables 1 and 2 respectively. In addition, the intercorrelations amongst the FAM-III overall and subscale scores are reported in Table 3, while the intercorrelations amongst the FFSS overall and subscale scores are reported in Table 4. Furthermore, correlations between the overall and subscale scores of the FAM-III and those of the FFSS are reported in Table 5. The magnitude and number of significant correlations between the two measures indicates a high degree of relatedness between the concept of family strengths and that of family functioning, which may have some theoretical implications for these concepts.

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Behaviour Problems

Three measures of the severity of behavioural problems were used in the statistical analyses for this study. The mean score on the CBCL Total Problems scale was 26.41 (SD = 18.34) across all participants. Mean scores on the CBCL Externalizing and Internalizing Problems scales were 9.59 (SD = 7.92) and 6.97 (SD = 4.56) respectively. Notably, these mean scores were all lower than the mean scores of the nonreferred (control) sample reported in the manual for this measure, which were 33.4 (SD = 18.8), 13.1 (SD = 7.8), and 8.7 (SD = 6.3) respectively (Achenbach & Rescorla, 2000). This underlines the impaired ability of data from this study to represent the appropriate clinical populations.

There was a high degree of correlation amongst scores on the three CBCL scales, with $r = .91$ ($p < .01$) between Total and Externalizing Problems, $r = .84$ ($p < .01$) between Total and Internalizing Problems, and $r = .64$ ($p < .01$) between Externalizing and Internalizing Problems. Each of these scales was used in many of the subsequent analyses. It is unsurprising that the results described below are quite similar for each of the three scales due to these high intercorrelations.

Overall Group Differences in Family Functioning and Family Strengths

The primary hypothesis of this study was to explore the group differences in specific patterns of family functioning and family strengths across the clinical groups. In order to determine the significance of group differences amongst the clinical groups of interest on the means of these family characteristic variables, three MANOVAs were run. In addition to the MANOVA's ability to detect differences in group means, this analysis was selected to minimize type I error and for it's robustness to unequal cell sizes. Due to the lack of any children presenting with the presence of a developmental delay and moderate levels of behaviour

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problems, the cells containing the moderate levels of behavioural problems were excluded from these analyses. Thus, the subsequently described MANOVAs compared four cells that reflect the four clinical groups of interest in this study, based upon the presence of developmental delays, high levels of behavioural problems, both, or neither.

To examine any patterns across the subscale areas of family functioning, a 2 (developmental delay vs. no delay) x 2 (high vs. low CBCL Total Problems score) MANOVA was performed. No significant effects were found for severity of behavioural problem, $F(7, 13) = .50, p = .82$, or for presence of developmental delay, $F(7, 13) = 2.05, p = .13$. No significant interactions were found, $F(7, 13) = .68, p = .69$. These findings are inconsistent with the hypothesis regarding distinct patterns of family functioning across the various groups.

To examine any patterns across the subscale areas of family strengths, another 2 (developmental delay vs. no delay) x 2 (high vs. low CBCL Total Problems score) MANOVA was performed. No significant effects were found for severity of behavioural problem, $F(5, 15) = 1.31, p = .31$, or for presence of developmental delay, $F(5, 15) = 1.56, p = .23$. No significant interactions were found, $F(5, 15) = 1.55, p = .23$. Thus, these findings are not supportive of the hypothesis for patterns of family strengths that differ based upon clinical group placement.

Another hypothesis of this study also predicted differences in overall levels of family functioning and strengths based upon the presence of clinical concerns of developmental delays, behaviour problems or both. In order to examine differences across the four groups described above, a 2 (developmental delay vs. no delay) x 2 (high vs. low CBCL Total Problems score) MANOVA was performed. No significant effects were found with regard to overall family functioning and total family strengths for severity of behavioural problems, $F(2, 18) = 1.81, p = .19$, or presence of developmental delay, $F(2, 18) = 2.20, p = .14$. No significant interactions

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were found, $F(2, 18) = .50, p = .61$. Clearly these findings did not support the hypotheses of this study.

However, the meaningfulness and validity of the results of each of the above MANOVAs are strongly questionable given the small sample size and severely unequal distribution of participants into each cell. Thus, several additional analyses were conducted to explore the data with respect to other hypotheses of this study. In order to explore trends in the data collected in this study that may exist, but which also may have been undetectable in the aforementioned analyses due to the limited nature of the sample, further analyses were conducted. In these additional analyses, each of the independent variables, behaviour problems and developmental delays, were examined separately. It was hoped that by examining each variable on its own, the increased power in each analysis might allow for trends supportive of the hypotheses of this study to become clearer, despite the limited sample size. However, it is recognized that in doing so, the chance of a type I error is substantially increased. This is particularly true with respect to the numerous ANOVAs listed below that assessed differences between families of children with and without developmental delays. Thus, it is imperative to recognize that the subsequent results described for this study must be interpreted with the utmost caution. In addition, it seemed appropriate to assess the relationship between behavioural problems and the various family functioning and strengths scales in a dimensional as opposed to categorical manner, so as to better explore the effects of severity, rather than simply presence, of behavioural problems.

Behaviour Problems and Family Functioning

A hypothesis of this study predicted that higher levels of behavioural problems would coincide with poorer overall family functioning. In support of this hypothesis, a linear regression found that CBCL Total Problems scores significantly predicted overall family functioning

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scores, $r^2 = .14$, $F(1, 32) = 5.26$, $p = .03$. In a separate linear regression, Internalizing Problems scores also significantly predicted overall family functioning, $r^2 = .11$, $F(1, 32) = 7.64$, $p = .01$. However, Externalizing Problems scores were not significant, but were approaching significance, as predictor of overall family functioning, $r^2 = .19$, $F(1, 32) = 3.75$, $p = .06$.

Furthermore, several significant positive correlations were found between the CBCL Total Problems, Externalizing Problems, and Internalizing Problems scores and the FAM-III Overall Rating and clinical subscale scores (see Table 6). In addition, there were correlations that approached significance found between scores on Total Problems and Control, $r = .31$, $p = .08$, on Externalizing Problems and overall family functioning scores, $r = .32$, $p = .06$, as well as on Internalizing Problems and Values and Norms, $r = .34$, $p = .05$. Thus, the results of this study appear to support the hypothesized relationship between behavioural problems and overall family functioning. It was additionally hypothesized that behavioural problems would be associated with a pattern of dysfunctions in the areas of communication, task accomplishment, control, affective expression, and involvement. As can be seen in Table 4, the results of this study are supportive of this hypothesis in some areas of functioning but not in others.

Behaviour Problems and Family Strengths

Another hypothesis of this study was that higher levels of behavioural problems would coincide with fewer family strengths. In support of this hypothesis, a linear regression found that CBCL Total Problems scores significantly predicted total family strengths, $r^2 = .24$, $F(1, 32) = 10.00$, $p < .01$. In separate linear regressions, Internalizing Problems scores also significantly predicted total family strengths, $r^2 = .17$, $F(1, 32) = 6.49$, $p = .02$, as did Externalizing Problems scores, $r^2 = .24$, $F(1, 32) = 10.02$, $p < .01$.

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Furthermore, several significant correlations were also found between the CBCL Total Problems, Externalizing Problems, and Internalizing Problems scores and the FFSS Total Strengths and subscale scores (see Table 7). In addition, there were correlations that were found to approach significance between Total Problems and Coping Strategies, $r = -.31, p = .07$, as well as between Externalizing Problems and Coping Strategies, $r = -.31, p = .08$. These results further support the hypothesis relating behavioural problems to overall fewer family strengths.

Developmental Delays and Family Functioning

Due to the small sample size of children identified with developmental delays ($n = 4$), several one-way ANOVAs were also performed to explore any effects of the presence versus absence of an identified developmental delay. A hypothesis of this study predicted that the presence or absence of a developmental delay would not significantly influence the overall level of family functioning. Indeed, the presence of a developmental delay was not significantly related to overall family functioning, $F(1, 32) = .25, p = .62$. Thus, the hypothesis with respect to overall functioning was supported.

With respect to a pattern of family functioning characteristics, another hypothesis predicted that the presence of a delay would be related to dysfunctions in role performance and positive characteristics in involvement, task accomplishment, values and norms, and control. There was a significant effect found for the presence of a developmental delay on the Task Accomplishment scale of the FAM-III, $F(1, 32) = 5.91, p = .02$. Families of children with delays scored significantly higher on this scale ($M = 7.00$, $SD = 1.63$, $n = 4$) than did families of children without an identified delay ($M = 4.77$, $SD = 1.74$, $n = 30$). However, the presence of a developmental delay was not significantly related to Role Performance, $F(1, 32) = .46, p = .50$, Communication, $F(1, 32) = .15, p = .71$, Affective Expression $F(1, 32) = .02, p = .90$,

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Involvement, $F(1, 32) = .10, p = .76$, Control, $F(1, 32) = .87, p = .36$, and Values and Norms, $F(1, 32) = .01, p = .94$. These results indicate that families of children with developmental delays tend to experience significantly more dysfunction in the area of task accomplishment, but not in any other functioning domains, when compared to families of children without developmental delays. Therefore, the pattern of family functioning characteristics suggested by these results is inconsistent with the hypotheses of this study.

Developmental Delays and Family Strengths

With respect to family strengths, it was hypothesized that the presence or absence of a developmental delay would not significantly influence the overall level of strengths. However, a significant effect was found for presence of a developmental delay with respect to Total Strengths scores, $F(1, 32) = 5.31, p = .03$. Families of children with identified delays scored significantly lower ($M = 88.50$, $SD = 21.56$, $n = 4$) than did families of children with no identified delays ($M = 105.37$, $SD = 12.68$, $n = 30$). Thus, this hypothesis was clearly not supported by the data in this study.

It was additionally hypothesized that differences in specific areas of strength would be found based upon the presence versus absence of a developmental delay. A significant effect was also found for presence of a developmental delay on the FFSS Interactional Patterns subscale, $F(1, 32) = 7.08, p = .01$. Families of children with identified delays scored significantly lower ($M = 38.50$, $SD = 9.00$, $n = 4$) than did families of children with no identified delays ($M = 48.17$, $SD = 6.56$, $n = 30$). A further significant effect was found for presence of a developmental delay on the FFSS Family Values subscale, $F(1, 32) = 6.75, p = .01$. Again, families of children with identified delays scored significantly lower ($M = 18.25$, $SD = 6.40$, $n = 4$) than did families of children with no identified delays ($M = 22.50$, $SD = 2.49$, $n = 30$). No

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significant effects were found for the presence of developmental delays on the subscales for Coping Strategies, $F(1, 32) = 1.18, p = .29$, Family Commitment, $F(1, 32) = 1.80, p = .19$, and Resource Mobilization, $F(1, 32) = .003, p = .96$. Thus, these findings do suggest support for the hypothesis of distinctive patterns of strengths. However, the validity of these results related to the presence of developmental delays should be carefully considered due to the extremely small sample size.

Discussion

This study was designed to solidify existing knowledge and to explore several gaps in the literature regarding family functioning and family strengths in several clinical preschool populations. Although it proved impossible to generate a sufficient clinical sample, the results of this study suggest that the hypotheses formulated from the existing literature are, at the very least, pointing in the right direction. One hypothesis of this study that was supported by the results was that overall levels of family functioning became poorer as behavioural problems increased. This was true for both overall severity of behavioural problems, as indicated by the CBCL Total Problems score, and internalizing behavioural problems. These findings are clearly consistent with prior research (Allison et al., 2003; Cunningham & Boyle, 2002; Kinsman et al., 1999), despite the limited range of behavioural problems reported in this study. The correlation and regression indicating this relationship for externalizing behavioural problems was found to approach significance. Interestingly, this lack of significant findings for externalizing behaviours has been found for other researchers using a community sample where the range of severity of behavioural problems was limited (Tschann et al., 1996). Thus, it is likely that with a larger sample size, especially one with a greater range of behavioural severity, the relationship with overall family functioning would also hold true for externalizing problems.

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In addition, it was hypothesized that higher levels of behavioural problems would be associated with fewer family strengths. This hypothesis was also supported by the significant negative correlations between total family strengths and overall severity of behavioural problems, as well as both externalizing and internalizing problem types. This is consistent with Allison and colleagues (2003) strength-based interpretation of results based on a family functioning measure with a larger sample of children and adolescents. Thus, this finding is particularly important as it provides new information specific to the overall strengths of families of preschoolers with behavioural problems, within the context of a strength-based theoretical perspective.

Another set of hypotheses addressed the relationship between the presence versus absence of developmental delays and overall levels of family functioning and family strengths. The results of this study suggest that the presence of developmental delays in a child is not related to the overall level of family functioning. This is consistent with the findings of other studies (Dyson, 1991; Reddon et al., 1992), despite the extremely small sample size in this study. However, the results of this study also suggest that overall family strengths are significantly fewer in families with a child with a developmental delay. This finding is somewhat surprising as overall strengths have been shown to be consistently high across families of children with a range of cognitive abilities, with the exception of fewer strengths only when a combination of the most severe physical and cognitive delays are present (Pirila et al., 2005). However, it is possible that all of the children with developmental delays involved in this study were at this severe end of the delay spectrum. As it was not practical to assess severity of delay in this study, there is no way to be certain. In addition, it is possible that comorbid behavioural concerns may have been a significant factor influencing the level of family strengths, as three of the four

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children noted to have delays also fell into the high behavioural problems group. Previous research has certainly suggested that behavioural problems are more important than presence of a developmental delay in determining family characteristics (Baker et al., 2002). A final factor that may have influenced these results is the specific diagnosis (e.g. Down Syndrome) of children in the developmentally delayed group, as diagnosis has been found to be related to the perceived negative impact of the child on the family (Eisenhower et al., 2005). In addition, it should be noted again that all conclusions drawn from the data comparing families of children with and without developmental delays should be taken with a grain of salt, due to the small number of children with developmental delays included in this study.

The multivariate analyses that were performed to specifically identify patterns of characteristics amongst families of children with differing clinical concerns found no significant differences with respect to patterns across the various dimensions of family functioning and strengths. This finding is somewhat surprising as the bulk of the literature discussed above indicates that there are certainly differences amongst families of children with behavioural problems or developmental delays when compared to families of children without clinically significant concerns, even if the specific patterns are unclear. However, perhaps these non-significant results are not so surprising when one considers the nature of the current sample. The small sample size, uneven group distribution, artificiality of cut-offs used to create levels of severity for behavioural problems, and exceedingly small number of children meeting clinical criteria in all groups are all factors that indicate that findings based upon the groups created within this study should be heavily questioned. It is possible that with a larger overall sample, and particularly with a larger number of children meeting clinical criteria for behavioural problems and/or developmental delays, distinctive patterns may have been found.

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In fact, some of the results from this study do suggest that there are variations in family functioning and family strengths that can be related to severity of behavioural problems. The correlational analyses in this study found that increasing all types of behavioural problems were significantly related to poorer family functioning in the domains of communication and involvement, with an additional trend towards poorer functioning for total behaviour problems in the control domain. All of these findings are consistent with the hypotheses of this study and the prior literature (Halpern, 2004; Keown & Woodward, 2002; Schoppe et al., 2001; Tschann et al., 1996). However, based on the existing literature, poorer family functioning was also hypothesized to be related to behavioural problems for the domains of task accomplishment (Allison et al., 2003; Cunningham & Boyle, 2002) and affective expression (Allison et al., 2003; Halpern, 2004; Schoppe et al., 2001). However, neither of these domains were found to be related to severity of behavioural problems in this study. Perhaps this is due to the limited range of severity of behavioural problems in this study. It is possible that functioning in these domains is more resilient compared to the domains where significant effects were found, such that impairments of functioning would only appear if children with more extreme behavioural problems were included in the sample. Another possible explanation of these results, involves self-selection of participants for this study. Perhaps those families who are naturally more able to effectively identify and resolve tasks and problems (task accomplishment) and who are more positive in affective tone (affective expression) were more likely to be able and willing to organize themselves to volunteer to participate in this study.

In the exploration of the relationships between various dimensions of family strengths and severity of behavioural problems, it was found that families of children with higher levels of behavioural problems had fewer strengths in the areas of interactional patterns, family values,

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and family commitment. That these families would have lower levels of strengths in these areas is logical based upon the overall tendency to have fewer strengths. However, the strength domain of coping strategies was only found to be approaching significance, which could be related to the small sample size or the range of severity of behavioural strategies. In addition, it could be that families who participated in the study are unrepresentative of the general population, as those with poorer coping strategies may have felt unable to participate in a study, which would have been one more unnecessary demand on their time and energy. Indeed, this was a theme of several conversations with clinicians regarding participant selection and recruitment for this study.

The analyses that addressed the relationship between the presence of developmental delays and the various domains of family functioning and strengths did not produce results that supported the hypotheses of this study. However, this is most likely attributed to the very small number of children with developmental delays included in this study as well as the high rate of co-occurrence of high levels of behavioural problems within this group. Due to these significant problems, it would be unwise to draw any firm conclusions regarding patterns of family characteristics in this population from the results of this study.

With respect to the underlying theory that guided this study, it is interesting to note the significance of the correlations between the various scales on the measures of family functioning and family strengths. As both measures attempt to address a variety of family characteristics, it is unsurprising that there is some level of correlation amongst the scales. In addition, each of the significant correlations is negative, indicating that more dysfunctional family characteristics tend to coincide with fewer family strengths. Theoretically speaking, these negative correlations support the perspective of the family functioning theorists, indicating that, at least to some

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degree, the presence of strengths is related to absence of dysfunction. However, these correlations do not contraindicate the perspective of the strengths theorists, such that strengths may be related to but not opposite to dysfunctional characteristics. At a practical level, these correlations may support the strengths movement. If strengths are clearly related to dysfunctional characteristics, then by working with and building upon a family's strengths, clinicians may be able to minimize dysfunctional family characteristics while maintaining a positive focus in their work. Such a positive focus is intuitively more appealing, and could improve family interest and participation when receiving mental health services for their children.

Clinical Implications

The relationships found between family characteristics and children's clinical presentation found in this study clearly demonstrate the importance of involving the whole family unit, and not just treating the individual child, when working with preschoolers with behavioural problems and developmental delays. Specifically, the results of this study suggest that clinicians should pay particular attention to the domains of communication and involvement when working with the families of preschoolers with behavioural problems. Difficulties in these areas may indicate that explicit communication is limited or unclear, producing a limited understanding of other family members, and also that members may have limited or excessive involvement and interest in each other's lives (Skinner et al., 1995). The domain of control was also found to be a potentially problematic for these families, which could indicate difficulties with routines, power struggles, and extreme rigidity or chaos in the family environment (Skinner et al., 1995). In addition, difficulties in the domain of task accomplishment appear to be especially relevant to families of children with developmental delays, which may indicate

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difficulties in identifying and solving problems (Skinner et al., 1995). Thus, the clinician should be alert to difficulties in these areas, which may be significantly influencing the child's clinical presentation. Though the findings regarding the presence of these family characteristics may not be surprising to the experienced clinician, they serve as a reminder that problems in these particular areas may need to be addressed in order to facilitate the best outcome for the child.

It is also important for clinicians to note that although the families of children with both behavioural problems and developmental delays were shown to have fewer strengths, this does not mean that these families do not have any strengths. As mentioned above, the clear relationship between strengths and dysfunctional characteristics supports the use of a strength-based approach to clinical work. The Family Functioning Style Scale is a short measure which could be used routinely by clinicians to identify a given family's strengths. These strengths could then be used in the formulation of goals for the family and the child. Bringing the focus of this formulation back to the positive capabilities of a family may result in increased cooperation and commitment by parents with respect to clinical services provided for their children. The strengths of a family are clearly relevant to the clinical concerns of children and thus have a place in clinical interventions.

Limitations

The initial goal of this study was to identify the patterns of family functioning and family strengths that are unique to the families of preschoolers with different common clinical concerns. Unfortunately, several difficulties were encountered in the process of recruiting participants for this study with the consequences of a severely limited clinical sample size and largely uneven group distributions. First of all, it would seem that original estimates for the desired number of participants per cell (30) were overly optimistic based upon the size of the targeted local clinical

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population. Secondly, the procedure of indirectly mailing out the initial letters and surveys to families is typically know for producing a less than ideal response rate. Although efforts were made to include clinicians who had a working relationship directly with the potential clinical group participants in the recruitment process, the response rate remained quite low. In addition, it would seem likely that the benefits for participation in this study were either not clear or not strong enough to motivate potential participants.

The low response rate for participation in this study and the study design also indicate another potential limitation. That is, regardless of the number of participants, those that did choose to participate may not be representative of the larger population of parents of preschoolers both with and without clinical concerns. It is highly plausible that the both the specific characteristics of a family and their overall level of functioning could influence a parent's decision to take the time to complete the questionnaires for this study. If a family is highly stressed and not functioning as well to begin with, it would seem less likely that they would bother to initiate contact with the researcher in order to participate in the study. This would seem especially plausible with regard to families of preschool aged children who are already managing a child's clinically significant concerns. Thus, both the size and quality of the sample recruited for this study have contributed to the extremely limited validity of any consequences drawn from the results discussed above.

Another potential limitation of this study is the use of the Family Functioning Style Scale. This scale is unpublished and only infrequently used, although the theory behind it and the existing reliability and validity data are supportive (Deal et al., 1988; Trivette et al., 1994; Trivette et al., 1990). It would be ideal to have evidence of support for this measure from outside the original research group that developed it. Notably, the correlations found in this

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study between this measure and the Family Assessment Measure (FAM-III) do support its use. An additional concern with the use of this measure is the nature of the subscales used in the analysis. It is highly desirable to have subscales in such a measure to allow for the exploration of different specific strength characteristics without resorting to an item level analysis. However, as the factors used as strength subscales in this study have not been formalized as such, their validity remains questionable.

Future Directions

Due to the aforementioned significant limitations of this study, the initial research question regarding the presence and nature of distinct patterns of family functioning and family strength characteristics remains open and should be addressed in future studies. However, researchers attempting to address this question should be careful of the difficulties encountered in the course of this study. Of critical importance will be finding a large enough clinical sample with the target diagnoses. It may be prudent to conduct a study of this nature in a large urban setting or across a much wider geographic area so that more participants may be included. In addition, providing a larger incentive or including the questionnaires as part of ongoing clinical intervention, including individual feedback of results, should be carefully considered in order to increase interest for participation.

Furthermore, this study was unable to adequately explore the family characteristics associated with the dually diagnosed population of preschool aged children with both clinically significant behavioural problems and developmental delays. Thus, future research should address this notable gap in the literature. Future comparisons of family characteristics should also address differences between families of children with specific clinical diagnoses and of children at various ages and stages of development.

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Another direction for future research could involve an in depth study of the relationship between family functioning characteristics and family strengths to further explore the theoretical relationship between strengths and weaknesses. That is, are strengths merely one end of a bipolar continuum with dysfunction, or is there support for an underlying conceptual uniqueness? An item level analysis, with a large sample, size, could be performed to test this relationship. The development of a better theoretical understanding of the relationships between family functioning characteristics and family strengths could only improve the applicability and use of these theories in clinical practice.

Despite its many limitations, this study has suggested that patterns of family functioning and family strengths do exist that may differentiate between clinical populations of preschoolers with developmental delays and behavioural problems. Further in depth study of the questions posed in this study is warranted to provide clarification of the existing literature. Moreover, use of the Family Functioning Style model of family strengths in both research and clinical practice should be promoted as this model has been shown to provide valuable information about families within the context of a positive strength-based approach.

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Table 1

Mean FAM-III Scores for Total Sample (N = 34)

Subscale	Mean	*SD*	Minimum Score	Maximum Score
Overall Functioning	42.29	7.20	36	70
Task Accomplishment	5.03	1.85	2	10
Role Performance	6.21	2.48	2	13
Communication	4.82	1.78	1	10
Affective Expression	4.88	1.86	1	11
Involvement	3.44	2.11	1	10
Control	4.56	1.85	0	10
Values and Norms	4.06	1.67	0	8

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Table 2

Mean FFSS Scores for Total Sample (N = 34)

Subscale	Mean	*SD*	Minimum Score	Maximum Score
Total Strengths	103.38	14.63	58	124
Interactional Patterns	47.03	7.43	25	58
Family Values	22.00	3.33	11	25
Coping Strategies	13.82	2.60	7	18
Family Commitment	13.24	1.99	6	15
Resource Mobilization	7.29	1.68	3	10

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Table 3

Intercorrelations Between FAM-III Overall and Subscale Scores

	1	2	3	4	5	6	7	8
1. Overall Score	-	.75**	.78**	.89**	.81**	.81**	.76**	.78**
2. Task Accomplishment		-	.56**	.55**	.76**	.53**	.35*	.50**
3. Role Performance			-	.59**	.62**	.52**	.44**	.55**
4. Communication				-	.62**	.77**	.80**	.66**
5. Affective Expression					-	.52**	.45**	.54**
6. Involvement						-	.65**	.56**
7. Control							-	.66**
8. Values and Norms								-

* $p < .05$, ** $p < .01$

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Table 4

Intercorrelations Between FFSS Overall and Subscale Scores

	1	2	3	4	5	6
1. Total Strengths	-	.97**	.89**	.82**	.84**	.39*
2. Interactional Patterns		-	.82**	.72**	.81**	.36*
3. Family Values			-	.69**	.76**	.20
4. Coping Strategies				-	.65**	.24
5. Family Commitment					-	-.003
6. Resource Mobilization						-

* $p < .05$, ** $p < .01$

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Table 5

Correlation Between FFSS and FAM subscales

	Total Strengths	Interactional Patterns	Family Values	Coping Strategies	Family Commitment	Resource Mobilization
Overall Functioning	-.705**	-.674**	-.639**	-.609**	-.586**	-.253
Task Accomplishment	-.672**	-.670**	-.644**	-.490**	-.447**	-.325
Role Performance	-.636**	-.651**	-.451**	-.515**	-.489**	-.393*
Communication	-.513**	-.453**	-.515**	-.510**	-.433*	-.144
Affective Expression	-.595**	-.567**	-.559**	-.470**	-.469**	-.280
Involvement	-.621**	-.572**	-.635**	-.550**	-.620**	-.029
Control	-.353*	-.335	-.281	-.345*	-.335	-.104
Values and Norms	-.522**	-.501**	-.409*	-.556**	-.507**	-.060

* $p < .05$, ** $p < .01$

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Table 6

Correlations Between Scores on CBCL/1½-5 and FAM-III Subscales

	Total Problems	Externalizing Problems	Internalizing Problems
Overall Functioning	.38*	.32	.44**
Task Accomplishment	.26	.18	.21
Role Performance	.23	.26	.25
Communication	.40*	.34*	.47**
Affective Expression	.11	.16	.22
Involvement	.51**	.37*	.55**
Control	.31	.19	.37*
Values and Norms	.28	.23	.34

* $p < .05$, ** $p < .01$

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Table 7

Correlation Between Scores on CBCL/1½-5 and FFSS Subscales

	Total Problems	Externalizing Problems	Internalizing Problems
Total Strengths	-.49**	-.49**	-.41*
Interactional Patterns	-.52**	-.50**	-.45**
Family Values	-.49**	-.46**	-.38*
Coping Strategies	-.31	-.31	-.22
Family Commitment	-.50**	-.47**	-.48**
Resource Mobilization	.07	-.09	.07

* $p < .05$, ** $p < .01$

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Appendix A. Introductory letter to the Children's Centre Thunder Bay

Assessing Patterns of Family Functioning and Family Strengths in the Families of Preschoolers with Developmental Delays, Behaviour Problems, and Both

To the Executive Director;
283 Lisgar Street
Thunder Bay, ON
P7B 6G6

A study has been developed that aims to explore and compare the patterns of family functioning and family strengths in the families of preschool aged children with behavioural problems and/or developmental delays. Research has suggested that different patterns of both positive or strength and dysfunctional family characteristics can be found in different populations of preschoolers. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Through the development of a comprehensive understanding of these patterns it becomes possible to provide optimal services for the families of preschool aged children who seek professional assistance in managing the challenges related to their child's diagnosis. Knowledge of a family's strengths, in particular, provides valuable information to help the family cope with stressors and to further promote well-being. Thus, the purpose of this study is to:

(1) develop an understanding of the patterns of both strengths and weakness in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to determine distinctiveness between families of preschoolers with and without behavioural problems, developmental delays, or both.

To accomplish these goals, we will require the primary caregivers (i.e. parents/guardians) of preschoolers with and without behavioural problems, developmental delays, or both to complete three questionnaires. The three questionnaires will cover the child's behavioural problems, family functioning, and family strengths respectively. It will take the caregiver a maximum of about one hour to complete the questionnaires. With regard to the clients of the Children's Centre, we would be looking for primary caregivers of preschoolers, aged 4 to 5 years, involved in the Early Intervention Program, whose clinical records reflect behavioural problems and/or developmental delays.

Furthermore, for classification purposes, behavioural problems will be considered present if the child's clinical records or other file reports indicate that behavioural problems are a predominant concern. Developmental delays will be considered present if the child's clinical records reflect either a speech/language delay, a developmental delay, or a developmental disability. In order to protect the confidentiality of the Children's Centre's clients, it is proposed that an agency staff reviews the records of the eligible children in the Early Intervention Program to identify potential participants for this study. Following this review, the agency staff would send out letters (see attached) explaining the study to the primary caregivers of the children meeting review criteria, inviting them to participate in the study. Interested participants would then contact the primary researcher to express their interest in participating in the study and to provide their contact information for distribution of the research packages. After obtaining this information, the

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primary researcher will send out a cover letter describing the study, the three questionnaires, and an informed consent form. Included in this package will be a self-addressed, stamped envelope which the primary caregivers can use to return their completed questionnaires and consent form to the primary researcher at Lakehead University. After receiving the participants' signed consent forms and completed questionnaires, the primary researcher will contact the agency staff and ask the agency staff to provide a list containing the names of the children of consenting participants and a notation indicating the presence of behaviour problems, developmental delays, or both for each child. This list will be used to determine appropriate group placement for the participants in this study. No further information will be disclosed to the researchers by the agency staff so as to protect the clients' privacy.

There is no anticipated risk for harm to the primary caregiver or their preschoolers through participation in this study as it is expected that the caregivers involved have already become familiar with their child's psychological conditions. Participants may become aware of a variety of characteristics, especially strengths, possessed by their family which were previously unrecognized. These characteristics may subsequently be used to foster well-being in the participants' families.

The responses to the questionnaires provided by the primary caregivers will be kept confidential. The information will be held in a secure place at Lakehead University for a period of seven years. Participation is completely voluntary. If a participant wishes to withdraw at any time during the study, he or she is free to do so without consequence.

Upon completion of this research, participants, including the Children's Centre, are entitled to receive a summary of the results. If you wish to access these results, or have any questions about this study, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix B. Consent form for the Children's Centre Thunder Bay

An authorized signature on this form indicates that the Children's Centre agrees to its participation in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths, and it also indicates that we agree to the following:

1. An agency staff will conduct a review of the clinical records of the children currently receiving services from the Early Intervention Program to identify potential participants for this study based on indications of behavioural problems and/or developmental delays.
2. An agency staff will send out letters explaining the study to the caregivers of children identified in the records review.
3. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
4. Following written consent from caregivers, the agency staff will give the researchers a list indicating the presence of behavioural problems and/or developmental delays for each child based on the records review.
5. All participants are volunteers and can withdraw at any time from the study without consequence.
6. There is no anticipated risk of physical or psychological harm to the staff, caregivers, or children involved in the study.
7. The information collected from caregivers will be kept confidential and not be shared with anyone.
8. If we wish, we will receive a summary of the results of the study following the completion of the study.
9. The data will be held in a secure place a Lakehead University for a period of seven years.

We have received explanations about the nature of the study, its purpose, and its procedures.

____

Authorized Signature Date

____

Signature of Researcher Date

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Appendix C. Consent form for staff at the Children's Centre Thunder Bay

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths, and it also indicates that I understand the following:

1. I will conduct a review of the clinical records of the children currently receiving services from the Early Intervention Program to identify potential participants for this study based on indications of behavioural problems and/or developmental delays.
2. I will send out letters explaining the study to the caregivers of children identified in the records review.
3. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
4. Following written consent from caregivers, I will give the researchers a list indicating the presence of behavioural problems and/or developmental delays for each child based on the records review.
5. All participants are volunteers and can withdraw at any time from the study without consequence.
6. There is no anticipated risk of physical or psychological harm to myself, caregivers, or children involved in the study.
7. The information collected from caregivers will be kept confidential and not be shared with anyone.
8. If I wish, I will receive a summary of the results of the study following the completion of the study.
9. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

____

Signature of Children's Centre Staff Date

____

Signature of Researcher Date

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Appendix D. Introductory letters for primary caregivers (Children's Centre Thunder Bay)

Dear Parent or Guardian:

The Children's Centre is involved in a research project being done at Lakehead University on the strengths and other characteristics of families with preschool aged children. Staff members at the Children's Centre have reviewed the clinical records of all 3- to 6-year-old children who received services from the Early Intervention Program in the past year to identify potential participants for this study. Your family has been chosen as a potential participant for this study based on your child's records, indicating that your child is receiving services for behavioural problems and/or developmental delays.

Caregivers (i.e. parents or guardians) who choose to participate in this study will be asked to complete three questionnaires, two about their family and one about their child. The information from these questionnaires will be sorted to compare the answers of families of children with and without behavioural problems, developmental delays, or both. If you choose to participate, your answers will be placed in the group that best describes your child, based on the review of your child's records by the Children's Centre staff that is explained above. The information learned from this study will be used to better understand the differences in strengths and other characteristics between families facing different challenges in raising their preschoolers.

Please read the attached letter from the researchers, which explains the study in more detail and provides the contact information for the researchers for you to use if you are interested in participating in the study or have any questions about the study. Also, please note that your decision of whether or not to participate in this study will have no impact on the services provided for you at the Children's Centre.

Sincerely,

____

Dr. Edward Rawana, Ph.D., C. Psych.

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Dear Parent or Guardian:

We are interested in the characteristics of your family and other families of preschool aged children.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding these family patterns will help to make it possible to provide the best possible services for families who seek professional help for their children. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

The information you provide will be used in a comparison of groups of families with preschool aged children with behavioural problems, developmental delays, both behavioural problems and developmental delays, or neither behavioural problems nor developmental delays. Your child's clinical records from the Children's Centre will be used to decide which group best describes your child. An agency staff at the Children's Centre has reviewed the records of all 3- to 6-year-old children in the Early Intervention Program to identify potential participants for this study and to decide which group placement would best describe your child. The researchers will not be looking at any clinical records on your child. Only if you decide to participate in this study will any information be given to the researchers. In order to protect your privacy, the only information about your child that would be given to the researchers, should you choose to participate, is a note saying whether behaviour problems, developmental delays, or both is the best group placement for your child in this study.

If you decide to participate in this study, you will receive a cover letter describing the study, the three questionnaires, and an informed consent form. Included in this package will be a self-addressed, stamped envelope which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

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The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of seven years. Your participation is completely voluntary. Your decision of whether or not to participate will have no impact on the services provided for you at the Children's Centre. If you wish to withdraw at any time during the study, you are free to do so without consequence.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you are interested in participating in this study or have any questions about the study, please contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

____

Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix E. Cover letter for primary caregivers (Children's Centre Thunder Bay)

Dear Parent or Guardian:

We are interested in the characteristics of your family and other families of preschool aged children.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding these family patterns will help to make it possible to provide the best possible services for families who seek professional help for their children. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with and without behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

The information you provide will be used in a comparison of groups of families with preschool aged children with behavioural problems, developmental delays, both behavioural problems and developmental delays, or neither behavioural problems nor developmental delays. Your child's clinical records from the Children's Centre will be used to decide which group best describes your child. An agency staff at the Children's Centre has reviewed the records of all 3- to 6-year-old children in the Early Intervention Program to identify potential participants for this study and to decide which group placement would best describe your child. The researchers will not be looking at any clinical records on your child. Only if you decide to participate in this study will any information be given to the researchers. In order to protect your privacy, the only information about your child that would be given to the researchers, should you choose to participate, is a note saying whether behaviour problems, developmental delays, or both is the best group placement for your child in this study.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of

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seven years. Your participation is completely voluntary. Your decision of whether or not to participate will have no impact on the services provided for you at the Children's Centre. If you wish to withdraw at any time during the study, you are free to do so without consequence.

If you decide to participate in this study, there is a self-addressed, stamped envelope in this package which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you have any questions about this study or if you have any concerns while completing the questionnaires or afterwards, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

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Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix F. Consent form for primary caregivers (Children's Centre Thunder Bay)

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths in my family, and it also indicates that I understand the following:

1. If I participate, I give the staff at the Children's Centre permission to provide the above three researchers with a signed statement regarding the presence of behavioural problems and/or developmental delays in my child as is indicated by prior assessment results.
2. If I participate, I am a volunteer and I can withdraw at any time from the study without consequence.
3. My decision of whether or not to participate will have no impact on the services provided for me at the Children's Centre.
4. If I participate, there is no anticipated risk of physical or psychological harm to either myself or my child.
5. If I participate, the information I provide will be kept confidential and not be shared with anyone.
6. If I participate, I do not need to write any identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires.
7. If I participate, I will receive a summary of the results of the study, upon request, following the completion of the study.
8. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

_____ Please check here if you would like to receive a summary of the group results at the completion of the study.

______________________ ______________________

Name of Child (Please Print) Name of Parent/Guardian (Please Print)

____

Signature of Parent/Guardian Date

____

Signature of Researcher Date

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Appendix G. Introductory letter to Communities Together for Children

To Maria Cole and Communities Together for Children:

A study has been developed that aims to explore and compare the patterns of family functioning and family strengths in the families of preschool aged children with behavioural problems and/or developmental delays. Research has suggested that different patterns of both positive or strength and dysfunctional family characteristics can be found in different populations of preschoolers. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Through the development of a comprehensive understanding of these patterns it becomes possible to provide optimal services for the families of preschool aged children who seek professional assistance in managing the challenges related to their child's diagnosis. Knowledge of a family's strengths, in particular, provides valuable information to help the family cope with stressors and to further promote well-being. Thus, the purpose of this study is to:
(1) develop an understanding of the patterns of both strengths and weakness in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to determine distinctiveness between families of preschoolers with and without behavioural problems, developmental delays, or both.

To accomplish these goals, we will require the primary caregivers (i.e. parents/guardians) of preschoolers with and without behavioural problems, developmental delays, or both to complete three questionnaires. The three questionnaires will cover the child's behavioural problems, family functioning, and family strengths respectively. It will take the caregiver a maximum of about one hour to complete the questionnaires. With regard to the clients of Communities Together for Children, we would be looking for primary caregivers of preschoolers, aged 3 to 6 years, whose clinical records reflect behavioural problems and/or developmental delays.

Furthermore, for classification purposes, behavioural problems will be considered present if the child's clinical records or other file reports indicate that behavioural problems are a predominant concern. Developmental delays will be considered present if the child's clinical records reflect either a speech/language delay, a developmental delay, or a developmental disability. In order to protect the confidentiality of Communities Together for Children clients, it is proposed that an agency staff reviews the records of the eligible to identify potential participants for this study. Following this review, the agency staff would send out introductory letters explaining the study to the primary caregivers of the children meeting review criteria, inviting them to participate in the study. Interested participants would then contact the primary researcher to express their interest in participating in the study and to provide their contact information for distribution of the research packages. After obtaining this information, the primary researcher will send out a cover letter describing the study, the three questionnaires, and an informed consent form. Included in this package will be a self-addressed, stamped envelope which the primary caregivers can use to return their completed questionnaires and consent form to the primary researcher at Lakehead University. After receiving the participants' signed consent forms and completed questionnaires, the primary researcher will contact the agency staff and ask the agency staff to provide a list containing the names of the children of consenting participants and a notation indicating the presence of behaviour problems, developmental delays, or both for each

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child. This list will be used to determine appropriate group placement for the participants in this study. No further information will be disclosed to the researchers by the agency staff so as to protect the clients' privacy.

There is no anticipated risk for harm to the primary caregiver or their preschoolers through participation in this study as it is expected that the caregivers involved have already become familiar with their child's psychological conditions. Participants may become aware of a variety of characteristics, especially strengths, possessed by their family which were previously unrecognized. These characteristics may subsequently be used to foster well-being in the participants' families.

The responses to the questionnaires provided by the primary caregivers will be kept confidential. The information will be held in a secure place at Lakehead University for a period of seven years. Participation is completely voluntary. If a participant wishes to withdraw at any time during the study, he or she is free to do so without consequence.

Upon completion of this research, participants, including Communities Together for Children, are entitled to receive a summary of the results. If you wish to access these results, or have any questions about this study, you may contact me by telephone at **(807) 625-5442** or by email at **jfranks1@lakeheadu.ca**. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

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Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

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Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix H. Consent form for Communities Together for Children

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths, and it also indicates that I understand the following:

1. I will conduct a review of the records of the children currently receiving services from the childcare programs and Communities Together for Children to identify potential participants for this study based on indications of behavioural problems and/or developmental delays.
2. I will send out letters explaining the study to the caregivers of children identified in the records review.
3. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
4. Following written consent from caregivers, I will give the researchers a list indicating the presence of behavioural problems and/or developmental delays for each child based on the records review.
5. All participants are volunteers and can withdraw at any time from the study without consequence.
6. There is no anticipated risk of physical or psychological harm to myself, caregivers, or children involved in the study.
7. The information collected from caregivers will be kept confidential and not be shared with anyone.
8. If I wish, I will receive a summary of the results of the study following the completion of the study.
9. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

____

Signature of Communities Together for Children Staff Date

____ ____________

Signature of Researcher Date

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Appendix I. Introductory letters for primary caregivers (Communities Together for Children)

Dear Parent or Guardian:

We are doing a research study and are interested in the characteristics of your family and other families of preschool aged children. A staff member at **Communities Together for Children** has identified your family as a potential participant for this study based on a review of statistical records of **3- to 6-year-old children**, indicating that your child is experiencing **behaviour problems and/or developmental delays**. If you decide to participate in this study, the information you provide about your family will be combined with information from other families and sorted to compare the answers of families of children with and without behaviour problems, developmental delays or both. The information learned from this study will be used to better understand the differences in strengths and other characteristics between families facing different challenges in raising their preschoolers.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding these family patterns will help to make it possible to provide the best possible services for families who seek professional help for their children. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

The information you provide will be used in a comparison of groups of families with preschool aged children with behavioural problems, developmental delays, both behavioural problems and developmental delays, or neither behavioural problems nor developmental delays. Information from statistical records at Communities Together for Children will be used to decide which group best describes your child. A staff member at Communities Together for Children has reviewed the statistical records of all 3- to 6-year-old children to identify potential participants for this study and to decide which group placement would best describe your child. The researchers will not be looking at or receiving information from any clinical records on your child. Only if you decide to participate in this study will any information be given to the researchers. In order to protect your privacy, the only information about your child that would

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be given to the researchers, should you choose to participate, is a note saying whether behaviour problems, developmental delays, or both is the best group placement for your child in this study.

If you decide to participate in this study, you will receive a cover letter describing the study, the three questionnaires, and an informed consent form. Included in this package will be a self-addressed, stamped envelope which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of seven years. Your participation is completely voluntary. Your decision of whether or not to participate will have no impact on the services provided for you at Communities Together for Children. If you wish to withdraw at any time during the study, you are free to do so without consequence.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you are interested in participating in this study or have any questions about the study, please contact me by telephone at **(807) 625-5442** or by email at **jfranks1@lakeheadu.ca**. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

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Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

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Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix J. Cover letter for primary caregivers (Communities Together for Children)

Dear Parent or Guardian:

We are interested in the characteristics of your family and other families of preschool aged children.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding these family patterns will help to make it possible to provide the best possible services for families who seek professional help for their children. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with and without behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

The information you provide will be used in a comparison of groups of families with preschool aged children with behavioural problems, developmental delays, both behavioural problems and developmental delays, or neither behavioural problems nor developmental delays. Information from statistical records at Communities Together for Children will be used to decide which group best describes your child. A staff member at Communities Together for Children has reviewed the statistical records of all 3- to 6-year-old children to identify potential participants for this study and to decide which group placement would best describe your child. The researchers will not be looking at or receiving information from any clinical records on your child. Only if you decide to participate in this study will any information be given to the researchers. In order to protect your privacy, the only information about your child that would be given to the researchers, should you choose to participate, is a note saying whether behaviour problems, developmental delays, or both is the best group placement for your child in this study.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of

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seven years. Your participation is completely voluntary. Your decision of whether or not to participate will have no impact on the services provided for you at Communities Together for Children. If you wish to withdraw at any time during the study, you are free to do so without consequence.

If you decide to participate in this study, there is a self-addressed, stamped envelope in this package which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you have any questions about this study or if you have any concerns while completing the questionnaires or afterwards, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

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Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

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Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix K. Consent form for primary caregivers (Communities Together for Children)

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths in my family, and it also indicates that I understand the following:

1. If I participate, I give the Special Needs Resource Coordinator at Communities Together for Children permission to provide the above three researchers with a signed statement regarding the presence of behavioural problems and/or developmental delays in my child as is indicated by existing statistical records.
2. If I participate, I am a volunteer and I can withdraw at any time from the study without consequence.
3. My decision of whether or not to participate will have no impact on the services provided for me by Communities Together for Children.
4. If I participate, there is no anticipated risk of physical or psychological harm to either myself or my child.
5. If I participate, the information I provide will be kept confidential and not be shared with anyone.
6. If I participate, I do not need to write any identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires.
7. If I participate, I will receive a summary of the results of the study, upon request, following the completion of the study.
8. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

_____ Please check here if you would like to receive a summary of the group results at the completion of the study.

______________________________	______________________________
Name of Child (Please Print)	Name of Parent/Guardian (Please Print)

____

Signature of Parent/Guardian Date

____

Signature of Researcher Date

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Appendix L. Introductory letter to Lakehead Public Schools

Assessing Patterns of Family Functioning and Family Strengths in the Families of Preschoolers with Developmental Delays, Behaviour Problems, and Both

To the Education Officer;
Jim McCuaig Education Centre
2135 Sills St.
Thunder Bay, ON
P7E 5T2

A study has been developed that aims to explore and compare the patterns of family functioning and family strengths in the families of preschool aged children with behavioural problems and/or developmental delays. Research has suggested that different patterns of both positive or strength and dysfunctional family characteristics can be found in different populations of preschoolers. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Knowledge of a family's strengths, in particular, provides valuable information to help the family cope with stressors and to further promote well-being. Thus, the purpose of this study is to:

(1) develop an understanding of the patterns of both strengths and weakness in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to determine distinctiveness between families of preschoolers with and without behavioural problems, developmental delays, or both.

To accomplish these goals, we will require the primary caregivers (i.e. parents/guardians) of preschoolers with and without behavioural problems, developmental delays, or both to complete three questionnaires. The three questionnaires will cover the child's behavioural problems, family functioning, and family strengths respectively. It will take the caregiver a maximum of about one hour to complete the questionnaires. With regard to the primary caregivers of students from your school board, we are interested in securing caregivers of 4- and 5-year-olds attending regular kindergarten classes, without clinically significant behavioural problems or developmental delays.

In order to access these primary caregivers, letters will be forwarded to kindergarten teachers at several schools, via the school's principal. The teachers will be responsible for distributing the cover letters to the primary caregivers by sending a copy home with each student in their class. These letters describe the study and invite the primary caregivers to participate. A total of [illegible] primary caregivers are needed. Interested primary caregivers will then contact the primary researcher by email or telephone to indicate that they wish to participate. Any questions regarding the study will be addressed during this contact. Packages including a copy of the cover letter, the three questionnaires, and an informed consent form will be sent to these caregivers via mail. Included in this package will be a self-addressed, stamped envelope which the primary caregivers can use to return their completed questionnaires and consent form to the primary researcher at Lakehead University.

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There is no anticipated risk for harm to the teacher, the primary caregiver, or their children through participation in this study. Participants may become aware of a variety of characteristics, especially strengths, possessed by their family which were previously unrecognized. These characteristics may subsequently be used to foster well-being in the participants' families.

The responses to the questionnaires provided by the primary caregivers will be kept confidential. The information will be held in a secure place at Lakehead University for a period of seven years. Participation is completely voluntary. If a participant wishes to withdraw at any time during the study, he or she is free to do so without consequence.

Upon completion of this research, participants are entitled to receive a summary of the results. If you wish to access these results, or have any questions about this study, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix M. Consent form for Lakehead Public Schools

An authorized signature on this form indicates that the Lakehead Public School Board agrees to its schools' participation in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths, and it also indicates that we agree to the following:

1. Junior and senior kindergarten teachers will send home letters explaining the study to the caregivers (i.e. parents and guardians) of all students in their classes.
2. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
3. All participants are volunteers and can withdraw at any time from the study without consequence.
4. There is no anticipated risk of physical or psychological harm to the teachers, caregivers, or students involved in the study.
5. The information collected from caregivers will be kept confidential and not be shared with anyone.
6. If we wish, we will receive a summary of the results of the study following the completion of the study.
7. The data will be held in a secure place a Lakehead University for a period of seven years.

We have received explanations about the nature of the study, its purpose, and its procedures.

____

Authorized Signature　　　　　　　　　　Date

____

Signature of Researcher　　　　　　　　　　Date

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Appendix N. Cover letter for principals

Dear Principal:

We are interested in exploring and comparing the patterns of family functioning and family strengths in the families of preschool aged children with and without behavioural problems and/or developmental delays.

Research has suggested that different patterns of both positive or strength and dysfunctional family characteristics can be found in different populations of preschoolers. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Knowledge of a family's strengths, in particular, provides valuable information to help the family cope with stressors and to further promote well-being. Thus, the purpose of this study is to:

(1) develop an understanding of the patterns of both strengths and weakness in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to determine distinctiveness between families of preschoolers with and without behavioural problems, developmental delays, or both.

To accomplish these goals, we would ask you to forward, to each of your kindergarten teachers, the letter outlining our study and the letters to be sent home to the primary caregivers (i.e. parents/guardians) of their students, so that the primary caregivers may contact me if they are interested in taking part in this study.

From your school, we are looking for primary caregivers whose child is 4- to 6-years-old, without clinically significant behavioural problems or developmental delays. These caregivers will be required to complete three questionnaires, which cover the child's behavioural problems, family functioning, and family strengths respectively. There are no right or wrong answers to these questions. We are interested in learning about patterns of strengths and weaknesses in the families of children in this age group. It will take the caregiver a maximum of about one hour to complete the questionnaires.

In order to access these primary caregivers, letters will be forwarded to kindergarten teachers at several schools. The teachers will be responsible for distributing the cover letters to the primary caregivers by sending a copy home with each student in their class. These letters describe the study and invite the primary caregiver to participate. A total of 30 primary caregivers are needed. Interested primary caregivers will then contact the primary researcher by email or telephone to indicate that they wish to participate. Any questions regarding the study will be addressed during this contact. Packages including a copy of the cover letter, the three questionnaires, and an informed consent form will be sent to these caregivers via mail. Included in this package will be a self-addressed, stamped envelope which the primary caregivers can use to return their completed questionnaires and consent form to the primary researcher at Lakehead University.

There is no anticipated risk for harm to the teacher, the primary caregiver, or their children through participation in this study. Participants may become aware of a variety of

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characteristics, especially strengths, possessed by their family which were previously unrecognized. These characteristics may subsequently be used to foster well-being in the participants' families.

The responses to the questionnaires provided by the primary caregivers will be kept confidential. The information will be held in a secure place at Lakehead University for a period of seven years. Participation is completely voluntary. If a participant wishes to withdraw at any time during the study, he or she is free to do so without consequence.

Upon completion of this research, participants are entitled to receive a summary of the results. If you wish to access these results, or have any questions about this study, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

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Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix O. Consent form for principals

My signature on this form indicates that I agree to my school's participation in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths, and it also indicates that I understand the following:

1. Junior and senior kindergarten teachers will send home letters explaining the study to the caregivers (i.e. parents and guardians) of all students in their classes.
2. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
3. All participants are volunteers and can withdraw at any time from the study without consequence.
4. There is no anticipated risk of physical or psychological harm to the teachers, caregivers, or students involved in the study.
5. The information collected from caregivers will be kept confidential and not be shared with anyone.
6. If I wish, I will receive a summary of the results of the study following the completion of the study.
7. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

____

Signature of Principal Date

____

Signature of Researcher Date

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Appendix P. Cover letter for teachers

Dear Teacher:

We are interested in exploring and comparing the patterns of family functioning and family strengths in the families of preschool aged children with and without behavioural problems and/or developmental delays.

Research has suggested that different patterns of both positive or strength and dysfunctional family characteristics can be found in different populations of preschoolers. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Knowledge of a family's strengths, in particular, provides valuable information to help the family cope with stressors and to further promote well-being. Thus, the purpose of this study is to:

(1) develop an understanding of the patterns of both strengths and weakness in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to determine distinctiveness between families of preschoolers with and without behavioural problems, developmental delays, or both.

From your class, we are looking for primary caregivers (i.e. parents/guardians) whose child is 4- to 6-years-old, without clinically significant behavioural problems or developmental delays. To accomplish this goal, we would ask that you send each child in your class home with the cover letters included, so that the primary caregivers may contact me if they are interested in taking part in this study. These caregivers will be required to complete three questionnaires, which cover the child's behavioural problems, family functioning, and family strengths respectively. There are no right or wrong answers to these questions. We are interested in learning about patterns of strengths and weaknesses in the families of children in this age group. It will take the caregiver a maximum of about one hour to complete the questionnaires.

In order to access these primary caregivers, your principal will forward letters to the kindergarten teachers at your school. You will be responsible for distributing the cover letters to the primary caregivers by sending a copy home with each student in your class. These letters describe the study and invite the primary caregiver to participate. A total of 30 primary caregivers are needed. Interested primary caregivers will then contact the primary researcher by email or telephone to indicate that they wish to participate. Any questions regarding the study will be addressed during this contact. After the primary caregivers have indicated an interest in participating, packages including a copy of the cover letter, the three questionnaires, and an informed consent form will be sent to them via mail. Included in this package will be a self-addressed, stamped envelope which the primary caregivers can use to return their completed questionnaires and consent form to the primary researcher at Lakehead University.

There is no anticipated risk for harm to yourself, the primary caregiver, or their children through participation in this study. Participants may become aware of a variety of characteristics, especially strengths, possessed by their family which were previously unrecognized. These characteristics may subsequently be used to foster well-being in the participants, their children, and their family unit.

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The responses to the questionnaires provided by the primary caregivers will be kept confidential. The information will be held in a secure place at Lakehead University for a period of seven years. Participation is completely voluntary. If a participant wishes to withdraw at any time during the study, he or she is free to do so without consequence.

Upon completion of this research, participants are entitled to receive a summary of the results. If you wish to access these results, or have any questions about this study, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

____

Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix Q. Consent form for teachers

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths in my family, and it also indicates that I understand the following:

1. I will send home letters explaining the study to the caregivers (i.e. parents and guardians) of all students in my class.
2. Caregivers will be invited to contact the researchers directly if they are interested in participating in the study.
3. All participants are volunteers and can withdraw at any time from the study without consequence.
4. There is no anticipated risk of physical or psychological harm to myself, caregivers, or students involved in the study.
5. The information collected from caregivers will be kept confidential and not be shared with anyone.
6. If I wish, I will receive a summary of the results of the study following the completion of the study.
7. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

____

Signature of Teacher Date

____

Signature of Researcher Date

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Appendix R. Introductory letter for primary caregivers (Lakehead Public Schools)

Dear Parent or Guardian:

We are doing a research study and are interested in the characteristics of your family and other families of preschool aged children. Your family has been chosen as a potential participant for the **control group** in this study because you have a child who is **4 to 6 years old** and who has **<u>not</u> been receiving services from the Children's Centre** for behavioural problems and/or developmental delays **in the past year**. If you choose to participate in this study, the information you provide about your family will be combined with information from other families in the control group. This combined information will then be compared to information about the families of children who have been receiving services from the Children's Centre for behavioural problems and/or developmental delays in the past year. The information we learn from this study will help us to better understand the differences in strengths and other characteristics between families facing different challenges in raising their preschoolers.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with and without behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

If you decide to participate in this study, you will receive, via mail, a cover letter describing the study, the three questionnaires, and an informed consent form. Included in this package will be a self-addressed, stamped envelope which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of

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seven years. Your participation is completely voluntary. If you wish to withdraw at any time during the study, you are free to do so without consequence.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you are interested in participating in this study or have any questions about the study, you may contact me by telephone at (807) 625-5442 or by email at jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____
Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____
Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

____
Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix S. Cover letter for primary caregivers (Lakehead Public Schools)

Dear Parent or Guardian:

We are interested in the characteristics of your family and other families of preschool aged children.

Research has shown that different families have different strengths and patterns of working. However, more research is needed to develop a complete picture of these characteristics, especially of the family's strengths. Understanding a family's strengths is particularly important because they provide valuable information to help the family cope with stress and to encourage healthy development. Therefore, the purpose of this study is to:

(1) develop an understanding of the patterns of strengths and other characteristics in the families of preschoolers with and without behavioural problems and/or developmental delays; and
(2) compare these patterns to discover differences between families of preschoolers with and without behavioural problems, developmental delays, or both.

To reach this goal, we would ask that you complete three questionnaires, one about your child and two about your family. We would also ask that the caregiver (i.e. parent or guardian) who is most familiar with your child be the one to complete the questionnaires. To protect your privacy, there is no need to fill out any of the identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires. There are no right or wrong answers to these questions. We are interested in learning about the characteristics of your family. It will take a maximum of about one hour to complete the questionnaires.

There is no expected risk for harm to yourself or your child through participation in this study. You may learn about a variety of characteristics, especially strengths, in your family which you may not have already recognized.

The answers you provide to the questionnaires will be kept confidential and not shared with anyone. The information will be held in a secure place at Lakehead University for a period of seven years. Your participation is completely voluntary. If you wish to withdraw at any time during the study, you are free to do so without consequence.

If you decide to participate in this study, there is a self-addressed, stamped envelope in this package which you can use to return the completed questionnaires and consent form to the primary researcher at Lakehead University.

Should you choose to participate, as a "thank you" for your involvement in this study, we would like to provide you with a $5.00 gift certificate to McDonalds and to enter you in a draw to win one of two $50.00 gift certificates to Wal-Mart.

Upon completion of this research, you are entitled to receive a summary of the results. If you have any questions about this study or if you have any concerns while completing the questionnaires or afterwards, you may contact me by telephone at (807) 625-5442 or by email at

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jfranks1@lakeheadu.ca. Further concerns or questions can be directed to Dr. Rawana at (807) 343-8453.

Sincerely,

____

Jessica Franks, Masters of Arts Candidate, Clinical Psychology, Lakehead University

____

Dr. Edward Rawana, Ph.D., C. Psych.
Assistant Professor, Department of Psychology, Lakehead University

____

Dr. Keith Brownlee, Ph.D., C. Psych.
Professor, School of Social Work, Lakehead University

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Appendix T. Consent form for primary caregivers (Lakehead Public Schools)

My signature on this form indicates that I agree to participate in a study by Jessica Franks, Dr. Edward Rawana, and Dr. Keith Brownlee on the assessment of patterns of family functioning and strengths in my family, and it also indicates that I understand the following:

1. If I participate, I am a volunteer and I can withdraw at any time from the study without consequence.
2. If I participate, there is no anticipated risk of physical or psychological harm to either myself or my child.
3. If I participate, the information I provide will be kept confidential and not be shared with anyone.
4. If I participate, I do not need to write any identifying information (e.g. name, age, etc.) in the spaces provided on the questionnaires.
5. If I participate, I will receive a summary of the results of the study, upon request, following the completion of the study.
6. The data will be held in a secure place a Lakehead University for a period of seven years.

I have received explanations about the nature of the study, its purpose, and its procedures.

_____ Please check here if you would like to receive a summary of the group results at the completion of the study.

______________________ ______________________

Name of Child (Please Print) Name of Parent/Guardian (Please Print)

____

Signature of Parent/Guardian Date

____

Signature of Researcher Date

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Appendix U. Child Behavior Checklist for Ages 1½-5 (CBCL)

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Please print. # CHILD BEHAVIOR CHECKLIST FOR AGES 1½-5

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl | CHILD'S AGE | CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo.______Day_____Year________ | CHILD'S BIRTHDATE Mo.______Day_____Year________

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.*

FATHER'S TYPE OF WORK ______________________________

MOTHER'S TYPE OF WORK ______________________________

THIS FORM FILLED OUT BY: (print your full name)

____

Your relationship to child:

☐Mother ☐Father ☐Other (specify):

Below is a list of items that describe children. For each item that describes the child ***now or within the past 2 months***, please circle the ***2*** if the item is ***very true or often true*** of the child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of the child. If the item is ***not true*** of the child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to the child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Aches or pains (without medical cause; ***do not*** include stomach or headaches)
0 1 2 2. Acts too young for age
0 1 2 3. Afraid to try new things
0 1 2 4. Avoids looking others in the eye
0 1 2 5. Can't concentrate, can't pay attention for long
0 1 2 6. Can't sit still, restless, or hyperactive
0 1 2 7. Can't stand having things out of place
0 1 2 8. Can't stand waiting; wants everything now
0 1 2 9. Chews on things that aren't edible
0 1 2 10. Clings to adults or too dependent
0 1 2 11. Constantly seeks help
0 1 2 12. Constipated, doesn't move bowels (when not sick)
0 1 2 13. Cries a lot
0 1 2 14. Cruel to animals
0 1 2 15. Defiant
0 1 2 16. Demands must be met immediately
0 1 2 17. Destroys his/her own things
0 1 2 18. Destroys things belonging to his/her family or other children
0 1 2 19. Diarrhea or loose bowels (when not sick)
0 1 2 20. Disobedient
0 1 2 21. Disturbed by any change in routine
0 1 2 22. Doesn't want to sleep alone
0 1 2 23. Doesn't answer when people talk to him/her
0 1 2 24. Doesn't eat well (describe): ________________
0 1 2 25. Doesn't get along with other children
0 1 2 26. Doesn't know how to have fun; acts like a little adult
0 1 2 27. Doesn't seem to feel guilty after misbehaving
0 1 2 28. Doesn't want to go out of home
0 1 2 29. Easily frustrated
0 1 2 30. Easily jealous
0 1 2 31. Eats or drinks things that are not food—***don't*** include sweets (describe): ________________
0 1 2 32. Fears certain animals, situations, or places (describe): ________________
0 1 2 33. Feelings are easily hurt
0 1 2 34. Gets hurt a lot, accident-prone
0 1 2 35. Gets in many fights
0 1 2 36. Gets into everything
0 1 2 37. Gets too upset when separated from parents
0 1 2 38. Has trouble getting to sleep
0 1 2 39. Headaches (without medical cause)
0 1 2 40. Hits others
0 1 2 41. Holds his/her breath
0 1 2 42. Hurts animals or people without meaning to
0 1 2 43. Looks unhappy without good reason
0 1 2 44. Angry moods
0 1 2 45. Nausea, feels sick (without medical cause)
0 1 2 46. Nervous movements or twitching (describe): ________________
0 1 2 47. Nervous, highstrung, or tense
0 1 2 48. Nightmares
0 1 2 49. Overeating
0 1 2 50. Overtired
0 1 2 51. Shows panic for no good reason
0 1 2 52. Painful bowel movements (without medical cause)
0 1 2 53. Physically attacks people
0 1 2 54. Picks nose, skin, or other parts of body (describe): ________________

Be sure you answered all items. Then see other side.

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www.ASEBA.org

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7-28-00 Edition-601

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Please print your answers. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 **2** 55. Plays with own sex parts too much
0 1 **2** 56. Poorly coordinated or clumsy
0 1 **2** 57. Problems with eyes (without medical cause) (describe): ____________
0 1 **2** 58. Punishment doesn't change his/her behavior
0 1 **2** 59. Quickly shifts from one activity to another
0 1 **2** 60. Rashes or other skin problems (without medical cause)
0 1 **2** 61. Refuses to eat
0 1 **2** 62. Refuses to play active games
0 1 **2** 63. Repeatedly rocks head or body
0 1 **2** 64. Resists going to bed at night
0 1 **2** 65. Resists toilet training (describe): ____________
0 1 **2** 66. Screams a lot
0 1 **2** 67. Seems unresponsive to affection
0 1 **2** 68. Self-conscious or easily embarrassed
0 1 **2** 69. Selfish or won't share
0 1 **2** 70. Shows little affection toward people
0 1 **2** 71. Shows little interest in things around him/her
0 1 **2** 72. Shows too little fear of getting hurt
0 1 **2** 73. Too shy or timid
0 1 **2** 74. Sleeps less than most kids during day and/or night (describe): ____________
0 1 **2** 75. Smears or plays with bowel movements
0 1 **2** 76. Speech problem (describe): ____________
0 1 **2** 77. Stares into space or seems preoccupied
0 1 **2** 78. Stomachaches or cramps (without medical cause)
0 1 **2** 79. Rapid shifts between sadness and excitement
0 1 **2** 80. Strange behavior (describe): ____________
0 1 **2** 81. Stubborn, sullen, or irritable
0 1 **2** 82. Sudden changes in mood or feelings
0 1 **2** 83. Sulks a lot
0 1 **2** 84. Talks or cries out in sleep
0 1 **2** 85. Temper tantrums or hot temper
0 1 **2** 86. Too concerned with neatness or cleanliness
0 1 **2** 87. Too fearful or anxious
0 1 **2** 88. Uncooperative
0 1 **2** 89. Underactive, slow moving, or lacks energy
0 1 **2** 90. Unhappy, sad, or depressed
0 1 **2** 91. Unusually loud
0 1 **2** 92. Upset by new people or situations (describe): ____________
0 1 **2** 93. Vomiting, throwing up (without medical cause)
0 1 **2** 94. Wakes up often at night
0 1 **2** 95. Wanders away
0 1 **2** 96. Wants a lot of attention
0 1 **2** 97. Whining
0 1 **2** 98. Withdrawn, doesn't get involved with others
0 1 **2** 99. Worries
0 1 **2** 100. Please write in any problems the child has that were not listed above.
0 1 **2** ____________
0 1 **2** ____________
0 1 **2** ____________

Please be sure you have answered all items. Underline any you are concerned about.

Does the child have any illness or disability (either physical or mental)? ☐ **No** ☐ **Yes—Please describe:**

What concerns you most about the child?

Please describe the best things about the child:

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Appendix V. Family Assessment Measure, Version 3 (FAM-III) – General Scale

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FAM-III: General Scale

Name:______________________ Date: ___/___/___ Age:________ Sex: Male Female

Family Position (check one): ☐ Father/Husband ☐ Mother/Wife ☐ Child ☐ Grandparent ☐ Other (____________)

Directions: On this page and the reverse side, you will find 50 statements about your family as a whole. Read each statement carefully and decide how well the statement applies to your family. Make your response by circling one of the provided answers ("strongly agree," "agree," "disagree," or "strongly disagree"). Circle only one response for each item. Mark an answer for every statement, even if you are not completely sure of your answer.

Statement				
1. We spend too much time arguing about what our problems are.	strongly agree	agree	disagree	strongly disagree
2. Family duties are fairly shared.	strongly agree	agree	disagree	strongly disagree
3. When I ask someone to explain what they mean, I get a straight answer.	strongly agree	agree	disagree	strongly disagree
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.	strongly agree	agree	disagree	strongly disagree
5. We are as well adjusted as any family could possibly be.	strongly agree	agree	disagree	strongly disagree
6. You don't get a chance to be an individual in our family.	strongly agree	agree	disagree	strongly disagree
7. When I ask why we have certain rules, I don't get a good answer.	strongly agree	agree	disagree	strongly disagree
8. We have the same views on what is right and wrong.	strongly agree	agree	disagree	strongly disagree
9. I don't see how any family could get along better than ours.	strongly agree	agree	disagree	strongly disagree
10. Some days we are more easily annoyed than on others.	strongly agree	agree	disagree	strongly disagree
11. When problems come up, we try different ways of solving them.	strongly agree	agree	disagree	strongly disagree
12. My family expects me to do more than my share.	strongly agree	agree	disagree	strongly disagree
13. We argue about who said what in our family.	strongly agree	agree	disagree	strongly disagree
14. We tell each other about things that bother us.	strongly agree	agree	disagree	strongly disagree
15. My family could be happier than it is.	strongly agree	agree	disagree	strongly disagree
16. We feel loved in our family.	strongly agree	agree	disagree	strongly disagree
17. When you do something wrong in our family, you don't know what to expect.	strongly agree	agree	disagree	strongly disagree
18. It's hard to tell what the rules are in our family.	strongly agree	agree	disagree	strongly disagree
19. I don't think any family could possibly be happier than mine.	strongly agree	agree	disagree	strongly disagree
20. Sometimes we are unfair to each other.	strongly agree	agree	disagree	strongly disagree
21. We never let things pile up until they are more than we can handle.	strongly agree	agree	disagree	strongly disagree
22. We agree about who should do what in our family.	strongly agree	agree	disagree	strongly disagree
23. I never know what's going on in our family.	strongly agree	agree	disagree	strongly disagree
24. I can let my family know what is bothering me.	strongly agree	agree	disagree	strongly disagree
25. We never get angry in our family.	strongly agree	agree	disagree	strongly disagree

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REMEMBER TO COMPLETE THE ITEMS ON THE REVERSE SIDE.

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FAM-III: General Scale

Side 2

26. My family tries to run my life.	strongly agree	agree	disagree	strongly disagree
27. If we do something wrong, we don't get a chance to explain.	strongly agree	agree	disagree	strongly disagree
28. We argue about how much freedom we should have to make our own decisions.	strongly agree	agree	disagree	strongly disagree
29. My family and I understand each other completely.	strongly agree	agree	disagree	strongly disagree
30. We sometimes hurt each others feelings.	strongly agree	agree	disagree	strongly disagree
31. When things aren't going well it takes too long to work them out.	strongly agree	agree	disagree	strongly disagree
32. We can't rely on family members to do their part.	strongly agree	agree	disagree	strongly disagree
33. We take the time to listen to each other.	strongly agree	agree	disagree	strongly disagree
34. When someone is upset, we don't find out until much later.	strongly agree	agree	disagree	strongly disagree
35. Sometimes we avoid each other.	strongly agree	agree	disagree	strongly disagree
36. We feel close to each other.	strongly agree	agree	disagree	strongly disagree
37. Punishments are fair in our family.	strongly agree	agree	disagree	strongly disagree
38. The rules in our family don't make sense.	strongly agree	agree	disagree	strongly disagree
39. Some things about my family don't entirely please me.	strongly agree	agree	disagree	strongly disagree
40. We never get upset with each other.	strongly agree	agree	disagree	strongly disagree
41. We deal with our problems even when they're serious.	strongly agree	agree	disagree	strongly disagree
42. One family member always tries to be the center of attention.	strongly agree	agree	disagree	strongly disagree
43. My family lets me have my say, even if they disagree.	strongly agree	agree	disagree	strongly disagree
44. When our family gets upset, we take too long to get over it.	strongly agree	agree	disagree	strongly disagree
45. We always admit our mistakes without trying to hide anything.	strongly agree	agree	disagree	strongly disagree
46. We don't really trust each other.	strongly agree	agree	disagree	strongly disagree
47. We hardly ever do what is expected of us without being told.	strongly agree	agree	disagree	strongly disagree
48. We are free to say what we think in our family.	strongly agree	agree	disagree	strongly disagree
49. My family is not a perfect success.	strongly agree	agree	disagree	strongly disagree
50. We have never let down another family member in any way.	strongly agree	agree	disagree	strongly disagree

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REMEMBER TO COMPLETE THE ITEMS ON THE REVERSE SIDE.

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FAM - III General Scale Scoring Grid

Name:______________________________ Date: ___/___/___ Age:________ Sex: Male Female

Family Position (check one): ☐ Father/Husband ☐ Mother/Wife ☐ Child ☐ Grandparent ☐ Other (____________)

Scoring Directions: For each item, one number (from 0 to 3) should be circled. Transfer that number to the box to the left of items 1-25 and to the right of items 26-50. After all numbers are transferred, add the numbers in each column following the unshaded or shaded lines. Put the sum for each column in the boxes labeled a1 - i1 and a2 - i2. Next, add a1 and a2 and put the total on the reverse side in the box marked "A." Similarly, add the boxes labeled b1 + b2, etc., and put the total on the reverse.

				Item	Item				
0	1	2	3	26	1	3	2	1	0
0	1	2	3	27	2	0	1	2	3
0	1	2	3	28	3	0	1	2	3
0	1	2	3	29	4	3	2	1	0
3	2	1	0	30	5	3	2	1	0
0	1	2	3	31	6	3	2	1	0
0	1	2	3	32	7	3	2	1	0
3	2	1	0	33	8	0	1	2	3
0	1	2	3	34	9	3	2	1	0
3	2	1	0	35	10	0	1	2	3
3	2	1	0	36	11	0	1	2	3
3	2	1	0	37	12	3	2	1	0
0	1	2	3	38	13	3	2	1	0
3	2	1	0	39	14	0	1	2	3
0	1	2	3	40	15	0	1	2	3
3	2	1	0	41	16	0	1	2	3
0	1	2	3	42	17	3	2	1	0
3	2	1	0	43	18	3	2	1	0
0	1	2	3	44	19	3	2	1	0
0	1	2	3	45	20	0	1	2	3
0	1	2	3	46	21	0	1	2	3
0	1	2	3	47	22	0	1	2	3
3	2	1	0	48	23	3	2	1	0
3	2	1	0	49	24	0	1	2	3
0	1	2	3	50	25	3	2	1	0

SUM OF BOXES ABOVE	a1	b1	c1	d1	e1	f1	g1	h1	i1	a2	b2	c2	d2	e2	f2	g2	h2	i2	SUM OF BOXES ABOVE

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FAM-III: General Scale

Name:________________________________ Date: ____/____/____ Age: ______ Sex: Male Female

%ile	T	Task Accomplishment		Role Performance		Communication		Affective Expression		Involvement		Control		Values & Norms		OVERALL RATING		Social Desirability		Defensiveness		T	%ile
		Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.		
99	124															124	124					124	99
99	122															122	122					122	99
99	120															120	120					120	99
99	118															118	118					118	99
99	116															116	116					116	99
99	114															114	114					114	99
99	112															112	112					112	99
99	110															110	110					110	99
99	108															108	108					108	99
99	106															106	106					106	99
99	104															104	104			24		104	99
99	102											15				102	102					102	99
99	100															100	100			23	24	100	99
99	98	15				15						14				98	98				23	98	99
99	96		15					15		15	15			15		96	96			22		96	99
99	94	14		15												94	94				22	94	99
99	92					14	15	14		14	14	13		14		92	92			21		92	99
99	90		14		15				15				15			90	90				21	90	99
99	88	13		14		13	14	13		13	13	12				88	88			20		88	99
99	86		13		14				14				14	13		86	86			19	20	86	99
99	84	12		13		12	13			12	12				15	84	84				19	84	99
99	82		12		13			12	13			11		12		82	82			18		82	99
99	80			12						11			13		14	80	80	21			18	80	99
99	78	11			12	11	12	11	12		11			11		78	78			17		78	99
99	76		11							10		10	12		13	76	76	20	21		17	76	99
99	74	10		11	11	10	11				10			10	12	74	74	19	20	16	16	74	99
99	72		10					10	11	9		9	11			72	72	18	19			72	99
98	70			10	10	9	10				9			9	11	70	70			15	15	70	98
96	68	9	9					9	10	8			10			68	68	17	18			68	96
95	66			9			9				8	8			10	66	66	16	17	14	14	66	95
92	64	8			9	8		8	9	7			9	8		64	64	15	16			64	92
89	62		8				8				7	7			9	62	62		15	13	13	62	89
84	60			8	8	7			8	6			8	7		60	60	14			12	60	84
79	58	7	7				7	7			6				8	58	58	13	14	12		58	79
73	56			7	7				7			6	7	6		56	56	12	13		11	56	73
66	54	6				6		6		5	5				7	54	54		12	11		54	66
58	52		6	6	6		6		6			5	6	5		52	52	11	11		10	52	58
50	50					5		5		4	4				6	50	50	10	10	10	9	50	50
42	48	5	5	5	5		5		5				5	4		48	48	9				48	42
35	46					4				3	3	4			5	46	46		9	9	8	46	35
27	44	4	4		4		4	4					4			44	44	8	8			44	27
21	42			4					4	2	2	3		3	4	42	42	7	7	8	7	42	21
16	40					3	3	3					3		3	40	40	6	6	7	6	40	16
12	38	3	3	3	3				3	1	1			2		38	38					38	12
8	36					2	2	2				2	2		2	36	36	5	5	6	5	36	8
6	34	2	2	2	2				2	0	0			1		34	34	4	4			34	6
4	32					1	1					1	1		1	32	32	3	3	5	4	32	4
2	30		1		1			1	1					0		30	30		2			30	2
1	28	1		1									0		0	28	28	2	1	4	3	28	1
1	26				0	0	0	0	0			0				26	26	1			2	26	1
1	24	0	0	0												24	24	0	0	3		24	1
1	22															22	22				1	22	1
1	20															20	20			2		20	1
1	18															18	18				0	18	1
1	16															16	16			1		16	1
1	14															14	14					14	1
1	12															12	12			0		12	1
%ile	T	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	Adult	Adol.	T	%ile
		Task Accomplishment		Role Performance		Communication		Affective Expression		Involvement		Control		Values & Norms		OVERALL RATING		Social Desirability		Defensiveness			
		A		B		C		D		E		F		G		Average of T-scores for A-G		H		I			

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Appendix W. Family Functioning Style Scale (FFSS)

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Family Functioning Style Scale

Angela G. Deal, Carol M. Trivette, and Carl J. Dunst

Name______________________________ Date__________________

INSTRUCTIONS: Every family has strengths and capabilities, although different families have different ways of using their abilities. This questionnaire asks you to indicate whether or not your family is characterized by 26 different qualities. Please read each statement. Then, *circle* the response, which is most true for your family (people living in your home). Please give your honest opinion and feelings. Remember that your family will not be like all the statements.

How is your family like the following statements:	Not At All Like My Family	A Little Like My Family	Sometimes Like My Family	Usually Like My Family	Almost Always Like My Family
1. We make personal sacrifices if they help our family..	1	2	3	4	5
2. We usually agree about how family members should behave....................................	1	2	3	4	5
3. We believe that something good always comes out of even the worst situations..........	1	2	3	4	5
4. We take pride in even the smallest accomplishments of family members............	1	2	3	4	5
5. We share our concerns and feelings in useful ways..	1	2	3	4	5
6. Our family sticks together no matter how difficult things get................................	1	2	3	4	5
7. We usually ask for help from persons outside our family if we cannot do things ourselves....	1	2	3	4	5
8. We usually agree about the things that are important to our family...........................	1	2	3	4	5
9. We are always willing to "pitch in" and help each other..	1	2	3	4	5
10. We find things to do that keep our minds off our worries when something upsetting is beyond our control................................	1	2	3	4	5
11. We try to look "at the bright side of things" no matter what happens in our family..............	1	2	3	4	5
12. We find time to be together even with our busy schedules....................................	1	2	3	4	5

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Family Functioning Style Scale (continued)

How is your family like the following statements:	Not At All Like My Family	A Little Like My Family	Sometimes Like My Family	Usually Like My Family	Almost Always Like My Family
13. Everyone in our family understands the "rules" about acceptable ways to act..........	1	2	3	4	5
14. Friends and relatives are always willing to help whenever we have a problem or crisis...	1	2	3	4	5
15. Our family is able to make decisions about what to do when we have problems or concerns..	1	2	3	4	5
16. We enjoy time together even if it is doing household chores.................................	1	2	3	4	5
17. We try to forget our problems or concerns for a while when they seem overwhelming...	1	2	3	4	5
18. Family members listen to "both sides of the story" during a disagreement....................	1	2	3	4	5
19. We make time to get things done that we all agree are important..............................	1	2	3	4	5
20. We can depend on the support of each other whenever something goes wrong..............	1	2	3	4	5
21. We usually talk about the different ways we deal with problems and concerns...............	1	2	3	4	5
22. Our family's relationships will outlast our material possessions.............................	1	2	3	4	5
23. We make decisions like moving or changing jobs for the good of all family members.......	1	2	3	4	5
24. We can depend upon each other to help out when something unexpected happens..........	1	2	3	4	5
25. We try not to take each other for granted......	1	2	3	4	5
26. We try to solve our problems first before asking others to help..........................	1	2	3	4	5

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Appendix X. Subscale items for the Family Functioning Style Scale

Interactional Patterns Subscale

2. We usually agreed about how family members should behave.
5. We share our concerns and feelings in useful ways.
8. We usually agree about the things that are important to our family.
9. We are always willing to "pitch in" and help each other.
12. We find time to be together even with our busy schedules.
13. Everyone in our family understands the "rules" about acceptable ways to act.
15. Our family is able to make decisions about what to do when we have problems or crisis.
16. We enjoy time together even if it is doing household chores.
18. Family members listen to 'both sides of the story" during a disagreement.
19. We make time to get things done that we all agree are important.
21. We usually talk about the different ways we deal with problems and concerns.
25. We try not to take each other for granted.

Family Values

1. We make personal sacrifices if they help our family.
4. We take pride in even the smallest accomplishments of family members.
6. Our family sticks together no matter how difficult things get.
20. We can depend on the support of each other whenever something goes wrong.
22. Our family's relationships will outlast out material possessions.

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Coping Strategies

3. We believe that something good always comes out of even the worst situations.
10. We find things to do that keep our minds off our worries when something upsetting is beyond our control.
11. We try to look "at the bright side of things" no matter what happens in our family.
17. We try to forget our problems or concerns for a while when they seem overwhelming.

Family Commitment

23. We make decisions like moving or changing jobs for the good of all family members.
24. We can depend upon each other to help out when something unexpected happens.
26. We try to solve our problems first before asking others to help.

Resource Mobilization

7. We usually ask for help from persons outside our family if we cannot do things ourselves.
14. Friends and relatives are always willing to help whenever we have a problem.

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