

Developmental psychopathology from family systems and family risk factors perspectives:
Implications for family research, practice, and policy¹

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INTRODUCTION

Family Process Perspectives: Alternatives to Psychopathology's Emphasis on the Individual

The word "psychopathology" can be translated literally as a disease or disorder of the mind. Psychological diagnosticians tend to follow the medical model when studying or treating people with "mental illness," on the assumption that the disease or disorder is located within a person. In contrast with this individual approach, we present two related, converging perspectives on psychopathology, both of which provide a contextual analysis from the viewpoint of the family. The first, the "family systems" approach, emerged meteorically in the 1950s as an alternative conception to psychopathology's traditional focus on individuals (Goldenberg & Goldenberg, 1996). Not only did family systems theorists focus on the family relationships assumed to be involved in producing and maintaining psychopathology, but they conceptualized disorder as located in the family system. The individual diagnosed with schizophrenia, for example, is described as the identified patient, but the pathology is located and treated in the system of family relationships. The main point is not that individuals with diagnosed disorders are affected by their families, but that some family systems show structures and patterns of interaction that are maladaptive.

The second, "family risk factors" approach has always been a part of psychopathology, but most often as background rather than foreground. This approach attempts to identify one or two aspects of family functioning that play a central role in both the etiology and treatment of people diagnosed with disorders or experiencing high levels of psychological distress. Past and present parent-child relationships are the most frequently cited family risk factors thought to affect both normal development and psychopathology. Many theoretical perspectives suggest that patterns of positive or negative parent-child relationships tend to be repeated across generations in ways that foster adaptive functioning or psychopathology in individual family members. Mounting evidence from the past two decades reveals that the quality of the relationship between the child's parents is associated with the level of externalizing and internalizing behavior problems

shown by the child. Although investigators using the family risk factors perspective occasionally examine the combined impact of two or more family risk or protective factors, their analysis is conceptualized as unidirectional – the effect of the family on individual adaptation or psychopathology in a family member.

Despite the fact that family systems and family risk factors approaches to psychopathology have not usually been differentiated from one another, we believe they are worth considering separately for three reasons. First, writings about family systems and family risk factors often appear in different books and different journals. Second, although there is some systematic research on whether family systems-oriented treatments are effective, there are very few tests of propositions derived from family systems theories because their assumptions do not match well with currently accepted models of scientific research. Thus, much of what we know about families and psychopathology from empirical studies comes from research using a family risk factors perspective. Third, the two perspectives lead to qualitatively different ideas about the etiology and locus of psychopathology and views of how family members should be involved in the structure and process of treatment.

Space precludes a detailed exploration of the applications of family systems and family risk factors perspectives to all, or even some, of the major disorders listed in DSM-IV. We also trust that it will become clear throughout the chapter that there are multiple, quite different versions of family systems theories. Our preference, in agreement with Schulz (1984), is to talk about family systems ideas as a set of lenses for looking at and thinking about the development of psychopathology from a family perspective. We see both family systems and family risk factors as contextual approaches to the understanding of psychopathology rather than as coherent, monolithic theories of how psychopathology emerges and progresses.

Family Structure Perspectives: The Political Context of Family Psychopathology

In the months leading up to the presidential election of 2004, the contemporary state of American families began to occupy increasing attention from political candidates and political

pundits. The nature of marriage, and the role of marriage and family processes in children's development, became significant topics of national and local debate. Post-election discussions suggested that voters' attitudes concerning some of these issues played an important role in the outcome of the election. Despite conflicting views concerning specific "family values," neither liberals nor conservatives questioned whether families were important or played a central role in children's well-being. The question was whether some family structures or arrangements (single parent families, cohabiting families, divorced families, gay or lesbian families) constitute risk factors for children's development, and whether other family arrangements (primarily two-parent married families) function to protect children from a variety of biopsychosocial risks. That is, over and above the notion that family processes play a central role in individual psychopathology is the idea that some families, described in terms of demographic characteristics, are less likely to support the positive development of their members.

We have deliberately chosen to begin our review of family systems and developmental psychopathology by noting some aspects of the political/policy/practice context of the discussion about the role of families in the development of psychopathology. Our point here, which we elaborate on at the end of the chapter, is that, just as perspectives on the role of the family in psychopathology make a difference to our understanding of etiology and the planning of treatment, so the social context in which family theories and treatments are developed and promulgated has profound effects on which theories of family function shape policy decisions about how scarce resources are to be allocated for the diagnosis and treatment of children and families in distress. In order to remain within our space limitations and provide a focused account of family systems theory, we illustrate this thesis with examples drawn primarily from the United States. We believe that the general principles we infer, and some of the specific family trends we recount (e.g., changing rates of divorce, marriage, and single parenthood), apply more broadly to Western industrialized countries and cultures.

We should note that books and papers on family systems and family factors in developmental psychopathology are written primarily by psychologists, psychiatrists, social workers, and other mental health professionals. Writings on family structures and social policy are more likely to be produced by sociologists, demographers, and economists. Unfortunately, the literatures on these two topics rarely take cognizance of each other. One of our tasks in this chapter is to bring the two closer together.

Outline of the Chapter

We begin with sections that define our central concepts: “developmental psychopathology”; family systems; and family risk factors. After describing where family systems and family risk factor theories fit in the pantheon of theories that compete for the allegiance of researchers and clinicians, we take a brief historical look at how these theories have changed over time. Then, three longer sections illustrate how family systems and family risk factors approaches can be applied to the understanding of developmental psychopathology.

Consistent with developmental psychopathology’s concern with normal development, we examine how family processes are implicated in explaining what happens when non-clinical families go through major life transitions – both expected (e.g., marriage, parenthood) and unexpected (e.g., divorce, illness). Our focus here is not only to demonstrate correlations between family relationship quality and individual developmental outcomes, but also to elucidate the mechanisms by which families have effects on their members. We then show how formulations from a family systems or family risk factor perspective can provide value-added information, both in predicting the trajectories people follow in their journeys toward or away from diagnosed disorders and in planning interventions for those at risk or already in distress.

The application of both family systems and family risk factor models of developmental psychopathology has been governed by a fairly traditional view of the family that was current in the mid-20th century when the family systems approach emerged. Toward the end of the chapter we step back to take a brief historical look at how families have been changing over the

past century. We use this perspective to raise some questions about whether a family systems or family risk factors approach to developmental psychopathology can deal adequately with the diversity and complexity of the families they are designed to understand and treat.

We conclude with a discussion of future directions in the application of a family perspective to the study of developmental psychopathology. We offer suggestions about important theoretical and research questions that constitute promising next steps in the development of the field of developmental psychopathology. In the end, we return to a discussion of the interconnection and disconnection between psychopathology research conducted from a family perspective and policy decisions about how family researchers, therapists, and families themselves will be supported.

PRINCIPLES OF DEVELOPMENTAL PSYCHOPATHOLOGY

The entire three-volume work in which this chapter appears is devoted to the definition and explication of the principles of developmental psychopathology. Here we briefly summarize the conception of the field that guides our discussion of family perspectives.

Definitions of Psychopathology

Family systems theorists and therapists do not generally devote much attention to issues in the definition of psychopathology. Different kinds of criteria are used in making the distinction between psychopathology and normal development. All of them involve a description of individuals with extreme, maladaptive deviations -- from social norms and values, from the mean of a population (a continuous view of psychopathology), or from some clinically-defined ideal of psychological functioning (a categorical view of psychopathology). In this chapter we take a rather broad view, with descriptions of family systems and family risk factor approaches to phenomena ranging all the way from statistically normative levels of stress or distress to clinically diagnosed disorders.

The Prospective Study of Pathways

A family approach to developmental psychopathology is concerned with understanding both mental illness and mental health in individuals by focusing on one of the primary contexts in which individuals develop. The study of developmental psychopathology involves intensive, prospective, longitudinal analyses of four major pathways or trajectories that individuals and families may follow: (1) Those at high risk for mental health problems who go on to develop disorders or debilitating psychological distress, or cause great distress to others; (2) Those at high risk for mental health problems who do not develop disorders, psychological distress, or severe behavior problems as we might have expected on the basis of their risk status; (3) Those at low risk who do not develop disorders, psychological distress, or behavior problems, as expected; and (4) Those at low risk who unexpectedly develop disorders, psychological distress, or behavior problems. In contrast with traditional approaches to the study of psychopathology, developmental psychopathology is equally interested in instances in which risk status correctly predicts or does not predict the expected outcomes. That is, the field is intensely curious about why some people develop optimally despite risk, while others develop problems despite conditions that typically facilitate adaptation.

Etiology: Causal Models Versus Risk Models

An axiom of the study of psychopathology is that it is essential to understand the etiology of each disorder. This task has been traditionally framed as identifying causal variables, events, or conditions (A) that are associated with a disorder (B), precede the disorder (A before B), and provide some force or action that brings the disorder into being ($A \rightarrow B$). Furthermore, to establish causal connections it is necessary to prove that B is not traceable to factors other than A; that there is a unique connection between cause and effect.

Providing evidence of causality in the study of families and children's development is a difficult task (P. A. Cowan, Powell, & Cowan, 1998). It is well known that correlations alone do not provide evidence of causality, although the absence of correlations poses a serious threat to

a causal claim. For example, if there is no association between the occurrence of schizophrenia in family members and double binding communication in the family, it is unlikely that this theory of communication-caused schizophrenia can be supported.

Etiological formulations that attempt to establish causal explanations of disorders are based on metaphors used in pre-20th century medicine, which, in turn, were based on models from 17th century physics. In these models there is always a direct connection between a cause and its effect. By contrast, developmental psychopathologists have adopted risk-outcome models from the practice of Public Health epidemiology (Kleinbaum, Morgenstern, & Kupper, 1982), in which: (1) A risk factor is an antecedent variable or condition associated with an elevated probability of a specified outcome in a population; (2) A protective factor is a variable or condition that reduces the probability of negative outcome despite the presence of risk; and (3) A vulnerability factor is a variable or condition that increases the probability of a negative outcome associated with a given risk.

Resilience is a difficult to define. Sometimes, in cases of high risk, children and adults do exceptionally well, and are described as resilient. Although resilience is sometimes conceptualized as a “Teflon” quality of a person, it should be interpreted more simply as a case in which risks create challenges that lead to positive outcomes.

In many cases, the predictive association between risk and outcome simply represents a correlation between the two, with no need to claim that the linkage is causal; the establishment of accurate predictors or markers is useful in identifying individuals at risk for potential problems that have a high probability of emerging in the future. In some cases, the connection can be described as a causal risk, when it can be demonstrated that a certain variable or condition sets a number of processes in motion that result in a given outcome. How can we determine the difference between statistical risk indicators and causal risks? The best way to establish causality is through intervention studies that use random assignment procedures to place comparable people in intervention and control groups, and we describe some examples of this

approach later in the chapter. Another way is to use comparison data and statistical controls in an attempt to rule out alternative possibilities, so that causal interpretations of the data become more plausible.

In developmental psychopathology, the ideal study is one that follows individuals and families forward, tracing the paths from risks to outcomes, rather than a follow-back design that begins with the diagnosis, followed by a retrospective search for antecedents. The main problem with retrospective designs in establishing causality is that, even when they show that a presumed antecedent (e.g., family conflict) is more frequent in families with a diagnosed member, they cannot reveal whether the same antecedent is associated with many disorders (multifinality) or whether there are multiple risk factors, each of which predict the same disorder (equifinality).

Acquisition Versus Maintenance

Most theories of etiology deal with what could be called the original precipitating causes of a disorder or the factors that govern its acquisition. We want to know, for example, whether extremely harsh parenting practices that border on abuse lead to the emergence of aggressive, acting out or shy, withdrawn depressed behavior in a child (Cicchetti, Toth, & Maughan, 2000). Equally important for clinical practice, and a central aspect of most family system theories, is the notion that regardless of how a problematic disorder is acquired, there are causal factors or risk factors involved in how or whether it is maintained. As we will see, there is ample evidence that genetic factors are important determinants of schizophrenia and bipolar disorders (Rutter & Sroufe, 2000) and in some cases may be considered as primary factors affecting whether and how maladaptive behavior is acquired. Nevertheless, even if the acquisition process is heavily dominated by genetics, there is evidence that family interaction processes can play a key role in whether gains from hospitalization are maintained or whether patients suffer a relapse once they return home (Hooley, 2004).

Prevention: Early Intervention and Treatment

Because traditional psychopathology studies begin with people who have already been diagnosed, questions about etiology are most often raised in the context of treatment. All theories of psychopathology assume that if a disorder can be described and assessed (diagnosed), and if its etiology can be established, it is possible to design a treatment that specifically targets the risk and causal factors known to affect the course of the disorder. By virtue of the fact that studies central to the field of developmental psychopathology are often concerned with the identification of risks long before disorders are manifested, this approach is ideally suited to the conduct of prevention science (Coie, Watt, West, & Hawkins, 1993). Once risk factors are identified, it is possible to set in motion preventive interventions that minimize risks and enhance protective factors, either to prevent a problem from occurring or to intervene early enough to reduce the severity of the problem before it becomes intractable.

FAMILY SYSTEMS APPROACHES TO PSYCHOPATHOLOGY:

EARLY BEGINNINGS

The task of identifying family systems perspectives on specific diagnostic disorders is a difficult one, because most of the leading figures in the field avoided the use of diagnostic terminology in their discussions, except for some general references to the diagnoses given to the identified patient. In part, then, we must infer conceptualizations of psychopathology from the ways in which family therapists characterized the central problems of the families they treated.

The Founding Fathers (mostly) of Family Systems Approaches

Around the middle of the 20th century, groups of clinicians in different parts of the United States, beginning from different theoretical premises, challenged the notion that a focus on individual psychopathology was sufficient to provide treatment guidelines for patients who were seriously mentally ill. In different ways, each group pointed to one or two central aspects of family functioning that they believed were responsible for causing schizophrenia or maintaining

the symptoms after patients returned home from the hospital. The fact that the origins of family systems approaches began with this population in mind shaped the first generation of family systems theorists and therapists.

Nathan Ackerman, a psychoanalyst heading what later became the Ackerman Institute in New York, was an early advocate of the importance of considering family risk factors in the treatment of children (Ackerman & Sobel, 1950). Fearing rejection by colleagues, he began to hint, rather than advocate directly, that this perspective suggested that family members should be seen conjointly – all together in one room. He was finally able to argue clearly (Ackerman, 1962) that all members of a household should be in conjoint treatment whenever a child is brought in for therapy. The therapy Ackerman proposed was unlike that of many subsequent family theorists because he focused on the inner dynamics of family members that made family interaction problematic. As a result, the therapist tended to conduct individual therapies in the context of the family as a whole.

Theodore Lidz and his colleagues (Lidz, Cornelison, Fleck, & Terry, 1957) at the Yale Psychiatric Institute in New Haven objected to the prevailing tendency to blame “schizophrenogenic” mothers for their children’s schizophrenia, pointing to the fact that families of patients diagnosed with schizophrenia were usually imbalanced in many ways, not just in the mother-child relationship. In a clinical study of families with a member having schizophrenia, this group found that fathers were not playing an effective parental role. Furthermore, the couple was either in a state of high unresolved conflict (marital schism) or showed patterns of avoidance of serious conflict in which one partner’s ideas were accepted overtly but undermined by the other partner -- and talk about the difference was forbidden (marital skew). Lidz and his group pointed to the transmission of distorted patterns across at least three generations -- from grandparents to parents to grandchildren.

Around the same time, at the National Institute of Mental Health in Washington DC, Lyman Wynne (Wynne, Ryckoff, Day, & Hirsch, 1958), later joined by Margaret Singer (Singer &

Wynne, 1965a), also attempted to describe families with a schizophrenic member. Wynne pointed to what he called pseudomutuality in all of the family relationships, not just the couple relationship. Singer and Wynne showed that the thought disorder central to the diagnosis of schizophrenia was more likely to be displayed when patients were brought together with their families to try to come to consensus on the meaning of a Rorschach (inkblot) card, but not when patients were seen alone by the researcher. That is, the disorder seemed to be located not in the functioning of the individual but in the family system. In another laboratory at NIMH, Murray Bowen (1961) emphasized the fact that although maternal or parental distance was often blamed for triggering schizophrenia in their offspring, families in which members had few personal boundaries and were highly enmeshed or sybiotic were overrepresented in the population of people with schizophrenia entering treatment (he described these families as an “undifferentiated ego mass”).

A group of clinicians at the Mental Research Institute (MRI) in Palo Alto, California extends our portrait of the founding fathers, with one founding mother as part of that group. The members represented different disciplines, with Don Jackson from psychiatry, Virginia Satir from social work, Gregory Bateson from anthropology, and Jay Haley, John Weakland, William Fry, and somewhat later, Paul Watzlawick, from various subfields of communication. Like investigators in other parts of the country, these clinicians focused on families with schizophrenia and came to the view that deviant communications among family members were a central problem in families with a severely mentally ill member. One of the first widely disseminated ideas from the MRI group was the “double bind” theory of schizophrenia in which a family member (typically a mother) gives contradictory demands in different modalities. For example, she might say to her child, “come sit by me”, but react with a shudder when the child did so. In obeying one message, the child violated the other. Another version of the double bind is a non-verbal message that conveys, “You are not to hear what I’m telling you or see what I’m doing”, with the result that after hearing or seeing what has in fact been communicated, the child

has disobeyed the implicit message. What makes the double bind so binding is that other implicit messages or “family rules” prohibit the victim from leaving the field or commenting on the conflicting messages. Although it is easy to imagine that repeated, ongoing double-binding communication from one or both parents would be highly disturbing to both adults and children, the double bind hypothesis has not been empirically validated, in part because examples are often so subtle and complex that observers cannot agree about when they occur (Ringuette & Kennedy, 1966).

Bateson brought to the MRI group’s writings two different models of systems theories without making a clear distinction between them. From Bertalanffy (Bertalanffy & Woodger, 1962), a philosopher and biologist who developed what he later called General System Theory (Bertalanffy, 1973), Bateson drew on the central idea that systems have self-regulating properties. That is, there are internal mechanisms that operate to pull the system back when too much change has occurred, or push forward when more change is needed. Bertalanffy’s model was based on living biological systems, which he described as open and always capable of moving toward new organizations. Bateson also used models and metaphors from the field of game theories (Von Neumann & Morgenstern, 1953), which assumed that bargaining takes place in a zero-sum environment (if I win, you lose, and vice versa), and from cybernetics (Wiener, 1961), a field in which machine systems were designed with deviation-reducing mechanisms to bring about a return to homeostasis whenever dysregulated subsystems threatened to drive the machine out of control. These systems are not necessarily open in the same way that biological systems are. Once some change has been introduced into the system, homeostatic mechanisms operate like thermostats to bring the organization back to a prior state, and are centrally important in explaining maladaptation and resistance to change. That is, within family systems theories are embedded two quite different models of self-regulation, one of which, the cybernetic example, emphasizes stability much more than change.

Why do some families continue to repeat patterns of behavior that are unproductive or destructive? Forces within the system tend to spring into action when new behavior emerges in ways that return the family to the previous homeostatic balance or set point. This formulation helps to explain why family therapists are so active compared to psychoanalytic colleagues who treat individuals. Unless the therapist disequilibrates the family with some dramatic statements, gestures, or homework assignments, the homeostatic properties of the system will frustrate the family's stated wish for change and frustrate the therapist's desire to help them change by introducing a countervailing force that resists the family's tendency to return to the tried and true.

In our view, one of the last major figures in the early origins of family systems theory is Salvador Minuchin. His initial book, Families of the slums, co-written with Montalvo, Bosman, and Schumer (1967), and his creation of the Philadelphia Child Guidance Clinic as a training center for family systems treatment, helped to demonstrate that family systems principles could be applied usefully to families with a wide range of problems in a wide range of economic circumstances. We continue with later developments in family systems theories below.

Defining Properties of Systems

Despite differences in the focus of their work, the early family systems theorists converged on a set of principles that defined the systemic approach (see Wagner & Reiss, 1995).

Wholeness. A system is composed of elements (parts) and a whole, with patterns of connections among the parts and between each part and the whole. In family systems theories, the elements are often individual family members. Each is in a relationship with each of the others, but together they constitute a family with a unique set of properties. The best-known principle describing family systems is that the whole is different from any single part, and from the sum of its parts. In family terms, it is not possible to predict the behavior or level of adaptation of an individual by considering him or her in isolation; one needs to know about the context of the individuals in his or her family, the pairwise relationships among the members,

and how the system functions as a whole. The father and the mother may not get along with each other, and at least one of the parent-child or sibling pairs may vibrate with unresolved conflict, but we cannot conclude that this family is dysfunctional, or that the child is at risk for mental illness, because from the limited information given here we do not know what happens when all the family members get together. It would make a great difference for the well-being of the children in the family whether, for example, the parents continue their escalating arguments or put aside their squabbles successfully when the child is present, or whether one parent compensates for the fact that the other parent and child are not getting along by being exceptionally nurturant with the child.

Locus of problems. Problems are located in the system, not in individual members. The family member brought into treatment because of highly deviant, hostile, or anxious behavior is regarded as the “identified patient (IP);” other family members have designated this person as the problem, but the therapist locates the pathology in the family as a whole, and helps the family to do the same.

Subsystems. Beyond the contrast between the system as a whole and the individual family members, it is necessary to be aware of how family subsystems operate. Families in which one child is allied with the mother and distant from the father, or the couple fail to work together, are quite different from families in which the couple forms a tight bond that excludes close relationships with the children.

Boundaries. Around each subsystem is an invisible enclosure called a boundary (Wagner & Reiss, 1995). One of the key defining properties of subsystems is whether the boundaries are rigid or permeable. Rigid boundaries denote subsystems that are disengaged from each other (e.g., the father has difficulty becoming included in the mother-son relationship). Families with rigid boundaries tend to promote authority and autonomy at the expense of closeness. At the other end of the adaptation continuum, boundaries can be so diffuse and permeable that subsystems become enmeshed, as, for example, when children occupy the attention of their

parents so constantly that there is no separation between the life of the couple and the life of the children.

Circular causality. We have noted that traditional scientific models and models of psychopathology describe causality in linear terms ($A \rightarrow B$) and that it is difficult to obtain evidence in support of linear causal claims. Family systems theories make the assumption that causality is “circular.” There is mutual regulation in that change in one person in a relationship can trigger a change in the other so that changes are simultaneous ($A \leftarrow \rightarrow B$), or change can take place in a reverberating chain ($A \rightarrow B \rightarrow C \rightarrow A$). If this is so, it does not always make sense to try to find out which came first, but rather to intervene to change the relationship patterns.

Structure and process. There are two kinds of questions one can ask about families: how are they structured or organized and, how do they function? The answers help us understand how families operate to produce both stability and change in the system over time. Although the comparison is oversimplified, the same questions can be asked of a battery-operated toy that has not yet been turned on. Structural questions include, “How do the parts fit together?” Process questions include, “What does it do once you turn on the power?” Structures do not exist independently of processes. Johnson (2005) notes that, “as dimensions of family life, family process and family structure can be thought of as two conceptually-distinct lenses applied to the same set of phenomena.” Structures are like static photographs or blueprints that diagram the formal relations between the parts and the whole, such as whether the parts are connected. Structural descriptions of families could include: size of family; whether the parents are unmarried, married, separated, or divorced; how many members are in each subsystem; and whether communication proceeds from the top down or occurs with each person having an equal opportunity to communicate. This last sounds more like a process issue, but from this description we do not have any idea about how people talk to each other. Rather, we have

simply described an aspect of structure that could be seen in a static organizational chart in a corporation.

The process aspect of a system refers to dynamic qualities that are often assessed in self-report questionnaires or interviews. A more direct way of assessing the dynamics requires videotape or other devices that allow observers to record the quality of interactions as they unfold over time. Process descriptions of families could include the quality of relationships (including closeness and distance, unresolved conflict, parenting style) and the permeability of boundaries. Although it is difficult to distinguish between structural and process levels of analysis, it can be useful to try to do so. For example, data concerning family structure (cohesion and organization) obtained in a non-clinical study of families during the pre-school period contributed independently to predicting children's behavior problems in first grade, over and above observational data on the quality of marital and parent-child interaction processes (V. K. Johnson, Cowan, & Cowan, 1999).

We should note here that the concept of "structure" within family system theories has a different meaning than the term as sociologists use it. The similarity is that both focus on the organization of the family. Family systems theorists use structure to refer to the way in which family processes are arranged. Sociologists use the term to refer to different family forms described by legal bonds, living arrangements, and kinship: cohabitating, married, separated, divorced couples or single-parent families, two-parent families, and stepfamilies.

Homeostasis. We described the biological and cybernetic models that researchers at the Mental Research Institute used to represent homeostatic properties of family systems. What is important about the concept of homeostasis, even when it is exemplified by a change-resisting cybernetic model, is that the system operates in self-regulating ways that can amplify or reduce the power of external stressors to affect the quality of family life.

The novelty of the early family systems approach. Some assumptions of family systems theory are so well accepted today that it is difficult to conceive of how new they were 50 years

ago, when most adult therapy was individual (although there were couples counselors and therapists), and when most children were treated in play therapy, with their parents as adjuncts to the treatment. Of course, psychoanalysts spent a great deal of time focusing on how past experiences in the family of origin operate to restrict ego and superego functioning in the present, but it would have been unthinkable (and may still be within orthodox psychoanalytic treatments) to bring the parents into the room with the child or adult patient in an effort to reconstruct the present relationship so that it functions more supportively to both generations. Child therapists in the mid-20th century certainly assumed that families were important, but they generally conceived of parents (mothers) as adjuncts in the treatment who could provide contextual information not available during the play therapy session or be educated about their role as a parent (A. Freud, 1965; Winnicott, 1987). Marital conflicts were often noted, and referrals for couples therapy made, but marital therapy or direct intervention in the three-generational transmission of family patterns was not included in the job description of the child therapist. The notion that child therapists may have been treating the identified patient but not intervening where the problem was located was not a part of therapeutic discourse inside or outside the consulting room then, nor is it part of therapeutic discourse in most child treatment settings today.

FAMILY RISK FACTOR APPROACHES TO PSYCHOPATHOLOGY:

EARLY BEGINNINGS

In accounting for the emergence of psychopathology in a child or adult, relationship patterns from different family domains can be considered as possible risk or protective factors that affect children's adaptation or maladaptation: qualities of parent-child relationships (Steinberg, 2001), couple relationships (Cummings & Davies, 1994), and intergenerational relationships (Caspi & Elder, 1988) top the list. Although genetic risk factors are usually considered in opposition to family and other environmental risk factors, as in the contrast between nature (genetics) and nurture (family, Rutter, 2002), we view the transmission of

genetic materials from parents to children as an inherently family-based process, even when the transmission is accomplished through sperm donation or other artificial means. The pattern of genes transmitted and combined in the new offspring is essentially an outgrowth of family patterns associated with the two biological parents. Let us emphasize that, in contrast with the family systems emphasis on the family as the unit of analysis and the locus of pathology, the family risk factor approach assumes that one or more risk factors combine to produce psychopathology in the individual family member.

The family risk factor approach to psychopathology has both a long and short history. One can infer a family factors approach to psychopathology from the Greek plays and myths used by Freud to illustrate his own psychodynamic views. While the Greeks placed great weight on fates, the gods, and literal *deus ex machina* forces that affect men's and women's behavior, the Oedipus, Electra, and Medea stories present vivid examples of how family struggles can result in destruction and madness in parents and their offspring.

Prior to the emergence of family systems theories in the 1950s and 1960s, psychodynamic theories suggested that normal development involved identification with one's parent of the same sex and internalization of their value judgments as necessary; failure to complete this identification was viewed as a prime risk factor for psychopathology (Sigmund Freud, 1905). Behavioral theories promulgated by Watson and others (Watson, 1928) supported the idea that how parents reinforced and punished their children played a central role in producing either well-adjusted or maladjusted children. At mid-century, however, research on children's development was remarkably a-contextual, with Gesell (Gesell, Ilg, Learned, & Ames, 1943) and Piaget (1950) paying virtually no attention to parents, and both Sigmund and Anna Freud (A. Freud, 1965; S. Freud, 1938) focusing only on the child's internalizations, not on parental behavior, in attempts to understand children's cognitive, social, and emotional development. With the possible exception of attachment theories (Bowlby, 1961) studies of variations in parenting styles with normal children stimulated by the work of Baumrind (1971), very little

systematic empirical research focused on family relationship qualities and children's adaptation. As we show below, most of the growth in the family factors approach to developmental research occurred toward the last third of the 20th century.

WHERE FAMILY SYSTEMS AND FAMILY RISK FACTOR THEORIES FIT IN THE PANTHEON OF PSYCHOPATHOLOGY THEORIES

How are family systems and family risk factor approaches similar to and different from the other main developmental psychopathology theories? One of us (PAC) had a professor who taught a course in theories of personality, and each week "covered" a new theorist in class. Instead of recounting what the theorist was trying to tell us, he always began with the questions the theorist was trying to answer, demonstrating that theorists differed not so much because of fundamental disagreements in their claims, but because of differences in their questions, focus of interest, and level of analysis. The professor's approach assumed that each theory had a corner on the truth and that there are many valid perspectives on the explanation of adaptation and psychopathology.

To the extent that we can generalize about a field, the assumption that there may be "many roads to Rome" is not widely accepted in the study of psychopathology. It is as if students entering the field are brought to a market bazaar, with sellers hawking their wares, each saying, "Buy my bracelets and ignore the merchant in the stall next to me. The ornaments on his bracelets are colored glass but mine are precious jewels." Is the field of psychopathology really as competitive and absolute as this? Not in textbooks, where writers acknowledge in measured statements that there are many valid approaches to understanding what goes awry in development. In practice, however, many diagnosticians and therapists focus on the individual and pay relatively little attention to the individual's relationships with family, friends, and work, unless those topics are raised by the client in discussing current problems. Child therapists pay attention to the relationships between mother and child but tend to ignore both the father and the relationship between the father and mother. Many biologically oriented therapists dispense

drugs but spend minimal time talking with the patient, while many psychodynamically oriented therapists focus on talk and avoid prescribing drugs. Most behaviorally oriented therapists would not spend therapeutic time discussing inner defense mechanisms of parents or children, whereas non-behavioral therapists rarely suggest systematic reinforcements or “time outs.” That is, emphases in the therapist’s theory of psychopathology shape the content and structure of both assessment and therapeutic practice.

In this section we present schematic models that summarize answers to two major questions raised by researchers and clinicians who attempt to understand the role of the family in developmental psychopathology. The first is: “Which domains of family life are necessary to examine when we assess families?” The second is: “How do we understand both change and stability within each of these family domains?”

A six-domain family risk model

Until the 1980s, most studies of family risk factors focused on one domain of the family at a time, although some assessed that domain in multiple ways. In 1984, Belsky proposed a three-domain (Belsky, 1984) model that included the personal psychological resources of the parents, characteristics of the child, and contextual sources of stress and support outside the family, as determinants of parenting quality leading to children’s developmental outcomes. In the same year, Heinicke (1984) proposed a different three-domain model that included individual, marital, and parent-child factors in the pre-birth period to predict postpartum adaptation in both mother and child. Our own five domain model (C. P. Cowan et al., 1985) hypothesized that children’s adaptation to elementary school could be predicted by a combination of information from 5 aspects of family life: (1) the individual personality and adaptation of mother, father, and child; (2) couple relationship quality; (3) parent-child relationship quality; (4) intergenerational family patterns, and (5) the balance of social support and life stress in family members’ relationships with people and institutions in the larger society. Because our research focused on the parents’ relationships with their first child, we ignored an important sixth domain: sibling relationships.

Insert Figure 1 about here

Recent evidence from our Schoolchildren and their Families Project (P. A. Cowan, Cowan, & Heming, in press) indicates that: (a) each of the first five domains assessed in the year before the oldest child enters kindergarten contributes unique variance to the prediction of the child's academic achievement and externalizing and internalizing behavior in kindergarten and first grade; and (b) taken together, these family risk measures account for substantial amounts of variance -- often over 50% -- in the child's adaptation to school. The design of our studies and the choice to assess multiple family domains using multimethod, multiperspective assessment tools (interviews, questionnaires, and observations of family interaction) was directly influenced by family systems theories as we described them above. Nevertheless, with only a few exceptions in which we examined family-level functioning (V. K. Johnson et al., 1999), our research designs are more consistent with a family risk factor model than a family systems approach, because we look at predictions from family functioning to children's outcomes. As we will see, there is ample evidence from many studies in support of the hypothesis that adaptation or maladaptation within each of these domains accounts for substantial variance in child and adolescent functioning.

A nine-cell Model of Alternative Explanations of Stability and Change in Each Family Domain

To understand and treat psychopathology in an identified patient, family systems theorists want us to look at the whole family, and perhaps at some of the subsystems outlined in the 6-domain model presented above. In part, their insistence on focusing on the family as a whole was stimulated by their frustration with the fact that traditional theories of psychopathology did not lead to therapies that produced change reliably (especially in patients with severe mental illness). In order to illustrate how family systems theories have come up with answers that are

quite different from most other theories of psychopathology, we examine the basic question: “What produces stability and change in individuals, relationships, and family systems?”

Why do some individuals or families show excessive resistance when situations call for change (e.g., they are unresponsive to reasonable social demands), whereas other individuals or families show excessive sensitivity to change (e.g., instantaneous reaction to the changing emotions of others)? Theoretical answers to these questions vary along two conceptual dimensions. The first dimension describes the preferred level of analysis of the theorist: Does he or she look for explanations of stability and change in biological, psychological, or social aspects of the person? The second dimension describes whether the source of change is considered to be internal, external, or interactive. Combining those dimensions yields a matrix of 9 major factors affecting stability and change, each located in a different “cell” (See Figure 2), Each cell, then, contains a different type of theory.

Insert Figure 2 about here

Within each cell, theorists generally choose the same answer to questions about explaining normal development, explaining psychopathology, and speculating about what kind of intervention would be necessary to address problems as formulated by the theory. For example, theorists who assume that internal factors that govern change and stability shape the emergence of normal development also assume that internal conditions affect the emergence of psychopathology; not surprisingly, these theorists assume that interventions focusing on internal factors (defense mechanisms, cognitive schemas) should be central in whatever treatment is provided. That is, within each cell, the answers to fundamental questions about stability and change tend to come in “boxed sets.”

We should state at the outset that the basic assumptions of family systems theories are consistent with social interactional theories of stability and change (cell 9). Relationships are

central. Stability or change occurs as products of interactions among individuals and subsystems in the context of the family as a whole. We can now locate other competing theories with reference to this cell. We will show that the family risk factors approach appears in a number of cells, depending on the level of analysis and the theorist's reliance on external or internal theories of change. Although our descriptions highlight the differences between cells as if they represented mutually exclusive choices, we know that the theories in different cells differ in emphasis and do not represent categorically distinct approaches to developmental psychopathology.

Biological Level of Analysis.

1. Internal. In this cell, theorists assume that the path toward normal development is regulated by a system of genetic, biochemical, neurophysiological, and physical processes operating inside the person. If they malfunction, these same processes are invoked as determinants of psychological disorders such as schizophrenia, depression, and antisocial personality. Theorists, researchers, and clinicians with a biological internal perspective often assume that biologically caused disorders will respond best, if they respond at all, to biological treatments such as the administration of psychoactive drugs. Because it is not possible to intervene at the level of genetic processes or brain functions, at least not yet, the biological internal view tends to emphasize stability and resistance to change, and to present a somewhat pessimistic picture of the possibility of treatment. If a disorder is inherited, the message seems to be, interventions can reduce the expression of basic symptoms but nothing much can be done to change the underlying disorder. We will see that this pessimism is unwarranted on both logical and empirical grounds.

2. External. So pervasive that it is not always acknowledged, the physical environment plays a central role in normal development (e.g., nutrition, clean air). Malnutrition and chemically toxic conditions (e.g., lead poisoning) can also cause psychotic reactions or extreme behavior

disorders (Zetin, Stasiek, Pangan, & Warren, 1988). From the biological external perspective, intervention should be directed toward the elimination of environmental deprivation or toxicity.

3. Interaction between physical environment and biological factors. A strictly internal view of biological factors in development is outmoded. Internal biological processes are always influenced by external biological, psychological, and social events. Genetic and neurological processes unfold within environmental niches that influence whether risk factors will be expressed in behavior. For example, even if brain scans obtained through functional magnetic resonance imaging (fMRI) show differences between groups of patients diagnosed as schizophrenic and non-schizophrenic, we do not know whether the brain (mal)function generated the schizophrenic behavior or whether biopsychosocial stressors over time led to the brain malfunction (Kandel, 2000). From the perspective of cell 3, intervention involves alterations in the biologically-based functions of the individual along with shifts in the external environment. A good example of this perspective would be in the treatment of children with Attention Deficit Hyperactivity Disorder with a prescription of Ritalin, along with an extensive reduction of stimulation in the children's school environment (Hinshaw, 1994).

Psychological Level of Analysis

4. Internal. Given a "goodenough" psychosocial environment (Winnicott, 1987), forces from within unfold to produce normal development. In this cell are the humanistic theorists (Maslow, 1962; Rogers, 1961) who assume that all human beings move toward self-actualization unless they are prevented from doing so, and psychoanalysts (e.g., Erikson, 1980; S. Freud, 1938) who assume that stages of development (oral, anal) unfold on a biologically given timetable. For these theorists, psychopathology arises when natural developmental forces are disrupted (often, though not always, by parents) and the child or adult develops internal defensive armor that may temporarily reduce anxiety but impedes the exploration and risk-taking necessary for developmental progress to occur. From the perspective of cell 4,

intervention involves the provision of a safe holding environment in which destructive defenses can let down long enough for normal development to move forward.

5. External. In this cell are the familiar socialization theories (Baumrind, 1989) and behavioral theories (G. R. Patterson, 1982) that look to parenting styles or specific patterns of reinforcement by parents or other significant adults as the forces that shape normal development. According to this view, behavior that deviates from the norm, including autism, schizophrenia, depression, and antisocial behavior, results from conditions in which socially inappropriate rather than appropriate behavior has been reinforced.

Psychological external theories, especially the behaviorist examples, make a point of distinguishing between acquisition of behavior and its maintenance. Therapists with a traditional behavioral perspective acknowledge the importance of establishing etiology in order to create new prevention programs, but they focus more of their efforts on changing the physical and social environmental patterns that maintain the behavior over time than they do on altering the psychological makeup of the person. Their theories of change lead to clear instructions to therapists to avoid searching for the origins of current problems in early family experiences and focus instead on what is maintaining the problematic behavior now. The most popular example of psychological external theories applied to interventions are parenting classes, self-help books (Dinkmeyer & McKay, 1982; Ginott, Ginott, & Goddard, 2003; Gordon, 1980), and behavioral “parent training” interventions (Forgatch & DeGarmo, 1999; Webster-Stratton, Reid, & Hammond, 2001) designed to provide parents with skills to manage their children’s aggressive and problematic behavior more effectively.

6. Interaction between internal and behavioral psychological factors. Even before family systems theories emerged in the 1950s, it was clear that both the nature of the child and the quality of parenting had to be taken into account to understand normal development and psychopathology. Parents should not get all the credit when their children turn out well or all the blame when they turn out badly. Children are agents of their own development, and the engine

driving fathers' or mothers' parenting behavior is sometimes located in the child (Bell, 1968, 1988). The child's age, sex, personality, and temperament influence how mothers and fathers respond to them, just as parents' behavior influences how their children respond in return.

Piaget's theory of child development provides a good example of an interactive theory of development (Piaget, 1967). As long as children's cognitive level is adequate to handle the environmental challenges they face, they can assimilate the stimulus into existing cognitive structures and respond appropriately, so that no change is necessary. When an unfamiliar stimulus or difficult problem occurs, disequilibrium follows and the child must accommodate (change their strategies to meet changes in environmental demands). As the child attempts to re-establish a new equilibrium between assimilation and accommodation, one possible outcome is cognitive reorganization at a new and higher level of intellectual functioning. Piaget's own emphasis was on interactions between the child and the physical environment, but it is clear that parents (P. A. Cowan, 1978) and peers (Piaget, 1962) also play central roles in providing external stimulation that helps to produce developmental change. Piaget himself was not much interested in psychopathology, but some of his associates (Inhelder, 1968; Schmid-Kitsikis, 1973) attempted to apply his theory to describing and understanding deviations from normal development. In general, they attempted to explain failures in developmental progression as resulting from imbalances in assimilation and accommodation (see P. A. Cowan, 1978), an internal perspective similar in form to the social interaction theories espoused by family systems theorists.

Another approach to psychological interactive models of change can be seen in cognitive behavioral theories (Reinecke, Dattilio, & Freeman, 2003). In a traditional behavioral approach, it is assumed that manipulating the stimulus should produce a change in the response (external psychological cell). However, the child's or adult's appraisal of the stimulus also plays a role in his or her subsequent behavior (Lazarus, 1984). For example, parents with high levels of conflict tend to have children who are more aggressive or depressed than children of parents

with low levels of conflict, but this linkage is more likely to occur when children blame themselves for their parents' fights (Grych, Fincham, Jouriles, & McDonald, 2000).

All psychological interaction theories of change assume that there is some optimal level of fit and an optimal level of mismatch between the external forces of the environment and the internal structure and function of the child. Positive developmental progress is more likely when there is an "optimal mismatch" between the demands of the environment and the demands of the child; Vygotsky (1978) described a similar concept of "scaffolding" (Wood, Bruner, & Ross, 1976) in which parents move in at the appropriate level to help a child who is having difficulty solving a problem, and then move out once the child is on the right track.

Social Level of Analysis

7. Internal. It is not immediately clear what a social internal theory of stability and change should look like, because the idea that social relationships influence both normal development and psychopathology seems to be incompatible with the notion that internal forces are the primary determinants of both stability and change. What resolves the dilemma is the notion from both object relations (Klein, 1932; Kohut & Wolf, 1978) and attachment theories (Bowlby, 1988; Main, Kaplan, & Cassidy, 1985) that an inner symbolic representation or schema of a primary relationship, usually formed early in life and typically focused on the mother-child relationship, operates as a template that shapes expectations and behavior in the significant close relationships that one establishes over the lifespan. Working models characterized as secure, because they assume that a loved one will provide a secure base to protect the child from the threat of loss, facilitate normal development. Insecure working models (defined below, p.xx) lead to various forms of psychopathology (Sroufe, Duggal, Weinfield, & Carlson, 2000). Therapists adopting the social internal perspective on psychopathology attempt to change insecure working models, in part by providing a safe, secure environment in which clients can use the relationship with the therapist to gain perspective on their early relationships and

develop the security needed to explore current and new intimate relationships in more productive ways (Klerman & Weissman, 1986; Mattinson & Sinclair, 1979).

8. External. In the psychological external cell (5), we described examples of how a parent's behavior provides reinforcement or punishment for a child's behavior. In the social external cell, we include socialization theories in which family and peer relationships (social support) and social institutions outside the nuclear family (workplace, government) affect whether individuals move toward normality or pathology in their life trajectories (Parke & Buriel, 1998). What differentiates this approach from the interactive position in the next cell (9) is that the effects are thought to be directional (acting on the person), rather than bi-directional (positing circular causality, a central tenet of the family systems approach). Theorists who emphasize social relationships and social system forces as causal risk factors that affect the development of psychopathology usually turn to social change programs in an effort to reduce or alleviate psychopathology in individuals (Sarason, 1974; Weinstein, 2002).

9. Interaction between internal and external social factors. Family system theories represent the quintessential example of social interaction theories of stability and change. "The system" is the major unit of analysis, although subsystem balances and imbalances are important. Reciprocal interactions among individuals, and the reciprocal impact of relationships on relationships, create the conditions for normal development or psychopathology, with treatment optimally conducted with all the "players" in the room at the same time.

Six Domains and Nine Cells

The 6-domain model describes where the investigation of psychopathology is focused -- on the system as a whole or on one or more of the subsystems. The 9-cell model helps us to understand the multiple ways of conceptualizing stability and change within each domain, with corresponding theories of how adaptation or psychopathology emerges. For example, within the couple domain, it is possible to account for stability or change at a biological level (the impact of illness), a psychological level (the impact of mismatched personality styles), or a social level of

analysis (the impact of dysregulated expression of negative affect). Theories can be focused on internal factors in change (attachment processes), external factors in change (cultural expectations), or the interaction between the two (what happens when a man with an insecure model of attachment marries a woman with a secure model of attachment and is unable to fulfill the culturally stereotyped strong, silent, protector role?).

Our 9-cell classification of theories of change and stability helps us to make a more differentiated distinction between family systems and family factors approaches to developmental psychopathology. We have reserved cell 9, the social interactional cell, for family systems theories with their emphasis on normality and psychopathology as a gestalt (whole) formed by the system of reciprocally interacting relationships. Especially in the early years of family systems theories, the focus was primarily on that system and not on the individuals within it. These homeostatic theories were better able to explain why families remain stable than why they change. As we will see, because a focus on the system as a whole was not always efficacious in producing family change, some aspects of family risk factor theories have been incorporated into family treatments.

Theories that focus on the family risk factors that affect individual psychopathology appear in all of the other cells – in genetic and other biological forces (cell 1), household environment effects (cell 2), the interaction between biological and physical environment factors (cell 3), an individual's defensive system, erected to provide relief from anxieties created in the family, or an individual's appraisal of family members' behavior (cell 4), parenting behavior (cell 5), the match between parental behavior and the child's psychological organization (cell 6), working models of intimate family relationships (cell 7), and the impact of family relationships on the individual (cell 8). Each of the factors, considered separately, and all of the factors in combination, can affect the pathways that individuals take toward or away from adaptive functioning.

In the examples of interactive theories of change presented above, we have described interactions between external sources of stability and change within biological, psychological, or

social levels of analysis. Physical environments have different effects on people with different genetic constitutions. Parenting behavior may be interpreted differently by children who have different interpretations of what their parents are trying to do. Family relationships may play out differently with individuals who have secure or insecure working models of relationships. It is easy to see, however, that biological processes interact with psychological and social factors to affect adaptive and maladaptive development. For example, a diathesis-stress model of psychopathology (Gottesman & Shields, 1971) suggested that genetic and other biologically-based predisposing factors (the diathesis, or vulnerability) develop into full-blown psychopathology only when triggered by severe social stressors and psychological vulnerabilities.

Independence of Etiology and Treatment

Our discussion of theories located within each cell pointed to parallels among theories of normal development, psychopathology, and intervention because this is the prevailing assumption of those who apply theories of development to their intervention programs. We believe that it is necessary to challenge the lock-step assumption of consistency between etiological and intervention theories on both logical and empirical grounds. The issue becomes clearer if we consider two “thought experiments.” First, let us assume that variations in genetic makeup actually cause a very high proportion of the variation in a person’s level of adaptation assessed at a given point in time. It is still possible that psychological or social interventions will produce positive change in behavior. Just as height, which is highly heritable, is profoundly affected by diet, so an individual’s level of psychopathology, regardless of the causal factors involved, can be changed by environmental manipulations.

Second, let us assume that instead of genes as etiological factors, variations in parents’ reinforcement patterns cause a very high proportion of the variation in a person’s level of adaptation assessed at a given point in time. It is still possible that, because the patterns of interaction have been persistent and cumulative over the years, no known psychosocial

intervention can produce positive change. Furthermore, well-managed drug treatments might provide conditions in which further psychosocial treatment will now be effective.

In sum, while we have followed standard practice by associating theories of etiology with theories of intervention, we emphasize that one's theory of how a disorder was caused does not necessarily dictate the most appropriate treatment approach. More specifically, if we find evidence that family risk factors play a role in causing or maintaining the disorder, this does not exclude biological or physical environment interventions as part of the treatment process. And even if we find evidence that genetic, brain, or physiological factors play a role in causing a disorder, we should be open to including family members as part of the treatment plan.

If our theory of treatment does not necessarily follow from our theory of etiology, why spend so much effort in attempts to identify the causes of a disorder? Without a well-supported etiological or risk-factor theory, it will be impossible to plan a program to prevent the occurrence of a disorder or to identify individuals and families in the early stages before the disorder reaches diagnosable levels.

CHANGES IN FAMILY SYSTEMS AND FAMILY RISK FACTOR APPROACHES TO PSYCHOPATHOLOGY OVER THE PAST 50 YEARS

Family systems theory has come a long way since its origins in the mid 20th century. As we look back, we see an interesting cycle in which the early family systems theories of the 1950s and 1960s had a delayed but important impact on family risk factor research in the 1970s and 1980s, which in turn, began to influence a move toward integration of quite different family systems approaches to diagnosis and treatment at the end of the century.

New Family Therapy Gurus and New Schools

New charismatic family therapists joined the "club" created by the early founders of the field, each using the early family system theories as a starting point but offering a slightly different central idea of what was wrong and needed "fixing" when families came into treatment. Although all of the new leaders focused on social interaction theories of stability and change in

the family system as a whole when explaining the etiology and locus of psychopathology, each one emphasized the role of one or more aspects of internal psychological factors in both individual and family maladaptation. This period, in which new, competing schools of family therapy training and services were established, but in which little systematic evaluation occurred, has been characterized aptly, though perhaps too harshly, as the “battle of the brand names (Hoffman, 1981).”

One of the few second generation family therapists to maintain a direct connection with treating mentally ill patients and their families was Carl Whitaker, who emerged as a leading figure, first at Emory in Atlanta and later in the Department of Psychiatry at the University of Wisconsin Medical School. His forte was not the construction of “grand theories” or the proposal of unique formulations of the central issues faced by families. His influence came through demonstrating his approach in large workshops and small, intense meetings of the movers and shakers of the family therapy world (Whitaker & Bateson, 1958). Although he focused on the systemic properties of the family, as a therapist Whitaker paid close attention to his own inner thoughts and feelings during the session, and expressed them to the family. That is, he used psychodynamic notions of transference and countertransference in the therapy, primarily as a way of joining with clients at the same time that he disequibrated them with cryptic but remarkably “on target” remarks.

An offshoot of a more consistently psychodynamic family theory such as Ackerman’s (1962) could be found at The Family Institute of Philadelphia led by Ivan Boszormenyi-Nagy and James Framo (Boszormenyi-Nagy & Framo, 1965; Framo, 1992). They developed what they called contextual family therapy, with an emphasis on adults coming to terms psychologically and in direct interaction with their parents as a way to repair distress at the individual, couple, and parent-child level.

After leaving the Palo Alto group, Jay Haley worked with Minuchin in Philadelphia to develop structural family therapy, with a focus on the role of the therapist in changing the

organization of family subsystems. Haley then started a new “school” of strategic therapy that focused on the family’s behavioral efforts to solve problems in the here and now (Haley, 1976; Madanes, 1984). Haley delighted in a “paradoxical” approach, telling families, as they described their problems, that they were objectively insoluble. The central task of the therapist was to help families reframe or redefine the problem, and prescribe a set of strategies that would overcome family homeostasis and facilitate change, including “prescribing the symptom,” in which he would ask families to repeat a maladaptive pattern in order to bring it into the open and place it under conscious control.

One of the strongest international developments in family therapy occurred in Italy, where Mara Selvini Palazzoli, Luigi Boscolo, Guiliana Prata, and Gianfranco Cecchin became the “Milan associates” (Selvini Palazzoli, 1985; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). Staying close in theoretical orientation to the Palo Alto group (Bateson and colleagues), they focused on short-term intensive interventions focused on disrupting the deviant communication “games” by which severely disturbed families (severe eating disorders, schizophrenia) maintained a maladaptive homeostasis. Haley and the Milan associates focused on behavior, but were not behaviorists, in the sense of direct teaching of communication rules, exchange of reinforcing behaviors, or consequences for unacceptable behavior.

A quite different offshoot of Bateson’s ideas from the Palo Alto group was narrative therapy (M. White, 1986; M. White & Epston, 1990), which focused on the idea that family narratives or stories were often impoverished in disturbed families, and the task of the therapist, through talking, writing letters to clients, and having clients write new narratives, is to reframe and refashion these stories with new possibilities. Like many postmodern theories, narrative therapies place great emphasis on the meaning of words, and the constructions that family members place on their realities, each of which has its own validity or truth.

The Feminist Critiques of Family Systems Theories

In 1978, Rachel Hare-Mustin issued an opening salvo in an ongoing feminist critique of family therapy (Hare-Mustin, 1978), making the point that early versions of family systems theories made highly gender-stereotyped assumptions about what constituted pathological and non-pathological functioning in families (Walters, Carter, Papp, & Silverstein, 1988). The early masters of family therapy, almost all men, had focused their interventions on re-establishing traditional roles in chaotic families, in part by encouraging fathers to take a more active, often patriarchal role. This work virtually ignored the issues associated with the changing of women's roles stimulated by the women's movement starting in the 1960s (Chodorow, 1989; Friedan, 1963; Greer, 1980). Judging by the fact that sharply worded feminist critiques continue to appear, these issues have not yet been resolved (Almeida, 1998; Bograd, 1991; Coleman & Ganong, 2004).

In addition to the issue of roles, feminist family therapists focused on power in relationships between men and women, advocating that therapists help families to buck the cultural trends in which men not only held the purse strings but the power to make decisions about many aspects of life inside and outside the family (Silverstein & Goodrich, 2003). The implication was that a feminist therapeutic approach would alleviate depression in women and provide examples of a better balance of gender roles for both daughters and sons. In fact, the systematic research that we are aware of suggests that less traditional divisions of labor are related to more satisfied and less symptomatic partners (Blair & Hardesty, 1994; Huppe & Cyr, 1997), but to our knowledge, there have been no direct tests of these assumptions by examining whether therapy-induced changes in the balance of power within couples are associated with more positive outcomes for the partners or their children.

Both family systems theories and feminist critiques were presented and argued in the 1970s and 1980s on the basis of clinical experience, training in each of the family therapy schools, detailed written case materials, and sharp exchanges at national gatherings of family therapists.

There was little reliance on empirical studies in the family research literature. We wonder whether the fact that family therapy training was primarily conducted in free-standing institutions that were not connected with academic or hospital research settings widened the gap between developments in the fields of family therapy and family research.

The Family Risk Factor Approach: An Expanding Focus on Family Relationships in Accounting for Psychopathology

During the 1970s and the 1980s, influenced by the active ferment in family systems theories and therapies, there was a rapid rise of interest in family research, in the study of both normal development and psychopathology. Before 1960, research interest in whole families was so low that fathers were virtually invisible in research on child development. “Eleven years after the publication of the first version of the Handbook of Child Psychology” (Carmichael, 1954), Nash (1965) pointed out that ‘father’ had not been included in the index. A number of researchers who would later become prominent published papers on the impact of father absence (Biller, 1968; Hetherington, 1966, 1972; Mischel, 1961), but it was not until the 1980s that a body of work emerged looking at how variations in fathers’ behavior were related to children’s development (Bronstein & Cowan, 1988; Lamb, Pleck, Charnov, & Levine, 1987; Power & Parke, 1983). Although general research interest in fathers has continued and grown (Tamis-LeMonda & Cabrera, 2002), most child psychopathology researchers continue to neglect fathers (Phares, 1992).

Just as “father absence” was the stimulus for early studies of fathers’ impact on their children, so the study of how the parents’ marriage affects children’s development was stimulated by studies of divorce in the early 1980s (Hetherington, Cox, & Cox, 1982; Wallerstein & Kelly, 1980). Over the following two decades, a wealth of evidence suggested that high, unresolved couple conflict is a risk factor for most dimensions of adaptation in children (academic achievement, externalizing, internalizing (Ablow, 2005; Cummings, Davies, & Campbell, 2000; Emery, 1999).

Research on the intergenerational transmission of disorders also increased. The belief that positive or negative patterns of family interaction are repeated across generations and function as an antecedent to many different diagnoses is supported by the results of behavioral genetic studies of twins and siblings (Gottesman, 1991), epidemiological studies of family records (Mednick, Schulsinger, & Griffith, 1981), and longitudinal studies of non-clinical families (Caspi & Elder, 1988). In the 1970s and early '80s, the risk factor approach attempted to identify one or at most two family domains associated with child psychopathology. Only later, as we shall see, did these models become more inclusive as they attempted to incorporate information from all of the family domains in Figure 1.

A New Wave of Researcher-Clinicians

From the 1970s to the present day, some academically based researcher-therapists, influenced by family systems theory, began to focus on interventions in family subsystems, which brought new concepts and techniques to therapies focused on either parent-child- or couple relationships. If we examine where the interventions were targeted, we can infer the assumptions of each approach concerning risk factors or causes of psychopathology.

Parent-child focus². Attempting to help parents to deal with their highly aggressive sons, Gerald Patterson began developing behavioral treatments in which parents learned techniques of reinforcement, time-outs, and social learning through imitation (G. R. Patterson, 1975). Presumably, parental failure to establish adequate controls was seen as the source of children's misbehavior. Seven years later, Patterson took a more systemic bi-directional approach in his theory of "coercive family processes" (G. R. Patterson, 1982). Observing mostly mothers and children in interaction, Patterson noted that when a child was aggressive and a parent responded ineffectively, the child escalated the aggression, the parent again responded ineffectively (e.g., by "nattering" instead of giving clear directions), and the child escalated again until the parent backed off, thus reinforcing high level aggression on the part of the child. Still later, risk factor models from Patterson's group expanded to include additional measures of

individual personality and functioning (G. R. Patterson & Capaldi, 1991), cognitive-behavioral conceptions, including parents' and children's interpretations of events, and the role of both sibling and peer relationships in the control of aggression.

Carolyn Webster-Stratton (Webster-Stratton, 1984, 1994) developed a videotape program for parents of aggressive children, which present dramatized vignettes of effective and ineffective parenting. In contrast with a more didactic teaching orientation characteristic of many behavioral interventions, Webster-Stratton's individual therapists or group leaders use the taped excerpts to elicit explorations and observations from the parents in an attempt to involve them actively in the process of adopting new strategies of discipline with their children.

A newer dimension of parent-child relationships has been investigated but not yet used in interventions. John Gottman describes meta-emotion coaching as parental behavior that helps children deal with their feelings of sadness or anger (J. Gottman, 2001; Katz, Wilson, & Gottman, 1999). When parents are able to help their children explore their negative feelings rather than criticizing them or dismissing the feelings, children show less externalizing or internalizing behavior. What makes this construct a candidate for therapeutic trial is the suggestion from correlational studies that positive meta-emotion coaching can protect children from the vicissitudes of marital conflict in the family.

Couples focus. Neil Jacobson, Gayla Margolin, Andrew Christensen, and Donald Baucom, separately and together, developed treatments for couples in distress (Baucom, Epstein, Rankin, & Burnett, 1996; Christensen et al., 2004; Christensen, Jacobson, & Babcock, 1995; Jacobson & Margolin, 1979). Like Patterson, most began by developing behavioral interventions based on different versions of exchange theories (one partner gives positive reinforcements in response to positive reinforcements) and on direct didactic teaching of communication strategies (e.g., using "I" statements and avoiding mind reading and blaming). Then, as Patterson had, these researcher-clinicians all moved toward more cognitive-behavioral approaches with an emphasis on how each partner interprets his own and his partner's

behavior, or on such non-behavioral concepts as the need for acceptance when partners have differences or reach impasses that cannot be resolved (Christensen & Jacobson, 2000).

Just as the early family systems theories could be divided into those with a behavioral emphasis on the transactions among family members and those with a psychodynamic emphasis on the individual in the system, the field of couples therapy encompassed both approaches to understanding trajectories of relationship health and maladaptation. Two theories of couples therapy based their assumptions on an intrapsychic view of how problems in the couple are generated, one stemming from the object relations theories of Melanie Klein (1932), the other from John Bowlby's attachment theory (Bowlby, 1982, 1989). Theories based on Klein's work focused more on the ways in which partners who are frustrated and unsatisfied with their primary object relationships (with mother) project their unacknowledged and rejected aspects of themselves on their partners (Dicks, 1967; Mattinson & Sinclair, 1979). One partner's anger that the other is frustrating his or her needs results in either anger or depression/withdrawal. In essence, as in Bowen's family systems approach, the partners exist in a state of fusion or enmeshment in which each sees the other as an extension of him/herself, and positive development through therapy involves a process of encouraging individuation. Object relations theories of couple functioning were later expanded and systematized by David and Jill Scharff (D. E. Scharff & Scharff, 1991; J. S. Scharff & Bagnini, 2002).

A different intrapsychic approach to couples therapy, based on attachment theory, was developed by Clulow and his associates at the Tavistock Marital Studies Institute in London (Clulow, 1996; Clulow & Cudmore, 1985). From this perspective, partners begin as separate individuals, and problems arise in the process of coming together. Anger or withdrawal in the couple relationship arises when individuals who are vulnerable because of insecure working models of attachment become threatened by fear of losing the relationship. One of the therapist's main tasks is to understand the working models that each partner brings to the relationship, and to provide a secure enough base in the therapy room that partners can use as

a platform to analyze and revise their distorted working models. The goal is to help each partner begin to function as a secure base for the other.

The Current Couple and Family Systems Scene: Integrations

A number of textbooks and handbooks describing couples and family therapy (Gurman & Jacobson, 2002; Gurman & Kniskern, 1981, 1991; Jacobson & Gurman, 1995) have been published over the past two decades. Even a brief comparison of later volumes with earlier ones suggests a move toward theoretical integrations. Lebow (1997) summarized the trend with an influential article in Family Process, noting the different meanings of "integration." Eclecticism is one alternative -- the incorporation of disparate theoretical ideas and intervention techniques into family assessment and therapy. At another extreme is an integration that synthesizes disparate elements into a coherent theoretical model. While some question whether this kind of integration is possible (e.g., Grunebaum, 1997), Lebow describes mid-level integrations -- attempts by a theorist or therapist to give equal attention to at least two family domains (e.g., couple and parent-child) or levels of analysis (a subsystem and the whole family) or explanations of stability and change (biological, psychological, social or internal, external, interactive). Given the rich array of recent integrations, we are able to provide only a few examples of these mid-level integrations.

Integration across domains: couple and parent-child. Behavioral interventions for parents of aggressive children have been remarkably successful (P. A. Cowan et al., 1998; G. E. Miller & Prinz, 1990), at least in the short run. Nevertheless, when therapist-researchers looked at evidence that some children did not change while others improved but later reverted to baseline, several began to suspect that parenting changes were more difficult to achieve when the child's parents were in high levels of conflict. Brody and Forehand (1985) added to their parenting intervention a new focus on co-parenting and marital issues. In the Brody and Forehand study and another intervention evaluation by Dadds and his colleagues (Dadds, Sanders, Behrens, & James, 1987), a combined marital and parenting emphasis was more successful in reducing

sons' problem behavior than a traditional parenting skills approach with mothers only. Webster-Stratton (1994) showed similar results in her recent work with couples whose children had behavior problems. These intervention results, as we have noted, provide evidence in support of the hypothesis that both marital and parent-child relationships play important roles in the development or maintenance of psychopathology in the child.

Integration across domains and levels of analysis. By far, the majority of family theory integrations attempted to combine a focus on how psychological or biological processes of each individual play out in the transactions between partners or among family members.

(a) Biological and family processes. Until relatively recently, family theorists have acknowledged but generally ignored the fact that genetic factors played some role in individual psychopathology. Plomin and his colleagues (Hetherington, Reiss, & Plomin, 1994; Plomin, 2003) have made what seems like a paradoxical claim -- that behavior genetic studies can be used to make the best case for the importance of family relationship risk factors in psychopathology. To begin with, these investigators depart from the usual practice of studying only one child in each family so that they can identify the contributions of both nature and nurture to variations between siblings in behavior and adaptation. Twin studies and adoption studies have been used for some time to make the case that there is a genetic component to schizophrenia, bipolar disorder, depression, and many personality traits in non-clinical populations (Gottesman, Shields, & Meehl, 1972). Somehow, the focus on finding proof of genetic risk factors obscured an obvious point: even in twins who are genetically identical, the probability that both will be diagnosed with schizophrenia is, at most, about 50% to 60%. This means that there must be some non-genetic factors that account for sibling differences. The contribution of Plomin and his colleagues was to calculate a heritability index for each outcome under investigation (with perfect heritability (h) = 1.0) and then to search for two sources to explain the remaining variance (1-h): (a) shared environmental similarities that tend to make siblings similar (e.g., being treated similarly by parents), and (a) non-shared environmental

conditions that tend to make siblings dissimilar (e.g., being treated differently by parents). Using data from sophisticated studies of identical twins, fraternal twins, and siblings in both adoptee and non-adoptee families, these investigators interpret their results as showing that once genetic factors are accounted for, much of the remaining variation in severe psychopathology comes from non-shared family factors – conditions that make for differences between siblings. Both shared and non-shared effects are aspects of family processes that are consistent with a social external view of adaptation.

Space precludes an elaborate analysis of the “non-shared” approach. It has been criticized on the grounds that heritability coefficients overestimate the contribution of genetic factors to psychopathology because the estimates are specific to the population they are assessing, and that restrictions in variation within each study necessarily inflate the size of the heritability coefficient (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). More recent critiques also suggest that the contributions of non-shared environments have been overestimated at the expense of shared environmental effects (Spinath, 2004). Nevertheless, in our view, Plomin and his colleagues have provided solid evidence supporting the hypothesis of an interaction of genetics and family processes in a number of DSM-disorders (see below, p. xx).

(b) Intrapersonal cognitive processes and interpersonal behavior. Consistent with the tenets of the cognitive-behavioral individual therapies growing in importance during the 1970s, some researcher-clinicians added to their analysis of couple communication patterns new ideas about how one partner’s interpretation of the other’s behavior could affect subsequent interactions between them. Attribution theories of couple interaction (Grych et al., 2000) pinpoint negative interpretations of the motivation behind a family member’s behavior (e.g., you did that just to frustrate me”) as a risk factor for increased interpersonal conflict. In another perspective on the importance of interpretation, Christensen and Jacobson (2000) show that behavior that violates the couple relationship (e.g., adultery) is not necessarily corrosive in the long term unless one partner refuses to forgive the transgression.

(c) Emotion processes, cognition, and interpersonal behavior. In laboratory research, Gottman and Levenson (J. M. Gottman & Levenson, 1986; Levenson & Gottman, 1983) first identified behavioral patterns (escalating negative affect) and physiological patterns (men's tendency to stonewall in verbal communication during a discussion of a marital disagreement, though their physiological arousal was high) as risk factors for couple dissatisfaction and distress. That is, both dysregulation of internal emotional arousal and dysregulation of emotional expression as partners interact are important ingredients of couple adaptation. Applying these findings to therapy (J. M. Gottman, Ryan, Carrere, & Erley, 2002), Gottman and his colleagues also emphasize the importance of each partner's aspirations and dreams, and the negative consequences for relationships when one or both partners fear disappointment that their life dreams will not be realized in this relationship. Behavioral, affective, and cognitive integrations are also featured in Christensen and Jacobsen's Integrative therapy (Christensen et al., 2004).

(d) Attachment processes and interpersonal behavior. Emotionally Focused Couple Therapy (EFT) was developed by Leslie Greenberg and Susan Johnson (Greenberg & Johnson, 1988), and later expanded by Johnson (2004). EFT represented a reaction to the behavioral approach. Based on observation of couples therapy tapes, they concluded that too much attention was given to cognition, problem-solving, and behavioral strategies, and not enough to emotional moments and attachment issues. Their primary hypotheses was that distress in couple relationships is caused by the fact that when differences arise, one or both partners may be vulnerable to the threat of separation and loss; one or both then react emotionally by dismissing, denying, and defending, or with high levels of anger, with either alternative driving the partners farther apart. Once insecurities about the relationship are aroused, Johnson argues, they are maintained by the manner in which the partners interact. Thus, explanations of psychopathology and attempts to treat couples are based on a psychological and social analysis that posits an interaction of internal and external contributions to individual distress and couple relationship disruption. Their retention of a behavioral communication focus in addition to

the attachment focus makes their therapy quite different from the attachment-based therapy described by Clulow (1995). The attempt to integrate attachment and behavioral theories has also been a central feature of Gurman's Brief Integrative therapy (2002), and Christensen and Jacobson's Integrative therapy (Christensen et al., 2004).

Why Integrations are Needed

From the perspective of 21st century theories of psychopathology, the need for integrations of theories explaining the development of psychopathology seems obvious. Although traditional individual and family therapies have been shown to be effective when participants are compared with control groups (Shadish, Ragsdale, Glaser, & Montgomery, 1995; Weisz, Weiss, Han, & Granger, 1995), it is clear that these therapies do not provide help for substantial numbers of people. On both conceptual and empirical grounds, it is easy to see that no single family domain could possibly explain how some families at similarly high levels of risk follow trajectories toward different kinds of psychopathology, while others move toward adequate or even superior levels of adaptation. Similarly, in a time when biopsychosocial models (Engel, 1980) are becoming widely accepted (Whitbourne, 2005), it does not seem reasonable to limit one's view to a single level of analysis – biological, psychological, or social – to account for the links between risks and outcomes. It seems futile to maintain either an internal or external explanation of stability and change, when there is so much evidence of protective or vulnerability effects; whether external risk factors eventuate in psychopathology depends on whether internal factors protect individuals from harm or represent vulnerabilities that make them particularly susceptible to greater distress. As Cicchetti and Dawson wrote (Cicchetti & Dawson, 2002, p. 418), "Progress toward a process-level understanding of mental disorder will require research designs and strategies that call for the simultaneous assessment of multiple domains of variables both within and outside the developing person."

Our six-domain family risk model (Figure 1) and the nine-cell matrix explaining stability and change (Figure 2) can be thought of as "checklists" that delineate possibilities from which

integrative family theories have made choices. For example, couples therapies have begun to include individual, couple, parent-child, and three-generations perspectives on the relationship, but except for feminist family theorists, they have paid relatively little attention to stresses and supports from outside the nuclear family (see Gurman & Jacobson, 2002 for descriptions of many different approaches to couples therapy). Family therapies, especially those treating delinquent or drug-abusing adolescents, have begun to address outside-the-family issues with peers, schools, and neighborhoods (e.g., Liddle & Hogue, 2000). Conceptualizations of stability and change in family theories now regularly include internal and external psychological and social explanations, but they pay attention to biological levels of analysis primarily when psychoactive drugs are part of the treatment.

This “both-and” rather than “either-or” approach to integrations argues for the need to integrate family systems and family factors theories of psychopathology. Each has important limitations that the other can address. Rosenblatt (1994) provides a cogent analysis and critique of the metaphors used by family systems theorists and shows how each of the central constructs is simultaneously enlightening and limiting. For example, the assumption that families as whole systems have properties that are independent of the parts leads to the useful idea that it is normal and expectable for systems to resist the disequilibrium associated with change and transition. At the same time, focusing on the system ignores the fact that specific strengths and vulnerabilities of individual family members often have a marked impact on the functioning of individuals, dyads, and the system as a whole. Conversely, the family factors approach addresses the contributions of individual family members and dyads to psychopathology and adaptation, but usually fails to consider the properties of the system as a whole that protect individuals and relationships from risks in specific domains, or amplify difficulties in one domain to the point where they spill over into other domains of family life.

DEVELOPMENTAL PSYCHOPATHOLOGY IN NON-CLINICAL FAMILIES

Before we examine evidence regarding family systems and family risk models of psychopathology in individuals already diagnosed by the mental health system and involved in treatment, we want to show how these models are relevant to understanding adaptation in non-clinical families. These families are not selected for studies because they are without problems, but rather because (a) they have not been identified by the mental health delivery system as in need of treatment, and (b) they have not volunteered to participate in a study because they have identified themselves or their families as in need of psychological help. Typically, they are families recruited to a study of marital relationships, parent-child relationships, normative family transitions, and the like. Nevertheless, as we know from developmental psychopathology research, some of the individuals in these families are suffering significant psychological distress, and a subset meet the criteria for one or more diagnosable disorders. Consistent with the tenets of developmental psychopathology, we believe that research on this population is essential to the understanding of who develops psychological problems and who does not.

Family Systems Assessments of Normal Families

Several systems-level assessment approaches have been developed to allow researchers to arrive at a picture of how the family as a whole functions. Although they have all been developed by clinicians and mostly been used in the study of families with already diagnosed problems, they were all created explicitly for use with non-clinical families and each explicitly focuses on strengths as well as weaknesses in both family structure and family process. The McMaster Model of Family Functioning (Epstein, Ryan, Bishop, Miller, & Keitner, 2003) has led to a multimethod assessment of family problem-solving, communication, family roles, affective responses and involvement, and behavioral control. Well-functioning families are able to solve problems, communicate directly and effectively, operate with a clear sense of who does what, express feelings in a context of empathy, and operate inside and outside the family in an appropriately controlled but not rigid way. The assessment includes an extensive interview of

the whole family (the McMaster Structured Interview of Family Functioning (McSiff), Bishop et al., 2000), and a questionnaire administered to each family member (the FAD, Epstein, Baldwin, & Bishop, 1983). The assessment has been used in clinical settings in a few studies conducted in the 1970s and 1980s (see Epstein et al., 2003), and more recently by the Providence Family Study (Dickstein et al., 1998). Results demonstrate the interconnection among various levels of family assessment in families with a mentally ill parent (see below, p. x).

Like the McMaster Model, the Beavers Systems Model (Beavers & Hampson, 2003) (earlier called the Beavers-Timberlawn model) uses a combination of observational ratings and self reports to describe the family system (the Interactional Competence Scale, the Beavers Interactional Style Scales, and the Self-report Family Inventory, Beavers & Hampson, 1990). Unlike the McMaster Model, the Beavers system uses classical constructs from Structural (Minuchin, 1974) and Strategic (Haley, 1990) family therapy such as boundaries, power, autonomy, communication, and problem-solving, to classify families along two orthogonal dimensions. The first dimension places families along a competence continuum from severely dysfunctional, borderline, and midrange, through adequate, healthy and optimal. The second describes families in terms of members' tendency to turn inward toward each other or outward toward the world in order to get their needs met. The scales have been used successfully in evaluations of marital therapy and family therapy (Hampson & Beavers, 1996; Hampson, Prince, & Beavers, 1999). The results demonstrate a linear relationship between a family's level of competence and therapy outcomes, in which more competent families benefited more. The authors also discuss the types of therapists who were most helpful to families at the low and mid-ranges of the scale.

Reiss and Oliveri (Reiss, 1981; Reiss & Oliveri, 1983) observed family members communicating with each other as they attempted to solve puzzle-like problems, and used both behavior and perceptions of the members to describe a "family paradigm" – the orientation of the family unit to each other and to the outside world. They describe three uncorrelated

dimensions: Configuration refers to the ability of family members working as a group to recognize patterns; Coordination refers to their ability to cooperate and integrate their actions; and Delayed closure reflects the openness of the family to new information. Empirical evidence reveals that high scores on all of these dimensions are correlated with successful coping with physical illness and alcoholism (Reiss, Costell, Jones, & Berkman, 1980; Reiss, Gonzalez, & Kramer, 1986; Reiss & Oliveri, 1983). Speculative extensions suggest how these dimensions could be related to various categories of mental illness (Reiss & Klein, 1987).

The Circumplex Model of Marital and Family Systems (Olson & Gorall, 2003) uses a single self-report instrument, the Family Adaptability and Cohesion Evaluation Scale (FACES), now in its fourth revision (FACES IV, Franklin, Streeter, & Springer, 2001). Questions cover two bipolar dimensions in which optimal functioning lies at the midpoint of a curvilinear dimension, and maladaptive functioning at each end of the curve. Relationships can range from disconnected (separateness, low closeness, low loyalty, high independence) through connected (balanced) to overly connected (too much togetherness, excessive loyalty demands, high dependency). Relationships can also range from inflexible (rigid, authoritarian, unchanging, strict discipline) through flexible, to overly flexible (constant change, lack of leadership, dramatic role shifts, erratic discipline). Olson and Gorall (2003) note that earlier versions of FACES failed to validate the curvilinear hypothesis because there were not enough items on the enmeshed and high change ends of the continua, but that there are promising indications that FACES IV shows the expected curvilinearity. About 10 studies find that this self-report measure correlates with observation (Kouneski, 2001). Space precludes a review of the many investigations that have used this instrument, primarily in studies of non-clinical families.

There are other self-report measures that attempt to take a whole system perspective on the family including the Family Environment Scale (Moos, 1974), with dimensions of cohesion, organization, and family growth orientation, and the Family Assessment Measure (Skinner, Steinhauer, & Sitarenios, 2000; Steinhauer, Santa-Barbara, & Skinner, 1984), with both whole

family and dyadic descriptions provided by each family member. Like FACES, but with less extensive research, both of these instruments demonstrate that they differentiate between well-functioning families and families with a member who has been clinically diagnosed.

Various authors have attempted to compare these whole-family measurement systems (e.g., Grotevant & Carlson, 1989; Hampson & Beavers, 2004), but none that we are aware of provide empirical studies of their intercorrelation or differential connections with adaptive and maladaptive outcomes. The McMaster and Beavers models include both observers' and family members' perspectives, whereas the Circumplex model relies on an inner view of family life from the perspective of each family member. All these models attempt to assess some level of cohesion and boundaries -- whether family members turn toward each other or focus their attention outside the family -- and all attempt to ascertain whether the family has a stable, flexible organization for solving problems and communicating feelings.

What remains to be worked out with these and all other measures of family functioning is that they present two different perspectives, what Reiss (1992) calls the represented and practicing family, with representations derived from family members' self-reports and descriptions of family practices derived from observers. We do not yet have very clear ideas about how well these perspectives fit together, how well they should be expected to correspond, or what the implications may be for family adaptation when family members perceptions fail to correspond with observers descriptions of family interaction.

Risk-Factors in Family Transitions

In contrast with times of relative quiescence when family coping processes may not be as visible to outsiders, family transitions bring new challenges that call for new resources. At these times, the characteristic strengths and vulnerabilities of family members and their relationships can be seen in sharper relief (P. A. Cowan & Cowan, 2003). Even more relevant to the study of developmental psychopathology, the disequilibrium associated with making a life transition can lead either to higher levels of adaptation or to lower levels of functioning that place the individual

or family farther along the path toward maladaptation (McCubbin & Patterson, 1983). Our definition of transition does not include any of the innumerable small shifts in family members or in the system as a whole, but rather changes that involve a qualitative shift in each individuals' view of self and the world, social roles, and central relationships (P. A. Cowan, 1991).

The couple's transition to parenthood and the first child's transition to school.

(a) Correlational studies. Non-normative life transitions are those triggered by suddenly occurring challenges that are either unexpected, such earthquakes, or unexpected at a given time such as serious illness. It is obvious that these transitions might increase the risks of disequilibrium and actual distress. Normative transitions are expectable and experienced by the majority of individuals or families in a given culture; e.g., emergence into adolescence or adulthood, entering the paid workforce, establishing an intimate relationship, cohabitation or marriage, or becoming parents. Often, though not always, these transitions are actively sought and welcomed when they occur. Nevertheless, it has become clear that even when the transition brings great joy, the individual and the family is at risk for increased levels of stress. The transition to parenthood and the child's transition to school are two cases in point in the early history of a family.

We and a number of others have described longitudinal studies that reveal the challenges faced by partners becoming parents (Belsky & Kelly, 1994; C. P. Cowan & Cowan, 2000; Cox, Paley, Payne, & Burchinal, 1999; Heinicke, 2002; Shapiro, Gottman, & Carrere, 2000). As men and women attempt to cope with the demands of caring for a small and unpredictable infant under conditions of uncertainty and sleep deprivation, they experience changes in each of the central domains of the family. They must incorporate their new identity as a parent. They take on more traditional role arrangements as couples than they expected. They each begin to forge a new relationship with their child, at the same time as they must reorganize their relationships with parents and kin. In modern couples, both partners struggle to balance the demands of work

and family responsibilities, maintain outside sources of support, and minimize outside sources of stress (Cowan & Cowan, 2000).

A review of more than 25 longitudinal studies (C. P. Cowan & Cowan, 1995) published a decade ago shows that during this period, couple conflict increases and, for the vast majority, marital satisfaction declines. A more recent overview comes to the same conclusion (Bradbury & Karney, 2004). In a second study of families with a child making the transition to elementary school, we found that, despite several positive changes in parents' lives during that period, marital satisfaction continued to decline.

For couples with relatively positive relationships who become parents or see their first child off to elementary school, this decline in marital satisfaction may not prove to be serious. As in other transitions, couples at the top of the distribution tend to maintain their position over time (Belsky & Pensky, 1988). Unfortunately those with quite negative views of the relationship show a further decline over time, which may have serious consequences³ because at the low end of the distribution, distressed marriages constitute a primary risk factor for children's adaptation (Cummings et al., 2000; Emery, 1999).

Studies of the transition to parenthood and the early childrearing years confirm that distressed couple relationships are important to understand, but they also make it clear that a troubled marriage is only one of the family risk factors that predict children's academic, social, and emotional problems. There is now ample evidence that the other four domains in our family risk model (p. xx) explain significant amounts of variation in children's development. Parents' depression, mental illness, and other indicators of psychopathology place children at risk for behavior problems and other cognitive and emotional difficulties (Campbell, Cohn, & Meyers, 1995; Fendrich, Warner, & Weissman, 1990; Nolen-Hoeksema, 1995; Sameroff, Seifer, & Zax, 1982). The behavior of each parent with the child, of course, explains substantial variance in children's adaptation (P. A. Cowan et al., 1998; Maccoby & Martin, 1983; Parke & Buriel, 1998). Intergenerational transmission of parent-child relationship quality from grandparents to parents

to children is the rule rather than the exception (Van IJzendoorn, 1992). Parents' work-related stress, economic stress, and other stresses from outside the nuclear family also function as risk factors for the development of psychopathology in their children (Conger, Ge, Elder, & Lorenz, 1994).

How do all of these risk factors combine to explain variations in children's adaptation? Static snapshots using multiple regression techniques suggest that family risk factors combine additively to predict children's outcomes. The more risk factors present (Sameroff, Seifer, Baldwin, & Baldwin, 1993), and the more intense the risk (Cummings & Davies, 1994), the more severe the child's problems are likely to be. In our own research, we used multiple regressions to analyze risk factors from each of the 5 family domains in our conceptual model. Results indicate that data from each domain contributed unique variance to the prediction of the children's achievement, externalizing problems, and internalizing problems in first grade.

Multiple regressions simply add risk predictors together but do not examine the interplay among the family factors – what we call the “dynamics” of family relationships. Structural equation models (path models) remedy this defect. In statistical terms, the connections among family domains can be direct or indirect. Depression in one or both parents may directly predict disruptions in parent-child relationships (Campbell et al., 1995; Hops, 1992). Or, it may be that depression in parents is associated with high marital conflict, and marital conflict is associated with more negative, less effective parent-child relationships (N. B. Miller, Cowan, Cowan, Hetherington, & Clingempeel, 1993).

(b) Preventive interventions. There are four central justifications for considering preventive intervention programs for non-clinical couples -- as they make the transition to parenthood and as their first child makes the transition to school. First, it is clear that marriages are at risk, with a divorce rate between 40% and 50%. If a physical health problem had a 40-50% probability of occurring in a population, it would be clear that steps would have to be taken to address it. Second, risk indices in other domains of family life are also high. For example, in both our

transition to parenthood and transition to school studies, with different families in each, about 33% of the men and women scored above the clinical cut-off on a widely used depression symptom scale (C. P. Cowan & Cowan, 2000). Third, we found a considerable proportion of the parents in both longitudinal studies in distress as a couple, and, as we have seen, [individual and] marital distress is also a [are both] risk factor for psychopathology in the children. Early intervention, before these problems become exacerbated, makes a good deal of sense. Fourth, if randomly assigned interventions show effects, they allow investigators to draw conclusions about the causal impact of family relationships on children's adaptation.

Our randomized clinical trial of a 24-week couples group for new parents, led by a male-female team of trained mental health professionals (C. P. Cowan & Cowan, 2000), and a similar trial of a 16-week couples group for parents in the year before their child entered kindergarten (C. P. Cowan, Cowan, & Heming, 2005), both showed statistically significant effects. Compared with controls, parents from the couples groups showed much smaller declines in marital satisfaction in the years following the transition. The impact of the transition to parenthood group, conducted in the months surrounding the transition, lasted at least until the child were in their first year of elementary school (Schulz, Cowan, & Cowan, in press), almost six years after the intervention. Preliminary analyses show that the published results of the transition to school intervention from pre-kindergarten to first grade (C. P. Cowan et al., 2005) were also found in subsequent follow-ups at fourth grade, almost six years after the intervention.

Another intervention for low-income mothers during the transition to parenthood by Heinicke and colleagues produced positive effects on self-reported symptoms and observed interactions with their infants (Heinicke et al., 1999; Heinicke, Rineman, Ponce, & Guthrie, 2001). Compared with couples in a no-treatment control condition, couples becoming parents who participated in a two-day psychoeducational workshop were more satisfied with their marriage; the wives reported fewer symptoms of depression, and were observed to be less hostile during a couple problem-solving discussion. Two other couple-focused interventions for

expectant parents are now in the process of being evaluated (Gottman, personal communication, Jordan, Stanley, & Markman, 2003).

In the intervention conducted in the year before the first child entered kindergarten (C. P. Cowan et al., 2005), there were two variations: the couples groups that emphasized parenting issues resulted in a positive change in parenting but no change in marital interaction; the couples groups that emphasized marital issues resulted in a reduction in conflict between parents during a family interaction task, as well as increases in parents' warmth and provision of structure with the child. In comparison with children whose parents were in the control condition, children whose parents participated in the couples groups had higher tested achievement scores in kindergarten, and lower levels of externalizing and peer problems in first grade. Finally, there were links between intervention-induced change and child outcomes. It appears that reductions in marital conflict and increases in effective parenting both played a causal role in children's academic and social adaptation to the early years of elementary school.

Divorce and remarriage.

(a) Correlational studies. Some time ago, we were intrigued to read an early account of the changes in families following divorce by Hetherington and Camara (1984). If the reader substituted the words "transition to parenthood" for "divorce," the description would be consistent with the literature on new parents and make perfect sense. Structural equation models and regression equations describing risk factors in family dissolution and reconstitution also bear a remarkable resemblance to those obtained in studies of family formation. Parental depression following divorce is a risk factor for children (Hetherington, 1999). There is ample evidence that children fare well in families in which couples have good marriages or "good divorces" (Ahrns, 2004), but not when the relationship between their parents is full of unresolved conflict (Arendell, 1997b; Cummings & Davies, 1994; J. R. Johnston, 1994). As it does in intact families, unresolved conflict in divorced families places parent-child relationships at risk, not only in terms of relationship quality (Tein, Sandler, MacKinnon, & Wolchik, 2004), but

also in terms of fathers' involvement in the daily life of the child, which understandably tends to decrease when the parents are at war (Braver & Griffin, 2000; Carlson & McLanahan, 2002a; Coley & Chase-Lansdale, 1999). Divorce has an intergenerational aspect, in that adult children of divorce are more likely to end their own marriages (Amato, 2000). And, as it does in intact families (Conger, McLoyd), poverty associated with divorce, especially for women, tends to have its effects on children by disrupting family relationships, which is followed by both academic and social difficulties for the children (Hetherington & Kelly, 2002). When income level is statistically controlled, many of the associations between family structure and children's problematic outcome are reduced (Amato, 2001; Furstenberg & Teitler, 1994). That is, the negative effects of divorce come in part from the consequences associated with poverty, rather than directly from family dissolution.

(b) Preventive interventions. Wolchik and her colleagues (Tein et al., 2004; Wolchik et al., 2002; Wolchik, West, Westover, & Sandler, 1993) tested two versions of a preventive intervention, one for divorced mothers, and one for divorced mothers and their 9-12-year-old daughters. Both programs provided 11 weekly session co-led by two master's level clinicians, who focused on improving mother-child relationship quality, effective discipline, increasing fathers' access to the child, and reducing interparental conflict. Follow-ups occurred immediately, and 3 months, 6 months, and 6 years after the intervention. The two programs had similar effects. An earlier evaluation at the immediate and 6-month posttests indicated that the reduction in children's externalizing behaviors was associated with reductions in the hypothesized risk variables – ineffective parental discipline and negative mother-child relationships. Neither program affected the young adolescents' internalizing.

Dilemmas in assessing the impact of family life transitions. Interventions focused on the transition to parenthood, to school, and to divorce have a great deal to contribute to discussions of whether family processes are causally related to children's outcomes. But the question of whether the transition itself can be interpreted as causing distress in family members is difficult

to answer. Several studies that compare childless couples with couples becoming parents show that couples without children also decline in marital satisfaction over time (e.g., Clements & Markman, 1996; S. M. McHale & Huston, 1985; L. K. White & Booth, 1985). All of these studies began with engaged couples who were young, and followed them for short periods of time. By contrast, our comparison of couples having children with a sample of couples not yet decided about having children, followed over six years, showed that the decline in marital satisfaction was steeper for the parents than for the couples who remained childless (Schulz et al., in press). A similar comparative study of couples with a wide range of age found the same trends (Shapiro et al., 2000). These findings do not prove that the transition to parenthood was the causal agent, because it is possible that selection factors that determined who decided to have children and who did not were operating to produce the differences.

Similar problems exist in making claims about the impact of divorce on children. Almost all studies of this topic have three serious flaws.

1. Until recently, investigations began only after the parents separated or divorced. It is reasonable to assume that there may be a selection factor in operation. Children of parents who eventually divorce have been exposed to the parents' relationship difficulty prior to the divorce (Block, Block, & Gjerde, 1989; Cherlin, Furstenberg, Chase-Lansdale, & Kiernan, 1991). It may be the cumulative effects of pre-divorce relationships rather than divorce itself that is responsible for difficulties that some children experience after their parents have separated.

2. Almost all studies compare children of divorced and non-divorced families, without considering the potentially detrimental impact on children of living with high conflict parents who stay together (see above).

3. A third design flaw, ubiquitous in current research, results from the undifferentiated research question: "Does divorce hurt children - yes or no?" We agree with Amato (2000), who suggests a more differentiated approach: "Divorce benefits some individuals, leads others to experience temporary decrements in well-being, and forces others on a downward trajectory

from which they might never recover fully. Understanding the contingencies under which divorce leads to these diverse outcomes is a priority for future research."

Family systems and family transitions. Our description of the transition to parenthood, like our description of divorce, has been formulated within the framework of family risk models that provide accounts of how change in various domains of family life affect the adaptation of the children. There are very few examples of research on family transitions that adopt a family systems perspective. A welcome exception is the work of James McHale (J. P. McHale et al., 2004; J. P. McHale & Rasmussen, 1998), who explores the interconnections among individual factors (e.g., child temperament, adult symptomatology), dyadic factors (e.g., the co-parenting relationship), and triadic, whole-family perspectives on the transition to parenthood and early family functioning. The whole-family measures in McHale's studies are adapted from the work of Fivaz-Depeursinge (Fivaz-Depeursinge & Corboz-Warnery, 1999), who created the Lausanne Trilogue play procedure. This observation paradigm involves videotaping a mother and father together first taking turns and then working together to engage the attention of their infant, who is seated in an orthopedic car seat that the parents can swivel as they attempt to direct the infant's attention. Although some of the coding of this interaction involves a focus on individuals and dyads, combined scores represent family levels of cooperation, competition, and warmth. Some dyadic co-parenting measures are derived from observation, while others are derived from discrepancies between the parents' self-reports. The research shows that prenatal marital quality in the parents sets the stage for postnatal coparenting quality and the atmosphere in the family as a whole. Furthermore, high prenatal marital quality kept the parents from responding negatively when their three-month-old babies were irritable.

Despite the relative absence of systematic studies of family transitions using a systems perspective, there have been detailed clinical descriptions of families from a systems point of view of families undergoing normative transitions such as the transition to adolescence or

marriage, and by non-normative changes resulting from illness, death of family members (e.g., Boss, 1999), and natural catastrophes (e.g., Carter & McGoldrick, 2005).

Overall similarities among systemic discussions of quite different life changes reveal that a transition in even one family member creates disequilibrium in the system as a whole. Whether families can use the period of transition as a catalyst for growth, or whether they succumb to passivity or depression, depends in part on a combination of family system competencies, the stressfulness of the transition, and the psychological, social, and financial resources of the family to meet the demands for change imposed by the transition. All of these formulations bear some resemblance to the ABC-X model initially proposed by lifespan sociologists Reuben Hill (1949), later expanded by Boss (Boss & Mulligan, 2003) and McCubbin (McCubbin, Thompson, Thompson, & Futrell, 1999), in which the outcome of any life stressor (X) depends on environmental demands (A), family resources (B), and appraisals of the meaning of the stressor (C).

Our conclusion is not that the family disequilibrium surrounding divorce is the same as disruptions that follow when partners become parents or the first child makes the transition to school, but rather that similar risk factor models can be applied to these and other family life transitions. A great deal more research will be needed to determine the precise arrangements of the patterns of prediction, and which variables may play stronger or weaker roles in different transitions at different times.

DEVELOPMENTAL PSYCHOPATHOLOGY IN FAMILIES IN WHICH AT LEAST ONE MEMBER HAS BEEN CLINICALLY DIAGNOSED

In the section above, we explored how multidomain family models account for variations in adaptation in non-clinical families. Here we show that similar principles apply to the explanation of clinically diagnosed psychopathology in families in which at least one of the members has received a diagnosis. Our strategy here is to focus selectively on a number of issues that illustrate current thinking about the linkage between families and psychopathology.

We begin with a discussion of the pitfalls involved in validating family systems theories and then discuss the evidence for the family factors approach.

Difficulties in Validating Family Systems Theories of Psychopathology

Two kinds of evidence are cited as supportive of family systems assumptions about the etiology of various psychopathologies. First, there is considerable evidence that, as a group, families with a clinically diagnosed member differ from non-clinical families in many of the ways that family systems theorists have hypothesized (e.g., Wenar & Kerig, 2000). Second, there is also considerable evidence that treatments of families using variations of conjoint family therapy have a significant positive effect when compared with randomly selected no-treatment controls (see below). Our task here is to explore which conclusions we can draw from these facts.

Correlational designs. Research that compares whole-system structures or processes in families with or without a member with a specific diagnosis is a necessary first step in validating family systems theories of psychopathology. The number of studies that fit this description is not large, but the results are consistent with the theories. For example, families with a member diagnosed with schizophrenia showed more instances of communication deviance (Singer & Wynne, 1965b) than comparable families without a member who fits that diagnostic category. Even more important for the purposes of establishing specific links between family processes and schizophrenia is the finding that these families also produced more disordered communication responses than families whose members had other diagnoses. Another set of studies investigated the construct of expressed emotion (EE) by asking relatives of an adult hospitalized patient diagnosed with schizophrenia or bipolar disorder to talk into a tape recorder for 5 minutes to describe the patient. Family members coded as high in EE make more hostile, critical, or emotionally overinvolved remarks than family members low in EE. A number of studies show that relatives of diagnosed patients are much more likely to have high EE scores than relatives of non-patients (Bebbington & Kuipers, 1994).

Except for families with a member diagnosed with schizophrenia or bipolar disorder, it is rare to find studies that show family-level differences between diagnosed and non-diagnosed families. Shaw and his colleagues (Shaw, Criss, Schonberg, & Beck, 2004) cite several studies showing that hierarchical parent-child boundaries are either too rigid or too diffuse in families of children with ADHD or general emotional difficulties, but note that previous to their own, there have been no studies that investigate the origins of hierarchical boundary differences among families. These authors assessed families at high risk by virtue of poverty when the child was a toddler, and followed up with assessments at age 10. Path models revealed direct links between early parent-child relationship difficulties and later vague or enmeshed boundaries reported by the mothers. Furthermore, parental adjustment, child temperament, marital difficulties, and ecological disadvantage (low education and income, dangerous neighborhood) were all indirectly linked with inadequate boundaries, which, in turn, were related to conduct problems as reported by the mothers and the children at age 10 and 11. Boundary disturbances have also been found to differentiate between families without a diagnosed child, and families with a 6-10-year-old with Attention Deficit Hyperactivity Disorder (ADHD) or depression, even after controlling for the presence of maternal depression (Jacobvitz, Hazen, Curran, & Hitchens, 2004). As predicted, boys in enmeshed families more often developed ADHD, while girls in similar families were more likely to develop depression. Taken together, these studies begin to raise important questions about why boundary disturbances are associated with different diagnostic outcomes in different families.

This first step -- establishing differences between families with and without a diagnosed member -- is necessary but far from sufficient to validate family systems theories. Almost all of these studies involve single time assessments and therefore employ the logic of correlation, even when the data are presented in the form of t-tests or Analysis of Variance (Shaw et al., 2004 is a welcome exception). Even if, for example, the chances of deviant communication are greater in families with a member with schizophrenia than in families without a member in this

diagnostic category, we do not know whether the deviant communication causes schizophrenia, the diagnosed member creates conditions that lead to deviant communication, or whether both result from a direct influence of a third variable such as underlying genetic vulnerability. These objections are not easily overcome.

Intervention designs. Although intervention designs have some advantages in determining sequences and directions of effects, they are not without problems of their own in the quest to validate family systems theories of psychopathology. It is difficult to find examples of systematic evaluations of family systems interventions, in part because investigators are often vague about what they mean by family treatment. Couple and family interventions are typically mixed together in research reviews and meta-analyses (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Shadish et al., 1995; Sprenkle, 2002). Existing examples show that, in studies using a randomized clinical trial design, conjoint family treatment produces more positive outcomes in families with members diagnosed with schizophrenia, conduct disorder, or substance abuse than some form of low-dose treatment or no treatment (e.g., Diamond, Serrano, Dickey, & Sonis, 1998). A closer look suggests that, although these studies allow us to conclude that a given treatment was effective, they rarely provide direct validation for the family systems theories on which they are based. First, as we have noted in the discussion of the nine-cell matrix of theories of stability and change, the demonstration that psychopathology diagnosed in a family member can be treated successfully in conjoint family therapy does not prove that family factors were the cause of the problems. What they do illustrate, and this is no small matter, is that family relationships can play a role in both stability and change in individual developmental pathways.

Second, what is missing from most family-based intervention studies is not only a demonstration that the treatment was effective, but also that the impact can reasonably be attributed to the family aspects of the treatment. This demonstration can occur by employing a research design that compares the outcomes of (a) conjoint family treatments for a given

disorder with (b) treatments of that use a family systems perspective, but not a conjoint treatment setting, and with (c) treatment of similar identified patients using a more traditional individually-focused theoretical paradigm. We acknowledge that most therapeutic intervention studies do not compare two intervention groups with a control, but that is what is needed as a beginning step to examine whether the “active ingredient” in family systems-oriented therapy is in fact a change in the structure and process of the family system.

Some progress toward establishing family mechanisms involved in treatment can be made even without a three-group intervention design. As outlined in a special issue of Development and Psychopathology (Cicchetti & Hinshaw, 2002), beyond the question of “whether it works,” intervention designs are uniquely equipped to address the question of how to test theories of developmental psychopathology. If we can target a family process with an intervention, demonstrate using the appropriate controls that the intervention (A) produces the desired effect on the family (B), and show that this effect is associated directly with changes in the desired outcome (C), then we have a powerful instrument for concluding that B has a causal connection with C. This would allow us to begin to confirm or disconfirm the theory on which the intervention was based.

A beginning move in the direction of identifying family mechanisms in psychopathology using intervention designs has been made in studies of EE in families with members diagnosed with schizophrenia or bipolar disorder, as mentioned above (Miklowitz, 2004; Pilling et al., 2002; Wahlberg & Wynne, 2001). Compared with traditional individual treatments of the patient, psychoeducational interventions with family members produce lower relapse rates after the patient leaves the hospital. Still needed in these and other intervention studies are detailed analyses of the changes in family interaction produced by these interventions and an examination of whether this change accounts for the variations in the patient outcomes.

Measurement and statistical issues in both correlational and intervention designs. Most studies of links between family functioning and psychopathology use measures and statistical

analytic techniques more appropriate to the study of individuals, and occasionally dyads, than to the assessment of the family as a system.

(a) Measurement. The source of information about the family can come from one or more family members (mother, father, child) or outside observers (family friends or researchers). The focus of that information can be on individual family members, dyads, or the system as a whole. To complicate an already complex picture, the information can be obtained in different contexts – individual interviews, dyadic interactions, the family system as a whole, or the family in the community. That is, there are 4 sources x 3 foci x 4 contexts, or 48 potentially different perspectives on family functioning. Only a few of these can be included in any single study. What is most lacking from current research, in our view, is the examination of the family as a whole using systemic concepts to assess how the family operates.

The most well-established family system measurement systems (see above), the McMaster model and the Beavers model, use family interviews to obtain data; this severely limits the technique to children who can talk and focus throughout a long session. A promising example of a new approach to families with infants, described briefly above, is the Lausanne Trilogue play procedure (Fivaz-Depeursinge, 2003; Frascarolo, Favez, Carneiro, & Fivaz-Depeursinge, 2004), in which mothers and fathers interact together with their infant and the coding of this interaction yields measures of both family structure and affective process.

Statistical techniques. Until recently, one of the chief impediments to family systems research has been statistical techniques directed toward a linear analyses of the effect of x on y, using either analysis of variance or multiple regression techniques. More recently, structural equation modeling, time series analyses, and hierarchical linear modeling allow researchers to contrast models in which there is a reciprocal effect of A on B and B on A. These techniques move us closer to testing hypotheses promulgated by family system theories 50 years ago.

What is needed? In sum, despite the fact that there is considerable evidence that treatments based on family systems theories are effective, the evidence supporting family

systems theories of psychopathology is at a preliminary stage. Families with a severely mentally ill member communicate differently from families without a diagnosed member, but it is not possible to tell whether the communication deviance is at the root of the disorder. The best evidence concerning the validity of family systems theories will come from follow-forward studies, with measurement that focuses on the system as a whole and demonstrates that the family-level measures contribute uniquely to our understanding variations in psychopathology and adjustment, over and above the contribution of risk factors in individual and dyadic domains. Because this kind of study is rare, and because so many studies will be needed to discover the links between measures of family-level functioning and each specific disorder we hope to understand, opportunities for research in this area will keep many investigators very busy for many decades.

Family Risk Factors and Psychopathology

In our view, the bulk of the evidence used to support the validity of family systems theories comes from family risk factor studies of the variables that each theory emphasizes as central to that approach. That is, family system theories may be located in cell 9 of our matrix (Figure 2), but different family theories have different emphases on specific risks, and these risks can be located in each of the remaining cells or in the interactions among them. We describe a number of examples of empirical evidence that provides support for the hypothesis that family risk factors play an important role in the understanding of psychopathology in clinical populations.

Genetic-family system interactions. There is no doubt that severe psychological disorders (schizophrenia, bipolar disorder, depression, antisocial personality, and others) “run in families” (Gottesman et al., 1972; Meehl, 1962; Rosenthal, 1967). Given a diagnosed patient as an index, relatives are more likely to be diagnosed with that disorder than a non-index control of the same age, sex, and general life circumstances. The central task in the field of behavioral genetics has been to disentangle the confounding due to the fact that closely related family members tend to live together, making it difficult to assess genetic effects separately from environmental effects.

We described above (p. xx) studies of heritability that compare monozygotic twins (MZ, identical), dizygotic twins (DZ, fraternal), families with two or more non-twin children, and sometimes families with adopted at-risk children. In combination, these studies represent attempts to tease apart the contributions of genetic and family environmental risks to psychological disorders.

A related, more central question for the field of developmental psychopathology is why some individuals with family-genetic vulnerabilities develop disorders while others do not. The most general answer to both of these questions originated more than four decades ago in a diathesis-stress model, which conceptualized genetic factors as a diathesis (vulnerability) that results in a disorder if triggered by sufficiently high levels of specific environmental stressors (Tienari, 1991; Wahlberg et al., 2004). The early work tended to describe environmental stressors in vague terms as effects not accounted for in estimates of heredity. Recent behavioral genetic studies create a more differentiated picture of the way in which careful consideration of genetic factors in research designs provide powerful support for the hypothesis that family risk factors play a causal role in the development of psychopathology.

(a) Heritability-environment interaction⁴. A very sophisticated Finnish Adoptive Family Study provides preliminary evidence for an interaction of heredity and family environment. Tienari and his colleagues (Tienari, 1991; Wahlberg et al., 2004) identified 155 people with at least one parent diagnosed with schizophrenia, who were adopted away, and 186 control cases, also adopted away, whose parents had no psychotic disorder. Using Singer and Wynne's (1965a) procedure for assessing communication deviance among the adoptive parents, in combination with other diagnostic material, these researchers produced a global rating of each adoptive family's level of functioning. Early reports show that 34% of the children whose biological parents were not psychotic, but 62% of the children with a psychotic biological parent, were diagnosed with schizophrenic spectrum disorders when their adoptive parents were rated as disturbed in terms of psychopathology or communication deviance. By contrast,

when the adoptive parents were rated as mentally healthy, 4% of the children with nonpsychotic biological parents, and 3% of the children with psychotic biological parents were diagnosed with schizophrenic spectrum disorders. Given this research design that separated biological risks associated with heredity and family risks associated with the adoptive living environment, this study provides strong evidence that genetic vulnerability brought by the adoptee is more likely to result in psychopathology in the context of mental illness or disordered communication in the adoptive family environment. Conversely, adoptive parents who function well may be able to protect children from the risks associated with having a biological parent with schizophrenia. The later results will be especially important, since the youngest adopted children have not yet reached the primary age for risk for schizophrenia.

An important point has recently become central in behavioral genetics research: heritability estimates hold only for a specific population. In a paper that helped to reframe the discussion of this topic (Turkheimer, Haley, Waldron, D'Onofrio, & Gottesman, 2003), Turkheimer and his colleagues showed that the heritability index of IQ is almost zero at low levels of socioeconomic status, but very high in financially well-off samples, where it explains about 60% of the variance. It follows, then, that family dynamics play a reduced role in high-income families and a more salient role in low-income families, in accounting for psychopathology. Parental treatment that fosters similarity between siblings (shared family environment) or difference between siblings (non-shared family environment) explains little of the variation in IQ in high-income families but about 60% of the variation in low-income families. How heritable is IQ? How important is family interaction in explaining variance in IQ? The answers depend on the sociocultural context of the families we study.

(b) Using genetic controls to study environmental variation. Twin studies are now being used in a new way – to “control” for genetic influences so that the effects of family environmental variation become clear. In the Environmental Risk Longitudinal Twin Study, Caspi and Moffitt and their colleagues (Caspi et al., 2004) studied a nationally representative

sample of British families with MZ and DZ twins. Mothers were asked to describe each twin for five minutes, as in the studies of EE above. Using ratings of negativity and warmth expressed toward each 6-year-old twin in mothers' speech samples, the investigators found that within each pair (controlling for genetic factors), the twin whose mother expressed more negativity and less warmth toward him or her was rated by the classroom teacher as showing more antisocial behavior at school.

(c) Biological relatedness and family structure. Twin studies are not the only way of studying the impact of biological and social relatedness in families. Hetherington and her colleagues (Hetherington et al., 1994) examined data from the national sample from the Nonshared Environment in Adolescent Development Project (Caspi et al., 2004). Eliminating the MZ and DZ twins from a sample of families with at least two same-sex adolescent children, the researchers studied nonstepfamilies, simple stepfamilies in which all siblings were the mother's biological children and the father's stepchildren, and complex stepfamilies in which the children were combinations of his, hers, and theirs. The last two groups allowed the investigators to contrast family systems in which the children had different degrees of biological relatedness to each other and to their parents. The investigators found few differences between nonstepfamilies and simple stepfamilies in the adjustment of the children or the quality of marital and parent-child relationships. In complex stepfamilies, however, more problems were observed in the family relationships and the adolescents showed less social responsibility and higher levels of externalizing problems. In the stepfamilies, greater caretaking and warmth was found in dyads in which parents were interacting with their biological children. That is, genes also have an impact on the social construction of biological relatedness held by children, parents, and others. These issues become very important in discussions of stepfamilies, adoption, and gay and lesbian families.

(d) Measuring gene-environment interactions. In studies of heritability, the impact of genetic factors on psychopathology is inferred from the differences in correlations between MZ

and DZ twins. Recent methods of measuring gene functions and dysfunctions directly, rather than estimating them from family heritability, are providing more precise indicators of genetic risk. In a nationally representative sample of more than 1000 children in Dunedin, New Zealand, Caspi and Moffitt and their colleagues (Caspi et al., 2002) measured the neurotransmitter-metabolizing enzyme monoamine oxidase A (MAOA), located on the X (male) chromosome. Deficiencies in this gene affect neurotransmitters such as norepinephrine, serotonin, and dopamine, which have been linked with male antisocial behavior (Huang et al., 2004). Also linked with antisocial aggressive behavior is childhood maltreatment by parents (Cicchetti et al., 2000; Dodge, Pettit, & Bates, 1997). The Caspi et al. study found that when MAOA activity was low (indicating deficiency), there was a very high incidence of diagnosed Conduct Disorder in adolescence, and elevated levels of disposition toward violence, convictions for violent offences, and antisocial personality disorder in adulthood. Conversely, high MAOA seemed to protect children who had experienced early maltreatment from developing antisocial behaviors later on. Note that both longitudinal studies by Caspi and Moffitt are of non-clinical populations. Nevertheless, these populations included individuals with a formal DSM-IV diagnosis. Behavior geneticists argue that limiting studies to clinical populations reduces the sample variance in ways that can lead to biased estimates of both genetic and environmental effects on psychopathology.

Among many important implications of this research, and other studies cited in this section, are two conclusions about the family as a system. First, genetic heritability is affected by the social context in which it operates and is measured. Second, genetic heritability affects the social environment through its impact on the behavior of family members by influencing their behavior in ways that have environmental impact. Although research studies have demonstrated impressively that these interactive effects occur, we do not yet have a clear idea of the mechanisms by which genetic factors affect environments, and how family and other environmental factors “get under the skin” (Taylor, Repetti, & Seeman, 1997) to affect biological

processes. Third, since behavior genetics analyses have been applied to a limited number of disorders in a limited number of countries or cultures, it is not clear how the “weighting” of genetic, family, and other environmental influences holds across diagnostic categories and across cultures.

Couple relationships and psychopathology. Both symptomatic and clinically diagnostic levels of depression co-occur with marital dissatisfaction, conflict, and distress (e.g., Whisman, Uebelacker, & Weinstock, 2004). Although each domain influences the other, declines in marital satisfaction may play an etiological role in depression more often than vice versa (Whisman & Bruce, 1999). Some corroborating evidence comes from a review of therapy studies reporting that marital therapy is an effective treatment for depression when compared with no-treatment controls, and more importantly, more effective than individual therapy with the depressed client (Teichman, 1997); the converse approach of treating depression in couples with marital problems has not been systematically evaluated. A more differentiated view of the marital quality link with depression comes from a short-term longitudinal study (Fincham, Beach, Harold, & Osborne, 1997), which suggests that for men, the causal path may be from depression to marital dissatisfaction, whereas for women, the causal path may be from marital dissatisfaction to depression. This is only one of many illustrations of the principle that gender affects the pathways between family risks and maladaptive outcomes.

We have noted throughout the chapter that couple relationship conflict and dissatisfaction are correlated with children’s externalizing behavior in both non-clinical and clinical samples. Marital conflict is also associated with children’s internalizing behavior, specifically anxiety and depression. In the Environmental Risk Longitudinal Twin Study, Jaffee and colleagues (2002) reported that, after controlling for genetic and non-shared parenting effects (behaviors toward siblings that enhances differences), domestic violence between parents was associated with significantly higher externalizing and internalizing behavior in children. Furthermore, the quality of relationships in the family had a particularly strong contribution to predicting co-morbidity –

children who were both aggressive and depressed. Note that in behavior genetics studies, the distinction between genetic and environmental effects is not entirely clear. In this case, genetic factors may contribute to both the parents' tendency to engage in violent behavior and the child's vulnerability.

Parenting and Psychopathology.

(a) Parenting behavior. Maltreatment is a serious social problem, with rates of reported child abuse in 2002 ranging from 16 per 1,000 0-3-year-olds to 6 per 1,000 16-17 year olds, with the result that more than 2,000,000 children are abused in a given year, an estimated 1400 fatalities resulting from abuse of children by their parents and other adults in the household. It is clear that although maltreatment is manifest in the parent-child relationship, the etiological picture involves a system of by now familiar family risk factors. Building on Belsky's ecological model (1980), Cicchetti and his colleagues argue that maltreatment involves: (1) maladaptive biological and psychological resources in maltreating parents, especially depression, and drug or alcohol use; (2) unsupportive and aggressive marital relationships; (3) parent-child relationships in which the parents are more controlling, hostile, coercive, and less affectionate and make more negative attributions about their children's behavior than non-abusing parents; (4) a history of abuse across generations (though the evidence is largely retrospective); and (5) stressors in the society outside the nuclear family, including racism, poverty, dangerous neighborhoods, unemployment, and lack of supportive social networks (for integrative summaries, see Cicchetti, 2004; Cicchetti & Lynch, 1995; Cicchetti & Toth, 2003).

A less severe but no less important form of negative interaction can be seen in the Patterson group's concept of coercive parent-child relationships. Structural equation models consistently reveal links between coercive parent-child patterns and children's and adolescents' aggression both inside and outside the family (Dishion & Patterson, 1997; G. R. Patterson, Reid, & Dishion, 1998). The model has also been tested in intervention studies demonstrating that reductions in coercive parenting are followed by decreases in adolescent

aggression. Whereas coercion represents an active, intrusive parenting style, Reid, Patterson, and Snyder (2002) summarize three decades of research showing that parental disengagement, especially in the form of lack of monitoring of adolescents, represents a significant risk factor for adolescent aggression. This variable is usually assessed by phoning parents in the evening and asking them if they know where their children are. We focus here on parenting, but as in Cicchetti's ecological model of maltreatment, Capaldi and colleagues present a multidomain family risk model in which parent-child relationships play a necessary but not sufficient role in explaining children's and adolescents' maladaptive behavior (Capaldi, Pears, Patterson, & Owen, 2003; Pears & Capaldi, 2001).

All of these studies attempting to link parenting behavior with child and adolescent outcomes are subject to the same caveats about inferring causality that we have discussed throughout the chapter. Harsh physical punishment or legally defined abuse is clearly detrimental to children and cannot be justified, but it is not always possible to determine whether child temperament or other characteristics play some role in eliciting the behavior. Coercion is by definition a reciprocal construct, describing the escalating pattern created in the interaction between parent and child. Even monitoring, which clearly sounds like a parental behavior, can be an ambiguous construct, since investigators point out that some adolescents spontaneously tell their parents where they are going and where they are, so that the correlations between monitoring and low aggression reflect the quality of the relationship, not whether the parent takes an active, coercive part in forcing their children to reveal information concerning their whereabouts.

(b) Parenting and children's Attention Deficit Hyperactivity Disorder (ADHD)⁵. A case for a bi-directional view of parenting behavior and children's characteristics can be seen very clearly in studies of children diagnosed with ADHD. There is no doubt that there are strong heritability factors in the etiology of both attention deficits and hyperactivity, but there is also evidence that the stress experienced by parents of children with these symptoms increases the probability of negative family interactions (C. Johnston & Mash, 2001). The lack of control, hyperactivity, and

defiant behavior shown by these children elicit harsh or permissive reactions in parents; these parenting behaviors predict antisocial and non-compliant behavior assessed later on, even after controlling for the child's earlier ADHD behavior (C. A. Anderson, Hinshaw, & Simmel, 1994). Comparing families with a male child diagnosed with ADHD and families without a diagnosed child, Hinshaw and his colleagues (Hinshaw, Zupan, Simmel, Nigg, & Melnick, 1997) found that in the ADHD sample only, mothers' authoritative parenting beliefs predicted social acceptance by the boys' peers in a summer camp, even when their behavior with those peers was observed to be quite negative. To the extent that parenting beliefs were reflected in behavior, the results are consistent with the hypothesis that an authoritative parenting style can protect children with ADHD from peer rejection, but that there may be many other routes to peer acceptance for boys without ADHD.

Finally, in a variation on the genetic designs described above, twins with low birthweight were the focus, because low birthweight is a risk factor for ADHD (Tully, Arseneault, Caspi, Moffitt, & Morgan, 2004). Only for these twins did mothers' warmth in a five-minute speech protect children against symptoms of ADHD 6 years later. All of these findings illustrate the general principle that parenting behavior interacts with child characteristics to predict adaptive or maladaptive outcomes.

(c) Attachment relationships. Our emphasis here shifts from a focus on parents' behavior to the inclusion of children's inner working models and behavior in situations in which they experience a separation or threat of loss of the parent. Four ways of coping with this loss have been identified in laboratory studies of attachment (Ainsworth & Wittig, 1969; Lyons-Ruth, Alpern, & Repacholi, 1993). When a parent comes back into the lab room, their 12-18 month old can (1) fuss but seek the parent as a secure base before continuing play (secure); (2) anxiously avoid the parent; (3) angrily attack the parent; or (4) become disorganized. Insecure attachment in the parent-child relationship has been associated with an expectable range of family risk factors, including parents' psychopathology, adolescent hospitalization (J. P. Allen, Hauser, &

Borman-Spurrell, 1996), insecure working models of attachment with their parents (the grandparents) (Fonagy, Steele, & Steele, 1991; van IJzendoorn & Bakermans-Kranenburg, 1997), and marital distress (Owen & Cox, 1997).

The overall classification of securely attached versus insecurely attached is relatively stable over long periods of time in middle class, but not economically disadvantaged samples (Vaughn, Egeland, Sroufe, & Waters, 1979). In low-income samples, changes in the child's attachment status has been related to changes in the circumstances of the parents, especially in the case of establishing or ending a romantic relationship with a partner (Egeland & Sroufe, 1981; Vondra, Hommerding, & Shaw, 1999). Infants with an early history of secure attachment are likely to show a number of positive adaptive traits in childhood and adolescence, including less anxiety, and more empathy and social competence (Egeland & Carlson, 2004). By contrast, early insecure attachments represent risk factors for anxiety, depression, and low social competence.

Several investigators who take a longitudinal perspective on the links between early attachment and later psychopathology have suggested that insecure attachment is not simply an index of psychopathology or a direct cause of psychopathology (J. P. Allen et al., 1996; Cicchetti & Barnett, 1991; Davies, Cummings, & Winter, 2004; Sroufe, Carlson, Levy, & Egeland, 2003). Rather, patterns of earlier insecure attachment, in combination with difficulties in family relationships, set in motion pathways that move in the direction of psychopathology over time if they are not counteracted by buffering forces in the family or other aspects of the child's environment (Egeland & Carlson, 2004). For example, maltreated children with perceptions of high positive relatedness to their mothers were more depressed than non-maltreated children, but less depressed than maltreated children who did not describe positive relatedness with their mother (Toth & Cicchetti, 1996).

Intergenerational transmission. We have already noted that most studies of "transmission," including those that employ the Adult Attachment Interview (George, Kaplan, & Main, 1985), rely

on retrospective data. There are some new findings from longitudinal studies of clinical populations that use observations of parents in generation 1 (G1) as they interact with their children (G2), and then observations of G2 as adults parenting their own children. In a useful review, Serbin and Karp (2004) point out that consistency across generations is higher when the assessments of parents and children in G1-G2 occur at approximately the same age as the assessments of parents in G2 and G3 (Capaldi et al., 2003).

The fact that children tend to resemble their parents, and to think (B. A. Miller, 2005) and behave in similar ways (Bengtson, 1996; Luescher & Pillemer, 1998) does not tell us a great deal about what has been transmitted or how the transmission has occurred. Five types of theoretical explanations of intergenerational continuity dominate the current scene. First, as we have just seen, attachment theory assumes that adults have developed “working models” of parent-child relationships based on experiences with key attachment figures in their families of origin, and these working models shape their expectations and reactions during interactions with their children (Bowlby, 1988). Second, some of the repetition of relationship patterns across generations is affected by genetic and other biological mechanisms (Plomin, 1994). Third, psychoanalytic formulations focus on the child’s identification with the same-sex parent and the internalization of that parent’s superego, both of which provide guidelines for what constitutes appropriate behavior in family relationships (Fraiberg, 1975; S. Freud, 1938). Fourth, in turn, these interactions between parent and child result in the child’s creation of working models that lead to the repetition of secure or insecure attachment patterns in the next generation. Fifth, social learning theorists (Bandura, 1977; G. R. Patterson, 1975) offer a simpler explanation that does not rely on assumptions about the child’s inner world: In the process of observing adults interact with others and noting which behaviors are reinforced or punished, children learn patterns of family behavior that they tend to repeat when they form their own families.

Most studies of intergenerational transmission focus on the parent-child relationship. Both family systems models and family risk models suggest that attention should be paid to three

additional perspectives on continuities and discontinuities of family patterns. First, as we (P. A. Cowan, Bradburn, & Cowan, 2005) and Caspi and Elder (1988) have shown in studies of non-clinical families, children with behavior problems who are involved in conflictful relationships with their parents, and may be insecurely attached to them, are more likely to form conflictful marriages, which are followed by combative parent-child relationships, which predict problematic behavior in their children. Second, new work on family rituals provides a more system-focused perspective, suggesting that in daily rituals such as gathering together for family dinners, and more anniversary or religious rituals, family members in well-functioning families co-construct stories that create family myths and preserve family values, while the absence of such rituals is often seen in families experiencing various forms of distress (Fiese, 1992; Pratt & Fiese, 2004). Finally, due to both genetic and environmental factors, families tend to remain in the same social class from one generation to the next, and the repetition of stressors may also contribute to continuity of adaptation across generations.

Families and peer groups. By referring more generally to measures of “externalizing” and “internalizing” in discussing family factors in psychopathology, and not focusing on the fact that these measures often refer to behavior with peers in schools and other social settings, we have not conveyed the central importance of the linkage between family and peer relationships. In an analysis of the data from the Oregon Social Learning Study, Patterson, Dishion, and Bank’s (1984) longitudinal study of aggressive boys showed that coercive parent discipline interacted reciprocally with irritable exchanges between the target child and other family members. Furthermore, irritable exchanges within the family, especially between siblings, were described as providing “fight training” that generalized to the peer group in 7th and 10th grade, and was associated with peer rejection, one of the major risk factors for adolescent antisocial behavior.

The question of whether fighting leads to peer rejection or rejection leads to fighting has been debated for a long time (see Parker & Asher, 1987 for the beginning of this debate). Evidence supporting the hypothesis that peer rejection may come first was found in our own

longitudinal study (P. A. Cowan & Cowan, 2004). Teacher-reported peer rejection in first grade predicted antisocial behavior in fourth grade (stealing, fighting, lying), over and above earlier aggressive behavior in kindergarten. Negative interactions between the parents and between the parents and children in pre-kindergarten and kindergarten were risk factors for peer rejection in first grade. Furthermore, based on data from the intervention with the parents as couples, we were able to show that intervention-induced positive changes in marital and parenting relationships resulted in the children suffering less peer rejection in first grade.

Multiple risk models. In each of the sections above, we saw how researchers were stretching to go beyond two domains or levels of analysis at a time and include yet another risk domain in their attempts to predict and understanding psychopathology. In this section are a few studies that attempt to bring all of the domains together.

(a) Correlational studies. At Bradley Hospital and Brown University School of Medicine in Rhode Island, a group of researchers (Dickstein et al., 1998) is attempting to validate family systemic approaches to psychopathology by constructing measurement models that rely on multiple methods and perspectives on 3 levels of family interaction: marital, parent-child, and whole family. These models combine a risk factor and family systemic analysis of the family. In about 75% of their sample of 185 families, mothers had a lifetime history of mental illness. The investigators' measurement scheme followed the McMaster model of normal family functioning described above (p. x), which included the McMaster Structured Interview of Family Functioning, a dinnertime observation, and individual questionnaires to arrive at a family-level assessment, along with questionnaires that describe the quality of marital and parent-child relationships. Although almost all the measures were significantly intercorrelated, each also showed some independence and unique contribution to explaining family health and maladaptation.

A unique feature of this study is that the researchers examined the correlations between family variables and groups representing a number of diagnostic categories: major depression,

anxiety disorder, bipolar disorder, and a “miscellaneous” group, comparing them with no-illness controls. As expected, family-level variables, marital variables, and parent-child variables (both father-child and mother-child) all revealed some significant differences between the no-illness controls and the other clinical groups, with little differentiation among diagnostic groups except for the fact that depressed mothers were the only ones to show significantly lower quality of parent-child relationships. Consistent with the family systems assumption that the whole is not equal to the sum of the parts was the finding that the presence or absence of psychopathology in the mothers was much more strongly related to measures of whole family functioning than to measures of marital or parent-child relationships. In other words, dyadic relationships were less disrupted than the family as a whole.

Multidomain interventions: Individual, interpersonal, and ecological. In response to the difficulty of treating families with adolescents who abuse drugs, several researcher-clinicians have demonstrated the importance of considering the levels of psychopathology in each family member, the patterns of interactions during conjoint family treatment, and the multiple settings in which families are embedded (high crime neighborhoods, ineffective schools, drug-encouraging peer groups, inaccessible health care systems, and inconsistent juvenile justice systems). The task of the therapist is not to intervene in all of these systems, though some attempt to work with schools and peer groups, but to help the adolescent and family mobilize resources and avoid contexts that reinforce drug-abusing behavior (Liddle, 1995; Liddle et al., 2001). Applications of this approach to the treatment of already-identified families have been successfully extended to preventive interventions for high risk adolescents who are not yet clinically diagnosed (Liddle & Hogue, 2000).

A conceptually similar approach to the treatment of delinquent adolescents and abusing families, Multisystemic Therapy (MS) was developed by Henggeler and his colleagues (Henggeler & Borduin, 1990; Henggeler, Schoenwald, & Pickrel, 1995). Both the Liddle and Henggeler multidomain treatments were developed in a context in which studies of traditional

child psychotherapy showed significant effects in studies conducted in university settings, but not when conducted in community clinic settings (Weisz, Donenberg, Han, & Weiss, 1995). Henggeler and colleagues argue that multisystemic therapies not only rise to the challenge of the level of pathology of clients in community clinics, but also fit better with the ideology of community clinics, which are more likely to use a combination of strategies including pharmacological treatment, parent training, and school interventions to address the problems of their clientele. Two large-scale intervention programs developed in the 1990s also attempt to match a multidomain treatment approach to their multilevel conceptions of psychopathology.

The Multimodal Treatment Study of Children with Attention-Deficit Hyperactivity Disorders (MTA) used a randomized clinical trials design to compare four 14-month treatments of boys with ADHD: (1) a double blind drug trial; (2) a set of behavioral treatments that included group and individual parent training, an intensive summer camp treatment, and school based interventions; (3) a combination of the first two; and (4) treatment as usual in the community. Different analyses produced different findings, but overall, the combined drug and behavioral treatments produced more positive outcomes than either the behavioral treatments alone or the treatment as usual conditions (Owens et al., 2003). Consistent with the systematic themes we have been discussing here, both parental depression and child severity of problem were associated with less successful outcomes. In addition, reductions in parental negative discipline were responsible for positive child outcomes in this condition and only in this condition; when families were assigned to the combined behavioral treatment and drug treatment, improvements in discipline were associated with improved social skills and reduced externalizing behavior into the normal range.

Finally, a multimodal prevention program attempting to intervene early with children identified as at risk for developing conduct problems because they were already highly aggressive in kindergarten combined individual social skills training with parent training programs and classroom behavioral interventions. Follow-up assessments showed that there

were significant advantages for the treatment groups, compared with the no-treatment groups (Conduct problems prevention research group, 1999a), and significant effects of the classroom intervention (Conduct problems prevention research group, 1999b). The success of the interventions appeared to stem from positive changes in targeted risk factors (e.g., the child's hostile attribution bias and problem solving skills, harsh physical parenting Bierman et al., 2002).

Tentative conclusions about family risk factors and psychopathology. Our summary of studies makes clear that there is some support for both the family systems and family risk models of psychopathology. Many studies provided evidence that two or more of the five domains of family life we described in Figure 1 accounted for unique variance in a number of pathological outcomes. Other studies also provided evidence in support of the 9-cell matrix, incorporating biological, psychological, and social risk factors in some combination, and paying attention to both internal and external sources of adaptation and maladaptation.

Despite these examples of how family risk domains are associated with various clinical diagnoses, there are still important gaps in our summary and in the literature itself. In this section we have provided evidence of family factors in only a few diagnostic categories. Schizophrenia, depression, bipolar disorder and aggression have been most frequently investigated, but there is some work on the more internalizing disorders -- anxiety disorders, eating disorders, drug and alcohol abuse – and some on family factors in cognitive or academic competence.

An emerging concern in the literature on developmental psychopathology is that disorders are often comorbid (e.g., Davison & Neale, 1996), but we were able to find only one family study (cited above) that investigated the links between family factors and comorbidity. Finally, although there has been increasing attention paid to the idea of pathways and trajectories in the study of developmental psychopathology, it is still not clear how family system processes or risk factors steer children and adolescents toward specific diagnostic categories -- why conflict and

negative interactions in marital, parent-child, and three-generational relationships leads some children in the direction of externalizing disorders, some toward internalizing, some toward both, and some toward adequate or above adequate levels of functioning.

DEVELOPMENTAL PSYCHOPATHOLOGY IN THE CONTEXT OF CHANGING FAMILIES

In this section, we shift theoretical frames for describing families from the process and structure conceptions of psychologists, psychiatrists, social workers, nurses and other mental health professionals to the fields of sociology and demography. The following historical view of family change focuses on demographic characteristics such as age, income, and ethnicity, and family structure characteristics in the sense of legal definitions and living arrangements such as cohabiting, married, separated, divorced. We present two conflicting interpretations of the meaning of the changes, one suggesting family decline, and the other family resilience. We discuss this as a background for considering whether family system and family factor theories of developmental psychopathology require modification in light of the realities of family life in the 21st century.

Definitions

One key issue in contemporary discussions of family life is how inclusive or restrictive the definition of family should be. Current inclusive definitions center around the idea that a family is a constellation of two or more people “related by birth, adoption, marriage, or choice...with socioemotional ties and enduring responsibilities, particularly in terms of one or more members’ dependence on others for support and nurturance” (K. R. Allen, Fine, & Demo, 2000). This definition encompasses couples without children, single parents with a child, and social units formed by choice, including adults who are “fictive kin,” members of a two-generational commune, and gay and lesbian parents and their children. At this time in American history, there are researchers and political activists who oppose the inclusion of some alternative family forms in the definition of family, particularly gay or lesbian relationships. The controversy has

become part of contemporary political debate in which some argue for a definition that encompasses diverse family forms while others advocate constitutional amendments or laws that would have the effect of limiting the rights and privileges associated with “family” to married heterosexual parents with children. The debate is not new. Twenty-five years ago, President Carter’s 1980 White House Conference on the Family ended prematurely when factional squabbles emerged about the same issues (S. L. Zimmerman, 2001, pp 21-22).

Political disagreement about the definition of family is directly relevant to the study of developmental psychopathology. If non-traditional family arrangements are considered as risk factors for children’s development and adaptation, then family structure becomes an indicator of potential psychopathology. One obvious strategy to resolve the issue would be an examination of empirical studies on the topic, but as we show later in this section, there are profound disagreements about the interpretation of existing research results, and some data do not address these dilemmas directly.

A Century of Change in Family Life

One of the most startling demographic shifts in family life in the last century is the fact that people live longer than they used to. A man and woman born in 1900 could expect to live approximately 48 years or 50 years⁶. By contrast, a man and woman born in the year 2000 could expect to live to the age of 74 or 80. Family size has been reduced dramatically. The average of four children per family in 1900 has been more than cut in half by 2000. A number of notable changes in marriage have taken place in the last 50 years. The mean age of marriage has been rising (from 23 to age 27 years for men and from 21 to 25 years for women). The proportion of adults never married rose from 6% of all women aged 30-34 in 1960 to 19% in 2000, and from 9% to 30% of men, with especially high rates of non-marriage in African American communities. Of course, the most frequently cited statistic about marriage is the rising incidence of divorce, which doubled from 1900 to 1960 and doubled again by 1980, although it seems to have leveled off or even declined in the last two decades of the 20th century.

Not only are children more likely to live without two parents in the home at night, but in a majority of married and cohabiting two-parent families, both parents are involved in paid work outside the home during the day. For many children, this means less adult supervision than in prior years. Changes in attitudes concerning the role of women, and economic circumstances in which real family income declined, also propelled this shift from 1950 when 12% of women worked outside the home, to the beginning of the 21st century when 67% of married and single mothers of children under five worked outside the home at least part time.

In 1900, only 10% of teens spent some time in high school, while 100 years later only 10% fail either to complete high school or receive their GED equivalent (Sealand, 2003). The marked lengthening of school careers, the impact of child labor laws that prevent children under the age of 18 from working full time, and an emerging tendency for offspring in their 20s to live with their parents after they finish college, combine to extend adolescence and delay young men's and women's transition to adulthood (Furstenberg, 2003).

These demographic shifts are related directly to the fact that families in America are more diverse than they used to be (Demo, Allen, & Fine, 2000). Clearly, children and adolescents now live in a variety of family arrangements. If we focus on families with two biological parents, there are children living with parents who are married or cohabiting, others living with one parent following separation or divorce, and others still who live with one parent who is a member of a couple who never married or lived together. Some of the never-married, non-cohabiting couples are in romantic relationships that could reasonably have some impact on the children, while other children living with their mothers have never met their fathers. In addition to families with two biological parents, there are stepparent families, adoptive families, and foster families. All of these categories of family structure have existed before, but over the past century the proportion of families with two married biological parents and children has contracted to approximately 25% of all families and membership in the other categories has increased markedly.

Other demographic changes buttress our claim that America is increasingly a land of family diversity. In 1900 the non-white population of the United States was 10%-12% overall, about 13% for children (Hernandez, 1996). By 1980, slightly more than 26% of Americans were children of color (8.9% Hispanic, 14.9% African American, and 2.2% other). By 1990 the figures increased again to 12.3% Hispanic and 15.4% African American, and by 2030, it is estimated that a child of color will no longer be described as “minority.” Differential birth rates, foreign adoption, and immigration have all contributed to this increasingly diverse portrait of American family members.

Should We Equate Family Change with Family Decline?

Two starkly contrasting views of family change have emerged, one, an extensive body of writing characterizing the changes as evidence for “family decline” and another, more limited body of work, evaluating the same changes as evidence for “family resilience.”

The family decline interpretation. In the 1990s, a number of sociologists and demographers (Popenoe, 1993; Waite & Gallagher, 2000), leaders of conservative family organizations (Dobson & Bauer, 1990), and politicians (Bennet, 1992), became alarmed by the changes in family life that we have described, interpreting them as leading to the decline of the American family, and, by implication, the decline of families in most Western industrialized societies[with similar historical trends]. From the roughly simultaneous shifts in family size, marriage rates, divorce rates, single parenthood, and mothers of young children working outside the home, these interpreters of family trends draw conclusions about the source of increases in the incidence of marital problems and divorce and of behavior problems in children and youth. Couples and their children are not doing well, they argue, because of the shifts away from traditional nuclear family structures. They attribute the shifts to a motivated move away from “family values” toward a self-focused concern by adults with their own development: “Quite clearly, in this age of the me-generation, the individual rather than the family increasingly comes first (Popenoe, 1993, p. 538).”

The family resilience interpretation. Another interpretation of the same historical data has sometimes been characterized as demonstrating family resilience (Amato, 2005; Demo et al., 2000; Skolnick, 1991; Stacey, 1996). The resilience interpretation holds that, although it is true that many social indicators are indicative of change in the family, the changes by and large represent flexible adaptations to changing and challenging circumstances. Men and women are wise to marry later, because marriages of younger couples are more at risk. It is sensible for couples to be wary of making commitments, given what they see happening to the marriages of their parents and friends. Some argue further that given a more complex, difficult, and diverse social structure, it is something to be celebrated that so many families do relatively well.

The family resilience view argues that the negative consequences of family change have been overstated. Single parenthood may not represent the arrangement that most men and women aspire to, according to interviews with children, adolescents, and adults (Ahrons, 2004; McLanahan, 2002), but most single mothers manage to raise children who function successfully in their world. Worries about mothers working outside the home are greatly exaggerated. In general, outside of children of mothers who are employed during the child's first year (Baydar & Brooks-Gunn, 1991), few differences have been found between children of mothers at home or employed outside the home (Harvey, 1999). Some of the differences that have been found are due to selection factors (Vandell & Ramanan, 1992) – especially economic or marital circumstances that propel some unwilling mothers into the workforce. It has been suggested that mothers who work outside the home bring not only economic benefits, but also positive role models and examples, especially to their daughters, of making successful, productive contributions in life (e.g., Moorehouse, 1993). Another argument supporting the family resilience view is that even though divorce can be difficult for all family participants, it may shield the child from ongoing conflict or violence between the parents, and many children of divorce lead successful lives over the long haul (Ahrons, 2004; Amato, 2000).

Problems with the family decline interpretation. Although the fact that the demographic trends in many social indicators follow a similar timeline makes the family decline interpretations seem plausible, we believe that this interpretation of the data is fundamentally flawed in a number of ways.

(a) Traditional families as the “gold standard.” Most interpretations of family decline hold up traditional families – two-married-parent families with fathers at work and mothers and children at home -- as the standard of comparison against which historical changes in family life are to be evaluated. As we briefly described above, many traditional two-parent families are under considerable stress, and significant proportions of parents show significant depressive symptoms and/or marital strain, and children show diagnosable problems early in their school careers. The data on family arrangements and relationship satisfaction suggest that even if risks of difficulty are higher in non-traditional families, a return to traditional arrangements would provide no guarantee that adults and children would fare much better or that family relationship quality would improve.

Most of our references to traditional families focused on heterosexual parents. There is a growing body of research focused on families with same-sex parents, primarily lesbian families. Contrary to the implicit or explicit expectations of family decline theorists that these families are less stable and less supportive of children’s adaptation, the evidence suggests that children of lesbian and gay parents are not significantly different from children of heterosexual parents on a number of major indicators of adjustment and adaptation (Arendell, 1997a; Golombok & Tasker, 1994; Lamb, 1999; C. J. Patterson, 2002). Stacey and Biblarz’s survey of the literature (2001) argues that findings revealing that children of lesbian and gay parents show superior adaptation have been downplayed or overlooked in these studies.

(b) Problems of causal inference. There are two major difficulties in inferring that associations between family change and increases in psychopathology are causally connected. First, a common practice in the evaluation of social trends is to note that two social indicators

change in the other. To draw such a conclusion, it would be necessary to show that these changes co-occur within the same families. That is, assuming that there is an increase in youth violence over time, researchers would have to show that this increase occurred in families who are “non-traditional” or became non-traditional in the process of separation and divorce. Even then, correlation would not establish conclusive proof of causation.

Studies of families in transition have not produced results that unequivocally support the family decline argument. For example, as we have seen, although divorce and single parenthood represent risk factors for elevated levels of behavior problems in children and adolescents, there are more exceptions to the rule than exemplars of the decline hypothesis (Hetherington & Kelly, 2002); most children of single parents fare reasonably well. By reporting only the fact that there are statistically significant differences between family types, family decline authors overstate the magnitude of the effects to make it appear that changes in the direction of non-traditional family structures account for the major proportion of social problems and psychopathology in children and youth.

(c) Conflicting evidence for the conclusion of declining well-being of children and youth. A central implication from most of the trends described above is that children and youth are living in less stable, less traditional families than they used to, and that, as a consequence, they are experiencing more difficulties than their age mates in earlier times. The facts relevant to conclusions about trends for children and youth are quite difficult to come by because many of the social indicators of health, behavior, and well-being have been gathered systematically only since the 1980s. After an extensive search of the literature, we conclude that there is a very mixed picture concerning the claim that today’s youth are in a state of intellectual, emotional, and moral decline.

We know that children’s physical health and life expectancy has improved dramatically from 1900 to 2000. In addition, from 1939 to 1970 both African Americans and European

Americans showed a marked reduction in the proportion living in poverty, with a leveling off in the subsequent 30 years (Brown et al., 1999). Public concerns about the state of American children and youth tend to focus on adolescent sexual behavior and teen pregnancy, substance abuse, and violence. There is no question that American youth are more sexually active, and active at a younger age than they were 100 years ago (Brown et al., 1999). Nevertheless, sexual risk-taking defined as engaging in unprotected sex has declined since 1982. Although the proportion of unmarried teenagers having babies increased from the 1970s to the 1980s, the most recent data show that teen pregnancy has been declining since then. The declines are even more evident in some subgroups than others. For example, the overall rate of teen pregnancy dropped by approximately 20% in the 1990s, but by as much as 30% in African American teens (Ventura, Anderson, Martin, & Smith, 1998), and there are wide variations among states in both the teen pregnancy rates and the declines in live births. The often-cited fact that American teen pregnancy rates are much higher than those in other countries is mitigated somewhat by the observation that the differences are substantially reduced when race and income are statistically controlled (Kirby, 1999). In contrast with public perceptions of increasing problems (Guzman, Lippman, Moore, & O'Hare, 2003), teen violence and substance abuse also show declining trends.

What has risen considerably in the last three decades is the frequency of diagnosed mental illnesses in children and youth (Eberstadt, 2004). Doctors are diagnosing an increasing number of children at younger ages with serious mental disorders, and many of those children are being treated with psychiatric drugs developed for adults. Diagnostic categories that have shown significant increases are: Attention Deficit Hyperactivity Disorder (more males than females); Eating Disorders, and Asberger's syndrome and other autistic spectrum disorders. It is not clear whether the increases in incidence and prevalence of the disorders represent a true increase in the occurrence of psychopathology or whether the trends reflect increased attention

to the mental health and illness of children and youth, increases in diagnostic skill, more efficient reporting and data collection, or media attention to these illnesses.

We are not arguing that the increases in child and youth mental illness are illusory, but rather that changes in the adaptation of young people require a great deal of further systematic research before we claim to understand the data. Whatever conclusion is ultimately drawn about historical trends, the picture is not consistent with the simple statement that the “decline” of American families has been responsible for a crisis in American youth.

(d) No proof that family values play a central role in family change. A central feature of the family decline interpretation has been the conclusion that changing family values are the motivating force behind changing family trends, and the argument that a shift in family values would have a salutary effect. Although there are studies indicating that, on the average, there have been shifts in some aspects of family values over the past few decades (S. L. Zimmerman, 2001), we are aware of no data relevant to the claim that men and women who have less traditional family arrangements value self more and family less, or that troubled children and youth are more likely to have parents who hold self-focused rather than family-oriented attitudes.

Those who accept the interpretation that family values are responsible for family change in the last century fail to consider the possibility that external social systems rather than internally held values may play a central role in how families are arranged. Families are embedded in the social and political structure of a society (Bronfenbrenner, 1979). Social and economic policies, and the institutions that administer them or fail to do so, have a great deal to do with the quality of family life. For example, despite a new government emphasis on promoting marriage (see below), there are “marriage penalties” in the tax law, and a couple can be declared ineligible for welfare because of the combined income of the two partners. That is, there are government policies and procedures that lower the incentive for low-income couples to enter into a formal marital arrangement. Women often work because their financial circumstances make it

necessary to have two parents' incomes to provide for and protect their children adequately. Laws regulating welfare, and marriage and economic conditions, are only two of many possible external contexts that affect family behavior and family change.

(e) Confounding of family diversity and family decline. Finally, we are concerned about an unfortunate slippage in discussions of family decline, in which the indicators of greatest concern (e.g., single parenthood, poverty) are associated with changes that have taken place with more frequency in members of minority groups, especially minority groups who are also experiencing economic hardship. It turns out, then, that policies suggested to remedy the ills of family decline are often directed at low income minority groups (e.g., marriage promotion), without recognition of the fact that in sheer numbers, the social indicators of concern occur more frequently in European American families, and that they occur across the whole socioeconomic spectrum.

Problems with the family resilience interpretation. Our conclusion from the fact that the family decline arguments are seriously flawed is not that the family resilience interpretation is the correct one. Writers advancing the family resilience view often criticize the family decline theories for focusing only on family structure (married or not, divorced or not), when it is the quality of family relationships that determines the developmental course of adaptation or psychopathology. Countering this argument, some authors point out that studies with careful statistical controls for income show reduced links between divorce or single parenthood and negative effects for children, but the associations are not eliminated completely (Cherlin, Chase-Lansdale, & McRae, 1998; Furstenberg & Kiernan, 2001). Similarly, to state that divorce has longterm effects in "only" 20% of the children, risks minimizing a significant and important social problem. The fact that 40% to 50% of contemporary couples who marry will divorce indicates that there are serious difficulties in maintaining adult intimate relationships over time.

We agree with Cherlin and Furstenberg (Cherlin et al., 1998; Furstenberg & Cherlin, 1991), family sociologists who conclude that historical increases in divorce, cohabitation, and single parenthood have brought with them the potential for increased risks for children's development

– by their nature or because they bring with them other potentially disruptive changes, especially poverty. We also agree with Amato (2000), a family sociologist, whom we quoted above (p. xx), who suggests that it is necessary to ask more differentiated questions about who will benefit and who will suffer when family changes and transitions occur.

A developmental psychopathology perspective on resolving the debate. We raised the question of whether family change should be equated with family decline. Our answer is “yes and no.” On one hand, it would be foolhardy for researchers, clinicians, or policy makers to ignore the possibility that there are some special challenges involved in raising a child in divorced and single parent families. On the other hand, we must recognize the fact that non-traditional family structures do not account for the vast majority of diagnosable problems in children, adolescents, or adults. Clearly, it is necessary to identify the strengths in non-traditional families that lead most of the children who live in them to meet the academic and social challenges that life imposes, just as we try to understand what is operating in “traditional” families when children in two-parent families succumb to diagnosable pathology.

A synthesis of the family decline and family resilience perspectives is entirely consistent with the assumptions of developmental psychopathology that we described earlier. First, it is necessary to acknowledge that some family structures are associated with higher risks for adaptation than others, while noting that (a) higher risks do not automatically mean higher levels of distress, (b) lower risk families are not problem-free, and (c) the majority of members of families in any of the structures we have described are functioning outside the realm of what is considered psychopathology.

Second, family structure represents a static picture of the family at a point in time. Families often go through multiple transitions simultaneously or in quick succession, and it is often the disequilibrium associated with the transition (e.g., moving house, drops in income, single parenthood, the birth of new children) rather than the end point (e.g., divorce) that plays a causal role in the adults’ and children’s adaptation (G. R. Patterson & Capaldi, 1991).

The issue, then, is not whether family decline or family resilience views of historical family change are correct, but that both views have implications for our understanding of developmental psychopathology. As family decline proponents have framed the discussion, psychopathology or resilience are located in some family forms by definition. In a view more consistent with the principles of developmental psychopathology, we conclude that (a) American families are becoming more diverse, (b) more families are moving toward non-traditional family structures, (c) some non-traditional families are having difficulties coping with the demands of raising children, and (d) a substantial number of families with more traditional family structures are having similar difficulties in personal adjustment, establishing satisfying family relationships, and coping with the challenges and demands of life outside the family.

Expanding Considerations of Family Diversity: Meeting the Challenge of Understanding Contemporary Families

How is the field of developmental psychopathology responding to the changes in family life that all observers agree have occurred? Our conclusion is that there is a fundamental gap in the research on developmental psychopathology, in which the research questions have not caught up to the realities of life in families. Despite some promising beginnings, we still know very little about differences in models of risk-protection-outcome in different populations. This is a critically important question not only for theories of developmental psychopathology, but also for the targeting of interventions directed toward reducing the family risk factors and increasing the family protective factors associated with specific problems or disorders. There is also a critical gap in the family intervention literature. Although a number of family theorists and clinicians argue that family theory and therapy practice need to pay attention to the diversity of families, and reject the idea that “one [intervention] size fits all” few if any of the creative modifications suggested to meet the needs of diverse populations have been subjected to rigorous evaluation.

(a) Gender. We have noted that there are marked gender differences in the incidence of some types of psychopathology (e.g., depression, externalizing), and that there may be gender differences in family risk patterns for these disorders, with depression more likely to be associated with difficulties in mother-daughter relationships, and aggression more likely to be associated with difficulties in fathers' relationships with both daughters and sons (P. A. Cowan, Cowan, Ablow, Johnson, & Measelle, in press). We have also noted that there appear to be gender differences in the way men and women deal with conflict and disagreement in their relationship as couples. The need to create more complex theoretical family models of psychopathology that take gender into account has been noted by the feminist critics of traditional family therapy (p. x), and has begun to occur in family therapies (T. S. Zimmerman, 2001), but it has not been regularly included in family research.

(b) Age. Despite the fact that marriages are occurring later in life, and the birth of a first child is extending to mothers in their early 40s and beyond, almost all of the contemporary research on couples, especially investigations that use observations of marital discussions, is based on couples between age 20 and 40. We know very little from direct observations about marriages of older couples (for an exception see Charles & Carstensen, 2002; Levenson, Carstensen, & Gottman, 1994), except that they tend to express more positive emotion than younger couples do when they discuss a disagreement. This finding may be attributable in part to the fact that studies of older couples are more likely to include those with positive relationships that have withstood the tests of time, but increased positivity could also come from the perspective that age brings or from a lessening of stresses associated with early careers and the rearing of young children.

Two sets of questions about age, relevant to developmental psychopathology, remain to be answered. First, are the models of risk factors that have been established for parents who have their first child in their 20s different from models for families in which parents are in their late 30s or mid 40s? For example, analyses of our own data (C. P. Cowan & Cowan, 2000) indicate that

marital satisfaction declines more after the birth of a first child for couples in their 30s than for couples in their 20s. We know of no data that address whether the risk of decline increases for samples of 40-year-old parents of young children.

Second, older parent-adult child relationships are rarely studied (Ryff & Seltzer, 1996), and there is almost no information based on direct observation of couples or observations of parents with their adult children. Are the risk factor models that account for distress and the protective factors that reduce distress different from models established in studies of younger couples? For example, does marital conflict and marital withdrawal in older couples have the same negative impact on their adult children that we have seen with couples with young children and adolescents? Also, outside of the assumption that children tend to become more autonomous and independent in late adolescence in Western industrialized societies (M. Bowen, 1978), we are not aware of family system theories suggesting that family process qualities change with the age of the participants. In other words, neither theory nor research on developmental psychopathology provide much of a developmental perspective on the links between family functioning and adaptation in clinical or non-clinical families. Especially given the longer life spans of modern adults, it seems important to seek answers to these questions if we are to understand the emergence of psychopathology through the life span.

(c) Income. We are struck by the fact that, although information and concern about low-income families exists in the form of thousands of studies and reports, there have been few systematically tested income-based interventions for this group (for an exception, see Gennetian, Knox, & Miller, 2000). Virtually all studies of couples therapy or early interventions for couples are comprised of middle class, primarily European American participants (Dion, Devaney, McConnell, Hill, & Winston, 2003). Family therapies have sometimes targeted low-income families, but almost always with a focus on minority status rather than low-income (Robbins, Schwartz, & Szapocznik, 2004; Robbins et al., 2003; Szapocznik et al., 2004). That

is, we have a great deal to learn about whether and how couple and family interventions require modification in order to address the needs of families in different economic circumstances.

(d) Ethnicity⁷

(i) Research on cultural differences and similarities. In the 1970s, a book reviewing research across all fields of psychology was entitled “Even the rat was white” (Guthrie, 1976). Over the past three decades, it has been encouraging to find a number of researchers studying families of color (e.g., Brody & Flor, 1996; Coll, Meyer, & Brillon, 1995; McLoyd, 1990; Parke & Buriel, 1998), describing mental health issues unique to each ethnic group (e.g., Serafica, 1990), and proposing necessary modifications of family therapies to create more culturally sensitive interventions that fit the beliefs and practices of ethnic minority families (e.g., McGoldrick, Giordano, & Pearce, 1996). As examples, we focus here on three major ethnic subgroupings, African American, Asian American, and Latino families. We recognize that there are many other subcultures within the United States and many other ethnic groups across the world, and that there are important variations within each of these subgroupings that we do not have the space to describe in adequate detail.

In the early years of research on minority mental health, almost all studies involved comparisons of one or more minority groups with Caucasian samples, with concepts and measures developed on middle class whites applied to minority participants. This research strategy led to an emphasis on differences that were interpreted as problems and deficits in the minority groups (Jones & Korchin, 1982). By contrast, most current writers have adopted an “emic” approach, which attempts to describe both strengths and vulnerabilities of individuals, families, and cultural institutions from the perspective of members of a specific group.

In reading a number of descriptions of minority families from within their own cultural perspective (e.g., McGoldrick et al., 1996), we were struck by the fact that over and above obvious uniqueness, there were a number of similarities among the accounts of different groups. Attempts to understand African American, Latino, and Asian American families typically

begin with a history of the circumstances of their emigration (voluntary or forced) to the United States, and, especially for Latino and Asian families, an account of differences between generations, depending on whether they immigrated as adults or children, or on whether they are first, second, or later generation citizens. To different degrees and in different ways, all three groups have experienced racism, discrimination, unemployment, and poverty, some in their countries of origin, and most at some time in the United States or other country of destination. Families in all three groups are more likely than European Americans to be church affiliated or influenced by religious beliefs, though this may be changing (Wilcox, 2004). One salient dimension in the lives of each group is the importance of family and extended kin networks, with grandparents centrally involved in the rearing of young children, together with parents, or in their absence due to work or other circumstances (Burton & Stack, 1993; Goodman & Silverstein, 2002; Strom et al., 1999).

One cultural influence on family cohesion is centrally important in thinking about psychopathology and family treatment. Especially in Latino and Asian American families in comparison with European American families, there is a high value on connectedness and a lower value on individuation from the nuclear and extended family as adolescents make the transition to adulthood. Current generations of teenagers and young adults struggle with the tension this creates between the two worlds (Falicov, 1996; Hines & Boyd-Franklin, 1996; Matsui, 1996). A second important influence on both the incidence and prevalence of psychopathology and the utilization of mental health services comes in the cultural shaping of beliefs about mental illness. For example, both Latino (Contreras, Fernandez, Malcarne, Ingram, & Vaccarino, 2004) and Asian (Mak & Zane, 2004) beliefs about depression focus more on physical characteristics and less on emotions, and therefore, symptom reporting by individuals and family members differs in different cultures. Third, partly on the basis of practices in their country/culture of origin, and partly based on experiences with health and mental health delivery in the United States, all three groups tend to turn elsewhere for help with

family members' emotional problems, and are often skeptical about whether therapeutic services offered to minority families will meet their need (e.g., Boyd-Franklin, 2003).

Finally, although the content is often different, family members in all ethnic minority groups struggle with issues of (at least) dual identities – who am I as a Latino, Asian, Black man or woman, who am I as an American, and how do those identities fit together? In part, this is an issue of acculturation, and so may vary with the length of stay in the host country (Tsai, Ying, & Lee, 2000). These issues often places second- and third-generation children and adolescents familiar with European American family practices at odds with their parents and grandparents, with the potential to lead to behaviors considered problematic or dysfunctional by the families or others in the community (teachers, mental health professionals).

Having focused on similarities among ethnic minority groups in thinking about how culture can affect psychopathology, it is important to acknowledge the obvious differences. The immigration experiences of African Americans are more likely to have occurred in the past, some under forced conditions of slavery, while some Latino and Asian communities are in a state of fluctuation due to immigration. There are differences in language and literacy, achievement patterns, religious affiliations, marriage and divorce practices, and possibly patterns of emotion regulation in close relationships. It seems reasonable to assume that there are modal differences among ethnic groups in the prevalence of the family risk factors that have been linked with developmental psychopathology in European American families.

Despite the welcome interest in ethnicity and families, a central dilemma remains for the understanding of developmental psychopathology. There is still a dearth of systematic study of how patterns of risk factors may differ from one cultural group to another. The few studies we are aware of that focus on risk-outcome patterns suggest that, despite differences in the prevalence of some very important risk factors such as poverty, family risk models operate similarly across groups. For example, reviews of research by McLoyd and her colleagues (McLoyd, 1990; Mistry, Vandewater, Huston, & McLoyd, 2002) suggest that poverty in African

American families has negative effects on children's adaptation because it disrupts family relationships in much the same way that Conger and his colleagues (1994) described for low-income European American farm families. A similar approach to comparisons between Mexican American and European American low-income families (Parke et al., 2004) finds that the same list of family factors (economic stress, parental depression, marital problems, hostile parenting) account for variations in children's adaptation or psychopathology, although there are two interesting differences. The primary predictors of children's adjustment problems were marital problems for Mexican American couples and hostile parenting for European American fathers. Acculturation also played a role in the links between family functioning and psychopathology in the Mexican American families: mothers who were more integrated into the Anglo culture were likely to be less hostile as parents, but more likely to report conflictful marriages.

It is too early, of course, to accept these two studies as proof that there are similarities with variations in risk-outcome patterns among ethnic minority families. It does lead us to expect that among the needed new studies, at least some will find commonalities that may generalize across an even wider range of ethnic groups. For example, new studies of interventions with refugees in African, Asian, and South American countries and in the United States (K. E. Miller & Rasco, 2004) point to the importance of family factors in post-immigration adjustment, especially when the circumstances of migration result in the disruption of family ties. Rasco and Miller (2004) summarize studies of immigrant families using a multidomain risk model that suggests the need for more systemic research on the way in which political violence and geographical displacement affect individuals, families, and communities, and a cautionary note that these models may show both similarities and differences in different ethnic communities that face different sets of circumstances.

(ii) Culturally sensitive interventions. It would be unreasonable to expect family therapists to wait until risk models for each ethnic group have been tested before considering how they can become more sensitive to cultural variations in families. Some edited books present separate

chapters with descriptions of different ethnic/racial subgroups (Ancis, 2004; Ho, Rasheed, & Rasheed, 2004; McGoldrick et al., 1996). Other authors avoid a comparative approach by focusing on specific approaches to African American (Boyd-Franklin, 2003), Asian-American (Jung, 1998; Ng, 1999), or Latino (Falicov, 1998; Flores & Carey, 2000) families.

Each of these works describes the historical, cultural, and political context leading to prejudice, discrimination, and oppression of minorities, the characteristic ways that families within each group are organized, the perceptions of majority cultures and institutions that may make it difficult for the families to utilize existing mental health services, and the special issues and challenges that families within each group may face. The authors, primarily clinicians, tend to focus on issues of language and inability to communicate with the English-speaking majority, loss due to immigration and social disruption, pressures to assimilate rather than adopt a bicultural stance, the obligation of deference to elders in Asian families, and distrust between males and females and the prevalence of single parenthood in African American families. All of this information is designed to provide a contextual definition of what is normal and abnormal from the perspective within a specific ethnic group. One goal of these authors is to make certain that the standards and values involved in the assessment of deviance, which are inevitably involved in the definition of psychopathology, are made more relevant to the culture of the minority. A second goal is to identify therapy practices that are more acceptable and helpful to family members in each group.

Unfortunately, the impressive work involved in developing, trying, and describing more culturally sensitive family interventions has not yet been subjected to empirical testing. That is, we do not yet know whether the attempts to make them more relevant to each target population produce benefits for participants, over and above the usefulness of more traditional therapies. Clinicians involved in these pioneering attempts would be correct to argue that it is necessary first to develop new interventions and to rely on in-depth qualitative analyses of their strengths and weaknesses before larger-scale clinical trials are done. This is a necessary first step in any

clinical-scientific intervention endeavor. Our aim here is to point out that, especially in a health delivery system context in which validated treatments are more often demanded before program support is given and insurance reimbursements are approved, it is time to embark on more concerted validation efforts of the new approaches have been created (see Pinsoff & Wynne, 2000).

(d) Non-traditional families. The research issues concerning family factors in psychopathology in families with gay or lesbian parents are similar to the ones we have discussed for families grouped on the basis of age, income, or ethnicity. We cited research that reveals few differences in adaptation between the children of gay or lesbian parents and those of heterosexual parents. However, questions about similarities or differences in patterns of risk have mostly been left unanswered. An exception is a set of studies showing that the risk models that predict distress in heterosexual couple relationships can be applied equally well to gay or lesbian relationships (J. M. Gottman et al., 2003). We are not aware of research that attempts to link personal distress, couple relationship distress, and parenting style with child outcomes in gay or lesbian parent families, so we do not know whether modifications of existing risk models are required for families with gay or lesbian parents. There have been some recent descriptions of specific issues and therapy approaches to working with gay and lesbian families (Laird, 2003; Laird & Green, 1996; Malley, 2002; Malley & McCann, 2002; Pachankis & Goldfried, 2004; Yarhouse, 2003). Like the writing on family therapy with minority families, this work presents a contextual analysis of special issues faced by gay and lesbian families because of legal, political and social stigmatization and because most of these families have no examples from prior generations of how families with two same-sex parents function most effectively.

Reading case studies in books and articles in family therapy, we conclude that much of what is currently described as family therapy occurs with a single parent and one or more children. As in many of the other variations we discuss here, there is evidence of higher risk in these families, but no evidence yet to show that the family risk models would differ in different

family structures. We have not found any relatively recent books for therapists and only a few articles that go beyond case studies to provide guidelines for treating single parents and their children (C. Anderson, 2003; Everett & Everett, 2000; Jung, 1996). It is not clear, then, whether new models of family therapy are needed to treat troubled parents or children in this large population.

This survey suggests that there are many sources that family therapists can consult in order to consider how their practices can meet the challenges of the diversity of contemporary families. Most of these sources refer to the available research on diverse families. However, we are alarmed by the fact that, with the exception of the prevention programs targeting family transitions, none have provided systematic research evidence that (a) the interventions they propose actually work, (b) the modifications they propose function as mechanisms of change, or (c) the therapies provide benefits over and above traditional family therapy approaches.

Family psychopathology researchers and therapists face a dilemma when they attempt to meet the challenges of family diversity. At one extreme, early family systems theories implied that universal system principles, relatively unmodified, could guide the treatment of all families. At the other extreme is the argument that family treatments must be adapted to be appropriate for each demographic group. To follow Tolstoy's dictum to its logical conclusions – that "happy families are all alike; every unhappy family is unhappy in its own way" (Tolstoy, 1899, p. 1) – therapists could be faced with the task of creating unique therapies for each family. Imagine the complexity of considering even a limited number of variations and trying to develop family therapies specifically targeted to older and younger European American, Asian American, African American, and Latino families in which parents are cohabiting, married, separated, or divorced, native or immigrant, and so on. Even with this specificity, it would be necessary to expand the variations to include other subcultures within the United States and other cultures across the world. Furthermore, it is necessary to remember that individuals and families within each category show wide variability in terms of family beliefs, practices, behavior, and

adaptation. One cannot simply assume that a particular older Chinese American couple, or an unmarried teen European American couple, or a Latino stepfamily actually display the modal characteristics typical of the group they identify with (Demo et al., 2000).

In the absence of specific risk-outcome models and validated treatment models for specific types of families, what are family therapists to do? In our view, the ideal solution involves a balance of universality and particularity. Clinicians who conduct assessments and therapists who work with family members will need to be aware of common principles that can be applied broadly across many different types of families, while staying attuned to the unique features of each family's needs and concerns, some of which may be related to their particular cultural background.

FAMILY RESEARCH AND FAMILY POLICY

Family policy -- decisions made by legislative and executive branches of government to regulate and enhance the well-being of families and allocate scarce resources -- covers a wide array of topics, including contraception, abortion, marriage and divorce, child support, adoption, family leave, health and mental health, welfare, child labor, the justice systems (adult and juvenile), child care, domestic violence, and child abuse (Sealand, 2003; S. L. Zimmerman, 2001). Family policy helps to determine what is defined as pathology. At the same time, research on families and psychopathology is often cited in discussions concerning laws, regulations, and service delivery systems.

The links between research-clinical findings and policy are tenuous at best, for three main reasons. First, many policy decisions are made on moral or value grounds, and these grounds provide a sufficient political justification for choosing a course of action. Despite the reliance on data by some political advocates and social scientists, research findings are often considered irrelevant to public debate. Second, research conclusions and policy proposals are framed in different languages. Policy makers are trying to find universal rules or solutions to societal problems. They want to know whether their proposed solutions will work for the largest number

of citizens. They seek yes or no answers to specific questions. By contrast, risk researchers are used to working with probabilities and individual differences. Their answer to a question about whether a plan of action will work is often, "It depends; it will for some and not for others." Given these different approaches to the nature of the discourse, it is almost inevitable that policy makers and family researchers or clinicians wind up talking past each other, with neither group benefiting from what the other has to offer. Third, as we have seen, research on hot issues having to do with understanding psychopathology almost always results in disputed interpretations. Researchers are often as divided on family issues as politicians are, and are not immune to the value biases that create controversies in the public or political arena. To illustrate the interplay of family policy and family research on psychopathology, we briefly mention three topics that are currently at issue, and likely to be central issues for some time to come:

Father Involvement.

Over the last 30 years, societal concern about the negative impact of absent fathers on their children's development stimulated efforts to design interventions that would encourage fathers to take a more active, positive role in their children's daily lives (Mincy & Pouncy, 2002). Research on the definition of father involvement, the consequences of father involvement, and the factors that encourage or discourage father involvement (Tamis-LeMonda & Cabrera, 2002) has led to multidomain risk-outcome models similar to those we have described throughout this chapter. In contrast with political arguments that father involvement is a matter of the motivation and will power of individual fathers (Blankenhorn, 1995), the research suggests that whether or not fathers take an active "hands-on" role in the daily lives of their children is a complex outcome of a variety of factors including demographic and psychological characteristics of individual fathers, the quality of their relationships with the mothers of their children, intergenerational patterns, and outside the family supports for and barriers to men becoming more involved (Tamis-LeMonda & Cabrera, 2002).

Our own summary of the research and intervention literatures (P. A. Cowan & Cowan, submitted) notes a remarkable disconnection between research on father involvement and programs to promote father involvement, just as we see in the family psychopathology field in general. A few program designers draw on risk factor research, but rarely provide systematic evaluations of outcomes or mechanisms that would reveal whether targeting the hypothesized risk factors and change mechanisms actually produces the desired change in psychopathology.

We are currently involved as part of a team with Marsha Kline Pruett and Kyle Pruett of Yale University in the Supporting Father Involvement Project, sponsored by the California Office of Child Abuse Prevention. The project evaluates variations of interventions in five California communities with a large proportion of low-income White and Hispanic families. The design of this randomized clinical trial contrasts participation of fathers and their partners in (a) a 16-week fathers group, (b) a 16-week couples group, and (c) a one-time information session about the importance of father involvement (the control condition). The decision to contrast these two styles of ongoing intervention was based in part on research showing that the single best predictor of fathers' involvement with their young children is the quality of their relationship with the child's mother (Bouchard & Lee, 2000; Cohen, 2001; Frosch, Mangelsdorf, & McHale, 2000). Outcome data are in the process of being gathered as this chapter goes to press.

Strengthening Marriage: Strengthening Couple Relationships.

Two research studies, one involving the gathering of new data, and one involving a survey of the literature, have played important roles in discussions of policy related to low-income unmarried couples. The policy issues are based on a moral concern by some about the high rate of divorce and single parenthood, and a financial concern by others that these families are likely to be poor and their children to have higher rates of problems than children in two-parent families. First, the Fragile Families study of hospital births in 20 American cities (Carlson & McLanahan, 2002b; McLanahan, 2002; McLanahan et al., 1998) found that around the time of childbirth, more than 80% of the biological fathers were involved in a romantic relationship with

the child's mother, and 50% of the couples were living together. Contrary to popular belief, interviews with the couples showed that most of them hope to get married. This "magic moment" around the birth of the baby dissipated somewhat, so that over the next year 58% were still in romantic relationships, mostly those who had been living together when the child was born. Second, an influential book, The case for marriage: why married people are happier, healthier, and better off financially (Waite & Gallagher, 2000), was used to support the argument that if women and children in unmarried families are at risk, then a wise policy alternative is to encourage them to marry. We have discussed elsewhere the frequently-ignored fact that correlations do not (should not) prove causal connections and are not adequate to provide support for policy decisions.

In part resulting from a moral concern, and in part using data from these two works as a justification, the U.S. Administration for Children and Families awarded two contracts to research and evaluation agencies for randomized control trials of (1) interventions for unmarried low-income couples making the transition to parenthood (Building Strong Families, administered by Mathematica), and (2) low-income married couples with and without children (Strengthening Healthy Marriages, administered by MDRC,) to work toward healthy couple relationships and marriages. Not surprisingly, discussions of these initiatives have generated some public disagreements. Because federal financial support for strengthening couple relationships is novel, the results of these randomized controlled studies of interventions addressed to couples' issues in low income communities may provide important information about how low-income partners struggle with issues in their lives as couples and whether it is possible to design interventions that make those struggles more manageable.

Welfare Reform

In 1996, President Clinton signed a bill that promised to "end welfare as we know it," in part by requiring women on welfare to work, and in part by limiting the time they could spend on welfare (see DeParle, 2004 for a fascinating account of the antecedents and consequences of

the legislation). Arguments about why this bill would enhance the lives of families were based in part on the assumption that parents' work provides both psychological and financial benefits to the parent and the child. This policy was undertaken without social science research to provide a justification. Evaluation of welfare reform is now in progress; clearly it has reduced the numbers of families on welfare and the costs associated with welfare programs. Studies of the impact on men, women, and children who move off, or who are forced off, the welfare rolls is still in progress (Chase-Lansdale et al., 2003; Fuller, Kagan, Loeb, Carroll, & Growing Up in Poverty Project., 2002).

These are only three examples of the complex and uneasy intersection of family research and family policy. We are optimistic about the fact that there seems to be a growing tendency at the federal level to encourage, and even fund, systematic evaluations of new policies and programs related to families. We are less optimistic about the tenor of public and academic debate in which research findings are cited in support of one position while ignoring the complexity of drawing conclusions from a welter of conflicting or incomplete evidence. Nevertheless, we believe that attempting to bring systematic evidence from social science into discussions of family policy has the potential for creating more differentiated and nuanced perspectives on the diversity of families for policy makers and social scientists alike.

FUTURE DIRECTIONS

We have attempted to include suggestions about where the field is and should be going in most of the sections above. In this final section, we summarize several salient points to highlight what we see as important next steps.

- 1) Addressing the diversity of families. We need investigations of a wider range of risk models for different groups, and evaluations of attempts to modify family therapies to fit the needs of these groups while preserving generic principles that may work across contexts.

2) Addressing the diversity of theories. We have suggested that ideas from family systems and family risk factor approaches are becoming more integrated in clinical work with families. The movement toward the integration of these approaches in research on understanding developmental psychopathology appears to be proceeding more slowly, although there are some indications of movement toward a synthesis of views in this area as well. One indication of the lack of integration is that systematic diagnostic systems for describing the psychopathology of families have been slow to develop (Kaslow, 1996). A second arena in which these two approaches remain separate is in family risk researchers' tests of linear causal risk models, in which they combine measures of family relationships as independent variables in accounting for variations in the functioning of identified patients -- despite family systems' assumptions about bi-directional causality.

In our view, integrations of the multiple perspectives we have outlined here have some way to go. The 6-domain family model summarizes the key aspects of family life in which individuals and dyads move toward or away from adaptation. The nine-cell matrix provides a checklist of alternative explanations of stability and change within each of the domains. At some point, family researchers and clinicians must accept the fact that the etiology of both individual and family psychopathology involves combinations of internal, external, and interactive factors that operate at biological, psychological, and social levels of a system.

3) Explaining risk-outcome linkages. Perhaps the main difference between research studies cited in this chapter and those in the chapter on family systems and developmental psychopathology in the previous edition of this volume (Wagner & Reiss, 1995) is the vast increase in research on mechanisms to explain how risks are connected with developmental psychopathology outcomes. The search for mediators and moderators has become something of an obsession, and despite Baron and Kenny's often-cited attempt to distinguish between them, there continues to be confusion on this point. Mediators account for existing correlations, for example, when the correlation between maternal depression and children's aggression can

be explained by the fact that depressed women are more likely to be in conflictful marriages (Miller et al., 1993). Moderators are markers of conditions that change the links between risks and outcomes, as for example in any finding that shows significantly different patterns for different groups such as boys or girls, or parents with high or low marital conflict.

The identification of both mediators and moderators is essential for family therapists. Learning about modifiable mediators -- family process mechanisms linking risks and outcome that can be changed -- could help clinicians increase the effectiveness of their interventions. Learning about modifiable moderators -- family process mechanisms that increase protective factors or reduce vulnerabilities -- could also protect family members from the negative effects of risks that cannot be modified.

4) Putting the development back in developmental psychopathology. We know that there are systematic variations in the age of onset of many disorders, such as the risk of externalizing, internalizing, and schizophrenia that emerges in adolescence. In part restricted by the ubiquity of the DSM, developmental psychopathology has not yet become fully developmental. Too many categories like depression and schizophrenia have the same diagnostic criteria for children and adults when it is absurd to think that a 7-, 17-, and 70-year-old depressed person has the "same" underlying disorder. Once a person enters a category, there may be a developmental course of the mental illness and a lawful, systematic change in both its structure and function over time. We believe that these are important questions for developmental psychopathologists in the next decade.

5) More effort directed toward empirically validated treatments. There has been increased pressure by research funding agencies, service delivery systems, and insurance companies to rely on evidence-based therapies, and decreased support of approaches that have not been validated in systematic studies. The outgoing editor of *Family Process* (Anderson, 2003) noted the profound gap between those who create solid research studies and "clinicians [who] tell me

that they neither read nor value the research data being produced and that they basically fail to see any relationship it has to the realities of their practice (p. 323).”

There is an important distinction to be made between “empirically validated treatments” and “evidence-based treatments” (Messer, 2004; J. E. Patterson, Miller, Carnes, & Wilson, 2004). Family therapists need to have more in their armamentarium than a list of “valid” therapies, especially when there is such a diversity of families and a dearth of large-scale tests of efficacy or effectiveness of a specific therapy for a specific group. Nevertheless, therapists have two obligations. The first is to read and evaluate the literature to inform their understanding of risk-outcome models of psychopathology, and to learn whether certain treatment approaches have received empirical support. The second is to provide systematic information on the course of each treatment, in the form of process notes, questionnaires, or audiotaped or videotaped observations that attempt to determine (a) whether families improve after a course of treatment, and (b) which characteristics of client, therapist, and their interaction appear to be associated with positive and negative outcomes.

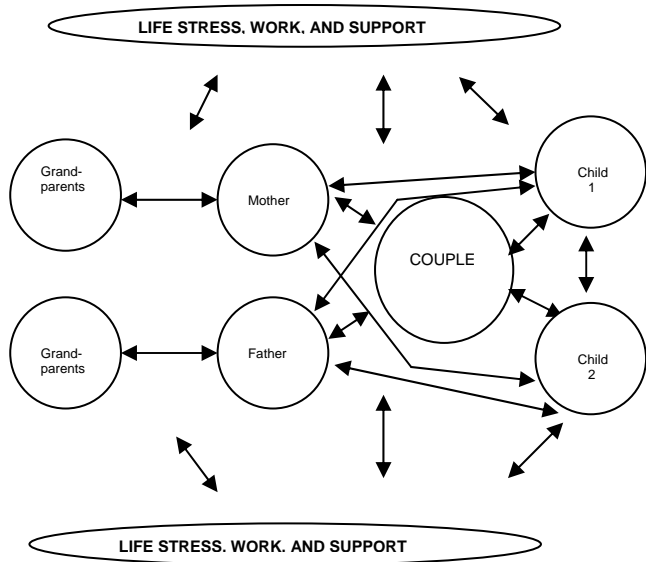
A final word

We believe that this is an opportune time for researchers and clinicians eager to grapple with a family systems or family risk factors perspective on developmental psychopathology. The field now has a solid fifty-year history in which there has been a remarkable unfolding of creative ideas about how to think about both mental health and mental illness in a family context. An increasing quantity and quality of systematic research studies has provided a solid empirical foundation for models of risk-outcome linkage and therapeutic and preventive intervention. And yet, there is almost endless opportunity to make important contributions to this field – by modifying existing theories to fit the increasing diversity of family life, by testing risk-outcome models in as-yet-untested diagnostic groups and cultural settings, and by developing new and even more complex models of how family structures and processes are linked with adaptive and maladaptive functioning inside and outside the nuclear family. It is our hope that contemporary

family researchers and clinicians will rise to meet the challenge of expanding our understanding of the family context of developmental psychopathology as the field moves into the next fifty years.

Figure 1: Six domains of family life involved in children's psychopathology

Figure 2: The 9-cell matrix: alternative theories of stability and change



	Internal	External	Interaction
Biological	CELL 1 Genetic	CELL 2 Toxic	CELL 3 Diathesis-stress
Psychological	CELL 4 Psychoanalytic Humanistic	CELL 5 Behavioral	CELL 6 Cognitive-behavioral Piaget
Social	CELL 7 Object relations Attachment	CELL 8 Socialization	CELL 9 Family systems

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Enhancing family relationships: Child and teen outcomes

³ We will address below whether the correlations actually represent causal influences of marital quality on children's adaptation.

⁴ The discussion in this section has benefited from a presentation made by Avshalom Caspi to an NICHD-sponsored group considering Family Change (Los Angeles, February, 2005)

⁵ The discussion in this section has benefited from discussion with Stephen Hinshaw

⁶ Most of the trends described in this section are based on data from US census reports. We cite specific authors who have contributed specific analyses. Despite the fact that the data are drawn from the US census, we found variations in different reports of the same trends, based on the year of publication and on the base data used by different authors in calculating percentages. The figures here represent our best estimates from various sources, based on the information available in 2004.

⁷ We do not have space here to deal with the complex issues involved in describing individuals and families in terms of ethnicity, race, culture, and minority status. We are aware that race is a social construction (APA article), ethnicity is unclear as a designation, and minority status is a

relative term depending on the demographics of the territory being discussed. Here we will use the terms ethnic group and minority group interchangeably, with the understanding that each of these terms has unresolved ambiguities.