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The Family Check-Up: Ecological Family-Based Assessments in the Context of Potential Child Abuse or Chaotic Home Environments

Robyn E. Metcalfe[1], **Claire L. Guidinger**[1], **Elizabeth A. Stormshak**[1]

[1]Counseling Psychology, University of Oregon

Abstract

One percent of all children in the United States are estimated to be abused or neglected each year, equating to about 700,000 children per year. Limited parenting skills are one of the most robust risk factors for child abuse and neglect. The present paper describes the Family Check-Up (FCU), a trauma-informed, strengths-based and comprehensive family management intervention aimed at promoting positive parenting skills, reducing child maladaptive behaviors, and optimizing child and family outcomes. By evaluating various ecological and contextual factors, the FCU targets a range of parenting and child behavior difficulties to prevent child abuse/neglect, while improving long-term child and family outcomes.

Keywords

family therapy; parenting intervention; family management; child maltreatment; child abuse

Clinical Vignette

Alyssa, a single mother living in a rural setting, arrives requesting help with her two daughters (ages 5 and 8). Both children reportedly experience nightmares, anxiety attacks, frequent temper tantrums, and significant difficulties regulating their emotions. These symptoms have impaired their ability to sleep, complete their schoolwork, and complete age-appropriate household tasks. Alyssa also reports physical violence between the two children that has resulted in the need for hospital-level care. Both daughters also demonstrate behavioral difficulties at school. Alyssa reports visiting a wide range of previous providers, including play therapists, psychiatrists, occupational therapists, and neurologists. Alyssa reports that she has “tried everything” and “nothing works on these kids.” Although Alyssa reports striving to use non-physical disciplinary strategies, she

Robyn Metcalfe, M.S., is a Counseling Psychology doctoral student at the University of Oregon and a therapist at the Child and Family Center, utilizing the Family Check-Up and other evidence-based interventions with Oregonian families. Her research interests include parenting behaviors and the prevention of child maltreatment.

Claire Guidinger, M.A., M.S., is a doctoral candidate in the Counseling Psychology program at the University of Oregon and a therapist at the Child and Family Center who also uses the Family Check-Up in clinical practice. Her research interests include eating behaviors and health promotion in underrepresented groups and children.

Elizabeth Stormshak, Ph.D., is a licensed psychologist and a Professor in Counseling Psychology and Human Services at the University of Oregon. Her research interests include family-centered interventions and the prevention of problem behavior in children and adolescents.

has used tactics like spanking and slapping, which she states are the only strategies that work. She reveals that her family has an active Child Protective Services (CPS) case after substantiated abuse by Alyssa's ex-husband, who has moved out at CPS insistence leading to financial insecurity. CPS reports continuing concerns. Alyssa denies current abuse and neglect in the home, and she claims that CPS is "out to get" the family. What are the most effective, trauma-informed ways to evaluate both child safety and Alyssa's current parenting skills? How can you best connect Alyssa to services that she believes may be constructive? What strategies might help Alyssa believe in her ability to improve her family management skills?

Clinical Challenge

Incidence and Prevalence of Child Abuse and Neglect

The United Stated Department of Health and Human Services (HHS; 2020) estimates that one percent of all children in the United States are abused or neglected each year, equating to about 700,000 children per year. The estimated number of referrals alleging abuse and neglect in 2018 totaled 4.3 million, involving 7.8 million children (HHS, 2020). A little over half of the referrals result in an active case file being opened. The number of active child protective services cases has been relatively stable for the last five years, with approximately 3.5 million children receiving care. The vast majority of victims (around 85%) suffer a single type of maltreatment, with 61% being neglect only. An estimated 1,770 children died of abuse and neglect in 2018, for a rate of 2.39 per 100,000 children in the national population (HHS, 2020).

Retrospective studies of young adults indicate that various forms of child maltreatment are relatively common throughout childhood, with supervision neglect being the most common form of maltreatment and reported by over 40% of participants (Hussey et al., 2006). Parenting skills deficits are central risk factors for child maltreatment (Stith et al., 2009). Children in their first year of life have the highest rate of victimization at 26.7 per 1,000 children of the same age in the national population (HHS, 2020).

Parenting Skills Deficits in Families Experiencing Child Abuse and Neglect

Extant data indicate that limited parenting skills are a robust risk factor for child abuse and neglect (Barth, 2009; Fortson et al., 2016). Contextual and individual challenges often render parents less emotionally responsive, physically available, and financially capable of consistently implementing appropriate parenting strategies (Crooks & Wolfe, 2007; Tyler et al., 2006). Thus, parents with abuse histories are often characterized by harsh parenting, lack of knowledge about non-violent discipline strategies, and lack of positive behavior support (Knerr et al., 2013). Lack of parenting skills may lead to increased parenting stress and decreased maternal mental health, both of which are strongly associated with both child maltreatment and poor child outcomes (Chen & Chan, 2015).

As poor parental responses exacerbate child misbehavior, families can become stuck in a coercive cycle. These coercive cycles are common in families who experience maltreatment (Lunkenheimer et al., 2016). Some parents may also respond to child misbehavior with

inconsistent or indiscriminate parenting (Dumas et al., 1995). When these patterns are combined, parents may respond inconsistently to their child's behavior, subsequently make a request, and then respond with rigid and harsh demands (Lunkenheimer et al., 2016). Better understanding and targeting how risk factors interact within individual and family-system levels is essential for enhancing positive parenting skills, reducing the potential for child abuse and neglect, and building a strong and safe family environment conducive for healthy child development.

Overview: The Family Check-Up

The Family Check-Up (FCU) is a brief, strengths-based and comprehensive family management intervention aimed at promoting positive parenting skills, reducing child behaviors, and optimizing child and family outcomes. The FCU identifies, at the individual and family level, barriers to positive and adaptive parenting strategies. In addition to enhancing parenting skills, the FCU applies family-centered prevention strategies to reduce later risk behaviors in both youth and families (Dishion & Stormshak, 2007). By evaluating various ecological and contextual factors, the FCU targets a range of parenting and child behavior difficulties to improve long-term child and family outcomes.

The traditional FCU model consists of three phases: (1) the initial intake interview, (2) ecological assessments in the home and school environments, and (3) the feedback session which applies principles of Motivational Interviewing (MI) to areas of strength and parenting goals (Dishion & Stormshak, 2007). Following the feedback session, families are provided with a "menu of options" detailing clinic services and suggestions for individual family members (i.e., individual therapy, parent skills training, family therapy). The three FCU components are generally completed over the course of two to four sessions, based on family needs and the context of service delivery. Typically, each session is completed in 50 minutes. The initial intake session and ecological assessments can also be completed in a joint, 75-90-minute session.

The FCU has demonstrated efficacy for a range of presenting concerns for children between the ages of 2 and 17, due to the flexibility of the intervention based on individual family circumstances. A summary of the impacts of the FCU on parenting behavior, younger children, and adolescents is shown in Table 1.

Clinically, the FCU has been used to target child abuse directly and it has been applied to a range of high-risk populations and parenting skill deficits (Dishion et al., 2003; Stormshak et al., 2020). The FCU has focused on targets for change linked to abuse, such as coercive parenting, limited positive parenting, and lack of monitoring/supervision. The ecological assessment involved with the FCU both directly and indirectly address a wide range of common maltreatment behaviors. For example, in a study of high-risk families with toddlers demonstrating clinically significant behavior problems, FCU video feedback procedures were associated with reduced parent–child coercive interactions at age 5 (Smith et al., 2013). Similarly, family conflict is a significant mediator in intervention models and a target of the FCU intervention that predicts reduced risk of mental health problems, including depression and problem behavior (Van Ryzin et al., 2012; Fosco et al., 2016).

The FCU Assessment Process

All clinical interventions must begin with a procedure to understand the family and their reasons for referral, assessment of the family and family members, and building a relationship with the family that motivates family members to engage in a process of change. The first step in the FCU is an initial intake session (session #1). But, unlike many clinical services, this is followed by continuing assessment in the home and, when relevant, in the school (session #2). The FCU ends with a feedback session, which is focused on motivating the family to seek various additional services and interventions to support their growth and development (session #3). After these three initial sessions, families may continue with the therapist in a variety of additional services to match their specific needs, such as parenting skills training and family therapy.

Step 1: Initial Intake Interview

The first step in the FCU model is the intake. A typical intake occurs within a 60-minute window. The intake provides the therapist and parent with the opportunity to discuss presenting concerns, build rapport, and establish treatment goals. After obtaining informed consent and assent, the therapist asks questions in order to assess the client's presenting concerns (i.e., "tell me what brings you here)." Similar to other psychotherapeutic interventions, throughout the intake session, clinicians use interpersonally-focused strategies, such as empathetic listening skills and demonstration of care and warmth in order to build rapport and to establish a strong, therapeutic relationship. For example, the therapist assesses the client's interpersonal style and patterns, while creating a safe, trusting, and collaborative working relationship through their use of a defined therapeutic frame, empathetic care, and open presence. In addition to structured interviewing and interpersonal techniques that are common to traditional intake procedures for psychotherapy services, FCU therapists assess client readiness for change and feedback (e.g. using Prochaska and DiClemente's [1984] Transtheoretical Model), as well as to inform feedback aimed to promote client change.

Parents operating in the context of potential child maltreatment may demonstrate additional clinical challenges in rapport-building. Clients may have had a number of invalidating experiences with institutions or may have previously sought help only to find that it has been ineffective. Ensuring that client feels heard may be particularly important to building rapport in this context. Indeed, parents seeking voluntary psychotherapeutic services show great strength by taking action in a situation that may feel extremely vulnerable. Parents may also vary in the extent to which they are ready to take responsibility for child problem behaviors. Therapists who are attuned to this may be able to present opportunities for change in a way that is less threatening. For example, the possibility of parent skill training can be highlighted in the context of the parent's need for additional support in an extremely chaotic environment, or by focusing on the child's need to practice specific skills when the therapist believes that both parents and children may benefit from this. Importantly, this presentation of information should be authentic and genuine rather than a way to subvert a parent's will or agency.

Parent intake—The overarching goal of the first interview with the parent(s) is to conduct a social-emotional assessment of each family member in order to better understand the family's presenting concerns. This includes assessing their affect, emotions, feelings about family, others and self. The parent intake also provides the opportunity to assess parental relational style (i.e., standoffish, shy, outgoing, warm), which provides valuable information regarding their parenting style and how they interact with others. The parent intake also allows the clinician and the caregivers to discuss potential areas for growth and treatment goals and gather information to help with case conceptualization. For example, presenting concerns can be conceptualized using an "antecedent, behavior, consequence" or "ABC" model of behavior. Under this model, behavior is viewed as a function of both the antecedents that come prior to the behavior and the consequences that come afterwards (Dyer, 2013). By gathering this information, a clinician can gain a more thorough understanding of a problem behavior.

Some sample parent intake questions include:

1. Can you tell me a little bit about each family member? Do you all live together?
2. Tell me what brings you here, can you identify 2-3 major concerns?
3. Please tell us about your child's developmental and medical history. What was your child like as a baby? Did they have any medical problems? Did they meet developmental milestones?
4. How does your child get along with siblings and friends?
5. Does your child have any school problems? What are their academic strengths and weaknesses?
6. Tell me about your family strengths. How do you cope when things get difficult?
7. What happens when the problem behavior begins? What happens before the behavior, and how do you respond? How does your response impact your child?

Child intake—Child intake interviews are conducted with school-age children and adolescents, separate from the parents. The child intake interview also entails a qualitative assessment of the child's social-emotional functioning. Rather than conducting a verbal interview, the child and therapist engage in structured, age-appropriate play to build rapport. Typically, the therapist selects a variety of age-appropriate games for the child to choose from, and the child selects their preferred activity. The specific activities used are chosen at the therapist's discretion. Throughout the intake session, the therapist uses praise and positive behavior support to set the foundation for shaping adaptive behaviors and creating a safe environment.

Through simple, open-ended questions and structured activities, the therapist explores various social emotional themes, such as: Can the child label emotions? How does the child process their emotions, and what are their predominant feelings? Can the child identify the presenting concern? Overall, the child intake provides a summary of the child's physical, social, behavioral, intellectual, play (if age-appropriate), and communication skills. Sample items from the child assessment are provided below:

1. Tell me about your favorite games, foods, and things to do? How about your least favorite?
2. Draw a picture of your family doing something together. Can you tell me about each family member?
3. If you had a magic wand that could give you three wishes, what three things would you want different at your house?
4. What do you like most about school ? What do you like least? What would you like to be different?
5. Tell me about your friends. What do you like to do with them?
6. Draw a picture of a sad face. What does it feel like when you are sad? What do you do when you are sad?

Following the child intake, the therapist summarizes their observations of the child's interpersonal skills, communication skills, attention, affect, ability to follow instructions, emotional regulation, and impulse control using a qualitative assessment form. This helps to provide a framework for behaviors and skills to target during subsequent treatment sessions. This information provides an important context to interpret the parent-report data.

Child intakes pose a number of potential therapeutic challenges. For example, children may be disinterested in receiving therapy, which may result in defiant behaviors in session. Clinicians should present their services in a way that is developmentally appropriate and ensure that they get child assent. If a child understands and declines services in a setting where treatment is not mandated, clinicians should consider working directly with parents and not including children in sessions, given research that suggests child sessions are less effective at reducing behavioral and mental health problems than parent sessions. Setting expectations, giving clear directions, offering behavior-specific praise, and providing incentives that are motivating to the specific child may be powerful methods of helping children succeed during the FCU process.

Assessment Measures—To assess domains of functioning in the family and child, a packet of questionnaires is provided to the family. Typically, the family takes these materials home in a printed packet, so that they can complete the forms at their own convenience. However, if scheduling and clinic resources allow, clients can complete the packets on a clinic computer or iPad and directly enter their responses into Qualtrics or a similar data collection software. For families with target children under the age of 11, parents complete all assessment measures. For families with target children aged 11 or older, both parents and adolescents complete their own questionnaires. These ages can be adjusted as needed based on the developmental stage of the child. A typical battery of assessments, including constructs and sample items, is available in Table 2. This list can be adjusted based on common clinic presenting concerns.

Norms and scoring information for each assessment are listed in the citations in Table 2. To request scoring information for all of the assessments listed, interested clinicians can contact the Child and Family Center at 1600 Millrace Dr., Suite 106, Eugene, OR 97403-1995.

Although parents are typically compliant and motivated to fill out these forms, some parents may struggle to complete them if they are in a chaotic environment. Depending on a client's ecological context and presentation, therapists of parents who do not complete these measures as agreed upon may choose to provide reminder texts to the parent, to re-schedule the feedback session to accommodate the parent's need for extra time, or to complete the written assessments in session as an interview.

Step 2: Ecological Assessment

When assessing clients, it is imperative to consider their ecological contexts. A developmental-ecological model guides our prevention approach to clinical assessment and intervention. Data are collected based on therapist observation, providing information on both strengths and areas of growth across a variety of settings and developmental domains (e.g., home and school, emotional vs. behavioral). The FCU ecological assessment primarily consists of a home-visit assessment. However, when relevant for the presenting concerns, a school-based assessment may also be conducted.

Home Visit Assessment—During the home-visit assessment, three to five semi-structured tasks are administered to the target child and their parent(s) and video recorded. Consent for the videotaping done in advance of this session, typically as part of the intake. Ideally, this session occurs as a home visit, providing important context and clinically relevant information about the home environment. We encourage clinicians to attend these home visits with a partner for added support and safety in unfamiliar environments. However, when circumstances do not allow for a home visit, these tasks can also be completed in the clinic. For example, a parent who has experienced a number of visits by Child Protective Services or the police may feel concerned about a home visit. Although home visits can provide important clinical information, choosing to conduct the assessment in the clinic may build trust with the family and minimize coercion, providing substantially greater clinical benefit. Importantly, this process may also vary based on typical clinic procedures and resources.

This session requires a video recording device, a timer, and a script of specific activity prompts. For younger children, a bag of age-appropriate toys that can be used in place of the pre-planned tasks. Recorded tasks include activities such as participating in collaborative and preferred activities (i.e., puzzle building and cleaning up).

Tasks should be developmentally appropriate for the child. Parents should be encouraged to behave in a way that is consistent with their typical interactions with their children. For example, a younger child and their parent(s) might complete the following five behavioral tasks:

1. Child Directed Play (5 minutes), in which the parent follows the lead of the child and plays along with games and activities of the child's choice.
2. Clean Up Task (3 minutes), in which the child cleans up the toys and puts them in the basket and parents are instructed not to physically help the child put anything away.

3. Teaching Tasks (3 minutes each), in which the parent leads the child through two tasks: completing a puzzle and building a block tower.
4. Family Drawing (5 minutes), in which the parent(s) and the child participate in making a drawing of the family using provided art supplies.

Older children need other, more complex tasks. For example, a teenager and their parent(s) might complete a different set of five behavioral tasks:

1. School Goals (5 minutes), in which families are tasked with discussing both child and parent goals for the adolescent related to school, as well as evaluating how this is going.
2. Monitoring (5 minutes), in which adolescents are asked to describe a time in the last month where they spent at least an hour with their friends without an adult around, and parents are asked to listen and gather information.
3. Limit Setting (5 minutes), in which parents are asked to describe a time they felt a need to set a limit in the last month and children are asked to comment, gather information, or discuss ways to avoid the problem in the future.
4. Problem Solving (5 minutes), in which families are asked to identify a problem in their family and come up with at least one solution.
5. Planning a Family Activity (5 minutes), in which families are asked to plan a fun, realistic family activity in as much detail as possible.

This task list includes the core FCU tasks for two age groups. School-aged children may use a combination of these specific tasks. Alternative tasks should be interactive activities or conversations that are developmentally appropriate and address aspects of effective parenting behaviors such as making effective requests, giving praise, addressing problem behaviors, monitoring and limit-setting, effective communication skills, and/or proactive parenting.

The clinician should set up the camera, read the script, and leave the room, to avoid influencing the family's interactions. After the time period for each task has been completed, the clinician can return, read the next script, and exit the room again. After all activities have been completed, therapists may choose to collect the family assessment forms at this time (provided at the intake session), thank the family for their participation, and leave the family home.

Before the feedback session, the clinician watches the observation tasks and codes the interactions. Various coding systems have been developed to help evaluate family interactions. For example, the Family Interaction Tasks (FIT) Coding Manual and the Relationship Process Code Coding Manual are both appropriate protocols for coding and scoring (Jabson et al., 2004). Our clinic uses the former manual and rates each interaction task on the following three dimensions: (1) relationship quality, (2) positive behavior support, and (3) monitoring and limit setting. Scoring information is available in Table 3. These 3 areas are key parenting skills that can be targeted in both the feedback session and subsequent intervention.

For highest coding fidelity, two therapists should independently rate the video and interrater reliability should be confirmed and recorded. However, in more informal clinical practice, it may be acceptable to have two therapists code the video together or, when multiple therapists are not available, have a single therapist code the video. The therapist uses these data, integrated with intake and self-report information, to inform parents about their areas of strength, as well as targeted areas for growth and improvement.

The therapists can then manually review their assessment forms (provided at intake and collected at the ecological assessment) and check for any areas of risk or other serious concerns. These forms can then be scored to compare the parents to a normative sample that includes a subset of both typical and clinical families (Dishion & Stormshak, 2007). At this time, the therapist prepares a personalized Child and Family Feedback Form, with various concerns rated along a continuum from “area of strength” to “needs attention.” Often, parent ratings and therapist observations are moderately congruent. In these cases, data can simply be averaged and a mark can be placed on the appropriate location on the Child and Family Feedback Form continuum. However, if parent self-report data and therapist observations appear dramatically incongruent, a therapist may choose to present both and discuss the discrepancy. An example of a blank feedback form is available in Figure 1. This Child and Family Feedback Form will be discussed during the Feedback and Motivation session.

School Assessment—When a substantial part of a child’s problem behavior occurs in a school setting, conducting a school observation and gathering teacher-report data can be an important piece of information gathering. With appropriate releases of information signed and communication with school personnel, clinicians may choose to engage in a structured school observation session and/or gather teacher report data using a standardized questionnaire such as the Child Behavior Checklist Teacher Report Form (Achenbach & Rescorla, 2001) or the Teacher Report Strengths and Difficulties Questionnaire (Goodman, 1997). This information can be further used to inform feedback for parents, goal setting, and treatment recommendations.

For a school observation, we recommend contacting the child’s teacher in advance to choose an ideal time for observation. When possible, the therapist should observe the child in both structured and unstructured times, which can provide information about both peer interactions and academic behavior skills, such as attention. Therapists may also choose a time of day when the child is more likely to have disruptive behavior. For example, if a child often has temper tantrums following lunch and recess, a therapist may want to choose this time for a school observation. This can provide the therapist with clarification about the interaction between the problem behavior and the environment to more specifically target strategies for change.

Step 3: Feedback and Motivation Session

The feedback session provides parents with their comprehensive, ecological, and individually tailored feedback using motivational interviewing (MI). MI, as described by Miller and Rollnick (2013), is a conversational style used to help clients move in the direction of change, comprised of a relational component, involving empathy, collaboration

and an interpersonal “spirit,” as well as specific techniques, such as evocation and reinforcement of client change talk. Core skills, such as open-ended questions, affirmations, reflections, and summaries, are used to engage, focus, evoke, and plan, with the ultimate goal of increasing change talk, strengthening client commitment to change, and develop a specific plan for change that incorporates the client’s unique perspective and needs. The spirit of MI is a core component of FCU feedback sessions.

Feedback sessions begin by simply asking parents about their experience with the FCU process so far, which can help the therapist to assess current parent concerns and insight. After this, the therapist may explain the structure of the feedback session. For example, it may be helpful to present a blank Child and Family Feedback Form and explain the form first, before showing the family’s individualized data. Next, norm-based FCU data is utilized to highlight areas of strength and growth using the Child and Family Feedback form (see Table 2). The therapist should include several example video clips to highlight particular parenting strengths from the video observation tasks. This use of video clips from a strengths-based perspective is particularly valuable in introducing or reinforcing positive parenting behaviors, as well as setting appropriate and achievable goals based on a parent’s current skill level and growth edges. When parents have a history of a highly strained or contentious relationship with their child, therapists should take even greater care to choose clear examples of an appropriate parenting behavior. Small victories for parents who show greater struggles with parenting skills may include avoiding an inappropriate response that they regularly give to their children (e.g. ignoring a maladaptive child behavior instead of yelling at the child), providing a direct command, or making a positive comment to their child.

Together, the therapist and parent(s) synthesize the initial intake, ecological assessment data, parent self-report data, and video clip examples, to support families in developing treatment goals that are consistent with their values and needs. Importantly, these goals are established collaboratively and through considering client readiness using MI techniques. For example, although the therapist will come prepared with a completed Child and Family Feedback Form based on previously collected data, with marks that reflect a parent’s level of strength or risk, a parent may decide that they need additional coaching related to positive behavior support beyond what is reflected by the mark on the Child and Family Feedback form. In this case, a therapist could simply adjust the placement of the marker on the assessment form to better reflect the parent’s understanding of their family’s needs. For example, the norm-based data may suggest that a parent has moderate levels of social support. However, if the parent states that, in fact, they have almost no social support, adjusting the feedback form may help demonstrate the therapist’s receptivity to client concerns.

Towards the end of the comprehensive feedback and motivation session (approximately the last ten minutes), the family is provided with a “menu of options” detailing clinic services and suggestions for individual family members. These options include the format of treatment (i.e., individual therapy, parent skills training, family therapy), location of treatment if not available within the same clinic conducting the FCU, as well as the content (focus on positive parenting skills, increase monitoring skills after school). Items from the “menu of options” may vary depending on clinic focus, common presenting concerns,

specific clinic services, and available community resources. In most cases, therapists should reserve about ten minutes to discuss these treatment options.

Examples of potential “menu of options” items may include:

- Weekly family management support using evidence-based parenting skills program from the Everyday Parenting Program (Dishion et al., 2012)
- Individual child therapy using evidence-based curriculums for child presenting concerns in addition to parent support
- Monthly check-ins with a child and family therapist to monitor current progress and goals
- Referral to an assessment clinic for diagnostic testing (e.g., Autism, developmental delay).
- Parenting support groups
- Parent referrals to individual psychotherapy or other individual resources, such as Dialectical Behavior Therapy Skills Groups
- Specific parenting related books or reading materials
- Consultation with teachers, school psychologists, or other school-based resources
- A referral to community-based resources such as housing support, legal support, pregnancy support, and health or nutrition services.

For research or clinical training purposes, the Feedback session can also be coded for treatment fidelity using the COACH Fidelity rating manual (Dishion et al., 2010). This is important, as accurate implementation of family-centered interventions is linked to benefits for both parents and children (Forgatch et al., 2005; Ogden et al., 2005). The COACH rating form evaluates the extent to which a provider is:

Conceptually accurate and adherent to the intervention model

Observant and responsive to the family’s needs

Active in structuring the session

Careful when teaching and providing feedback

Helpful in building hope and motivation

This form can be used to support learning the FCU process, to provide supervisors with specific areas to offer feedback, and to ensure fidelity in trained clinicians. Additional information about COACH rating can be found in Smith and colleagues (2013).

Additional Maltreatment-Related Considerations for Psychotherapists

Children are widely considered a vulnerable population, deserving of additional protections such as mandated reporting for issues such as abuse and neglect (Kalichman, 1999).

Psychotherapists working with children and families should take appropriate steps to prepare for potential issues that may arise. Our recommendations are presented below:

1. Informed consent is an important component of all psychotherapeutic interventions. For ethical provision of services, all clients must be adequately informed about issues such as the limits of confidentiality (American Psychological Association, 2017). For families, living up to this ethical standard may require a more thorough and detailed discussion about how mandated reporting of child abuse and neglect looks at this setting. Barnett and colleagues (2007) recommend that therapists provide both written and oral information, while maintaining a dialogue to ensure that informed consent remains an active process.

   Consider: What constitutes abuse or neglect? Will families be informed if a mandated report is made?

2. Organizations providing psychotherapy should have clear guidelines for mandated reporting, in line with ethical and legal responsibilities, that dictates a therapist's responsibilities.

   Consider: Who makes the final decision about the need for mandated reporting? How is mandated reporting documented?

3. When multiple therapists are involved in a family's care, these therapists should have clear plans for communication in the event of suspected child abuse and neglect.

   Consider: What happens if the child reports an incident of maltreatment while the parent or parent therapist is occupied in a different space?

4. The ability to recommend and implement a course of treatment that is based in evidence is an issue of professional competence for psychologists and other psychotherapists (Blease et al., 2016). While this should always be a consideration for service providers, the stakes are particularly high for families at high risk for maltreatment.

   Consider: What is the evidence base for these treatment recommendations?

5. Therapists working with families who have a substantiated history of child abuse or neglect may want to consider obtaining a release of information for providers such as the family's Child Protective Services caseworker or a pediatrician who made a mandated report.

   Consider: What other sources of information may help this clinician evaluate risk factors?

Summary

While the FCU holds substantial potential for a range of clinical issues with children and families, the FCU poses a particularly powerful opportunity for the comprehensive assessment of high-risk families with abuse histories. By integrating a range of data

including parent self-report data, teacher report data, questionnaires compared to a norm-based sample, and coded behavioral assessments, the FCU provides a comprehensive and ecologically-focused method of family-centered assessment and connection to intervention.

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Key Takeaways for Clinical Practice

- Assess ecological factors
  - By evaluating the impact of contextual factors on family functioning, the FCU targets a range of factors impacting parenting and child behavior difficulties to improve long-term outcomes.
- Observe behavior directly
  - While self-report data can provide important information, a comprehensive family assessment should include direct observation of parent behavior and family functioning.
- Build rapport with families
  - Therapists should use interpersonal strategies to build rapport with families and improve family buy-in.
- Utilize Motivational Interviewing (MI) techniques
  - Therapists should use MI techniques to elicit behavioral change and to determine potential obstacles, such as resistance and ambivalence.
- Provide clients with strengths-based, comprehensive feedback
  - Family feedback should highlight family strengths, while also addressing areas for growth and goals for treatment.
- Provide clients with a “Menu of Options”
  - This helps clients to personalize their family treatment plan.

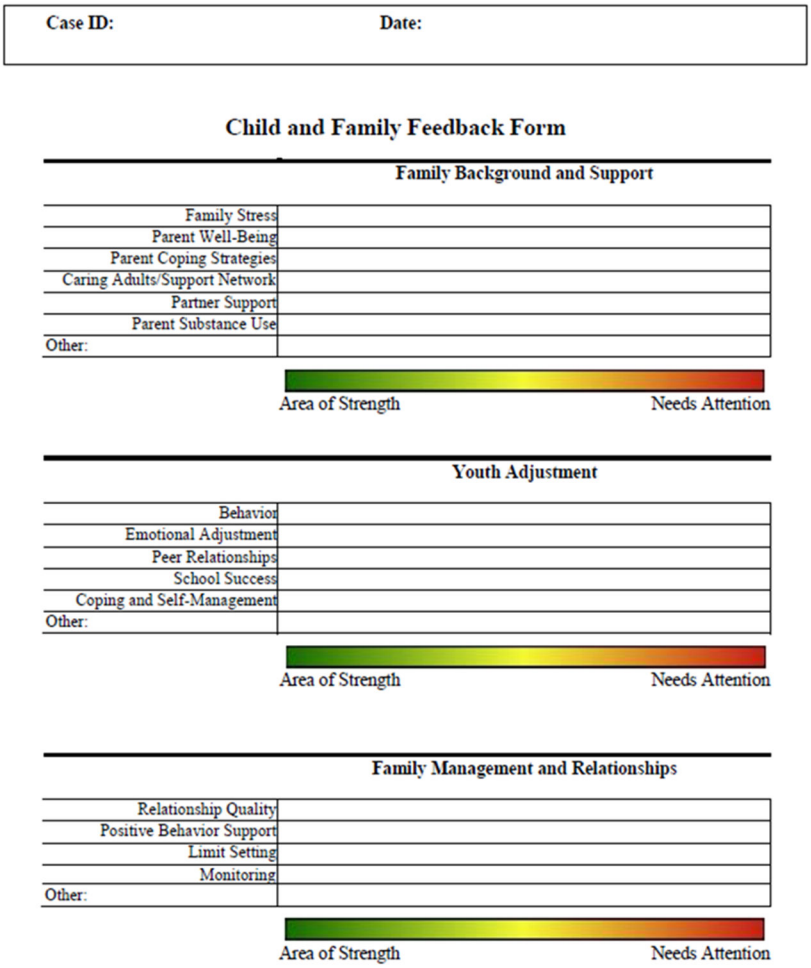

Figure 1. Example Blank Child and Family Feedback Form

Note. From Dishion & Stormshak (2007)

Table 1

FCU Impacts Across Age

Age Group	Effect on Presenting Concern	Prevalence of Presenting Concern
Adolescents	Reduces substance use (Dishion et al., 2003)	8% of 8th graders, 18% of 10th graders, and 29% of 12th grades used alcohol in the last 30 days. Rates are 6.6, 18.4, and 22.3% for marijuana (National Institute on Drug Abuse & University of Michigan, 2019)
	Reduces risk of arrest (Connell et al., 2007)	Affects 2% of adolescents annually (OJJDP, 2018)
	Indirectly associated with reduced high risk sexual behavior (Caruthers et al., 2014)	About 40% of sexually active adolescents did not use a condom in most recent sexual intercourse (Smith et al., 2020)
	Lowers rates of Major Depressive Disorder (Fosco et al., 2016)	20% of boys and almost 30% of girls show high rates of depressive symptoms (Twenge et al., 2018)
	Improves academic outcomes, such as child GPA and attendance (Stormshak et al., 2009)	Truancy rates exceed 10% of adolescents (Maynard et al., 2017)
Young children	Improves inhibitory control and language development (Lunkenheimer et al., 2008)	Delays found in 5-10% of preschoolers (Wang et al., 2018)
	Reduces risk of obesity (Smith et al., 2015)	10 to 20% of American children, depending on the age group surveyed (CDC, 2017)
	Reduces internalizing and externalizing behavior (Smith et al., 2013)	20% have internalizing profile and 20% externalizing across early school years (Willnert et al., 2017)
Parents	Increases positive behavior support (Dishion et al., 2009)	87% of the mothers reported using at least one form of harsh parenting for toddlers (Kim et al., 2011)
	Increases family-school engagement (Garbacz et al., 2019)	23% of parents did not attend any school general meetings (Barnett et al., 2020)
	Improves parenting skill for high stress families (Stormshak et al., 2020)	51% of mothers and 39% of fathers report doing a “very good job” parenting (Pew, 2015)

Table 2

Example written assessments by age

Client	Survey	Sample Item	Constructs
Early Childhood Measures (age 2-5). Completed by parent(s) only.	The Strengths and Difficulties Questionnaire (Goodman, 1997)	"Often loses temper"	Conduct problems, hyperactivity, emotional problems, peer problems, prosocial behavior
	Language Skills Single Item Measure	"How would you rate your child's language skills in comparison to other children of the same age?"	Language skills (Information only)
	The Children's Behavior Questionnaire (Rothbart, 2001)	"Can lower his/her voice when asked to do so."	Effortful control
	Positive Social Activities Single Item Questions	"Participate in sports or other organized activities?"	Positive social activities
	Minor Parenting Stresses (Crnic & Greenberg, 1990)	"You have trouble getting privacy (like in the bathroom)."	Parenting stress
	Adult Child Relationship Scale (Pianta & Nimetz, 1991)	"If upset, this child seeks comfort from me."	Parenting warmth, family conflict
	Parenting Young Children (PARYC; McEachern et al., 2012)	"Play with your child in ways that were fun for both of you?"	Quality time, incentives and encouragement, proactive parenting, limit setting
	Project Alliance 2 Parent Survey, select measures (Good Clinical Practice Network, 2006).	"You yelled or shouted at your child"	Negative parenting behaviors
Elementary Age Childhood Measures (age 6-10). Completed by parent(s) only.	The Strengths and Difficulties Questionnaire (Goodman, 1997)	"Often loses temper"	Conduct problems, hyperactivity, emotional problems, peer problems, prosocial behavior
	Peer Association and Social Acceptance (Dishion et al., 2014)	"How much time did you spend with people who took school seriously and completed their homework?"	Prosocial peer association, deviant peer association
	Project Alliance 2 Parent Survey, select measures (Good Clinical Practice Network, 2006).	"Like going to school?"	School success, coping, self-management, monitoring, family routines, negative parenting behavior
	The Children's Behavior Questionnaire (Rothbart, 2001)	"Can lower his/her voice when asked to do so."	Effortful control
	Child and Family Center Youth Questionnaire (CFCQC) Positive Activities Scale (Child and Family Center, 2001).	"Participate in sports or other organized activities (such as drama, music or scouts)?"	Positive social activities
	Minor Parenting Stresses (Crnic & Greenberg, 1990)	"You have trouble getting privacy (like in the bathroom)."	Parenting stress
	Adult Child Relationship Scale (Pianta & Nimetz, 1991)	"If upset, this child seeks comfort from me."	Parenting warmth, family conflict
	Community Action for Successful Youth Questionnaire (Metzler et al., 1998).	"One of us got so mad, we hit the other person."	Family conflict, incentives and encouragement
	Parenting Children and Adolescents (PARCA; Ringle et al., 2019).	"Do an enjoyable activity together?"	Quality time, incentives and encouragement, proactive parenting, limit setting
Adolescent Measures (age 11-17). Completed by both parent(s) and target child.	The Strengths and Difficulties Questionnaire (Goodman, 1997)	"I get very angry and often lose my temper."	Conduct problems, hyperactivity, emotional

Client	Survey	Sample Item	Constructs
			problems, peer problems, prosocial behavior
	Substance Use Single Item Measures (Frequency of alcohol, tobacco, marijuana, and other drugs)	"Use tobacco (smoke, chew, etc.)?"	Substance use
	Peer Association and Social Acceptance (Dishion et al., 2014).	"How much time did you spend with people who took school seriously and completed their homework?"	Prosocial peer association, deviant peer association
	Project Alliance 2 Parent Survey, select measures (Good Clinical Practice Network, 2006).	"Like going to school?"	School success, coping, self-management, monitoring, family routines
	Sleep Single Item Measures	"What time do you usually go to bed at night?"	Sleep
	Early Adolescent Temperament Questionnaire (Ellis & Rothbart, 2005)	"It is easy for me to really concentrate on homework problems."	Effortful control
	Child and Family Center Youth Questionnaire (CFCQC) Positive Activities Scale (Child and Family Center, 2001).	"Participate in sports or other organized activities (such as drama, music or scouts)?"	Positive social activities
	Community Action for Successful Youth Questionnaire (Metzler et al., 1998).	"One of us got so mad, we hit the other person."	Family conflict, incentives and encouragement
Family Measures (all ages). Completed by parent(s) only.	Family income	"What is your approximate monthly household income? Number of people this income supports?"	Poverty
	Project Alliance 2 Parent Survey, single item (Good Clinical Practice Network, 2006).	"How much money does your family have?"	Perceived financial stress
	Not being able to control hostile or aggressive feelings.	"You or someone in your household experienced violence or abuse"	Stressful life events
	Patient Health Questionnaire (Kroenke et al., 2003)	"Little interest or pleasure in doing things."	Depression
	Generalized Anxiety Disorder Scale-2	"Feeling nervous, anxious, or on edge."	Anxiety
	Project Alliance 2 Parent Survey, select measures (Good Clinical Practice Network, 2006).	"Not being able to control hostile or aggressive feelings."	Anger and aggression, coping, denial,
	Parent Self Check (Good Clinical Practice Network, 2006).	"Friend or coworker"	Parent social support
	Dyadic Adjustment Scale (Sabourin et al., 2005).	"In general, how often do you think that things between you and your partner are going well?"	Partner relationship
	Substance Use Single Item Measures (Frequency of alcohol, tobacco, marijuana, and other drugs)	"In general, how often do you have any drink containing alcohol?"	Parental substance use
Teacher Measures (all ages). Completed by teacher only (optional).	The Strengths and Difficulties Questionnaire (Goodman, 1997)	"Restless, overactive, cannot stay still for long"	Conduct problems, hyperactivity, emotional problems, peer problems, prosocial behavior.

Table 3

Family Interactions Coding Example (Early Childhood)

Item Rated	Description	Rating for Each FCU Task	Global Rating (Averaged Across All Tasks)
Caregiver Behavior			
Relationship Quality	Attends to child's needs and interests; Adjusts own behavior to meet child's needs; Uses developmentally appropriate language; Responsive to cues.	Scale 1-5 (each)	Scale 1-5
Positive Behavior Support	Prompts and praises positive behaviors; makes effective (clear, non-blaming) requests; anticipates issues and corrects in advance.	Scale 1-5 (each)	Scale 1-5
Monitoring and Limit-Setting	Mindful and attentive to child; tracks child behaviors; sets clear, reasonable limits and follows through; not overly harsh or critical.	Scale 1-5 (each)	Scale 1-5
Child Behavior			
Behavior	Engages in tasks; Responds to instructions; Cooperative.	Scale 1-5 (each)	Scale 1-5
Emotional Adjustment	Appropriate emotional responses to context; no evidence of dysregulation (e.g. flat affect, extreme laughing, temper tantrums).	Scale 1-5 (each)	Scale 1-5