Salud Mental 2015;38(3):209-215
ISSN: 0185-3325
DOI: 10.17711/SM.0185-3325.2015.029

Marital functioning in parents who take their children for a psychiatric evaluation

Mauricio Leija Esparza,[1] Israel Itzaman Jiménez Navarro,[2] Lidia Karina Macias Esparza[3]

Original article

ABSTRACT

Background
In recent decades, research on families with psychopathology has demonstrated the relationship between childhood mental disorders and problems in the marital subsystem.

Objective
To describe the degree of marital adjustment in a group of parents who sought psychiatric care for their children and compare it with the severity of the psychopathology present in children.

Method
The study included a group of 48 children and 76 parents. The children's psychopathology was assessed using the MINI-Kid, while their parents' degree of dyadic adjustment was evaluated through the Dyadic Adjustment Scale (EAD-13).

Results
A total of 72.9% of the children had at least one parent who reported low dyadic adjustment. The EAD-13 scores of each member of the couple showed low correlation ($p<0.05$). Moreover, there was a negative correlation ($p<0.05$) between the EAD-13 scores answered by the mothers (the lower the score, the lower the adjustment) and the number of diagnoses present in the children. However, a comparison of the means of the number of diagnoses present in the children, according to the degree of adjustment perceived by the fathers, showed that those with a high adjustment had children with a higher number of psychiatric diagnoses ($p<0.05$).

Discussion and conclusion
The results suggest that denied or concealed conflict, at least by the father, and marital difficulties perceived by the mother, led to children's increased susceptibility to psychopathology.
Ignoring marital conflict in the assessment of children and adolescents has huge implications in the evolution, prognosis, and response to treatment of pediatric patients.

Key words: Dyadic adjustment, couple relationship, marital satisfaction, child psychopathology.

RESUMEN

Antecedentes
Recientemente, la investigación en familias con psicopatología ha demostrado la relación entre los trastornos mentales infantiles y los problemas en el subsistema conyugal.

Objetivo
Describir el ajuste conyugal de un grupo de padres de familia que solicitaron atención psiquiátrica para sus hijos, y asociarlo con la gravedad de la psicopatología presente en éstos.

Método
Se incluyó a un grupo de 48 niños y adolescentes, y a 76 progenitores. La psicopatología infantil se evaluó por medio de la MINI-Kid y el ajuste conyugal se evaluó mediante la Escala de Ajuste Diádico (EAD-13).

Resultados
El 72.9% de los menores tuvo al menos un progenitor que reportó un bajo ajuste diádico. La correlación entre las puntuaciones de la EAD-13 obtenidas de cada miembro de las parejas fue baja ($p<0.05$). Existió una correlación negativa ($p<0.05$) entre las puntuaciones de la EAD-13 contestadas por las madres (cuanto menos se puntúa, menor es el ajuste) y el número de diagnósticos presentes en los hijos. Sin embargo, al comparar las medias del número de diagnósticos presentes en los menores, según el grado de ajuste percibido por los padres (varones), se encontró que aquellos que presentaban un alto ajuste tenían hijos con un mayor número de diagnósticos psiquiátricos ($p<0.05$).

Discusión y conclusión
El conflicto negado por parte del padre y las dificultades conyugales percibidas por la madre redundan en una mayor predisposición de los hijos a la psicopatología.
Ignorar el conflicto conyugal tiene enormes implicaciones en la evolución, pronóstico y respuesta al tratamiento de los pacientes pediátricos.

Palabras clave: Ajuste diádico, relación de pareja, satisfacción marital, psicopatología infantil.

Translation of the original version published in spanish in:
Salud Mental 2015, Vol. 38 Issue No. 3.

[1] Child and Adolescent Clinic at the Jalisco Institute of Mental Health.
[2] "Dr. Juan N. Navarro" Child Psychiatric Hospital.
[3] Bateson Institute of Systemic Psychotherapy A.C.

Correspondence: Mauricio Leija Esparza. Jalisco Institute of Mental Health (SALME). Av. Zoquipan 1000-A, Col. Zoquipan, CP. 45170, Zapopan, Jalisco, México. Phone: (01-33) 3633 - 9383 ext. 254. E-mail: mauricio.leija@gmail.com

Received first version: January 17, 2014. Second version: October 30, 2014. Accepted: January 20, 2015.

BACKGROUND

Since families began to be studied, in the middle of the last century, many researchers inspired by the work of Gregory Bateson[1,2] found another way of understanding child psychopathology. Previously, the individual focus, driven primarily from psychoanalysis, constituted the main model for understanding children's emotional and behavioral problems.

The development of research into families with psychopathology demonstrated the close relationship between children's mental disorders and problems in the family system, specifically within the marital subsystem.

During the 1970s, authors such as Salvador Minuchin[3,4] and Mara Selvini-Palazzoli[5] indicated that difficulties and conflicts in the marital relationship generated a context which favored the development of psychopathology in children and adolescents.

Also during the 70s, Julián de Ajuriaguerra published his *Manuel de psychiatrie de l'enfant* [Manual of Child Psychiatry]; a classic work, widely studied and commented on by those interested in children's mental disorders. This work indicated that "In some cases, it was enough to treat certain family members to improve the state of the child".[6]

Some years later, Ajuriaguerra and Marcelli published *Psychopathologie de l'enfant* [Childhood Psychopathology]; this work discussed the relationship between disagreements among progenitors and the child's state of mental health: "The child rarely remains outside of the disagreement; they usually participate in it, passively or actively".[7]

Advances in medicine based on evidence from the 1990s led researchers to study child psychopathology through more rigorous means which would generate quantitative results. In 1995, King et al.[8] found lower marital satisfaction in parents of patients who required psychiatric hospitalization compared to a control group. In 2002, Nomura et al.[9] found that children exposed to family conflicts and parental depression suffered a greater proportion of psychopathology. In 2006, Cabrera et al.[10] found that marital satisfaction, parental satisfaction, marital conflict, and parental stress were all important in explaining the variability of behavior of psychological adjustment of their children.

In spite of these investigations, still relatively little is known about how different types of "quality" in partner relationships influence their children's wellbeing. It should be noted that the construct of "quality" in the marital relationship is complex, and covers concepts that are not always easy to describe such as satisfaction, happiness, adjustment, and integration.[11]

The interest in objectively evaluating quality in marital relationships led Spanier to develop the most widely-used measure of marital adjustment, the *Dyadic Adjustment Scale* (*DAS or EAD for its Spanish initials*).[12] As proof of this, Spanier indicated that in the decade following its creation, the scale was used in more than 1,000 studies.[13]

Without a doubt, the use of this instrument can facilitate evaluation of the marital relationships of parents in families that seek psychiatric care for their children. It should be noted that the American Academy of Child and Adolescent Psychiatry, by means of the respective practical parameters, has recommended that all children who attend an appointment with a child psychiatrist must also receive a family assessment;[14] this clearly also implies an assessment of dyadic adjustment.

The aim of the present investigation is to describe the characteristics and quality of the partner relationship of family parents* who sought psychiatric treatment for their children and associate it with the severity of the children's psychopathology.

METHOD

The study included a group of 48 children and adolescents aged between 6 and 16, and 76 family parents (47 women and 29 men). It was possible to have both parents participating in 58.33% of the children and adolescents (N=28).

The children and adolescents who participated in this study were brought by their parents for a first psychiatric evaluation at the Child and Adolescent Clinic at the Jalisco Institute of Mental Health.

The parents of the family who agreed to participate in the study signed an informed consent letter and the children and adolescents gave their consent verbally. This project was approved by the Research Ethics Committee of the Jalisco Institute of Mental Health, and was registered with the Health Secretary of Jalisco State.

The children and adolescents met the following inclusion criteria: they had to have been accompanied by at least one parent and be aged between 6 and 16 years old. Those who presented any incapacitating cognitive defect were excluded from the study. In order for the parents of the family to be included in the study, they had to live with the other member of the partnership (even if they did not attend the assessment) regardless of their civil (marital) status. Those who declared when making the appointment that they could not read or write were excluded from the study.

The following instruments were used:

1. *Mini-International Neuropsychiatric Interview for Children and Adolescents* (*MINI-Kid*). The *Mini-International Neuropsychiatric Interview* (*MINI*), developed for adults, is a brief, structured, diagnostic interview which explores the main psychiatric disorders in axis I of the DSM-IV and the ICD-10.[15] There is published data about its reliability and validity in accordance with the SCID and

* When the term "padres de familia" appeared in the text, it was translated as "family parents" as it generally referred to both parents; when the word "padres" appeared alone, it was translated as "fathers" in accordance with the text.

the CIDI.[16,17] The *MINI-Kid* was developed by the same authors as the *MINI* with the aim of having an instrument that was applicable to young people, shorter, and easier to administer compared to others. It uses language that is easy to understand for that age group and retains the essential characteristics of the *MINI*.

In October 2004, in a meeting of the American Academy of Child and Adolescent Psychiatry, a study was presented of the validity and reliability in Mexico of the Spanish version of the *MINI-Kid*. The inter-assessor and temporal reliability were from 0.9 to 1 and from 0.60 to 0.75, respectively, and the concurrent validity with the open clinical interview carried out by an expert in child and adolescent psychopathology was from 0.35 to 0.50.*

2. *Dyadic Adjustment Scale* (*DAS*). The *DAS* has been the most widely-used instrument in assessing the quality and adjustment of a couple.[13,18] It was developed as a multi-dimensional scale, applicable both to marriage and other types of partnerships. The original version was comprised of 32 questions which gave an overall score of the dyadic adjustment. It is a self-applied, Likert-type scale with scores from 0-151; a higher score means a better marital adjustment. It has traditionally been used by applying it to just one half of the partnership. It consists of four subscales: *Agreement, Satisfaction, Cohesion, and Expression* of Affection, which can be applied singly without losing reliability or validity. Psychometric studies carried out generally advise adequate reliability of internal consistency with values ranging between 0.50 and 0.96, both for the global scale and the distinct subscales. Validity studies offer raised correlations with other measures of adjustment and marital satisfaction.[12]

   The *DAS* has a version validated for the Mexican population.[19] Currently, there is a brief version of 13 questions (DAS-13) with a cutoff point of 44. The DAS-13 retains the subscales of Agreement, Cohesion, and Satisfaction, with internal consistency reliability values of 0.73, 0.70, and 0.63, respectively. The reliability for the whole scale is 0.83. Analysis of convergent validity showed that both the overall DAS-13 scale, as well as its various subscales, correlated positively with the subscale of *Assertion from the Dating and Assertion Questionnaire* and negatively with the subscales of *Aggression, Submission, and Passive Aggression*.[18] This version was used in the present investigation.

Statistical analysis

Parameters of descriptive statistics were used to analyze the sociodemographic characteristics of the children and adolescents who participated in this study, as well as the diagnoses obtained from the *MINI-Kid* interview. Parameters from descriptive statistics were also used for the initial analysis of the scales applied to the progenitors.

For the bivariate analysis, the *Student's t* test was used to determine the differences in scores on the DAS-13 applied to each member of the 28 participating couples. Assuming no directionality, we determined through *Pearson's correlation* the grade of association between the DAS-13 scores of each partner who participated, as well as to determine the level of association between the DAS-13 score of each one of the progenitors and the average number of diagnoses present in each child (this last value was considered as an estimator of severity of psychopathology). This analysis was carried out on all parents in participating families, regardless of whether they came alone or with a partner.

Finally, the *Student's t* test was used for independent samples, in order to compare the medians of the number of diagnoses presented in the children, grouped according to the level of dyadic adjustment expressed by the mother, and also according to the level of adjustment expressed by the father. The latter analysis was carried out with all participating progenitors.

All statistical analyses were carried out with the IBM SPSS® program, version 21. A level of significance of p was established with a value of <0.05.

RESULTS

The average age of patients was 10.2 years (SD ± 2.9). The majority of children and adolescents were male, from the municipality of Zapopan, Jalisco, and were elementary school students (table 1).

The most frequent diagnosis found in this pediatric sample was Oppositional Defiant Disorder (77.1%), followed by Attention Deficit Hyperactivity Disorder (60.4%) and Dissocial Disorder (37.5%) (table 2). The median number of diagnoses present in the children and adolescents was 4.0 (SD ± 2.29).

The frequency of female patients who only presented internalized disorders was greater than that found in males (17.6% *vs*. 3.2%, respectively). Conversely, externalized disorders with no other comorbidity were more frequently present in males (35.5% *vs*. 11.8% in females). However, the majority of patients had both internalized and externalized disorders (61.3% in males *vs*. 70.6% in females).

It should be noted that 72.9% of the sample of children and adolescents had at least one parent whose score on the DAS-13 resulted in a low dyadic adjustment (some pairs did not show agreement in terms of marital adjustment, and we therefore decided to emphasize the fact that at least one obtained a score corresponding to a low dyadic adjustment. To date, there has not been data published on how to estimate

* Palacios L, de la Peña F, Heinze G. (2004, October). Validity and reliability of the MINI-KID. Poster presented at the Conference of the American Academy of Child and Adolescent Psychiatry. Washington, D.C., USA.

Translation of the original version published in spanish in:
Salud Mental 2015, Vol. 38 Issue No. 3.

Table 1. Sociodemographic characteristics of children and adolescents who participated in the study

	N	%
Age		
6-9 years	23	47.9
10-13 years	16	33.3
14-16 years	9	18.7
Sex		
Male	31	64.6
Female	17	35.4
Education		
Kindergarten	1	2.1
Primary	27	56.3
Secondary	20	41.7
High School	0	0.0
Place of residence (municipality)		
Guadalajara	12	25.0
Zapopan	22	45.8
Tlajomulco de Zúñiga	3	6.3
Tlaquepaque	3	6.3
Tonalá	4	8.3
Other towns	4	8.3

dyadic adjustment if the scale is applied to both members of a couple.

Of the total of 28 couples who responded to the instrument, both had a high dyadic adjustment in 7 couples (25%), and both had a low adjustment in 13 (46.4%). The rest of the participating couples did not show agreement in terms of their marital adjustment. Six couples (21.4%) showed a low adjustment according to the responses of the mother and a high adjustment according to the responses of the father. Two couples (7.1%) showed a high adjustment according to the mother and a low adjustment according to the father.

The median scores of the DAS-13 answered by the mothers (37.93) were below the cutoff point (low dyadic adjustment) and the median score of their partners (44.75) was just above the cutoff point (high adjustment).

Differences in the median scores on the DAS-13 obtained by each member of the couple, according to the *Student's t* test, were statistically significant ($p<0.05$).

Pearson's correlation showed a low association ($r=0.37$) in the total scores of the DAS-13 obtained in each member of the couples; this correlation was statistically significant ($p<0.05$). The subscales of *Agreement* and *Cohesion* did not show correlation ($r=0.16$ and 0.15, respectively); but the subscale of *Satisfaction* did, which had a moderate association ($r=0.50$) and was statistically significant ($p<0.01$).

Pearson's correlation did not show association ($r=0.26$) between the scores on the DAS-13 responded to by the parents and the number of diagnoses present in the children. Conversely, there was a negative ($r=-0.32$) and statistically significant correlation ($p<0.05$) between the mothers' average score on the DAS-13 and the number of diagnoses present in their children; in other words, the lower the dyadic adjustment according to the mother's perception, the greater the number of psychiatric diagnoses the child would tend to have.

As can be seen in table 3, mothers with high dyadic adjustment had children with a greater number of psychiatric diagnoses in comparison to mothers with low adjustment. However, this difference was not statistically significant ($p=0.37$).

In terms of fathers, those who had a high dyadic adjustment had children with a higher number of psychiatric diagnoses compared to fathers who had a low adjustment. This phenomenon was opposed to what was observed with the mothers of the participants and was statistically significant ($p<0.05$).

DISCUSSION AND CONCLUSION

The present study assessed the marital adjustment level of family parents who brought their children for child psychiatry treatment and compared it to the severity of the children's psychopathology.

Table 2. Frequency of MINI-Kid categories diagnosed for children and adolescents who participated in the study

	N	%
By diagnostic category		
Major depressive disorder	15	31.30
Suicide risk	17	35.40
Dysthymic disorder	5	10.40
Bipolar disorder	0	0.00
Anxiety disorder	9	18.80
Agoraphobia	12	25.00
Separation anxiety disorder	12	25.00
Social phobia	14	29.20
Specific phobia	8	16.70
Obsessive-compulsive disorder	1	2.10
Post-traumatic stress disorder	0	0.00
Alcohol abuse/dependency	2	4.20
Substance abuse/dependency	1	2.10
Tic disorders	1	2.10
ADHD	29	60.40
Dissocial personality disorder	18	37.50
Oppositional defiant disorder	37	77.10
Schizophrenia	2	4.20
Anorexia nervosa	0	0.00
Bulimia nervosa	1	2.10
Generalized anxiety disorder	8	16.70
Adjustment disorder	0	0.00
By psychopathology group		
Affective disorders	24	50.00
Anxiety disorders	29	60.40
Externalized disorders	44	91.60
Substance consumption disorders	3	6.25
Psychotic disorders	2	4.10
Other disorders	2	4.10

MINI-Kid= Mini-International Neuropsychiatric Interview for Children and Adolescents.

Table 3. Comparison of median number of diagnoses present in minors according to the level of dyadic adjustment perceived by the parents

	Adjustment		Student's *t*		
	High	Low	*t*	*gl*	*p*
Mothers	N=15 Median (SD) 3.60 (2.32)	N=32 Median (SD) 4.25 (2.30)	-0.90	45.0	0.37
Fathers	N=12 Median (SD) 5.17 (2.48)	N=16 Median (SD) 3.31 (2.12)	2.13	26.0	0.04

SD= Standard deviation.

The high frequency of externalized disorders, especially Oppositional Defiant Disorder, is notable, followed by Attention Deficit Hyperactivity Disorder and Dissocial Disorder. The externalized and combined disorders (both externalized and internalized) represented the prime cause for psychiatric consultation, far above internalized disorders without comorbidity.

The differences we observed in terms of the distribution of the sample in groups of disorders with regard to sex, have been reported by other authors. Externalized disorders predominate in men, and internalized disorders predominate in women.[20-22]

It is relevant that almost three quarters of the children and adolescents who participated in the study (72.9%) had at least one parent who reported low dyadic adjustment. This result indicates the need for services which can assess and treat couples in healthcare institutions offering psychiatric care for children and adolescents. Carrying out interventions for children and adolescents without treating the parents of the family who have low dyadic adjustment implies maintaining a risk factor related to the development and persistence of psychopathology. Unfortunately, due to limited resources in public health institutions, therapeutic work with couples is not a common intervention, even in institutions dedicated to mental healthcare.[23]

In our results, the differences in terms of sex in measuring the DAS-13 scores obtained by the parents were not minor. The mothers obtained a median in the DAS-13 that represented a low dyadic adjustment, while fathers obtained a median that showed a high adjustment (just five tenths above the cutoff point). This finding was statistically significant and it evidenced a difference in the evaluation that each partner makes of their own relationship. This includes the possibility that some of the mothers could have depression. It is also possible that their depressive mood had contributed to perceiving their partner relationship more negatively and that their attitudes and parenting techniques have not been adequate (which also constitutes a risk factor for the mental health of their children). Our aim was not to evaluate the parents' psychopathology; however, there is no doubt that the presence of mental disorders, very often with a clear biological implication, represents a risk factor for maintaining marital conflicts.

In contrast with our results, a non-published study carried out in Barcelona did not find differences in the median scores of the DAS-13 of each member of a sample of partners which represented a non-clinical population.*

In spite of these differences in scoring, Pearson's correlation demonstrated that there was a low level of correlation in the total scores from the DAS-13 applied to each member of a couple. Even if there was no expectation of finding an exact linear correlation between the scores of each member of a partnership, the presence of a low, statistically significant correlation shows a process of individual construction in which the partner relationship is perceived and assessed very differently by both people in it. We might deduce that the couples who participated in the study mostly did not maintain a marital relationship that meant a mutual and reciprocal process. This could be considered an indicator of pathology in the partner relationship.

On carrying out Pearson's correlation with the subscales of the instrument, we found that there was no correlation in terms of the subscales of *Agreement* and *Cohesion*, however, there was a moderate and statistically significant correlation in the subscale of *Satisfaction*. It seems, therefore, that partners coincided more in terms of the level of satisfaction (or lack of) they experienced within the relationship, than in terms of other themes related to conjugal life.

Without a doubt, another relevant result was that from the Pearson's correlation which measured the grade of association existing between scores on the DAS-13 of each of the parents and the number of diagnoses present in the children and adolescents. There was a negative and statistically significant correlation between the mothers' DAS-13 and the number of diagnoses present in their children. The lower the mother's perception of dyadic adjustment, the greater number of psychiatric diagnoses the child would tend to have. According to this statistical test, the father's perception of the partner relationship was not relevant in terms of the number of diagnoses present in the children.

However, the relationship between the level of dyadic adjustment perceived by the father and the number of diagnoses in the children could be established by means of the *Student's t* test. Fathers who had a high dyadic adjustment had children with a higher number of psychiatric diagnoses compared to fathers who had a low adjustment. This result appears to be confusing and contradictory if we forget that what the DAS-13 really measures is not dyadic adjustment, but rather the perception of it. How is it that if a father perceives a high adjustment in their marital relationship, we find greater psychiatric comorbidity in their children?

* Salla M. *El paper de la construcció del si mateix i de la parella en la qualitat de la relació de parella*. Non-published Doctoral thesis. Catalunya: University of Barcelona; 2010.

Translation of the original version published in spanish in:
Salud Mental 2015, Vol. 38 Issue No. 3.

Could this "high adjustment" be a denial, even more so if we consider that the majority of these parents have a partner who perceives a low adjustment? Does one parent's denial of marital conflict represent an element related to greater psychiatric comorbidity in their children?

At the beginning of the last century, Carl Jung approached the subject of the "false family attitude" and wrote: "the child is so much a part of the psychological atmosphere of its parents, that the secret and unresolved difficulties between them are susceptible to notably influencing their [the child's] health [...] It could almost be said that open conflict or visible difficulty will never have such an infectious effect as the difficulties and problems that parents keep hidden or unconscious".[24]

In the majority of the sample studied, it was evident that the presence of marital conflict lost all importance compared to concern for the child's symptoms. The majority of the family parents who attended the Jalisco Institute for Mental Health to seek assessment of their child by a psychiatrist had a partner relationship with low adjustment; this was more often the case when the child or adolescent exhibited greater morbidity. As such, the goal of the parents was a psychiatric assessment for their children and not a treatment leading to an improved partner relationship. It is important here to remember that expressed by Sauceda and Maldonado: "as children are the lowest in the family hierarchy, they are subject to the decisions of adults in terms of who should be assessed and treated".[25] Starting psychiatric treatment in a minor without evaluating the rest of the family system, simply because the parents have requested it that way, presents ethical problems that we must not sidestep.

Because each member of the couple assessed their relationship differently, without it being possible to find a high or even moderate correlation in the DAS-13 scores, the result of this instrument should be taken with precaution when applied to only one member of a couple. The DAS-13, rather than evaluating adjustment itself, allows for an evaluation of the *perception* of dyadic adjustment. If parents who take their children for psychiatric treatment perceive a low adjustment in their partner relationship, it will be necessary to carry out a *reframing*[26] which allows a systemic approach to problems.

Ignoring marital conflicts has enormous implications in the development, prognosis, and response to treatment of patients of pediatric age. If a child receives individual psychopharmacological or psychotherapeutic treatment, but the context in which the psychopathology was produced does not change, the intervention used is only dealing with the symptoms. Palliative measures, as in all medical practice, should only be adopted when all therapeutic measures available at the time of intervention have been exhausted.

Starting a treatment without having clarity about what is happening in the couple relationship can cause the child specialist to complicate family problems further. Without knowing it, they might believe that they are forming an alliance with one of the parents, but in reality they are participating in a covert coalition between them.

Certainly, one important limitation of our study was that the severity of the children's and adolescents' psychopathology was only estimated based on the number of psychiatric diagnoses (comorbidity) and psychosocial functioning was not assessed. Furthermore, the sample of family parents was not homogenous; women predominated, and not all the families were in the same conditions, as in some cases information was only obtained from one parent.

The results of this study support the systemic model for understanding child psychopathology and allow emphasis to be made on the need to have couples' therapy services in institutions which offer mental health treatment for children and adolescents.

Funding

None.

Conflict of interest

The authors do not declare any conflict of interest.

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Translation of the original version published in spanish in:
Salud Mental 2015, Vol. 38 Issue No. 3.