THE ASSOCIATION BETWEEN THE QUALITY OF FAMILY RELATIONSHIPS AND CHILD PSYCHOPATHOLOGY

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By
Cassian BK Kimhan

Thesis Committee:
Bruce F. Chorpita, Chairperson
Charles Mueller
Kelly Vitousek
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Abstract

Past research has examined the association between family relationships and child psychopathology utilizing a variety of methods. Most recently, examinations of family variables using paper and pencil measures have become common practice, given their practicality and high potential for clinical utility. However, despite such widespread use of these measures (e.g., FES; Moos & Moos, 1976), there is little evidence to support their appropriateness within a clinical realm. The present investigation therefore sought to examine whether a widely available measure of theoretically important family relationship constructs would perform adequately within a sample of children experiencing clinical difficulties. Questionnaires examining family relationships and affective and behavioral symptomatology, as well as a semi-structured diagnostic interview, were administered to 51 youths, ages six to seventeen, seeking mental health evaluations from the Child and Adolescent Stress and Anxiety Program. Results indicated that the measurement of the family environment by the child report was unreliable. However, the parental report of Cohesion and Conflict demonstrated adequate reliability. Among those scales that were reliable only one significant association was observed, with poorer global family relationships negatively correlated with parental report of child internalizing symptomatology.
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Family Relationships and Child Psychopathology

Introduction

Methodological Strategies of Family Relationship Research

Past research has established that multiple influences affect the development of childhood psychopathology. One central factor in this process is familial relationships. It has been recognized that both the genetic and social factors of the family strongly influence a child’s emotional and behavioral development (Barkley, 1997; Lonigan & Phillips, 2001; Patterson, 1982). Consequently, extensive examination has been conducted to evaluate interactions among family members in light of their associations to different expressions of childhood psychopathology (Baumrind, 1967; Bowlby, 1970; Chorpita & Barlow, 1998; Moos & Moss, 1976; Parker, 1979). Two methods have been used to examine family relationships: observation and self-report.

An extensive literature exists summarizing observational data of the parent-child interaction. Early on, this was the preferred method of assessment, as it was suggested that observational data are less subject to informational bias and more independent of perception (Messer & Gross, 1995). Numerous studies have established a link between the parent-child interaction and childhood psychopathology using observational data. Specifically, studies have characterized parent-child interactions as more commanding and critical among children exhibiting externalizing behaviors, whereas findings have suggested those interactions among parents and their children with internalizing difficulties to be less positive and more solitary (Messer & Gross, 1995; Roberts, 2001). Whereas observational data have
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provided the field with a wealth of information, there have been some questions regarding the validity and reliability of observational data, as well as the practicality of this method (Roberts, 2001).

Consequently, over time, development and use of paper and pencil measures within the field of family relationships has occurred. A variety of measures have been created, with the Family Environment Scale (FES; Moos & Moos, 1976) and an adaptation, the Family Relationship Index (FRI, Holohan & Moos, 1983) being among the some of the most widely used measures. Similar to past research using observational data, comparable associations among family relationships and child psychopathology have been established with self-report measures. However, the majority of these studies have been conducted with normal populations. It appears that the use of self-report measures is appropriate in the examination of family relationships; however, the utility of these measures within a clinical population has yet to be established.

The collective evidence to date has established that familial relationships are influential in the development of childhood psychopathology, as seen through the observational assessment literature, as well as recent examinations using paper and pencil measures. As methodology to examine these associations has evolved, additional questions have been spurred regarding the validity and reliability of paper and pencil measures. Consequently, examination of the associations among family relationship dimensions and internalizing and externalizing disorders of
childhood psychopathology, using the aforementioned self-report measures continues to be warranted in context of a clinical population. The present investigation will address these issues by examining the familial report on the FRI in relation to childhood symptomatology among a sample of children referred for clinical difficulties.

**Family Relationship Measures**

The Family Environment Scale (FES, Moos & Moos, 1976) is among the most widely used instruments employed in the study of family environment. The FES examines the family environment from family members' perspectives on ten specific dimensions: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational, moral-religious emphasis, organization, and control. The FES has demonstrated adequate internal consistency and good test-retest reliability among a diverse sample of 285 families (1000 participants) of multiple ethnicities (e.g., Caucasian, Hispanic, and African American), including families with both normal and clinically disturbed members (Moos & Moos, 1976; Moos, 1990).

In addition to the original FES (1976), several adaptations have been created in attempts to improve the psychometric properties as well as determine other important characteristics of family functioning (Bloom & Naar, 1994). The Family Relationship Index (FRI, Holohan & Moos, 1983) comprises three dimensions from the FES, "conflict", "cohesion", and "expressiveness" and yields a global composite score suggested to provide a
general measure of family relationships. Similar to the FES, the FRI has also
demonstrated good internal consistency among a community sample (Moos,
1990).

The Self-Report Measures of Family Functioning (SRMFF, Bloom,
1985) was derived through a factor analysis of the FES and three other
commonly used family functioning scales, yielding sixteen dimensions of
family relationships. In 1994, Bloom and Naar reviewed and revised the
SRMFF in relation to the FES and determined that whereas items on the
Conflict scale of the FES remained relatively the same, the Cohesion and
Expressiveness scales of the FES loaded highly on the Family Idealization
and Democratic Style scales of the SRMFF (1985), respectively. Thus, in
research conducted using the SRMFF the dimensions of Cohesion and
Expressiveness have been examined using these different scales. All of these
measures, the FES, FRI and the SRMFF have been used extensively in the
study of family relationships.

Measurement Strategies in Family Relationship Research

Traditionally, clinical researchers have examined the association
between family relationships and child psychopathology using two distinct
approaches. The first approach involves global definitions of family
relationship quality, based on composite scores of several relationship
components, such as communication, warmth, and conflict. This method
provides the use of a broad understanding, allowing sensitivity to a variety of
psychopathology dimensions. On the other hand, it may be that the use of
global definitions overshadows the unique contributions of the specific components of family relationships. The second approach involves specific characteristic definitions. This strategy allows one to identify unique associations between family relationship components (e.g., conflict) and psychopathology, but creates difficulties for a broader understanding and assimilation of constructs. Given that each approach has yielded unique insights to the understanding of the role of family relationships in childhood psychopathology, one purpose of this study was to further examine the associations between global and specific dimensions of family relationships and different expressions of childhood psychopathology.

*Global Definitions of Family Relationships and Child Psychopathology*

A link between family relationships and child psychopathology has been suggested using global definitions of family relationships. Family relationships, as measured by a composite score of the Conflict and Cohesion scales of the FES (1976), have been found to be associated with both internalizing and externalizing expressions of psychopathology among adolescents hospitalized on a psychiatric inpatient unit (Halloran, Ross, & Carey, 2001). Findings from this investigation suggested that poor global relationships (i.e., high conflict combined with low cohesion) were related to Major Depressive Disorder, Attention-Deficit/Hyperactivity Disorder, and Conduct Disorder among both boys and girls. In addition, these results revealed that higher familial conflict combined with lower cohesion was related to Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and
Overanxious Disorder in girls, and Dysthymic Disorder and alcohol use in boys (Halloran et al. 2001). No evidence of an association was found between a composite score of high conflict and low cohesion and Manic Depression, Obsessive-Compulsive Disorder, or Separation Anxiety. Associations among specific dimensions of family relationships and child psychopathology were not reviewed.

In another study using the FRI (1983), the association between family relationships and internalizing symptomatology related to depression were examined among a sample of 12 and 13 year old boys and girls from a normal population (Lau & Kwok, 2000). Results revealed that poorer family relationships (i.e., higher conflict combined with lower cohesion and lower expressiveness) were related to increased depressive emotionality, and physiological irritation, as well as a lack of positive experiences.

Furthermore, in a comparison of families with a depressed parent and those without, parental scores on the FRI (1983) indicated that families in which one parent was depressed were characterized by poorer relationships as defined by the presence of higher conflict, less expressiveness, and lower cohesion (Billings & Moos, 1983). In addition, children from families with a depressed parent exhibited significantly more health problems, internalizing psychological problems (i.e., depression and anxiety), disciplinary problems within the school system and academic difficulties than did children without a depressed parent. Thus, past research indicates that children with a depressed parent experience poorer familial relationships and are also at a
higher risk for psychological, physical, and academic difficulties as reported by their parents.

The same study examined the effects of positive familial relationships and their effects on psychopathology. This examination revealed that families with a depressed parent experiencing positive family relationships, as measured by the FRI, were characterized by higher support and higher activity, and were more likely to have children displaying fewer symptoms of psychopathology than those who had poor family relationships (Billings & Moos, 1983). Thus, family relationships appeared to mitigate the risk associated with having a depressed parent.

In sum, previous research using global definitions of family relationships has established that poorer family relationships are associated with increased risk for psychopathology. However, it appears that past research has used various methods of defining poor global relationships to establish these findings. While certain studies have reviewed global relationships by examining cohesion, conflict, and expressiveness combined, others have examined only conflict and cohesion combined. It remains unclear, which is the best method for defining global relationships. Furthermore, this line of research has yet to investigate in detail the association between specific characteristics of family relationships and specific aspects of child psychopathology. Therefore, this research has established connections between family relationships and psychopathology by employing broad-based global definitions; however, it is unclear what the
best method for defining global relationships is as well as how specific dimensions of relationships relate to childhood psychopathology.

_Specific Definitions of Family Relationships and Child Psychopathology_

**Conflict.** One of the most widely examined characteristics of family relationships is conflict, defined as “the extent to which the open expression of anger and aggression and generally conflictual interactions are characteristic of the family” (Moos & Moos, 1976). Past studies have examined the association between conflict and childhood psychopathology. The association between conflict and internalizing symptomatology was examined in a study of young adolescents in a normal population of children compared with children with DSM-III anxiety and depressive disorders (Stark, Humphrey, Crook & Lewis, 1990). These results revealed that children experiencing anxiety, depression, and mixed anxiety and depression reported significantly higher conflict in their family relationships than did controls, using the Conflict scale of the SRMFF (Bloom, 1985), suggesting that familial conflict is related to child anxiety and depression.

A further association between family conflict and depressive symptomatology has also been found, using the Conflict scale of the FES (1976), in a sample of normal adolescent girls and their parents (Smith & Forehand, 1986). A link was established between mother-daughter conflict and daughters’ depressive symptomatology, but not father-daughter conflict. Further evidence of this association between conflict and depressive symptomatology was found in a sample of normal adolescents ranging from
12 to 13 years old (Dekovic, 1999). Higher levels of conflict within the family were associated with poorer family relationship quality. In turn, poorer relationship quality was associated with higher reports of depression and low self-esteem. Therefore, past research has indicated that higher family conflict is associated with internalizing expressions of childhood psychopathology including anxiety and depression, depressive symptomatology, and lower self-esteem.

Despite the substantial amount of research conducted in this area, past research has not examined the relationship between objective measures of conflict using the FES, FRI, and SRMFF and externalizing forms of childhood psychopathology. However, other lines of research have established such links. Particularly, in the field of domestic violence, research has established the link between conflict and childhood difficulties, such as externalizing conditions of Attention Deficit, Oppositional Defiant Disorder, and Conduct Disorder (McCloskey, Figuerdo & Koss, 1995). Furthermore, the theoretical orientation suggests that high levels of family conflict are significantly associated with or are heavily implicated in the causal model of externalizing behaviors.

_Cohesion._ Another widely examined variable in the investigation of family relationships and psychopathology is cohesion. Family cohesion has been associated with constructs such as support, warmth, and idealization (Bloom & Naar, 1994; Moos & Moos, 1976). Specifically, cohesion has been defined as the extent to which family members are concerned with and
committed to the family, and the degree to which they are helpful and
supportive of one another (Moos & Moos, 1976). Studies have examined the
connection between cohesion and psychopathology among “high-risk”
families, characterized as espousing parental attitudes and values that
condone physical and psychological coercion (Garbarino, Sebes, &
Schellenbach, 1984). Results revealed that adolescents from high-risk
families exhibited higher rates of developmental problems, including
externalizing difficulties. Results further indicated that high risk families
were not found to have poorer cohesion as measured by the Cohesion scale of
the Family Adaptability Cohesion Environment Scale (FACES, Olson,
Russell, & Sprenkle, 1979), suggesting that poorer cohesion was not
associated with a higher risk of adolescent emotional and behavioral
difficulties. This study further examined children’s perceptions of parental
support among high-risk families. Support is thought to be a concept related
to cohesion (Bloom & Naar, 1994; Moos & Moos, 1976). Results indicated
that high-risk families reported less support on the Cornell Parent Behavior
Description. Thus, although high-risk families, whose children exhibited high
levels of psychopathology, were characterized as unsupportive, they were not
found to display poor levels of cohesion.

The role of support was further examined in a study reviewing the
relationship between parental support and alcohol use in a normal adolescent
sample (Brody, Flor, Hollet-Wright, McCoy & Donovan, 1999). Results
suggested that more supportive families were associated with less adolescent alcohol use.

Other studies have specifically examined the connection between cohesion and child psychopathology (Stark et al., 1990). Findings suggested that children experiencing anxiety, depression, and mixed anxiety and depression as indicated by the DSM-III were characterized with families having significantly lower levels of cohesion than the normal control group. In addition, Aydin and Oztutuncu (2001) found that poorer familial cohesion was related to higher levels of self-reported depression and more negative automatic thoughts in a sample of normal adolescents.

In sum, family cohesion has been associated with anxiety and depression, depressive symptomatology, and automatic negative thoughts. Moreover, family support, a dimension related to cohesion, has been associated with developmental difficulties and variations in rates of alcohol use. It appears that past research has established an association between cohesion and internalizing expressions of childhood psychopathology; however, the association between cohesion and externalizing conditions of psychopathology has only been briefly addressed.

Expressiveness. Expressiveness is characterized by the extent to which family members are allowed and encouraged to act openly and to express their feelings directly (Moos & Moos, 1976). Expressiveness can also be defined as communication and contact between family members. Past research has found that expression-oriented families exhibit high rates of
psychiatrically disturbed and delinquent juveniles (Moos & Moos, 1976). Additionally, an examination of the relationship between family communication and alcohol use norms in a normal adolescent sample (Brody et al. 1999), suggested that more communicative families were associated with less liberal use norms.

In addition, familial democratic style and child psychopathology has been connected (Stark et al., 1990). Family democratic style has been found to be closely linked to expressiveness (Bloom, 1994). Results indicated that children experiencing anxiety, depression, and mixed anxiety and depression were characterized by significantly lower democratic style than the families of controls (Stark et al., 1990).

Hence, higher levels of expressiveness have been associated with psychiatric disturbance, juvenile delinquency, and more liberal alcohol use, while lower levels of democratic style have been associated with anxiety and depression. It might be that a moderate level of expressiveness within a family is beneficial to children's mental health, whereas both high and low levels of expressiveness may be detrimental. Therefore, it remains unclear whether expressiveness relates more strongly to internalizing conditions or to externalizing conditions, or whether differing levels of expressiveness relate to different forms of psychopathology.

Reporter Perspective

An important caveat of past research and future studies within this domain is the inclusion of multiple informants. Parents' and children's
perceptions often differ in regard to children’s experience of psychopathology as well as the familial environment. Historically, literature on parent-child agreement has shown correlations in the moderate to low range (Achenbach, McConaughy, & Howell, 1987). Furthermore, several studies have indicated that it is the child who often reports the most difficulties related to psychopathology (Stanger & Lewis, 1993) and family environment (Bonne, Lahat, Kfir, Berry, Katz, & Bachar, 2003; McDermott, Batik, Roberts, & Gibbon, 2002). Such findings may suggest that different reporters hold different perspectives. However, these findings may also suggest reporter bias. For instance, parents’ tendencies to rate their children’s psychopathology and familial environment difficulties lower may relate to social desirability concerns. However, children’s tendencies to rate difficulties higher may suggest a propensity to over-report problems or to hold their families responsible for their difficulties. Consequently, combining reports that hold only moderate agreement at best may undermine findings. Awareness of these past findings is essential to interpreting and understanding the present results.

*Dimensions of Psychopathology*

Over the past twenty years the literature on childhood emotional and behavioral problems has offered an increasingly well and specified set of constructs, which have been organized into the broad categories of “internalizing” and “externalizing” psychopathology. These broad categories
offer a useful framework for understanding clinical difficulties and how they relate to dimensions of family relationships.

_INTERNALIZING DISORDERS_

Internalizing disorders, also referred to as over-controlled disorders (Reynolds, 1992), are syndromes in which children display deficits in desired behaviors (e.g., relationships with peers, difficulties with expression). They reflect dimensions of psychopathology related to somatic complaints, as well as withdrawn, and anxious/depressed symptomatology (Achenbach, 1993). The collective evidence to date points to three broad psychosocial factors that appear important to the susceptibility for developing an internalizing disorder: familial influence, high parental control, and low parental warmth. Familial influence encompasses variables such as inherited temperament as well as learned response strategies to life’s difficult or scary situations. A specific definition of temperament is as follows:

Temperament consists of relatively consistent, basic dispositions inherent in the person that underlie and modulate the expression of activity, re-activity, emotionality, and sociability. Major elements of temperament are present early in life, and these elements are likely to be strongly influenced by biological factors (Goldsmith et al., 1987, p. 524).

Therefore, children are often born with stable characteristics that influence their emotional and behavioral expressions. It is not surprising that parental temperament strongly influences child temperament. Consequently, children
of parents with a temperament prone to internalizing difficulties are at a higher risk for developing such difficulties themselves (Lonigan & Phillips, 2001).

Learned responses are strategies that are taught or modeled to children by parents. For example, past studies have found that when asked to interpret ambiguous situations, parents of children with anxiety disorders will produce answers that ultimately influence their children to respond using anxious or avoidant tactics (Dadds, Barrett, Rapee, & Ryan, 1996). In this way, everyday interactions between parents and children allow children the opportunity to learn ways to deal with stressful situations, which can eventually affect children’s later development of psychopathology.

Theorists have also proposed that early experiences with control lead to differing levels of attachment security (Chorpita & Barlow, 1998, Parker 1979), which can further influence the later development of internalizing difficulties. Specifically, infants may seek to communicate, influence, and interact with their caregivers and through their efforts, infants begin to determine whether or not they exhibit control over their environment. On the one hand, denial of access or separation from the caregiver can lead to insecure attachment, characterized by the child’s overdependence on, or lack of interest in the parent. On the other hand, if the infant’s efforts are met with a response, over time the child will gain a sense of predictability, leading to a sense of security. Secure attachment is characterized as a healthy parent-child connection, signaled by the child’s confidence when the parent is present,
distress at the parent’s absence, and comfort when the parent returns. Children exhibiting secure attachment are thought to have a better sense of control over their environment (Chorpita & Barlow, 1998).

These patterns continue to evolve throughout childhood and adolescence. Specifically, the ability to engage in a variety of activities throughout childhood and adolescence leads to the development of coping, mastery and resolution skills (Chorpita, 2001). These skills are limited by the number of experiences in which children are able to engage. The level of control or protectiveness exerted by the caregiver affects children’s sense of control over their environment. Thus, children of caregivers who are overprotective, too intrusive, and who restrict the child’s range of experiences suffer a diminished sense of control, which lessens the chance that the child will develop appropriate tools or methods for engaging in various situations.

Additionally, theories have proposed that parental warmth moderates the effects of parental control on childhood psychopathology. For example, when parents are overprotective, children will experience a diminished sense of control out of the parent-child realm (Chorpita, 2001). In other words, children with limited experiences and few mastery skills will lack a sense of control in how to deal with situations in the absence of a parental figure. Yet, children may still have the opportunity to gain a sense of control within the parent-child realm. In a warm environment children may exhibit control over certain situations (e.g., parental attention). However, children in an
environment characterized by high parental control and low parental warmth are at increased risk of developing internalizing difficulties. In this pattern, the child lacks control both outside and inside the parent-child realm. Children in this situation are both unable to engage in outside experiences to gain coping or mastery skills, and unable to seek parental attention or aide when they are desired. Consequently, it appears that past research has specified three risks for developing internalizing disorders: parental control, parental warmth, and familial influence (e.g., inherited temperament, learned responses; Garber & Flynn, 2001; Malcarne & Hansdottir, 2001).

Externalizing Disorders

Much like internalizing disorders, externalizing difficulties have been linked to a number of psychosocial developmental influences. Externalizing difficulties are defined as under-controlled disorders (Reynolds, 1992) and are related to delinquent and aggressive behaviors which affect others (Achenbach, 1993). Specifically, four factors have been consistently identified in the development of disruptive behaviors: child characteristics, parental characteristics, contextual factors, and the parent-child relationship (Barkley, 1997; Patterson, 1982; Patterson, DeBaryshe, & Ramsey, 1989).

Past research has established that certain child characteristics suggest an increased risk for the development of disruptive behavior disorders. Past findings appear to indicate that characteristics such as temperament, difficulty sustaining attention, excessive levels of energy, and high
emotionality (low threshold for emotional response) increase a child's risk for developing externalizing psychopathology (Barkley, 1997).

Furthermore, past research has also established that several parental characteristics lead to an increased risk for the development of disruptive behaviors. As with children, those parents exhibiting negative temperament or high emotionality are at a greater risk for having children with disruptive behavior difficulties. Moreover, it appears that parental experience of psychopathology is another important risk factor, as are parental immaturity and inexperience. Parents with such characteristics often display patterns of poor monitoring and inconsistent management, greater aggression and resentment towards their children, as well as the use of contingencies that provide little positive reinforcement for prosocial behaviors (Barkley, 1997).

A third factor in the development of externalizing behaviors involves larger contextual issues. These often consist of familial and environmental factors, including marital status, marital discord, and socioeconomic status. These factors often lead indirectly to patterns of parenting involving less positive reinforcement, greater inconsistency, and poorer management. Furthermore, parents faced with such stressors as marital discord and unemployment are often less responsive, affectionate, and involved, as well as more punitive and irritable (Patterson, 1982). Another important contextual factor is maternal social isolation; it is proposed that children of mothers who are isolated from other families and/or their own immediate family are at a greater risk for the development of disruptive behaviors. It is
believed that such isolated mothers lack resources, have poor parenting models, and are more prone to experience stress (Barkley, 1997).

The last factor, the parent-child interaction, captures the amalgamation of the aforementioned variables and the development of disruptive behavior. Specifically, Patterson (1982) suggests that the emergence of behavioral difficulties often begins in early childhood. Families characterized by the above-mentioned vulnerabilities often employ poor and inconsistent management and monitoring strategies regarding children’s behavior. Consequently, families often maintain noncompliance through the use of escape-avoidance patterns of reinforcement. Children begin to avoid negative or boring experiences, such as homework, chores and so on, by whining, tantruming or outright refusal. Parents often either reinforce noncompliance by continued arguing with the child (e.g., negative attention) or by submitting to the child’s demands. Over time, parents learn that a child’s whining or tantruming will often cease when the child receives their desired outcome, whereas children learn that disruptive types of behavior result in their desired outcome. Consequently, children engage in disruptive types of behavior more often and parents submit to their children’s demands, engage in yelling, or avoid interactions with their children altogether (Patterson, 1982). This pattern has been named the “Coercive model.”

Over time, a child’s use of coercive patterns often pervades school and peer environments. Noncompliant and under-controlled behavior impedes learning, with children spending less time on task, which can
eventually lead to academic failure (Barkley, 1997). Furthermore, aggressive behavior leads to rejection by normal peers, placing the child at risk for deficiency in social skills. Moreover, these children tend to drift to similarly rejected or deviant peers, leading to further engagement in deviant acts. There is empirical support for Patterson's theory, in that externalizing conditions of child psychopathology (those characterized by aggression, delinquency, or impulsivity) have often been associated with high levels of family conflict, inconsistent parenting, and low levels of parental involvement (Barkley, 2003; Hinshaw & Lee, 2003; McCloskey, Figuerdo & Koss, 1995).

Again, as with internalizing disorders, it is the interaction among the multiple vulnerabilities that often leads to the development of psychopathology. It is notable that in both major theoretical areas the parent-child interactions or the familial influence appears to significantly affect these progressions. Recognizing the importance of the family environment, in particular the interaction patterns among parents and children, the current investigation sought to expand the current knowledge regarding family relationships. More specifically, the current investigation sought to examine how different aspects of family relationships relate to different expressions of child psychopathology, as well as to evaluate practical and timely strategies to identify these associations within a clinical population.

**Summary**

Although previous research has demonstrated the association between global and specific components of family relationships and childhood...
psychopathology, important gaps in the research exist. Specifically, past research has not conclusively determined the distinct associations between relationship dimensions and child psychopathology. First, whereas, a global dimension of family relationships has been found to act as both a protective factor and as a risk factor for the development of child psychopathology, research has not examined the global dimension of family relationships and its relation to internalizing and externalizing disorders. Furthermore, the relationships between specific components of family relationships (i.e., conflict, cohesion, and expressiveness) and internalizing and externalizing conditions of psychopathology have not been studied systematically.

The present study addressed these issues by employing both global and specific approaches to characterizing family relationships. The first step was to examine the association between the global composite score of family relationships and child psychopathology. It was hypothesized that the global composite score of family relationships would be negatively correlated with both externalizing and internalizing measures of psychopathology. The second step was to examine the association between the specific family relationship variables (conflict, cohesion, and expressiveness), and child psychopathology. Although findings have established that conflict, measured using the FRI and the SRMFF, is related to internalizing conditions of psychopathology, this has not been explicitly investigated using these scales in relation to externalizing conditions of psychopathology. It was hypothesized that conflict would be associated with increased internalizing
and externalizing symptomatology. Furthermore, with respect to cohesion, as measured by the FRI and SRMFF, an association to internalizing symptomatology has been established; however, once again, externalizing conditions appear to be overlooked. It was hypothesized that the cohesion score would be negatively associated with internalizing and externalizing conditions of psychopathology. In addition, past studies have linked both high and low levels of expressiveness to a range of childhood disorders, thus a clear understanding of how expressiveness relates to childhood psychopathology remains unclear. Based on past research it was hypothesized that high levels of expressiveness would be associated with externalizing conditions of psychopathology, while low levels of expressiveness would be associated with internalizing conditions of psychopathology.

Methods

Participants

Participants consisted of 51 families (i.e., one parent and one child) obtained from 98 consecutive referrals seeking a mental health evaluation at the Center for Cognitive Behavior Therapy (CCBT) at the University of Hawai‘i at Manoa. School system personnel were the predominant source of referrals. Evaluations were sought for those children experiencing social, emotional, and behavioral difficulties within the school system. Of the 51 participants, primary diagnoses included Oppositional Defiant Disorder (n=11, 21.6%), no diagnoses (n=8, 15.7%), Conduct Disorder (n=7, 13.7%),
Social Phobia (n=5, 9.8%), and Attention-Deficit/Hyperactivity Disorder, Combined Type (n=5, 9.8%; see Table 1). Diagnoses were determined using a semi-structured diagnostic clinical interview for parents and children, the Anxiety Disorders Interview Schedule for Children-IV, Child and Parent Versions (ADIS-IV-C/P, Silverman & Albano, 1996).

Clinical severity among the current population was examined using the T scores from the Childhood Behavioral Checklist. The internalizing T scores had a mean of 61.39 ($SD=10.45$) and ranged from 34 to 80. The externalizing T score had a mean of 60.94 ($SD=12.44$) and ranged from 33 to 83. Finally, the Total Problems T score had a mean of 63.02 ($SD=10.04$) and ranged from 34 to 88. Examination of the Total Problems T score revealed that approximately forty-five percent of the population fell above the sub-clinical cut off range (T=65), whereas twenty-six percent fell above the clinical cut off range (T=70; see Table 2).

Of the 51 families, the child population consisted of 37 boys (72%) and 14 girls (28%). The mean age for the child sample was 12.6 years, ($SD=3.17$, range 6 to 17; see Table 2). The parent sample consisted of 10 males (20%) and 41 females (80%), ranging in age from 30 to 71 years old ($M=43.8$, $SD=9.64$). Major ethnic groups represented included multi-ethnic ($n=33$; 67.3%), Caucasian ($n=4$; 8.2%), and Filipino ($n=4$; 8.2%; see Table 1).

The current sample included forty-one families in which the participating caregiver was the biological parent, five families in which the
caregiver was a foster parent, two families in which the caregiver was an adoptive parent, and three families in which the caregiver was a grandparent. For those families in which the participating caregiver was a non-biological parent, the duration of time lived with the caregiver was examined. Duration of time living with the participating caregiver ranged from 6 months to 15 years ($M=6$, see Table 3).

Those children with developmental or intellectual impairments ($n=1$) or psychosis ($n=2$) were excluded from participation in this study. Furthermore, families were also excluded if either the child or the parent was unable to either participate in the interview or complete the entire battery of questionnaires ($n=44$).

**Measures**

*Anxiety Disorders Interview Schedule for DSM-IV, Child and Parent Versions (ADIS-IV-C/P).* The ADIS-IV-C/P (Silverman & Albano, 1996) is a revision of the ADIS-C/P, which was a downward extension of the adult ADIS (DiNardo, O’Brien, Barlow, Waddell, & Blanchard, 1983). The ADIS-IV-C/P is a semi-structured diagnostic interview designed for the assessment of DSM-IV diagnoses of childhood anxiety, mood, behavioral, and attentional disturbances. This interview schedule, which is intended for use with youth between the ages of 7 and 17, presents questions worded to assess current functioning. Ratings from both the parent and child are obtained for both symptom severity and symptom interference. Excellent test-retest reliability has been found for the ADIS-IV-C/P ($k=0.80-0.92$, Silverman, Saavedra, & Pina, 2001).
The ADIS-IV-C consists of eleven sections, each relating to a specific diagnostic syndrome (i.e., Separation Anxiety Disorder, Social Phobia, Specific Phobia, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, Obsessive-compulsive Disorder, Posttraumatic Stress Disorder, Dysthymic Disorder, Major Depressive Disorder, and Attention-Deficit/Hyperactivity Disorder.) The ADIS-IV-P consists of thirteen sections each relating to previously mentioned diagnostic categories as well as Oppositional Defiant Disorder and Conduct Disorder. Each section in the ADIS-IV-P and-C consists of a number of symptoms that are presented to child and parent. For example, the Separation Anxiety Disorder section in the ADIS-IV-C consists of seventeen questions or symptoms that are endorsable. Each child’s internalizing symptomatology was determined through summing the symptoms endorsed on the ADIS-IV-C and ADIS-IV-P on the following sections: Separation Anxiety Disorder, Social Phobia, Specific Phobia, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, Obsessive-compulsive Disorder, Posttraumatic Stress Disorder, Dysthymic Disorder, Major Depressive Disorder. Externalizing symptomatology was indicated by summing the items endorsed on the ADIS-IV-P on the Oppositional Defiant Disorder and Conduct Disorder sections. The selection of these two scales was chosen to reflect the Childhood Behavioral Checklist’s inclusion of only Delinquent and Aggressive Behaviors as an expression of the Externalizing Score. Thus, the ADHD portions of the child and parent interview were not included in either the internalizing or externalizing symptom score.
Interviewers were thoroughly trained in the administration of the ADIS-IV-C and ADIS-IV-P. Training included observation of three pairs of parent-child interviews conducted by previously trained interviewers. Subsequently, the trainee student conducted child and parent interviews using the ADIS-IV under the observation of a trained interviewer. The graduate student trainee was considered “trained” after matching on diagnostic profile and severity of each diagnosis with a trained observer on three separate occasions.

*Child Behavior Checklist (CBCL).* The CBCL (Achenbach, 2001) is a parent-report questionnaire consisting of 113 statements regarding behavioral and emotional competencies of children and adolescents. Each statement is rated on a 3-point scale, with 0= (not true), 1= (somewhat or sometimes true), and 2= (very or often true). The CBCL (2001) consists of eight narrow-band subscales (withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior). Furthermore, the CBCL consists of two broad-band scales, Internalizing and Externalizing. The Internalizing scale consists of three of the eight narrow-band scales including Withdrawn, Anxious/Depressed, and Somatic Complaints. The Externalizing Scale is a composite of two of the eight original broad band scales, Delinquent Behavior and Aggressive Behavior. The CBCL has been found to have adequate reliability and validity in a large sample of children ranging in age, socioeconomic status, and country of origin (Achenbach, 1991). This
instrument has also been found to demonstrate acceptable discriminant and convergent validity between non-clinical and clinical samples (Su, Li, Lou, Wan, & Yang, 1998).

Children's Inventory of Anger-20 (CIA-20). The CIA-20 (Francis, Fernandez & Chorpita, 2001) is a shortened version of the original 71-item CIA (Nelson & Finch, 1978). The CIA-20 is a self-report paper-and-pencil measure used to assess anger in children. Items are rated on a 4-point scale assessing how mad or angry the child is in a particular situation. Responses are indicated with 1 = (don't care) to 4 = (really mad). In an administration of the CIA-20 to a sample of 123 children from O'ahu public schools, in grades 4, 5, 6, ranging from ages 8 to 13 years old, a coefficient alpha of .91 was yielded, and item total correlations ranged from .45 to .69. Investigations regarding the validity of the original CIA have established significant correlations with the CDI in both normal and clinical populations, as well as with peer nominations of anger. However, the CIA was not found to discriminate between psychiatrically disturbed populations and normal populations nor did it differentiate between children exhibiting disruptive behavior difficulties and normal populations, thus, the validity of the measure remains questionable. In explanation of such findings, researchers have suggested that the internal experience of anger cannot be externally validated (Finch, Saylor, & Nelson, 1987, Nelson, Hart, & Finch, 1993).

Dimensional Ratings of Clinical Severity (DRs). Dimensional Ratings of Clinical Severity are designed to correspond to the level of distress and
disruption of functioning resulting from a given symptom cluster. DRs were adapted from interference ratings initially developed for use with the ADIS-IV (Silverman & Nelles, 1988; Silverman & Albano, 1996). Dimensional ratings represent an attempt to extend upon the earlier work of Silverman and Nelles (1988) and Silverman and Albano (1996) by quantifying the presence and severity of a symptom constellation that need not meet diagnostic criteria. Dimensional ratings are scored on a nine-point rating scale from 0 to 8. The assessing clinician employs ratings of ‘0’ to indicate the absence of any symptoms associated with a given syndrome, ‘2’ to suggest the presence of few or slight features of a syndrome, ‘4’ to indicate the presence of several or definite symptomatic features, ‘6’ to reflect the presence of many or marked symptomatic features, or ‘8’ to indicate the presence of very many or severe features of the disorder. Dimensional ratings are assigned by the assessing clinician for the child’s interview, the parent’s interview, and the composite interview separately. Only the DRs from the composite interview were examined in the present study. Dimensional Ratings were found to demonstrate good to excellent interrater reliability for both child and parent ratings (ranging from \( r = 0.63 \) for the Oppositional dimension to \( r = 1.0 \) for the Agoraphobia dimension; Gray, Francis, & Chorpita, 2001). Preliminary support for the convergent validity of the DRs was also indicated, such that significant correlations were observed between the DRs and corresponding child- and parent-report measures (Gray et al., 2001), including the Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Yim et al., 2001),
the Revised Children’s Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978), the Children’s Depression Inventory (CDI; Kovacs, 1980/1981), and the Child Behavior Checklist (CBCL; Achenbach, 1991). Raters are trained in the assignment of DRs during the course of their training in the administration of the ADIS-IV. Trainees are initially provided with an underlying rationale for assigning DRs, and instructed in the use of the nine-point rating scale. Subsequent to each interview that the trainee observes and then conducts while being observed, DRs are completed based on the child interview, parent interview, and from all available reporters’ perspectives for each of the thirteen symptom dimensions assessed by the ADIS-IV. The degree of correspondence between the trainee and trainer’s ratings is then examined, and discrepancies are addressed by the trainer who reviews with the trainee the appropriate means by which to arrive at specific ratings. The Separation Anxiety, Social Anxiety, Generalizing Anxiety, Depression/Dysthymia, Obsessions/Compulsions, Specific Phobia, and Posttraumatic Stress scales were summed to create an internalizing score. The Delinquent and Oppositional scales were summed to create an externalizing score. Therefore, scores on the Dimensional Ratings Summed Internalizing Score could range from 0 to 52, while scores on the Summed Externalizing scores could range from 0 to 16. Although the Dimensional Rating Sheet includes four other scales, Panic, Agoraphobia, Inattentive, and Hyperactive, these four scales were not included in the internalizing and externalizing scores. Panic and Agoraphobia were excluded from the Internalizing Score as
no participants were judged to display any difficulties related to panic or agoraphobia. Thus, both scales exhibited no range. In addition, the Inattentive and Hyperactive Scales were not included in the Externalizing Score reflecting the Childhood Behavioral Checklist’s selection of only Delinquent and Aggressive Behaviors in representing externalizing expressions.

Family Relationship Index (FRI). The FRI (Holohan & Moos, 1983) is a 27-item measure which can be filled out by each parent and child member of the family to assess the quality of social relationships in the family. The FRI (1983) consists of three of the original FES scales (1976), conflict, cohesion, and expressiveness. Each of these subscales consists of nine true-false items. The FRI has demonstrated high internal consistency and good construct validity (Holohan & Moos, 1983).

Revised Child Anxiety and Depression Scale (RCADS). The RCADS (Chorpita, Yim, Moffit, Umemoto, & Francis, 2000) is a 47-item adaptation of the Spence Children’s Anxiety Scale (SCAS; Spence, 1998) designed to correspond more closely to DSM-IV anxiety disorders while also incorporating a subscale for major depression. On this instrument, children are asked to rate the extent to which each item is true of them by indicating their responses on a 0 to 3 scale, corresponding to anchors of “never”, “sometimes”, “often”, and “always”. The RCADS consists of six subscales: Panic Disorder, Obsessions/Compulsions, Social Phobia, Separation Anxiety, Generalized Anxiety, and Major Depression. The RCADS has demonstrated good factorial validity, internal consistency, one-week test-retest reliability,
and good convergent and discriminant validity (Chorpita et al., 2000),
suggesting that it is a reliable and valid measure of internal distress.

**Procedures**

Informed consent was obtained from parents and children to participate in a semi-structured diagnostic interview, and for use of materials for subsequent research purposes. Subsequently, a mental health evaluation using the ADIS-IV-P and-C was then conducted by trained graduate students. In addition, the RCADS, the CIA-20, and the FRI were administered to the children as part of a standard battery of assessment measures. Furthermore, the FRI and the Child Behavioral Checklist were administered to the parents as part of a standard battery of assessment measures. A family FRI score was computed using a summed raw score from the parent and child FRI for each of the three specific dimensions of relationships as well as the global score. Dimensional ratings were filled out by the assessing clinician based on the summation of all reports. Summed internalizing (i.e., Social Anxiety, Specific Fear/Phobia, Generalized Anxiety, Obsessions-Compulsions, Separation Anxiety, Posttraumatic Stress, Depression/Dysthymic) and externalizing (i.e., Oppositional, and Delinquent) dimensional ratings scores were then created.
Results

Analysis of Measures

Missing data

A small number of participants failed to fully complete all question items on the FRI, RCADS, CIA-20, and CBCL measures. Specifically, 0.005% of all parent FRI data, 0.02% of all children FRI data, 0.004% of all RCADS data, 0.002% of all the CIA-20 data, 0.009% of the CBCL-I, and 0.008% of all CBCL-E data were missing. No significant differences were observed between those with complete data and those without. Data on a single measure for nine participants were excluded from analyses when using the CIA-20, due to a non-random pattern of missing data (e.g., participants did not complete the second page of measure). Participant mean substitution was used for all other missing data, which involved replacing missing values with the average score among all completed questions for that particular participant. Therefore, statistics involving the CIA-20 are reported using 42 subjects, whereas all other statistics are reported using 51 subjects.

Assumptions

Descriptive statistics of all measures were examined (see Table 4). Subsequently, data were reviewed for assumptions of normality. Fifteen of twenty measures exhibited positively skewed patterns. Three of these measures displayed significantly positively skewed patterns ($p < .05$), which violated the assumption of normality (i.e., ADIS Internalizing Symptom Count, Childhood Behavioral Checklist Externalizing Score, and the ADIS
Externalizing Symptom Count; see Table 5). These variables were transformed using the square root function (Tabachnick & Fidell, 2001). Following the transformations normality was improved (see Table 5). Statistical analyses are reported using the transformed variables. Kurtosis was also examined among all variables. Nine of twenty measures exhibited positive kurtosis patterns. No kurtosis values were significantly different from zero either prior or subsequent to transformations.

*Internal consistency of indicator*

Cronbach’s alpha coefficients were calculated for all continuous measures used in the present study (see Table 6). The internal consistency of the ADIS Internalizing symptom count was not able to be computed as it consisted of 904 items, exceeding the computational limits of available statistical software. Therefore, split-half and odd-even internal consistencies were conducted on the 904 items. Most symptom measures demonstrated adequate inter-item reliability (see Table 6).

Two exceptions were noted with the Internalizing and Externalizing Dimensional Ratings measures demonstrating only moderate internal consistency. This appears appropriate as these scores reflect the summation of distinct dimension of psychopathology (e.g., posttraumatic stress disorder, specific phobia). Correlations among the other internalizing and externalizing measures were examined to determine validity of measures (see Table 7). Both Dimensional Ratings scales were found to be associated in the expected direction with internalizing or externalizing measures. However, the
Dimensional Ratings Externalizing Score was not found to relate to the CIA-20, which was thought to be an indicator of externalizing expressions from the child's perspective. The CIA-20 was not found to relate to any externalizing measure within the current study. Thus, it is possible that the CIA-20, and not the Dimensional Ratings Externalizing scale, may prove to be a poor indicator of externalizing expressions.

Regarding the family relationship measures, all four measures (i.e., global, conflict, cohesion, and expressiveness) exhibited poor internal consistency in all but two measures. Initially, the alpha coefficients were examined for the combined parent-child report. Upon indications of poor internal consistency, parents' and children's reports were examined separately to determine the internal consistency among each reporter (see Table 6). Results indicated that only the Conflict and Cohesion Scales by the parents' reports demonstrated good internal consistency; however, all three family relationship measures by the child's report exhibited poor internal consistency.

Further examination was conducted to examine the relation of children's age to the internal consistency of the FRI. Although the FRI (1983) has been used in the past with children ages seven to seventeen years old, interviewers occasionally observed instances when the wording of the FRI was challenging for younger children. Internal consistency was compared separately within the adolescent and child populations. Internal consistency for adolescents fell within the low range. Internal consistency for children
ranged from poor to worse than chance (see Table 6). Therefore, poor internal consistency was observed in both the child and adolescent populations.

As the global relationship scale is the composite of the three specific dimension scales, it is appropriate that the items of three distinct scales would not demonstrate good internal consistency. Support was found for the measure when examining the correlations among the three distinct relationship measures. Results indicated that the Cohesion and Conflict scales were negatively and significantly correlated as expected (see Table 7). Associations among Expressiveness, Conflict and Cohesion were in the expected direction; however, these associations were not significant. Consequently, due to the poor internal consistency of the Expressiveness scale as well as weak correlations with its related measures, it appears that reviewing associations with the Expressiveness scale either by itself or within the Global Relationship Score is a poor strategy to detect associations among hypothesized family dimensions and psychopathology. Therefore, with the indications of adequate validity for the Global scale, as well as the methodology used with past research summing only the cohesion and conflict categories (Halloran, Ross, & Carey, 2001), the current study examined the Global Relationship score as the composite score of Cohesion and Conflict scales from the parental report. Based on the entirety of these findings, it appears that it is appropriate to examine only the parental report of Cohesion
and Conflict, as well their global composite indicator in relation to the symptomatology measures of child psychopathology.

Correlational Analyses Using Parental Reports on the FRI

Global relationships

Correlational analyses were conducted to examine the associations between the global relationship from the parent’s perspective and internalizing and externalizing symptomatology. After indications that the expressiveness scale exhibited poor internal consistency across reporters, it was excluded from the global family relationship score. Although no specific predictions were made regarding the association between the parent’s report on the FRI and symptomatology, it is assumed that the hypotheses made regarding the summed FRI report and symptomatology would hold for individual reporters. Specifically, it was expected that better global relationships would be associated with lower rates of internalizing and externalizing disorders. Parent’s report indicated that better global relationships were significantly associated with less symptomatology on the CBCL-Internalizing scale. In addition, patterns indicated that all other measures except the RCADS and CIA-20 were associated with the parental report of the Global relationships in the expected direction.

Specific relationship dimensions

Similarly, to examine the unique associations between parental report of conflict and cohesion and childhood psychopathology, correlational analyses were conducted.
Conflict. It was predicted that high levels of conflict would be associated with higher levels of internalizing and externalizing symptomatology. The expected direction of association was observed in seven of eight analyses, although no significant correlations were observed (see Table 7).

Cohesion. It was expected that high levels of cohesion would be associated with lower levels of internalizing and externalizing symptomatology. Again, no significant relationships were observed, however, correlations for seven of the eight correlation variables were in the expected directions (see Table 7).

Discussion

Overall, findings indicated that the psychopathology measures performed well within the current sample. The FRI however, functioned poorly within the child portion of the population. Specifically, findings indicated that all four relationship measures reported from the child’s perspective, as well as the parent’s report of expressiveness were internally inconsistent. Therefore, the Conflict and Cohesion scales as well as their global composite indicator from the parent’s perspective were the only relationship scales reviewed within the current study. Although no initial hypotheses were made regarding individual reporters, it was assumed that associations would be similar in directionality. Initially, it was hypothesized that the global composite score (i.e., high levels of cohesion and expressiveness and low levels of conflict) of family relationships would be
negatively correlated with both externalizing and internalizing measures of psychopathology, however the expressiveness score was excluded upon indications of poor internal consistency. Consequently, this association was examined using the composite score of the Conflict and Cohesion scales of the FRI. One significant association was observed, with poorer global relationships negatively correlating with parental report of child internalizing symptomatology. Furthermore, patterns suggested that poorer global relationships were associated with higher levels of symptomatology among the majority of symptom measures. These findings are consistent with past research, indicating that poor relationships among family members are associated with higher levels of clinical dysfunction for children.

With regard to the specific components of family relationships, it was hypothesized that the distinct component of conflict would be positively associated with both internalizing and externalizing conditions of psychopathology, whereas the distinct component of cohesion would be negatively associated with both internalizing and externalizing conditions of psychopathology. No significant associations were observed, however, patterns indicated that lower levels of conflict and higher levels of cohesion were associated with less internalizing and externalizing symptomatology. Two exceptions were noted to this overall pattern. Specifically, higher levels of cohesion were linked to higher levels of internalizing symptomatology as indicated by the RCADS (2000) or child report of internalizing psychopathology. Furthermore, higher levels of conflict were associated with
lower levels of externalizing psychopathology as indicated by the CIA-20 or child report of externalizing symptomatology. Such discrepancies may relate to differing perspectives among reporters (e.g., child's indication of symptomatology and parent perception of family relationships). Regardless, the overall patterns are congruent with past research. Moreover, this study provides preliminary findings establishing associations of higher levels of conflict and lower levels of cohesion to externalizing symptomatology, using self-report measures of familial relationships.

Although these associations were in the expected directions, the scarcity of significant findings may be due to the premature examination of results. This study lacks the power needed to examine the full effects. Thus, those internalizing or externalizing measures that did not significantly relate to family relationship constructs may possibly be found significant with the full number of participants, as better estimates of population parameters are obtained.

Overall, current findings and patterns are in line with past literature. However, poor internal consistency of relationships measures within a child sample is inconsistent with past findings. Specifically, the Expressiveness scale across reporters, and the Cohesion and Conflict scales among the child population exhibited poor internal consistency. It may be that these scales were poorly constructed, and in regards to expressiveness this appears likely as it did not perform well in both the parent and child samples. However, further elucidation is warranted regarding the poor internal consistency of the
Conflict and Cohesion scale, as these scales were internally consistent among the parent population.

An important consideration regarding this matter may relate to the characteristics of the current sample. First, both the ethnic origin and family composition of the current population differs from previous samples used when examining these associations. Specifically, previous investigations have mostly examined familial relationships among families with European descent. While a few studies have reviewed familial relationships among non-Caucasians, these populations have mostly included African Americans as well as Latin Americans. Only one study to date has examined familial relationships in an ethnically comparable population, with Chinese Adolescents from Hong-Kong (Lau & Kwok, 2000). However, it may be assumed that this population is culturally distinctive.

Secondly, the diverse make-up of families included in the study may account for differences in the internal consistencies of measures. In the present study, approximately one-fifth of the sample consisted families in which the participating caregivers were not the child’s biological parent. The current sample includes biological children and parents, adopted children and parents, children and their grandparents, and children and their foster parents. Therefore, the current examination of familial relationships included a diverse sample in which in some cases the reporting caregiver and child had not lived together the entirety of the child’s life. Previous examinations have had limited use of this measure within such a population. It may be that some
confusion may have occurred for the child as to the specific familial situation about which they were reporting, thus limiting the internal consistency of the measure.

Lastly, the more salient explanation of poor internal consistency may relate to initial purpose of this study. The current investigation sought to examine the association of family relationships and child psychopathology as well as the utility of the Family Relationship Index among a sample of children experiencing clinical difficulties. The majority of previous studies examined these associations among normal populations. Thus, preliminary findings may suggest that the FRI is not an adequate measure of family relationships within a clinical population of children, from the child’s perspective. It may be that children experiencing clinical difficulties have harder times attending to questionnaires or may over-report difficulties, such that use of the FRI proves unreliable. Thus, it appears that continued investigation is needed to determine the most clinically useful child measure of family relationships. Finally, when examining family relationships, regardless of the specific method; current findings suggest that it is important to review the perspective and reliability among each reporter.

Implications and Conclusions

An important focus in future research efforts may be the utility of familial self-report measures among clinical child populations. Self-report measures were employed as they were deemed practical and timely tools to examine relationships among family members. Findings in the current study
indicate that while the FRI is practical and timely, it may not be clinically useful as the children’s report was unreliable in a clinical sample of children. Future research must determine if the results obtained from this study were anomalous or if familial relationship self-report measures are inappropriate when examining children experiencing clinical difficulties. Future research could also focus on the effects related to the inclusion of a diverse composition of families, as well as the validity of the FRI among younger populations. As a whole, this investigation along with past research in this area will supply knowledge regarding the influence of familial relationships on childhood psychopathology to researchers and clinicians.

While it remains unclear if the child’s report on the FRI is clinically useful, with respect to the parental report, it appears that applied use of this information could aid clinicians in early detection and preventative treatment. It appears that with future research the FRI Conflict and Cohesion scales, as well as the global composite measure (comprised of the Conflict and Cohesion scales) from the parental perspective, may become a practical tool for clinicians to quickly capture perceptions of family relationships, determine areas of concern, and provide relevant treatment targets for families.

In conclusion, the purpose of this study was to determine the associations between familial relationships and child psychopathology. It appears that familial relationships, globally as well as specifically defined, relate to various forms of psychopathology. Considering that this study
encountered limitations such as limited power, poor internal consistency of
certain measures, diverse populations, and the inclusion of young children
results should be interpreted with caution. However, the continuation of the
present study will address some of the current limitations as well as provide
further knowledge for this line of research within the clinical realm.
Table 1

*Summary Statistics for Sample*

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<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
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### Table 2

**Descriptive Statistics for Sample**

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<tr>
<td>Parent’s age</td>
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<td>88</td>
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</table>

*Note. CBCL = Childhood Behavioral Checklist*
Table 3

*Duration of Time Lived with Caregiver in Years among Non-biological Caregiver Families*

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Number of participants</th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
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</thead>
<tbody>
<tr>
<td>Adoptive</td>
<td>2</td>
<td>3.9</td>
<td>.5</td>
<td>15</td>
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<tr>
<td>Foster</td>
<td>5</td>
<td>9.5</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Grandparent</td>
<td>3</td>
<td>7.16</td>
<td>.5</td>
<td>14</td>
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</tbody>
</table>
### Table 4

**Descriptive Statistics of All Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global relationship score</td>
<td>16.00</td>
<td>44.00</td>
<td>32.76</td>
<td>7.40</td>
</tr>
<tr>
<td>Conflict</td>
<td>1.00</td>
<td>16.00</td>
<td>7.10</td>
<td>4.03</td>
</tr>
<tr>
<td>Cohesion</td>
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<td>18.00</td>
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<tr>
<td>Expressiveness</td>
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<td>15.00</td>
<td>9.47</td>
<td>2.11</td>
</tr>
<tr>
<td>RCADS</td>
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<td>34.09</td>
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<tr>
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<tr>
<td>DR-I</td>
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<tr>
<td>CIA-20</td>
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<td>80.00</td>
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<tr>
<td>CBCL-E</td>
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</tr>
<tr>
<td>DR-E</td>
<td>0.00</td>
<td>12.00</td>
<td>4.29</td>
<td>3.61</td>
</tr>
</tbody>
</table>

*Note. RCADS = Revised Child Anxiety and Depression Scale Total Raw Score, CBCL-I = Childhood Behavioral Checklist Internalizing Raw Score, ADIS-I = Anxiety Disorders Interview Schedule Internalizing Symptom Count, DR-I=*
Dimensional Ratings Internalizing Raw Sum, CIA-20 = Child Inventory of Anger-20 item version Raw Score, CBCL-E = Childhood Behavioral Checklist Externalizing Raw Score, ADIS-E = Anxiety Disorders Interview Schedule Externalizing Symptom Count, DR-E = Dimensional Ratings Externalizing Raw Sum
Table 5

*Descriptive Statistics of Distributions for Original Variables and Their Square Root*

<table>
<thead>
<tr>
<th>Transformations</th>
<th>Variable</th>
<th>Skewness</th>
<th>Z score</th>
<th>Kurtosis</th>
<th>Z score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Original</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Global measure</td>
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<td>-2.48</td>
<td>.0</td>
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<tr>
<td>Conflict</td>
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<tr>
<td>Cohesion</td>
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<td>-.60</td>
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<tr>
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<td>1.50</td>
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<td>1.02</td>
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<tr>
<td>CBCL-I</td>
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<tr>
<td>ADIS-I</td>
<td>.96</td>
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<td>DR-I</td>
<td>.28</td>
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<td>CIA-20</td>
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<td>2.77*</td>
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<td>ADIS E</td>
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<td>2.86*</td>
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<td>DR-E</td>
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</table>

*Note.* RCADS = Revised Child Anxiety and Depression Scale Total Raw Score, CBCL-I = Childhood Behavioral Checklist Internalizing Raw Score, ADIS-I= Anxiety Disorders Interview Schedule Internalizing Symptom Count, DR-I= Dimensional Ratings
Internalizing Raw Sum, CIA-20 = Child Inventory of Anger-20 item version Raw Score, CBCL-E = Childhood Behavioral Checklist Externalizing Raw Score, ADIS-E = Anxiety Disorders Interview Schedule Externalizing Symptom Count, DR-E= Dimensional Ratings Externalizing Raw Sum.

p < .05.*
Table 6

Internal Consistency (Cronbach's Alpha) of All Indicators

<table>
<thead>
<tr>
<th>Relationship measures</th>
<th>Youth report Ages 12 &lt;</th>
<th>Youth report Ages &gt;13</th>
<th>Youth report full sample</th>
<th>Parent report</th>
<th>Parent and child report combined</th>
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</thead>
<tbody>
<tr>
<td>Global measure</td>
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<td>Conflict</td>
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<tr>
<td>Cohesion</td>
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<td>Expressiveness</td>
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Symptom measures

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<tr>
<th></th>
<th>Youth report Ages 12 &lt;</th>
<th>Youth report Ages &gt;13</th>
<th>Youth report full sample</th>
<th>Parent report</th>
<th>Parent and child report combined</th>
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</thead>
<tbody>
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<td>.96*</td>
<td>.95*</td>
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Child measures

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<th>Youth report Ages 12 &lt;</th>
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<th>Parent report</th>
<th>Parent and child report combined</th>
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</table>

Parent measures

**Note.** RCADS = Revised Child Anxiety and Depression Scale Total Raw Score, CBCL-I = Childhood Behavioral Checklist Internalizing Raw Score, ADIS-I = Anxiety Disorders Interview Schedule Internalizing Symptom Count, DR-I = Dimensional Ratings Internalizing Raw Sum, CIA-20 = Child Inventory of Anger-20 item version Raw Score, CBCL-E = Childhood Behavioral Checklist Externalizing Raw Score, ADIS-E = Anxiety Disorders Interview Schedule Externalizing Symptom Count, DR-E = Dimensional Ratings Externalizing Raw Sum.

* Panic scale was not included in Symptom count

**Coefficient reflects split-half and odd-even internal consistency analyses. All coefficients were .91
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<th>FRI Cohesion</th>
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<th>ADIS-I</th>
<th>DR-I</th>
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<th>CBCL-E</th>
<th>ADIS-E</th>
<th>DR-E</th>
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<tbody>
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<td>Global measure</td>
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<tr>
<td>FRI Conflict</td>
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<td>.54**</td>
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<tr>
<td>DR-I</td>
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<td>.09</td>
<td>-.16</td>
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<td>.58**</td>
<td>.71**</td>
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<tr>
<td>CIA-20</td>
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<td>-.04</td>
<td>-.07</td>
<td>.31*</td>
<td>.20</td>
<td>.32*</td>
<td>.15</td>
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<tr>
<td>CBCL-E</td>
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<td>.19</td>
<td>-.14</td>
<td>-.12</td>
<td>.33*</td>
<td>.02</td>
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<td>-.00</td>
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<td>-.11</td>
<td>.07</td>
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<td>DR-E</td>
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<td>.15</td>
<td>-.17</td>
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<td>-.16</td>
<td>.05</td>
<td>.62**</td>
<td>.70**</td>
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</tbody>
</table>
Note. RCADS = Revised Child Anxiety and Depression Scale Total Raw Score, CBCL-I = Childhood Behavioral Checklist Internalizing Raw Score, ADIS-I = Anxiety Disorders Interview Schedule Internalizing Symptom Count, DR-I = Dimensional Ratings Internalizing Raw Sum, CIA-20 = Child Inventory of Anger-20 item version Raw Score, CBCL-E = Childhood Behavioral Checklist Externalizing Raw Score, ADIS-E = Anxiety Disorders Interview Schedule Externalizing Symptom Count, DR-E = Dimensional Ratings Externalizing Raw Sum.

p < .05.*

p < .01.**
Listed below are some things that sometimes make people angry or mad. Please read each statement carefully and try to imagine that it’s actually happening to you. Then decide how angry or mad you would get.

Please put a circle around the word or words that shows how angry you would get in each of these settings. There are no right or wrong answers. Remember, please circle the answer that is most true of you.

1. At lunch, you choose a dessert and the kid behind you knocks it out of your hand. Don’t care A little upset Kinda mad Really mad

2. The teacher marks “X’s” all over your homework. Don’t care A little upset Kinda mad Really mad

3. You want to go to sleep, but your brother or sister keeps making noise. Don’t care A little upset Kinda mad Really mad

4. You tell the truth about something but your parents don’t believe you. Don’t care A little upset Kinda mad Really mad

5. Someone tries to trip you on purpose. Don’t care A little upset Kinda mad Really mad

6. Someone in your classroom acts up, so the whole class has to stay after school. Don’t care A little upset Kinda mad Really mad

7. Being told you are not old enough to do something. Don’t care A little upset Kinda mad Really mad

8. You want to go somewhere with a friend, but your mom says no without any reason. Don’t care A little upset Kinda mad Really mad

9. Your mom makes you do chores that were supposed to be your brother’s or sister’s chores. Don’t care A little upset Kinda mad Really mad

10. You have to go to bed at 9:30 even in the summertime and your friends get to stay up until 10:30 or 11:00. Don’t care A little upset Kinda mad Really mad

11. Your mom yells at you, gives you a scolding, and embarrasses you in front of other people. Don’t care A little upset Kinda mad Really mad
<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Don't care</th>
<th>A little upset</th>
<th>Kinda mad</th>
<th>Really mad</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Your sister breaks your favorite toy after you have asked her not to play with it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>People won't be quiet when you are trying to watch your favorite T.V. show.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>You are watching T.V. and someone changes it to another station.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>You are trying to do your work in school and someone bumps your desk on purpose and you mess up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Your friend is playing a game but won't let you play too.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Someone in your class tells the teacher on you for doing something.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Being blamed for something that was not your fault.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Your mom and dad promise you something and you don't get it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>You do something special for a friend and later they won't do something for you.</td>
<td></td>
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<td></td>
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</tbody>
</table>
Here are 36 statements about families. You are to decide which of these statements are true of your family and which are false. If you think the statement is True or mostly True of your family, circle the T (True) to the left of the statement. If you think the statement is False or mostly False of your family, circle the F (False) to the left of the statement.

You may feel that some of the statements are true for some family members and false for others. Circle T if the statement is True for most members. Circle F if the statement is False for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly. Please circle either T or F for each statement.

Remember, we would like to know what your family seems like to you. So do not try to figure out how other members see your family, but do give us your general impression of your family for each statement.

T F 1 Family members really help and support one another.
T F 2 Family members often keep their feelings to themselves.
T F 3 We fight a lot in our family.
T F 4 Family members are rarely ordered around.
T F 5 We often seem to be killing time at home.
T F 6 We say anything we want to around home.
T F 7 Family members rarely become openly angry.
T F 8 There are very few rules to follow in our family.
T F 9 We put a lot of energy into what we do at home.
T F 10 It's hard to "blow off steam" at home without upsetting somebody.
T F 11 Family members sometimes get so angry they throw things.
T F 12 There is one family member who makes most of the decisions.
T F 13 There is a feeling of togetherness in our family.
T F 14 We tell each other about our personal problems.

T F 15 Family members hardly ever lose their tempers.

T F 16 There are set ways of doing things at home.

T F 17 We rarely volunteer when something has to be done at home.

If we feel like doing something on the spur of the moment we often just
T F 18 pick up and go.

T F 19 Family members often criticize each other.

T F 20 There is a strong emphasis on following rules in our family.

T F 21 Family members really back each other up.

T F 22 Someone usually gets upset if you complain in our family.

T F 23 Family members sometimes hit each other.

T F 24 Everyone has an equal say in family decisions.

T F 25 There is very little group spirit in our family.

T F 26 Money and paying bills is openly talked about in our family.

If there is a disagreement in our family, we try hard to smooth things over
T F 27 and keep the peace.

T F 28 We can do whatever we want to in our family.

T F 29 We really get along well with each other.

T F 30 We are usually careful about what we say to each other.

T F 31 Family members often try to one-up or out-do each other.

T F 32 Rules are pretty inflexible in our household.

T F 33 There is plenty of time and attention for everyone in our family.

T F 34 There are a lot of spontaneous discussions in our family.

T F 35 In our family, we believe you don't ever get anywhere by raising your voice.
T  F  36 You can't get away with much in our family.
## REVISED CHILD ANXIETY AND DEPRESSION SCALE

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things. | Never | Sometimes | Often | Always
2. I feel sad or empty. | Never | Sometimes | Often | Always
3. When I have a problem, I get a funny feeling in my stomach. | Never | Sometimes | Often | Always
4. I worry when I think I have done poorly at something. | Never | Sometimes | Often | Always
5. I would feel afraid of being on my own at home. | Never | Sometimes | Often | Always
6. Nothing is much fun anymore. | Never | Sometimes | Often | Always
7. I feel scared when I have to take a test. | Never | Sometimes | Often | Always
8. I feel worried when I think someone is angry with me. | Never | Sometimes | Often | Always
9. I worry about being away from my parents. | Never | Sometimes | Often | Always
10. I get bothered by bad or silly thoughts or pictures in my mind. | Never | Sometimes | Often | Always
11. I have trouble sleeping. | Never | Sometimes | Often | Always
12. I worry that I will do badly at my school work. | Never | Sometimes | Often | Always
13. I worry that something awful will happen to someone in my family. | Never | Sometimes | Often | Always
14. I suddenly feel as if I can’t breathe when there is no reason for this. | Never | Sometimes | Often | Always
15. I have problems with my appetite. | Never | Sometimes | Often | Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)
   Never Sometimes Often Always

17. I feel scared if I have to sleep on my own.
   Never Sometimes Often Always

18. I have trouble going to school in the mornings because I feel nervous or afraid.
   Never Sometimes Often Always

19. I have no energy for things.
   Never Sometimes Often Always

20. I worry I might look foolish.
   Never Sometimes Often Always

21. I am tired a lot.
   Never Sometimes Often Always

22. I worry that bad things will happen to me.
   Never Sometimes Often Always

23. I can't seem to get bad or silly thoughts out of my head.
   Never Sometimes Often Always

24. When I have a problem, my heart beats really fast.
   Never Sometimes Often Always

25. I cannot think clearly.
   Never Sometimes Often Always

26. I suddenly start to tremble or shake when there is no reason for this.
   Never Sometimes Often Always

27. I worry that something bad will happen to me.
   Never Sometimes Often Always

28. When I have a problem, I feel shaky.
   Never Sometimes Often Always

29. I feel worthless.
   Never Sometimes Often Always

30. I worry about making mistakes.
   Never Sometimes Often Always

31. I have to think of special thoughts (like numbers or words) to stop bad things from happening.
   Never Sometimes Often Always

32. I worry what other people think of
   Never Sometimes Often Always
<table>
<thead>
<tr>
<th></th>
<th>Descriptor</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds).</td>
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<tr>
<td>34</td>
<td>All of a sudden, I feel really sacred for no reason at all.</td>
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<tr>
<td>35</td>
<td>I worry about what is going to happen.</td>
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<tr>
<td>36</td>
<td>I suddenly become dizzy or faint when there is no reason for this.</td>
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<tr>
<td>37</td>
<td>I think about death.</td>
<td></td>
<td></td>
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<tr>
<td>38</td>
<td>I feel afraid if I have to talk in front of my class.</td>
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<tr>
<td>39</td>
<td>My heart suddenly starts to beat too quickly for no reason.</td>
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<tr>
<td>40</td>
<td>I feel like I don't want to move.</td>
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<tr>
<td>41</td>
<td>I worry that I will suddenly get a scared feeling when there is nothing to be afraid of.</td>
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<tr>
<td>42</td>
<td>I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).</td>
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<tr>
<td>43</td>
<td>I feel afraid that I will make a fool of myself in front of people.</td>
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<tr>
<td>44</td>
<td>I have to do some things in just the right way to stop bad things from happening.</td>
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<tr>
<td>45</td>
<td>I worry when I go to bed at night.</td>
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<tr>
<td>46</td>
<td>I would feel scared if I had to stay away from home overnight.</td>
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<tr>
<td>Statement</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
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<tr>
<td>I feel restless</td>
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</tbody>
</table>
References

Burlington: University of Vermont, Department of Psychiatry.


