Rapid Changes in American Family Life: Consequences for Child Health and Pediatric Practice

abstract

Pediatricians are in the unique position of being on the front line of care for children and having access to their families. This article presents both a rationale and the evidence base for identifying the family characteristics and processes that affect child health and suggests approaches that pediatricians can implement to improve the care of children, using data from 3 recent reports of the Institute of Medicine and National Research Council, as well as other recent family research. Evidence regarding the impact on child health of 3 family factors in particular (family composition and living arrangements, family routines, and parental depression) is highlighted, and implications for pediatric practice are described. *Pediatrics* 2013;132:552–559

AUTHORS: Barbara H. Fiese, PhD,[a] Holly G. Rhodes, PhD,[b] and William R. Beardslee, MD[c]

[a]Department of Human and Community Development, University of Illinois at Urbana-Champaign, Champaign, Illinois; [b]Rhodes for Early Learning, LLC, Leesburg, Virginia; and [c]Department of Psychiatry, Boston Children's Hospital, Harvard University, Boston, Massachusetts

KEY WORDS

child health status, prevention, depression, families, patient–doctor communication

ABBREVIATIONS

IOM—Institute of Medicine
NRC—National Research Council

Dr Fiese contributed to the conceptualization and drafting of the article; Dr Rhodes contributed to the conceptualization and drafting of the article; Dr Beardslee contributed to the conceptualization and drafting of the article; and all authors approved the final manuscript as submitted.

www.pediatrics.org/cgi/doi/10.1542/peds.2013-0349

doi:10.1542/peds.2013-0349

Accepted for publication Jun 18, 2013

Address correspondence to Holly G. Rhodes, PhD, Rhodes for Early Learning, LLC, 311 Locust Knoll Dr, NW, Leesburg, VA 20176. E-mail: hgrhodes@gmail.com

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: Preparation of this article was supported by NIH contract number N01-OD-2139 T0# 256. Funded by the National Institutes of Health (NIH).

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

Pediatricians have long recognized the centrality of families in rendering effective care for children. At the same time, families are changing dramatically in terms of their composition, challenges, and needs. Recent research both about ways to study and understand families and effective intervention strategies has direct relevance to pediatric practice. The purpose of this report is to present information from current research and recent reports on families from the Institute of Medicine (IOM) and National Research Council (NRC) and to offer suggestions for how to use these data in pediatric practice to improve care for children and their families.

The American Academy of Pediatrics issued a groundbreaking report of its taskforce in 2003 emphasizing that children's outcomes are strongly influenced by how well their families are doing and offering numerous ways that practicing pediatricians can support families.[1] That report also revealed rapid changes in family composition, demographics, and increasing cultural diversity. The rapidly changing nature of the family and new methodologies for understanding families also prompted the IOM and the NRC to conduct *The Science of Research on Families: A Workshop*. This workshop brought together researchers from various disciplines describing how a wide range of qualitative and quantitative methods can be integrated to understand the diverse structures and dynamic qualities of family environments. The report emphasized family contributions to understanding the social determinants of child health and developmental outcomes.[2]

In addition, the IOM and the NRC recently published 2 relevant consensus reports, one on the prevention of emotional, behavioral, and mental disorders in children, youth, and families,[3] and the other with a specific focus on both the challenges and opportunities for families with parents who are depressed.[4] The prevention report revealed strong evidence for parenting interventions, even across such diverse circumstances as parental bereavement, parental mental illness, divorce, and universal drug abuse prevention with families. The report on depression indicated that child health visits provide an opportunity "to identify individuals who are at a higher risk for depression, provide education and support, assess parental function, and link child development screening with maternal depression screening (p. 184)."[4]

In the following, we focus primarily on the implications of these recent reports and subsequent studies for pediatric practice. Pediatricians are in the unique position of being on the front line of care for children and having access to their families. We present both a rationale and the evidence base for identifying the family characteristics and processes that affect child health and suggest approaches that pediatricians can implement to improve the care of children, including moving toward more collaborative and family-centered care. We focus on 3 factors in particular ([1] family composition and living arrangements; [2] family routines; and [3] parental depression) because they have serious consequences for child health, are actionable in pediatric practice, and are currently being underutilized but if addressed, may have a profound positive effect on child health care.

UNDERSTANDING FAMILIES IN CONTEXT

An ecological model of development frames the way many researchers understand how children are affected by their environments.[5,6] According to this approach, children are most directly affected both positively and negatively by factors in their primary environment, the family, which are affected by the larger contexts of neighborhoods and society. For example, poverty affects parents and families in various ways that ultimately have an impact on children. The transactional regulation model[7] further refines this ecological model and demonstrates that any 1 single factor predicts only a small amount of variation in child outcomes.[7] The number of risk factors a child experiences (eg, low socioeconomic status, parental depression, low maternal education, poor nutrition) is far more powerful. Moreover, the converse of this can be demonstrated as well. Children who experience more "promotive" factors tend to have better developmental outcomes.[7] Within families, children experience these risks or supportive factors through interactions and behaviors that reflect individual parents', family, and cultural characteristics, beliefs, and values.

Considerable research has focused on understanding these proximal risks and promotive factors, particularly mother–child interaction and other parent characteristics; however, a growing body of recent research indicates that whole-family factors, such as family routines, stability, and chaos, deserve more attention. They contribute uniquely to understanding how well children function[8,9] and are amenable to intervention. In addition, the role of parental depression is receiving increased attention because of its profound impact on multiple domains of family functioning and child development.[4] Further, parental depression is common particularly in high risk situations such as families facing multiple risks, like poverty or bereavement.[4] The mental health functioning of a parent and the overall predictability and functioning of the whole family unit are important for helping to regulate children's health and development.

FAMILY FACTOR 1: FAMILY COMPOSITION AND LIVING ARRANGEMENTS

The nature and basic structure of the family in the United States is rapidly changing. As noted at the *Science of Research on Families* workshop, the 2-biological parent household still remains the most common family form with 60% of children living in such households[2]; however, today, 40% of births are to unmarried women, with half of those to unmarried couples living together.[10,11] In fact, up to half of children today will spend time in a household with a mother living with a romantic partner.[12] Cohabiting relationships include those where both biological parents live with the child, and those where 1 parent's romantic partner is present in the household as a "social parent." Census data indicate that 20% of children are born into single-mother families.[11,13] In addition, great variation exists within these various types of family structures[12] and change in family structure is common, particularly in homes with unmarried partners.[14] Recent data indicate that there are nearly 600 000 same-sex households, with ~20% of these with children.[15] Adding to the complexity are the increasing numbers of children regularly spending time in >1 household and the important parental, sibling, and other family relationships that can extend across households.[12]

Complex living arrangements have resulted in less stability for many children and adolescents. Children often experience disruptions in caregiving, increased conflict and turmoil, and alterations in economic resources when relational transitions occur. Several studies indicate that reduced stability is associated with poorer child health outcomes. Children born to cohabitating parents were less likely to experience excellent health 5 years later based on parent report than those born to married parents.[16] Further, if cohabitating parents married at some point during the 5-year period, their children were protected from the worst health status categories but did not receive the full advantage of excellent health. The authors speculate that cohabitating relationships produce more stressful parenting environments that in turn affect children's health. Children who experience unstable living arrangements in the first 5 years after birth are also at increased risk for receiving a diagnosis of asthma and to a lesser extent risk for developing obesity.[17] Similar patterns are found when considering adolescent health. Adolescents living in cohabitating households are more likely to smoke and drink alcohol in comparison with adolescents living in married or single-parent households.[18] Households with 1 biological parent and 1 social parent often have fewer shared resources of time and money, and a higher risk of child abuse and neglect.[19] However, positive father involvement even by a social father can be promotive to child development. Although more research is needed to explain these relationships, for pediatricians, knowledge of current living arrangements and of changes in these arrangements as the child is followed over time is essential. Identification of consistent caregivers to administer medications, monitor symptoms, and provide environmental supports can be compromised with constant shifts in the number of adults in the household.

FAMILY FACTOR 2: FAMILY ROUTINES

One way that families provide stability and predictability for children is through the creation of daily routines. Household routines such as mealtimes, bedtimes, and rules about television viewing have been found to be related to important child health outcomes including obesity and dietary practices[20–22] and substance use.[23] Planning ahead, setting aside a regular time for the routine, removing distractions, and communicating expectations in a clear and direct manner are common elements of successful routines.[8,24] For example, families that share 3 or more meals together during the week reduce the odds of their children being overweight by 12%, eating unhealthy foods by 20%, having an eating disorder by 35%, and increase the odds of their children eating healthy foods by 24%.[25]

Maintaining regular household routines may be particularly important for children with chronic health conditions such as asthma. Families with a child with asthma that practice more regular bedtime routines have children who are more likely to sleep through the night and have less severe asthma symptoms.[26] Family routines also predict asthma outcomes at the biological level, most likely through their promotion of increased medication use.[27,28] Households that include predictable and organized routines are more likely to fold medication routines into their daily life and thus have children who are more adherent and have reduced symptomatology.[28,29]

The ability to carry out and sustain household routines over time may be compromised by economic strain and poor mental health. Parents who are stressed, depressed, or experience symptoms of attention deficit disorder find it more difficult to maintain regular routines and positive parenting is compromised.[30–32] Families who experience considerable chaos in their daily life (high levels of noise, crowding, low levels of predictability, and lack of family routines) are more likely to experience parental depression and stress.[33] Environmental chaos and the lack of family routines have been found

to be associated with poor mental[31] and physical health[34] in adolescents. For practicing pediatricians, awareness of the relative predictability of household routines such as mealtime, bedtime, and "screentime" may provide important insight into how health behaviors are promoted or managed by families. However, these routines will likely be moderated by socioeconomic circumstances and parental mental health.

FAMILY FACTOR 3: PARENT PSYCHOPATHOLOGY: THE EXAMPLE OF DEPRESSION

Parental depression, as an important part of the family context,[35] was explored at the *Science of Research on Families* workshop and addressed in detail in the IOM/NRC consensus report.[4] Children of depressed parents by the end of adolescence are 2 to 4 times more likely to have experienced a major depression than their counterparts in homes without illness.[4] With depression affecting an estimated 7.5 million parents each year,[4] ultimately up to 15.6 million children each year are at risk for poor outcomes. Left untreated, depression interferes with parenting quality and affects family and work life more broadly in ways that indirectly affect children.[4] Depression among parents affects employment, human capital, household production, parenting, and social capital.[4]

Across the developmental span of childhood, a series of impairments have been described in studies that compare children of depressed parents to children of nonill parents. Early in life, these can be manifested as difficulties in regulation, establishing routines, and in growth and development; in the school years, difficulty concentrating, poorer school outcomes, and difficulties in peer relationships and in addition to the diagnosis of depression, there are higher rates of other diagnoses.[4] A number of medical difficulties are also present in children of depressed parents. At the same time, many children with depressed parents do well because of the presence of health promotive and protective factors.

Similarly, consistent with the transactional regulation model, there is clearly a bidirectionality of impact that is not only due to the effect of depressed parents on their offspring but the effect of offspring on their parents. In terms of mechanisms, 4 different classes of influence are important. First, within certain families, there is a clear biological predisposition to depression. Secondly, unrecognized and untreated depression often leads to impairments in parenting which in turn, over time, in and of themselves, can lead to difficulties for both parents and children. Thirdly, depressed individuals have more negative life events occur than those who are not depressed.[4] Thus, outcomes in youngsters can be influenced by the direct effect of negative life events. Fourthly, depression interferes with the capacity of parents to follow complex routines such as are involved in the care of asthma or to provide the necessary structure (meals, bedtimes, etc) that young children need.

Estimates indicate that 40% to 70% of adults with depression do not get treatment. To combat this problem, depression screenings are recommended annually when treatment is available[36]; however, more efforts specifically targeted toward parents may be needed because of the significant psychological and health implications for their children. Very good treatments for depression are available from both cognitive-behavioral and psychopharmacologic perspectives, so patients can have a choice. Moreover, these treatments have been shown to be effective both in mainstream and nonmainstream cultures and can be delivered in primary care practices as well as mental health clinics.[4,35]

IMPLICATIONS FOR PEDIATRIC PRACTICE

We recognize that although pediatricians increasingly are called upon to cover more and more in the limited amount of time they have with their patients, they are the linchpin to children's health and well-being. We have focused on 3 family factors that affect children's health: household composition and living arrangements, family routines, and parent depression. Although it is beyond the scope of practice to conduct a thorough assessment of each of these, pediatricians may be able to better serve their patients with guidance in these areas. We offer examples of how to use this information along a continuum of increasing attention on the family as the focus of care. These examples include the following: (1) gathering key information about families; (2) informing and improving regular developmental guidance and using family-centered health education; (3) conducting screening and referral for parental depression; (4) providing ongoing counseling and intervention; and (5) moving toward providing integrated family-centered care.

Gathering Key Information About families

The structure of families in the United States is changing dramatically. Blended families composed of various groupings of parents or grandparents are increasingly common as are varying kinds of sibling relationships. Households with same-sex couples with children are also becoming more common. Children may live in multiple households in a given day, week, or month. Pediatricians can benefit from

asking families how they define the family being cognizant of these changes in family composition and living circumstances. Including the important adults in a child's life in the conversation about health care and enforcing best practices increases opportunities for partnerships.

Determining where and with whom a child lives, and individuals' relationships to the child, is critical information to gather, particularly in forming plans for treatment and follow-up. Awareness of these possibilities can help pediatricians to ask pertinent questions to determine who is primarily responsible for a child's health, medication administration, symptom monitoring, and management of chronic/acute problems, transportation, or simply the carrying out of regular routines around eating and sleeping so important to good health.

We suggest that awareness of these demographic trends can assist pediatricians in modifying existing in-take forms with brief questions (Appendix). Better understanding household composition, family structure, and changes in caregiving or living arrangements can also provide pediatricians with insight into the protective supports and stresses on the family. Promising opportunities exist for using technology through smart telephone applications, computers, and tablets to ease the burden of providing and collecting this information (eg, CHADIS).[37] Applications are available to create genograms (visual representations of family structure) that include both medical and psychosocial information on multiple generations of family and household members. Continued research is crucially important to develop simple screening systems that can accurately identify who is in the family, who is responsible for care, and changes in family composition since last visit that can lead to improved quality of care.

Informing and Improving Regular Developmental Guidance and Using Family-Centered Health Education

Pediatricians are uniquely situated to provide developmental guidance in the creation and sustainability of routines for child health. Many pediatricians are familiar with the use of positive bedtime routines to address sleep disturbances in young children.[38] However, healthy eating and mealtime routines, physical activity routines, and routines associated with disease management for children with chronic health conditions are also opportunities for health promotion in pediatric practice. However, a one-size-fits-all approach is likely to fail. Effective guidance will rely on knowledge of family living circumstances and cultural beliefs about daily routines. Pediatricians can also help families sort through conflicting advice about child health that can arise with complex living arrangements, step-parenting relationships, and/or involvement with multiple social agencies. Further, pediatricians can capitalize on surveillance of parent–child interactions during clinic visits to reinforce positive parenting practices.[39]

Universal educational approaches to promote more regular routines are available through online resources such as the American Academy of Pediatrics' patient/family education Web site (healthychildren.org). Age-paced newsletters and Web sites such as Just in Time Parenting (www.extension.org/parenting) provide information about establishing routines based on the child's age.[40] Public service announcements with supporting parenting materials have been developed to assist families in creating more regular family mealtimes and to address the barriers to sustaining pleasant mealtimes such as sibling conflict and picky eating (http://family-resiliency.illinois.edu/MealtimeMinutes.htm).

Intervention programs such as *The Incredible Years*[40] include routines as part of their behavioral strategies. Interventions aimed at promoting healthy eating and physical activity adapted to cultural traditions surrounding mealtimes have been developed.[41] Tailored interventions to promote medical adherence routines have also been proposed.[29] Central to all of these approaches is having parents identify current routines, barriers to maintaining routines, and strategies to incorporate new routines through small and manageable steps.

Pediatricians have a unique opportunity to educate families about warning signs of parental depression, to increase positive parenting, and develop healthy habits early in a child's life. Incorporating these educational practices into routine care should be rewarded to reduce expensive emergency care and more costly attention to chronic conditions. Greater emphasis on prevention and reimbursement for developmental guidance on healthy practices is warranted. For parents who are acutely depressed, referral for treatment along with guidance is important. For those who are not acutely ill or already receiving adequate treatment, education, and support can be valuable.

Family education can be 1 useful approach for helping families when parents are depressed. Beardslee et al[42] developed family-based public health interventions and compared a clinician-based intervention that leads to a family conversation with simple public health lectures much like the information a pediatrician could provide. Both interventions showed merit after a 4.5-year interval with more changes in the more intensive

intervention. This work has been adapted for single parent African-American and Latino families[43] and used in Head Start[44] and in Holland, Finland, Norway, Sweden, and Costa Rica.[45,46] These studies indicate that substantial positive effects on parents and children can result from educational family-centered preventive interventions.

In clinical terms, recognition of parental depression and either treatment in primary care or appropriate referral is indicated. Clearly, reimbursement systems need to reflect payment to pediatricians for screening adults for depression and referring just as they should for children. In Massachusetts, for example, there is reimbursement for mental health screening for children by private insurance. Furthermore, inquiry about how the children are doing and what concerns parents may have when parental depression is indicated is in order. Often, simple guidance and reassurance is enough, but referrals should be considered in situations in which children appear to be experiencing significant difficulties. Given both the high prevalence of depression in adults and its episodic nature, ongoing follow-up of both how parents and children are doing is also indicated. Although we have presented these recommendations for depression, many of them would apply also in related parental difficulties such as posttraumatic stress disorder or anxiety disorders.

Conducting Screening and Referral for Parental Depression

Screening for parental depression is useful when readily available referral resources have been identified.[4] Effective screening tools are available to identify adults with depression and screening in pediatric practices. For example, the Patient Health Questionnaire-2[47] consists of the following 2 questions, "(1) During the past month, have you often been bothered by feeling down, depressed, or hopeless? And (2) during the past month, have you been bothered by little interest or pleasure in doing things?" With a positive screen, a 9-item diagnostic measure (Patient Health Questionnaire-9) can be administered. A trusting, safe relationship between the parent and the pediatrician can form the basis of the supportive setting needed for discussing possible depression and acting on recommendations for follow up.[4] Importantly, a variety of safe and effective treatments exist for depression, both pharmacologic and talking therapy. The *Patient Protection and Affordable Care Act* may make treatment of parents more readily available.[48]

Providing Ongoing Counseling and Intervention

It has been our experience that there is a tremendous value in seeing parents as parents first and the depression as secondary. A wide array of prevention strategies exists across the life span with strong evidence to support their use. Direct practical implications for pediatricians dealing with parents facing adversity include first recognizing the adversity and the difficulties the parent is experiencing.

Trying to address or treat the parent's difficulty is an essential part, be it alcoholism, anxiety, or depression. Perhaps equally important is hearing the parent's concerns. Clearly, if the parent is worried about difficulties in a child, evaluation is in order and also, education either about the parent's illness or, in the case of a child, the child's illness, and provision of follow-up. Screening for depression in primary care practice can also be more effective if clinicians also asked parents if they want help with their problem.[49] Ideally, screening, treatment, and prevention efforts should target both parents and children together in a 2-generation approach.[4,35]

Addressing the parenting skills of depressed parents can lead to improved child health and development. For example, Compas et al[50] developed an intervention for families with parental depression that focused on parenting skills and coping. At 24-month follow-up, both skills had improved and the youngsters had fewer cases of depression than those who did not receive the intervention.

Moving Toward Integrated Family-Centered Care

Ultimately, finding ways to have integrated family-centered care will be absolutely essential. Finding a way to care for families and to fund evidence-based preventions done by pediatricians are important issues for the future that were highlighted in all IOM/NRC reports. Support is needed for collaborative integrative health care with a focus on treatment of families, not individuals. In addition, payment for collaborative care for mental health issues for children is needed as is access to behavioral health consultation for pediatricians. Collocating behavioral health specialists with pediatricians is important to explore. One central issue in the care of families is that the health care reimbursement system and many other systems focus only on individuals, and health care coverage can differ among children in the same family. Increasingly, many of the issues pediatricians are required to address are social and behavioral. Working alongside behavioral health care specialists, pediatricians stand to better serve their patients in this rapidly changing environment. Pediatricians are also poised to connect families to community-based organizations such as the YMCA (http://ymca.net/) that promote healthy lifestyles

and faith-based organizations that offer sources of support.[51] Overall, increasing resources available to pediatricians and providing educational help in dealing with difficult family matters such as depression are indicated.

CONCLUSIONS

Undoubtedly, American family life is changing at a rapid pace. Although there may be a nostalgic desire to return to simpler more predictable times, there is little evidence to suggest that family instability, threats to household routines, or risks for depression will be ameliorated in the next decade. What is critically apparent is that unless health care providers are able to offer real solutions to the very real problems families face, children will continue to be placed at risk. There is hope, however. Recent advances in family research have identified some of the essential ingredients associated with family structure, organization, and parental depression that may reduce risks and promote healthy child outcomes. It is incumbent upon the next generation of researchers to translate these findings for practitioners so that they are accessible, transportable, and can be tailored for use by diverse and complex families. The future health of America's children depends on it.

APPENDIX: SAMPLE QUESTIONS FOR HOUSEHOLD STABILITY

1. How much of the time does your child spend living in your home?
2. Are there other homes where your child spends a significant amount of time?
3. In addition to you, who else cares for your child?
4. In addition to you, who else does your child spend significant amounts of time with?
5. Does your child have different living arrangements on the weekends?

ACKNOWLEDGMENTS

The authors wish to thank Kimber Bogard, Director of the Board on Children, Youth, and Families of the NRC and IOM for her oversight of the initial drafting of the article. We also thank Dr Ellen Perrin of Tufts University and Dr Frank Franklin of the University of Alabama at Birmingham for their thoughtful reviews and suggestions for the article.

REFERENCES

1. Schor EL; American Academy of Pediatrics Task Force on the Family. Family pediatrics: report of the Task Force on the Family. *Pediatrics*. 2003;111(6 pt 2):1541–1571
2. Institute of Medicine/National Research Council. *Toward an Integrated Science of Research on Families: Workshop Report*. Washington, DC: The National Academies Press; 2011
3. O'Connell M, Boat T, Warner K. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: National Academies Press; 2009
4. Institute of Medicine/National Research Council. *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*. Washington, DC: The National Academies Press; 2009
5. Bronfenbrenner U. *The Ecology of Human Development*. Cambridge, MA: Harvard University Press; 1979
6. Guralnick MJ. Why early intervention works: a systems perspective. *Infants Young Child*. 2011;24(1):6–28
7. Sameroff AJ, Fiese BH. Transactional regulation: the development ecology of early intervention. In: Shonkoff JP, Meisels SJ, eds. *Handbook of Early Childhood Intervention*, 2nd ed. New York, NY: Cambridge University Press; 2000:135–159
8. Fiese BH, Tomcho TJ, Douglas M, Josephs K, Poltrock S, Baker T. A review of 50 years of research on naturally occurring family routines and rituals: cause for celebration? *J Fam Psychol*. 2002;16(4):381–390
9. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012; 129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e232
10. Martin JA, Hamilton BE, Sutton PD, et al. Births: Final Data for 2006. In: Report NVS, ed. Vol. 57. Hyattsville, MD: National Center for Health Statistics; 2009
11. Brown SL. Marriage and child well-being: research and policy perspectives. *J Marriage Fam*. 2010;72(5):1059–1077
12. Raley RK. Cohabitation and other aspects of household structure and instability. In: The Science of Research on Families: A Workshop; July 13–14, 2010; Washington, DC
13. Kreider RM. *Living arrangements of children: 2004*. In: Reports CP, ed. Washington, DC: US Census Bureau; 2007:70–114
14. Harris KM. Capturing intergenerational aspects of change in family patterns. In: The Science of Research on Families: A Workshop; July 13–14, 2010; Washington, DC
15. Lofquist D. *Same-Sex Couple Households*. Washington, DC: US Census Bureau; 2011
16. Schmeer KK. The child health disadvantage of parental cohabitation. *J Marriage Fam*. 2011;73:181–193
17. Bzostek SH, Beck AN. Familial instability and young children's physical health. *Soc Sci Med*. 2011;73(2):282–292
18. Brown SL, Rinelli LN. Family structure, family processes, and adolescent smoking and drinking. *J Res Adolesc*. 2010;20(2): 259–273
19. Waldfogel J, Craigie T-A, Brooks-Gunn J. Fragile families and child wellbeing. *Future Child*. 2010;20(2):87–112
20. Anderson SE, Whitaker RC. Household routines and obesity in US preschool-aged children. *Pediatrics*. 2010;125(3):420–428
21. Andaya AA, Arredondo EM, Alcaraz JE, Lindsay SP, Elder JP. The association between family meals, TV viewing during

meals, and fruit, vegetables, soda, and chips intake among Latino children. *J Nutr Educ Behav*. 2011;43(5):308–315

22. Gable S, Chang Y, Krull JL. Television watching and frequency of family meals are predictive of overweight onset and persistence in a national sample of school-aged children. *J Am Diet Assoc*. 2007;107(1):53–61
23. Eisenberg ME, Neumark-Sztainer D, Fulkerson JA, Story M. Family meals and substance use: is there a long-term protective association? *J Adolesc Health*. 2008;43(2):151–156
24. Fiese BH. *Family Routines and Rituals*. New Haven, CT: Yale University Press; 2006
25. Hammons A, Fiese BH. Is frequency of shared family meals related to the nutritional health of children and adolescents? A meta-analysis. *Pediatrics*. 2011;127(6). Available at: www.pediatrics.org/cgi/content/full/127/6/e1565
26. Fiese BH, Winter MA, Sliwinski M, Anbar RD. Nighttime waking in children with asthma: an exploratory study of daily fluctuations in family climate. *J Fam Psychol*. 2007;21(1):95–103
27. Schreier HMC, Chen E. Longitudinal relationships between family routines and biological profiles among youth with asthma. *Health Psychol*. 2010;29(1):82–90
28. Fiese BH, Wamboldt FS, Anbar RD. Family asthma management routines: connections to medical adherence and quality of life. *J Pediatr*. 2005;146(2):171–176
29. Fiese BH, Wamboldt FS. Family routines, rituals, and asthma management: A proposal for family based strategies to increase treatment adherence. *Fam Syst Health*. 2001;18:405–418
30. Evans GW, Gonnella C, Marcynyszyn LA, Gentile L, Salpekar N. The role of chaos in poverty and children's socioemotional adjustment. *Psychol Sci*. 2005;16(7):560–565
31. Mokrova I, O'Brien M, Calkins S, Keane S. Parental ADHD symptomology and ineffective parenting: The connecting link of home chaos. *Parent Sci Pract*. 2010;10(2):119–135
32. Deater-Deckard K, Chen NW, Wang Z, Bell MA. Socioeconomic risk moderates the link between household chaos and maternal executive function. *J Fam Psychol*. 2012;26(3):391–399
33. Evans GW, Lepore SJ, Shejwal BR, Palsane MN. Chronic residential crowding and children's well-being: an ecological perspective. *Child Dev*. 1998;69(6):1514–1523
34. Evans GW, Kim P, Ting AH, Tesher HB, Shannis D. Cumulative risk, maternal responsiveness, and allostatic load among young adolescents. *Dev Psychol*. 2007;43(2):341–351
35. Beardslee W. Conducting research with families with mental health issues from a preventive and resilience-based perspective. In: The Science of Research on Families: A Workshop; July 13–14, 2010; Washington, DC
36. US Preventive Services Task Force. Screening for depression in adults, topic page. Available at: www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm. Accessed February 16, 2012
37. System CCHaDI. Family meal times build strong family bonds. Available at: www.extension.org/pages/22968/family-meal-times-build-strong-family-bonds. Accessed November 7, 2012
38. Moore M, Meltzer LJ, Mindell JA. Bedtime problems and night wakings in children. *Prim Care*. 2008;35(3):569–581, viii
39. Dworkin PH. Society for Developmental and Behavioral Pediatrics 2006 presidential address: Coming full circle: reflections at the interface of developmental-behavioral and general pediatrics. *J Dev Behav Pediatr*. 2007;28(2):167–172
40. Bauer NS, Webster-Stratton C. Prevention of behavioral disorders in primary care. *Curr Opin Pediatr*. 2006;18(6):654–660
41. Hammons AJ, Wiley AR, Fiese BH, Teran-Garcia M. Six-week Latino family prevention pilot program effectively promotes healthy behaviors and reduces obesogenic behaviors [published online ahead of print May 30, 2013]. *J Nutr Educ Behav*.
42. Beardslee WR, Wright EJ, Gladstone TR, Forbes P. Long-term effects from a randomized trial of two public health preventive interventions for parental depression. *J Fam Psychol*. 2007;21(4):703–713
43. D'Angelo EJ, Llerena-Quinn R, Shapiro R, et al. Adaptation of the preventive intervention program for depression for use with predominantly low-income Latino families. *Fam Process*. 2009;48(2):269–291
44. Beardslee WR, Ayoub C, Avery MW, Watts CL, O'Carroll KL. Family Connections: an approach for strengthening early care systems in facing depression and adversity. *Am J Orthopsychiatry*. 2010;80(4):482–495
45. Beardslee WR, Paez A, Herrera LD, et al. Adaptation of a preventive intervention approach to strengthen families facing adversities, especially depression. Costa Rica: initial systems approaches and a case example. *Int J Ment Health Promot*. 2011;13(2):5–13
46. Solantaus T, Toikka S, Alasuutari M, Beardslee WR, Paavonen J. Safety, feasibility and family experiences of preventive interventions for children and families with parental depression. *Int J Ment Health Promot*. 2009;11:15–24
47. Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med*. 1997;12(7):439–445
48. Howell E, Golden O, Beardslee W. Emerging Opportunities for Addressing Maternal Depression Under Medicaid. Washington, DC: Urban Institute; 2013
49. Arroll B, Goodyear-Smith F, Kerse N, Fishman T, Gunn J. Effect of the addition of a "help" question to two screening questions on specificity for diagnosis of depression in general practice: diagnostic validity study. *BMJ*. 2005;331(7521):884–888
50. Compas BE, Forehand R, Thigpen JC, et al. Family group cognitive-behavioral preventive intervention for families of depressed parents: 18- and 24-month outcomes. *J Consult Clin Psychol*. 2011;79(4):488–499
51. Taylor RJ, Ellison CG, Chatters LM, Levin JS, Lincoln KD. Mental health services in faith communities: the role of clergy in black churches. *Soc Work*. 2000;45(1):73–87