Commentary: Family Processes and Outcomes: Research Advances and Future Directions

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This definition of family was provided as an example in the American Academy of Pediatrics (AAP) policy statement describing patient- and family-centered health care (2012, p. 394). As this example illustrates, families take various forms; they are complex and dynamic. Personally and professionally, we all know this. As researchers and clinicians, this simultaneously intrigues and challenges us. We accept that all family members and the functioning of the family as a whole are affected when a child has a medical condition. We also accept that the ways in which the family reacts and responds will have an effect on the child’s adjustment and health course (Alderfer & Stanley, 2012). However, answers to questions such as, “How can we adequately capture and quantify the family? What aspects are key when a family contends with a pediatric medical condition? Why do some families manage well while others struggle? Where and when should we intervene?” remain elusive. As such, this special issue of the Journal of Pediatric Psychology on Family Processes and Outcomes is an important contribution to the literature. It is my honor to provide a commentary on these papers, highlighting one recurring theme, outlining some of their important strengths, and providing thoughts about future directions.

A Recurring Theme: The Importance of Parents Communicating Warmth and Support

While reading through these papers, one interesting theme emerged again and again: the importance of parents communicating warmth and support to their children. While not groundbreaking at that level of abstraction, the detailed findings of the relevant studies build interestingly on one another.

First, in their topical review of observational research, Murphy, Murray, and Compas (2016) surmise that families of children with chronic illness display less warm, less structured, more hostile/intrusive, and more withdrawn communication patterns than families of typically developing children. Within the discussion of their findings, however, they specifically note that the number of available studies do not allow for distinguishing between communication patterns when discussing illness-related topics versus other topics. Interestingly, the study by Sharp et al. (2016) suggests that children who identify cancer as their most stressful life event rate their parents as more supportive and reassuring when discussing this experience than children with cancer who identify non-cancer-related events as their most stressful experiences. Perhaps the pattern is context specific.

Of course, communication is bidirectional and both sides of this interpersonal interaction need to be considered. Birnie, Chambers, Chorney, Fernandez, and McGrath (2016) found that typically developing children expressed more symptom complaints during acute pain when their parents were observed to exhibit greater emotional support and less negativity and conflict. Berg and colleagues (2016) also found that teens were more likely to disclose information about their diabetes management when they perceived their parents as warm, accepting, knowledgeable, and helpful.

Further, the child sharing his/her medical/physical experience with a warm and supportive parent may impact adjustment. Our meta-analysis indicates that...
poorer communication and expressiveness and less support within families of children with cancer is associated with poorer child adjustment (Van Schoors et al., 2016). More specifically, Sharp and colleagues found that the expression of support by parents fostered posttraumatic growth among their children with cancer. This may be one mechanism through which maternal posttraumatic growth influences sibling adjustment as found in Stephenson et al. (2016). Further, lack of such expression is discussed by Santos, Crespo, Canavarro, and Kazak (2016) as possibly playing a role in associations between avoidant romantic attachment styles of parents, decreased meaning within family rituals and decreased cohesion among families of children with cancer. It is also discussed by Gutiérrez-Colina, Lee, VanDellen, Mertens, and Marchak (2016) as possibly explaining linkages between caregiver depressive symptoms and adolescent and young adult cancer survivor reports of poorer family functioning.

This interpersonal family pattern may also promote better medical outcomes. As mentioned above, Berg and colleagues found that teen disclosure of diabetes management information to parents was more common when parents were perceived as warm, accepting, knowledgeable, and helpful. Such disclosures were also associated with fewer self-regulation failures and better adherence. Similarly, Rybak and colleagues (2016) found that HBA1c and health-related quality of life were better for children with diabetes when their families were consistently perceived by youth and caregivers to have high levels of expressiveness and cohesion and low levels of diabetes-related conflict.

In sum, these studies suggest that pediatric medical conditions are family-level stressors that may tax parents’ ability to consistently express warmth and support and may result in hostile or conflictual patterns. However, the ability of parents to specifically share in their child’s medical experience with empathy, support, and understanding may promote child adjustment, better family functioning, and more positive medical outcomes. Within the context of pediatric illness, however, possible exceptions to this pattern also need to be considered. In some cases, family processes that promote family harmony and child development may undermine medical adherence or exacerbate medical problems (e.g., chronic pain). It remains important to examine processes within families of children with medical illness simultaneously considering the range of needs that these families must address.

**Strengths of the Studies in this Special Issue**

There are many strengths of the papers included in this special issue. Methodological strengths include hypothesis formation and interpretation of data based on theory (e.g., Murphy et al., 2016; Sharp et al., 2016); the use of multiple methods (e.g., Birnie et al., 2016) and multiple indicators of constructs (e.g., Berg et al., 2016); the use of longitudinal (e.g., Santos et al., 2016; Stephenson et al., 2016) and repeated measure (daily diary) designs (e.g., Berg et al., 2016; Stone & Walker, 2016); attention to the psychometric properties of measures within the population of interest (e.g., Stone & Walker, 2016); and the application of advanced statistical techniques (e.g., Gutiérrez-Colina et al., 2016; SieBerg et al., 2016; Rybak et al., 2016; Van Schoors et al., 2016). There are, however, three specific strengths that I would like to highlight: (a) embracing the complexity of families; (b) collecting and integrating multiple family perspectives; and (c) reaching beyond mothers and patients.

**Embracing the Complexity and Diversity of Families and Family Processes**

One of the most impressive aspects of the papers in this special issue is the willingness of the authors to embrace the complexity and diversity of families, family interactions, and family functioning. Families are composed of individuals with personal characteristics, subsystems with specific goals, roles, rules, and responsibilities, and the various interactions and relationships between and among them. They also exist within a certain context (e.g., culture, developmental stage) and vary from day to day. Processes within this dynamic system comprise family functioning.

Within this issue, Santos and colleagues embrace this complexity by examining how characteristics of the romantic parental subsystem influence family-level processes (i.e., finding meaning in rituals) and family functioning (i.e., cohesion). They also comment on cultural diversity. As a second example, Berg and colleagues examine various aspects of interactions between late teens and their parents (i.e., form of contact; teen perceptions of parental acceptance and helpfulness; parental solicitation of information) both within and between families to identify family and contextual factors that promote teen disclosure of diabetes management issues and successful control. They and Birnie and colleagues (2016) specifically comment on possible diversity across families owing to developmental issues. Also, Rybak and colleagues assess various domains of family functioning (i.e., cohesion, expressivity, and general and diabetes-specific conflict) from multiple perspectives and derive profiles of family functioning within their sample of families of children with diabetes, capturing congruence between youth and caregiver perspectives. Associations between these diverse family functioning profiles and diabetes-related outcomes (i.e., HbA1c, health-related quality of life) are then demonstrated.

At its core, diversity among families typically reflects differences in beliefs, needs, or goals. Indeed,
Various authors within this special issue commented that family processes within families of children with chronic illness may differ from those of typically developing families because of the unique demands the medical condition places on the family (e.g., Murphy et al., 2016; Sharp et al., 2016). Each of these examples illustrate and embrace the complex and diverse nature of families and family processes across time and within context.

**Collecting and Integrating Multiple Perspectives Within the Family**

Another laudable aspect of the papers in this special issue is the collection and analysis of multiple perspectives within the family. Frequently recommended (e.g., Alderfer et al., 2008), this practice raises some complicated issues of analysis. Rybak and colleagues, mentioned above, provide an excellent example of one way of integrating caregiver and child reports of family functioning through latent profile analysis. Dyadic analysis has also been promoted as a useful way to approach family data (see Kenny, 2011). In this approach, both “actor” (i.e., associations between self-reported indices) and “partner” effects (i.e., associations across reporters) are assessed simultaneously when multiple family respondents report on variables. Within this special issue, Gutiérrez-Colina and colleagues and Birnie and colleagues used this statistical approach.

Papers in this special issue also used reports from multiple family members in an effort to replicate findings. For example, Rybak and colleagues replicated differences in child health-related quality of life across their identified family functioning profiles using both child self-report and caregiver proxy-report. Stephenson and colleagues showed partial replication of associations between maternal posttraumatic growth and internalizing, externalizing, and total behavioral problems of siblings of children with complex chronic health conditions using mother-report and sibling-report data. Similarly, Santos and colleagues demonstrated associations between parental avoidant attachment and family ritual meaning and family cohesion in parallel analyses of caregiver and child data; mediation effects were also replicated in parallel analyses. These replicated findings speak to the reliability and validity of the effects.

**Reaching Beyond Mothers and Patients**

It is exciting to see that researchers are reaching beyond mothers and patients in their examination of families of children with chronic illness. In this issue, Sieberg and colleagues examined the impact of a pediatric pain rehabilitation program on both mothers and fathers of patients. In fact, they were able to compare fathers participating in the intervention with those unable to participate, demonstrating important favorable effects for participants that were not evident for nonparticipants. Also, Berg and colleagues and Stone and Walker had adolescent patients with diabetes and chronic pain (respectively) report perceptions of both their mothers and fathers in their studies of family processes. Stephenson and colleagues specifically examined associations between maternal posttraumatic growth and adjustment of siblings of children with complex health conditions. We also included studies of sibling adjustment in our meta-analysis of associations between family functioning and child adjustment after pediatric cancer (Van Schoors et al., 2016).

The inclusion of family members and family subsystems beyond the mother and patient in research is vital to produce a more complete understanding of family functioning and family processes when a child has a medical condition. Even in studies not including fathers or siblings, they were often mentioned in discussion sections as important to consider in future research (e.g., Gutiérrez-Colina et al., 2016; Stephenson et al., 2016). Progress is being made.

**Moving Forward**

The papers in this special issue illustrate the strides that pediatric psychologists are making in family research. Creative and sophisticated methods are being used to capture and quantify family processes and functioning, and advanced research designs and statistical techniques are being used to examine associations between family-based variables and important outcomes. As previously discussed, we need to continue to improve the ways we assess family processes within pediatric populations (Alderfer et al., 2008; Barakat & Alderfer, 2011; Holmbeck & Devine, 2011). I would like to emphasize, however, two additional recommendations to continue our progress.

**Disentangling Bidirectional Relationships: An Argument for Mixed Methods**

A perplexing challenge in the conduct of family-based research is disentangling bidirectional relationships. Sometimes, this may not matter. For example, as Gutiérrez-Colina and colleagues discuss, we may not need to know whether youth and caregiver depressive symptoms lead to poor family functioning or whether poor family functioning leads to an individual family member’s depressive symptoms. Screening of and intervention targeting both (or perhaps either) may be adequate in that case. However, there are other situations where teasing apart these associations may have important implications. The work by Berg and colleagues is an excellent example of this. Here the association found between disclosure and better diabetes management could indicate that disclosure to mothers
is part of a process that leads to better diabetes management. Alternatively, this association could indicate that only those teens who are managing their diabetes well disclose this to their mothers. These are different family processes. In such situations, care needs to be taken in our research to evaluate possible alternative hypotheses.

Here is where reliance on quantitative methods alone may be insufficient. Qualitative methods are specifically designed to answer questions of how and why, and provide a nuanced understanding of experiences (Carroll & Rothe, 2010). As such, they can help us to better understand the complexity of family processes and the diversity of beliefs, needs, and goals that may underlie those processes. As qualitative methods gain attention and acceptance in pediatric psychology (Wu, Thompson, Aroian, McQuais, & Deatrick, 2016), they may provide a valuable complement to quantitative research methods in mixed methods designs.

Informing and Improving Family-Centered Care
At the beginning of this article, I provided a description of the family included in the AAP policy regarding patient- and family-centered care (2012). Parents of children with special health care needs were instrumental in making family-centered care the standard of care in our health system today. This model of care is currently envisioned as a key component in meeting the needs of families, improving outcomes, and even decreasing health care costs (Alderfer, Kazak, & Canter, 2016).

All of the papers in this special issue have implications for family-centered care. For example, Gutiérrez-Colina and colleagues specifically recommend that along with adolescent and young adult survivors of cancer, caregivers should be screened for depression. Rybak and colleagues recommend that assessments of family functioning be completed with multiple family members. Stephenson and colleagues discuss the importance of considering the impact of complex chronic health conditions on siblings. Both Stone and Walker and Sieberg and colleagues illustrate the importance of involving parents in interventions for chronic pain. Many of the papers also support the recommendation that Sharp and colleagues put forth regarding teaching parents to be warm and supportive in response to their child’s illness-related distress.

It is important to draw out the implications of our descriptive research for family-centered medical care. It is also important for pediatric psychologists to develop family-centered care interventions based on theory and research, implement them, and evaluate them from various perspectives (e.g., feasibility, efficacy, and return on investment). Pediatric psychologists are well poised to make substantial contributions to the design and delivery of family-centered care; through research, practice, advocacy, and policy, we need to ensure that this promise is realized.

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References


