Practice Parameter for the Assessment of the Family

ABSTRACT

The family assessment is one component of the comprehensive psychiatric assessment of the child or adolescent with a psychiatric disorder. This guideline reviews the basic principles in conducting a family interview that gathers history relevant to the child's disorder and observes family interaction associated with the child's disorder. It reviews basic information that must be covered in all evaluations and the information required in complex and specialized situations. The parameter emphasizes that all assessments should include a review of family strengths and resources. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007;46(7):922–937. **Key Words:** practice parameter, family assessment, parents, evaluation.

Families influence children and children influence families. When a child or adolescent has a psychiatric disorder, this influence is magnified. For diagnostic purposes, the effect of the family on the child and the child's effect on the family must be assessed to prepare for optimal treatment. The family's role in psychiatric treatment must be based on a balanced case formulation, which, in turn, must be based on a thorough family assessment.

A family assessment is always indicated in the psychiatric evaluation of a child or adolescent. At a minimum, this means the clinician obtains family history from a caregiver and observes the interaction of the child with at least one caregiver. This indication is underscored by the fact that the family is the child's primary resource for healing and may be the child's primary source of distress. Its influence should never be underestimated. In some instances, it may be helpful to see the entire family together and in others it may be essential to do so. How the family interviews should be sequenced or combined varies with the case and clinical setting.

The family assessment must recognize and describe family strengths as well as identify family problems. If family therapy is indicated, the family assessment identifies areas for intervention and engages the family in a collaborative manner.

This parameter is consistent with the purposes of the general child and adolescent psychiatric assessment, which are to determine whether psychopathology is present and, if so, define its nature and its treatment. Once an accurate picture of the child's condition is described, clinicians need to identify potential family factors that may account for, influence, or ameliorate these difficulties. The purpose of this parameter is to help clinicians integrate these factors into a comprehensive understanding of the child/adolescent as a prelude to establishing a treatment plan. This document is not a review of family therapy technique or outcome studies.

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Assessment of the family is important for several practical reasons: families, parents in particular, possess historical information regarding the child or adolescent's disorder; parents, or other legal custodians, have the legal power to initiate assessment and to give permission for treatment; and families provide financial resources for clinical care.

There are clinical reasons why family assessment is beneficial: family strengths are identified; the identified patient is not the sole focus of attention; the disorders or concerns of other family members can be identified; parenting styles are clarified as parents interact with all their children; statements from siblings and observation of their interaction provide data otherwise not available; a family's involvement in treatment is facilitated in that all family members see that they can benefit from such intervention; and the clinician can observe and the family can experience possible links between family relationships and patterns of interaction and the presenting problem.

This account covers the spectrum of family assessment, from a minimal review to a thorough, in-depth consideration of characteristics of family functioning. This document presumes that clinical interviews of parent and child have elicited history of the onset and evolution of the child's psychiatric disorder, developmental history, and medical history. The primary audience for this parameter is child and adolescent psychiatrists, yet it is also intended to be used by other medical and mental health practitioners whose clinical practice involves work with families.

In this review the term "family" refers to those individuals who have daily interaction with children and assume the responsibility of meeting the children's developmental needs. The term "parent" refers to the individual(s) who perform executive functions for the family. The review recognizes the multiplicity of contemporary changes in family structure, which may include biological parents and siblings (i.e., nuclear family); shifts in membership related to the legal alterations of divorce, remarriage, custody change, foster care, and adoption; and informal arrangements (e.g., extended family members, live-in partners). Newer reproductive technologies are further changing the ways families are formed and structured.

Finally, the attitude of the clinician conducting the assessment affects the information-gathering process, inferences made about the child and family, and the family's receptivity to the clinician's recommendations for treatment. The clinician should "presume the positive" by assuming the family cares about the child and has areas of competency in promoting child well-being (Hodas, 2001). Emphasizing these areas of competency does not preclude careful attention to the ways that the family may be maintaining or exacerbating clinical problems.

METHODOLOGY

The literature review included bibliographies of book chapters, review articles, source materials from the Committee on the Family of the American Academy of Child and Adolescent Psychiatry, and consultations with clinicians and researchers with specific expertise in this area. A review of *Medline* psychiatry abstracts from 1985 to 2005 and *PsycInfo* from 1990 to 2005 was conducted with the search phrase "family assessment," which yielded about 160 articles.

HISTORICAL REVIEW

Family assessment has been strongly influenced by the field of family therapy. An appreciation for working with parents began in the early 1900s, when child guidance clinics emphasized that the problems of children were embedded in a family context (Broderick and Schrader, 1991). The psychiatrist treated the child and the parents were seen by a social worker because family interviews were seen as ancillary to the treatment of the child's internal conflicts. Although this early work was not termed family therapy, pioneers of family therapy modified psychoanalytic theory to include social forces and pragmatically experimented with family contacts in cases in which positive effects of individual treatment appeared to be undermined by family factors (Bowlby, 1949).

In the 1950s and 1960s, a dramatic change in thinking about the family and in understanding psychopathology was ushered in by "systems theory" (Von Bertalanffy, 1968). According to systems theory, the family was a system that attempted to maintain homeostasis or balance. Family members responded to one another in ways that maintained this balance. The systems view focused on here-and-now observations, de-emphasizing individual symptoms, diagnostic classification, and individual differences. It proposed

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that systemic factors maintained the child's problem and that the clinical problem was an expression of systemic dysfunction. Family intervention was the logical way to intervene. Coincident with this development, the psychiatric literature began to link family processes to development (Erikson, 1963) and to psychopathology (Johnson and Szurek, 1952). Various methods and "schools" of family therapy were developed in the 1970s and 1980s, which addressed specific aspects of family functioning, such as the emphasis of Minuchin and colleagues on family structure and role functioning (Minuchin, 1974). The systems view tended to emphasize the use of techniques in working with the here-and-now interactions of families and gave less importance to family history.

Most clinicians and researchers view family treatments as an important part of psychosocial interventions. There has been a return to an emphasis on life experience and individual narrative, without sacrificing certain strengths of the system concept. Child development research has emphasized that life experience becomes internalized ("internal working models," "self-representations") and may serve as a predisposing factor for the onset of psychopathology (Siegel, 2001). The child's biological predisposition is another internal factor that is influenced, positively or negatively, by family interaction. Research on transactional models of development provides empirical support for family treatments (Sameroff and Fiese, 1989).

The present approach to family assessment occurs in the context of the movement to integrate family interventions with other psychosocial and biomedical therapies, coincident with clinicians' growing dissatisfaction with single explanations of a child's problematic behavior (Malone, 2001; Snyder et al., 2002). For example, several clinical conditions, such as anorexia nervosa and oppositional behavior, can be equally conceptualized as manifestations of individual psychopathology or psychopathology in family context (Russell et al., 1994). The parallel emphasis of systemic factors and developmental dynamic factors is exemplified in the phenomenology of family assessment interviews. Some interviews move from gathering history to observing interactions, whereas others start by observing interactions and in the process gather the data of family history (Josephson and Moncher, 1998a). In recent years family assessment has been influenced by strong cultural forces that emphasize the need for clinicians to collaborate with, rather than "judge," families.

DESCRIPTION OF PROCEDURE

Most children and adolescents in need of psychiatric evaluations present with parent(s) or caretaker(s). When they do not, every effort is made to contact and/or meet with the child's parent(s). In the initial assessment, which may take more than one session, the clinician gathers history of the onset and evolution of the presenting complaint, history as it relates to the presenting complaint, the family context and developmental antecedents, what solutions to problems have been tried, and parents' perspectives on the causes of the problems. A concomitant of history gathering is the naturalistic observation, often incidental, of the nature and quality of parent–child interaction. Such observations help the clinician understand the impact of the child's symptoms on the family and the family's influence on the child.

The following goals of the family assessment may not all be met in each clinical instance. All do apply to a comprehensive assessment of the family, during which the clinician attempts to:

- Gather relevant history to identify family factors that determine, influence, or ameliorate a child's psychiatric disorder.
- Observe and identify any relationship between intrafamilial patterns of interaction and a child's psychiatric disorder.
- Organize clinical data in the areas of family structure, family communication, family belief, and family regulation of child development (see Appendixes A–C).
- Explore specific, unique issues such as ethnic and cultural distinctions on child rearing, ethical perspectives (e.g., confidentiality), and legal issues (e.g., custody conflicts).
- Prepare for family involvement in treatment through the development of a formulation that emphasizes the influence of child on family and family on child. Family problems are identified in the context of existing family strengths.

The assessment of clinical problems often involves different levels of family assessment (Hayden et al., 1998; Marvel et al., 1994). Put simply, the complaints

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of some children (e.g., enuresis) may require minimal family assessment, whereas other symptoms (e.g., adolescent suicide attempt) may necessitate a comprehensive evaluation of family functioning. This parameter addresses the level of detail necessary for a practitioner to thoroughly understand family functioning, even though such a level may not be obtained in each clinical instance. However, whether the assessment enables the clinician to reach a more complete understanding of family functioning is determined by several factors:

- The skill and orientation of the practitioner: Family-oriented child and adolescent psychiatrists will typically use face-to-face interviews with families and categorize their observations, whereas individually and/or biologically oriented clinicians will often depend on information reported about the family.
- The clinical setting: Some settings, such as the emergency department, have significant time restrictions on assessments, and others, such as a school clinic, have basic restrictions on access to family members.
- Purpose of the assessment: A consultation requested by another professional (educational, legal, medical, mental health) may be delineated specifically enough that the family component is minimized (e.g., Is the child psychotic? Does the child need medication?).
- Severity and type of clinical problem: Some disorders (e.g., enuresis, uncomplicated attention-deficit/hyperactivity disorder) require parental report of child symptoms and parental monitoring of a medically based treatment plan. Family relationships are not explored in detail, and practical matters of disease management are emphasized.

Even in these instances, the clinician must be aware that family function may be significantly affecting the clinical problem. If, in the clinician's judgment, family factors are not especially relevant, then that premise may need to be re-evaluated as other clinical data are available.

The family assessment can and should cover more detail in most clinical encounters. The most common presentation in most clinical settings is a parent or parents presenting a symptomatic child for assessment. This acknowledges the reality of the identified child as symptom bearer. Yet the assessment data gathered often indicate the need for an interview of the entire family or its subunits (e.g., parents), and this typically occurs later as a case evolves. This shift can lead to parental objection because they came to the clinic for assessment of the child's condition. Therefore, the clinician needs to proceed tactfully and empathically when obtaining information related to the family as a whole and the parents as individuals and as a couple.

Less commonly, a family will present with a family problem and request a family interview at the outset. Some clinicians may request that the entire family attend the first clinical contact, believing this most clearly conveys that a child's symptoms should be seen in a systemic context (Cox et al., 1995).

When an entire family is asked to attend an interview, the family needs an explanation as to why all of the family members need to attend. Members naturally assume that the symptomatic child, not asymptomatic family members, needs evaluating. In this instance, the clinician should explain that while one child has difficulties, it is helpful to understand all of the family members' perspectives on the problem because each family member's difficulty likely affects other family members. If all children and members of the household are not seen, then a systematic review of these individuals and any problems they may be experiencing should be undertaken, often aided by the preparation of a genogram (McGoldrick and Gerson, 1985).

Although some family assessments may be abbreviated, it is also clear that an in-depth understanding and a full exploration of family functioning are often imperative in certain situations in which clinical assessment reveals:

- Historical data regarding family risk factors (e.g., parental substance abuse, marital discord, recent geographic moves) or data regarding specific interactional problems (e.g., child oppositional behavior, intrafamilial aggression, child running away from home)
- Observations of problematic parent–child interactions (e.g., an overly close parent–child interaction, harsh parental limit setting)
- Minimal progress of an individual psychotherapeutic or pharmacological treatment
- Other symptomatic family members

Most cases unfold over time; family factors become more and more salient in some cases and less so in

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others. It is important for the clinician to begin with covering the basics and to adopt a flexible approach regarding the extent of future family evaluations. The following recommendations are intended to assist clinicians in gathering enough family data to develop a rational treatment plan. They include comments on the content and the process of family assessment.

EVIDENCE BASE FOR PRACTICE PARAMETERS

The AACAP develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward the best treatment practices. Treatment recommendations are based both on empirical evidence and clinical consensus and are graded according to the strength of the empirical and clinical support. Clinician-oriented parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

PRINCIPLES

Principle 1. The Psychiatric Assessment of a Child or Adolescent Must Include Both Historical and Current Information About the Family and Its Functioning, Typically Gathered From the Child and Primary Caretaker(s).

The first aspect of a family assessment is often the information gained through a telephone intake contact. The first element of the assessment process is how a family presents to the clinic and how the family describes a child's needs. Family strengths, such as parental commitment to the child, and family limitations, such as inconsistent parental limit setting, often become manifested at initial intake. Family demographic data are often complicated and extensive and, as such, many clinics use a demographic family history form to gather data on psychiatric disorders, family development, and family structure. Demographic data should document family moves, changes in family composition, socioeconomic circumstances, family illness, legal difficulties, and altered family structure.

The family's historical report should be supplemented by ancillary sources of data. These sources can include history from other professionals who have evaluated or treated family members, as well as information from schools, local social service agencies, the courts, and child welfare agencies. These sources often provide a broader perspective of family functioning by providing information that the family either sees as unimportant or is unable or unwilling to communicate clearly to the clinician. Parents must give their consent for clinicians to gather history from these sources, with an adolescent's assent also prudent practice.

Gathering family history by interviewing ex-spouses, common-law partners, and stepparents also raises legal issues. The clinician may receive history from any individual regarding a child but should divulge information about the child only to those who have a legal right or permission to receive it. The types of questioning that facilitate history gathering are presented in Appendix A.

Principle 2. The Family Assessment of a Child or Adolescent Must Include an Observation of the Child's Interaction With Caretaker(s).

History taking occurs simultaneously with ongoing observation of parent–child interaction. Parent–child interactions reflect important aspects of family structure and problem-solving abilities. For example, in the evaluation of a young child with a behavior disorder, it is not uncommon to observe parents struggle with setting effective limits on the child. The sources of this difficulty require assessment. During the evaluation of a child with an anxiety disorder, the clinician may observe a lack of age-appropriate independence when the child is seen with his or her family or interactions that insufficiently support anxiety regulation (Bernstein et al., 1990).

Family communication, particularly hostile communication, has been seen as a familial risk factor for psychiatric disorder (Leff and Vaughn, 1985). Ambiguous family communication with lack of clarity in purpose may be a risk factor in child development. Expressed affect should be congruent with the expressed behavior of family members (e.g., anger should not be accompanied by a smile).

Finally, clinicians should be attuned to any interactive process that contravenes known principles of healthy child development. For example, familial unavailability leading to poor attachment (Sexson et al., 2001), inconsistent limit setting associated with poor impulse control, and overinvolvement frustrating adolescent

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independence are several examples that, when observed, suggest more in-depth assessment. (The categories that organize family observation data and guidance for interviewing are summarized in Appendix B.)

Principle 3. The Family Interview Can Comprise Interviews With Individual Family Members, Groups of Members, or the Entire Family.

The family interview is the cornerstone of family assessment. In addition to members of the immediate family, the interview should include those who interact with the child on a regular, sustained basis, in a manner that the clinician judges to be influential. This could include, for example, grandparents, other family members, or live-in partners. Several meetings may be necessary to fully observe patterns of interaction and gather historical data, particularly if the family possesses complex interactional characteristics.

It is important to keep legal issues in mind when planning interviews. Parents with legal custody should provide information to the clinician and can receive information about their child. However, the caregiver(s) with primary physical custody and children who have regular contact with the identified patient are usually those who attend interviews. A parent without primary physical custody should provide information and when the child visits this parent on a regular basis, a separate interview with that parent and child will provide a more comprehensive database.

Valuable information is obtained when data obtained from a family subunit interview are contrasted with data obtained from a whole family interview. The clinician must determine whether and in what sequence other family members should be interviewed and observed in interaction with the symptomatic child or adolescent. An individual interview with a child may supplement information gathered from an initial family interview, with its importance increasing coincident with a child's increasing age. An interview with a very young child is optional, and an interview with an adolescent is essential (Leventhal and Crotts, 2004). Interviewing parents alone may provide an opportunity for the parents to freely discuss their relationship and provide differing views on their symptomatic child. Interviewing the child alone may allow the child to freely discuss conflicts that may not be easily divulged with parents present. This is particularly true with adolescents. Discrepant views of clinical problems often emerge more sharply in individual interviews and, once identified, may suggest family treatment as part of the treatment plan.

It is not uncommon for some family members to fail to attend, even when their presence has been requested. In this instance the clinician should interview all who actually attend but should be attentive to the absence of certain members and its meaning for the family. The absence of a member, most often a reluctant parent or adolescent, powerfully affects what happens in the session and is often an opportunity to understand some of the family difficulties associated with the child's presenting complaint. The family interview with members missing, although less than optimal, can nonetheless serve to provide important information, particularly when efforts to ensure their attendance at future sessions are resisted. Furthermore, some families bring individuals who are not asked to attend. Although the presence of these individuals may be socially awkward, the information provided by them often enhances the completeness of the assessment.

The child or adolescent is invariably the identified patient, and interviewing other individuals regarding the child or adolescent's functioning raises the issue of confidentiality. Parents should be made aware of issues that are of concern to the younger child. As the child becomes an adolescent, this issue becomes more complicated and the adolescent's desire for confidence is respected unless an issue of dangerousness precludes maintaining confidentiality. Although interviewing individuals separately often helps them share their history more freely, confidentiality is maintained wherever possible.

The family interview is best conducted in a comfortable room large enough to accommodate the expected number of individuals. Furniture or objects potentially harmful to younger children should be removed. Games or activities for younger children should be present to facilitate rapport with them and decrease the likelihood of their behavioral disruption (Josephson and Moncher, 1998b). The family interview can be expected to take from 1 to 2 hours depending on the clinical situation, the number of family members, and the ages of the children. Follow-up family interviews may be needed because of the complexity of clinical problems involved and the number of symptom bearers. It is not uncommon for

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one child to be the identified patient and another child to appear more symptomatic. It is important for the clinician to manage flexibly the simultaneous tasks of history taking and observing family interaction. At times, acute problems such as suicidal ideation or intense disagreement about an issue can prevent systematic gathering of background family history, effectively terminating some content data gathering while providing powerful experiential process data.

In the beginning of a family interview, each member is addressed in an informal manner that is consistent with his or her developmental level, with a goal of establishing rapport. One way that this is accomplished is by the clinician identifying family strengths and resources at the outset, best achieved through an informal interview style (Combrinck-Graham, 1994). The clinician then defines the problem by gathering relevant current and past history. While this is taking place, the clinician observes family interactions and facilitates the interactional stage with the use of probing questions. By asking family members about their individual responses, behaviors, and feelings, the clinician begins to understand how events have acquired specific meanings for each member and how these meanings differ.

It is not uncommon for conflict to emerge in the session while the clinician gathers history. At such points the antecedents and consequences of behavioral problems are not merely reported but demonstrated. A history of successful problem resolution should be reviewed, as well as discussing situations in which problems remain unresolved. A completion of the family interview includes the summation stage, in which the clinician formulates what he or she has observed, its relevance to the identified patient's problems, and the role, if any, family members may play in subsequent treatments. All of the family members should feel that they have been understood, and, whenever possible, the clinician should convey a sense of hope with respect to future family adjustment.

Principle 4. When the Clinical History Suggests Interactional Problems, the Family Members in Daily Contact With the Child Should Be Interviewed, With the Goal of Establishing An Understanding of the Family Context of Symptomatic Behaviors.

Because most families present to the clinic with a symptomatic child, it is prudent to begin a family assessment with a review of the child's symptomatology. Some problems present with an interactive focus: oppositional behavior, a child running away from home, a self-harm gesture after a family argument, or a child's refusal to eat. In these instances it is important to obtain a history of the sequence of events, behaviors, and family interactions associated with the clinical problem. The assessment goal is not only to describe the problematic behavior but also to understand the meaning and function of the behavior in relationship to the child's family. A given symptom, such as a temper tantrum, may have different meanings in different children and different families. To draw such distinctions, the family assessment must include a review of family circumstances and consequences of the problematic behavior. Questions should include a review of the family's past attempts at solving problems. In this sense, history taking, diagnostic formulation, and observation of the family occur concomitantly. During the assessment process the clinician must keep in mind the reciprocal nature of family influences. Although family interaction may be associated with symptoms in the child, the child's symptoms may provoke family responses.

Principle 5. The Family Interview Should Include Questioning Regarding Family Risk Factors for Specific Disorders.

The clinician should recognize that some disorders are associated with typical family or parenting styles, and this knowledge should inform history taking (e.g., coercive and inconsistent discipline in conduct-disordered youths [Patterson et al., 1993], parental illness, and vulnerability in children with separation anxiety). Present research is further demonstrating that psychiatric disorders have family risk factors about which clinicians should inquire (Diamond and Josephson, 2005). Acute family stress and chronic patterns of family interactions both influence clinical presentation. Acute changes, such as parental separation and divorce, may mobilize fears of abandonment (Buchanan et al., 1991). Chronic patterns of family life, such as parental unavailability and unpredictability due to substance abuse, may be associated with depression (Tamlin and Goodyer, 2001). Finally, a history of clinical symptomatology must include a review of which behavior management techniques parents have tried, either successfully or unsuccessfully. The clinician must always keep in mind that patterns of

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interaction may be primarily a response to a child with a biological vulnerability.

Principle 6. The Family Evaluation Should Provide Enough Data for a Clinician to Characterize Adequately the Family's Structure, Level of Communication, Belief System, and Regulatory Functioning.

Perhaps the most challenging aspect of family assessment is the systematic observation and categorization of the basic elements of family functioning. There is a range of dimensions, categories, and elements that various schools of assessment use (Miller et al., 2000), yet four elements are described most frequently and subsume the most clinically relevant aspects of family function: structure, communication, belief systems, and regulatory processes. (See Appendix B for a full description of the elements.) This phase of assessing family interaction is analogous to the individual mental status examination of individuals, yet it involves some skills often not part of the day-to-day practice of child and adolescent psychiatrists. (See Appendix B for interviewing guidelines.) This "systemic" evaluation includes formal history taking regarding past and present family functioning, but not infrequently interactional problems are demonstrated in the consulting room (e.g., difficulties with limit setting with an oppositional child, lack of responsivity to a child in a drug-abusing parent, lack of knowledge of child development in youthful, inexperienced parents). The assessment encourages the identification of normative processes as well (e.g., parental provision of nurturance and/or the teaching of internal self control).

Principle 7. The Family Assessment Is Enhanced by a Family Developmental History, a Marital/Relationship History, and Individual Parent History, Including a History of Psychiatric Disorders in Family Members.

Most parents recognize that how they interact with their children has an effect on them and that these interactions are in part influenced by personal and marital factors. In an empathic interview it is often possible to explore these areas with parents in a manner which unfolds naturally and is always focused on understanding their child. There is no recommended order for this exploration.

The developmental histories of each of the parents and the history of the marital relationship are foundational aspects of a family history. A systematic developmental history of each parent, including their experiences in family of origin, informs an understanding of parental personality functioning that mediates parental role functioning. Most parents' adaptive and maladaptive parenting strategies have been influenced significantly by how their parents raised them. Furthermore, as the clinician notes parental responses to the specific developmental needs of children, insights into parental personality structure are gained.

A history of both parents should identify psychiatric and/or medical disorders that may be transmitted to their children, whether through experiential or genetic mechanisms (Beardslee et al., 1996). It is important to assess the parents' level of knowledge of child development and of the child's disorder and identify specific knowledge deficits of clinical significance. The overall goal of the parent history is to allow the clinician to achieve a full perspective of parental strengths and weaknesses (Lieb et al., 2000).

The marital history is a natural extension of the individual parent history. After historical data are gathered for each parent, a natural question arises. What led these two individuals to decide to marry and/or have children together? A chronological review of relationship questions allows the clinician to understand how the choice of marital partner facilitated strengths and/or perpetuated weaknesses in each individual. A careful marital history includes data on the level of marital satisfaction, the strengths of the marriage, and each partner's comfort with roles. The strength of a marriage, or relationship, is indicated by how successfully a couple has negotiated the stages of the family life cycle. This negotiation includes anticipated challenges, such as children graduating from high school, and unanticipated challenges, such as serious childhood illness. A history of such events and the family's response to them reveals marital resources.

Furthermore, the family's position in the developmental life cycle requires that the clinician gather history relevant to each stage (Carter and McGoldrick, 1999; Combrinck-Graham, 1985; Walsh, 1993). Families with infants are dealing with issues of nurturance and emotional availability. Toddlers evoke issues of limit setting and the effects of the need for constant parental supervision. Families of school-age children work on socialization and achievement.

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Parents of adolescents are concerned about imminent independence of their child, often with contradictory evidence regarding the adolescent's readiness for complete emancipation, and they are often struggling with the mortality of their own parents. Common variations in the family life cycle, such as postdivorce relationships, blended families, and single-parent families, require specific questions as part of the family assessment. Finally, questions with developmental implications include the following: How has the parent's internalization of family experience influenced his or her parenting? How does current interactional family experience affect the developing internalized psychological life of the child? (See Appendix A for interviewing guidelines.)

Principle 8. For Complex Cases, the Clinician Should Consider Ancillary Techniques to Gather and Organize Relevant Data About Family Functioning.

Two helpful products of the family interview can be the family genogram and the family timeline. A genogram is a diagram made in conjunction with the family, or by the clinician alone, that identifies facts and relationship patterns of three or more generations of family members (Hartman, 1995; McGoldrick and Gerson, 1985). Such a tool is essential in more complex family histories. The content of the genogram allows a family history to be seen in generational context beyond the presenting complaint and concerns of immediate family members. A timeline is a simple yet graphically useful instrument that maps a sequence of important events. The timeline provides a visual representation of the onset of psychiatric problems linked to clear precipitants and family context.

Because of the complexity of family assessment, a video record of family interactions can be useful for the clinician and, at times, for the family to view themselves. Video is often used in training settings but has limitations in other settings, largely due to the time-intensive nature of video review.

Structured individual interviews that gather data on the family history of major mental disorders have been a useful research strategy (Carr, 2000). Self-report instruments describing family interaction and structure have also been used for research but may be useful in supplementing clinical assessments (Wiedemann et al., 2002). Three of the more common instruments are the Family Assessment Device (Ridenour et al., 1999), the Family Assessment Measure (Skinner et al., 2000), and the Family Adaptability and Cohesion Evaluation Scale (Olson et al., 1985). The *DSM-IV* describes the Global Assessment of Relationship Functioning, which is a clinical rating scale categorizing relationship health. Several resources summarize family measurements as assessment tools (Holm et al., in press).

Principle 9. The Evaluation of the Family Requires the Clinician's Sensitive Awareness of Cultural Differences.

The family's cultural background directly affects its views of normative family structure, communication style, belief systems, and child development (Canino and Inclan, 2001; Parke, 2000). The involvement of extended family members, style of emotional expression, and family values are examples of culturally influenced aspects of family function. It is important to understand the family's religion or world view/philosophy of life, especially when the presenting complaint involves issues directly related to these ideas (Moncher and Josephson, 2004). When families contend with issues such as precocious sexual behavior, birth control, substance use, divorce, and delinquent behavior of children, they inevitably bring to this discussion their view of how life should be lived (Josephson and Peteet, 2004). It is important for the clinician assessing the family to understand the characteristics of such a world view and its cultural correlates. On occasion, an individual from the family's culture or religion may help the clinician understand its key elements, improving the clinical accuracy of the assessment.

Principle 10. A Comprehensive Family Assessment Should Lead to Treatment Interventions That Interrupt Family Functions That May Precipitate, Predispose, or Maintain Clinical Problems and Potentiate Family Functions That Promote Health and Optimize Disease Management.

Contemporary developmental psychopathology emphasizes risk and protective factors as etiologically relevant in the onset of psychopathology. The family is but one of these factors. When the family assessment is complete, it should be integrated with the other findings of the comprehensive psychiatric assessment. With the integrated data, the clinician can develop a formulation with respect to the reciprocal effects of family influence. The clinician must have a clear

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understanding of the factors within the family that have affected the child and the aspects of the child's condition that have stressed the family. The complex judgment of determining the directional effects of family influence can be facilitated by considering certain aspects of the data gathered. Once complete, this case formulation guides the clinician in determining an approach to the family's role in treatment. Appendix C delineates assessment content areas that aid in this determination.

The goal in preparation for psychiatric treatment is to determine how and when to include the family on the basis of the collection of historical and observational family data. When it is determined that the family's interactions are responses to a child's condition that is primarily biologically mediated, a supportive psychoeducational approach follows that optimizes disease management. In some cases the family assessment suggests that family factors have maintained the problem, predisposed the child to the problem, or acutely precipitated the problem. Such a formulation indicates the need for an intervention to alter patterns of family interaction. Some family treatments will involve a combination of both approaches (Josephson, 2000; Wamboldt and Wamboldt, 2000). The communication of a formulation is an essential part of the assessment and must be empathically presented, in comprehensible terms, to parents and child.

PARAMETER LIMITATIONS

AACAP practice parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

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APPENDIX A. STRUCTURED GUIDE TO ELICITING FAMILY HISTORY

The following is a guide to the areas that should be covered in gathering a detailed family history. These are questions the clinician should consider and may, in some cases, directly ask the family or family members.

1. Family Demographics
   a. This information should include names and ages of parents and siblings, parents' occupations, current composition of family/household (including nonbiological members), health and psychiatric status of family members, and custody status.
2. Clinical Symptomatology of the Child
   a. What is the interactional context of the symptomatic behavior (e.g., oppositional behavior)? What are the typical sequences of family interaction associated with the problem?
   b. Is there a characteristic family profile associated with the clinical problem being assessed (e.g., coercive, inconsistent parenting practices in conduct-disordered children)? If so, questions related to this profile should be pursued.
   c. Is one particular person blamed for the problem? Does the family feel responsible for the clinical problem (e.g., a child's dependency), or do they perceive themselves as responding to something deviant within the child (e.g., a child's difficulty sustaining attention)?
   d. Are there family interactions that precipitated the current problem, predisposed to the current problem, or maintain the current problem?
   e. Do individual symptoms appear to maintain a family's preferred interactional pattern? What are the mechanisms?
3. Individual Parent History
   a. How did each parent negotiate his or her formative developmental years? Are there specific events in the parent's family of origin that appear to have had particular impact (e.g., sexual abuse)? Has cumulative developmental experience (e.g., having experienced harsh, punitive parenting) had an enduring effect on the parents' current parenting behaviors?
   b. Does the parent have a diagnosed mental disorder or a medical disorder that affects parenting? How does it affect parenting?

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c. What is the style of the parents' pervasive personality functioning? How does it affect parenting?
   1. Are there identifiable patterns in occupational or marital functioning that suggest personality strengths or weaknesses?
   2. Is there a particular developmental stage of child development that is problematic for the parent?
   3. How does each parent respond to siblings of the identified patient?
   4. What is the parents' level of insight and self-observation?

4. Parent Relationship History
   a. What attracted the mother and father to each other? What is the chronological history of their relationship?
   b. What were the couple's early relationship (e.g., premarital) expectations of each other? How have these been modified?
   c. Were there previous marriages or relationships? Were children the result of the relationships? What were the factors in termination of these relationships? Do such factors affect the current marriage? In what way do ex-spouses affect the current marriages?
   d. What are the current areas of satisfaction and dissatisfaction with respect to vocation, finances, sexual relationship, and parenting?
   e. What is the legal status of the parents' relationship?
5. History of Family as a Unit
   a. How has the family negotiated the anticipated events of each family developmental stage: birth of first child, young children, adolescents, and launching young adults?
   b. What are the unanticipated or unique challenges that this family has faced (e.g., unemployment, family illness)? Has the family responded in an adaptive or maladaptive manner?
   c. How has the family's socioeconomic status affected their children? Is it related to clinical presentation?
   d. How has the family's cultural and religious perspective affected their children? Is it related to clinical presentation?
   e. Are there specific events of significance (e.g., family moves, remarriages)?
   f. Is the family isolated from the larger community or is it interrelated to other groups?
   g. Is there a current theme or challenge that dominates the family's attention? How is this related to the symptomatic child?

APPENDIX B. STRUCTURED GUIDE TO ASSESSMENT OF BASIC ELEMENTS OF FAMILY FUNCTIONING

The following is a guide to four elements of basic family functioning, areas that should be covered in a comprehensive family assessment. It is structured in the format of questions the clinician should consider and, in some cases, may ask the family. The following data are gathered through family members' historical report and clinician observation of family interaction.

1. Family Structure: Family structure refers to the typical organizational and transactional patterns and hierarchies that exist between the individuals or subsystems within the family. Important components of the family structure are its adaptability or flexibility, its level of cohesiveness, and the nature of its subsystems (e.g., spousal, parental and sibling) and the boundaries between them (Minuchin, 1974).
   a. Adaptability: Healthy family function denotes a flexible structure in which transactional patterns are stable but can shift when circumstances dictate that change is needed. Clinical families may be too chaotic, with patterns and individual family roles constantly changing, or too rigid, where the family is unable to change typical ways of interacting as life's circumstances demand change. (Here, and in subsequent text, the term *clinical family* denotes families whose problems in a specific area of functioning are associated with a clinical disorder in one of their children.)
      i. How have family roles adapted to anticipated (e.g., childbirth) and unanticipated (e.g., job loss) developmental challenges? Have the family supported each other and found creative ways to persevere in the face of challenge?
      ii. What are the family rules? Are family rules clear to each member of the family? What types of discipline are used? Is unsuccessful disciplinary action modified

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when appropriate? Are there rewards as well as punishments?

b. Cohesion: Healthy family functioning is indicated by a balance between connectedness and separateness. Clinical families may be either too emotionally close (enmeshment) or too emotionally distant (disengaged).
   i. How do individuals express their autonomous selves? Is such expression seen as disloyal? Can this expression occur without family members being distressed?
   ii. Is the familial response to a member's disappointment or failure supportive or neglectful?
   iii. What is the degree and quality of concern for each other's welfare?

c. Boundaries and subsystems: Healthy family functioning is indicated by emotional boundaries between individuals and subsystems that are permeable but clear, whereas in clinical families, boundaries may be rigid, diffuse, or misaligned.
   i. Describe the composition of family subsystems: normal (e.g., marital) and pathological (e.g., father–child coalition). Have they been stable over time?
   ii. Is there evidence of boundary violation (e.g., sexual abuse, parentified child, cross-generational coalitions)? Are children drawn into parental conflict?
   iii. What is the level of executive functioning? Who is in authority? Who is in submission? Who makes decisions and how are they implemented?
   iv. Are family, especially parental and marital, roles clear, complementary, internally consistent, and comprehensive?
   v. What boundaries does the family have with the community? Does the family have membership in other groups or is it isolated? What are the boundaries with the extended family? Is there evidence of support, inclusion, or exclusion? What are the boundaries between the current family and members from previously formed families?

2. Family Communication: Family communication refers to the verbal and behavioral interactions by which family members impart information to each other about their individual needs and their perceptions of, and feelings about, others in the family. Components of family communication to be considered are clarity, directness, emotional expression, and problem solving (Walsh, 1993).

a. Clarity: Healthy family functioning is indicated by communication that is clear, direct, and consistent, with affective responses congruent to the message conveyed. Clinical families tend to communicate ambiguously and indirectly about both minor transactions and those with major importance, with affective expression that is muted, inappropriate, or incongruent.
   i. Does the family present the clinical issues clearly to the interviewer? Are family rules clear?
   ii. Are emotionally laden messages conveyed directly toward their intended effect (e.g., communications delivered conveying anger or seriousness)?

b. Emotional expression: Healthy family communication is characterized by affect that is congruent with the message conveyed. Clinical families may block the expression of feelings and do not express affect congruent with life experiences.
   i. What is the nature of family emotional expression (warm or hostile, supportive or critical)?
   ii. Is emotional expression congruent with the issues being considered (e.g., anger toward unacceptable behavior; sadness correlated with loss)?
   iii. Is there a sensitivity toward the emotional state of each family member?
   iv. Is it acceptable to express any emotion, including anger?
   v. What feelings does the family communication style evoke in the clinician?

c. Problem solving: Healthy family functioning identifies that problems exist, negotiates differences or conflicts, emphasizes positive reciprocal interactions among members, and uses new information in modifying behavior and/or perspective. Clinical families tend to have multiple individual perceptions of the problem, are unable to sacrifice toward common family

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goals, and are unable to perform the tasks necessary to assist family coping. Clinical families may be ineffective at problem solving and may have parent(s) who are poorly communicating, authoritarian, or indecisive.

i. How has the family solved past problems?
ii. Are some family members more active in the solving of problems? Are there parent-related differences in problem-solving strategies?
iii. Who makes decisions? Does he or she solicit the thoughts of all family members? What is the child's role in problem solving? Does the child have too much or too little influence?
iv. Do all of the family members contribute to the resolution of a problem, or do only those members who are involved contribute? Are there elements of enmeshment or disengagement in the process?

3. Family Belief: The third area of observation, perhaps the most difficult to assess in initial interviews, is of family belief systems or shared constructions of reality. This refers to the observation that families have a type of memory function that goes beyond that of the beliefs and memories of each of its members. Clinical observations should attempt to ascertain beliefs termed "family myths" and "family legacies." This concept refers to ideas that guide decisions and actions in the family and help contribute to repetitive patterns of interaction that families demonstrate across generations (Reiss, 1989). Healthy family beliefs empower family continuity and adaptation (e.g., a family tradition of heroism and bravery). Clinical families may have beliefs that foster maladaptation (e.g., men always leave their partners; adolescents are rebellious).
   a. What are the recurring themes in family life? Are there clusters of related problems such as alcohol-related problems, legal difficulties, or unquestioned beliefs or perceptions (e.g., men will abuse you and leave you; adolescent girls will be promiscuous).
   b. Are family roles rooted in family beliefs?
   c. Are there puzzling patterns of family interaction? Did they exist in previous generations?
4. Family Regulation of Child Development: In family health the developmental needs of children are met and their developmental tasks are mastered in the context of *family regulation* (Anders, 1989). The family must regulate the child's negotiation of these inevitable developmental tasks. Such regulation implies an equilibrium between inhibiting and facilitating interactions between caretaker and child. The parents are attuned to their child's developmental needs and facilitate the emergence of the child's autonomous regulatory capacities. Family assessment should observe behaviors and gather history, which allows the clinician to clarify the nature and impact of regulatory processes. The following questions guide the clinician's task:
   a. Does the family have a balanced, empathic response to developmental needs of its children? This can be evaluated by the following review of basic developmental issues.
      i. How does the family nurture and support?
      ii. How does the family set limits and teach internal self-control?
      iii. How does the family foster early socialization efforts?
      iv. How does the family facilitate achievement and success, including academic success?
      v. How does the family facilitate independence/selfhood and individuation?
   b. Do parents regulate development in a coordinated pattern or is there a contrast in their efforts (e.g., one parent overinvolved with children and one parent underinvolved)?
   c. Is the family pattern of regulating developmental need characterized by overregulation (an excessive response to a child's developmental need that usurps the child's autonomous regulatory capacities), underregulation (a deficient response to a child's developmental need, which thus fails to support and nurture the child's emerging regulatory capacities), inappropriate (the family's responses are appropriate for an earlier developmental stage but are inappropriately applied to a child's developmental need in the current stage), irregular (the family that is consistent in one domain of function (e.g., feeding) but inconsistent in another [e.g., monitoring socialization]), or chaotic (no discernible pattern of family response to a child's developmental need) regulation?

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APPENDIX C. AREAS OF FAMILY ASSESSMENT RELATED TO TREATMENT PLANNING

After the family assessment, the clinician should have integrated assessment data to enhance the understanding of the following areas of family functioning. This understanding can then be used in case formulation and treatment planning, specifically determining whether to primarily educate families regarding disease management or to primarily work with them on altering family interactions influencing the clinical problem.

Family Understanding of Developmental Norms

Clinical families frequently do not identify social, emotional, and cognitive development norms. They will, for example, discuss behavioral expectations with a 3-year-old child and yet refuse to discuss matters with a cognitively advanced teenager. Similarly, parents may attribute volition to the activities of a child under the age of 5, an approach that would be appropriate to understand the goal-directed behavior of a teenager. A treatment plan derived from a family assessment would necessitate at the very least educative work about development and in many instances delineate other factors that may be interfering with the parents' ability to appropriately interpret a child's behavior and development.

Influence of Parental Psychiatric Disorder

In addition to the genetic transmission of psychiatric disorders, psychiatric problems in parents affect the task of parenting. Whether it is providing nurturance, setting limits, being available for effective role modeling, or facilitating educational achievement, the psychiatric disorders of parents necessarily impinge on the needs of the child. Data from the family assessment regarding parental impairment are important for treatment planning.

Quality of Parental Commitment to the Child's Well-Being

Family correlates of conduct problems, such as lack of supervision, inconsistent and harsh discipline, and parental unavailability, may reflect a behavioral lack of commitment to the child's well-being. Aspects of parents' lives that draw them away from the labor-intensive elements of parenting may be associated with the psychiatric disorders of children. This determination is often made by inferences from the developmental and family history and clinical observations and not solely from parental self-report.

Parental Achievements Apart From Child Rearing

Another psychiatric risk factor, contrasted with relative unavailability, is relative overavailability. Facilitating a child's self-regulating autonomous capacities is an important aspect of parenting. A parent whose sense of achievement and self-esteem are overly invested in his or her children may impede a child's healthy autonomous strivings. Parents who have other interests and responsibilities in addition to parenting are often available to have a balanced view of their child's needs.

Family Members and Developmental Task Mastery

Families with parents or other children who have significant developmental problems are likely to be transmitting some of these problems to their children. Parents who have not emancipated from their family of origin, who have on a persistent basis failed to sustain intimate relationships, or who have demonstrated significant vocational failure would be examples of adults who have not mastered specific developmental tasks. Family history ascertains which children have mastered their relevant developmental tasks and are asymptomatic. A high degree of adaptive functioning in other siblings and parents suggests that a family difficulty may be a response to a child's illness rather than a cause or risk factor for psychopathology.

Assessment of the Heritability of the Child or Adolescent's Disorder

Some disorders with a strong genetic component significantly stress familial coping. Coping and adaptation difficulties should be largely attributed to the stress engendered by managing a biologically vulnerable child. Family history and observation may suggest both possibilities: a child with a genetic vulnerability and a stressful family environment.

Level of Parents' Mutual Support of Each Other

Families who are meeting the developmental and clinical needs of their children have parents who work together, are supportive of each other, and complement each other's strengths. Parents who are mutually supportive may still be contributing to a child's

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psychiatric difficulties, but this is much less likely than when there is open conflict between parents. Families in difficulty often are led by parents with diametrically opposed parenting approaches. This parental conflict has a destabilizing effect on child development.

Relationship of the Child's Behavior to Environmental Change

Sensitivity to environmental change is a strong indication that the context of the environment is a significant risk factor for psychopathology. A specific example would be the child who is not a behavior management problem at school but whose parent complains bitterly about his or her noncompliance. In contrast, concern expressed by school personnel may be met with the parents' comment: "He's not a problem for us; he is just going through a stage." Clinical problems that are not particularly responsive to a change of environment may suggest a biologically based disorder (e.g., learning disorder) about which the family may be educated. Pathology that persists across environments may not solely be due to organic factors, however, because family interactional pathology can become internalized as a child's persistent mode of behaving (e.g., oppositional behavior).

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Adolescent Depression Screening in Primary Care: Feasibility and Acceptability Rachel A. Zuckerbrot, MD, FAAP, Laura Maxon, BSN,Dana Pagar, BA, Mark Davies, MPH, Prudence W. Fisher, PhD, David Shaffer, FRCP, FRCPsych

Objective: Despite available depression treatments, only one fourth to one third of depressed adolescents are receiving care. The problem of underdiagnosis and underreferral might be redressed if assessment of suicidality and depression became a more formal part of routine pediatric care. Our purpose for this study was to explore the feasibility and acceptability of implementing adolescent depression screening into clinical practice. *Methods:* In this study we implemented a 2-stage adolescent identification protocol, a first-stage pen-and-paper screen and a second-stage computerized assessment, into a busy primary care pediatric practice. Providers tracked the number of eligible patients screened at both health maintenance and urgent care visits and provided survey responses regarding the burden that screening placed on the practice and the effect on patient/parent-provider relationships. *Results:* Seventy-nine percent of adolescent patients presenting for health maintenance visits were screened, as were the majority of patients presenting for any type of visit. The average completion time for the paper screen was 4.6 minutes. Providers perceived parents and patients as expressing more satisfaction than dissatisfaction with the screening procedures and that the increased time burden could be handled. All providers wished to continue using the paper screen at the conclusion of the protocol. *Conclusions:* Instituting universal systematic depression screening in a practice with a standardized screening instrument met with little resistance by patients and parents and was well perceived and accepted by providers. **Pediatrics** 2007;119:101–108.

Screening for Depression in an Urban Pediatric Primary Care Clinic Howard Dubowitz, MD, MS, Susan Feigelman, MD, Wendy Lane, MD, MPH, Leslie Prescott, BA, Kenneth Blackman, MS, Lawrie Grube, LCSW, Walter Meyer, MS, J. Kathleen Tracy, PhD

Objectives: The goals were to estimate the prevalence of parental depressive symptoms among parents at a pediatric primary care clinic and to evaluate the stability, sensitivity, specificity, and positive and negative predictive values of a very brief screen for parental depression. *Methods:* A total of 216 mothers (because 96% of caregivers were mothers, we use this term) bringing in children <6 years of age for child health supervision completed a parent screening questionnaire in a primary care clinic. The parent screening questionnaire, a brief screen for psychosocial problems developed for the study, includes 2 questions on depressive symptoms. Mothers then completed the computerized study protocol within 2 months. This included the parent screening questionnaire as well as the Beck Depression Inventory II. Different combinations of the depression questions were evaluated against Beck Depression Inventory II clinical cutoff values. *Results:* Twelve percent of the mothers met the Beck Depression Inventory II clinical cutoff value for at least moderate depressive symptoms. There was moderate stability of the screening questions. When a positive response to either or both of the 2 questions was considered, the sensitivity was 74%, the specificity was 80%, the positive predictive value was 36%, and the negative predictive value was 95%. *Conclusions:* Maternal depressive symptoms are prevalent. A very brief screen can identify reasonably those who could benefit from additional evaluation and possible treatment. This should benefit mothers, families, and children. **Pediatrics** 2007;119:435–443.

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