

What's a Family?

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Interest in the family of a child has a long and critical history in child psychiatry. In modern psychiatric research, at least 3 concepts of family can be identified: the environmental family, that is, the biological and nonbiological relatives a child lives with; the biological family who carry the child's genes; and the caretaking family, who can be all of the above. Although these overlapping concepts can be identified and studied, clinical care requires attention to all 3. An extraordinary article by Ranning *et al.*¹ in this issue of the *Journal* draws attention to these models and provides the most comprehensive data ever available on the first model: who the child lives with.

The article includes the largest (nearly 2 million), prospective (28 years), population-based (Danish register) data on every child born since 1982 and their parents and describes the living arrangements of children whose parents have a serious mental illness (SMI), specifically depression, schizophrenia, or bipolar disorder. The prospective design allowed the investigators to examine changes in living arrangements. They concluded that fewer children of parents with SMI compared with children of parents without live with both parents. They also found that more of these children live with a single parent or are separated from both parents and that more marriages of parents with SMI dissolved during the study period. The effects were somewhat stronger in families in which the parent had schizophrenia. Although these findings are not surprising, they have never been documented before with such a large sample and a prospective design. However, the demographic characterization does not tell us about all possible effects on the child. For example, a divorce from a hostile marriage might calm rather than upset the family environment.

These investigators present a thoughtful discussion of these possibilities and the supporting scientific literature. They also explore sociodemographic variables such as employment, education level, and mother's use of substances, which can confound the association between family structure and child outcomes. They are to be congratulated on their perhaps anticipatory classification of family. Although they include mothers and fathers (whether biological or not is unclear), they also include mother or father and new partner. The generic "new partner" might begin to capture changing concepts of a modern family or *new family forms* as termed by Golombok.² These new forms include lesbian or gay parent families, families headed by single mothers by choice, and families created by assisted reproductive technologies such as in vitro fertilization, egg donation, sperm donation, embryo donation, surrogacy, or old-fashioned adoption. In her book, Golombok made a distinction between the new modern families adjusting to new parental configurations and families that result from

relationship breakdown and reformation. The investigators' broad classification of "partner" allows for a beginning exploration of these new family arrangements, which clearly will challenge the notion about there being 1 ideal family arrangement.

Let's consider the concept of the biological family. Family genetic studies of parents with bipolar disorder, schizophrenia, or major depression have clearly shown transmission of the same disorder to their biological children, whether or not the children and parents are living together.³⁻⁵ In the longest follow-up to date (30 years), my colleagues and I found that the biological offspring of a parent with major depression, compared with a parent without, had an increased risk of major depression, recurrence of depression over the years, poor social functioning, and increased mortality.⁶ This risk was strongly transferred to the third generation if the parent and grandparent were affected.⁷ We concluded that until a more biologically based understanding of individual risk is found, a simple family history or assessment of biological relatives as part of clinical care will help predict an individual's long-term risk for depression. However, these family studies do not stress who the child lives with, who cares for the child, or the quality of the care received.

Let's consider the caretaking family, which can include any of the families described earlier, biological or not, and whether living with the child full time or not. Much has been written about childhood adversity and its relation to the psychological wellbeing of a child.⁸ The most comprehensive work is a 45-year prospective epidemiologic study that followed 98% of births in 1 week in 1958 in England, Scotland, and Wales. Childhood adversity from multiple informants was assessed at 7, 11, and 16 years of age, and interviews were conducted 6 times until the participants were 42 years of age.⁸ Adversity included physical and nutritional neglect, parental illness, absence, or divorce, and physical or sexual abuse. Even after controlling for socioeconomic status, childhood adversities were associated with adolescent, early adulthood, and midlife psychopathology, mainly anxiety and/or depression. The effects of adversity did not attenuate with age, were cumulative, and were mediated mainly by early adulthood psychopathology. The study by Clark *et al.*⁸ and numerous others cited by them focused on adversity. A more difficult concept to measure is parent-child affection, bonding, and attachment. Bowlby⁹ in 1977 was a pioneer in defining secure and insecure parent-child attachment. Subsequently, others have shown that securely attached children, that is, children whose parents are sensitive and consistent in responding to their child's needs, are more competent, self-reliant, and secure adults. The Parental Bonding Instrument, which measures parental

attachment and caring, has been the most widely used and predictive of parent–child relationships.¹⁰ Family genetic studies take caretaking as a confounder or mediator. The large epidemiologic studies take these into account by measuring proxies that affect caretaking, divorce, parental unemployment, or substance abuse but might not measure actual child outcomes. Neither the family genetic studies nor the large studies measuring living arrangements measure the quality of care directly as a primary outcome.

All 3 of these domains provide information and insights that are useful for the clinical assessment of a child. A good clinical assessment should borrow from each. An extended assessment of a child's family might include the clinical psychiatric status of the biological relatives (alive or dead) as a measurement of biological risk; an extended pedigree or history of who the child lives with regardless of gender of parent, sexual orientation, or biological origin; and a historical assessment of the care the child has received over time and is receiving from whomever is in their life, biological or not. Simple tools for all these assessments exist.

As yet, there are no data showing that one or another of these new family forms is protective or poses risks to the child. Traditional and nontraditional family forms vary considerably as to whether they provide a loving supportive

environment for the child. Assessing who is in the child's life, the child's biological legacy, and the environment provide important information. Evaluating the child's family context from these 3 different perspectives also is critical to understanding the onset and course of the disorder and helps to inform treatment. It is worth the extra time it might take in clinical practice. &

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