

The Family Check-Up in Early Childhood: A Case Study

ANNE M. GILL, LUKE W. HYDE, DANIEL S. SHAW, THOMAS J. DISHION, MELVIN WILSON

ABSTRACT

This article describes a case study in the use of the Family Check-Up (FCU), a family- and ecologically based intervention for children at high risk for problem behavior. The FCU is an assessment-driven intervention that utilizes a health maintenance model which was applied to families with toddlers at high risk for early conduct problems. This case study follows one family through their initial Family Check-Up and reviews the process and basic structure of the intervention as well as their progress over time. Through the use of motivational interviewing to promote the parents' desire for change and the use of empirically-validated family management procedures to guide intervention, the current family showed clinically meaningful improvements in child and parent functioning despite the presence of child, parent, and neighborhood risk factors. The case is discussed with respect to the pattern of findings from a current multisite RCT using the FCU and its application to other populations.

There is growing interest in identifying very young children at risk for early and persistent trajectories of antisocial behavior (Shaw & Gross, in press). This interest is motivated by several studies of early- versus late-starting antisocial youth (Moffitt, 1993). Several researchers have documented that compared to late starters, who begin delinquent activity in mid- to late-adolescence, early starters show a more persistent and chronic trajectory of antisocial behavior extending from middle childhood to adulthood (Moffitt, 1993; Moffitt & Caspi, 2001). Early starters represent approximately 6-7% of the population, yet are responsible for almost half of adolescent crime and three-fourths of violent crimes (Offord, Boyle, & Racine, 1991). During the past two decades, prevention scientists have focused on generating interventions for preventing early-starting pathways from developing, including programs for expectant mothers with first-born children (Olds, 2002) and preschool-age children (Webster-Stratton & Hammond, 1997). One such preventive intervention that has been adapted specifically to address the normative challenges parents face during the 'terrible twos' is the Family Check Up (FCU, Dishion et al., 2007; Shaw et al., 2006). The current paper discusses a case study that follows one family

through their involvement in the FCU.

The FCU was initially developed and empirically validated to reduce problem behavior in high-risk youth (and their parents) in early and middle adolescence (Connell et al., in press; Dishion & Kavanagh, 2003) and has recently been associated with reductions in young children's conduct and internalizing problems, improvements in maternal depression, involvement, and positive parenting in two independent, randomly controlled trials (RCT) (Dishion et al., 2007; Shaw et al., 2006, 2007). Changes in maternal positive parenting and depression were found to mediate improvements in child problem behavior.

The current case, drawn from the Early Steps Multisite Study (ESMS), aims to illustrate how the FCU represents the integration of basic research on the developmental antecedents of early-starting pathways and validated methods for effecting change in young children's problem behavior. The intervention, the FCU, is part of a broader approach to intervention, termed the Ecological approach to Family Intervention and Treatment (EcoFIT). The EcoFIT model emerged from a series of prevention trials designed to intervene with young adolescents at high risk for escalation in problem behavior and substance use

(Dishion & Kavanagh, 2003). A key feature of an ecological approach to intervention is that it is assessment driven and tailored to the needs of youth and families as revealed by family observations, assessments in extra-familial contexts (e.g., schools, day care), and reports from important individuals in the child's life (e.g., parents, teachers, youth when of age; Dishion & Stormshak, 2007; Stormshak & Dishion, 2002). The FCU used in the ESMS is the core of this EcoFIT approach (see Dishion & Stormshak, 2007; Stormshak & Dishion, 2002) with young children, and specifically targets family management and socialization practices in early childhood to reduce and prevent early-onset problem behavior and factors that disrupt parenting (e.g., maternal depression).

In many ways, the FCU model differs from traditional clinical models and practice, emphasizing the salience of assessment and capitalizing on validated methods to motivate change. In contrast to the standard clinical model, the FCU is based on a health maintenance model, which explicitly promotes periodic contact with families (at a minimum yearly) over the course of key developmental transitions. Whereas traditional clinical models are activated in response to clinical pathology, the health maintenance model involves periodic contact between client and provider to promote health and proactively prevent problems. Examples of health maintenance models include the use of biannual cleanings in dentistry and well-baby check-ups in pediatrics aimed at preventing future illnesses and promoting healthy behaviors.

The Family Check-Up also differs from traditional clinical practice with its explicit focus on providing a comprehensive assessment of child and family functioning. Data obtained from assessments are shared with families in feedback sessions to provide them

motivation for change (Miller & Rollnick, 2002). Feedback sessions are often followed by the introduction of family management techniques (Forgatch, Patterson, & DeGarmo, 2005) to achieve change in parenting and child problem behavior. The comprehensive assessment essentially drives the intervention, providing detailed information about domains of child (e.g., negative emotionality), family (e.g., parental depression, marital quality), and community-level (e.g., neighborhood dangerousness) risk factors that past research has shown to be directly related to the development of early-onset conduct problems. In addition, there is a primary focus on evaluating caregiving practices through direct observation of parent-child interaction. In the case of the FCU for toddlers, this is accomplished by having parent-child dyads participate in a series of structured (e.g., clean-up and teaching tasks) and semi-structured (e.g., preparing a meal and serving it to child) tasks. The FCU is also "ecological" in its emphasis on improving children's adjustment across settings (home, school, and neighborhood) by motivating positive parenting practices and involvement in those settings.

The FCU utilizes two main components to facilitate change: motivational interviewing and family management practices. The motivational interviewing component is based on Miller and Rollnick's work (2002) using the Drinker's Check-Up, in which assessment data regarding the negative consequences of drinking on individual's work and family life are shared in a feedback interview with clients. This approach has been shown to be as effective as 28 days of costly inpatient treatment for reducing problem drinking in adults (Miller & Rollnick, 2002). In working with families of young children, the FCU feedback session is designed to elicit motivation for the parent(s) to change problematic behavior in their child, which is often achieved by modifying parenting behavior (Forgatch et al., 2005) or aspects of the caregiving context that compromise parenting quality.

The family management component includes a collective set of parenting skills, commonly referred to as 'parent management training,' based on social learning principles of reinforcement and modeling (Patterson, 1982; Webster-Stratton et al., 1997) and repeatedly found to be associated with improvement in parenting and subsequent reductions in child problem behavior, particularly conduct problems (Bullock & Forgatch, 2005; Patterson, Reid, & Dishion, 1992). Parent Management Training focuses on four main skill sets for the parents of young children, including: limit setting, proactive parenting, positive reinforcement, and relationship building. Education in parent management techniques involves providing parents with a rationale to stimulate interest, careful

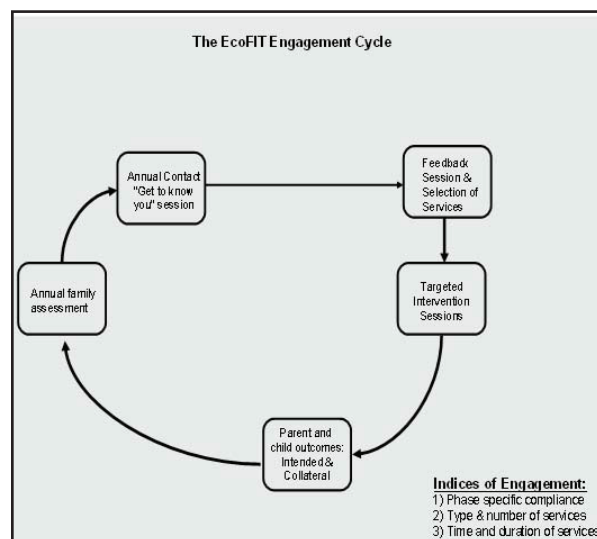


Figure 1. The EcoFIT engagement cycle used in the FCU.

explanation of the new skills, and in-session practice through the use of role play and in-vivo practice with the child.

Overview of the Family Check-Up in the Early Steps Multisite Study

The current case study was part of a larger RCT examining the efficacy of the FCU among 731 low-income families with toddlers recruited between 2002 and 2003 from WIC programs in the metropolitan areas of Pittsburgh, Pennsylvania, and Eugene, Oregon, and within and outside the town of Charlottesville, Virginia. The current case was recruited from the Pittsburgh site. Families were approached at WIC offices and invited to participate if they had a son or daughter between 2 years 0 months and 2 years 11 months of age, following a screen to ensure that they met the study criteria by having socioeconomic, family, and/or child risk factors for future behavior problems.

The Family Check-Up (FCU). The FCU intervention involves at least three sessions. First is the in-home family assessment. The second session involves rapport-building via the Parent Consultant's (PC) initial interview with the caregiver(s), referred to as the Get to Know You (GTKY) visit. The third is a feedback session during which the PC discusses the results of the assessment and initial interview with attention focused on the caregiver's readiness to change and the delineation of specific change options.

The assessment, which is the first component of the FCU, typically takes place in the family's home. The early childhood assessment is organized by three central theoretical domains including: (a) family management, (b) sociocultural contexts and resources, (c) problem behavior and emotional distress at home and in alternative care settings. When possible, constructs within each domain are measured with multiple informants (parents, other care providers, observers) and use multiple methods (e.g., questionnaires, interviews, observations). This assessment provides a wealth of information about child behavior, parenting skills, family dynamics, and life stressors, and it sets the stage for the therapeutic contact between caregivers and parent consultants. The initial contact between the Parent Consultant (PC) and the family is always by telephone when the PC calls to set up an initial interview session. At this time, the PC introduces him/herself, briefly explains the study, and invites the parent to participate in an introductory meeting and a feedback session. The caregivers' first session with their PC, called the "get to know you" (GTKY) visit, is usually held in the family's home. The GTKY focuses on developing a collaborative framework for subsequent intervention activities (Dishion & Kavanagh, 2003; Dishion & Stormshak, 2006). In the GTKY ses-

sion of the FCU, the PC emphasizes building rapport and exploring concerns with respect to parenting and the family context. During the GTKY, the PC interviews the adult caregivers about their concerns and needs, with a focus on child behavior, parenting practices, and family management. In addition, caregivers indicate family resources (e.g., help of extended family members) and liabilities (e.g., unstable housing, criminal father). By the end of this visit, caregivers have discussed their concerns and their perceptions of their motivation for change. The PC works to ensure that caregivers are understood and clarifies discrepancies between caregivers' goals and current family functioning, and provides support and empathy. Finally, the PC discusses the purpose of the feedback session and explains that the family assessments will be reviewed to address caregivers' identified concerns. For example, given a concern about noncompliance and temper tantrums, the PC will review the assessment with attention to specific strategies that might help improve the cooperation between the caregiver and the child.

The third session of the FCU, the family feedback session, takes place at the family's home or at an Early Steps Project office, whichever is preferable to the family. Case conceptualization is a critical feature of the feedback session and particular attention is given to harm reduction. Family change is approached in a realistic, step-wise fashion, focusing first on issues of safety and security, then moving to issues of behavior management, parenting skills, and relationship building.

The feedback session in the FCU involves a delicate balance between reporting the facts about strengths and problem areas as well as building motivation for change and rapport between Parent Consultant (PC) and parent(s). The feedback session is a collaborative process, one in which the PC delivers the factual information and frequently checks in with parents about their perspectives as she reports to parents about the assessment data (see Figure 2). Statements about problem areas are framed in such a way that they reflect the current research in any given area and in doing so, ground the information in a meaningful way for the parents. The PC tailors the feedback material so that it takes into consideration the contextual factors of the family, including cultural variation, developmental issues, family structure, socioeconomics, and community and neighborhood factors.

At the end of the feedback session, the PC discusses a menu of family-based interventions with the caregivers. The intervention options are based on the literature about behavior family therapy, FCU pilot work, and focus groups with parents (Dishion & Stormshak, 2006). These options include (a) monthly,

Profile for: _____ Child's Age: 2 Date: _____

Child and Family Profile

Parent Report of Child

Child Temperament	★
Child Behavior Problems	★
Language Development	★
Quality of Relationship	★

Strength Needs Attention

Parent Report of Family Well-Being

Daily Hassles	★
Emotional Well-Being	★
Significant Other Relationship	★
Parenting Confidence	★

Strength Needs Attention

Videotaped Observation of Parent/Child Interaction

Child Contribution	
Positive Play	★
Follows Directions	★
Aggressive Behavior	★
Parent Contribution	
Incentives/Encouragement	★
Limit Setting	★
Proactive Parenting	★
Relationship Quality	★

Strength Needs Attention

Parent Report of Family Support

Social Support	★
Neighborhood Resources	★
Employment/Financial	★
Harassment Other	★

Strength Needs Attention

rev. 10/1/03

Figure 2. Child and family profile from age 2..

bi-monthly or weekly follow-up support in-person or on the phone, (b) brief training on specific parenting issues, (c) family management therapy, (d) preschool/day care consultations, and (e) community referrals. The PC encourages the parents to choose the level of service that best fits with the family's needs.

Background and Referral

The case presented here is a participant family in the ESMS study. The family qualified for inclusion in the ESMS study based on the presence of sociodemographic risk (i.e., low income and educational attainment), child risk (i.e., high levels of reported conduct problems and high levels of parent-child conflict), and family risk (i.e., elevated maternal depressive symptoms and parenting hassles).

This case study focuses on one family's involvement at their first FCU and reports more generally on their subsequent progress. At the initial assessment, the family was not only at high risk for later child problems based on child risk and maternal depression, but also because of several other less proximal but important risk factors, including low SES and residence in a high crime neighborhood. Improvements in child conduct problems were also accompanied by increases in the mother's positive

parenting and decreases in maternal depression.

Assessment

Family background. At the time of their Age 2 Assessment, the G family consisted of Mom, a 34 year old Lebanese-American female, and Dad, a 36 year old Caucasian male, and five children living in the home (boys, ages 15, 6, 4; girls ages 2 and 11 months). The Target Child (TC) is their 2 year old daughter. Mom is a homemaker and Dad is an unemployed former truck driver. Neither parent holds a high-school diploma. This was Mom's third marriage and she has multiple children by each husband, including two daughters to her current husband. Dad has two daughters with whom he has no contact from a previous marriage.

Initial Phone Contact and "Get-to-Know-You" Visit

Following the age 2 assessment, the PC's attempt to schedule the initial GTKY revealed that while Mom was concerned about TC's current behavior, she was too busy to meet in person until after the holidays. The GTKY was scheduled accordingly.

Both Mom and Dad were present for the GTKY at age 2. Mom was very talkative during the interview, which lasted for one hour. Mom provided a detailed history of the family and talked openly about her own struggles with depression. Mom reported that she refused antidepressant medication because of unpleasant side effects. Mom also talked about an ongoing source of familial stress: severe harassment by her second ex-husband despite the procurement of several Protection From Abuse (PFA) orders. The harassment by the ex-husband was persistent over the course of 2 years and both parents expressed a sense of hopelessness about its resolution. Additionally, the family lived in a high-crime neighborhood, as described by both parents and observed by the PC and assessment team. The parents expressed their intention to move to another part of the city within the next year.

When asked about the target child (TC), their 2-year-old daughter; Mom reported concerns about her developmental progress and Dad reported that she had a "bad attitude." When asked about the TC's behavior problems, Mom and Dad agreed that it was "her anger." Both parents reported that TC had a "quick temper and lashes out," that she hits her siblings, and yells frequently. The parents also agreed that she has an "emotional problem," referring to her temper tantrums. The parents did not spontaneously state any positive qualities about the TC; when asked, Mom reported that she feels she has a good relationship with the TC.

Feedback Preparation and Case Conceptualization

Consistent with typical practice, the Feedback session at age 2 was held one week after the GTKY. The PC used videotaped and questionnaire data from the assessment to prepare a Child and Family Profile (see Figure 2) designed to visually represent the child's and family's strengths and areas for concern. Areas of strengths and concern are determined based on published norms when available as well as data from similar high-risk samples (Shaw et al., 2003). At a broader level, components of the data were used to generate a conceptualization of the family's strengths and challenges so the review follows a logical storyline for the parents to absorb.

In the FCU process, the PC prepares a comprehensive report about the family's and child's strengths and potential problems based on the assessment. Scoring the assessment measures revealed a number of child and parent strengths, including that Mom and Dad viewed their marital relationship positively and were willing to participate in the feedback session. In addition, Mom felt confident in her parenting skills (See Table 1). When coding the observational tasks, the PC observed that Mom was responsive to her daughter's bids for positive attention and that she demonstrated a warm and affectionate relationship with TC during the videotaped portion of the assessment. The child demonstrated strengths in her language ability, as indexed by a score at the 94th percentile on the McArthur Communicative Development Index (Fenson, Pethick, & Cox, 1994).

Several areas of concern were evident, most notably, the TC's level and breadth of problem behavior and the mother's level of depressive symptoms. According to mother's report on two different measures of child behavior, the TC was well into the clinical range in terms of her scores for both internalizing and externalizing problems (see Table 1). When the TC's behav-

ior during the assessment was coded, she was found to be in the clinical range for compliance (i.e., followed directions less than 50% of the time) and in the borderline clinical range for positive play (i.e., exhibits neutral to positive affect; references caregiver) and aggressive behavior (two to five instances of aggression toward both objects and people; defiant behavior). Compared with other girls her age, this TC appeared to be on a worrisome behavioral trajectory.

There were some areas of concern regarding Mom, namely that she reported levels of depressive symptoms consistent with clinical depression, a high level of daily stress, high level of conflict with her daughter, and demonstrated few skills for setting limits and being proactive during observational tasks. The family's residence in a high crime neighborhood was also seen as an important factor that impacted their level of stress and quality of life (see Table 1).

The combined clinical picture for the TC and Mom suggested that there were deficits in parenting skills, perhaps due to Mom's depressive symptomatology and daily stress that contributed to the child's behavioral and emotional problems. In addition, the child was demonstrating a range of behavioral and affective problems (e.g., anxiety, defiance), which were posited to contribute to coercive cycles of interaction with Mom (Patterson, 1982). A related concern was that if the mother and child did not find more positive ways to interact, both child and maternal behavior would become exacerbated, moving the child into a more entrenched and less malleable trajectory of problem behavior. Interventions aimed at improving these areas could capitalize on existing family strengths, namely, the positive marital relationship, parental willingness to participate, and TC's language skills.

Feedback Session

During the Age 2 feedback session, the G family

Table 1: Selected Summary of Evaluation and Outcomes of Areas of Strength and Concern

Measure		Age 2		Age 3		Age 4	
Areas of Concern		Score	Clinical Range	Score	Clinical Range	Score	Clinical Range
Maternal Depression	Center for Epidemiological Studies on Depression Scale	28	Clinical	21	Clinical	9.5	Normative
Child Behavior	Eyberg Child Behavior Inventory (Robinson et al., 1980)	3.80	Borderline	4.9	Borderline	4	Borderline
Child Behavior	Child Behavior Checklist – 1.5-5 (Achenback & Rescorla, 2000)	T Scores		T Scores		T Scores	
Externalizing		73	Clinical	57	Normative	59	Normative
Internalizing		61	Borderline	53	Normative	49	Normative
Total Problems		69	Clinical	53	Normative	54	Normative
Parent Stress	Parenting Daily Hassles (Crnic & Greenberg, 1990)	71	Red	41	Green/Yellow	50	Yellow
Areas of Strength							
Marital Relationship	Marital Adjustment Test (Lock & Wallace, 1958)	57	Green	57	Green	64	Green
Parenting Confidence	Parenting Sense of Competence Scale (Johnson, Mash, 1989)	92	Green	81	Green	74	Green
Therapist Video Observations							
Child Positive Play		Yellow	Green			Green	
Child Follows Directions		Red	Green			Green/Yellow	
Child Aggressive Behavior		Yellow	Yellow/Green			Green	
Parent Incentives and Encouragement		Yellow/Green	Yellow/Green			Yellow	
Parent Limit Setting		Red	Green			Green	
Proactive Parenting		Yellow	Red/Yellow			Green	
Relationship Quality		Green	Green			Green	

Note. Red = Clinical Range and Area for Concern, Yellow = Borderline or Area for Concern, Green = Normative or Strength

expressed a willingness to receive information about their daughter and some hope that they might receive help to better manage her aggressive behavior. After a brief rapport-building introduction, the PC began the feedback session and asked the self assessment question ("Over the course of the assessment, what did you learn about TC? What stood out for you?"). Mom and Dad responded by stating that their child "behaves better when other people are around." The PC clarified that Mom believed that the videotaped portions of the assessment reflected better-than-usual behavior from the TC.

After orienting the parents to the FCU profile and explaining the feedback process, the PC discussed the identified areas of strength and concern (See Figure 2).

Child behavior. The Child and Family Profile (CFP) begins with a focus on child behavior, in an effort to align parents with a shared focus about their child's well-being. The PC informed Mom and Dad that TC was in the clinical range for her aggressive behavior and anxiety-related problems. Mom's initial response to this information was to elaborate on the areas where TC is aggressive, in particular with her siblings. When the PC asked Mom about her biggest concerns related to TC's fights with siblings, Mom initially minimized the problem by stating that TC will probably outgrow her aggressive behavior. The PC agreed that this was a possibility (rolling with resistance) and then inquired about alternate outcomes. When invited by the PC to consider what would happen if TC did not "outgrow" the problem, Mom admitted to her fears that TC and siblings might seriously hurt each other "by accident." Mom then elaborated on several parenting strategies she and Dad had tried to alleviate this problem without success. The PC affirmed their efforts and then offered a normalizing statement about the parents' struggles with TC.

Next, the PC discussed the potential usefulness of additional or new parenting strategies to address TC's behavior problems. The PC also provided psychoeducation about TC's current behavioral trajectory (i.e., that the problem would likely get worse in the next few years) and the benefits of early intervention versus "wait and see." The PC utilized observational data about TC's observed defiance and non-compliance to underscore the seriousness of the concerns about her conduct problems. Additionally, the PC and parents discussed TC's fearfulness and anxiety, as reported by Mom and observed by the PC. Mom and Dad expressed moderate concern here and were able to identify some ways in which TC's fearfulness is a problem for them, including her "clinginess" and inability to sleep through the night in her own bed. PC also reported on TC's strengths, most notably her

language skills and positive affect when spending time with Mom.

Parental behavior. When reviewing the profile sections on parent well-being, the PC informed the parents that Mom's scores on self report measures were indicative of clinical depression. The PC expressed concern about the severity of Mom's depressive symptoms and when PC inquired about them, Mom began to cry and stated that she "didn't want to talk about it." The PC utilized basic reflection and acknowledged that it would be difficult to parent when feeling so depressed. When Mom was ready to move on, PC provided her with information about the impact of maternal depression on child behavior and psychoeducation about effective treatments and possible resources. Later in the feedback session, the PC reported to Mom that her level of daily parenting stress was also an area of concern and linked this to her depressed mood. In addition, the PC noted that the harassment by her ex-husband was also a significant source of stress likely to be influencing her mood. Mom expressed agreement with the areas of concern and made several change-statements, including stating a willingness to look into treatment and an intention to resolve the situation with her ex-husband.

When the PC reported to Mom about her strengths, including her parenting confidence and relationship with TC, Mom responded with big smiles and verbalized appreciation. She reported that it was reassuring to know what she is doing well, particularly in areas where this was her perception. Acknowledgement of her strengths also provided Mom with the opportunity to verbally elaborate on what she does well and to appreciate the relationship she has with her daughter and husband.

Summarizing and goal-setting. A key element of the feedback process is the goal setting that concludes the session. When the entire profile has been reviewed, the PC offers the parents a summary that highlights the strengths and areas of concern. In this case, the PC re-visited the concerns about Mom's depressive symptoms and linked them to other areas of stress and challenges in parenting. The PC also highlighted the parents concerns about TC's behavior problems and noted the congruence with the videotaped observations of non-compliance and defiance. The PC then asked Mom and Dad to consider the feedback and invited them to set goals for their child and for themselves. Mom and Dad set three goals: 1) for the family to move to a new neighborhood that was safer and removed from the ex-husband, 2) for Mom to meet with a psychiatrist to discuss antidepressant medication and explore treatment options, and 3) for Mom and Dad to work with their daughter to reduce her

tempter tantrums and aggressive behavior. Mom also expressed interest in meeting with the PC to address these goals.

Intervention

As part of the FCU, families are able to determine the amount and intensity of follow-up treatment, if any, they wish to receive. The treatment plan is derived in a collaborative manner, focusing on the issues identified in the feedback session and other issues parents want to address. In this case, the PC met with Mom and Dad for 6 sessions following the feedback session. Sessions were scheduled for every other week.

Early sessions focused on Mom's depressive symptoms and the harassment from her ex-husband. One of the services a PC provides for families is referral and advocacy for accessing community resources. The FCU and the broader EcoFIT model value assisting families in connecting with services in their community to increase their network of support and self-sustainability. In this case, while the PC communicated her willingness to work with Mom to reduce her symptoms of depression, Mom was primarily interested in locating a psychiatrist to try antidepressant medication. The PC facilitated this referral. Regarding the harassment from Mom's ex-husband, the PC explored possible responses with Mom and Dad. The family formalized their plans to move to a better neighborhood farther away from the ex-husband and completed this move within three months of the feedback session.

Once these initial issues were addressed, Mom expressed willingness to address TC's aggression. Specifically, Mom was interested in reducing the number of fights her children had during the day and increasing TC's compliance. Over the course of the next six sessions, the PC explored TC's problem behaviors and their associated patterns with both parents using several tools, among them the Good Behavior Game (Dishion & Patterson, 1996) which promotes prosocial behavior among young children, the use of incentives, praise and encouragement, troubleshooting problem areas, and teaching the proper administration of a Time Out. The PC provided psychoeducation about motivating children, the benefits of praise and encouragement, the role of parent involvement, and key components of proactive parenting. In addition, the PC introduced the book, "Preventive Parenting with Love, Encouragement and Limits" (Dishion & Patterson, 1996) and provided ESMS project-based brochures and informational materials.

Follow-Up

Over the course of the next two assessment periods when TC was age 3 and 4, respectively, both TC and

Mom demonstrated marked improvement in several domains. At the Age 3 assessment, TC's behavior had improved to the extent that she was no longer in the clinical range for either the internalizing or externalizing scales on the CBCL, improvement that was maintained at the Age 4 assessment. In addition, Mom's CES-D score, which was well into the clinical range at the age 2 assessment, dropped to well within the normal range at the age 4 assessment. In addition, observations of parent-child interaction revealed steady and step-wise improvement over the next two years, including marked improvements in child non-compliance and aggression, as well as maternal limit setting and proactive parenting (see Table 1).

Summary and Discussion

The Family Check-Up was designed to integrate developmental and intervention research into an ecologically-oriented, family-based intervention to prevent problem behavior among high-risk families with toddlers. The G family is a representative illustration of this innovative method to reach families at key developmental transitions. In the present case, the G family presented with a complicated family history, a number of contextual risk factors and a 2-year old daughter who was demonstrating both conduct and anxiety-related problems. Over the course of the FCU process, the family showed improvement in several areas, including parenting and child problem behavior, as well reductions in maternal depression and contextual risk.

This family was atypical in one respect—most of the families in the ESMS have an average number or 3.7 in-person session with the parent consultant per year, including the GTKY and the Feedback session, whereas this family engaged in 10 sessions their first year, and then three to four in the following two years. After their first year of more intensive involvement, which was consistent with the family's breadth of risk, the family followed the more typical pattern of involvement associated with the FCU.

One of the strengths of this health-maintenance model is the repeated nature of intervention. The FCU model of intervention involves yearly "check-ups" which provide clinician's with the unique opportunity to collaboratively track family and child behavior over time and continue to motivate families to change persistent areas of difficulty. For example, it is not uncommon for a family to minimize problems and decline intervention in the first year and then engage in the intervention the next year when they discover that the problem behavior has not changed. With some frequency, during the age 3 GTKY, families are able to acknowledge the reality of a problem situation in their second year that they were "waiting

to see” about during the age 2 FCU. It is sometimes the repeated review of data, demonstrating that without intervention these problems persist and often get worse over the course of a year that can elicit motivation from parents to take action for change. Additionally, it is common for the interventionists to spend time working with basic issues related to safety and harm reduction early in intervention (e.g., harassment from ex-husband, neighborhood safety) and to find that this early work sets the foundation and trust in the PC for families to be open to viewing their child’s behavior more realistically and to learning new child management strategies.

It is important to note that the FCU can be adapted and tailored for use in a range of clinical settings. As a health-maintenance model, the FCU is a cost- and time-effective way to assist families and mobilize action for change. The FCU, in combination with the EcoFIT model of intervention demonstrates robustness for promoting improvements in child behavior via improvements in parenting skills and maternal depression (Dishion et al., 2007, Shaw et al., 2006, 2007). Additionally, the FCU has been effective for promoting change in a wide range of family structures, cultural backgrounds, types of clinical problems, and contextual risk factors as well as across a broad range of age groups (Dishion et al., 2007; Shaw et al., 2006, 2007). For example, the FCU is currently being used with older children and adolescents in Oregon and with Native American families living on a reservation.

Perhaps the most novel feature of the FCU is the flexibility it provides clinicians in tailoring interventions to the individual family’s challenges and strengths, as well as the family’s perception of the child’s problem behavior. By integrating the use of motivational interviewing within an ecological framework and utilizing empirically-validated methods for promoting change, the model fits well with current conceptualizations of developmental psychopathology that recognize multiple risk factors and pathways that lead to similar problematic outcomes for children—equifinality (Richters & Cicchetti, 1993). The FCU demonstrates its effectiveness with both internalizing and externalizing problems as well as maternal depression and provides an efficient way to intervene with complicated family systems (Dishion et al., 2007; Shaw et al., 2006, 2007).

As indicated, the FCU assessment and feedback process represents a clinically robust intervention that can easily be tailored to address a range of developmental stages and to meet the needs of a particular service agency or clinical population.

References

- Achenbach, T. M. & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms and profiles*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Bullock, B. M., & Forgatch, M. S. (2005). *Mothers in transition: Model-based strategies for effective parenting*. In W. M. Pinsof & J. L. Lebow (Eds.), *Family psychology: The art of Science* (pp. 349-371). New York: Oxford University Press.
- Connell, A., Dishion, T., Yasui, M., & Kavanagh, K. (in press). *An ecological approach to family intervention to reduce adolescent problem behavior: Intervention engagement and longitudinal change*. In S. Evans (Ed.), *Advances in School-Based Mental Health: Vol. 2*. Kingston, NJ: Civic Research Institute.
- Crnic, K. A. & Greenberg, M. T. (1990). *Minor parenting stresses with young children*. *Child Development*, 57, 209-217.
- Dishion, T. J., & Kavanagh, K. (2003). *Intervening in adolescent problem behavior: A family-centered approach*. New York: Guilford.
- Dishion, T. J., & Patterson, S. G. (1996). *Preventive parenting with love, encouragement, & limits: The preschool years*. Eugene, OR: Castalia.
- Dishion, T. J., Shaw, D. S., Conell, A., Wilson, M. N., Gardner, F., & Weaver, C. (2007). *The Family Check Up with high-risk families with toddlers: Outcomes on positive parenting and early problem behavior*. Submitted to *Child Development*.
- Dishion, T. J., & Stormshak, E. (2007). *Intervening in children’s lives: An ecological, family-centered approach to mental health care*. Washington, DC: APA Books.
- Fenson, L., Pethick, S., & Cox, J. L. (1994). *The MacArthur Communicative Development Inventories: Short-form versions*. Unpublished manuscript.
- Forgatch, M. S., Patterson, G. R., & DeGarmo, D. S. (2005). *Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon Mode of Parent Management Training*. *Behavior Therapy*, 36, 3-13.
- Johnston, C. & Mash, E. J. (1989). *A measure of parenting satisfaction and efficacy*. *Journal of Clinical Child Psychology*, 18, 167-175.
- Moffitt, T. (1993). *Adolescence-limited and life-course persistent antisocial behavior: A developmental taxonomy*. *Psychological Review*, 100, 674-701.
- Moffitt, T. E. & Caspi, A. (2001). *Childhood predictors differentiate life-course persistent and adolescence-limited pathways among males and females*. *Development and Psychopathology*, 13, 355-375.
- Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change (2nd Ed.)*. New York: Guilford.
- Offord, D. R., Boyle, M. H., & Racine, Y. A. (1991). *The epidemiology of antisocial behavior in childhood and adolescence*. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 31-54). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Olds, D. (2002). *Prenatal and infancy home visiting by nurses: From randomized trials to community replica-*

- tion. *Prevention Science*, 3, 153-172.
- Patterson, G. R., (1982). *A social learning approach: III. Coercive family process*. Eugene, OR: Castalia.
- Patterson, G. R., Reid, J. B., & Dishion, T. J. (1992). *Antisocial Boys*. Eugene, OR: Castalia.
- Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Richters, J.E., & Cicchetti, D. (1993). Mark Twain meets DSM-III-R: Conduct disorder, development, and the concept of harmful dysfunction. *Development and Psychopathology*, 5, 5-30.
- Robinson, E., Eyberg, S. & Ross, A. (1980). The standardization of an inventory of child conduct problem behaviors. *Journal of Clinical Child Psychology and Psychiatry*, 16, 125-140.
- Shaw, D. S., Dishion, T. J., Connell, A., Wilson, M. N., & Gardner, F. Maternal depression as a mediator of intervention in reducing early child problem behavior (2007). Submitted to *Development and Psychopathology*.
- Shaw, D. S., Dishion, T., Supplee, L. H., Gardner, F. M., & Arnds, K. (2006). A Family Centered Approach to the Prevention of Early-Onset Antisocial Behavior: Two-year effects of the Family Check Up in early childhood. *Journal of Consulting and Clinical Psychology*, 74, 1-9.
- Shaw, D.S., & Gross, H. (in press). Early childhood and the development of delinquency: What we have learned from recent longitudinal research. In A. Lieberman (Ed.), *The yield of recent longitudinal studies of crime and delinquency*. New York: Springer.
- Stormshak, E. A., Dishion, T. J. (2002) An ecological approach to child and family clinical and counseling psychology. *Clinical Child and Family Psychology Review*, 5, 197-215.
- Webster-Stratton, C. & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, 65, 93-109.

Manuscript In Progress