



Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment of the family.

BIBLIOGRAPHIC SOURCE(S)

Josephson AM, AACAP Work Group on Quality Issues. Practice parameter for the assessment of the family. J Am Acad Child Adolesc Psychiatry 2007 Jul;46(7):922-37. [50 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Psychiatric disorders

GUIDELINE CATEGORY

Evaluation

CLINICAL SPECIALTY

Family Practice
Pediatrics
Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To assist clinicians in gathering enough family data to develop a rational treatment plan

TARGET POPULATION

Children and adolescents with psychiatric disorders and their families

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment of the patient's family including:

1. Gathering historical and current information about the family and basic elements of family functioning
2. Observation of the patient's interaction with caretakers
3. Interviews with family members including questions regarding family risk factors for specific disorders
4. Use of ancillary techniques if indicated, such as genogram and family timeline
5. Assessment of family's cultural background

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature review included bibliographies of book chapters, review articles, source materials from the Committee on the Family of the American Academy of Child and Adolescent Psychiatry, and consultations with clinicians and researchers with specific expertise in this area. A review of Medline psychiatry abstracts from 1985 to 2005 and PsycInfo from 1990 to 2005 was conducted with the search phrase "family assessment," which yielded about 160 articles.

NUMBER OF SOURCE DOCUMENTS

160 articles

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The American Academy of Child and Adolescent Psychiatry (AACAP) develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward the best treatment practices. Treatment recommendations are based both on empirical evidence and clinical consensus and are graded according to the strength of the empirical and clinical support. Clinician-oriented parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the Member Forum at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP) in October 2005. From July 2006 through September 2006, this parameter was reviewed by a Consensus Group convened by the Work Group on Quality Issues.

This practice parameter was approved by the AACAP Council on October 11, 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Principle 1. The Psychiatric Assessment of a Child or Adolescent Must Include Both Historical and Current Information about the Family and Its Functioning, Typically Gathered from the Child and Primary Caretaker(s).

Structured Guide to Eliciting Family History

Demographic data should document family moves, changes in family composition, socioeconomic circumstances, family illness, legal difficulties, and altered family structure.

The family's historical report should be supplemented by ancillary sources of data. These sources can include history from other professionals who have evaluated or treated family members, as well as information from schools, local social service agencies, the courts, and child welfare agencies. These sources often provide a broader perspective of family functioning by providing information that the family either sees as unimportant or is unable or unwilling to communicate clearly to the clinician. Parents must give their consent for clinicians to gather history from these sources, with an adolescent's assent also prudent practice.

Gathering family history by interviewing ex-spouses, common-law partners, and stepparents also raises legal issues. The clinician may receive history from any individual regarding a child but should divulge information about the child only to those who have a legal right or permission to receive it.

The following is a guide to the areas that should be covered in gathering a detailed family history. These are questions the clinician should consider and may, in some cases, directly ask the family or family members.

1. Family Demographics
 - This information should include names and ages of parents and siblings, parents' occupations, current composition of family/household (including nonbiological members), health and psychiatric status of family members, and custody status.
2. Clinical Symptomatology of the Child
 - What is the interactional context of the symptomatic behavior (e.g., oppositional behavior)? What are the typical sequences of family interaction associated with the problem?
 - Is there a characteristic family profile associated with the clinical problem being assessed (e.g., coercive, inconsistent parenting practices in conduct-disordered children)? If so, questions related to this profile should be pursued.
 - Is one particular person blamed for the problem? Does the family feel responsible for the clinical problem (e.g., a child's dependency), or do

they perceive themselves as responding to something deviant within the child (e.g., a child's difficulty sustaining attention)?

- Are there family interactions that precipitated the current problem, predisposed to the current problem, or maintain the current problem?
- Do individual symptoms appear to maintain a family's preferred interactional pattern? What are the mechanisms?

3. Individual Parent History

- How did each parent negotiate his or her formative developmental years? Are there specific events in the parent's family of origin that appear to have had particular impact (e.g., sexual abuse)? Has cumulative developmental experience (e.g., having experienced harsh, punitive parenting) had an enduring effect on the parents' current parenting behaviors?
- Does the parent have a diagnosed mental disorder or a medical disorder that affects parenting? How does it affect parenting?
- What is the style of the parents' pervasive personality functioning? How does it affect parenting?
 - Are there identifiable patterns in occupational or marital functioning that suggest personality strengths or weaknesses?
 - Is there a particular developmental stage of child development that is problematic for the parent?
 - How does each parent respond to siblings of the identified patient?
 - What is the parents' level of insight and self-observation?

4. Parent Relationship History

- What attracted the mother and father to each other? What is the chronological history of their relationship?
- What were the couple's early relationship (e.g., premarital) expectations of each other? How have these been modified?
- Were there previous marriages or relationships? Were children the result of the relationships? What were the factors in termination of these relationships? Do such factors affect the current marriage? In what way do ex-spouses affect the current marriages?
- What are the current areas of satisfaction and dissatisfaction with respect to vocation, finances, sexual relationship, and parenting?
- What is the legal status of the parents' relationship?

5. History of Family as a Unit

- How has the family negotiated the anticipated events of each family developmental stage: birth of first child, young children, adolescents, and launching young adults?
- What are the unanticipated or unique challenges that this family has faced (e.g., unemployment, family illness)? Has the family responded in an adaptive or maladaptive manner?
- How has the family's socioeconomic status affected their children? Is it related to clinical presentation?
- How has the family's cultural and religious perspective affected their children? Is it related to clinical presentation?
- Are there specific events of significance (e.g., family moves, remarriages)?

- Is the family isolated from the larger community or is it interrelated to other groups?
- Is there a current theme or challenge that dominates the family's attention? How is this related to the symptomatic child?

Principle 2. The Family Assessment of a Child or Adolescent Must Include an Observation of the Child's Interaction with Caretaker(s).

History taking occurs simultaneously with ongoing observation of parent-child interaction.

Clinicians should be attuned to any interactive process that contravenes known principles of healthy child development.

Structured Guide to Assessment of Basic Elements of Family Functioning

The following is a guide to four elements of basic family functioning, areas that should be covered in a comprehensive family assessment. It is structured in the format of questions the clinician should consider and, in some cases, may ask the family. The following data are gathered through family members' historical report and clinician observation of family interaction.

1. **Family Structure:** Family structure refers to the typical organizational and transactional patterns and hierarchies that exist between the individuals or subsystems within the family. Important components of the family structure are its adaptability or flexibility, its level of cohesiveness, and the nature of its subsystems (e.g., spousal, parental and sibling) and the boundaries between them.
 - **Adaptability:** Healthy family function denotes a flexible structure in which transactional patterns are stable but can shift when circumstances dictate that change is needed. Clinical families may be too chaotic, with patterns and individual family roles constantly changing, or too rigid, where the family is unable to change typical ways of interacting as life's circumstances demand change. (Here, and in subsequent text, the term clinical family denotes families whose problems in a specific area of functioning are associated with a clinical disorder in one of their children.)
 - **Cohesion:** Healthy family functioning is indicated by a balance between connectedness and separateness. Clinical families may be either too emotionally close (enmeshment) or too emotionally distant (disengaged).
 - **Boundaries and subsystems:** Healthy family functioning is indicated by emotional boundaries between individuals and subsystems that are permeable but clear, whereas in clinical families, boundaries may be rigid, diffuse, or misaligned.
2. **Family Communication:** Family communication refers to the verbal and behavioral interactions by which family members impart information to each other about their individual needs and their perceptions of, and feelings about, others in the family. Components of family communication to be considered are clarity, directness, emotional expression, and problem solving.

- Clarity: Healthy family functioning is indicated by communication that is clear, direct, and consistent, with affective responses congruent to the message conveyed. Clinical families tend to communicate ambiguously and indirectly about both minor transactions and those with major importance, with affective expression that is muted, inappropriate, or incongruent.
 - Emotional expression: Healthy family communication is characterized by affect that is congruent with the message conveyed. Clinical families may block the expression of feelings and do not express affect congruent with life experiences.
 - Problem solving: Healthy family functioning identifies that problems exist, negotiates differences or conflicts, emphasizes positive reciprocal interactions among members, and uses new information in modifying behavior and/or perspective. Clinical families tend to have multiple individual perceptions of the problem, are unable to sacrifice toward common family goals, and are unable to perform the tasks necessary to assist family coping. Clinical families may be ineffective at problem solving and may have parent(s) who are poorly communicating, authoritarian, or indecisive.
3. Family Belief: The third area of observation, perhaps the most difficult to assess in initial interviews, is of family belief systems or shared constructions of reality. This refers to the observation that families have a type of memory function that goes beyond that of the beliefs and memories of each of its members. Clinical observations should attempt to ascertain beliefs termed "family myths" and "family legacies." This concept refers to ideas that guide decisions and actions in the family and help contribute to repetitive patterns of interaction that families demonstrate across generations. Healthy family beliefs empower family continuity and adaptation (e.g., a family tradition of heroism and bravery). Clinical families may have beliefs that foster maladaptation (e.g., men always leave their partners; adolescents are rebellious).
- What are the recurring themes in family life? Are there clusters of related problems such as alcohol-related problems, legal difficulties, or unquestioned beliefs or perceptions (e.g., men will abuse you and leave you; adolescent girls will be promiscuous)?
 - Are family roles rooted in family beliefs?
 - Are there puzzling patterns of family interaction? Did they exist in previous generations?
4. Family Regulation of Child Development: In family health the developmental needs of children are met and their developmental tasks are mastered in the context of *family regulation*. The family must regulate the child's negotiation of these inevitable developmental tasks. Such regulation implies an equilibrium between inhibiting and facilitating interactions between caretaker and child. The parents are attuned to their child's developmental needs and facilitate the emergence of the child's autonomous regulatory capacities. Family assessment should observe behaviors and gather history, which allows the clinician to clarify the nature and impact of regulatory processes. The following questions guide the clinician's task:

- Does the family have a balanced, empathic response to developmental needs of its children? This can be evaluated by the following review of basic developmental issues.
 - How does the family nurture and support?
 - How does the family set limits and teach internal self-control?
 - How does the family foster early socialization efforts?
 - How does the family facilitate achievement and success, including academic success?
 - How does the family facilitate independence/selfhood and individuation?
- Do parents regulate development in a coordinated pattern or is there a contrast in their efforts (e.g., one parent overinvolved with children and one parent underinvolved)?
- Is the family pattern of regulating developmental need characterized by overregulation (an excessive response to a child's developmental need that usurps the child's autonomous regulatory capacities), underregulation (a deficient response to a child's developmental need, which thus fails to support and nurture the child's emerging regulatory capacities), inappropriate (the family's responses are appropriate for an earlier developmental stage but are inappropriately applied to a child's developmental need in the current stage), irregular (the family that is consistent in one domain of function [e.g., feeding] but inconsistent in another [e.g., monitoring socialization]), or chaotic (no discernible pattern of family response to a child's developmental need) regulation?

Refer to Appendix B in the original guideline document for additional details on assessment of basic elements of family functioning.

Principle 3. The Family Interview Can Comprise Interviews with Individual Family Members, Groups of Members, or the Entire Family.

The family interview is the cornerstone of family assessment. In addition to members of the immediate family, the interview should include those who interact with the child on a regular, sustained basis, in a manner that the clinician judges to be influential. This could include, for example, grandparents, other family members, or live-in partners.

It is important to keep legal issues in mind when planning interviews. Parents with legal custody should provide information to the clinician and can receive information about their child. However, the caregiver(s) with primary physical custody and children who have regular contact with the identified patient are usually those who attend interviews. A parent without primary physical custody should provide information and when the child visits this parent on a regular basis, a separate interview with that parent and child will provide a more comprehensive database.

Valuable information is obtained when data obtained from a family subunit interview are contrasted with data obtained from a whole family interview. The clinician must determine whether and in what sequence other family members should be interviewed and observed in interaction with the symptomatic child or adolescent. An individual interview with a child may supplement information

gathered from an initial family interview, with its importance increasing coincident with a child's increasing age. An interview with a very young child is optional, and an interview with an adolescent is essential. Interviewing parents alone may provide an opportunity for the parents to freely discuss their relationship and provide differing views on their symptomatic child. Interviewing the child alone may allow the child to freely discuss conflicts that may not be easily divulged with parents present. This is particularly true with adolescents. Discrepant views of clinical problems often emerge more sharply in individual interviews and, once identified, may suggest family treatment as part of the treatment plan.

It is not uncommon for some family members to fail to attend, even when their presence has been requested. In this instance the clinician should interview all who actually attend but should be attentive to the absence of certain members and its meaning for the family. The absence of a member, most often a reluctant parent or adolescent, powerfully affects what happens in the session and is often an opportunity to understand some of the family difficulties associated with the child's presenting complaint.

The child or adolescent is invariably the identified patient, and interviewing other individuals regarding the child or adolescent's functioning raises the issue of confidentiality. Parents should be made aware of issues that are of concern to the younger child. As the child becomes an adolescent, this issue becomes more complicated and the adolescent's desire for confidence is respected unless an issue of dangerousness precludes maintaining confidentiality. Although interviewing individuals separately often helps them share their history more freely, confidentiality is maintained wherever possible.

The family interview is best conducted in a comfortable room large enough to accommodate the expected number of individuals. Furniture or objects potentially harmful to younger children should be removed. Games or activities for younger children should be present to facilitate rapport with them and decrease the likelihood of their behavioral disruption. It is important for the clinician to manage flexibly the simultaneous tasks of history taking and observing family interaction. At times, acute problems such as suicidal ideation or intense disagreement about an issue can prevent systematic gathering of background family history, effectively terminating some content data gathering while providing powerful experiential process data.

In the beginning of a family interview, each member is addressed in an informal manner that is consistent with his or her developmental level, with a goal of establishing rapport. One way that this is accomplished is by the clinician identifying family strengths and resources at the outset, best achieved through an informal interview style. The clinician then defines the problem by gathering relevant current and past history. While this is taking place, the clinician observes family interactions and facilitates the interactional stage with the use of probing questions. By asking family members about their individual responses, behaviors, and feelings, the clinician begins to understand how events have acquired specific meanings for each member and how these meanings differ.

It is not uncommon for conflict to emerge in the session while the clinician gathers history. At such points the antecedents and consequences of behavioral problems are not merely reported but demonstrated. A history of successful problem

resolution should be reviewed, as well as discussing situations in which problems remain unresolved. A completion of the family interview includes the summation stage, in which the clinician formulates what he or she has observed, its relevance to the identified patient's problems, and the role, if any, family members may play in subsequent treatments. All of the family members should feel that they have been understood, and, whenever possible, the clinician should convey a sense of hope with respect to future family adjustment.

Principle 4. When the Clinical History Suggests Interactional Problems, the Family Members in Daily Contact with the Child Should Be Interviewed, with the Goal of Establishing An Understanding of the Family Context of Symptomatic Behaviors.

Because most families present to the clinic with a symptomatic child, it is prudent to begin a family assessment with a review of the child's symptomatology. Some problems present with an interactive focus: oppositional behavior, a child running away from home, a self-harm gesture after a family argument, or a child's refusal to eat. In these instances it is important to obtain a history of the sequence of events, behaviors, and family interactions associated with the clinical problem. The assessment goal is not only to describe the problematic behavior but also to understand the meaning and function of the behavior in relationship to the child's family. A given symptom, such as a temper tantrum, may have different meanings in different children and different families. To draw such distinctions, the family assessment must include a review of family circumstances and consequences of the problematic behavior. Questions should include a review of the family's past attempts at solving problems. In this sense, history taking, diagnostic formulation, and observation of the family occur concomitantly. During the assessment process the clinician must keep in mind the reciprocal nature of family influences. Although family interaction may be associated with symptoms in the child, the child's symptoms may provoke family responses.

Principle 5. The Family Interview Should Include Questioning Regarding Family Risk Factors for Specific Disorders.

The clinician should recognize that some disorders are associated with typical family or parenting styles, and this knowledge should inform history taking (e.g., coercive and inconsistent discipline in conduct-disordered youths, parental illness, and vulnerability in children with separation anxiety). A history of clinical symptomatology must include a review of which behavior management techniques parents have tried, either successfully or unsuccessfully. The clinician must always keep in mind that patterns of interaction may be primarily a response to a child with a biological vulnerability.

Principle 6. The Family Evaluation Should Provide Enough Data for a Clinician to Characterize Adequately the Family's Structure, Level of Communication, Belief System, and Regulatory Functioning.

Perhaps the most challenging aspect of family assessment is the systematic observation and categorization of the basic elements of family functioning. Four elements are described most frequently and subsume the most clinically relevant aspects of family function: structure, communication, belief systems, and

regulatory processes. (See Principle 2 of this summary and Appendix B in the original guideline document for a full description of the elements.)

Principle 7. The Family Assessment Is Enhanced by a Family Developmental History, a Marital/Relationship History, and Individual Parent History, Including a History of Psychiatric Disorders in Family Members.

A history of both parents should identify psychiatric and/or medical disorders that may be transmitted to their children, whether through experiential or genetic mechanisms. It is important to assess the parents' level of knowledge of child development and of the child's disorder and identify specific knowledge deficits of clinical significance. The overall goal of the parent history is to allow the clinician to achieve a full perspective of parental strengths and weaknesses.

See Principle 1 above and Appendix A in the original guideline document for interviewing guidelines.

Principle 8. For Complex Cases, the Clinician Should Consider Ancillary Techniques to Gather and Organize Relevant Data About Family Functioning.

Two helpful products of the family interview can be the family genogram and the family timeline. A genogram is a diagram made in conjunction with the family, or by the clinician alone, that identifies facts and relationship patterns of three or more generations of family members. Such a tool is essential in more complex family histories. The content of the genogram allows a family history to be seen in generational context beyond the presenting complaint and concerns of immediate family members. A timeline is a simple yet graphically useful instrument that maps a sequence of important events. The timeline provides a visual representation of the onset of psychiatric problems linked to clear precipitants and family context.

Because of the complexity of family assessment, a video record of family interactions can be useful for the clinician and, at times, for the family to view themselves. Video is often used in training settings but has limitations in other settings, largely due to the time-intensive nature of video review.

Principle 9. The Evaluation of the Family Requires the Clinician's Sensitive Awareness of Cultural Differences.

The family's cultural background directly affects its views of normative family structure, communication style, belief systems, and child development. The involvement of extended family members, style of emotional expression, and family values are examples of culturally influenced aspects of family function. It is important to understand the family's religion or world view/philosophy of life, especially when the presenting complaint involves issues directly related to these ideas.

Principle 10. A Comprehensive Family Assessment Should Lead to Treatment Interventions That Interrupt Family Functions That May Precipitate, Predispose, or Maintain Clinical Problems and Potentiate Family Functions That Promote Health and Optimize Disease Management.

Contemporary developmental psychopathology emphasizes risk and protective factors as etiologically relevant in the onset of psychopathology. The family is but one of these factors. When the family assessment is complete, it should be integrated with the other findings of the comprehensive psychiatric assessment. With the integrated data, the clinician can develop a formulation with respect to the reciprocal effects of family influence. The clinician must have a clear understanding of the factors within the family that have affected the child and the aspects of the child's condition that have stressed the family. The complex judgment of determining the directional effects of family influence can be facilitated by considering certain aspects of the data gathered. Once complete, this case formulation guides the clinician in determining an approach to the family's role in treatment.

Areas of Family Assessment Related to Treatment Planning

- Family understanding of developmental norms
- Influence of parental psychiatric disorder
- Quality of parental commitment to the child's well-being
- Parental achievements apart from child rearing
- Family members and developmental task mastery
- Assessment of the heritability of the child or adolescent's disorder
- Level of parents' mutual support of each other
- Relationship of the child's behavior to environmental change

Refer to Appendix C in the original guideline document for more information on the areas of family assessment related to treatment planning.

The goal in preparation for psychiatric treatment is to determine how and when to include the family on the basis of the collection of historical and observational family data. When it is determined that the family's interactions are responses to a child's condition that is primarily biologically mediated, a supportive psychoeducational approach follows that optimizes disease management. In some cases the family assessment suggests that family factors have maintained the problem, predisposed the child to the problem, or acutely precipitated the problem. Such a formulation indicates the need for an intervention to alter patterns of family interaction. Some family treatments will involve a combination of both approaches. The communication of a formulation is an essential part of the assessment and must be empathically presented, in comprehensible terms, to parents and child.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment of the family of the child or adolescent with a psychiatric disorder

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

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2007 Jul

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

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American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

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This parameter was developed by Allan M. Josephson, MD, principal author.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Bukstein receives or has received research support from, acted as a consultant to, and/or served on the speakers' bureaus of Cephalon, Forest Pharmaceuticals, McNeil Pediatrics, Shire, Eli Lilly, and Novartis. Drs. Josephson, Bernet, and Walter have no financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#).

Print copies: Available from AACAP, Communications Dept., 3615 Wisconsin Ave, NW, Washington, DC 20016. Additional information can be obtained through the [AACAP Publication Store for Parameters and Guidelines](#).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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