Family Pediatrics
Report of the Task Force on the Family

ABSTRACT/EXECUTIVE SUMMARY

Why a Task Force on the Family?

ABSTRACT. The practice of pediatrics is unique among medical specialties in many ways, among which is the nearly certain presence of a parent when health care services are provided for the patient. Regardless of whether parents or other family members are physically present, their influence is pervasive. Families are the most central and enduring influence in children's lives. Parents are also central in pediatric care. The health and well-being of children are inextricably linked to their parents' physical, emotional and social health, social circumstances, and child-rearing practices. The rising incidence of behavior problems among children attests to some families' inability to cope with the increasing stresses they are experiencing and their need for assistance. When a family's distress finds its voice in a child's symptoms, pediatricians are often parents' first source for help.

There is enormous diversity among families—diversity in the composition of families, in their ethnic and racial heritage, in their religious and spiritual orientation, in how they communicate, in the time they spend together, in their commitment to individual family members, in their connections to their community, in their experiences, and in their ability to adapt to stress. Within families, individuals are different from one another as well. Pediatricians are especially sensitive to differences among children—in their temperaments and personalities, in their innate and learned abilities, and in how they view themselves and respond to the world around them. It is remarkable and a testament to the effort of parents and to the resilience of children that most families function well and most children succeed in life.

Family life in the United States has been subjected to extensive scrutiny and frequent commentary, yet even when those activities have been informed by research, they tend to be influenced by personal experience within families and by individual and cultural beliefs about how society and family life ought to be. The process of formulating recommendations for pediatric practice, public policy, professional education, and research requires reaching consensus on some core values and principles about family life and family functioning as they affect children, knowing that some philosophic disagreements will remain unresolved. The growing multicultural character of the country will likely heighten awareness of our diversity.

Many characteristics of families have changed during the past 3 to 5 decades. Families without children younger than 18 years have increased substantially, and they are now the majority. The average age at marriage has increased, and a greater proportion of births is occurring to women older than 30 years. Between 1970 and 2000, the proportion of children in 2-parent families decreased from 85% to 69%, and more than one quarter (26%) of all children live with a single parent, usually their mother. Most of this change reflects a dramatic increase in the rate of births to unmarried women that went from 5.3% in 1960 to 33.2% in 2000. Another factor in this change is a slowly decreasing but still high divorce rate that is roughly double what it was in the mid-1950s.

Family income is strongly related to children's health, and the financial resources that families have available are closely tied to changes in family structure. Family income in real dollars has trended up for many decades, but the benefits have not been shared equally. For example, the median income of families with married parents has increased by 146% since 1970, but female-headed households have experienced a growth of 131%. More striking is that in 2000, the median income of female-headed households was only 47% of that of married-couple families and only 65% of that of families with 2 married parents in which the wife was not employed. Not surprising, the proportion of children who live in poverty is approximately 5 times greater for female-headed families than for married-couple families.

The composition of children's families and the time parents have for their children affect child rearing. Consequent to the increase in female-headed households, rising economic and personal need, and increased opportunities for women, the proportion of mothers who are in the workforce has climbed steadily over the past several decades. Currently, approximately two thirds of all mothers with children younger than 18 years are employed. Most families with young children depend on child care, and most child care is not of good quality. Reliance on child care involves longer days for children and families, the stress imposed by schedules and created by transitions, exposure to infections, and considerable cost. An increasing number and proportion of parents are also devoting time previously available to their children to the care of their own parents. The so-called "sandwich generation" of parents is being pulled in multiple directions. The amount and use of family time also has changed with a lengthening workday, including the amount of commuting time necessary to travel between work and home, and with the intrusion of television and computers into family life. In public opinion polls, most parents report that they believe it is more difficult to be a parent now than it used to be; people seem to feel more isolated, social and media pressures on and enticements of their children seem greater, and the world seems to be a more dangerous place.

Social and public policy has not kept up with these changes, leaving families stretched for time and stressed to cope and meet their responsibilities. What can and what should pediatrics do to help families raise healthy and well-adjusted children? How can individual pediatricians better support families?

From the American Academy of Pediatrics, Elk Grove Village, Illinois.
Received for publication Jan 30, 2003; accepted Jan 31, 2003.
PEDIATRICS (ISSN 0031 4005). Copyright © 2003 by the American Academy of Pediatrics.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Family Pediatrics

The American Academy of Pediatrics (AAP) Board of Directors appointed the Task Force on the Family to help guide the development of public policy and recommend how to assist pediatricians to promote well-functioning families (see Appendix). The magnitude of the assigned work required task force members to learn a great deal from research and researchers in the fields of social and behavioral sciences. A review of some critical literature was completed by a consultant to the task force and accompanies this report. That review identified a convergence of pediatrics and research on families by other disciplines. The task force found that a great deal is known about family functioning and family circumstances that affect children. With this knowledge, it is possible to provide pediatric care in a way that promotes successful families and good outcomes for children. The task force refers to that type of care as "family-oriented care" or "family pediatrics" and strongly endorses policies and practices that promote the adoption of this 2-generational approach as a hallmark of pediatrics.

During the past decade, family advocates have successfully promoted family-centered care, "the philosophies, principles and practices that put the family at the heart or center of services; the family as the driving force." Most pediatricians report that they involve families in the decision making regarding the health care of their child and make an effort to understand the needs of the family as well as the child. Family pediatrics, like family-centered care, requires an active, productive partnership between the pediatrician and the family. But family pediatrics extends the responsibilities of the pediatrician to include screening, assessment, and referral of parents for physical, emotional, or social problems or health risk behaviors that can adversely affect the health and emotional or social well-being of their child.

Family Context of Child Health

The power and importance of families to children arises out of the extended duration for which children are dependent on adults to meet their basic needs. Children's needs for which only a family can provide include social support, socialization, and coping and life skills. Their self-esteem grows from being cared for, loved, and valued and feeling that they are part of a social unit that shares values, communicates openly, and provides companionship. Families transmit and interpret values to their children and often serve as children's connection to the larger world, especially during the early years of life. Although schools provide formal education, families teach children how to get along in the world.

Often, efforts to discuss families and make recommendations regarding practice or policy stumble over disagreements about the definition of a family. The task force recognized the diversity of families and chose not to operate from the position of a fixed definition. Rather, the task force, which was to address pediatrics, decided to frame its deliberations and recommendations around the functions of families and how various aspects of the family context influence child rearing and child health.

One model of family functioning that implicitly guided the task force is the family stress model (Fig 1). Stress of various sorts (eg, financial or health problems, lack of social support, unhappiness at work, unfortunate life events) can cause parents emotional distress and cause couples conflict and difficulty with their relationship. These responses to stress then disrupt parenting and the interactions between parent and child and can lead to short-term or lasting poor outcomes. The earlier these events transpire and the longer that the disruption lasts, the worse the outcomes for children. The task force favors efforts to encourage and support marriage yet recognizes that every family constellation can produce good outcomes for children and that none is certain to yield bad ones. Unequivocally, children do best when they are living with 2 mutually committed and loving parents who respect and support one another, who have adequate social and financial resources, and who are actively engaged in the upbringing of their children.

Conclusions

From its discussions with family experts, its review of research literature, and its own intensive discussions, the task force was able to draw about the American family a limited number of conclusions that are relevant to pediatrics. Two overriding conclusions were apparent. First, children's outcomes—their physical and emotional health and their cognitive and social functioning—are strongly influenced by how well their families function. Second, there is much that practicing pediatricians can do to help nurture and support families and, thus, promote optimal family functioning and children's outcomes.

Other conclusions were organized into 4 categories: 1) family function and structure, 2) family circumstances, 3) pediatric practice, and 4) policy. Within the first category, there are conclusions about the effect of family structure, values, beliefs, roles, and relationships on child rearing and child outcomes. The second category, family circumstances, summarizes information on the emotional climate within and outside the home that can promote or impede children's healthy development. Third, to provide appropriate care for children, pediatricians must expand their practices to encompass the assessment of family relationships, health, and behaviors. They must have the skills and comfort to inquire and learn about individual families, address family issues realistically, and link families to support groups and community resources. Pediatricians' ability to practice family pediatrics is influenced by training, personal experience and orientation, the work environment, and professional relationships. Finally, there is a need to develop policies that support reimbursement of pediatricians for services

Fig 1. Family stress model. (Source: Conger KJ, Rueter MA, Conger RD. The role of economic pressure in the lives of parents and their adolescents: the family stress model. In: Crockett LJ, Silbereisen RJ, eds. *Negotiating Adolescence in Times of Social Change*. Cambridge, England: Cambridge University Press; 2000:201–233)

Downloaded from www.aappublications.org/news by guest on July 12, 2019

for families; that acknowledge the importance of marriage, parenting, and families for children; and that set clear expectations for parents while providing opportunities for them to obtain desired support.

Recommendations

The task force intended that its recommendations follow logically from the conclusions it was able to draw. The scope of family issues that were reviewed and discussed was very wide; consequently, in some cases, the conclusions are broad and the associated recommendations are numerous. The 80 recommendations also were organized into 4 categories to facilitate their consideration by individual physicians and various bodies within the pediatric profession. The first category, education, offers suggestions on family content for resident training and for continuing education for practitioners. It also contains some guidance on priority topics that should be addressed by parent education materials published by the AAP.

The second category, policy and advocacy, suggests public policy positions that would support families and promote good child outcomes. It also addresses reimbursement policies, including diagnostic and procedure coding, which could enable pediatricians to practice family pediatrics. Some suggestions for internal AAP policies that would highlight the importance of a family orientation for the organization also are provided. Finally, opportunities are identified for the AAP to promote local and national policies and activities that support and strengthen families through its chapters and its relationships with other professional organizations.

The third and most extensive category comprises recommendations about pediatric practice. This category includes suggestions for how pediatricians can modify their practice behaviors to promote good family functioning and effective parenting. Included are recommendations for how pediatricians can help strengthen parental partnerships in different family types, screen for family circumstances that put children at risk, and help create family-friendly practice environments. For additional guidance, some characteristics of a family-friendly pediatrician are listed in the final table of the report.

The final category makes recommendations for research that the AAP should encourage or undertake to better enable pediatricians to provide family-oriented care. Areas for research include the mechanics, content, and effectiveness of family-oriented pediatrics practice; public policies and programs that promote family functioning and family-oriented care; and progress toward adopting the principles and content of family pediatrics among health care organizations, insurers, and AAP members.

Taken as a whole, the recommendations provide a comprehensive plan for the AAP and pediatricians to assist families to function well and meet the needs of their children. The scope of work that is required is extensive and touches on nearly every aspect of the work done by the organization. It also requires modifications in pediatric practices to accommodate changes in the characteristics and circumstances of families that are served.

Next Steps to Ensure Implementation

The task force report is only the first step in what needs to be an ongoing process to ensure that children's health care is effectively provided in the context of their families. Attention to families should become integrated into the work of the AAP. This report should be reviewed and discussed by AAP staff, committees, sections, and members to determine which recommendations apply to their work and to plan strategies for their implementation. A single entity needs to take ongoing responsibility for monitoring and promoting activities related to the task force's recommendations. These responsibilities should be assigned with high priority to a standing committee of the AAP.

ABBREVIATIONS. AAP, American Academy of Pediatrics; CME, continuing medical education.

INTRODUCTION

The practice of pediatrics is unique among medical specialties in many ways, among which is the nearly certain presence of a parent when health care services are provided for the patient—a child. Regardless of whether parents or other family members are physically present, their influence is pervasive. Families are the most central and enduring influence in children's lives regardless of their composition, income, education, or values. The health and well-being of children are inextricably linked to their parents' physical, emotional and social health, social circumstances, and child-rearing practices. The rising incidence of behavior problems among children attests to families' inability to cope with the increasing stresses they are experiencing and their need for assistance. When a family's distress finds its voice in a child's symptoms, pediatricians are often parents' first source for help.

Families are the most central and enduring influence in children's lives.

The American Academy of Pediatrics (AAP) acknowledges the importance of the family in its vision statement to "ensure that the decision-making affecting the health and well-being of children and their families is based on the needs of those children and families." Yet, expecting pediatricians and the AAP not only to consider but also to address families' needs raises a number of difficult issues. These issues range from pragmatic considerations to complex philosophic questions. Are pediatric training, practice behaviors, and reimbursement sufficient to enable pediatricians to extend their scope of care to include the family? Does our society expect parents to be so self-reliant and consider child rearing to be so private that support from nonfamily members, such as pediatricians, is considered intrusive and inappropriate?

The AAP Task Force on the Family carefully considered these issues in preparation for proposing recommendations for policy, education, and practice. We found that the apparently simple concept of "family" is, in fact, extremely complicated and strongly influenced by personal and social values. We found that experience and research left many fundamental questions unanswered, thus limiting our ability to support our recommendations with the scientific assurance we desired. We also acknowledged that reasonable people commonly disagree and that a certain degree of ambiguity is likely to persist even after careful review and thoughtful consideration. Nonetheless, task force members shared a belief in the importance of families to children and in

Downloaded from www.aappublications.org/news by guest on July 12, 2019

the need for the profession to embrace more fully and actively the roles that support families.

HISTORY

The appointment of the task force was preceded by the adoption of a number of resolutions by the AAP Annual Chapter Forum in 1993 and 1994. These resolutions urged the AAP to develop public policies that 1) were family friendly and supported the maintenance of 2-parent households and 2) would help pediatricians provide guidance to single-parent households. They also called on the AAP to promote methods to encourage the promotion of nurturing families for all children. (The Annual Chapter Forum has continued to be a source of ideas and support for AAP involvement in family issues.) In 1994, the AAP Board of Directors added responsibility for promoting healthy lifestyles for families to its fiscal year 1995–1996 goals. In 1995, the Committee on Early Childhood, Adoption, and Dependent Care recommended to the board that it identify ways by which the Academy can strengthen its public presence as an advocate for families. The AAP Executive Committee endorsed this recommendation. Also in 1995, the periodicity table for preventive pediatric health care was modified to include a recommendation that appropriate discussion and counseling be an integral part of each visit for preventive care. In late 1997, the AAP Board of Directors appointed the Task Force on the Family. The task force consisted of 6 pediatricians who were to meet 4 times over approximately 2 years. The board recognized the complexity of the issues the task force was to address and provided a series of directives to guide its work (Appendix).

Approach of the Task Force

The task force spent its first year immersing itself in scientific literature on a variety of family topics and meeting with experts in family demographics, sociology, policy, and therapy and in child development, behavior, psychology, and psychiatry. Arrangements were made for a national expert in child development to prepare a review of published literature on family influences on children's outcomes. Task force members also devoted considerable time to exploring and clarifying their own beliefs about families and reconciling them with what is known about the effects of families and their circumstances on children. The task force spent its remaining time reviewing existing AAP policies and materials and developing this report.

Report Organization

This report is organized into a number of major sections. Although necessarily long, the background section on family functioning and structure only briefly reviews a portion of what has been published about those subjects. Subsequent sections discuss the effects of families' circumstances on children, the nature of pediatric training, and the practice environment. Brief reviews are provided of AAP policies and the role of the AAP in public policy. Resource materials relevant to family-oriented pediatrics available through the AAP are discussed. Following is a summary section and a checklist of characteristics of a family-oriented pediatric practice. A section on conclusions precedes a final section of recommendations.

Because of the absence of research addressing some specific question, some of what is written here, especially our conclusions, is not fact in the purest scientific sense but has had to be extrapolated or inferred from related research and information. At the conclusion of our work, it is apparent that the importance of families to children and society and the scope of issues that a family orientation raises for pediatrics leave much to be done. It is equally clear that interdisciplinary efforts are needed to address the needs of even 1 family, let alone the needs of families in general. This report is a first step toward identifying opportunities for action by the AAP and its members. Future work will find, as did the task force, that many family issues are likely to remain unresolved by research. Future issues for families and how they are best managed will continue to be shaped by the diversity that is the strength of our society and reflected in the talents, skills, and experience of the AAP membership.

FAMILY FUNCTIONING AND STRUCTURE

The concept of family is held in high regard in the United States, and families are ascribed a central role in creating and maintaining American society. Naturally, then, when social problems arise, the family is looked to as the root of those problems and the source of the solutions—both unrealistic and simplistic formulations. Such a view ignores the social context in which families are formed, develop, and function, a context that is increasingly stressful and not always supportive of parents or children.

> "The social tapestry supporting families has been weakened due to the considerable pressure and stress of the speed of social change."[1]

Many current public polices are based on an idealized, self-sufficient "traditional family" (ie, working husband, stay-at-home wife, and dependent child), which is not an accurate depiction of many families today or even of the past. Certainly there has been a dramatic increase in the number of single-parent households, and this trend has led to much consternation about a breakdown of the family. Despite this public concern, the United States stands apart from most similarly developed countries in having no coherent set of public policies that would create a social context supportive of families, traditional or otherwise. For example, the United States has conflicting policies that encourage and, in some cases, demand that women participate equally in the workforce yet permit wage discrimination on the basis of gender and fail to provide accessible, good-quality child care. As another example, of the 130 countries that have national maternity leave policies, only 3—Ethiopia, Australia, and the United States—provide only unpaid leave, and in the United States, this leave is guaranteed only to employees of companies with 50 or more workers (less than 60% of the working population). The United States is unusual,

Downloaded from www.aappublications.org/news by guest on July 12, 2019

however, in providing gender-neutral parental leave; most countries provide no leave for fathers or paternity leave that is shorter and/or unpaid.[2]

One immediate obstacle in policy development is lack of agreement on a definition of "family." The US Census Bureau uses a purely structural definition: "a group of 2 or more persons related by birth, marriage, or adoption and residing together in a household." Under this definition, childless households are most common, a fact that may bode poorly for public support for families with children; children are present in only 26% of households in the United States. The task force chose to use a functional definition of "family" and tried to reach agreement on the types of things that families ought to provide children. Although helpful, such an approach quickly led to questions such as, "What is a successful family, a good parent, and a good child outcome?" Such questions vexed the task force, because in some measure, they are questions of values that are difficult to answer empirically. This report reflects the consensus we reached on those and other complex questions.

Family Diversity

There is great diversity in family types and family structure. Single men and women can create families or can be single as a result of the death of 1 partner. Other families include 2 parents who are living apart because of separation or divorce. Two-parent family households could be cohabiting, married for the first time, or remarried or reconstituted. Other family types include the adoptive family, the foster family, and the estranged or separated family. Parents can be of the same or opposite sex. In addition, there are nuclear, extended, and multigenerational households. In economic terms, families can have 0, 1, 2, or multiple wage earners. The variety of families is also influenced by ethnicity, geographic and regional influences, sexual orientation, and religion.

The families of the United States represent a diversity of national and ethnic origins of its citizens unmatched anywhere else in the world. The behavior of many families, including spousal roles and relationships and child-rearing practices, consciously and unconsciously reflects beliefs and values passed down through generations. Our national heritage and history and the increasing diversity among the population of young families demand great cultural sensitivity and competence on the part of pediatricians to meet the needs of children effectively.

Family Structure and Its Limitations

Family structure affects child development largely through its impact on family processes—how family members behave and interact. The evidence is overwhelming that, in general, children do best when they are living with 2 mutually committed parents who respect and support one another, who have adequate social and financial resources, and who both are actively engaged in their upbringing. On average, the risks for emotional, behavioral, and educational problems are lower among children in 2-parent households.[3] The reason for this is important to emphasize: a 2-parent household structure facilitates (but does not guarantee) successful families and effective parenting behaviors. Effective parenting can and does occur within families of all types of configurations.

> "Researchers will always disagree about whether family structure plays a *causal* role in determining child well-being."[3]

Although many children who are raised by single or separated parents do well and many in 2-parent families do poorly, there is no question that children who are reared in single-parent households are at greater risk of a variety of problems. Scientifically, controversy arises from efforts to determine the relative contribution of family structure to children's outcomes. Although children of single or separated parents have significant increases in risk, children from educationally and economically deprived backgrounds have far more substantial risks—regardless of whether they live with 1 parent or 2. Complicating our ability to draw conclusions is the unfortunate fact that children who are reared in single-parent households are more likely to be poor.[3]

Single-parent households generally differ from 2-parent households in terms of economic and parental resources. Single-parent households have 3 to 5 times higher rates of poverty than do 2-parent households. In addition, parents who do not share parenting with another adult experience the psychologic strain of making decisions of potential lifelong consequence alone, they lack time to carry out household and child-rearing tasks, and they often experience the transitional and continuing conflict and resentment that plague some separated and divorced families. Children and parents in single-parent households also are less likely to have access to the support and resources of extended families.[3]

Still, for an individual child, one cannot predict with assurance that any particular family structure per se will be detrimental to his or her development. In general, it seems that each family structure has its own set of stresses, burdens, and complicated social pressures that intersects with each family's unique circumstances and personal, economic, and material resources. Divorce is traumatic, as is ongoing family conflict, and single or separated parents are more likely to be poor and especially in need of social support. However, no particular family constellation makes poor outcomes for children inevitable.

> No particular family constellation makes poor or good outcomes for children inevitable.

A stable, well-functioning family that consists of 2 parents and children is potentially the most secure, supportive, and nurturing environment in which children may be raised. That children can be successfully brought to adulthood without this basic functioning unit is a tribute to those involved who have developed the skill and resiliency to overcome a difficult and fundamental challenge.

Successful Families

When the family environment enables their developmental needs to be met, children generally turn

Downloaded from www.aappublications.org/news by guest on July 12, 2019

out well socially and psychologically and parents are satisfied with their lives and marriages. Throughout children's dependent years, families provide them with food, clothing, shelter, a safe and clean environment, adequate supervision, and access to necessary health care and education. Families are also where children receive support; come to feel loved, valued, and competent; are provided with companionship; and learn to believe in a shared set of values. Families transmit their own values and those of the outside world, including general principles of what is right and wrong and principles based on spirituality or religion. They also provide connections to the community. Finally, families teach how to cope with adversity and how to get along in the world.[4] Doing all of these things and doing them well is difficult regardless of the personal and material resources that families bring to the task of raising children.

Although success as a family is difficult to measure and individual families differ on the specific outcomes they value, successful families share certain characteristics. They are enduring, cohesive, affectionate, and mutually appreciative. Family members communicate with one another often and effectively. Although not trouble free, successful families are able to adapt and deal with crises constructively. Family members spend time together, are committed to their family, and embrace a common religious or spiritual orientation. Although the underlying logic is admittedly circular, successful families raise children who go on to form successful families themselves.[5]

> "What we often take to be family values—the work ethic, honest, clean living, marital fidelity, and individual responsibility—are, in fact, social, religious, or cultural values. . . . There is one value, however, that does originate in the family. It is the value of close relationships with other family members, and the importance of these bonds relative to other needs.[6]

Parents' own psychologic resources, including their problem-solving abilities, coping skills, sense of self-esteem and mental health, and how they relate to other adults and to their children, are critical to how children turn out. Although child rearing is a dynamic process that also depends on the characteristics and psychologic resources of the child, it occurs within a social and emotional environment that is strongly determined by the parents. What is experienced within the family is transferred to social relationships beyond the family, and events that occur within the context of parent-child interactions affect children's behavior in other settings. If families are successful, their children will develop toward adulthood able to form close emotional relationships, becoming progressively more autonomous in appropriately managing their lives.

Children need good-quality parenting, including receiving unconditional love and adequate time from their parents. Within this framework, a wide range of parenting styles can result in positive child outcomes. In general, parents whose style is "authoritative" (ie, they combine warmth and affection with thoughtful, firm limit setting; are responsive and flexible; and demonstrate their respect for their child and his rational abilities) are more likely to have children who are happy, creative, and cooperative; have high self-esteem; are achievement oriented; and do well academically and socially.[7] Other styles of parenting, including being authoritarian, permissive, or disengaged, can tend to yield less consistently positive outcomes. The emotional well-being of children may be jeopardized when parents are rigid, inconsistent, controlling, unresponsive, and uninvolved.[8,9] In addition, success is more likely when parents monitor and supervise their children inside and outside the home; encourage their participation in growth-enhancing activities at home, in school, and in the community; and move toward shared decision making and greater personal responsibility as the child grows.

Communities, from neighborhoods to nations, are strengthened when their families are successful. Families are important to society because of the many functions they can fulfill, including providing a structure for reproduction, creating economic cooperation between husbands and wives, organizing inheritance of property, and socializing children. Public opinion assigns most of the value of families to this last function, socializing children. Americans believe that families perform 2 primary functions: 1) caring for and nurturing children and 2) being the place where values are taught and learned. Other entities can provide food and clothing, but families seem essential to the process of raising socially and emotionally healthy children. When families fail in this task, the costs to communities and society as well as to children and families are high. Table 1 lists characteristics of strong, healthy families.

> "Marriage has declined as the central institution under which households are organized and children are raised. People marry later and divorce and cohabit more. A growing proportion of children [have] been born outside marriage."[10]

Married (or Not) With Children

Marriage remains a goal for most adults. Across the political spectrum, people overwhelmingly want their children and grandchildren to be born into marriages and want those marriages to be characterized by love, stability, and durability. Although many young people reject the idea that marriage and having children is a personal necessity, most continue to value marriage. Ninety percent of all high school seniors say that it is quite or extremely important that they have a good marriage and family life, and most expect to marry.

Advances in contraception and in career opportunities for women have made marriage less imperative and women less reliant on men for financial support. In fact, our economy relies on women's participation in the workforce. Despite these changes, annual marriage rates have been relatively

TABLE 1. Characteristics of Strong, Healthy Families[5]

Communication	Social connectedness
Encouragement of individuals	Ability to adapt
Expressing appreciation	Clear roles
Commitment to family	Time together
Religious or spiritual orientation	

Downloaded from www.aappublications.org/news by guest on July 12, 2019

steady since the 1950s (ranging from 8.8 to 10.9 per 1000 people). However, when people marry and how long they stay married have changed substantially. Since the 1960s, the median age of first marriage has increased by approximately 4 years. Cohabitation has also increased and is nearly twice as common as 2 decades ago. Today, people who marry may have established a pattern of economic self-sufficiency and a lifestyle that makes the interdependence of marriage less necessary and perhaps less attractive. Rates of divorce have been decreasing from their high in 1981, but the most recent rate is still approximately half (48%) of the marriage rate. There is little reason to expect current patterns of marriage and divorce to change in the foreseeable future.

Marriage Matters

Marriage is beneficial in many ways. Married men and women are physically and emotionally healthier and are less likely to engage in health risk behaviors, such as alcohol or drug abuse, than are unmarried adults. Married men and, to a slightly lesser extent, married women live longer. These positive health outcomes of marriage are not primarily the result of self-selection but reflect that people behave differently when they are married. They have healthier lifestyles, eat better, and monitor each other's health. Being part of a couple and a family also increases the number of people and social institutions with which an individual has contact; this, in turn, increases sources of social support and increases the probability that the family will be a successful one.

Marriage is good for the economy. Married individuals earn and save more and are more likely to be homeowners. Married couples are, on average, approximately twice as wealthy as unmarried couples. Employers benefit from good marriages, because the distress that accompanies marital problems contributes to workers' absenteeism and decreases their productivity.

There is no doubt that the decrease in the stability of marriage and the relaxation of social mores that limit childbearing to wedlock have increased poverty and the need for personal resources and supports; this consequently increases the public cost of many health and social service programs. For example, after a divorce, women usually experience a significant decrease in their standard of living, and many enter poverty. The median income of mother-only families has always been a fraction of the median income of 2-parent families. Although being unmarried has its costs, poverty appears to challenge marriage. Out-of-wedlock births occur most often in circumstances of poverty, and economic stress appears to contribute to marital conflict and divorce. Regardless of the direction of cause, single-parent households are much more likely to be impoverished and dependent on social programs to meet their basic needs. Poverty is the dominant social factor associated with poor outcomes for parents and children.

Many people hold strong beliefs about the importance of marriage to parenthood. A number of studies have documented a positive relationship between the quality of marital life and parental functioning. Yet, a persistently high rate of divorce and an increasing rate of out-of-wedlock births preclude that relationship for many children. With nearly one third (32.8%) of births occurring to unmarried mothers and approximately one half of marriages ending in divorce, many children spend a portion of their childhood in a single-parent household. In 1999, only 68% of children lived in families with 2 parents, and only three quarters of those were living with both biologic parents.

How else has marital status affected the living circumstances of children in the United States? Over the past 3 decades, the proportion of children who live with 1 parent increased from 11.8% in 1968, to 18.5% in 1978, and to 27.7% in 1998.[11] There are large differences across racial and ethnic groups (Fig 2).

Of children who live with 1 parent, most (84%) live with their mothers; the proportion of children who live with their fathers has doubled in the past 20 years. Of all children who live with 1 parent, 36% do so because of divorce; a sizable proportion (21%) live with a married parent whose spouse is absent. Approximately 10% of all children live with a never-married mother. The distinction between these family types is somewhat artificial. Approximately one third of children who are born outside marriage are born to formerly married women, and approximately one quarter are born to cohabiting parents, approximately two thirds of whom eventually marry each other.[3]

"The trajectory of failure is intergenerational."[12]

Fig 2. Proportion of children who live with 1 parent. *Not available for 1970.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Cohabitation, sometimes called pseudo-stepparenting, is becoming increasingly common among households with children. In 1997, among the approximately 4 million unmarried couples were nearly 1.5 million with at least 1 child younger than 18 years. Social acceptance of cohabitation rests on the notion that relationships can be explored and compatibility can be ensured by a test before marriage. However, cohabitation is associated with a substantially higher rate of divorce among those who later marry as well as breakups during the cohabitation period.[13] Cohabitation is more unstable for children than either married 2-parent or single-mother families and tends to produce worse outcomes for children. This high disruption rate of cohabiting couples may reflect choices being made by people who are reluctant to make commitments. Cohabitation also may reinforce the acceptance of relationships being temporary. Conversely, at the birth of a child, the majority of cohabiting parents say they intend to marry; however, 1 year later, few will have actually done so. The economic status of cohabiting couples tends to be low, resembling those of single-parent families more than of married families.[14] Finally, there is some evidence from England that children who live with a mother and cohabiting boyfriend are more likely to experience child abuse than those who live with married biologic parents, although the reasons for that increased risk have not been elucidated.[15]

The rate of out-of-wedlock births has been increasing since the 1940s among all segments of society, stabilizing in the late 1990s at approximately 32% to 33%. A number of factors are thought to have contributed to this trend, including the growing economic independence of women, the increase in women's earning power relative to men's, and the decreased stigma associated with divorce and nonmarital childbearing.[3] Also contributing are a greater social acceptance of divorce and perhaps a lower commitment to and a loss of confidence in marriage. The rate of out-of-wedlock births has increased nearly fivefold since 1960 and has contributed to an increase in single parenthood in part as a result of lower rates of marriage by teenagers. The peak of teenaged parenthood was in 1957, when the rate of births to teenagers (96.3 per 1000) was nearly double what it is today, but most of those teenagers were already married or got married shortly after becoming parents. In 1960, 46% of teenaged mothers were single when their child was conceived and 22% were still single when their child was born. In contrast, by 1988, 81% of teenaged mothers were single when their child was conceived, and 62% remained single.

Although the evidence is mixed and often conflicting, it appears that publicly funded entitlement programs (eg, welfare) increase nonmarital childbearing, discourage first marriage, and delay marriage. However, the magnitude of this effect is not large, and poverty itself tends to produce single-parent families. High rates of male unemployment depress marriage rates. Married couples who are stressed by economic uncertainties or by the husband's unemployment are more likely to divorce. It is too early to draw conclusions about the effects of recent national changes in welfare programs on marriage and childbearing.

Partners in Parenting

The functions of a successful family are more difficult to perform when only 1 parent provides day-to-day care for a child. Mothers head most single-parent families. In those households in which parents live apart, fathers may take a diminished role in their children's upbringing. When a noncustodial parent participates less actively, their influence is decreased and children are deprived of the full social, emotional, and financial support of their immediate and extended family. Paternal absence also results in the absence of a consistent source of physical and emotional support for the mother. Studies show that multiple and sometimes lifelong disadvantages are more likely to accrue to children who live with mothers only. Their disadvantaged outcomes include health problems; problems with school attendance, achievement, and completion; emotional and behavioral problems; adolescent parenthood; substance abuse; and other risk behaviors. Children so affected are more likely to grow up poor, to spend large parts of their childhood without 2 parents, to become single parents themselves, and to be out of work as young men and women.[3] When fathers stay involved, the adverse effects of divorce are substantially reduced.

> "I think adulthood has to mean the ability to take care of more than yourself, which generally means marriage and family."—Frances Goldsheider, PhD

Raising children is easier and likely to be more successful when done as a shared partnership. In partnership, parents can develop complementary roles and support each other's efforts. For example, in some 2-parent, father-mother households, fathers have typically not played an active or consistent role in rearing their children, depriving themselves and their children of the shared love and support that comes from active parenting. However, when parents are able to achieve a mutually agreed on division of roles and responsibilities, it tends to generate greater involvement in the home and family by both parents. Being raised in a family that consists of 2 actively involved parents strengthens children's claims to the love and affection, economic resources, nurturing, and social connections of both parents and their extended families.

Although marriage can influence parenthood, the reverse is also true—parenthood affects marriages. At its best, having a child is emotionally gratifying. It evokes a capacity for love that may not previously have been recognized. It provides a sense of maturity and an enhanced sense that the former couple is now a family. More than 80% of adults regard family as 1 of their top 2 sources of pleasure in life, the other being work. When all goes well, raising a child leads parents through a series of stages of personal growth. New adult parents develop an additional identity; learn new meanings for being responsible; test ways of being an authority; clarify their own

Downloaded from www.aappublications.org/news by guest on July 12, 2019

values, beliefs, and assumptions; learn the boundaries of their personal influence; and eventually reappraise their own life course and achievements. Having children also expands parents' social contacts and can alter how they perceive and rely on relatives, neighbors, and friends and on affiliations with civic, social, and religious communities.

However, becoming a parent can test marriages as well. Parents can expect their marital relationship to go through some difficult transitions. Having a child creates differences between parents and crystallizes others that lie below the surface of their marriage. Parenthood forces couples to find balance between being autonomous and being connected. It can reveal or provoke conflict and highlight shortcomings in how couples communicate. It can reveal differences in personal expectations and heighten disagreements over gender roles and division of labor. Having a child also increases economic pressure on families.

Marriages are not merely legal unions. They become distinct living systems, and like all such systems, what happens to 1 person in it affects the other person, too. The more supportive each spouse is to the other, the stronger their marriage and the better able they are to nurture their child. When couples are able to focus on what unites them and what creates mutual delight, they are likely to have closer relationships, better and happier marriages, and more successful families.

Divorce and Discord

Annually, more than 1 million children are involved in a divorce. The divorce rate, although decreased slightly since 1992, still hovers at approximately half the marriage rate (2 344 000 marriages vs 1 150 000 divorces in 1996). Approximately 40% to 50% of first marriages end in a divorce. Children and parents experience many consequences when marriages are dissolved. These include a decrease in economic status, a change in the living situation, separation from 1 parent (usually the father), absence of that parent's extended family in the life of the child, and ongoing stress related to visitation and economic support.

On average, children of divorced parents are at greater risk of emotional and behavior problems, including depression, and of poorer school performance. They tend to have more negative self-concepts, more social difficulties, and more problematic relationships with 1 or both parents. The effects of parental divorce on children may continue to be evident into adulthood and can create future marital instability. This heightened risk experienced by children of divorce arises especially when their parents are less able to engage in competent parenting and more likely to engage in parental conflict.[16] One third of divorced parents report continued conflict over child-custody and visitation issues.

"Children raised apart from one of their parents are less successful in adulthood... many of their problems result from a loss of income, parental involvement and supervision, and ties to the community."[3]

The most powerful factor that affects children's adjustment to divorce is the quality of the parenting they continue to receive.

The impact of divorce on individual children varies widely, and their adjustment after divorce is sensitive to a variety of factors, including their individual differences. Generally, adjustment seems to be somewhat more difficult for boys than for girls; however, in some areas, including academic achievement, conduct, and psychologic adjustment, boys do as well as girls after divorce. The most powerful factor that affects children's adjustment to divorce is the quality of parenting they receive from their custodial parent, usually their mother. The quality of mothers' parenting and postdivorce conflict explain the relationship between divorce and girls' externalizing behaviors. Depression among girls is not common when their mother is able to avoid depression themselves and engage in competent parenting after marital breakups. Boys, though, seem prone to depression after divorce regardless of the quality of parenting they receive. For boys, the level of their father's continuing involvement in parenting is a powerful factor explaining their adjustment, as are predivorce conflict and maternal depression.[16] Fathers who are merely visitors in their children's lives are a poor substitute for being a continuing, meaningful parental figure.[17] Studies of age and ethnic differences in the short-term response of children whose parents divorce do not reveal clear differences. However, it should be emphasized that most children of divorced parents are well-adjusted and adapt well to their new life situation.

Living in a 2-parent household is no guarantee of good child outcomes. Parental conflict has deleterious consequences for children's development. Highly troubled marriages have important and sometimes underappreciated damaging effects on children's adjustment.[18] It appears that, like divorce, marital conflict exerts most of its negative effects by disrupting parenting. Parental conflict seems to affect children's adjustment most when it is perceived as threatening the parents' marriage. Thus, in intact families, parental conflict probably rarely reaches the high levels that would give children concern about the stability of their family structure. In divorced families, conflict not only has resulted in the "loss" of their family, but also is apt to decrease the opportunities to interact with 1 of the parents.

Experts in domestic violence distinguish between families with frequent and high levels of discord and disagreement and those in which there is physical or emotional abuse. Although the distinction may not be clear-cut, children who are abused or who have witnessed domestic violence are at greater risk of adjustment problems, aggressive behavior, and poor cognitive development. When children are evaluated for behavior problems, including antisocial and self-injurious behavior, a history of domestic violence should be considered. Families of such children tend to make frequent use of health care services, especially of emergency departments, and thus may be identified for treatment. A history of physical or sexual abuse during adulthood was reported by 52%

Downloaded from www.aappublications.org/news by guest on July 12, 2019

of women who brought children to a pediatric emergency department; most reported that the abuse was perpetrated by a relative.[19] Child abuse and spousal or other forms of domestic violence tend to co-occur. The risk of child abuse increases with increasing instances of parental violence, and abuse of male children is more likely than of female children in such families.[20]

> "The problems facing single-parent families are not very different from the problems facing all parents. They are just more obvious and more pressing."[3]

Fathers Matter

The physical absence of fathers from the home was seen as the most significant family or social problem facing America by a strong majority of respondents (79%) to a recent public opinion poll.[21] Father absence is an issue intimately related to the outcomes of being raised in mother-only households. The central question is, "What is lost, apart from things related to income, when fathers are not part of children's lives?" Undoubtedly, in households in which another adult is absent, mothers are deprived of the emotional and physical support of another committed parent with whom to share child-rearing and housekeeping responsibilities. This circumstance can produce distress and fatigue for the mother and leave many desirable child-focused activities undone and many appeals for attention and affection unrequited. But what in addition is lost when an adult male, especially a father, is not present for a child?

> "We know that the father's closeness and friendliness to his children will have a vital effect on their spirits and character for the rest of their lives. So the time for him to begin being a real father is right at the start."[22]

A significant proportion of children in mother-only households have at least weekly contact with their father, 30.3% living with divorced mothers and 38.5% living with never-married mothers. Although the frequency of contact with nonresident fathers seems to have little or no impact on children's well-being, the quality and intensity of interaction with their father and the closeness children feel toward their father likely is key to children's adjustment.

Fathers can have a powerful influence on the development and future of their children. However, the mere presence of a father is far less important than the nature of his involvement with his children. When fathers play a visible and nurturing role in their children's lives, the children have better emotional and social outcomes[17] and are more likely to have stronger coping and adaptation skills, be better equipped to solve problems, stay in school longer, have longer-lasting relationships, and have higher work productivity.[23] Fathers' involvement also has beneficial effects for children in terms of educational and economic attainment, delinquent behavior, and psychologic well-being.[24] Regular involvement of fathers with their high-risk infants has yielded improved cognitive outcomes for the child.[25]

Fathers can be as nurturing as mothers can; however, their styles of play and conversation seem to be different. Some of these differences reflect the different settings and circumstances in which parent-child interactions occur. Because fathers, in general, spend less time with their children than mothers do, they may interact more intensely. Although mothers continue to shoulder a disproportionate share of household and child-rearing responsibilities, over the past several decades, fathers have increased their family time. Men today not only are spending more time at home than did their fathers, but also are spending more time as primary caregivers for their children, expressing interest in having custody of children after a divorce, and heading single-parent households. Public policy has not taken into account these trends, and most states do not actively enforce a father's right to spend time with his child.

There seems to be little about the biologic sex of the parent that distinctively affects his or her influence on children. The characteristics of the father as a parent rather than as a man are most likely to influence child development. However, gender roles and associated masculine and feminine behaviors, while reflecting early life imprinting of the brain with testosterone and/or other androgens, are certainly learned from examples in children's lives. Although living with a father and a mother provides powerful models for a variety of social relationships and roles, including gender roles, children may find influential role models outside their nuclear family.[26]

Same-Sex Parents*

A substantial number of children live with parents who are gay or lesbian. Many of these children are from heterosexual marriages that have dissolved; some are born or adopted into lesbian or gay households. It is estimated that 8 to 10 million citizens in the United States, adults and children, have at least 1 homosexual parent. Because of negative stereotypes and stigmatization, these families may face ostracism and social isolation. Societal (cultural and legal) biases may prevent open disclosure of a parent's sexual orientation to the child, school, friends, family, the community, and the pediatrician. Deprived of opportunities for open discussion, these families may experience some difficulty obtaining ordinary social support. Many opportunities exist to support these families, reduce discrimination, and provide individualized, nonjudgmental care. These families and children appear to be resilient. A substantial number of studies have been done to explore the outcomes for these children, although these studies are hampered by small sample sizes and a homogeneity of the families that have been studied. That research has found that parental sexual orientation per se has no measurable effect on the quality of parent-child relationships or on children's mental health or social adjustment.[27–29] Certainly, these children's experiences are unique and some differences

*A minority of the Task Force (Marilyn M. Billingsley, MD, and Linda D. Meloy, MD), although supportive of the report, take exception to the section on same-sex parenting. We truly believe that all children, regardless of the circumstances of their rearing, deserve the best possible pediatric care. The evidence supporting the number of children involved is not scientifically convincing. The data of positive long-term outcomes for children who are raised in same-sex-parent homes is collected from small and nonrandom samples; therefore, it cannot be generalized for the entire population.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

should be expected. For example, although there is less research on the subject, children with gay or lesbian parents appear less inclined to conform rigidly to those social roles traditionally defined by gender than do children in the general population.[28]

Grandparents as Parents

Approximately 4 million children in the United States are being raised by their grandparents instead of their parents.[30] Grandparents assume parental responsibility for many reasons, but most include tragedy, illness, substance abuse, or young age of the biologic parent. In these families, role confusion, custody battles, financial difficulties, and health problems on the part of the grandparents may complicate the difficulties inherent in parenting.[31]

Stepparenting

Approximately 75% of divorced people eventually remarry and 65% of remarriages involve children from previous marriages and, thus, form stepfamilies. Currently, approximately 8% of children live in a stepfamily in which they have not been adopted by their stepparent; another 7% to 9% live with a cohabiting parent. During the course of their lives, approximately 30% of all children are likely to spend some time in a stepfamily if that term includes cohabiting adult couples.[32] Unfortunately, almost half of all remarriages involving children end in divorce before children are 18 years of age. Nearly all children in stepfamilies have lived in a single-parent household, and nearly all of them experience having more than 2 parenting adults. When a parent remarries, the child's life is made more complicated and is again disrupted. Having an additional parent in the household potentially increases the amount of adult time available to a child. It does not necessarily improve the experience for the child, and, in general, children who are raised in a stepfamily do about as well as do children of single mothers.[3] Children who live with stepmothers who do not have regular contact with their birth mother are less likely to have routine doctor and dentist visits or to have a place for usual medical or sick care, and they are less likely to wear seat belts.[33] Like children in single-parent families, children who live in stepfamilies are more likely to experience unintentional injuries; this appears to be attributable to higher exposure to psychosocial risks among these types of families.[34] Certainly, the circumstances that led to the dissolution of their first family can adversely affect children's subsequent relationships and adjustment. Despite the more frequent poor outcomes for children in stepfamilies, many do well and benefit from the presence of another adult and the support it provides for their birth parent.

FAMILY CIRCUMSTANCES AND CHILD OUTCOMES

Although children's health is better today than it has ever been, this is true only in a biologic sense. The social strains on families—manifested in their extreme as parental mental illness, substance abuse, violence, and divorce—have spawned a growing epidemic of new morbidities that are evidence of children's inability to cope without the social support of their families.

> The child as he grows has a relation not only to his family but also to the culture within which his family is a small but integral unit.[35]

Poverty

Families with children are poorer, on average, than are families without children. The reasons for this pattern and for the high rate of child poverty in the United States include the decrease in real wages of low-wage and entry-level workers, women's lower wages coupled with the rise in nonmarital births and mother-only families, unpaid child support from noncustodial parents, and the trade-off of wages for stay-at-home child care. Although children who grow up in poverty certainly have a lower standard of living than do children who are raised in more affluent households, they do not necessarily have a lower quality of life. Nonetheless, without countervailing opportunity, poverty and its accumulating risks diminish poor children's health, educational achievement, and ability to contribute to the economy and society as a whole during their lifetimes.

Because family poverty limits opportunity and increases the likelihood of a variety of risk factors, it is the single strongest predictor of diminished health and well-being for children. Children of poor families are considerably more likely to be born prematurely or with a low birth weight and have considerably higher mortality rates throughout childhood. They are at high risk of depression, low self-confidence, peer conflict, and conduct disorders. They are more likely to witness or be the object of violence in their families and neighborhoods. Poverty is also associated with higher rates of chronic health problems and injuries in children. Poor families are more likely to experience adolescent school failure and dropout, teen pregnancy, and substance use and abuse.

Much has been written about the feminization of poverty, which simply means that poverty is much more likely to affect women and women-headed households. The reasons for this pattern are multiple and include nonmarital pregnancies, school dropout, limited career opportunities and lower salaries available to women, high rates of mother-only families and the difficulty of providing for a family with only 1 paycheck, and the lack of financial support from nonresident fathers. Government agencies are attempting to address this last issue of abrogated paternal responsibility by more aggressively trying to determine paternity at birth and when families apply for public assistance and by assisting single mothers to obtain child support.

Welfare reform has crystallized some of the paradox that pervades social policy. Federal and state policies now curtail access to public assistance programs and limit eligibility to promote economic self-sufficiency of poor families. Unfortunately, replacing welfare with low-paying jobs has not enabled most recipient families to rise above poverty-level incomes. In addition, the many poor mothers who

Downloaded from www.aappublications.org/news by guest on July 12, 2019

enter the workforce now must find child care for their young children. However, despite some public subsidies, access to high-quality child care is inadequate in this country, and such care generally is available only to those who are able to pay higher fees. Ironically, although public sentiment supports mothers staying at home with their young children, public policy precludes that option for many poor families. Furthermore, many employers of such mothers do not provide benefits, such as family health insurance, vacation, sick leave, and flexible hours, needed by most families. These circumstances are particularly likely to have an impact on the health of poor children who are at greater risk of chronic conditions.

It is extremely difficult to disentangle the outcomes of poverty itself from other associated social determinants of health, such as being raised in a single-parent family. Risk factors interact, and their effects are more than additive. Poor families are more likely to have lower levels of educational attainment; fewer social resources; less stable personal relationships; more health risk behaviors, including poor nutrition and substance use; and a greater frequency of stressful life events (eg, inadequate housing, contact with the police, economic insecurity, job loss, family illness). Furthermore, because single-parent, female-headed households are among the poorest families, it is not clear to what degree poverty, family structure, and other factors are responsible for the poorer outcomes of children in these families.

Thus, the stresses of poverty take their toll on parents and tend to alter their child-rearing behaviors and expectations. Children in poor families are more likely to be unsupervised and, thus, more exposed to the physical and social dangers of their environment. Parents with low incomes are more commonly socially isolated and, thus, have fewer social supports and role models. Research has shown that the consequences of stress and poverty include having less time and less patience for their children and deriving less satisfaction from being a parent. Parents with higher rates of psychologic distress and illness may be less able to nurture their children.

A style of parenting labeled "authoritative" has been found to yield the best outcomes for children. Authoritative parenting involves a combination of affection and attentive responsiveness to children's needs, along with clear, firm expectations for developmentally appropriate, socially responsible behavior. In contrast, parenting in the circumstance of poverty characteristically tends to be less warm and responsive and more inconsistent and punitive. There is good evidence that such "authoritarian" parenting adversely affects children's development, including their self-esteem and academic achievement, and fosters problem behaviors.[36,37] Certainly, because child-rearing practices are to some extent shaped by culture and the immediate social environment of families, advice to parents needs to take those factors into account.

Although poverty may influence parenting behaviors, low-income parents are no less emotionally invested in their children than are other parents. Love is not influenced by socioeconomic status. Low-income parents usually are aware of how their social circumstances and emotional states affect their interactions with their children, but when such families lack the personal and social resources of other families, they tend to perceive fewer alternatives to their behaviors and can be frustrated in their efforts to effect change and provide their children with different experiences.

Financial Access to Care

Families may experience financial barriers to gaining access to appropriate, timely health care. These barriers may be attributable to the family's lack of health insurance; their lack of insurance coverage for dental, mental health, or other specialized services; or their inability to pay directly for care. Many uninsured families have at least 1 employed family member whose employer does not provide insurance or does not provide dependent coverage. Research from the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) reported that the increase in the proportion of uninsured children is linked to the proportion of single-parent families.[38] Limited family income also can be a barrier to preventive care for families whose health insurance requires a substantial copayment or deductible. In addition, few child health insurance policies or plans will provide additional reimbursement to primary care physicians to address family issues that are having an adverse impact on children's health status.

In addition to insurance limitations, poor families often must make difficult choices about which essential needs to meet with a limited income. Low-income families also are more likely to have health care located farther from their residence, less access to efficient transportation, and less latitude within their job to attend to needs of their children. Consequently, health resources are often sought in the evenings or on weekends and from emergency care providers. The financial costs of care in such settings are much higher and can add to families' outstanding debt. Families whose primary language is not English may experience communication barriers to care and a limited appreciation of their culturally influenced beliefs and practices. Occasionally, health care professionals and systems actively discourage poor families or families who are otherwise different from most patients from seeking care from them. All of these factors may lead families to delay obtaining necessary health care and contribute to poorer health status of all family members. Undoubtedly, the higher prevalence of some chronic disorders among poor children and the lower ratings of health status which low-income parents ascribe to themselves and their children have their roots in the social circumstances of their families.[39] Although publicly funded programs, such as Medicaid and the State Children's Health Insurance Program, have improved children's access to health insurance, they do not necessarily address the many other barriers associated with family poverty.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Working Parents, Stress, and Time

> "Americans hold parents responsible for what's happening to children and for what kids are doing. . . even as the public acknowledges that parenting is harder than ever." Public Agenda Online (www.publicagenda.org)

Unfortunately, the stresses families face are increasing, and children are experiencing the consequences. Many of these stresses are work related. "Two-parent family" usually means that 2 parents work, and most people are working longer hours. Although family-friendly work environments are increasingly common, they remain the exception. Parents seem to have maintained the amount of time they spend with their children. However, time together as a family has diminished, as has time together as a couple, time spent with friends and neighbors, and time alone. Young children spend much of their waking hours in the care of someone other than a parent, and older children are often unsupervised after school. As many as 15 million children come home to an empty house each day. Somehow, probably at the cost of time together and personal time, parents have managed to maintain the amount of time they spend with their children. Naturally, parents in 2-parent households have and are able to spend more time with their children than do single parents.[40]

The proportion of families in which the single parent or both parents work has increased steadily. The percentage of children who live with their parents who had at least 1 parent working full-time all year increased 5 percentage points to 77% between 1993 and 1998. A large share of this increase was attributable to the increase in the percentage of children who live with employed single mothers, which increased from 33% in 1993 to 44% in 1998. Among 2-parent families, 71% have both parents in the labor force. Fifty percent of mothers with infants and 64% of mothers with children younger than 6 years are in the workforce, most in full-time jobs. These employment patterns have decreased the opportunities for neighbors to know and rely on one another and share responsibility for monitoring and mentoring children.

In large measure, these trends in workforce participation obscure that many women work out of economic necessity and would rather stay at home with their children. Over the past 2 decades, the proportion of working women who work full-time for reason of personal satisfaction has remained relatively constant, whereas the proportion who work for financial reasons has increased by nearly 64%. In a recent public opinion survey, 41% of women thought that a family in which the father worked and the mother stayed at home was best for raising children; only 17% said it was beneficial for children and society to have mothers work outside the home. The highest-ranking concern among women is combining family and work. A public opinion survey found that 79% of respondents agreed that "it would be better if [mothers] could stay home and just take care of the house and children." Reflecting this view is an increasing call to encourage mothers to stay home with their children and even to provide support for stay-at-home mothers and fathers through tax policies. Conversely, out-of-home child care of high quality is beneficial to children who are at high risk of poor developmental outcomes. When such care is provided, it can have a positive effect on children's cognitive development, social competence, and behavior. Child care of such high quality is, however, expensive and difficult to access.

> "The conclusion that working mothers are not going to return home—that, on the contrary, their attachment to the labor force is likely to grow—has profound implications for public policy."[41]

Many parents, both men and women, report significant conflict between their work and family obligations. Today's jobs consume more time and more emotional energy, leaving less of both for the work of parenting. Work schedules can be unpredictable, and nearly one third of parents with young children work evenings; nights; and rotating, split, and variable shifts. Low-paying and entry-level jobs tend to not provide the types of benefits that young families need, such as health insurance coverage for family members, assistance finding child care, flexible hours, job sharing, telecommuting, financial assistance, and parental leave. Working mothers are less likely to seek medical care when their children have mild illnesses or need well-child care, although they make equal use of services in cases of more serious illness.

Parents' employment and experiences at work can influence child rearing in different ways and vary with families' circumstances. In general, fatigue, unhappiness, and stress at work can have adverse effects on parents' physical health and undermine their self-esteem and emotional well-being; parents also may bring home their dissatisfaction. Parents who experience higher levels of stress and strain have children who develop less well. Conversely, parents who are gratified by their work are more likely to interact in positive ways at home. The effects of a mother's employment on the family are far less clear and seem to depend on multiple additional factors, including mother's marital status and relationship, access to assistance with child care and housework, income, and satisfaction with the work itself. Through their work, parents learn or learn to value certain styles of relating to others. They tend also to bring these values home. Thus, parents who work in autocratic or coercive environments are more likely to practice authoritarian parenting. Parents whose work involves self-direction and independence are likely to support those traits in their children.

In the aggregate, current research fails to show any consistent support for the concern that mother-child attachment, family relationships, or children's development is harmed when mothers work. However, each family's situation is unique. Problems in these arenas, however, may signal that any 1 or several personal, family, job, or workplace factors are causing stress within the family. In addition, there is some evidence that children appreciate significant cognitive gains when their mothers stay home for at least 2 to 3 years after giving birth.[42]

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Parent's Own Health

Pediatricians have both opportunity and reason to take note of the health of their young patients' parents. Parents' mental health affects their individual functioning; social relationships with their spouses, partners, co-workers, and other adults; and their child-rearing behaviors.[43,44] Rates of depression among mothers range from 12% to 40% or 50%, with the highest rates among women who are poor or homeless or have a chronic health problem. Five key risk factors associated with the onset of depression include 1) having a parent or other close biologic relative with a mood disorder; 2) experiencing a severely stressful event; 3) having low self-esteem, a sense of low self-efficacy, and a sense of helplessness or hopelessness; 4) being female; and 5) living in poverty.[45] Mothers who live at the lower levels of poverty report higher levels of depressive symptoms.[46] Depression among women is particularly high during the postpartum period, a time of frequent contact with child health care professionals.

Maternal depression can adversely affect family functioning, parents' attitudes, and mother-child interactions. Depressed mothers tend to be less interactive with their children, and their interactions are more negative, unsupportive, and intrusive.[47] Young children of depressed mothers are at increased risk of developmental, behavioral, and emotional problems. Depressed mothers also tend to exaggerate their children's behavior problems, thus creating a cycle that increases the children's risk.

Most maternal depression goes unidentified and untreated. Only approximately 10% of women with postpartum depression discuss their symptoms with a health care professional. Mothers of low birth weight infants, especially infants classified at risk of health or developmental problems, have high rates of depression that may persist for several years if untreated. Because of a variety of life circumstances, some mothers and fathers who are not clinically depressed are still emotionally unavailable to their children. Pediatricians have the opportunity to identify maternal depression, because children of depressed mothers are brought for health care more frequently than are children of mothers without depression.[48] They can also identify parents who are emotionally unavailable not only to their child but also to one another.

The effects of parents' physical health and health behaviors on their family are less well documented. There seems to be some positive correlation between maternal and child health status and mother's health-seeking behaviors during pregnancy to predict, to some extent, subsequent rates of obtaining well-child care. Certainly, being uninsured is a family condition not restricted to children or adults and affects access to health care.[49] Most mothers have health concerns and problems of their own, and most have some appreciation of the impact of their own health on their children's well-being. Surveys have found that most mothers would welcome or not mind at all if pediatricians were to screen for parental health problems and initiate a referral for care.[50]

Parental alcohol and other substance abuse are important problems that are commonly overlooked or not addressed. The detrimental effects of intrauterine drug exposure have been well publicized. The effects of growing up with substance-abusing parents on the social, psychological, and emotional well-being of children and their families are less well appreciated. Ten percent of adults in the United States are addicted to alcohol or other drugs, and parents in substance-abusing families are more likely to be depressed. Most children who are born into substance-abusing families develop normally and become socialized, competent, and self-confident individuals. However, their family life is often disrupted, structure and discipline may be lacking, and family conflict and violence are more prevalent than in non–substance-abusing households. Alcohol and other substance abuse erode the functioning of families and may contribute to poverty, divorce, and violence within the home. These children are at greater risk of abusing alcohol and other drugs themselves and have higher rates of behavior problems.[51]

The implications of these social trends and parents' own circumstances and health on family functioning and structure are profound. Children's health and well-being are jeopardized when decreased time and energy interfere with parents' ability to nurture, teach, and enjoy their children; when families are or feel unconnected to surrounding society; when decreased family income and education foreshorten life options and experiences; and when compromised contact with parents or extended families limits material and social support.

> Children learn much about relationships from the examples they observe and experience in their homes.

Counseling, Referral, and Relationship Education

Research shows that marital failure is highly predictable. This has led to the development of a number of marriage education courses designed to decrease known risks. There is evidence that behaviorally oriented, skills-based marriage preparation programs can lead to behavioral changes that may help prevent the emergence of marital dysfunction.[52] There are also some data suggesting that brief, skill-based educational programs for couples can "increase couple satisfaction, improve communication skills, reduce negative conflict behaviors including violence, and may prevent separation and divorce."[53] Courses may focus on such topics as communication and problem-solving training, empathy training, clarification of relationship expectations, and enhancing sexual relationships.[54–56] Pediatricians traditionally have played a role in referring families to community resources, and relationship education courses can be one such resource.

> Curricula and programs must be developed to help couples to grow together and accommodate each other and thereby lessen our society's rate of divorce.[57]

Attempts to strengthen marriages and families have traditionally come from churches, synagogues, mosques, and other local community-based organizations that espouse values and offer marriage en-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

richment opportunities. Recently, Florida passed legislation encouraging couples who are contemplating marriage to participate in a premarital education class and requiring high school students and couples who are seeking divorce to participate in relationship skills training programs. Currently, most high schools discuss marriage as part of a health or life skills class. According to a published review of commonly used textbooks published between 1993 and 1997, courses tend to focus on self-esteem and self-actualization and generally avoid topics such as love, religion, commitment, and values. Although all of these efforts are an acknowledgment that the consequences of discord in marriage and of divorce are costly for society as well as for children involved, there does not appear to be a public consensus on whether these topics belong within school curricula.

Families' Social Support

The quality and extent of social support available to parents affect their children. Social support has been defined as information leading to 1 or more of 3 outcomes: 1) the feelings of being cared for; 2) the belief that one is loved, esteemed, and valued; and 3) the sense of belonging to a reciprocal network.[58] Parents do better with raising children and maintaining their spousal relationship when they have social supports outside the family; they feel more competent and deal better with stress. Parents' own experience with social networks and their own relationships are models and resources for their children, and mothers' social networks are a likely source of friends for their young children. Parents' perceived support strongly influences child rearing. Predictably, children from families with low social support are much more likely to have psychosocial problems.[59]

The communities in which families live are an essential element in the formation and support of strong, stable families. Ironically, families most in need of communities with good resources are least likely to reside in them. Single-parent households, for example, are more likely to live in neighborhoods with higher rates of poverty, female-headed households, welfare use, and high school failure and dropout.[3] Mothers with the least support from their extended families have the weakest ties to other sources and have the highest levels of distress—circumstances that tend to make mothers less emotionally available to their children and to other adults. Children do better when their families believe that they are part of a community of shared norms and values and mutual or reciprocal obligations—that is, when the families have social capital.[60] Socially isolated families are more likely to have values and beliefs that are discordant with their community's values, more likely to feel alienated, and less likely to adopt conventional child-rearing practices and health habits.[3] They are also more likely to abuse their children.

> "Caring, compassionate, and knowledgeable pediatricians must address the needs of their patients and all children in the context of the community."[61]

Religious or spiritual communities are an important source of support for many families, and religion plays a central role in the lives of many Americans. A growing body of literature has found associations between religiosity or spirituality and health, illness, and well-being. Regular participation in congregate religious activities has been associated with a variety of positive outcomes for families and children. Family stability is higher among more religiously observant families, which alone bodes well for children. Adolescent risk behaviors, such as substance use and violence, are lower among such families. The benefits of religious participation and spirituality for families may derive from a variety of associated factors, but its value to many families merits its consideration in the course of pediatric care.

Residential Stability

Contributing to social connectedness is living in a community sufficiently long to develop friendships and feel a part of that community. Approximately 18% of children move each year, a figure that has stayed constant or decreased slightly during the past 3 decades. Families with younger children are somewhat more likely to move than are those with older adolescents. Research has demonstrated a strong relationship between residential stability and child well-being, with frequent moves associated with such negative outcomes as dropping out of high school, delinquency, depression, early initiation of sexual activity, and nonmarital teenaged births. Families who move out of communities also disrupt the continuity of their children's medical care.

PEDIATRIC TRAINING AND EDUCATION TO CARE FOR FAMILIES

Given the importance of the family context to children's health, how ready and able are pediatricians to provide family-oriented care? Awareness of the need for such an orientation by the profession is not new. In 1978, the Task Force on Pediatric Education noted a dramatic increase in the recognition of child health problems associated with poverty, a deteriorating physical environment, changing family structures, and other social and psychologic factors.[62] Their report made special mention that in the future, pediatricians would be called on increasingly to manage children with problems of a developmental, psychologic, and social nature and recommended that all pediatricians have the skills to cope with these problems. A recent study found that the number of children who visit pediatricians' offices with recognized psychosocial problems more than doubled between 1979 and 1996.[63] In 1999, the Task Force on the Future of Pediatric Education II reaffirmed the earlier report and began their own recommendations stating, "Pediatric medical education at all levels must be based on the health needs of children in the context of the family and community." That report also recommended that "pediatricians should collaborate with families and other child health professionals . . . in the communities they serve."[64]

Downloaded from www.aappublications.org/news by guest on July 12, 2019

No pediatrician finishes training without the realization that he is almost always working with at least 2 patients simultaneously—a child and a parent.[65]

Pediatric training is strongly influenced by the Residency Review Committee on Pediatrics' *Program Requirements for Residency Education in Pediatrics*. The 2000 edition of that document mentions the family in several sections, including those addressing inpatient experience, training in behavioral/developmental pediatrics, and adolescent medicine.[66] Training programs are expected to provide residents the opportunity to learn "interviewing techniques with specific emphasis on behavioral, psychosocial, environmental, and family unit correlates of disease" and "utilization of appropriate members of the health care team to ensure comprehensive yet cost-effective care of the patient and family." Residents also are expected to develop appropriate skills in family structure; adoption; foster care; interviewing parents and children; needs of children at risk (eg, those in poverty, those from fragmented families, victims of child abuse or neglect); and impact of chronic diseases, terminal conditions, and death on patients and their families. The adolescent section of the guidelines includes residency training in "psychosocial issues, such as peer and family relations, depression, eating disorders, substance abuse, suicide, [and] school performance."

There is limited information about how comfortable pediatricians feel with managing family issues; no survey has asked explicitly about those skills. A recent survey by the Task Force on the Future of Pediatric Education II found that only small percentages of respondents believed their training was poor in the following topics related to working with families: caring for patients from different socioeconomic backgrounds (4.5%), providing preventive care counseling (9.4%), caring for patients from different cultures (15.9%), and coordinating patient care with community services and resources (23.2%).[67] A survey of recently trained pediatricians found with a few exceptions, none of which related to child or family psychosocial issues, that they feel well prepared for practice.[68] However, in a recent survey of parents of young children enrolled in Medicaid, fewer than half (49%) reported that their child's physician had inquired about psychosocial issues and safety within the family.[69]

Continuing medical education (CME) opportunities for pediatricians abound, but the family context of child health does not seem to be a common topic. The AAP offers a large number of courses and other educational opportunities of interest to its members. The AAP does not have data on the number of lectures that have been given on various topics. A number of courses have addressed topics of behavioral pediatrics, and, recently, some have focused specifically on family issues. At annual meetings, the individual pediatrician decides which sessions to attend, and no requirements for CME on family topics exist.

AAP publications play a central role in CME activities. *Pediatrics in Review*, the AAP journal specifically designed as part of a continuing education program, published a review article, "Family-Focused Pediatrics," in 1995[70] and has published various articles on topics of concern to families. *Pediatrics*, the signature journal of the AAP, publishes articles on a variety of topics. A brief review of articles published in that journal during the past decade found that among more than 15 000 citations were 69 articles that mentioned "family" as a keyword. Of these articles, nearly one third dealt with chronic illness; the next most common theme was psychosocial and community influences on health and health care, and approximately one third seemed to deal specifically with pediatricians' recognition and management of family issues.

The AAP produces a number of manuals and monographs to serve as reference materials and to assist in establishing standards of care for its members and other child health professionals. These materials and a number of others produced for pediatricians to use as part of parent, patient, and health education are reviewed later in this report.

PEDIATRIC PRACTICE TO MEET FAMILIES' NEEDS

Family advocates, especially those for children with special health care needs, make a distinction between family-focused and family-centered care. Family-focused care implies practices that focus on the family as the unit of intervention but are not empowering or based on a recognition of family strengths and competence. Family-centered care includes the latter characteristics and includes "the philosophies, principles, and practices that put the family at the heart or center of services; the family as the driving force."[71] Most pediatricians report that they involve families in the decision making around the health care of their child and make an effort to understand the needs of the family as well as the child.[72] Family pediatrics, or family-oriented pediatrics, like family-centered care, requires an active, productive partnership between the pediatrician and the family, but it also extends the responsibilities of the pediatrician to include screening, assessment, and referral of parents with physical, emotional, or social problems that might adversely affect the health and emotional or social well-being of their child.

Family pediatrics extends the responsibilities of the pediatrician to include screening, assessment, and referral of parents with physical, emotional, or social problems that might adversely affect the health and emotional or social well-being of their child.

Families' Expectations

Parents want guidance raising their children, and although they consider pediatricians to be good sources of information and support, they seek their counsel inconsistently. There also is evidence that pediatricians and parents communicate poorly about children's mental health problems. Pediatricians are unusually well positioned to help parents, having earned their respect and trust over the course of their professional relationship. Parents' confidence in their pediatrician rests on the professional expertise displayed when treating children's illness but often extends to behavioral and social issues. In 1978, the

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Task Force on Pediatric Education surveyed a sample of mothers to learn what they thought about the quality of medical care their children received. They felt that pediatricians were the best-qualified physicians to care for their children and reported that they would seek their counsel for a range of children's psychosocial problems. Mothers also have reported that physicians are their main source of parenting information. Still, in the course of child health visits, parents give priority to discussion of physical health and development over behavioral or family issues, although mothers of higher socioeconomic status are more interested in the latter compared with other mothers.[73]

Most parents, especially parents of young children, believe it is appropriate to discuss psychosocial problems with their child's physician, are receptive to information from pediatricians, and would find more information helpful, but fewer than half actually discuss these issues with their physician.[74,75] Only 15% to 20% of parents report that their child's physician assesses psychosocial issues of the family. Among those topics for which parents report the greatest gaps between the guidance they need and what they get are in areas of their child's communication, behavior, and discipline.[76] Parents believe that pediatricians are meeting the physical needs of their children, but most (79%) believe that they could use more information in child rearing.[74,77] Overall, surveys find that today's parents of young children are awed by their responsibilities and wish ardently that their children will grow up to be happy, healthy, productive citizens but struggle with the enormous responsibility of ensuring good outcomes for their children. The health care system provides only partial assistance during this critical period. Much more could be done to support parents in fulfilling their most important responsibility. The focus and the process of well-child care could encourage discussion about child rearing. Currently, family problems often come to light through a culturally acceptable physical or behavioral complaint. Sometimes they are voiced at the end of the visit when no more time remains. The availability of resources and referrals at these critical, teachable times may be key to resolving the family's problem.

Structure and Staffing

As of a decade ago, approximately 70% of pediatric practices offered some evening hours; currently, approximately 43% say they always and 18% say they sometimes offer weekday evening appointments.[72] According to an earlier survey, approximately 20% restricted evening service to the care of sick children. Approximately the same proportion of practices (70%) offer Saturday morning appointments; a decade ago, approximately one third of those practices restricted care to ill children, but no more recent data are available. Anecdotal reports suggest a recent trend toward fewer evening and weekend hours in some areas of the country.

The proportion of AAP members who are female has grown over time. In 1987, 26.9% of members surveyed were women; by 1992, 36.4% were women. This is reflective of the growing numbers of female pediatricians in general. According to the American Medical Association's 1998 data, 46.4% of pediatricians who practice in the United States are female—a proportion that is expected to rise, because 65% of categorical pediatrics residents in 1999 were female. Also notable is that on completion of their training, more women are entering general pediatric practice than subspecialty practice. One university-based pediatric primary care practice found not only that female physicians were spending more time with patients and in providing encouragement and reassurance but also that parents were more satisfied with female physicians.[78] In addition to the pediatrician, the office staff establishes the emotional tone and policies of pediatric practices.

Contents and Problems Seen

Pediatricians provide two thirds of all pediatric care to children through age 18, and preventive visits constitute approximately 27% of that care.[79] Pediatricians spend approximately 20% of a typical day counseling patients or their parents, but there are very few reliable data about what pediatricians actually discuss with parents. In a 1996 periodic survey of AAP fellows, 85% of respondents believed that ensuring a healthy family environment was a somewhat to very important goal of preventive care, although they ranked it last after goals involving physical health, development, developing a supportive relationship, emotional health, and safety issues.[80] Ensuring a healthy family environment was also viewed as the goal least successfully achieved. Although they rated family stress and substance abuse as important problems, they felt relatively unable to prevent these problems and had lower levels of confidence in counseling about these topics.

In a 1996 periodic survey of AAP fellows, 85% of respondents believed that ensuring a healthy family environment was a somewhat to very important goal of preventive care, but it was also viewed as the goal least successfully achieved.[80]

Child care is consistently reported as the dominant issue in the lives of most young families. Eight of 10 pediatricians say that they routinely inquire about time spent in child care among patients younger than 4 years, although fewer inquire about child care for older children. Most report that they initiate discussions with parents about returning to work after childbirth and about breastfeeding while working.[81] Fully 79% believe that they should be involved in a family's child care decisions.

Although there is great pressure for pediatricians to be productive, the average number of minutes devoted to a typical well-child visit has increased and now stands at approximately 15 minutes.[82] However, the portion of such visits that is devoted to activities in which a family problem might be identified and initially managed seems to vary greatly.[83]

Services Provided

Preventive services that pediatricians provide are most strongly influenced by the significance they ascribe to a problem; their experience, comfort, and

Downloaded from www.aappublications.org/news by guest on July 12, 2019

knowledge in specific topics; and their perceptions of their effectiveness. Time available for counseling ranked somewhat lower as a determining factor. Reimbursement was generally believed to be inadequate but seemed not to affect reported provision of preventive care. Slightly more than half of respondents (53%) believed that they had enough time to provide counseling to parents.[80] Among a group of physicians who participated in a program to promote developmentally appropriate care, between one half and three quarters discuss maternal depression and appropriate discipline practices, but less than half routinely discuss domestic violence. Factors that were most commonly reported to affect the ability to deliver the best-quality care were shortage of support staff; limited referral sources; managed care restrictions on referrals or special services; excessive paperwork; and lack of time for follow-up, teaching parents, and answering questions.[84]

Reimbursement

The source of payment for health care drives the policy and, to an unknown extent, the practice of health care by dictating services that are reimbursable and outcomes that are reportable. For example, children whose care is publicly funded have significantly fewer well-child visits than do privately insured children.[85] Prenatal care visits are recommended by the AAP, yet when pediatricians offer them, it is done without the expectation of reimbursement. Behavioral health "carve-outs" sometimes prevent primary care physicians from being reimbursed for counseling or other behavioral or mental health services and may even prevent parents from seeking help. In addition, physicians and physicians' organizations no longer serve as the primary source of medical wisdom regarding appropriate benefits, treatments, and health outcomes from a business perspective. Corporate benefits managers, managed care organizations, health care accreditation organizations, and insurance companies are setting these standards. Payers for health care services recognize that only the most cost-effective care should be rendered to minimize the tax burden (for government-sponsored programs) or the health premium (for private insurance models). Changes in reimbursement are driven by payer preferences, and these are determined by perceived and real cost of care versus benefit, health outcomes, and employee and member demand. In our current health care environment, the focus has been on efficiency of care as determined by these factors. However, important indicators of quality health care, such as family-focused or family-centered care, are not tracked or evaluated.

Innovative Concepts, Services, and Programs

There have been a number of efforts to promote preventive services and, to some extent, family pediatric care. For example, among its essential elements, the AAP definition of a medical home includes linking families to needed services, respecting families' cultural backgrounds, and providing family-centered care. The idea of family-centered care itself has been championed by the federal Maternal and Child Health Bureau and by parents of children with special needs. Case management and care coordination programs generally focus on the needs of the family as well as the needs of the child. Group well-child care and care of children with chronic health problems often promote the development of parent-to-parent support.[86] Some programs for adolescent parents purposefully involve young fathers in their child's care, but other rewards for spousal attendance are rare. High-quality preventive care is promoted by health insurance programs, including Medicaid, which do not require copayments or deductibles for preventive services. Reach Out and Read programs provide books as a component of and as an incentive for attending preventive care visits. The Healthy Steps demonstration projects (Commonwealth Fund) provide an expanded and family-oriented developmental component to child health supervision. Some pediatric practices include a child psychologist or developmental expert. Some practices and managed care plans make special efforts to coordinate physical and mental health care, and some plans allow self-referral for mental health and substance abuse services.

Group-based parent education programs, integrated into pediatric practices or community based, are effective resources for families. They can promote positive behavior change in parental perceptions and objective measures of children's behavior and can prevent risk behaviors among adolescents.[87,88] On the level of individual families, a review of parent education approaches found that parents respond best to brief, verbal information that focuses on their specific area of concern. Reinforcement with appropriate written material is helpful for more complex issues. Modeling and role playing are useful to address problematic parenting and child behavior.[89] Research has demonstrated that agreement on problem recognition between physicians and patients yields better compliance. Media, such as advertising campaigns or office posters, can be helpful for broadening parents' range of interests.

Parents respond best to brief, verbal information that focuses on their specific area of concern.

Family Lives of Pediatricians

Historically, little attention has been paid to residents' families during residency training, although interest in the impact of medical training on the families of physicians increased as women were admitted to medical school in greater numbers beginning in the 1970s. Women have outnumbered men in pediatric residency training programs since the 1980s. The proportion of women who experience pregnancy during residency training has been reported to be as high as 50%.[90] Most women who have been pregnant during residency training have reported that their pregnancy was planned, although surveys of pediatricians who were pregnant during residency training have yielded mixed results concerning their feelings about the wisdom of their choice to become pregnant. According to several studies, between 0% and 37% of female pediatricians

Downloaded from www.aappublications.org/news by guest on July 12, 2019

who were pregnant during residency training regretted becoming pregnant then or, if they could make the choice again, would have delayed pregnancy.[91–93]

The Accreditation Council for Graduate Medical Education has required that there be institutional parental leave policies for residents. In addition, the Family and Medical Leave Act[94] requires that as much 12 weeks of leave time (unpaid) be available for new parents. Although the impact of these policies has not been studied carefully, it is likely that their implementation and the gradual increase in available women role models who have balanced pregnancy, family life, and a medical career have decreased emotional stress and guilt among pregnant residents. In summarizing 1 survey of women who were pediatricians and mothers, it was suggested that "these respondents believed that they were better pediatricians and better parents than they would have been had they not pursued both activities."[93]

There have been recommendations that residency training programs offer shared and part-time training opportunities for pediatric trainees with children and other family obligations.[95] Thus far, there are no data on the extent to which these recommendations have been implemented or of the effect of shared or part-time training on programs or trainees.

In addition to the influence of their professional training, pediatricians' beliefs and behaviors regarding family issues are shaped to an unknown extent by their personal experiences as children, marriage partners, and parents. Thus, the background of pediatricians as a group may be important to understand. Pediatricians' own behaviors sometimes serve as models for families in their practice and in their communities. A trend revealed by a recent survey of young pediatricians with a median age of 34 years found that most (60%) were female.[96] Among the entire surveyed group of young pediatricians (male and female), 79% were married; 19% were single; and only 1% were divorced, widowed, or separated. Two thirds had children younger than 18 years living at home. Among another sample of female pediatricians with a mean age of 40, 84% were married, and none younger than 40 years was divorced; 4% of those older than 40 years were divorced, widowed, or separated. Among this sample, of women younger than 40 years, 69% had children at home, whereas 59% of those older than 40 years had children at home.[97]

Physicians' marriages seem to be atypical, because they occur later in life and are more stable, having somewhat lower rates of divorce than other occupational groups.[98] Certainly, the number of pediatric residents who are married and who have children has increased over the past several decades.

Approximately half of physicians, 63% male and 45% female, report high levels of marital satisfaction, although gender differences disappear after adjusting for age. Marital satisfaction was related to having a supportive spouse and low role conflict (ie, conflicting demands between professional and personal responsibilities).[99] Marriage and parenting seem to spur male physicians' commitment to work and earnings but have the reverse effect for female physicians.[100]

The proportion of physicians of all types with children is not well established, although 1 survey found that approximately two thirds of male and one third of female physicians have children. AAP member pediatricians seem more likely to have children (80.5% in 1989) than do other physicians and had an average of 2.8 children, slightly above the average for all families with children. Approximately two thirds of physicians with children were at least moderately satisfied with their parental roles. The same factors that affected marital satisfaction (the level of role conflict and having a supportive spouse) influenced parental satisfaction; having a salaried practice also contributed. More female than male physicians have made career changes for their children (85% vs 35%), although younger male physicians were more likely than their older peers to have made a career change for marriage or children.[101]

Physicians' satisfaction with their practices is influenced by a variety of factors, including relationships with patients, autonomy in clinical decision making, office resources, and professional relationships. Most physicians are satisfied with their overall practice and income. Among primary care physicians, general pediatricians are, on average, more satisfied with most aspects of their practices[102]; in 1989, 85% of AAP member pediatricians reported being satisfied or very satisfied with their careers. Physicians who are highly satisfied with their work are more likely to be satisfied with their marriages and to have fewer psychiatric symptoms.

There have been few studies on children of pediatricians or on child-rearing practices of pediatricians. A 1989 survey found that 41% of AAP member pediatricians who responded had spouses who worked outside the home full time, and another 21% had spouses who worked part time. Of those with children younger than 5 years, child care was provided by the spouse 54.9% of the time, 20.4% were cared for in the home of a nonrelative, and 16.3% were enrolled in a child care center.[103] Pediatricians reported that their greatest concerns for children of working mothers were in the areas of discipline and emotional behavior; of least concern were intellectual development and nutrition.

AAP POLICIES

Review of Existing AAP Policies

The task force was charged with undertaking a careful review of existing AAP policies relative to their impact on family and family function, making recommendations to committees and the board with respect to policy modification based on data development and analysis. Although all materials published by the AAP constitute policy, formal polices are reviewed and continually updated by AAP committees and can be found on the Web site at www.aap.org/policy/pprgtoc.cfm.

The task force reviewed 315 AAP policies and identified those that seemed to have a potential im-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

pact on families and family functioning. These policies range from issues such as vaccine preparations and Pediatrics Review and Education Program changes, which are targeted at pediatricians, to issues such as foster care, adoption, and sports participation, in which families' roles are clearly central. The review found that 63% of the 315 policies had an impact on the family. The identified policies were further reviewed to determine whether the family was mentioned in a positive manner, in a negative manner, or not at all. In 65% of these policies, the family was mentioned in a positive manner, and only 1% of the policies had a negative comment. In 34% of the policies, the family was not mentioned, and its role in the problem or solution addressed in the policy was not explored.

Some committees seem especially aware of the centrality of the family in pediatric practice. For example, in the statement "The Pediatrician's Role in Family Support Programs," the Committee on Early Childhood, Adoption, and Dependent Care states, "The health and welfare of children depend on the ability of families and their community support systems to foster positive emotional and physical development. . . . The primary responsibility for the development and well-being of children lies within the family."[104] After defining the role of the family, the policy defines the role of the pediatrician in the following manner: "Pediatricians can provide family support by engaging in a relationship with parents based on collaboration and shared decision making so that parents feel and become more competent."

The role of pediatricians assisting not only the child but also the family is also found in the policy statement "The Pediatrician's Role in Helping Children and Families Deal With Separation and Divorce" by the Committee on Psychosocial Aspects of Child and Family Health: "For many families, pediatricians may be the only readily accessible professional with expertise in the psychosocial aspects of child and family health."[105]

In its policy statement "Death of a Child in the Emergency Department," the Committee on Pediatric Emergency Medicine clearly describes the respectful interaction with the family in the event of a child's death: "A pediatrician working in the [emergency department] should remain sensitive to the grief of the family while obtaining a medical and social history and conducting a thorough physical examination and evaluation, attempting to determine the cause of the child's death. . . . Interventional counseling and support for the parents, siblings, and other family members is essential to facilitate a normal grieving process. . . . The grief of siblings, other family members, or other children involved in the death should not be overlooked. The [emergency department] should have a private, established area where the family may grieve and speak with physicians, nurses, chaplains, social workers, child protection services, or police."[106]

Other AAP policies mention families but do not explicitly discuss the pediatrician's role, the involvement of the family, or how to strengthen the family. For example, in "Home, Hospital, and Other Non–School-Based Instruction for Children and Adolescents Who Are Medically Unable to Attend School,"[107] the Committee on School Health describes non–school-based instruction and mentions parents only as a source of information rather than as a partner and the primary decision maker for the child: "Information should be exchanged among the school, parents, and primary care physician to select the most appropriate type of non–school-based instruction for the child."

One recent revision of a policy statement might indicate that policies are becoming more family oriented. The 1989 version of the policy statement "Adolescent Pregnancy" did not address the role of the family in prevention, support, and collaboration with the pediatrician.[108] The only mention of family was "the anger and distress engendered in some families by pregnancy in a young, unmarried daughter makes it apparent that these girls bear a significant social burden." The family is not seen in a positive manner in this statement, and the impact on the family is not to include them in the decision-making process. However, the most recent revision of that statement does address families more explicitly: "Factors associated with a delay in the initiation of sexual intercourse include living with both parents in a stable family environment, regular attendance at places of worship, and increased family income."[109] It also lists parents, along with many others, as having roles in successful pregnancy prevention programs. Overall, there is little attention to the positive role that families can play. Absent from the statement are advice to pediatricians on how to engage, educate, and support the adolescent's extended family and mention of that family's long-term involvement in their adolescent's care.

Assessing Family Orientation

New AAP policies are constantly being developed, and existing policies are regularly reviewed. Through the process of review and group discussion, the Task Force on the Family developed a series of questions to assess the presence of family orientation in AAP policies (Table 2). These questions can assist AAP committees when they review existing policy statements and develop new ones. The questions are meant only as a guide to avoid some of the shortcomings identified in existing policy statements during the course of the task force's review. A related, second series of questions was developed that can be used by the AAP to evaluate public policies, programs, and services that they might endorse or promote (Table 3).

Practice Policies

The AAP has endorsed a number of guidelines and policies related to recommended contents of child health supervision. *Bright Futures: Guidelines for the Health Supervision of Infants, Children, and Adolescents* was developed in part because, "health supervision policies and practices have not kept up with the pervasive changes that have occurred in the family, the community, and society . . . a new ''health supervision' is urgently needed to confront the ''new mor-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

TABLE 2. Assessing Policy Statements for Family Orientation

Does the policy statement
Potentially have an impact on families or family functioning?
Explicitly and positively mention the family or parents?
Respect the family's autonomy and values?
Address the ongoing role of the family in the child's care?
Acknowledge that parents are experts about their child and are the child's primary caregivers?
Identify and promote family strengths and skills?
Promote family involvement in decision making?
Consider the structure of the household and circumstances of the family?
Strengthen the partnership relationship between the family and the pediatrician?
Discuss the role of the pediatrician with regard to assisting and strengthening the family?
Promote the pediatrician's role in screening and referral of parents for physical and mental health problems?

TABLE 3. Assessing Public Policy Positions for Family Orientation

Does the public policy, program, or service
Promote and support decision making by the family regarding their child's health care?
Strengthen the health, safety, and well-being of families?
Enhance family knowledge and skills regarding child rearing?
Require family involvement in the development of programs and public policies?
Increase services to children and families?
Support families to be primarily responsible for addressing the needs of their child?
Promote family connections to their community?
Promote marriage and social stability of families?

bidities' that challenge today's children and families."[110] Appropriately, it recommends that "health supervision goals include enhancing families' strengths, addressing families' problems, promoting resiliency, building parental competence, and helping families share in the responsibility for preventing illness or disability and promoting health."[110]

In the AAP *Guidelines for Health Supervision III*[111] developed by the Committee on Psychosocial Aspects of Child and Family Health, pediatricians' responsibilities for families are explicitly discussed as follows: "Pediatricians are in a unique position to recognize the manifestations of stressors in parenting, evaluate the risks involved, and determine the necessary interventions. Pediatricians may observe evidence of difficulties in the family system as they assess the parents, the child, and the interactions among them. When pediatricians identify children or families at risk, they should recommend appropriate interventions to strengthen the family's resources."

"Pediatricians are in a unique position to recognize the manifestations of stressors in parenting, evaluate the risks involved, and determine the necessary interventions."[111]

In addition, the various age-specific chapters of *Guidelines for Health Supervision III* include a number of recommended questions to screen for family problems. These questions explore changes in family constellation, recent stresses, changes in work or child care arrangements, parents' physical and emotional health, and many other topics, most of which are outlined in Table 4.

TABLE 4. Parental Characteristics That Place Children at Risk

Individual parent illness or vulnerability
Chronic physical or mental illness
Mental retardation or education deficiencies
Personality disorders
Alcoholism or other drug abuse and addiction
Lack of social or economic support systems
Poverty
Conflictual marriage
Family relationships
Unavailable social support
Limited child care resources
Privacy
Excessive child rearing responsibilities
Chronically ill or disabled child
Large family
Multiple birth
Difficult temperament in child
Disagreement about child rearing
Other demands on parents
Work schedule
Responsibilities for extended family members
Job responsibilities or dissatisfaction
Insufficient personal time
Household chores

FEDERAL AND STATE POLICY

Role of the AAP in Shaping Public Policy: Process

Public policies established by federal, state, and local governing and administrative bodies clearly have great impact on the health, safety, and welfare of children and their families and on the ability of pediatricians to serve them. The AAP and its members have a long history of advocating for public policies that benefit children and pediatricians' ability to serve children. Two AAP departments are charged with working on public policy issues: the Department of Federal Affairs and the Department of Chapter and State Affairs, Division of State Government Affairs. The positions of the AAP on public policy issues are based on existing AAP policy, as manifested in policy statements, model legislation, and other publications and directives from the executive committee or board of directors, which are usually advised by the appropriate national committees, task forces, or other AAP bodies. The AAP takes the lead in advocating policy positions with respect to certain issues, such as health insurance coverage for children. On other issues, the AAP has been less involved, lending its support as part of a coalition of organizations. Generally, AAP involvement is greater when pediatricians' expertise is closely relevant to an issue or the matter has a significant or widespread impact on children or pediatricians.

A number of federal programs are aimed at helping low-income children, pregnant women, and families with children. There are also federal policies that help children and families regardless of income, such as the Family and Medical Leave Act, and programs that provide funding for child protection, education, public health infrastructure, and medical education and research. Other federally funded programs are aimed primarily at supporting the integrity of the family by decreasing the incidence of child abuse and neglect (eg, the Child Abuse Prevention and Treatment Act[112] and funds used for family preser-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

vation activities) or federal funding sources that can be used by federal agencies or states for a variety of activities, including programs that would provide support to families.

> "Our society—especially our public and economic institutions—does not give sufficient time, status, and financial support for the essential task of care-giving in families, schools, or child care centers."[1]

Some public policies and programs may have unintended consequences on families or family structure. For example, for many years, families with 2 parents were not eligible for federal welfare assistance and concomitant Medicaid benefits, a policy believed by some to have discouraged marriage. Many policy makers and commentators argue that current income tax policies result in a "marriage penalty," because in some cases, a married couple must pay more taxes jointly than the 2 individuals would pay if they were not married. However, tax policies are very complex; some couples enjoy tax benefits from marriage.

Given the myriad of public policies that affect children and families at all levels and in all branches of government, how can the AAP decide where to focus its energies to best serve children and their families? To what extent should the advocacy efforts of the AAP be aimed at helping to improve family functioning if it means that scarce resources are thereby diverted from advocacy on matters more directly related to child health?

As this document has described, a child's health and well-being are intimately related to the health and well-being of the child's family, including the relationship between the child's parents. Public policy can have an influence on family structure, functioning, and well-being. Accordingly, the AAP has concerned itself with public policies that affect families as a way of promoting child health and well-being.

The task force identified 2 types of public policies for which the AAP could advocate: 1) those that will enhance the ability of pediatricians to provide support for families and 2) those that will directly support and strengthen families. In the first category are policies that ensure that pediatricians have adequate training, time, resources, and reimbursement to provide family-oriented care. These include reforms that could be achieved through changes in state insurance benefit mandates, changes to Medicaid policies at federal or state levels, other federal programs and policies, and attempts to change the reimbursement policies of private insurers, directly or through employers who provide the benefit to their employees.

Reforms to the insurance system that would provide better coverage for family-centered counseling, education, and mental health services would include securing reimbursement for pediatricians for such services. This would allow pediatricians to be economically able to practice family pediatrics, which would include the following:

- discussing effective parenting with parents;
- assessing and responding to the needs of all families for social support;
- ascertaining how conflict is managed within families;
- screening for domestic violence;
- inquiring and advising patients about child care, parental time allocation, and the importance of balancing work and family responsibilities;
- ascertaining the mental health of the parents in their practice; and
- routinely assessing the entire family's health, health practices, and health behaviors.

In the second category of public policies for which the AAP could advocate are those that would better enable parents to provide adequate emotional and material support for their children. Among these policies would be those that will enhance the health and strength of families, parental involvement in children's lives, the skills of parents, and parents' ability to provide financial security for their children. The list of potential topics is long and ranges from ensuring access to good-quality child care to labor law reform. The task force's recommendations are designed to identify some first steps in building a policy agenda.

Existing policies represent a piecemeal approach to addressing the needs of children and families in the United States. Although continuing to advocate for specific policy changes, the AAP may wish to consider taking a leading role in promoting the development of a cohesive, coherent approach to family policy for the country.

RESOURCE MATERIALS

The AAP produces patient and parent brochures on a variety of subjects. Most of these are designed to provide parents with anticipatory guidance about managing common developmental and family issues and preventing dangerous events and behaviors. For example, topics include sleep problems, temper tantrums, television and the family, discipline, substance abuse prevention, and environmental tobacco smoke. Others more specifically address family issues, such as single parenting and divorce. The brochure *You and Your Pediatrician* notes that pediatricians will work with parents on issues of emotional and family problems.[113]

In addition to educational pamphlets, the AAP publishes a series of age-specific parent and child guides to pediatric visits.[114] These pamphlets, designed to be given to parents in advance of a health supervision visit, provide some developmentally appropriate information and assist parents in identifying areas of concern they would like to discuss with the pediatrician. Among the list of topics that parents may identify as child health and development concerns are many that specifically relate to family issues, including death or illness of a family member, financial problems, family psychologic problems, conflict, violence and substance abuse, and parents' childhood experiences that may be influencing their child-rearing practices.

The AAP also produces a 3-book series on caring for children from birth through age 5, ages 6 through 12, and age 13 and older.[115–117] Each of these books

Downloaded from www.aappublications.org/news by guest on July 12, 2019

devotes a great deal of space to discussing family issues. These books, thoroughly reviewed by AAP committees and board members, discuss a large number of family issues, including communication, problem solving, routines, moving, parents' work, marriage and divorce, and single and stepparents. These publications can be useful not only to parents but also to professionals who work with children and families.

Resources for Resident Education

The AAP *Guidelines for Health Supervision III*[111] is a primary resource that could be used for resident education regarding family issues. The more recent editions of these guidelines have devoted more attention to the therapeutic alliance that should exist between the pediatrician and patients and their families. Many of the task force's recommendations were anticipated by the content of this publication. In addition to age-appropriate health assessment material, information is presented to help the pediatrician-in-training be aware of and discuss family relationships and parenting practices. Many AAP public education brochures that deal with family and emotional issues also could be helpful in resident education.

SUMMARY

Overview: Importance of the Family

A well-functioning family of 2 parents and their children is potentially the most secure, supportive, and nurturing environment for children. Parenting is difficult and is easier when shared. Children do best when raised by 2 caring, cooperative parents with adequate social and financial resources. Having married parents, in general, is good for children—economically, socially, spiritually, and psychologically. Marriage strengthens children's claims to the economic resources, love and affection, nurturing, and social capital of both parents, including access to extended families. Marriage helps promote and support responsible and caring parenting. Moreover, parents' help, support, encouragement, and love for each other enhance their effectiveness as parents. Parents' love and respect for each other promote the child's well-being.

> "Good-hearted parents who aren't afraid to be firm when it is necessary can get good results with either moderate strictness or moderate permissiveness. . . . The real issue is what spirit the parent puts into managing the child and what attitude is engendered in the child as a result."[118]

Children seem to do better when there is a fit between the temperament, personality, and needs of children and the style of parenting they receive. That fit is best achieved when parents are authoritative—when they are warm and affectionate, clear and firm about their expectations, and not rigid. Too strong parental control is associated with more school problems, lower sociability, and less initiative.[119]

Feeling connected to their family is healthy for children, adolescents, mothers, and fathers. Belonging to a family is a dynamic process in which parents influence children, spouse affects spouse, and children change parents. Children's physical and emotional health and their cognitive and social functioning are strongly influenced by how well their families function. It is essential that pediatricians realize that the family is their patient—not just the child. Everything the pediatrician does for the child is within the context of the family. Therefore, for pediatric care to be effective, it must be family oriented.

Families need more support than even the best-intentioned pediatrician can provide. Pediatricians are expected by society to advocate for children and families. All social institutions, especially the workplace, places of worship, schools, and community and social agencies and organizations, need to be encouraged to support families. It is particularly appropriate, pragmatically and from a spiritual standpoint, for organized religion to encourage the initiation and maintenance of marriages. In addition to assisting individual families, communities should institute policies and programs that promote social connectedness—families knowing and helping families.

The State of Pediatric Practice

Families with children are struggling to succeed. To be most helpful, pediatricians must understand not only the problems families face but also what is required for families to be successful. They must learn to recognize families' strengths as well as their needs to help families function optimally. Table 5 lists the characteristics of a family-oriented pediatrician.

The task force strongly endorses the belief that assessing and addressing the health and well-being of the family should be an integral part of pediatrics. The family as a unit is so basic and central to the care and welfare of the child that it is imperative that the profession embrace the concept of family pediatrics and what it entails. In the context of family pediatrics, traditional medical therapy, anticipatory guidance, and managing the new morbidities should become standard parts of pediatric training and practice. Families, because of a number of interacting factors, may be unable to meet the medical or social needs of their children. The pediatrician must consider the dynamics involved while screening for and diagnosing problems and developing a management plan or initiating a referral. The challenge is to obtain and incorporate the necessary information as completely and concisely as possible into a functional plan. Those who take the time, mostly at their own expense, to listen and offer suggestions can make a difference.[120] It is appropriate for pediatricians to identify the types of support that enhance family stability and function and offer connections to those services and activities. However, the task force recognizes that some pediatricians may not be willing and others may not be ready to provide care that considers and encompasses the family. Shortcomings in their training, experience, referral networks, reimbursement, and available time all present barriers to this expanded role.

Opportunities abound for the practicing pediatrician to become involved in the nurturing of the fam-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

TABLE 5. A Family-Oriented Pediatrician

Learns about
Family members' health and well-being
Parenting issues and practices
Values and goals of the family
Family's relationships and time together
Impact of the child on the family
Community activities and involvement
Work and child care
Family strengths and social supports
Marriage
Provides
Information about the practice-its schedules, policies, web site, special services, and recommended consultants
Information about how the physician handles family issues
Adequate evening and weekend hours for sick and well care
Accommodations for other family members (eg, chairs, space, reading materials)
Written, age-specific materials on parenting, family issues, and local family support services
Space for breastfeeding
Telephone consultation hours
Opportunities for groups of parents to meet to discuss common issues
Prenatal visits
Encouragement for maintaining a healthy marriage
Opportunities to discuss parent and family issues
Establishes
Active roles for each family member during the clinical encounter
That both parents or significant caregivers should attend scheduled appointments
A welcoming, courteous, and culturally competent medical home
Refers
Parents preventively to relationship or marriage education courses
To mental health professionals who offer family-oriented services
Patients for appropriate medical care when problems are identified
Displays
Lists of community and volunteer organizations that incorporate parental participation
Lists of local family-oriented activities and services
Information about parenting courses and relationship education
Information on child care resources and baby-sitting
Symbols or visual cues signaling that all types of patients and families are welcome
Pictures of families of all types

ily. Involvement may vary from extensive counseling to referral and resource recommendations and from community to state and national advocacy. Participation in the local community as a parent or a volunteer may enhance credibility. The pediatrician's experience of parenting and family relationships makes him or her more appreciative of the dedication, effort, frustration, and rewards of family growth.

Pediatricians ordinarily have no problem identifying which resources to bring to bear in caring for an ill child, but resources for families may not be as well known. Consultation with colleagues in child development and mental health professions provides the broadest selection of needed services. School guidance counselors and the family services division with the state health department are good sources of assistance. Many community and private foundations, religious organizations, information and referral agencies, and other organizations that focus on the family may be of assistance to patients and families. Most communities also have informal associations and groups that share interests or goals that also can be of great assistance.

Professional Education and Training

Medical education traditionally has not provided adequate education about families and the family unit. There is a need to improve the quality of such education. Growth and development of the individual, the effect of culture on childhood and adolescence, family planning, marriage, family development, and family functioning all are subjects of anticipatory guidance and are clearly within the realm of the practice of family pediatrics. Pediatricians must learn more about the family context of child health, but questions persist about how and by whom it is to be taught. Pronouncements about the family often polarize discussions, and objective information is sometimes lost. Reliable and useful research-based information on families and child development must be made available to pediatricians and pediatric educators. The information should be culturally sensitive.

Advocacy and Policy

There is a growing appreciation that nurturing children must be a shared responsibility of the family, the state, and the community, including professionals. Pediatricians have a unique opportunity to assist families and strengthen their ability to meet their children's needs. To do this effectively requires the pediatric profession to expand its roles and responsibilities to include partnering with the family and caring for it in new ways.

The AAP, founded to address the needs of mothers and children, is long overdue to expand its concern to include the needs of families. As a national organization and through its state chapters, committees, and sponsorships, the AAP is well positioned to provide the stimulus and background for a national discussion on the desirability of stable, healthy, and well-functioning families.

A Future for Pediatric Practice

The task force recognizes that some of its recommendations are derived from principles with underlying values shared by the task force members. Similarly, in establishing the Task Force on the Family, the AAP responded to the principle that the family is important to the practice of pediatrics and to the well-being of children. The AAP further supported that perspective in its latest strategic plan in which it committed itself to addressing the needs of families as well as of children and communities. The task force concurs with that point of view and has concluded that in addition to meeting the health care needs of children, high-quality pediatric care requires attention to caregivers' relationships, health, and behaviors. The task force has further concluded that there is a need to achieve a consensus regarding the importance of parenting and families not only within the pediatric profession but also more broadly throughout society. That consensus should be based

Downloaded from www.aappublications.org/news by guest on July 12, 2019

on science within a moral and cultural context. Accordingly, the Task Force on the Family offers the following conclusions and recommendations.

CONCLUSIONS

The Task Force on the Family reviewed research literature and demographic information about American families. From that review, it is clear that children's outcomes, physical and emotional health, and cognitive and social functioning are strongly influenced by how well their families function. There is much that practicing pediatricians can do, acknowledging current constraints, to help nurture and support families and thus promote optimal family functioning and children's outcomes. From its review, the task force has tried to draw a limited number of cogent conclusions that are relevant to pediatrics. Underlying each of the specific conclusions is the principle that, to address effectively the health and well-being of children, pediatricians must approach the family—not just the child—as the patient.

Family Function and Structure

1. In general, children grow up to be healthier, more productive, and more well-adjusted adults when their parents are married and live together, support each other, communicate effectively, maintain good mental and physical health, and eschew violence.
2. Each family's circumstances are unique, and a family's composition, including marital status, number and gender of adults and children in the household, race, ethnicity, cultural, religion, and sexual orientation, does not accurately predict its functioning.
3. Children can thrive in a variety of family types in addition to the traditional 2-parent, married household.
4. Active involvement of fathers in the lives of their children is important for their emotional, educational, and economic success.
5. Children do best when authoritative parenting is provided by parents who are responsive to their needs and feelings and combine warmth with thoughtful, firm limit setting consistently over time.
6. Parents' approach to child rearing reflects their experiences within their own families of origin, within their current family, and with their other relationships.
7. The birth of a child and the many other events, transitions, and crises that families experience are times when parents are especially available and open to education and advice.
8. Sufficient economic and social support is needed by all families and, in addition, can decrease the special challenges of being a single parent.

Family Circumstances

9. Children are at special risk for health, behavior, and emotional problems when their families 1) expose them to conflict, anger, and aggression; 2) fail to meet their emotional needs; and 3) do not effectively discipline them or help them to internalize appropriate social norms and values.
10. Depression and other emotional problems of parents, marital tension, and parental substance abuse (which is often associated with domestic violence) have a detrimental impact on children.
11. The circumstances of a divorce—especially the previous and subsequent relationship between the parents, between the parents and the child, and between the child and the parents' extended family and friendship network and the custodial parent's financial circumstances—are powerful determinants of its impact on a child.
12. Remarriage and stepparenting, although common events, require major readjustments for families and often are very difficult for children.
13. The responsibilities and structure of parents' employment often are time consuming and stressful and can adversely affect child rearing.
14. Safe, nurturing, and developmentally appropriate child care inside and outside the home can enhance outcomes for children; poor-quality child care can have detrimental effects on children's development and behavior.

Pediatric Practice

15. Family-oriented care often requires that pediatricians refer to and collaborate with other professionals to address the needs of families.
16. Although there are few studies about the family circumstances and family lives of pediatricians and pediatric residents, it is likely that their personal family experiences affect their approach to patient care and education.
17. The workplaces of pediatricians vary greatly in how well they adopt and implement family-friendly policies.
18. Pediatric practice should encompasses the well-being of the family as well as the health of the child.
19. To provide appropriate care for children, pediatricians must expand their practices to encompass the assessment of family relationships, health, and behaviors.

Policy

20. Families face many barriers to accessing family-oriented care, such as prenatal visits, family-centered counseling and mental health services, and parent advice or education visits.
21. There is a need to achieve a broad consensus within the medical profession and society at large regarding the importance of marriage, parenting, and families that is based on science within a moral and social context.
22. Parents have primary responsibility for meeting their children's physical, emotional, social, educational, and spiritual needs but need to be supported in carrying out this responsibility by family, friends, community, and society.

Parents and other caregivers, as well as the larger community, share responsibility for emotional and material support of children as well as the transmission of values. We grossly

Downloaded from www.aappublications.org/news by guest on July 12, 2019

underestimate the material and nonmaterial resources needed by families to undertake successfully the role of parenting.[121]

RECOMMENDATIONS

The task force's recommendations have implications for the training and continuing education of pediatricians, for the policies supported and implemented by individual pediatricians and the AAP, for the way in which individual child health care is provided within a family context, and for research that needs to be done.

Recommendations for Education of Pediatricians and Parents

Resident Education

The AAP should encourage the Residency Review Committee for Pediatrics to require pediatric residents to have the skills and knowledge to carry out a family assessment and provide family-oriented care.

1. Residents should understand the impact of family structure, family dynamics, and family functioning on children and adolescents.
2. Residents should be able to convey information on effective child rearing, including communication between parents and children and between parents.
3. Residents should recognize the importance of knowing about and knowing how to refer families to public child health programs, support services, and community resources.
4. Residents should be capable of screening for family stress and identifying mental illness, substance abuse, and domestic violence in parents and suggesting assistance.
5. Residents should make available to parents information on the value of social support of all types.
6. Residents should recognize the special stresses faced by single parents compared with 2-parent families.
7. Residents should be able to explain the potential benefits of the father's involvement in the home.
8. Residents should be capable of helping families understand the effects of divorce on the physical and emotional health of children and counseling families in decreasing the adverse effects of divorce on their children.
9. Residents should be able to recognize and assist families to manage the problems and risks associated with stepfamilies and live-in partners.
10. Residents should understand and acknowledge the potential advantages and disadvantages of at-home parenting and out-of-home child care to children, families, and communities.
11. Through the Residency Review Committee for Pediatrics, the AAP should encourage training programs to implement policies, procedures, services, and accommodations that support residents who are pregnant or have children.

Continuing Education of Pediatricians

The AAP should develop a comprehensive plan to provide practicing pediatricians with continuing education in family-oriented care so they have the skills to screen, assess, advise, and assist all families in their practice and thus promote the best outcomes for children. These include, at a minimum, the skills and knowledge included in recommendations for resident education. In addition, the AAP should promote family-oriented care by doing the following:

12. All CME offerings should consider their impact, consequences, and opportunities for enhancing family functioning.
13. CME courses should consider the impact of a child's health problem on the family and vice versa.
14. CME offerings should consider the family context of a child's problem as an opportunity to educate the family and address their need for services.
15. There should be CME offerings to address practical, time-efficient approaches to providing family-oriented care in office practice.

Educational Materials for Parents

The AAP should continuously review its parent education materials to ensure that they include information that promotes a family-oriented approach to child rearing.

16. AAP materials should be consistent in recommending effective parenting strategies that are developmentally appropriate and responsive to children's individual needs.
17. The AAP should develop a brochure on the importance of fathers and how they can be involved in promoting the successful development of their children.
18. The AAP should develop a brochure on the impact of family well-being on children's behavior and development.

Recommendations for Public and Internal Policy and Advocacy Activities

Public Policy for Children and Families

The AAP should become more active in advocating for public policies to better enable parents to provide adequate emotional and material support for their children (see Table 3). To this end:

19. The AAP should advocate for public policies and public education programs that encourage, support, promote, and help to sustain healthy marriages.
20. The AAP should support reforms of the public and private insurance system that would provide better coverage for parents in addition to children and for family-centered counseling, education, and mental health services by primary care physicians.
21. The AAP should support public policies that help all families meet the needs of their children regardless of the families' composition or structure.
22. The AAP should support public policies that give priority to helping families with young children meet the needs of their children.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

23. The AAP should advocate for public policies that ensure the availability of affordable, healthy, safe, and developmentally appropriate educational child care.
24. The AAP should develop a mechanism to assess the impact on families of all proposed legislation that it promotes or targets for support.
25. The AAP should promote public policies that hold parents responsible for meeting their children's needs while providing support to enable families to meet those responsibilities effectively.

Advocacy for Pediatricians

The AAP should advocate for public policies to ensure that pediatricians have adequate time, resources, billing options, and reimbursement to provide family-oriented care.

26. The AAP should investigate the possibility of advocating for an insurance benefit or other incentives to encourage both parents to be present for health supervision visits.
27. Insurers should be encouraged to pay for prenatal pediatric visits.
28. The AAP should assist pediatricians to design practice models and provider contracts that include services for family-oriented care.

Internal AAP Policy

29. The AAP should encourage pediatricians to act as family advocates and should help equip members for that role by providing appropriate continuing education experiences and materials.
30. The AAP should serve as a model for family-friendly policies, practices, and work environments.
31. The AAP should establish a visible and influential process that continues the work of the Task Force on the Family, promoting the development and adoption of family pediatrics (see Table 2).

Local Advocacy and Institutional Policy

Through its chapters and its relationships with other professional organizations, the AAP should promote local and national policies and activities that support and strengthen families.

32. The AAP should encourage schools and communities to make skills-based relationship education available.
33. The AAP should support the availability of prepregnancy education, relationship education, premarital counseling, and pre- and postdivorce counseling for parents.
34. The AAP should promote and participate in public education regarding the important role fathers can play in the successful development of their children.
35. The AAP should advocate for family-friendly workplaces and policies that enhance the ability of parents to be available for their children.
36. The AAP should adopt a definition of the family-friendly work environment that includes but is not limited to one that has flexible hours, adequate staffing, and parental leave policies that acknowledge the family responsibilities of both parents.
37. The AAP should encourage purveyors of public media to present and promote positive family role models.

Recommendations for Pediatric Practice

Pediatricians should promote good family functioning by providing advice, support, and appropriate referrals to assist families to meet their children's needs.

Key Practice Behaviors

38. Pediatricians should be knowledgeable about the structure and functioning of families for whom they provide care.
39. Pediatricians should encourage families to set aside time to be together, share activities, and establish routines.
40. Pediatricians should routinely discuss effective parenting with parents and should support child rearing that is responsive to their child's needs and feelings and combines warmth and thoughtful, firm limit setting consistently over time.
41. Pediatric practices should be designed to welcome and meet the needs of families of diverse composition and beliefs (see Table 5).
42. Pediatricians should provide nonjudgmental, culturally sensitive, family-oriented care to all of their patients. This requires that the family's history, interactions, and preferred solutions are considered, used, and supported.
43. Pediatricians should help families identify their strengths and the assets that they bring to the task of child rearing.
44. Pediatricians should assess and respond to the needs of all families for social support, not only those who they anticipate may have a greater need.
45. Pediatric practices should emphasize helping parents to meet their responsibilities as the adults primarily responsible for their children's physical, emotional, and social health and development.

Promote Parental Partnerships

46. Pediatricians should assess and seek ways to enhance and strengthen the marriage and relationship between their patients' parents.
47. Pediatricians should inquire about and screen for tension in the home over key areas, such as behavior management, expectations, responsibilities, and communication.
48. Pediatricians should encourage both parents to be involved in the health care, education, discipline, and emotional support of their children.
49. Pediatricians should routinely inquire about the involvement of the father in child rearing, educate parents about the importance of the father's involvement in child rearing, and voice their expectation that the father will be present at child health supervision visits.

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Marital Issues

50. Pediatricians should be aware of the negative impact of marital conflict and divorce on children of different ages and should educate divorcing parents about what they can do to decrease the adverse effects on their child. They should provide advice, written materials, and referrals to other professional services and support groups.
51. Pediatricians should recommend and support an active role and assumption of some child-rearing responsibilities by the noncustodial parent, if appropriate.

Specific Services

52. Pediatricians should use prenatal and early visits with new parents to discuss the importance of parents' relationships, the predictable changes in relationships between parents and among parents and children, and the value of both parents sharing in the care of the child.
53. During family crises and transitions, pediatricians should focus on the impact of these events on the family as well as on the individual child.
54. Pediatricians should be familiar with and help families find and use resources that can assist them to obtain educational, supportive, and clinical services from their extended family, community agencies and services, faith organizations, and neighbors.
55. Pediatricians should ascertain how disagreement and conflict are managed within families, routinely screen for domestic violence, and intervene or make a referral when problems are identified.
56. Pediatricians should actively identify and refer families who might benefit from counseling and support services because of medical or social problems.

Personal Advocacy

58. It is appropriate for pediatricians to review the practices and policies of the environment in which they work to ensure that they and their employees are able to fulfill personal and family responsibilities.

Child Care

59. Pediatricians should inquire about daily child care arrangements for their patients and respect the choices that parents make regarding work while educating them about the needs of their children. This includes discussing parental time allocation, characteristics of good-quality child care, and the importance of balancing work and family responsibilities.
60. Pediatricians should know what constitutes good-quality child care and should be aware of the potential advantages and disadvantages of at-home parenting and out-of-home child care for children, families, and communities. They should support and advise parents as they create or identify safe, healthy, and developmentally appropriate educational environments for their child.

Family Health

61. Pediatricians should ascertain the physical and mental health of the parents in their practice and periodically review the importance of parents' attention to their own mental health needs.
62. Pediatricians should routinely inquire about and discuss the use of tobacco, alcohol, and other drugs by family members and the effect of these behaviors on children's health and well-being.
63. Pediatricians should routinely ask about and assess the entire family's health, health practices, and health behaviors.

Recommendations for Future Research

The AAP should encourage or undertake research to better enable pediatricians to provide family-oriented care.

Practice Policy

64. Research should be performed on the impact and cost of family-oriented care on child health outcomes.
65. Research should be performed on barriers to family-oriented care and how to remove those barriers.
66. Research should be performed on patient satisfaction, including provider responsiveness to family concerns and problems.

Pediatric Practice

67. The best practical interventions should be identified for pediatricians to promote effective parenting and to strengthen families, including those with children who are born outside marriage or living outside the parenting partnership.
68. Methods or protocols should be evaluated and recommended for screening for parental stress and identifying mental health problems, substance abuse, and domestic violence.
69. Instruments and protocols should be developed and recommended for the assessment of and intervention with families in the context of child health care.
70. The AAP should encourage research on the consequences of different family structure, child-rearing models, and the role of government in supporting families.
71. The ways and extent to which parents participate in well-child care and children's daily lives should be studied.
72. Interdisciplinary team practice models should be developed and evaluated as vehicles for more effective care.

Public Policy

73. Research should be performed on how to involve effectively adolescent and other high-risk fathers in the lives of their children and when it is appropriate to do so.
74. The most effective public policies to provide support for single parents should be identified.
75. The impact of carve-outs and different levels of benefits and reimbursement for mental health

Downloaded from www.aappublications.org/news by guest on July 12, 2019

services on child health and pediatric practice should be evaluated.

76. Research should be performed on the effects of relationship education on child health outcomes.
77. Research should be performed on the effects of family stability, parental workforce participation, and families' community involvement on children's health and well-being.

AAP Policy

78. Studies should be performed on the family compositions and parenting practices of AAP members and on factors that influence their family experiences.
79. Standards for evaluating parent education programs and materials should be developed.
80. The AAP Periodic Survey of Fellows should monitor the progress of the profession toward becoming more family oriented.

Task Force on the Family
*Edward L. Schor, MD, Chairperson
Marilyn M. Billingsley, MD
Alma L. Golden, MD
Julia A. McMillan, MD
Linda D. Meloy, MD
Ben C. Pendarvis, Jr, MD

Consultants
William L. Coleman, MD
Donald Wertlieb, PhD

Staff
Crystal Milazzo, MPA

**Lead author*

APPENDIX: CHARGE TO THE TASK FORCE ON THE FAMILY

In 1993 and 1994, the American Academy of Pediatrics Annual Chapter Forum passed resolutions urging the Academy to "foster the development of public policy that is family-friendly and supports the maintenance of a 2-parent household." These resolutions further requested that the Academy "develop policy to help pediatricians to provide guidance to single-parent households in situations in which 2-parent households are not possible" and finally to "promote methods to be used to encourage the promotion of nurturing families for all children." Although the issues are complex, we must move rapidly in this direction if we are to fulfill our Mission.

Directives to the Task Force on the Family

1. Analyze the social science and medical literature to quantify the nature of those factors that strengthen the family's ability to nurture children.
2. Develop materials to enable Academy members to teach parenting skills to families in their practice, and assist residency programs in developing health education curricula that support teaching about optimal family function in a culturally sensitive manner.
3. Guide the Academy in the development of federal and state legislative policy that is family friendly and supports the maintenance of 2-parent households, including changes in tax policy, welfare, and other social services policies that now may encourage family dissolution.
4. Guide the Academy in the development of policy to help pediatricians to provide guidance to single-parent households in support of their children.
5. Undertake a careful review of existing Academy policies relative to their impact on family and family function, making recommendations to committees and the Board of Directors with respect to policy modification based on data development and analysis.

REFERENCES

1. *Strengthening American Families: Reweaving the Social Tapestry.* Final report of the ninety-seventh American Assembly, September 21–23, 2000. Available at: www.americanassembly.org/programs/uas_families_TOC.htm. Accessed August 9, 2001
2. Kamerman SB. From maternity to parental leave policies: women's health, employment, and child and family well-being. *J Am Med Womens Assoc.* 2000;55:96–99
3. McLanahan S, Sandefur G. *Growing Up With a Single Parent: What Hurts, What Helps.* Cambridge, MA: Harvard University Press; 1994:98
4. Schor EL. Developing communality: family-centered programs to improve children's health and well-being. *Bull N Y Acad Med.* 1995;72:413–442
5. Krysan M, Moore KA, Zill N. *Research on Successful Families.* Washington, DC: Child Trends; 1990
6. Elkind D. *Ties That Stress. The New Family Imbalance.* Cambridge, MA: Harvard University Press; 1994:63
7. Baumrind D. Effects of authoritative control on child behavior. *Child Dev.* 1966;37:887–907
8. Spieker SJ, Larson NC, Lewis SM, Keller TE, Gilchrist L. Developmental trajectories of disruptive behavior problems in preschool children of adolescent mothers. *Child Dev.* 1999;70:443–458
9. Simons RL, Johnson C, Conger RD. Harsh corporal punishment versus quality of parental involvement as an explanation of adolescent maladjustment. *J Marriage Fam.* 1994;56:591–607
10. Smith TW. *The Emerging 21st Century American Family.* Chicago, IL: National Opinion Research Center, University of Chicago; 1999 (GSS Social Change Report No. 42)
11. Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being.* Washington, DC: US Government Printing Office; 1999
12. Harris I. *Children in Dependency: Can We Break the Cycle of Poverty?* New Haven, CT: Yale University Press; 1996:20
13. Demaris A, Rao KV. Premarital cohabitation and subsequent marital stability in the United States: a reassessment. *J Marriage Fam.* 1992;54:178–190
14. Manning WD, Lichter DT. Parental cohabitation and children's economic well-being. *J Marriage Fam.* 1996;58:998–1010
15. Whelen R. *Broken Homes and Battered Children: A Study of the Relationship of Child Abuse and Family Type.* London, England: Family Education Trust; 1993:29
16. Simons RL, Kuei-Hsiu L, Gordon LC, Conger RD, Lorenz FO. Explaining the higher incidence of adjustment problems among children of divorce compared with those in two-parent families. *J Marriage Fam.* 1999;61:1020–1033
17. Pruett MK, Pruett KD. Fathers, divorce, and their children. *Child Adolesc Psychiatr Clin North Am.* 1998;7:389–407, viii
18. Kelly JB. Marital conflict, divorce, and children's adjustment. *Child Adolesc Psychiatr Clin North Am.* 1998;7:259–271, v-vi
19. Duffy SJ, McGrath ME, Becker BM, Linakis JG. Mothers with histories of domestic violence in a pediatric emergency department. *Pediatrics.* 1999;103:1007–1013
20. Ross SM. Risk of physical abuse to children of spouse abusing parents. *Child Abuse Negl.* 1996;20:589–598
21. National Center for Fathering. Fathers in America: 1996 Gallup Poll on Fathering. Available at: www.fathers.com/research/gallup.html. Accessed November 16, 2001
22. Spock B. *The Pocket Book of Baby and Child Care.* New York, NY: Pocket Books; 1946
23. Levine JA, Pitt EW. *New Expectations: Community Strategies for Responsible Fatherhood.* New York, NY: Families and Work Institute; 1995
24. Harris KM, Furstenberg FF Jr, Marmer JK. Paternal involvement with adolescents in intact families: the influence of fathers over the life course. *Demography.* 1998;35:201–216
25. Yogman MW, Kindlon D, Earls F. Father involvement and cognitive/behavioral outcomes of preterm infants. *J Am Acad Child Adolesc Psychiatry.* 1995;34:58–66
26. Nelson C, Valliant PM. Personality dynamics of adolescent boys where the father was absent. *Percept Mot Skills.* 1993;76:435–443
27. Perrin E. Children whose parents are lesbian or gay. *Contemp Pediatr.* 1998;15:113–130
28. Stacey J, Biblarz TJ. (How) does the sexual orientation of parents matter? *Am J Sociol Rev.* 2001;66:159–183
29. Perrin EC and American Academy of Pediatrics, Committee on Psy-

Downloaded from www.aappublications.org/news by guest on July 12, 2019

chosocial Aspects of Child and Family Health. Technical report: coparent or second-parent adoption by same-sex parents. *Pediatrics.* 2002; 109:341–344
30. Bryson K, Casper LM. Coresident grandparents and grandchildren. *Curr Population Rep.* 1999;May:23–198
31. Hackworth SR. Grandparents raising grandchildren. *Contemp Pediatr.* 1998;15:75–83
32. Bumpass LL, Raley RK, Sweet JA. The changing character of stepfamilies: implications of cohabitation and nonmarital childbearing. *Demography.* 1995;32:425–436
33. Case A, Paxson C. *Mothers and Others: Who Invests in Children's Health*? Cambridge, MA: National Bureau of Economic Research; 2000 (Working Paper No. 7691)
34. O'Connor TG, Davies L, Dunn J, Golding J. Distribution of accidents, injuries, and illnesses by family type. ALSPAC Study Team. Avon Longitudinal Study of Pregnancy and Childhood. *Pediatrics.* 2000; 106(5). Available at: www.pediatrics.org/cgi/content/full/106/5/e68
35. Allen FH. Family relationships. *J Pediatr.* 1939;15:130–135
36. Maccoby EE. The role of parents in the socialization of children: an historical overview. *Dev Psychol.* 1992;28:1006–1017
37. Chase-Lansdale PL. How developmental psychologists think about family process and child development in low income families. Paper presented at the Preconference for Family Process and Child Development in Low Income Families, Northwestern University/University of Chicago Joint Poverty Research Center; May 7, 1998; Chicago, IL
38. Weinick RM, Monheit AC. Children's health insurance coverage and family structure, 1977–1996. *Med Care Res Rev.* 1999;56:55–73
39. Halfon N, Newacheck PW. Childhood asthma and poverty: differential impacts and utilization of health services. *Pediatrics.* 1993;91:56–61
40. Sandberg JF, Hofferth SL. Changes in children's time with parents: United States, 1981–1997. *Demography.* 2001;38:423–436
41. Cherlin AJ, ed. *The Changing American Family and Public Policy.* Washington, DC: The Urban Institute Press; 1988:7
42. Ruhm CJ. *Parental Employment and Child Cognitive Development.* Cambridge, MA: National Bureau of Economic Research Inc; 2000 (Working Paper No. 7666)
43. Zuckerman BS, Beardslee WR. Maternal depression: a concern for pediatricians. *Pediatrics.* 1987;79:110–117
44. McLennan JD, Kotelchuck M. Parental prevention practices for young children in the context of maternal depression. *Pediatrics.* 2000;105: 1090–1095
45. *Mental Health: A Report of the Surgeon General.* Washington, DC: US Department of Health and Human Services, Public Health Service; 1999
46. Lanzi RG, Pascoe JM, Keltner B, Ramey SL. Correlates of maternal depressive symptoms in a national Head Start program sample. *Arch Pediatr Adolesc Med.* 1999;153:801–807
47. Najman JM, Williams GM, Nikles J, et al. Mothers' mental illness and child behavior problems: cause-effect association or observation bias? *J Am Acad Child Adolesc Psychiatry.* 2000;39:592–602
48. Krugman SD, Wissow LS. Helping children with troubled parents. *Pediatr Ann.* 1998;27:23–29
49. Institute of Medicine, Board on Health Care Services, Committee on the Consequences of Uninsurance. *Health Insurance Is a Family Matter.* Washington, DC: National Academies Press; 2002
50. Kahn RS, Wise PH, Finkelstein JA, Bernstein HH, Lowe JA, Homer CJ. The scope of unmet maternal health needs in pediatric settings. *Pediatrics.* 1999;103:576–581
51. Chatterji P, Markowitz S. *The Impact of Maternal Alcohol and Illicit Drug Use on Children's Behavior Problems: Evidence From the Children of the National Longitudinal Survey of Youth.* Cambridge, MA: National Bureau of Economic Research Inc; 2000 (Working Paper No. 7692)
52. Sayers SL, Kohn CS, Heavey C. Prevention of marital dysfunction: behavioral approaches and beyond. *Clin Psychol Rev.* 1998;18:713–744
53. Doherty WJ. *The Scientific Case for Marriage and Couples Education in Health Care.* Minneapolis-St. Paul, MN: Family Social Science Department, University of Minnesota; 1997. Available at: www.smartmarriages.com/hpmarr.html. Accessed November 16, 2001
54. Kaiser A, Hahlweg K, Fehm-Wolfsdorf G, Groth T. The efficacy of a compact psychoeducational group training program for married couples. *J Consult Clin Psychol.* 1998;66:753–760
55. Stanley SM, Markman HJ. *Acting on What We Know: The Hope of Prevention.* Denver, CO: Center for Marital and Family Studies, University of Denver; 1997
56. Wampler. An update of research on the couple communication program. *Fam Sci Rev.* 1990;3:21–40
57. Blankenhorn D, Bayme S, Elshtain JB, eds. *Rebuilding the Nest: A New Commitment to the American Family.* Milwaukee, WI: Family Service America; 1990:256
58. Cobb S. Presidential address—1976. Social support as a moderator of life stress. *Psychosom Med.* 1976;38:300–314
59. Murphy JM, Kelleher K, Pagano ME, et al. The family APGAR and psychosocial problems in children: a report from ASPN and PROS. *J Fam Pract.* 1998;46:54–64
60. Runyan DK, Hunter WM, Socolar RR, et al. Children who prosper in unfavorable environments: the relationship to social capital. *Pediatrics.* 1998;101:12–18
61. American Academy of Pediatrics, Committee on Community Health Services. The pediatrician's role in community pediatrics. *Pediatrics.* 1999;103:1304–1306
62. American Academy of Pediatrics, Task Force on Pediatric Education. *The Future of Pediatric Education.* Evanston, IL: American Academy of Pediatrics; 1978
63. Kelleher KJ, McInerny TK, Gardner WP, Childs GE, Wasserman RC. Increasing identification of psychosocial problems: 1979–1996. *Pediatrics.* 2000;105:1313–1321
64. American Academy of Pediatrics, Task Force on the Future of Pediatric Education II. The Future of Pediatric Education II: organizing pediatric education to meet the needs of infants, children, adolescents, and young adults in the 21st century. *Pediatrics.* 2000;105(suppl):161–212
65. Allmond BW Jr, Buckman W, Gofman HF. *The Family is the Patient: An Approach to Behavioral Pediatrics for the Clinician.* St Louis, MO: CV Mosby Co; 1979:13
66. Accreditation Council on Graduate Medical Education. *Program Requirements for Residency Education in Pediatrics.* Chicago, IL: Accreditation Council on Graduate Medical Education; 2000. Available at: www.acgme.org. Accessed November 16, 2001
67. American Academy of Pediatrics. Summary of FOPE II project survey results. Available at: www.aap.org/profed/fope1.htm. Accessed June 4, 2001
68. Roberts KB, Starr S, DeWitt TG. The University of Massachusetts Medical Center office-based continuity experience: are we preparing pediatrics residents for primary care practice? *Pediatrics.* 1997;100(4). Available at: www.pediatrics.org/cgi/content/full/100/4/e2
69. Bethell C, Peck C, Abrams M, Halfon N, Sareen H, Scott Collins K. *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid.* New York, NY: The Commonwealth Fund; 2002
70. Coleman WL, Howard BJ. Family-focused behavioral pediatrics: clinical techniques for primary care. *Pediatr Rev.* 1995;16:448–455
71. Edelman L, ed. *Getting on Board: Training Activities to Promote the Practice of Family-Centered Care.* Mt Royal, NJ: Association for the Care of Children's Health; 1991
72. American Academy of Pediatrics. *Periodic Survey of Fellows #44. Health Services for Children With and Without Special Needs: The Medical Home Concept.* Elk Grove Village, IL: American Academy of Pediatrics; 2000
73. Cheng TL, Savageau JA, DeWitt TG, Bigelow C, Charney E. Expectations, goals, and perceived effectiveness of child health supervision: a study of mothers in a pediatric practice. *Clin Pediatr.* 1996;35:129–137
74. Young KT, Davis K, Schoen C, Parker S. Listening to parents. A national survey of parents with young children. *Arch Pediatr Adolesc Med.* 1998;152:255–262
75. Wissow LS, Roter DL, Wilson ME. Pediatrician interview style and mothers' disclosure of psychosocial issues. *Pediatrics.* 1994;93:289–295
76. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics.* 2001;107:1084–1094
77. Horwitz SM, Leaf PJ, Leventhal JM. Identification of psychosocial problems in pediatric primary care: do family attitudes make a difference? *Arch Pediatr Adolesc Med.* 1998;152:367–371
78. Bernzweig J, Takayama JI, Phibbs C, Lewis C, Pantell RH. Gender differences in physician-patient communication. Evidence from pediatric visits. *Arch Pediatr Adolesc Med.* 1997;151:586–591
79. American Academy of Pediatrics, Department of Practice and Research. Research update: pediatricians provide majority of care to children: survey. *AAP News.* 2001;19:154
80. Cheng TL, DeWitt TG, Savageau JA, O'Connor KG. Determinants of counseling in primary care pediatric practice: physician attitudes about time, money, and health issues. *Arch Pediatr Adolesc Med.* 1999; 153:629–635
81. American Academy of Pediatrics. *Periodic Survey of Fellows #41. Pediatricians' Experiences With Child Care Health and Safety.* Elk Grove Village, IL: American Academy of Pediatrics; 1999
82. Ferris TG, Saglam D, Stafford RS, et al. Changes in the daily practice of primary care for children. *Arch Pediatr Adolesc Med.* 1998;152:227–233

Downloaded from www.aappublications.org/news by guest on July 12, 2019

83. LeBaron CW, Rodewald L, Humiston S. How much time is spent on well-child care and vaccinations? *Arch Pediatr Adolesc Med.* 1999;153: 1154–1159
84. Minkovitz C, Mathew MB, Strobino D. Have professional recommendations and consumer demand altered pediatric practice regarding child development? *J Urban Health.* 1998;75:739–750
85. Byrd RS, Hoekelman RA, Auinger P. Adherence to AAP guidelines for well-child care under managed care. *Pediatrics.* 1999;104:536–540
86. Taylor JA, Kemper KJ. Group well-child care for high-risk families: maternal outcomes. *Arch Pediatr Adolesc Med.* 1998;152:579–584
87. Barlow J, Stewart-Brown S. Behavior problems and group-based parent education programs. *Dev Behav Pediatr.* 2000;21:356–370
88. Spoth RL, Redmond C, Shin C. Reducing adolescents' aggressive and hostile behaviors: randomized trial effects of a brief family intervention 4 years past baseline. *Arch Pediatr Adolesc Med.* 2000;154:1248–1257
89. Glascoe FP, Oberklaid F, Dworkin PH, Trimm F. Brief approaches to educating patients and parents in primary care. *Pediatrics.* 1998;101(6). Available at: www.pediatrics.org/cgi/content/full/101/6/e10
90. Greganti MA, Fletcher SW. House staff pregnancy in internal medicine residencies. *Ann Intern Med.* 1985;102:123–125
91. Klevan JL, Weiss JC, Dabrow SM. Pregnancy during pediatric residency. Attitudes and complications. *Am J Dis Child.* 1990;144:767–769
92. Wilson MD, Carpenter RO, Radius SM, Oski FA. Attitudes and factors affecting the decisions of men and women pediatrics residents toward having children during their residencies. *Acad Med.* 1991;66:770–772
93. Sells JM, Sells CJ. Pediatrician and parent: a challenge for female physicians. *Pediatrics.* 1989;84:355–361
94. Family and Medical Leave Act. PL No. 103-3 (1993)
95. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. Parental leave for residents and pediatric training programs. *Pediatrics.* 1995;96:972–973
96. Inform Research & Marketing. *Membership Needs Assessment Study. Report: Young Physicians. Prepared for the American Academy of Pediatrics.* Chicago, IL: Inform Research & Marketing; 2000
97. Inform Research & Marketing. *Membership Needs Assessment Study. Report: Female Physicians. Prepared for the American Academy of Pediatrics.* Chicago, IL: Inform Research & Marketing; 2000
98. Doherty WJ, Burge SK. Divorce among physicians. Comparisons with other occupational groups. *JAMA.* 1989;261:2374–2377
99. Warde CM, Moonesinghe K, Allen W, Gelberg L. Marital and parental satisfaction of married physicians with children. *J Gen Intern Med.* 1999;14:157–165
100. Uhlenberg P, Cooney TM. Male and female physicians: family and career comparisons. *Soc Sci Med.* 1990;30:373–378
101. Warde C, Allen W, Gelberg L. Physician role conflict and resulting career changes. Gender and generational differences. *J Gen Intern Med.* 1996;11:729–735
102. Bates AS, Harris LE, Tierney WM, Wolinsky FD. Dimensions and correlates of physician work satisfaction in a midwestern city. *Med Care.* 1998;36:610–617
103. American Academy of Pediatrics. *Periodic Survey of Fellows #8: Working Mothers.* Elk Grove Village, IL: American Academy of Pediatrics; 1989
104. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. The pediatrician's role in family support programs. *Pediatrics.* 2001;107:195–197
105. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. The pediatrician's role in helping children and families deal with separation and divorce. *Pediatrics.* 1994;94: 119–121
106. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Death of a child in the emergency department. *Pediatrics.* 1994;93:861–862
107. American Academy of Pediatrics, Committee on School Health. Home, hospital, and other non–school-based instruction for children and adolescents who are medically unable to attend school. *Pediatrics.* 2000;106:1154–1155
108. American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy. *Pediatrics.* 1989:83:132–134
109. American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy—current trends and issues: 1998. *Pediatrics.* 1999;103: 516–520
110. Green M, ed. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Arlington, VA: National Center for Education in Maternal and Child Health; 1994
111. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. *Guidelines for Health Supervision III.* Elk Grove Village, IL: American Academy of Pediatrics; 1997
112. Child Abuse Prevention and Treatment Act. PL No. 104-235 (1996)
113. American Academy of Pediatrics. *You and Your Pediatrician.* Elk Grove Village, IL: American Academy of Pediatrics; 2000
114. American Academy of Pediatrics. *Guide to Pediatric Visits.* Elk Grove Village, IL: American Academy of Pediatrics; 1997
115. Shelov SP, Hannemann RE, eds., and American Academy of Pediatrics. *Caring for Your Baby and Young Child: Birth to Age 5.* New York, NY: Bantam Books; 1999
116. Schor EL, ed., and American Academy of Pediatrics. *Caring for Your School-Age Child: Ages 5–12.* New York, NY: Bantam Books; 1999
117. Greydanus DE, ed, and American Academy of Pediatrics. *Caring for Your Adolescent: Ages 12–21.* New York, NY: Bantam Books; 1991
118. Spock B, Rothenberg MB. *Baby and Child Care.* New York, NY: EP Dutton; 1985:8
119. Mosly J, Thomson E. Fathering behavior and child outcomes: the role of race and poverty. In: Marsiglio W, ed. *Fatherhood: Contemporary Theory, Research, and Social Policy.* Thousand Oaks, CA: Sage Publications; 1995:148–165
120. Jellinek M. Pediatric psychosocial screening: of sufficient benefit to encourage. *Dev Behav Pediatr.* 1998;19:353–354
121. Public Health Policy Advisory Board. *Health and the American Child: Risks, Trends, and Priorities for the Twenty-First Century.* Washington, DC: Public Health Policy Advisory Board; 1999

Downloaded from www.aappublications.org/news by guest on July 12, 2019

Family Pediatrics: Report of the Task Force on the Family
American Academy of Pediatrics
Pediatrics 2003;111;1541

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/111/Supplement_2/1541
References	This article cites 74 articles, 23 of which you can access for free at: http://pediatrics.aappublications.org/content/111/Supplement_2/1541#BIBL
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): **Advocacy** http://www.aappublications.org/cgi/collection/advocacy_sub **Child Health Financing** http://www.aappublications.org/cgi/collection/child_health_financing_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.aappublications.org/site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: http://www.aappublications.org/site/misc/reprints.xhtml

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by guest on July 12, 2019

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Family Pediatrics: Report of the Task Force on the Family

American Academy of Pediatrics

Pediatrics 2003;111;1541

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/111/Supplement_2/1541

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2003 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Downloaded from www.aappublications.org/news by guest on July 12, 2019