Chapter 12

Assessing Family Context

Chapter Questions

- Why is assessing a child's family context important in the clinical assessment of children's emotional and behavioral functioning?
- What dimensions of a child's family context are most important to the assessment process?
- How can one assess these important dimensions of family functioning?

Introduction

In the summary of research on childhood psychopathology provided in Chap. 3, one of the more important findings was that children's and adolescents' emotional and behavioral functioning was heavily influenced by the demands and stressors they experienced in their environment. As a result, to truly understand a child's or adolescent's psychological adjustment, one must not limit the assessment to obtaining characteristics of the youth but must also assess the important contexts that shape a child's or adolescent's behavior. There is no context more important to understanding a child or adolescent than the family context.

Causal Role of Familial Influences

Research on childhood psychopathology consistently suggests that factors within the family play a major causal role in the development of personality and psychopathology (Erickson, 1998). At times the causal role of

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a child's family has been overemphasized, either by ignoring the potential effects that a child or adolescent can have on the family (Pardini, 2008), or by ignoring the factors that can influence both the family and child (Frick & Jackson, 1993). These caveats indicate that a child's family context is only one piece of a very complex puzzle in understanding the psychological adjustment of a child or adolescent. However, research also suggests that it is a very important piece of the puzzle. Family factors play an integral role in the causal theories of many types of problems across many theoretical orientations. Box 12.1 provides examples of three different types of childhood problems from three different theoretical perspectives, all of which emphasize the family context as a causal agent in a child's adjustment problems. Therefore, if the goal of an assessment is to uncover the possible causes of a child's or adolescent's emotional or behavioral difficulties and, thereby, point the way to important treatment goals, the assessment of family functioning is critical to the assessment process.

Box 12.1

Childhood Problems in a Family Context: Examples of Three Problems and Three Theoretical Orientations

Childhood Anxiety: An Operant Perspective

One way of conceptualizing the causes of childhood anxiety has been from an operant perspective. In this model a child receives reinforcement from his or her environment that functions to maintain and increase the anxious behavior. Often this reinforcement is provided in the family context. A good example is provided by Ross (1981) of an 8-year-old girl, Valerie, with school phobia. Valerie refused to attend school, and an assessment of her home context revealed that the consequences of her refusal to go to school were indeed quite positive. Instead of going to school, Valerie was able to sleep an hour later than her three siblings who were attending school. Until her mother left for work, she was allowed to follow the mother around the house and then was taken to a neighbor's house for the day. At the neighbor's house Valerie was free to do whatever she pleased for the rest of the day, such as playing games and making occasional trips to a corner store where she bought candy, gum, and soft drinks. It was clearly a comfortable routine for both child and mother, who thereby avoided Valerie's temper tantrums.

Childhood Aggression: A Social Learning Perspective

Gerald Patterson (Patterson, 1982) and his colleagues at the Oregon Social Learning Center have developed a social learning model for the development of aggression. In this model, family interactions provide a training ground for a child to learn coercive methods of controlling interactions with others. Through analyses of micro-social interactions between parents and children, Patterson outlines the development of a coercive cycle that develops between parent and child and which escalates through aversive conditioning. The cycle starts when a parent makes a demand of a child and a child reacts aversively (e.g., whines, becomes defiant). Rather than pushing the child, the parent withdraws the demand, which reinforces the child's aversive response. During the next phase of the cycle, the parent again makes a demand of the child but decides not to give in to the child's aversive behaviors. As the child becomes more aversive (e.g., temper tantrum), the parent becomes more aversive (e.g., yelling, spanking). As the parent becomes more aversive, the child eventually complies, which reinforces the parent's increase in aversive behavior.

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Box 12.1 (Continued)

This cycle repeats itself over and over again, leading to each party reinforcing increasing levels of aversiveness in the other. This training in coercive responses is then carried over by the child into other settings with other people (e.g., teachers, peers). It is evident that the cycle is transactional: that is, both the child and the parent contribute to the escalating cycle. However, for the purpose of the current discussion, it is evident how important the child's family environment, especially parent–child interactions, is to the development of aggression within this theoretical framework.

Eating Disorders: A Family Systems Perspective

Sargent, Liebman, and Silver (1985) describe family characteristics that provide a context in which the psychological features of anorexia nervosa fit and are adaptive.

Families of a person with anorexia have been found to have parents who are overinvolved in their child's life. This overinvolvement prevents the child with anorexia from perceiving her own sensations, including hunger. It also prevents the child from developing a sense of self-competence and the ability to use problem-solving skills. As the anorexia worsens, the family becomes more protective and involved and further inhibits the affected child from acting more maturely and adaptively. Families of a child with anorexia also tend to have difficulty resolving conflict. As a result of unresolved marital conflict, the parents have difficulty collaborating to handle the child's symptoms and actually counteract each other in their attempts. These are just a few of the family dynamics that family system theorists have proposed to explain the development and maintenance of anorexia nervosa in a child. However, it clearly illustrates the primary role of the family context for understanding a child with an eating disorder.

Family History and Differential Diagnoses

Two other facts emerge from research on childhood psychopathology that point to the importance of assessing a child's family context in clinical assessments. First, childhood emotional and behavioral problems tend to be rather amorphous, lacking clear boundaries, more so than is the case in adult psychopathology (see Lilienfeld, 2003). Stated another way, children with problems often have multiple types of problems, and it is often difficult to know what is primary and what might be secondary. Second, there seems to be a parent–child link to many types of psychopathology, with parents and children showing similar patterns of adjustment (McMahon & Dev Peters, 2002). Taking these two facts together, assessment of the adjustment of parents in whom the type of problem may be more clearly defined may provide clues to the primary problem of the child.

An example from research on childhood affective disorders illustrates the use of family history data in making a differential diagnosis. Prior to adolescence, the diagnosis of a bipolar affective disorder is difficult to make. But research suggests that a significant proportion of children with a depressive disorder will develop a bipolar disorder later in life (Geller, Fox, & Fletcher, 1993). Geller et al. found that obtaining a family psychiatric history helped to predict which children with a depressive disorder were at most risk for developing a bipolar disorder. Specifically, the presence of a family history of a bipolar disorder significantly predicted which of the children with depression would later begin to cycle between manic and depressive states. This study also illustrates the important treatment implications for mak-

ing differential diagnoses. Children who were depressed and had a family history of bipolar disorders were more likely to have manic behaviors develop following treatment with anti-depressant medication than were the depressed children without a family history of bipolar disorder. A case study in which family history information was used in making a differential diagnosis is provided in Box 12.2.

Interpreting Information Provided by the Parent

Many of the assessment techniques discussed throughout this book rely on the report of family members in the assessment of child or adolescent adjustment. As a result, another important reason for assessing a child's family context is that factors within the family can affect the

Box 12.2

Family History and Differential Diagnosis: A Case Study of a 7-Year-Old Girl with Social Phobia

Claire is a 7-year, 2 month-old girl who was in the middle of the first grade when her teacher recommended that she be tested at an outpatient mental health clinic. Her teacher was concerned that she might have Attention Deficit Hyperactivity Disorder. Claire seemed bright and capable of learning and, in fact, performed quite well in one-on-one situations with the teacher or teacher's aide. However, in the general classroom setting, Claire rarely finished her work. She was often noted to be staring off into space and she had to be constantly redirected back to her work. Her teacher emphatically stated that Claire was not a behavior problem. In fact, Claire was quite quiet and reserved and even had difficulty asking for help when it was needed.

There were several differential diagnoses that were considered in the psychological evaluation of Claire. A psychoeducational evaluation that included an intelligence test and an academic screener indicated that Claire was quite capable of learning at or above a level expected for her age. Therefore, her problems in school did not seem to be caused by the presence of an intellectual deficit or a learning disability. However, the differential diagnosis between an attention deficit disorder and an anxiety disorder was more difficult, as she exhibited many behaviors consistent with both types of problems. Several pieces of information helped make the decision that Claire's primary problem was one of anxiety, and particularly, social anxiety.

First, Claire's attentional difficulties tended to be much milder than would be expected for children with attention deficit hyperactivity disorder, as indicated by structured interviews conducted with Claire's mother and teacher and rating scales completed by her mother and teacher. Second, Claire showed a number of other symptoms of anxiety in social situations. For example, she refused to go to Sunday school at church and to other social activities (e.g., parties) and she had one good friend in the neighborhood but would only spend time with her if they were alone. Third, Claire's mother had a history of agoraphobia that had led to several lengthy periods in which she could not leave the house because of her fears.

In this example a family history of anxiety was just one piece of the assessment that helped to make the differential diagnosis. However, it seemed to be an important piece. The diagnosis itself ended up being important because rather than treatment focusing on Claire's attentional problems, a treatment strategy that used systematic desensitization to social situations was implemented, with Claire's teacher reporting dramatic improvements in Claire's school performance by the end of the year.

information provided by family members on the child's adjustment. To appropriately interpret the information obtained from parents and other family members, one must understand those factors that could influence a parent's accuracy in providing information on a child. For example, a noncustodial parent involved in a custody dispute may try to inflate the problems of a child in an effort to get a more favorable court decision. In contrast, the custodial parent may have motivations to present the child in a more positive light. A second example would be parents who are trying to have their child placed in a residential treatment center and who may inflate problems in an effort to justify this placement. These are just two examples of a myriad of familial factors that can affect how one interprets the information provided by family members.

De Los Reyes and Kazdin (2005) provide a review of several family factors that can influence parent ratings of the child including family stress, the parent–child relationship, and the level of marital discord. De Los Reyes and Kazdin (2005) also note several aspects of parental adjustment that can influence how parents rate their children's adjustment. One area that has been the focus of substantial research is on the effects of depression on parents' report of their child's adjustment. There have been numerous studies that have called into question the accuracy of depressed mothers' reports about their children's behavior (see De Los Reyes & Kazdin, 2005 and Richters, 1992 for reviews). This research has suggested that depressed mothers report more problems in their children than are reported by nondepressed parents and teachers and more than are detected using direct behavioral observations of the children. These findings have led many authors to conclude that parents' depression leads to a distorted view of the children's behavior. We summarize Richter's (1992) review and critique of this literature in Box 12.3.

Box 12.3

Research Note: Depressed Mothers as Informants About Their Children: A Critical Review

John Richters (1992) conducted a critical review of the research on the effects of depression on a parent's rating of a child's behavior. Richters cited 17 studies that have been published calling into question the accuracy of depressed mothers' reports. In general, depressed mothers have tended to report more behavior problems in their children than the level reported by teachers, fathers, or children and greater than that observed in behavioral observations. All of these studies led researchers to the conclusion that depressed mothers' perceptions of their children's behavior were biased by their own level of depression. However, Richters's critical review of several methodological and interpretive problems that have plagued this body of research calls into question this depressive bias theory.

The first major problem in these studies was the fact that most of the comparisons between mothers and other informants used measures that were discordant on either the types of behaviors assessed or the situation in which the behaviors were assessed. The best example was the frequent comparison between mothers' and teachers' ratings on a behavior rating scale that had a different item content. In this case, both the behaviors assessed and the situation in which the behaviors were being observed were discordant. As a result, it is unclear whether the differences between mothers and the other raters were due to maternal depression or to differences in the behaviors and/or situations being assessed. Only 27% of the comparisons between depressed mothers and

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Box 12.3 (Continued)

other informants used ratings that were both behaviorally and situationally concordant.

The second pervasive problem in this literature is the fact that most of the studies (94%) did not demonstrate that the mothers' overreporting was systematically related to maternal depression. Twenty-four percent of the studies simply documented that depressed mothers reported more behavior problems in their children than did nondepressed mothers. Seventy-one percent indicated that maternal depression predicted variance in mothers' ratings of their children that was not accounted for by criterion ratings provided by other informants. Richters argues that the most direct evidence for the depression distortion hypothesis would be if mother-criterion disagreements were systematically related (correlated) with measures of maternal depression.

The third problem discussed by Richters is that most of the studies (94%) focused only on maternal depression. It is well established that depression is related to other factors within the individual (e.g., other forms of psychopathology) and the environment (e.g., marital satisfaction). Therefore, it is unclear whether or not mothers' disagreements with informants were due to the depression or to other aspects of the mothers' adjustment and/or concomitant stressors in the family environment.

As a result of these problems, Richters suggested that we must be cautious in accepting the depression distortion hypothesis until more refined research is conducted. In fact, Richters cites five studies that used better methodology and found that depressed mothers agreed with other informants as well or even better than nondepressed mothers. However, these are only a few studies, and they are not without flaws themselves. At this point, however, clinical assessors should at least be aware of the issues, many of which are unresolved, in this very important body of research.

Source: Richters, J. E. (1992). Depressed mothers as informants about their children: A critical review of the evidence for distortion. *Psychological Bulletin, 112*, 485–499.

Like parental depression, there is also evidence that parental anxiety may influence a parent's report of childhood problems (Briggs-Gowan, Carter, & Schwab-Stone, 1996). Frick and colleagues (Frick, Silverthorn, & Evans, 1994) found that in a sample of 41 clinic-referred children between the ages of 9 and 13, mothers tended to report more symptoms of anxiety disorders than did the child. This overreporting was systematically related to anxiety in the mother. Specifically, the more anxious the mother, the greater the overreporting of anxiety in the child. These authors also reported that maternal anxiety was not associated with overreporting of other types of maladjustment but seemed to be more specifically related to anxiety. This pattern of results would be consistent with the possibility that anxious mothers project their anxiety symptoms onto their reports of anxiety in their children.

Assessing Family Functioning: General Issues

To this point we have discussed several reasons why assessing the family is an important part of clinical assessments of a child or adolescent. In this section we discuss more specifically *what* areas of family functioning should be assessed and *how* this can be accomplished. However, before discussing specific areas and techniques, two general points deserve mention.

First, many of the behavior rating scales that were reviewed in previous chapters have subscales that assess various aspects of a child's family context. For example, the parent-completed Personality Inventory for Children-2 (PIC-2; Lachar & Gruber, 2001) and the child self-report Personality Inventory for Youth (PIY; Lachar & Gruber,

1994) both include a Family Relations scale. Included in this scale are items assessing marital stability, consistency in discipline, emotional tone of family, community connectedness, and parental adjustment. The MMPI-A contains a supplementary content scale, the Adolescent-Family Problems scale (Archer, 1992), which includes 35 items assessing an adolescent's perceptions of family conflict, level of love and acceptance in the home, family communication, and emotional support provided by the family. The BASC-2 Self-Report Scale (Reynolds & Kamphaus, 2004) contains a Relations with Parents scale that assesses a child's perceptions of being important in the family, the quality of parent–child interactions, and the degree of parental trust and concern. All of these scales provide a time-efficient screening of many important aspects of a child's family environment. The main drawback is that each scale combines many different aspects of a child's family environment, making it impossible to uncover specific areas of strength and/or dysfunction that could be important in understanding a child and in making treatment recommendations.

This criticism leads to our next general comment for assessing a child's family context. What areas to assess and how rigorous the assessment should be within these areas will vary depending on the purpose of the evaluation. In the sections that follow we make the case that several aspects of the family should be routinely assessed: parenting style and parenting practices, parenting stress, marital conflict, and parental adjustment. The depth of the assessment in each area and which additional areas of family functioning should be assessed will vary depending on the individual case. For example, the assessment of a child by a school psychologist to document emotional and behavioral factors that might be impairing academic performance may include only minimal assessment of the child's perception of the family environment and only as it may influence his or her behavior in the classroom. In contrast, an assessment designed to assess a child's adjustment to a recent parental divorce in order to make treatment recommendations on factors that could aid in the child's post-divorce adjustment may include a substantial family component. This assessment will most likely include obtaining extensive information on the level of parental conflict and level of parental cooperation in child-related issues, as these factors are crucial to understanding a child's adjustment to divorce (Amato & Keith, 1991).

Another type of assessment that requires very detailed and somewhat specialized assessment of family functioning is in the case of known or suspected child abuse. A recommended assessment strategy for cases of child abuse is summarized in Box 12.4. These examples illustrate the point that how intensive the assessment of family factors will be and which familial factors will be assessed may vary somewhat from case to case.

General Considerations in Assessing Family Functioning

In the subsequent sections, we review several critical areas of family functioning that we feel are particularly important in the clinical assessments of children and adolescents. In each case, we provide a brief overview of the research supporting the importance of each aspect of family functioning for understanding a child's adjustment. This is followed by a summary of some commonly used measures to assess that domain of functioning. It is important to note that most of the assessment methods that were chosen for review were parent-report or child-report measures of family functioning. This was done for several reasons. First, these methods typically are the most time

Box 12.4

Research Note: A Child Abuse and Neglect Assessment Strategy

Crooks and Wolfe (2007) outline a conceptual model to guide assessments of child abuse and neglect. Their model emphasizes the need to understand, not only the abusive behavior of the parent, but the family context in which the abuse takes place. They note that "the impact of maltreatment depends on not only the severity and chronicity of the abusive events themselves but also how such events interact with the child's individual and family characteristics" (p. 646). As result, an assessment must focus on a myriad of individual, familial, and cultural factors that research has related to child abuse and neglect, as well as the possible protective factors that can reduce the impact of these risk factors.

On the basis of this view of child abuse and neglect, Crooks and Wolfe suggest that most assessments need to be comprehensive and need to address the following general purposes: (1) identify the general strengths and needs of the family system; (2) assess parental responses to the demands of child-rearing; (3) identify the needs of the child; and (4) assess parent–child relationship and abuse dynamics. A summary of the important assessment objectives that follow from these overall goals is provided below. Interested readers are referred to the Crooks and Wolfe chapter in which they provide recommendations for specific techniques to accomplish each of these goals. Many of these techniques are reviewed in other chapters of this text.

Goal 1: Identify General Strengths and Problem Areas of Family System

A. Family Background
   1. Parental history of rejection and abuse during own childhood.
   2. Discipline experienced by parents during own childhood.
   3. Family planning and effect of children on the marital relationship.
   4. Parents' preparedness for and sense of competence in child rearing.

B. Marital Relationship
   1. Length, stability, and quality of marital relationship.
   2. Degree of conflict and physical violence in marital relationship.
   3. Support from partner in child rearing.

C. Areas of Perceived Stress and Supports
   1. Employment history and satisfaction of parents.
   2. Economic stability of family.
   3. Social support for parents, both within and outside the family (e.g., number and quality of contacts with extended family, neighbors, social workers, and church members).

D. Parental Physical and Mental Health
   1. Recent or chronic health problems
   2. Drug and alcohol use
   3. Emotional disturbance and social dysfunction

Goal 2: Assess Parental Responses to Child-Rearing Demands

A. Emotional Reactivity of Parent
   1. Parents' perception of how abused child differs from siblings and other children.
   2. Parents' feelings of anger and loss of control when interacting with child.
   3. Typical methods of coping with arousal during stressful episodes.

B. Child-Rearing Methods
   1. Appropriateness of parental expectations for child behavior, given child's developmental level.
   2. Typical methods used by parents for controlling/disciplining the child.
   3. Willingness of parents to learn new methods of discipline.
   4. Parents' perception of effectiveness of discipline strategies.
   5. Child's response to discipline attempts.

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Box 12.4 (Continued)

Goal 3: Identify Needs of the Child

A. Child Social, Emotional and Behavioral Functioning
   1. Behaviors that may place this child at risk for abuse.
   2. Problems in adjustment resulting from abuse and living in family with multiple stressors.

B. Child Cognitive and Adaptive Abilities
   1. Identify child's developmental level and coping capacity to determine most appropriate method and level of intervention.
   2. Determine if abuse or chronic family stressors have led to cognitive delays or delays in the child's development of adaptive behaviors.
   3. Child's attributions for the abuse and reaction to family difficulties.

Goal 4: Assessing Parent–Child Relationship and Abuse Dynamics

A. Risk of parent for future abuse and neglect.
B. The quality of the parent-relationships.
C. Parental empathy toward children's feelings

Source: Crooks, C. V., & Wolfe, D. A. (2004). Child abuse and neglect. In E. J. Mash & R.A. Barkley (Eds.), *Assessment of childhood disorders* (4th ed., pp. 639–684). New York: Guilford Press.

efficient method for collecting information on the child's family. Second, these measures are often standardized and easily obtainable. Third, these rating scales tend to have the best normative data that allow for interpretations of scores based on some comparison group. Thus, these rating scales tend to be the most useful in many clinical assessments.

However, such assessment methods are not without limitations. Morsbach and Prinz (2006) reviewed eight measures that use parent-report of their own parenting behaviors. Their evaluation of these measures suggests that most demonstrated acceptable internal consistency (.70 and above). Further, most measures showed moderate concordance between parent and child ratings of parenting (.23–37) with somewhat higher concordance between reports of the two parents and between parent report and observations of parenting behavior. However, these authors noted that parents are often asked to make estimates of high-frequency behaviors (e.g., yelling) over long periods of time (e.g., 6 months) which may make accurate reports difficult. Further, they noted that many of the questions deal with sensitive issues that may not be socially desirable and may be considered intrusive by parents. As a result, such questions could result in biases in their responses. Finally, these authors also noted that many scales often include vague quantifiers (e.g., frequently, sometimes, never) that may also influence the accuracy of parents' responses.

Thus, although we have chosen to focus largely on ratings scales for the assessment of family functioning for the reasons noted above, it is important to recognize the limitations in the information obtained by this assessment format. As noted by McMahon and Frick (2007), information obtained by these measures should be interpreted with other assessment information, such as interviews and behavioral observations, whenever possible.

Parenting Styles and Practices

There is broad consensus that parenting behaviors exert a significant influence on child development. There is less consensus regarding the specific aspects of parenting that are most crucial to child adjustment. However, Darling and Steinberg (1993) provide a good context for conceptualizing parenting and its effect on child and adolescent adjustment.

Darling and Steinberg (1993) divide parenting into two main components: parenting styles and parenting practices. These authors define parenting styles as "a constellation of attitudes toward the child that are communicated to the child and create an emotional climate in which the parents' behaviors are expressed" (p. 493). These authors use Baumrind's (1971) typology to exemplify parenting style. Baumrind divides parenting styles into three types. The *authoritarian* style is characterized by a rule-adherence orientation that de-emphasizes autonomy and emotional support. The *permissive* style is a child-centered style in which child autonomy is of primary importance and rules and demands are minimal. The *authoritative* style is characterized by emotional support and respect for appropriate autonomy in the child but in the context of clearly defined and consistently enforced rules. It is this last parenting style, Authoritative, that research has consistently linked to healthier child adjustment.

In contrast to parenting style, parenting practices are defined as the techniques used by the parent to socialize their child and enforce rules. For example, a specific discipline practice (e.g., degree of corporal punishment), use of positive parenting strategies (e.g., praise and reward for appropriate behavior), consistency in parenting, and appropriate supervision and monitoring of a child's behavior by a parent are all examples of parenting practices that have been linked to child adjustment (Frick, 1994).

The unique contribution of Darling and Steinberg's model of parenting is not only its explicit distinction between parenting style and parenting behaviors but also its clear specification of how these factors interact to influence child development. Specifically, parenting style provides a context in which parenting behaviors influence a child's development. As a result, the same parenting behavior may have different effects on a child depending on the parenting style. For example, there is a generally accepted association between adolescents' school performance and their parents' involvement in their schooling. However, the effectiveness of parents' school involvement in facilitating academic achievement has been found to be greater among parents who have an authoritative parenting style than among parents who show an authoritarian parenting style (Steinberg, Lamborn, Dornbusch, & Darling, 1992).

The implications of this model of parenting are important for clinical assessments of children and adolescents. It suggests that, to understand the effects of parenting on a child or adolescent's development, one must assess both parenting style and parenting practices. In the following sections, we provide a review of some measures that have been used to assess both parenting style (The Family Environment Scale – Moos & Moos, 1986) and parenting practices (Alabama Parenting Questionnaire – Shelton, Frick, & Wootton, 1996; the Parenting Scale – Arnold, O'Leary, Wolff, & Acker, 1993; Dyadic Parent–Child Interaction Coding System; Eyberg, Nelson, Duke, & Boggs, 2005).

Family Environment Scale-Second Edition (FES)

The FES (Moos & Moos, 1986) is a 90-item true-false questionnaire that is widely used to assess persons' perceptions of their family environment. It is one of the most widely used instruments for assessing

family processes (Piotrowski, 1999). It has been used to assess family functioning in a wide variety of cultures (Bao-Yu & Lin-Yan, 2004; Teufel-Shone et al., 2005) and in families of children with a range of adjustment problems including Attention Deficit Hyperactivity Disorder (Pressman et al., 2006), anxiety disorders (Suveg, Zeman, Flannery-Schroeder, & Cassoano, 2005) and affective disorders (Belardinelli et al., 2008).

The FES can be completed by the parent and/or child (over 11 years). There are three forms of the FES. We focus on the Real Form (Form R) of the FES, which measures the respondent's actual perceptions of the family environment. However, there are also two special forms of the FES. The Ideal Form (Form I) allows the respondent to answer items in terms of the type of family he or she would ideally like. The Expectations Form (Form E) allows the respondent to answer items in terms of what he or she expects family environments to be like.

Content

The FES is divided into ten subscales from three domains: Relationships, Personal Growth, and System Maintenance. A description of the ten subscales within these domains is provided in Table 12.1. The item content was primarily developed on the basis of family systems theory. This is evident from the emphasis on family structure and organization and the focus on the transactional patterns between members of

Table 12.1 Subscales of the Family Environment Scale

Dimension	Subscale	Description of Item Content
Relationship	Cohesion	Commitment, help, and support provided by family members
	Expressiveness	Extent to which family members are encouraged to express feelings
	Conflict	Amount of anger, aggression, and conflict among family members
Personal growth	Independence	Extent to which self-sufficiency, assertiveness, and independence are encouraged in the family
	Achievement orientation	Extent to which activities of family members are achievement-oriented and competitive
	Intellectual-cultural orientation	Degree of interest in political, social, and cultural activities
	Active-recreational orientation	Emphasis placed on participation in social and recreational activities
	Moral-religious emphasis	Importance placed on ethical and religious issues
System maintenance	Organization	Importance placed on having a clear family structure and well-defined roles
	Control	Degree to which rules and procedure for family are explicit

Source: Moos & Moos (1986).

the family in the FES item content. Also, as evident from the content, the FES is best thought of as a measure of parenting style or family climate, rather than of specific parenting practices.

Norms

The FES manual reports information on a large normative sample that included 1,125 families from all regions of the country, single-parent and multi-generational families, families drawn from ethnic minority groups, and families of all age groups (Moos & Moos, 1986). It is unclear how representative the sample is on each of these variables. However, the authors note that 294 families from the normative sample were drawn randomly from specified census tracts in the San Francisco area, and the means and standard deviations of FES scales did not differ between this group and the rest of the normative sample.

Although the normative group includes families of all age groups, it is notable that the majority of the normative samples was based on the reports of adults, with much less data available on the reports of children and adolescents. This is important because the authors found small but systematic differences between the scales completed by parents and adolescents (Moos & Moos, 1986). Specifically, adolescents perceived less emphasis on cohesion, expressiveness, independence, and intellectual/religious orientation and more emphasis on conflict and achievement than did their parents.

Reliability and Validity

The ten subscales of the FES generally have been shown to have acceptable levels of reliability in many samples. The manual reports internal consistency estimates in a large community sample (n = 1,067) ranging from α = 61 to α = 78 (Moos & Moos, 1986). Two-month test-retest reliability in a smaller community sample (n = 47) ranged from r = 68 to r = 86. One note of caution for the reliability of the FES is finding that the reliability of the scales may be lower in adolescent samples (Boyd, Gullone, Needleman, & Burt, 1997).

Moos and Moos (1986) provide a good summary of over 100 research articles using the FES, which attests to its correlation with other measures of family functioning, its ability to differentiate distressed from nondistressed families, and its sensitivity to treatment effects. Many more studies have been published since this review (Piotrowski, 1999).

As noted above, the FES has been widely used with several different clinical populations of children and adolescents. For example, using the FES, Suveg et al. (2005) noted that mothers of children with an anxiety disorder showed less emotional expressiveness than non-clinic referred children (ages 8–12). As another example, Pressman et al. (2006) found that families of children and adolescents with Attention Deficit Hyperactivity disorder reported higher rates of family conflict on the FES. Finally, Lucia and Breslau (2006) reported that higher levels of family cohesion, as measured by the FES when children were age 6, were associated with fewer emotional and attentional problems in the children at age 11.

Probably the biggest threat to the validity of the FES is the failure to validate the scale structure through factor analyses. The scales were designed primarily on the basis of content and face validity. Unfortunately, factor analyses have generally isolated anywhere from two (e.g., Fowler, 1982) to six (Sanford, Bingham, & Zucker, 1999) or seven (Robertson & Hyde, 1982) factors on the FES. No study has provided convincing evidence supporting the ten-scale structure that is the basis for most interpretations from the FES.

Alabama Parenting Questionnaire (APQ)

The APQ (Shelton et al., 1996) is a measure of parenting behavior that was developed for use with parents of elementary-school-aged children and adolescents (6 to 17 years old). However, it has been used in samples as young as ages 3 and 4 (Clerkin, Marks, Policaro, & Halperin, 2007; Dadds, Maujean, & Fraser, 2003) with some modification of its content. It consists of 42 items that are presented in both global report (i.e., questionnaire) and telephone interview formats, and there are separate versions of each format for parents and children. Also, Elgar, Waschbusch, Dadds, and Sivaldason (2007) have developed a 9-item short version of the scale for use as a brief screener.

Most of the research using the APQ has used the questionnaire formats. Items on this format are rated on a five-point Likert-type frequency scale and ask the informant how frequently each of the various parenting practices typically occurs in the home. On the telephone interview format, four interviews are conducted with parents and children with at least 3 days between each interview. The informant is asked to report the frequency with which each parenting practice has occurred over the previous 3 days and responses for each item are averaged across the four interviews.

Content

The content of the APQ was developed to assess the five dimensions of parenting that have been most consistently related to behavior problems in youth: Involvement, Positive Parenting, Poor Monitoring/Supervision, Inconsistent Discipline, and Corporal Punishment (Shelton et al., 1996). It also includes several other items assessing "other discipline practices," such as use of time out or taking away privileges. The items on the APQ and its subscales are provided in Table 12.2. The items used on the 9-item short version are also designated in this table (Clerkin et al., 2007). Studies using the APQ often have used scores from the individual scales (e.g., Frick, Christian, & Wootton, 1999) or they have used composites of these scales (e.g., Frick, Kimonis, Dandreaux, & Farrell, 2003). There

Table 12.2 Subscales of the Alabama Parenting Questionnaire

Involvement
1. You have a friendly talk with your child
4. You volunteer to help with special activities that your child is involved in (such as sports, boy/girl scouts, church youth groups)
7. You play games or do other fun things with your child
9. You ask your child about his/her day in school
11. You help your child with his/her homework
14. You ask your child what his/her plans are for the coming day
15. You drive your child to a special activity
20. You talk to your child about his/her friends
23. Your child helps plan family activities
26. You attend PTA meetings, parent/teacher conferences, or other meetings at your child's school

(Continues)

Table 12.2 (Continued)

Positive parenting

2. You let your child know when he/she is doing a good job with something[a]
5. You reward or give something extra to your child for obeying you or behaving well
13. You compliment your child when he/she does something well[a]
16. You praise your child if he/she behaves well[a]
18. You hug or kiss your child when he/she has done something well
27. You tell your child that you like it when he/she helps around the house

Poor monitoring/supervision

6. Your child fails to leave a note or to let you know where he/she is going[a]
10. Your child stays out in the evening past the time he/she is supposed to be home[a]
17. Your child is out with friends you do not know[a]
19. Your child goes out without a set time to be home
21. Your child is out after dark without an adult with him/her
24. You get so busy that you forget where your child is and what he/she is doing
28. You don't check that your child comes home from school when he/she is supposed to
29. You don't tell your child where you are going
30. Your child comes home from school more than an hour past the time you expect him/her
32. Your child is at home without adult supervision

Inconsistent discipline

3. You threaten to punish your child and then do not actually punish him/her[a]
8. Your child talks you out of being punished after he/she has done something wrong[a]
12. You feel that getting your child to obey you is more trouble than it's worth
22. You let your child out of a punishment early (like lift restrictions earlier than you originally said)[a]
25. Your child is not punished when he/she has done something wrong
31. The punishment you give your child depends on your mood

Corporal punishment

33. You spank your child with your hand when he/she has done something wrong
35. You slap your child when he/she has done something wrong
38. You hit your child with a belt, switch, or other object when he/she has done something wrong

Other discipline practices

34. You ignore your child when he/she is misbehaving
36. You take away privileges or money from your child as a punishment
37. You send your child to his/her room as a punishment
39. You yell or scream at your child when he/she has done something wrong
40. You calmly explain to your child why his/her behavior was wrong when he/she misbehaves
41. You use time out (make him/her sit or stand in corner) as a punishment
42. You give your child extra chores as a punishment

[a]Items that are included in the 9-item short screening version of the APQ (Clerkin et al., 2007).

are two common ways of forming composite scores. The first way is to standardize the scores (e.g., create z-scores) and then combine the Involvement and Positive Parenting scales into a Positive Parenting Composite and the Poor Monitoring/Supervision, Inconsistent Discipline, and Corporal Punishment scales into a Negative Parenting Composite. The second method for forming composites from the APQ is to create a single Dysfunctional Parenting composite by standardizing all five scales, inversely scoring the positive parenting scales, and summing all five dimensions.

Norms

One of main limitations in the APQ is the lack of norm-referenced scores that can be used to interpret the scales. However, there are now two studies that provide scores from fairly large samples of non-referred children, from which cut-scores can be developed. The first study was conducted with 1,402 children ages 4 to 9 (Elgar et al., 2007) in Australia and the second study was conducted with 1,219 German school children ages 10 to 12 (Essau, Sasagawa, & Frick, 2006).

Reliability and Validity

As noted previously, most of the published research using the APQ to date has utilized the global report formats of the scale, with the exception of Shelton et al. (1996). Across studies, the reliability and stability of APQ scores have generally been acceptable with several notable exceptions. First, the internal consistency of the short three-item Corporal punishment scale has often been quite low on all formats. Second, the internal consistency of the Poor Monitoring/Supervision scale has been low in the interview format (all alphas below .50 – Shelton et al., 1996). Third, Frick et al. (1999) showed poor reliability of the child-report formats in very young children (below age 9) (see also Shelton et al., 1996).

Several studies have provided factorial support for the five dimensions around which the scale was developed (Elgar et al., 2007; Essau et al., 2006). Also, parent ratings on the APQ are significantly associated with observations of parenting behavior in 4- to 8-year-old boys (Hawes & Dadds, 2006). However, the most common use of the APQ has been to study parenting in families of children with conduct problems. An association between APQ scales and conduct problems has been reported in community (Dadds et al., 2003), clinic-referred (Frick et al., 1999; Hawes & Dadds, 2006), and inpatient samples (Blader, 2004), as well as in families with deaf children (Brubaker & Szakowski, 2000) and families with substance-abusing parents (Stanger, Dumenci, Kamon, & Burstein, 2004). Also, these studies have documented this relationship in samples as young as age 4 (Dadds et al., 2003; Hawes & Dadds, 2006) and as old as age 17 (Frick et al., 1999).

Importantly, Frick et al. (1999) reported some differences in which dimensions of parenting were most strongly associated with conduct problems at different ages, with Inconsistent Discipline being most strongly associated in young children (ages 6–8), Corporal Punishment being most strongly associated in older children (ages 9–12), and Involvement and Poor Monitoring/Supervision being most strongly related in adolescents (ages 13–17).

Although the most common use of the APQ has been to assess parenting in families of youth with conduct problems, it has been used to assess family correlates to anxiety disorders (Pfiffner & McBurnett, 2006) and to assess parenting in families of depressed parents (Cummings, Keller, & Davies, 2005). Finally, several studies have used the APQ scales to test changes in parenting behaviors following treatment (e.g., Feinfield & Baker, 2004; Hawes & Dadds, 2006).

Parenting Scale (PS)

The PS (Arnold et al., 1993) is another commonly used measure of parenting. It is a 30-item parent report scale that focuses specifically on parents' attitudes and beliefs about discipline. The items are all rated on a seven-point scale in which the parent is asked to estimate the probability with which they would use a particular discipline strategy (e.g., when my child misbehaves, I spank, slap, grab, or hit my child). It was originally developed for use with young children (ages 18–48 months; Arnold et al., 1993) and has primarily been used to assess parenting in preschool children. However, there is evidence for its utility in samples of children as old as 11 years of age (Prinzie, Onghena, & Hellinckx, 2007; Steele, Nesbitt-Daly, Daniel, & Forehand, 2005).

Content

The PS items can be grouped into three dimensions: Laxness, Overreactivity, and Verbosity. There has been some debate over the appropriateness of this three scale structure because it has obtained factor analytic support in some studies (i.e., Arney, Rogers, Baghurst, Sawyer, & Prior, 2008; Arnold et al., 1993; Rhoades & O'Leary, 2007) but not in others (Prinzie et al., 2007; Reitman et al., 2001; Steele et al., 2005). The difference in the factor analyses typically involves whether the Verbosity factor emerges as a separate dimension. Also, Rhoades and O'Leary (2007) developed a PS-Should scale that was designed to assess how parents believe they "should discipline their children," rather than assessing their report of actual discipline practices.

Norms

One of main limitations in the PS is the lack of norm-referenced scores that can be used to interpret the scales. However, there are several studies that provide scores from fairly large samples of non-referred children from which cut-scores can be developed. Arney et al. (2008) provided data from 1,656 mothers of children (ages 3–5) from South Australia and Prinzie et al. (2007) provided data from 596 mothers and 559 fathers of children ages 5 to 11 years in Belgium. Finally, Rhoades and O'Leary (2007) provided data on 453 families of children ages 3 to 7 years from the northeast United States.

Reliability and Validity

Most studies of the PS show adequate internal consistency and test-retest reliability for the PS (e.g., Arnold et al., 1993; Rhoades & O'Leary, 2007) with the exception of the Verbosity scale (Arney et al., 2008). Further, the PS has been shown to be correlated with other measures of parenting practices (Rhoades & O'Leary, 2007; Steele et al., 2005) and has been associated with measures of adjustment problems in children (Arney et al., 2008; Prinzie et al., 2007). Scores on the PS have also been shown to be sensitive to effects of interventions designed to improve parenting behaviors (Sanders, Markie-Dadds, Tully, & Bor, 2000).

Dyadic Parent–Child Interaction Coding System (DPICS)

The DPICS (Eyberg et al., 2005) is a highly structured coding system designed to assess maternal behaviors and parent–child interactions in several standard settings. In contrast to the other measures of parenting that have been reviewed, the DPICS is an observational system. It has typically been used to code parent–child interactions of preschool children (e.g., Eisenstadt, Eyberg, McNeil, Newcomb, & Funderbunk, 1993; Robinson & Eyberg, 1981). Parents and

children are observed in two 5-min periods, typically in a clinic playroom setting. In the Child Directed Interaction (CDI) the parent is instructed to allow the child to choose any activity and to play along with the child. In the Parent Directed Interaction (PDI) the parent is instructed to select an activity and to keep the child playing according to parental rules.

Content

The 5-min interactions are videotaped for later coding. The DPICS includes a detailed manual for coding several parent and child behaviors. The system codes 12 parent and 14 child behaviors. A summary of these behaviors included in the DPICS is provided in Table 12.3. In addition to discrete behaviors, several additional categories are included in the DPICS to code sequences of behaviors. Parental responses (i.e., ignores or responds) to child's defiant behavior and child responses (i.e., compliances, non-compliances, or no opportunity) to parental commands are coded. The coding system is a continuous frequency count of all behaviors observed during the 5-min interaction periods.

Norms

The normative information available on the DPICS is quite limited. Robinson and Eyberg (1983) provide data on 22 families with children between the ages of 2 and 7. The sample was primarily two-parent families (73%) and highly educated (mean of 15.2 years of education for parents). As a result, the generalizability of this information to other samples is questionable.

Reliability and Validity

Not surprisingly, given the very detailed behavioral descriptions provided by the DPICS manual, trained observers have been able to achieve quite high interrater reliability with the DPICS. In a sample of 42 families (20 clinic-referred and 22 normal control) the mean interrater reliability for parent behaviors was .91 and for child behaviors was .92 (Robinson & Eyberg, 1981). In addition, DPICS scores have been shown to differentiate families of clinic-referred children with conduct problems from families of normal control children (Eyberg et al., 2005; Robinson & Eyberg, 1981). Scores from

Table 12.3 Categories from the Dyadic Parent–Child Interaction Coding System

Maternal behaviors

1. Praise
   (a) Labeled praise
   (b) Unlabeled praise
2. Command
   (a) Direct commands
   (b) Indirect commands
3. Other verbalizations
   (a) Descriptive/reflective questions
   (b) Descriptive/reflective statements
   (c) Irrelevant verbalization
   (d) Verbal acknowledgment
4. Responses to child behavior
   (a) Physical positive
   (b) Ignore
   (c) Critical statement
   (d) Physical negative

Child behaviors

1. Deviant
   (a) Whine
   (b) Cry
   (c) Smart talk
   (d) Yell
   (e) Destructive
   (f) Physical negative
2. Response to commands
   (a) Compliance
   (b) Noncompliance
   (c) No opportunity

Source: Eyberg & Robinson (1983).

the DPICS have also been shown to be sensitive to interventions for families of children with behavior problems (Eisenstadt et al., 1993; Eyberg & Robinson, 1982; Hembree-Kigin & McNeil, 1995).

Parenting Stress

The second dimension of family functioning that is critical to assess in most clinical assessment of children and adolescents is parental stress. A high level of stress can influence children's adjustment in a number of ways, one of which is by making it more difficult for a parent to use optimal parenting strategies (Whiteside-Mansell et al., 2007). For example, elevated stress can lead to lower levels of parental warmth and higher rates of harsh parenting (Dopke, Lundahl, Dunsterville, & Lovejoy, 2003; Haskett, Ahern, Ward, & Allaire, 2006).

There are two types of measures that can be used in clinical assessment of children and adolescents. The first are measures of general life stress (e.g., life event scales) and the second are measures of stress specific to parenting. Examples of general measures of stress include the Life Experiences Survey (Sarason, Johnson, & Siegel, 1978) and the Family Events List (Patterson, 1982). Such measures of general stress have proven to be important for understanding children with behavior problems (Johnston, 1996; Snyder, 1991) and they have been related to abusive behavior in parents (Whipple & Webster-Stratton, 1991). However, in the sections below, we focus on two measures of stress more specifically related to parenting.

Child Abuse Potential Inventory-Second Edition

The CAPI (Milner, 1986) is a 160-item rating scale completed by a child's parent. As the name implies, the CAPI was originally developed to assess dimensions of parental behavior that have proven to be risk factors for physical abuse of children. However, the CAPI assesses multiple areas of family functioning that are important in many clinical assessments. Further, several of the scales focus directly on stressors related to parenting a child or adolescent. The items require a third-grade reading level to complete and each item is presented in a forced-choice, agree-disagree format. The full form takes approximately 15 min to complete. However, a brief 24-item version of the scale has been developed and has proven to be highly correlated with the full version (Ondersma, Chaffin, Mullins, & LeBreton, 2005).

Content

The CAPI contains three validity scales: Lie, Random Response, and Inconsistency. The Lie scale was designed to detect tendencies to distort responses in a socially desirable manner. Both the Random Response and Inconsistency scales were designed to detect haphazard or random responses to items without regard to item content. To test the usefulness of these validity scales, Milner and Crouch (1997) had two groups of parents, 106 community volunteer parents and 80 parents attending a program for parents at risk for abuse, complete the CAPI in several different ways: answering honestly, answering in a way to make themselves "look good," answering in a way to make themselves "look bad," and answering inconsistently. These differing instructions did affect how parents answered the CAPI questions, suggesting that parents can intentionally distort their ratings. With the exception of detecting the faking-bad condition (58% correct identification), the CAPI validity indexes were good at detecting most of the other response conditions, ranging from 82 to 100% correct identification across both samples of parents.

There are six primary scales of the CAPI that are combined into a composite Abuse scale. The items were developed from an extensive review of the child

abuse and neglect literature. The Distress scale assesses parental anger, frustration, impulse control, anxiety, and depression. The Rigidity scale assesses parents' flexibility and realism in their expectations of children's behavior. It includes such items as "A child should never disobey," "A child should always be neat," and "A child should never talk back." The Unhappiness scale assesses a parent's degree of personal fulfillment as an individual, as a parent, as a marital/sex partner, and as a friend. Problems with Child and Self is a scale with items tapping parents' perceptions of their child's behavior and their perceptions of their own self-concept as a parent. The last two scales, Problems with Family and Problems with Others, assess the level of family conflict in the extended family and the level of conflict with persons outside the family or community agencies.

Norms

Normative information is available in the CAPI manual (Milner, 1986) from a sample of 836 parents, child care workers, and parent aides from Florida, California, North Carolina, Hawaii, Oklahoma, Illinois, New York, and West Germany. It is unclear how this normative sample was selected, and the representativeness of this sample in terms of parental education, socio-economic status, and ethnicity is also unclear. This is crucial information because there is evidence that family functioning can vary as a function of these variables (Maccoby & Martin, 1983). As a result, lack of accessible information on the normative sample hinders the ability to make norm-referenced interpretations from the CAPI scales.

Reliability and Validity

The CAPI manual provides evidence that the composite Abuse scale and the Distress and Rigidity scales exhibit acceptable internal consistency and temporal stability. The reliability of the four other individual scales tends to be more inconsistent across samples. In terms of validity, there is evidence that CAPI scores are associated with documented risk factors for child abuse (Budd, Heilman, & Kane, 2000; Grietens, De Haene, & Uyteeborek, 2007; Haskett, Scott, & Fann, 1995). Also there is evidence that the composite Abuse scale can successfully discriminate between proven abusers and control subjects (Milner & Wimberley, 1980), and this extends across cultural groups (Haz & Ramirez, 1998). Finally, the Abuse scale has proven to be sensitive to the effects of intervention with high-risk parents (Wolfe, Edwards, Manion, & Koverola, 1988). Therefore, it appears that the CAPI provides a reliable method of assessing dysfunctional elements of a child's family environment, including several aspects of parental stress that are associated with child abuse. In addition, the composite Abuse scale does seem to be an index of risk for abuse, although it is important to recognize that many parents who score high on the CAPI have no documented evidence of abuse in the home (i.e., false positive) (Haz & Ramirez, 1998).

Parenting Stress Index-Second Edition (PSI)

The PSI (Abidin, 1986) is unique in its focus specifically on stressors related to parenting. It was primarily designed to assess the family context of preschool children between the ages of 1 and 4, although it has been used in older samples of pre-adolescent children. Completion of the PSI requires at least a fifth-grade education. It contains 151 items and generally takes 20–30 min to complete. A short-form of the PSI has been developed with 36 items (Abidin, 1995).

Content

The items of the full PSI are divided into two main categories: Child Domain (47

items) and Parent Domain (54 items). The Child Domain consists of items that assess qualities of a child that make it difficult for parents to fulfill their parental role. The Parent Domain assesses sources of stress and disability related to parental functioning. Table 12.4 provides a summary of the scales that constitute the Child and Parent domains. The PSI also allows for the computation of a composite score that provides an overall indicator of the amount of stress in the parent–child system.

Table 12.4 Item Content of the Parenting Stress Index-Second Edition

Scale	Items	Characteristics of High Scorers
Child domain	47	Child displays qualities that make it difficult for the parent to fulfill parenting roles
Adaptability	11	Child shows inability to change from one task to another without emotional upset, avoids strangers, is overreactive to changes in routine and difficult to calm
Acceptability	7	Child is not as attractive, intelligent, or pleasant as the parent had hoped or expected
Demandingness	9	Child is very demanding of parents' time and energy, with patterns such as frequent crying, frequent requests for help, and frequent minor problem behaviors
Mood	5	Child is frequently unhappy, sad, and crying
Distractibility/ Hyperactivity	9	Child displays overactivity, restlessness, distractibility, and short attention span, fails to finish things, and shifts from one activity to another
Reinforces parent	6	Interactions between child and parent fail to produce good feelings in the parent; associated with parental feelings of rejection and poor self-concept as parent
Parent domain	54	Indicates significant stress on the parent–child system that is related to dimensions of parental functioning
Depression	9	Parent reports significant feelings of depression and guilt. High scores may prevent parent from mobilizing sufficient levels of psychic and physical energy to fulfill parenting responsibilities
Attachment	7	Parent does not feel emotional closeness to child and parent perceives an inability to accurately read and understand child's feelings and needs
Restriction of role	7	Parents feel that parental role restricts their freedom and impairs their attempts to maintain own identity
Sense of competence	13	Parents do not feel that they can adequately fulfill their parental roles either because of a lack of knowledge of child development or a limited range of child-management skills
Social isolation	6	Parents perceive themselves as socially isolated from their peers, relatives, and other social support systems
Relationship with spouse	7	Parents perceive that they do not receive emotional and physical support from their spouse in area of child management
Parent health	5	Parents report a deterioration in physical health that is impacting their ability to fulfill parental responsibilities

Source: Abidin (1986).

The 36-item short form of the scale has been tested and items form two relatively distinct factors of parental distress and dysfunctional parent child interactions (Haskett et al., 2006). Importantly, the correlation between the total scores on the short and long form is generally quite high (e.g., $r = 87$; Abidin, 1995).

Norms

The normative sample for the PSI consisted of 534 parents of children referred to a small group of pediatric clinics in Virginia; the median age of the children was 9 months (SD = 23.2 months). The representativeness of the normative sample is one of the major weaknesses of the scale. The sample consisted of primarily White (92%), highly educated (1/3 with college degrees) parents from central Virginia. Thus, the use of norm-referenced scores for families that do not match these characteristics is questionable.

Reliability and Validity

The manual of the PSI provides convincing evidence for the internal consistency and temporal stability of the three composite scores: Total Stress, Parent Domain, and Child Domain. The reliability coefficients for the individual scales, however, are much more variable and typically exhibit relatively low reliability estimates. The manual provides one of the best summaries of the extensive use of the PSI in research on the family context of preschoolers (see also Abidin, Flens, & Austin, 2006 for an updated review). In general, the PSI scales have been correlated with other measures of family functioning (Pinderhughes, Dodge, Bates, Petit, & Zelli, 2000), including correlations with observations of parenting behavior (Bigras, LaFreniere, & Dumas, 1996). Also, the PSI has differentiated families who are experiencing major stressors from nonstressed families (Holden & Banez, 1996; Whiteside-Mansell et al., 2007) and has proven sensitive to treatment effects (Nixon, Sweeney, Erickson, & Touyz, 2003).

Also, factor analyses generally support the broad Parent and Child Domains for grouping the various PSI subscales, although some studies have provided support for a third Parent–Child Interaction Domain, which includes the subscales of Child Acceptability, Child Reinforces Parent, and Parent Attachment to Child (Hutcheson & Black, 1996; Solis & Abidin, 1991). Further, Bigras et al. (1996) reported that, in a sample of 218 mothers of preschoolers, the Parent and Child Domains predicted parental, familial, and child outcomes different from those obtained from other sources. Specifically, the Parent Domain was more strongly and independently associated with measures of marital adjustment and maternal depression, whereas the Child Domain was more strongly and independently associated with child difficulties reported by the mother and children's problems observed during parent–child interactions. These results are important in suggesting that the two domains are valid in assessing somewhat independent dimensions of family functioning.

Marital Conflict

There is a long history of research showing a link between divorce and child behavior problems. The most comprehensive summary of this research comes from Amato and Keith (1991). These authors conducted a meta-analysis of 92 published studies of the impact of divorce on a child's psychological well-being. The combined samples from the 92 studies involved over 13,000 children. This meta-analysis revealed that divorce consistently had a

negative impact on several types of child well-being (e.g., conduct problems, school achievement, social adjustment, and self-concept). These studies suggested that the relationship between divorce and psychological difficulties in children was greatest within the 2 years immediately following a divorce.

The meta-analysis also provided intriguing data in support of the theory that it is the conflict that occurs between parents before and during the separation that has the most detrimental impact on a child's adjustment (see also Emery, 1982). Whereas children of divorced families tended to have poorer adjustment than children in low-conflict, intact families, children in *intact, high-conflict* homes tended to have the poorest adjustment of all three groups. Also consistent with this perspective, several studies found that less conflict and better divorce cooperation between parents predicted better post-divorce adjustment for children.

The implications of these findings are important to clinical assessments of children and adolescents. They suggest that it is not simply enough to determine the marital status of a child's parents for understanding the potential impact of the parents' marital relationship on the child. A more important focus of assessment is the overt conflict between parents that is witnessed by the child.

There are several marital inventories that are frequently used in research and clinical practice, and often included in the clinical assessment of children and adolescents (McMahon & Frick, 2007). The Marital Adjustment Test (MAT; Locke & Wallace, 1959) and the Dyadic Adjustment Scale (DAS; Spanier, 1976) are two self-report instruments that have been shown to produce reliable scores and differentiate persons in distressed and nondistressed marriages. However, these inventories tend to focus on general marital satisfaction rather than on overt conflict per se. The O'Leary-Porter Scale (OPS; Porter & O'Leary, 1980) is a brief rating scale that focuses on overt marital conflict and, even more specifically, on marital conflict that is witnessed by the child or adolescent. As a result, the OPS is uniquely suited for use in clinical assessments of children and adolescents.

O'Leary-Porter Scale (OPS)

The OPS (Porter & O'Leary, 1980) was developed specifically for studying the association between marital adjustment and child behavior problems. The OPS is a 20-item self-report inventory within which are embedded nine items that assess the degree of marital conflict witnessed by the child. A parent rates on a five-point frequency scale (Never to Very Often) how often the child witnesses arguments between himself or herself and the spouse over money, discipline, wife's role in family, and personal habits of the spouse. Two questions also ask for overall estimates of the amount of verbal and physical hostility between spouses that is witnessed by the child.

There is little normative data on the OPS. However, 2-week test-retest reliability in a sample of 14 families was found to be quite high (r = 92) (Porter & O'Leary, 1980). These authors also reported that the OPS was correlated with several types of maladjustment in children. Highlighting the importance of focusing specifically on overt conflict, these authors found that the OPS was more consistently associated with child adjustment difficulties than was a measure of general marital satisfaction (i.e., the MAT). This association between scores on the OPS has been replicated in other studies (Forehand, Long, & Hedrick, 1987; Mann & MacKenzie, 1996). Thus, it appears that the OPS captures the critical component of marital discord in terms of its detrimental effect on child adjustment.

Parental Adjustment

In the introduction to this chapter, we discussed several ways in which assessing parental psychiatric adjustment is critical to the clinical assessment of children. We discussed two areas of research, one on parental depression and another on parental anxiety, that suggest that information obtained from a parent must be interpreted in light of the parent's level of emotional distress. We also discussed the importance of obtaining a family psychiatric history for making differential diagnoses and treatment recommendations. In this section, we provide a brief overview of basic research showing the link between parent and child adjustment difficulties that can aid the clinical assessor in structuring assessments and making appropriate interpretations from the assessment information.

Parental Depression

One type of parental adjustment that has a well-documented link to child development is parental depression. Studies have found that between 40% (Orvaschel, Walsh-Allis, & Ye, 1988) and 74% (Hammen et al., 1987) of the children of depressed parents exhibit significant adjustment problems. Depression in parents places children at risk for a number of problems spanning academic, social, emotional, and behavioral domains (Downey & Coyne, 1990). Therefore, it seems that parental depression is a *nonspecific* risk factor for problems in children. That is, it is not specifically related to the development of a single type of child behavior problem.

There are two possible exceptions to this non-specific relationship, both related to subtypes within affective disorders. First, Weissman, Warner, Wickramaratne, & Prusoff (1988) found some preliminary evidence that *early-onset* recurrent depression (depression that has its initial onset before adulthood) might have a more specific link with childhood depression. Second, family histories of bipolar disorders in parents predict a risk for subsequent bipolar disorder in adolescents with a childhood-onset of depressive symptoms (Geller et al., 1993).

Goodman and Gotlib (1999) reviewed the literature on the risk for problems in adjustment in children of depressed mothers. They outline four possible mechanisms to explain this risk: (a) an inherited predisposition transmitted from parent to child; (b) failure of the child to develop appropriate emotional regulation strategies; (c) exposure to negative maternal moods, thoughts, and behaviors; and (d) exposure to a high rate of stressors associated with mother's depression (e.g., higher rates of marital conflict). These links clearly illustrate the need to assess parental depression to understand several potential causal factors that could help to explain a child's or adolescent's problems in adjustment.

Parental Substance Abuse

A comprehensive review of the literature found that, like parental depression, parental alcoholism is associated with a number of child adjustment problems. West and Prinz (1987) reported studies finding an association between parental alcohol abuse and the following problems in their children: hyperactivity, conduct problems, delinquency, substance abuse, intellectual impairment, somatic problems, anxiety, depression, and social deficits. Like depression, some of the lack of specificity in its effect on child adjustment may be due to a failure to define subgroups within parents who abuse substances (Frick, 1993). Alternatively, West and Prinz reviewed several studies suggesting that the effects of having a substance-abusing parent on a child's adjustment may be mediated through the

impact on the home environment and the impact on parent and child interactions. Consistent with this view, parental substance use has been linked to a host of problematic parent practices, including higher rates of abuse (Ondersma, 2007; Walsh, MacMillan, & Jamieson, 2003).

Parental Antisocial Behavior

The intergenerational link to antisocial behavior is a consistent finding in research and one that has long intrigued social scientists and policy-makers alike (see Frick & Loney, 2002, for a review). Early studies tended to focus on the intergenerational link to criminality. This research found that the link was independent of socioeconomic status, neighborhood, and intelligence (Glueck & Glueck, 1968). More recent studies have focused on psychiatric definitions of antisocial disorders. As in studies of criminality, children diagnosed with antisocial disorders are significantly more likely to have parents with antisocial disorders than are children without conduct problems (Frick et al., 1992; Monuteaux, Faraone, Gross, & Biederman, 2007).

An important methodological point in the more recent family history studies was the fact that each used clinic control groups and found that histories of antisocial disorders in parents were specific to conduct problems in children. That is, children with conduct problems not only had higher rates of parental antisocial disorder (APD) than normal controls, but they also had higher rates of parental APD than clinic-referred children with other problems in adjustment (Frick et al., 1992). Therefore, unlike parental depression and substance abuse, parent antisocial behavior appears to have a more specific relationship to a particular child problem (i.e., conduct problems).

Frick and Loney (2002) reviewed data supporting several potential mechanisms to explain this link including an inherited disposition passed from parent to child, parental modeling of antisocial behaviors, and disruptions in the family caused by the parent's antisocial behavior. In support of at least some inherited predisposition, Tapscott, Frick, Wootton, and Kruh (1996) showed that a paternal history of antisocial personality disorder was associated with a higher rate of Conduct Disorder in their biological offspring, even if the father had no contact with the child since the first year of life.

Parental ADHD

There is evidence that parents and other biological relatives of children with ADHD show more attentional problems (Albert-Corush, Firestone, & Goodman, 1986) and a higher rate of ADHD (Faraone, Biederman, Keenan, & Tsuang, 1991). However, these studies may have underestimated the link between parent and child ADHD by studying the parents' *current* adjustment. Given that 30–50% of children with ADHD may not be diagnosed with this disorder as adults (Barkley, Fischer, Smallish, & Fletcher, 2002), it may be that many of the parents of ADHD children exhibited ADHD as a child but are not currently showing symptoms.

To test this possibility, Frick et al. (1991) studied the childhood histories of parents of clinic-referred children. A child's biological parent reported on whether or not he or she had problems associated with ADHD before the age of 18 and then completed a similar family history questionnaire for all first-degree relatives. Children with ADHD were more likely to have mothers, fathers, and other biological relatives who also exhibited ADHD as children than were other clinic-referred children. In fact, approximately 75% of the 103 children with ADHD had one biological relative with a significant history of ADHD (27% of mothers and 44% of fathers) and 46% had two biological relatives with a significant history of ADHD. This

study suggests that an assessment of parents' childhood histories of behavior problems could aid in the assessment of ADHD in children.

Parental Anxiety

Another type of problem that appears to have a familial link is anxiety. Last, Hersen, Kazdin, Francis, and Grubb (1987) reported that in their sample of children with an anxiety disorder (n = 58), 83% of the children had a mother with a lifetime history of anxiety disorders. Furthermore, 57% had a mother experiencing significant levels of anxiety concurrently with the child. Both of these proportions were significantly greater than what was found in parents of clinically referred children without anxiety disorders.

Importantly, Frick et al. (1994) found similar results but also found that the link between mother and child anxiety could not solely be attributed to anxious mothers *reporting* more anxiety in their children. All of the children in the Frick et al. study who self-reported an anxiety disorder had a mother with a history of an anxiety disorder. Further, there are a number of studies suggesting that parental anxiety can influence the attachment between the parent and child (Costa & Weems, 2005) and can lead to parenting behaviors (e.g., overprotectiveness, failure to encourage independence) (Dadds, Barrett, Rapee, & Ryan, 1996) that can place a child at risk for anxiety and other problems in adjustment. Thus, it is clear from these findings that parental anxiety is an important area to be assessed in clinical assessments of anxious children.

Parental Schizophrenia

Another type of maladjustment with a clear familial link is schizophrenia. Children of one schizophrenic parent appear to have a 10 to 15% likelihood of developing schizophrenia; the children of two schizophrenic parents have about a 25 to 46% risk (Gottesman, McGuffin, & Farmer, 1987). These rates of disorder in offsprings of schizophrenic parents are striking given that the prevalence of schizophrenia in the general population is between 1 and 10 per 1,000 individuals (Helzer & Pryzbeck, 1988). However, parents who have another relative with schizophrenia are often quite concerned over the risk for their children, on the basis of the evidence for a familial transmission. Therefore, it is often important for clinical assessors to also view these risks from the point of view that the vast majority of children with a schizophrenic relative, even if that relative is a parent, do not develop schizophrenia.

Assessment of Family History

From this very brief overview of the familial link to childhood disorders it is evident that obtaining a family history is a critical component of most clinical assessments of children and adolescents. However, like all aspects of the assessment process, what areas to be assessed and the depth at which they will be assessed depend on the individual case. In some cases a screening for psychiatric disorders in a child's relatives can be conducted as part of an unstructured interview followed by a more in-depth family history assessment only if this is judged to be warranted from the initial screening. In other cases a more detailed and structured assessment may be needed from the outset.

It is beyond the scope of this book to cover assessment of adult psychopathology in great detail. However, it is important to note that one can assess a wide range of problems in parents or other relatives through omnibus rating scales or structured interviews. For example, the NEO-Personality Inventory (NEO-PI; Costa & McCrae, 1985) and the Minnesota

Multiphasic Personality Inventory-Second Edition (MMPI-2; Hathaway & McKinley, 1989) are two widely used and readily available objective personality inventories that cover a number of areas of psychological functioning. There are also numerous structured diagnostic interviews that are available, like the NIMH Diagnostic Interview Schedule-Third Edition (DIS-IIIA: Helzer & Robins, 1988) and the Structured Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995).

When considering what type of assessment may be needed, it is important to note that structured interviews tend to focus on more severe pathology, assessing for diagnosable disorders, than the objective personality inventories do. In addition, the structured interviews tend to be more amenable to the family history method of assessment, in which a family member reports on him- or herself and other relatives who cannot be assessed directly.

There may be some assessments when a more focused family history is deemed appropriate, such as when one wants to focus on some specific domain of parental adjustment. For example, the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) and the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) are brief screening measures for depression and anxiety, respectively that are often used to assess parental adjustment in clinic-referred children. These are just a few of a host of domain-specific rating scales that can be used to assess a specific area of adjustment in a child's parent or other relatives (see McMahon & Frick, 2007 for others).

Conclusions

In this chapter we discussed several reasons why the assessment of the family environment is critical to most clinical assessments of children and adolescents. Family factors often play a critical causal role in child maladjustment and familial factors can aid in making differential diagnoses and treatment recommendations, two important goals of many clinical assessments. Further, factors within the family are often important for interpreting information provided by members of the family on a child's or adolescent's adjustment.

There are a large number of dimensions of family functioning that can influence child adjustment. We focused on four dimensions that we think are especially important to assess in most clinical assessments of children and adolescents: parenting styles and practices, parenting stress, marital conflict, and parental adjustment. For each of these dimensions, we reviewed the research linking them to child adjustment and then provided several methods for assessing them in clinical assessments.

Chapter Summary

1. There is no context more important to understanding a child's emotional and behavioral functioning than understanding the child's family context. This is because of the following factors:
   (a) Familial influences often play major causal roles in a child's or adolescent's psychological difficulties.
   (b) A family psychiatric history can be instrumental in making differential diagnoses.
   (c) Understanding a child's or adolescent's family context can help to interpret information provided by members of the family.
   (d) Understanding a child's family context can help to determine the most important targets for intervention.
2. Many behavior rating scales reviewed in previous chapters, such as the PIC-2, the PIY, the MMPI-A, and the BASC-

2-SRP, have scales that assess various aspects of a child's family context.

3. Research suggests that two critical dimensions of family functioning related to child adjustment are parenting style, which is the emotional climate provided by the parents, and parenting practices, which are techniques used by parents to socialize their children and enforce rules.
4. The Family Environment Scale-Second Edition (FES) is a commonly used measure of parenting style and the emotional climate of the family. The FES is divided into subscales from three domains: Relationships, Personal Growth, and Systems Maintenance.
5. The Alabama Parenting Questionnaire (APQ) and the Parenting Scale (PS) are measures that focus more specifically on parenting behaviors, such as parents' discipline strategies.
6. The Dyadic Parent Child Interaction Coding System (DPICS) is an observational coding system designed to assess parent and child behaviors in two standardized parent–child interaction tasks.
7. The amount of stress experienced by parents is also important to child adjustment. Scales can assess general stressors or stressors specific to parenting.
8. The Child Abuse Potential Inventory-Second Edition (CAPI) was developed to assess parents' risk for abusing their children and includes several scales related to family stress.
9. The Parenting Stress Index-Second Edition (PSI) focuses specifically on stressors related to parenting.
10. The level of marital discord and overt marital conflict in the home has proven to be important in understanding children's functioning.
11. Assessing parental adjustment can provide critical information in clinical assessments, especially family histories of depression, anxiety, antisocial behavior, attention deficit disorder, substance abuse, and schizophrenia.