

Family Systems Practice in Pediatric Psychology

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Objective: To present a pediatric psychology consultation treatment framework based on family systems and developmental theories.

Methods: After reviewing background relevant to family systems interventions, a five-step protocol (referral, assessment, collaboration, outcome) for consultation is presented, using case examples from our pediatric oncology service, to illustrate joining, focusing, promoting competence and collaboration with patients, families, and staff.

Results: Using protocols based on family systems frameworks, pediatric psychologists can offer systems-oriented consultation to patients, families, and healthcare teams.

Conclusions: Further development and evaluation of family systems protocols are necessary to understand the efficacy of these approaches and their role in training and practice.

Key words: families; consultation; pediatric psychology; pediatric oncology.

We write this article reflecting on the lack of established family intervention approaches in pediatric psychology. Ten years ago, Mullins and his colleagues (Mullins, Gillman & Harbeck, 1991) described the state of systems-oriented work in pediatric psychology and correctly pointed out that systems theorists have “often used nonscientific language, and many of their concepts cannot be operationalized” (p. 379). The chapter goes on to outline systems-oriented approaches to intervention and is cautiously optimistic in foreshadowing greater integration of family systems approaches in pediatric psychology.

What has happened over the past 10 years with regard to families and pediatric psychology? In terms of articles published in the *Journal of Pediatric Psychology*, the percentage of empirical studies that include data from multiple members of the family

has doubled from 28% in 1988 (Kazak, 1994) to 56% in 2000. Given the *Journal's* emphasis on chronic illness and the predominance of family-centered care in pediatrics, inclusion of some parent data is expected in many studies. Much of this work is promising in terms of the *potential* for developing intervention research. That is, the work of Holmbeck studying the transition to adolescence in spina bifida (e.g., McKernon et al., 2001), the biobehavioral model of Wood in pediatric gastrointestinal diseases, asthma, and epilepsy (e.g., Bleil, Ramesh, Miller, & Wood, 2000), and Quittner's research on families of children with cystic fibrosis (e.g., Quittner et al., 1998) are a few of the research laboratories producing clinically relevant family research.

Yet a gap persists between the inclusion of family variables in explicative research and the integration of family interventions in clinical practice. Conducting family interventions necessitates an understanding of the behavior of systems and training in the ways therapists engage and operate within systems. However, family interventions may

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be perceived as time-consuming or too difficult to deliver within the constraints of pediatric practice. Family therapy training is, therefore, often absent in pediatric psychology. As Seagull notes, "it is as if, in practice, our training models cannot get past the old ideas of the 1950's, and fall back on seeing mothers and children" (2000, p. 163).

Progress is seen in intervention studies that evaluate family interventions for pediatric health problems. For example, Wysocki reported favorable outcomes on parent-adolescent conflict and diabetes-specific conflict in a controlled trial of behavioral family systems therapy (BFST) (Wysocki et al., 2000). Also related to diabetes, Anderson showed the effectiveness of family interventions in promoting adherence (Anderson, Brackett, Ho, & Laffel, 2000). Hoekstra-Weebers and colleagues piloted an intervention for parents of newly diagnosed children with cancer (Hoekstra-Weebers, Heuvel, Jaspers, Kamps, & Klip, 1998). Others have designed and piloted interventions that highlight cultural competence (Kaslow & Brown, 1995; Kaslow et al., 2000).

Our group has advocated for the integration of family and systems intervention approaches with others (e.g., cognitive behavioral therapy), and for their rigorous evaluation. We have shown, for example, that a family-focused psychological intervention for procedural pain in children with cancer is effective (Kazak, Penati, Brophy & Himelstein, 1998) and that the outcome works at a systems level (Kazak et al., 1996). We are also conducting a randomized clinical trial of an intervention that integrates cognitive behavioral therapy and family therapy and have published pilot data supporting its efficacy (Kazak et al., 1999). Finally, in an article cowritten with the mother of a young man with cerebral palsy, epilepsy, and mental retardation, we have described the potency of combining family therapy and behavioral approaches and its acceptability to the family (Kazak & Sorkin, 1997).

In this article, we describe use of a family systems approach in pediatric psychology, based on our work with children with cancer and their families. We provide background on family systems approaches, including the concept of the therapeutic triad. Four tenets of our work (join, focus, promote competence, and collaborate) are presented, followed by a protocol that we use for consultations. Brief case vignettes are used to illustrate major points.

Family System Frameworks Guiding Pediatric Psychology Practice

Family systems frameworks are broad and multidisciplinary, sharing the common assertion that human behavior should be conceptualized at a level broader than the individual. There are many different family therapy models, based on distinct theoretical approaches. The techniques may vary, but what is common is a view of families as interactive systems with shared histories and a focus on change at the level of the family system, usually involving consideration of more than one generation of the family, and often encompassing systems outside the family in formulating change. Structural family therapist Salvatore Minuchin and colleagues were among the first family therapists to treat families of children, including children with chronic illnesses (Minuchin, Rosman, & Baker, 1979), describing family patterns and intervention approaches to alter dysfunctional family patterns. Medical family therapists, frequently associated with family practice, provide another family therapy perspective relevant to the work of pediatric psychologists. Using a biopsychosocial framework, medical family therapy argues for a collaborative approach to families with health care concerns and focuses not only on the family system but also that of the health care staff and related systems (McDaniel, Hepworth, & Doherty, 1992).

Consultation is an area of clinical practice for which a family systems framework may be useful. Most training in consultation acknowledges the importance of a biopsychosocial approach but in practice emphasizes patient-oriented (individual) consultation (Resnick & Kruczek, 1996). This divergence between theory and practice is not surprising, given the complex issues that can either impede or promote effective consultation (Hamlett & Stabler, 1995). As Drotar notes, consultation is a more "ambiguous task" (1995, p. 143) than other activities such as assessment or intervention. The pressures inherent in medical settings, most prominently attempts to resolve a problem quickly, often with uncertainty about reimbursement for the time spent, can result in increased use of a patient-oriented consultation. A family systems framework may, in fact, provide an alternative.

As background, a social ecological framework guides our clinical and research work (Kazak, Segal-Andrews, & Johnson, 1995). Based on the work of de-

Table 1. A Family Systems Protocol for Pediatric Consultation

Consultation step	Goals of consultant	Specific consultation steps
Referral	Determine the referral question Identify consultee/s. Create a focused referral question.	Discuss referral and plan entrée into the family Ask questions about interactions, and expectations. Identify therapeutic triads.
Assessment	Generate hypotheses about problem and solution. Determine what resources are necessary. Focus on solution.	Ask family and staff, "How may I be helpful?" Use ARCH. Involve the therapeutic triad in defining the problem. Define the therapeutic triad's roles and functions. Reduce isolation by including others.
Collaboration	Use competence to reframe symptoms. Change relationships such that presenting problem resolves. Collaborate with therapeutic triad to maintain solution	Reframe symptoms as solutions gone awry. Highlight competence of patient, family and team. Facilitate new patterns of interaction Assure ongoing connection among triad members. Solidify new patterns of interaction.
Outcome	Assess patient, staff, and family beliefs about the outcome. Appraise if future adversities will be handled competently. Make a mutual decision about next steps.	Identify competent responses to adversity. Assess ability to meet likely future challenges. Decide when to exit and define future role.

developmental psychologist Bronfenbrenner (1979), social ecology conceptualizes the child as encapsulated within a series of concentric circles (environments), each with increasingly more distal relationships to the child. For example, the child is inherently dependent upon the family at the most immediate level, and the family interacts closely with the health care team at the next less proximal level. On increasingly distal levels, extended families, schools, neighborhoods, and communities are interacting subsystems.

This conceptualization of the influence of context on children's (and families') development helps to guide our consultation framework. Regardless of the disease or referral questions posed, health care providers are part of the child's social ecology. Within the health care setting alone, children and families interact with multiple medical, nursing, psychosocial, and other providers, and these relationships persist and change over time. Using the framework of family therapy and family systems theory, we believe that a systems-oriented intervention—one that connects multiple entities in the social ecology—serves the best interests of child, family, and health care team. The specific approach used in our practice generally focuses on building a *therapeutic triad* within the broader social ecology, which aims to join the patient, family, and health care team in a process to promote positive adaptation (Table I).

Four tenets associated both with social ecology

and family systems characterize our work within the therapeutic triad: join, focus, promote competence, and collaborate. They illustrate that our consultation goal is broader than removal of a specific pathology. The major goal is to help the family and the medical team accomplish their responsibilities effectively.

We focus on three major tasks that families face every day: (1) to soothe themselves in order to handle emotional challenges, (2) to develop trusting relationships to ensure effective collaboration over the course of illness and treatment, and (3) to manage conflict within the family and between the family and others (e.g., the medical team). The medical team has a parallel set of tasks. They also regulate their emotional reactions, trust each other and patients/families, and navigate conflict. From a systems perspective, a consultation request suggests that at least one of these tasks (for family and/or health care team) has gone awry. An effective consultation should help patients, families, and staff re-establish effective emotional responses, maintain trust, and navigate conflict. When families and staff have mastery over these processes, symptoms can be targeted quickly and effectively before they escalate.

Join

Establishing (and maintaining) a therapeutic relationship is essential to all work with patients and

families, across theoretical orientations. In family therapy, the process of relationship building with members of a family is often referred to as joining. We use a principle known as ARCH (Micucci, 1998) that advocates using Acceptance, Respect, Curiosity, and Honesty in all interpersonal interactions with and about the family. An important aspect of ARCH is acceptance of patients, families, and staff as they are. In initiating a consultation on a busy pediatric service, the consultant must join with the patient and team in the face of potential uncertainty and conflict about the nature and goals of the consultation. Joining includes patients, parents, family, and the health care team.

For example, consider Kwame, an 11-year-old African American survivor of multiply relapsed leukemia. Due to long-term effects of his treatment, Kwame is chronically fatigued and smaller than his peers. His mother expressed concern to their oncologist about Kwame's increasing aggressive behaviors, including two arrests for physically assaulting peers. Developmentally, we expect that Kwame's physical challenges and limitations would lead to some distress and require that he make accommodations as he tackles the social demands of adolescence. With these developmental issues in mind, we used acceptance to describe Kwame as using the best strategies he had available to manage his distress over his physically diminutive stature. We acknowledged that this was particularly salient for Kwame because he lived in what his mother described as a tough, inner-city neighborhood in which physical power was highly valued. In communicating acceptance, we emphasized curiosity (e.g., to Kwame and his mother, we asked questions about the neighborhood and about how his mother has helped Kwame to deal with distress in the past) and respect (e.g., identifying Kwame's problem-solving strengths and helping him to develop other solutions to his present problem). ARCH emphasizes that we use our reactions and ourselves with patients and families (e.g., we shared our concern about Kwame's aggression but also expressed a sincere commitment to him and belief that we could be helpful).

Focus

Although we believe that interventions will result in change at the systems level, a consultation focus must be narrowed to the issues directly relevant to the referral. A tight focus can be challenging for a

systems-oriented consultant who is trained to conceptualize broadly. Direct answers to a consultation question (e.g., what can be done to reduce the patient's distress during procedures?) may appear insufficient from a systems perspective. That is, a behavioral or cognitive behavioral intervention for procedural pain may seem insufficient in the context of family conflict, parental substance use, or disease-related complications.

To focus, we conceptualize the intervention as a problem-solving triangle requiring the collaboration of patient, family, and health care team. Two adults linked to the child with clearly established roles (e.g., parent, primary nurse) are identified to form the therapeutic triangle.

The following case example, using a common referral request regarding intense anxiety related to invasive procedures, illustrates use of the triad. We began by asking how Emily, a 5-year-old with leukemia, and her family coped in general when she was scared. Using their developmentally appropriate response (storytelling), we coached the family to use storytelling as a relaxation exercise. We included Emily's oncologist and primary nurse by asking that they guide the storytelling pace and length. Applying this intervention during two procedures resulted in a dramatic decrease in Emily's anxiety. The family also used the technique at home and found that it reduced anticipatory nausea. Our focus was on the patient-family-staff problem-solving collaboration. Helping the family and team more successfully soothe their anxiety and encouraging them to connect with greater trust promoted the family's overall well-being.

Competence

Our approach is competence- or strength-based. Competence-based family therapy views symptoms as well-intentioned attempts at adaptive functioning that have been thwarted and seeks to enhance functioning by identifying and refining the competence underlying the symptoms (Waters & Lawrence, 1992). From the point of referral, we conceptualize the presenting issue in terms of competencies, not psychopathology or deviant behavior. For example, a "depressed" 16-year-old can be described as an adolescent who is developmentally capable and very good at recognizing losses and grieving over them (Kazak & Simms, 1996). The teen is then coached to harness emotional strengths to shape a more adaptive response. On a more gen-

eral level, we expect that family members and all members of the medical team have the ability to help the patient with the referral issue. They are also competent.

A competence-based orientation necessitates use of language quite different from that of a psychopathology or diagnosis-oriented approach. It is not uncommon for the consultant to find extreme, upsetting behavior during the initial exploration of the referral. One may find, for example, a teenager spitting, throwing objects, and screaming at parents and staff. The more traditional language of psychopathology and resulting diagnosis would lead toward exploration of mental status, psychiatric diagnoses, and resulting treatments directed toward “controlling” the behavior (e.g., reducing the symptom).

In contrast, we probe for alternative understandings of the behavior. For example, children and adolescents with cancer and their families experience daily adversities that disrupt their lives. We frame behavior problems as immature or maladaptive responses to these stressors. By understanding symptoms as responses to adversity, we can normalize the situation (Kazak, 2001) and can develop a collaborative intervention plan. A teenager who is spitting and throwing objects is not behaving at that time as a typical teen but more like a preschooler. The behavior may be understood as temporary immaturity, associated with an overwhelming situation. The consultant can explore ways in which more adaptive (age-appropriate) behavior can be recognized (e.g., when is the teen functioning competently?) and supported (e.g., how can parents and staff help prevent or avert a reoccurrence of the situation?). This intervention thereby offers a competency-based alternative for patient, family, and staff (Simms, 1995).

Collaborate

The consultant is a collaborator with the family and medical team, not an isolated service provider. In the collaborator role, the consultant partners with the family and the medical team, effects change, and exits the relationship when appropriate (Simms, 1995; Simms & Kazak, 1998). If the consultant were to take primary responsibility for solving the problem, the opportunity for the child, parents, and medical team to determine and implement a solution may be diminished. By maintaining shared responsibility for problem solving, the competence

of all parties to find solutions is encouraged. For example, Julia, a 17-year-old girl, was referred to us for ongoing postsurgical pain after the removal of an abdominal tumor. Rather than working alone with Julia on pain management strategies (which could imply our taking responsibility for managing her pain), we formulated a collaboration highlighting shared responsibility across the treatment triad. On daily walking rounds with the oncology team, we highlighted the roles of the oncologist (to prescribe pain medications as needed), the psychologist (to coach on pain-control strategies) and Julia (to use medication as needed, to practice pain-control strategies, to communicate with her team and family about her progress). This supported her growth, as an adolescent, toward greater independence from her family and increased responsibility for her health care needs.

A Family Systems Consultation Protocol

Based on the family systems perspectives that we have developed in this article, we present an outline of a consultation approach consistent with family systems theory. We present this protocol as a general guide for integrating family systems perspectives into pediatric psychology consultation. The protocol has five closely linked, sometimes overlapping steps: referral, assessment, collaboration, intervention, and outcome (Figure 1).

Referral

Referrals to psychologists in medical settings generally come from staff (e.g., attending physician, fellows, residents, nurses, social workers). From the

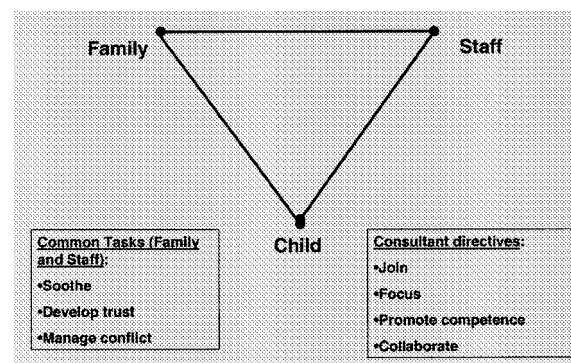


Figure 1. Therapeutic triad.

outset, our conversation with referring staff redirects the traditional expectation that the consultant will treat the patient and report back on his or her (hopefully effective) treatment. We believe that it is not helpful for the referring staff member to indicate that the patient should “see a psychologist.” Instead, we coach the staff member to frame the inquiry in a way that shows shared responsibility for creating a solution to the problem.

To accomplish this end, we ask at the point of referral about the staff member’s interactions with the patient, their expectations of the consultation, and their ideas about the types of help that they (staff member, team) would like to receive. How is the concern about the patient understood by the patient, the family, and the team? We guide the staff member to create a referral question that is precise, to facilitate patient, family, and staff understanding and acceptance of the patient’s struggle with his or her disease and treatment.

For example, Sharlene, a 17-year-old with a large metastatic tumor, was referred to us for depression, a common consultation issue for adolescents with cancer. The medical team viewed her alternating emotional outbursts and withdrawal as psychopathological. We learned that Sharlene and her family came from a Caribbean culture that typically responded to a cancer diagnosis with immediate and overt grieving. As our questions encouraged clarifying conversations between the medical team and Sharlene, we were able to frame the presenting issue not in terms of “depression,” but rather as a need to facilitate patient, family, and staff understanding and acceptance of the patient’s and family’s process. We encouraged the attending physician to acknowledge to the patient and family that the adversity of cancer often generates sadness and that sadness may be expressed in many different ways. The oncologist communicated that she is an expert at treating cancer but would like help in treating Sharlene’s sadness, so that the sadness does not complicate the treatment of cancer. Linking Sharlene, her oncologist and her family in this way built a therapeutic triad that could support her competent adaptation to her illness.

Assessment

Clarification of the referral leads to hypotheses about the likely problem and possible solution that are subsequently evaluated. The question “How may we be helpful?” is part of a normative,

competency-based assessment to join with patients, families, and staff in a respectful and nonthreatening manner. It is essential to identify the structure and membership of the family and of the team treating the patient and family and to clarify their roles and functions. While some family members may be disinterested, uninvolved, or even hostile to a consultation, the competence-based orientation of our approach is generally acceptable to most family members, when applied creatively and, if necessary, persistently. We are curious in the course of assessment to learn about the patient’s, family’s, and staff’s understanding of the concern and to elicit their assistance in solving the problem.

Assessment is for the consultant as well as the patient and family. The problem is crystallized and the consultant is determining whether and how he or she can be helpful. The consultant also asks himself or herself what additional resources are needed. That is, the consultant is not expected to solve the problem alone. In fact, working in isolation is actively discouraged. The therapeutic triad must build an explicit and shared understanding of the problem. This agreement will engage patient, family, and staff around the problem, give the consultant permission to enter and participate in the system, and assure the investment of all members of the triad in constructing and conducting the intervention.

The pressures on pediatric psychologists during assessment can lead to some predictable difficulties. When anxious about a consultation, it is tempting to rely on child-focused interventions. Attending to child issues is important but *must* occur within the framework of the family and system. It is also likely the consultant may become distracted by urgency around medical diagnoses, treatment, or symptoms. It is important to retain a focus on the perceptions and beliefs of the patient, family, and staff, balancing medical and psychological factors but not becoming overly organized by either. Finally, time pressures and competing demands are omnipresent. The ability to respond quickly but strategically increases with practice.

Collaboration

The heart of the intervention is the utilization of the collaborative relationships of the therapeutic triad. While the actual interventions are many and depend on the presenting problem and assessment process, a key component is the involvement of the

patient, family, and health care team. The consultant does not work in isolation. In a substantial number of our consultation requests, the assessment process suggests that family, or family-staff interactional factors, plays a major role in sustaining the problem behavior.

An example is the case of Lamar, a 12-year-old survivor of an aggressive Wilm's tumor. Due to severe medical late effects of his treatment, Lamar had a G-tube placed at age 3 to ensure that his nutritional needs were met. For the past 6 years, physicians believed that Lamar no longer needed the tube. Despite extensive outpatient treatment from the feeding team, Lamar was unable or unwilling to take in enough food to maintain his weight. Lamar, his family, and the treatment team were frantic and discouraged. After a visit to the oncology clinic, the family was referred to us, and we employed our family systems model with this family.

Our initial assessment was that prior intervention attempts focused on getting Lamar to eat and evaluating how well he and his family (usually his mother) met eating-related goals. Two drawbacks to this approach were apparent to us. First, it asked Lamar and his family to persist with something that they had already failed at accomplishing, and second, it fueled conflict among Lamar, his family, and the team, all of whom had clear but different ideas of how to increase Lamar's intake.

In the initial consultation, we framed the problem in developmental and competence-based terms. Lamar was described as a bright young man who knew what he liked and disliked. He was encouraged to use this strength to formulate a developmentally grounded goal, which he did easily (i.e., getting the tube out so that he could change without embarrassment for gym class). We emphasized collaboration by formulating a therapeutic triangle including Lamar, his parents, and the medical team, with roles that drew on each person's strengths. Dad, who was typically absent from the eating struggles at home, joined mom. They were given the role of selecting foods for the house and of systematically reinforcing Lamar's food choices, not catering to him, or pushing foods. They were asked not to argue or coerce Lamar but to discuss the food availability plan, to advise Lamar of his food choices, and to use positive reinforcement for achievement of daily food goals. This slight shift in the parents' role and explicit sharing of responsibility harnessed their competence and encouraged them to support each other. Lamar was asked to

make food choices, from the array of food provided by his parents. He understood the kinds and amounts of food that he should eat and the consequences of eating or not eating. Everyone acknowledged that Lamar was sufficiently responsible to make these choices. Finally, the medical team's role was to help Lamar monitor the success of his choices and make new choices toward his goal. This process led to many discussions directly between Lamar and his team about his treatments. For the first time, Lamar felt empowered and in control of his health.

This new process short-circuited the escalating cycle of conflict around eating that had organized Lamar, the family, and his treatment team. The collaboration helped the family navigate a developmental transition to an increasingly independent role in his caregiving. Over the next month, Lamar gained more weight than in any equivalent previous interval and he and his parents expressed increased hope. A year later, Lamar had maintained his weight and made progress toward his goals. The therapeutic triad continues to work together to maintain effective collaboration and problem solving.

Outcome

The outcome of a family systems intervention is determined by its impact on the broader system. A consultation is a time-limited intervention with a patient, family, and team, and the expectation is that the consultant will exit when the intervention has been completed. One gauge of outcome is the consultee's satisfaction. The consultee may be several different individuals, including the child, his or her family, or any member of the health care team. Satisfaction is not necessarily dependent on removal of the symptom but reflects the extent to which the members of the therapeutic triangle are able to continue meeting the adversities that prompted the referral. Consistent with our emphasis on ecological context, judgments of effectiveness must be based on direct communication with *all* members of the therapeutic triad. In the case of a depressed teenager, for example, we hope that the patient will accept responsibility for behaving/coping differently, that the family will acknowledge getting through the adversity, and that staff will benefit from a model that encourages competence.

One readily identified obstacle in the consultation model may be the reluctance of the consultant

to conclude the consultation. We view serious pediatric illness and its treatment as a process and offer consultation as needed. The consultant enters and departs the system specifically for intervention around well-defined concerns (Simms & Kazak, 1998). This process may be episodic or regular. This approach does not preclude the potential advantage of ongoing therapy, but rather highlights the more encapsulated role of the consultant in a family-centered pediatric healthcare setting.

Discussion

The family systems model presented here is intended as a guide for pediatric psychologists incorporating family orientations in their clinical practice. Despite the broad appreciation of a family-oriented pediatric psychology, relatively little has been published related to the practice of a family systems pediatric psychology. The approach presented emphasizes the importance of establishing a therapeutic triad early in the consultation process and using it from referral through outcome.

The approach presented is compatible with medical family therapy (McDaniel et al., 1992) and other collaborative family health care models. It is consistent, for example, with the adaptive changes that psychologists are making to their practice in primary care settings to respond quickly, effectively, and collaboratively in modern medical care environments (Haley et al., 1998). This work is also complementary with the growing body of family research in pediatric psychology and will be enhanced when the flow between clinical research and practice becomes more fluid.

There are several additional potential benefits of family systems practice in pediatric psychology. First, it is oriented toward strengths of families, rather than focused on individual psychopathology. Children are viewed in the context of their broader family system, where they live and function on a daily basis. Families are part of the solution to a child-focused problem and are engaged as "experts" in helping their child. Behaviors of family members are viewed as well-intended efforts to solve problems, and interventions are directed toward channeling the energy of the system toward to new solutions to challenging situations. Second, by focusing on understanding families contextually, a family systems approach facilitates an understanding of diversity, the many different family structures

and ethnic and cultural factors that influence family well-being. Third, a family systems approach directly confronts the issue of the family's connectiveness with its members and the outside world, as a gauge of its isolation and risk or resilience for the escalation of difficulties. Finally, the broader system view provides a wide angle lens and helps to anticipate ways in which changes made by an individual may not result in sustained change for the system.

In presenting an approach that differs from others, it is tempting to ask for direct "side by side" comparisons among the possible choices. In the absence of data regarding efficacy about all consultation models, comparisons among family systems and other models appear premature. We are at an early stage in the development of research related to these questions. The development of practice protocols like the one presented here may facilitate such comparisons.

Interventions in pediatric psychology have tended to focus on specific problems (e.g., pain, adherence) or have been disease-specific. This family systems model provides an alternative by illustrating a process of intervention across a broad range of referral questions. That is, while presenting problems vary, the common elements of joining, focusing, enhancing competence, and collaborating apply across problem areas. The steps in the initial protocol presented could be operationalized more fully (e.g., manualized) and measured in terms of medical and psychological outcomes. Essential, but often overlooked, outcomes include the satisfaction of patients, families, and providers. Finally, methods to assess the shared responsibility of problem resolution across the therapeutic triad will need to be developed, with respect to both short- and long-term outcomes.

The general underlying principles we discuss have broad applicability, across diseases and settings. The major referral questions in pediatric oncology (e.g., pain, anxiety, depression, acting out) are similar across conditions. We have used this approach outside of oncology with no apparent limitations based on disease or treatment parameters, nor related to the structure of health care teams. Our experience has been that nursing and pediatrician colleagues are concerned primarily that a consultation is effective. They often do not recognize differences among theoretical orientations or techniques and are open to family systems approaches.

Resistance to psychological interventions is not uncommon. Our approach retains a significant por-

tion of the responsibility for the patient's care in the hands of the treatment team making the referral. Other forms of consultation may relieve the anxiety of the referring party more quickly (i.e., shifting responsibility to the consultant). We address the possibility of resistance to our approach in several ways. We think of a medical team's reluctance as an indication that they feel stuck or uncertain about how to manage issues not directly medical. Our experience has been that most medical teams want to retain responsibility but have struggled with not being able to do so effectively. The family systems consultation framework described shows how responsibility can be shared. This approach is viewed by multidisciplinary staff as interesting and helpful to them in providing patient care. We also educate multidisciplinary teams in psychosocial rounds, providing both general and case-specific examples.

The outcomes of this work should be evaluated at the level of health care systems and not exclusively in terms of patient, family, or staff satisfaction with individual consultations. In our setting, for example, hospital administrators have data showing that family complaints ("difficult families") in oncology are rare. The absence of these families in oncology is attributed, in part, to our psychosocial team, with recognition that our preventative approach effectively resolves conflicts earlier and at the "local" level, as opposed to escalating to the point of becoming complaints to hospital administration. In turn, the hospital has asked for more family systems-oriented consultations on other services. Related to our work in oncology, the Complex Case Consultation Team (CCCT) was developed to provide this model of consultation throughout the hospital.

Carter and colleagues, in their evaluation of a consultation liaison service, document that children with chronic illness continue to have difficulties at home and require ongoing outpatient psychological intervention (Carter et al., 2001). While one might argue that interventions that enhance family competence and support development of chronically ill children may have a broader impact as families return to their home communities, this question remains to be addressed.

Finally, the cost-effectiveness of a family systems consultation model warrants exploration.

These interventions are ultimately brief and parsimonious. That is, our typical initial consultations can be completed in about an hour a day over the course of several days during an inpatient admission or in a short series of outpatient consultations, with follow-up with patient, family, and staff as needed over time.

Family systems approaches have intuitive appeal to pediatric psychologists, yet relatively little emphasis has been placed on training in these interventions. Whereas family assessment, intervention, and advocacy is recommended as part of comprehensive pediatric psychology training recommendations (Roberts et al., 1998; Spirito et al., in press), important next steps include identification of relevant theoretical and empirical work and development of specific training objectives for family systems work in pediatric psychology. It may be tempting to think that inclusion of family members in treatment (e.g., sharing a treatment plan with parents, interviewing parents to obtain information) represents family intervention, but this is not the case, as we hope this article illustrates. Indeed, training materials specific to practicing family therapy in pediatric psychology still need to be developed and utilized by instructors and supervisors with family therapy training themselves, who may be from disciplines other than psychology. Finally, given our field's focus on empirically supported treatments, openness to alternative methods needs to be encouraged, lest our repertoire of intervention approaches narrow only to those that meet scientific standards predominantly influenced by behavioral and cognitive behavioral approaches.

We hope that, by outlining a clinical consultation approach that is family-oriented and practiced in a pediatric setting, we can spark further discussion on the use of this approach across pediatric settings and point to directions for future empirical validation.

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References

- Anderson, B., Brackett, J., Ho, J., & Laffel, L. (2000). An intervention to promote family teamwork in diabetes management tasks: Relationships among parental involvement, adherence to blood glucose monitoring and glycemic control in young adolescents with Type 1 diabetes. In D. Drotar (Ed.), *Promoting adherence to medical treatment in childhood chronic illness: Concepts, methods, and interventions* (pp. 347–365). Mahwah, NJ: Lawrence Erlbaum.
- Bleil, M., Ramesh, S., Miller, B., & Wood, B. (2000). The influence of parent-child relatedness on depressive symptoms in children with asthma: Tests of moderator and mediator variables. *Journal of Pediatric Psychology, 7*, 481–491.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Carter, B., Baker, J., Grimes, L., Smith, C., Crabtree, B., McGraw, K., & Kronenberger, W. (2001, April). *A case controlled study of pediatric consultations in a tertiary care children's hospital setting: Parent report, self-report and nursing report of psychological symptoms and adjustment*. Poster presented at the 8th Florida Child Health Psychology Conference, Gainesville, FL.
- Drotar, D. (1995). *Consulting with pediatricians: Psychological perspectives*. New York: Plenum.
- Haley, W., McDaniel, S., Bray, J., Frank, R., Heldring, M., Johnson, S. B., Lu, E., Reed, G., & Wiggins, J. (1998). Psychological practice in primary care settings: Practical tips for clinicians. *Professional Psychology: Research and Practice, 29*, 237–244.
- Hamlett, K., & Stabler, B. (1995). The developmental progress of pediatric psychology consultation. In M. Roberts (Ed.), *Handbook of pediatric psychology* (2nd ed., pp. 39–54). New York: Guilford.
- Hoekstra-Weebers, J., Heuvel, F., Jaspers, J., Kamps, W., & Klip, E. (1998). Brief report: An intervention program for parents of pediatric cancer patients: A randomized clinical trial. *Journal of Pediatric Psychology, 23*, 207–214.
- Kaslow, N., & Brown, F. (1995). Culturally sensitive family interventions for chronically ill youth: Sickle cell disease as an example. *Family Systems Medicine, 13*, 201–213.
- Kaslow, N., Collins, M., Rashid, F., Baskin, M., Griffith, J., Hollins, L., & Eckman, J. (2000). The efficacy of a family psychoeducational intervention for pediatric sickle cell disease. *Families Systems and Health, 18*, 381–404.
- Kazak, A. (1994, August). *Research on families in medical settings*. Paper presented at the Annual Meeting of the American Psychological Association, Los Angeles, CA.
- Kazak, A. (2001). "We're at the breaking point": Family distress and competence in serious childhood illness. In S. McDaniel, D. D. Lusterman, & C. Philpot (Eds.), *Integrating family therapy casebook*. Washington, DC: American Psychological Association.
- Kazak, A., Blackall, G., Boyer, B., Brophy, P., Buzaglo, J., Penati, B., & Himelstein, B. (1996). Implementing a pediatric leukemia intervention for procedural pain: The impact on staff. *Families, Systems and Health, 14*, 365–380.
- Kazak, A., Penati, B., Brophy, P., & Himelstein, B. (1998). Pharmacologic and psychologic interventions for procedural pain. *Pediatrics, 102*, 59–66.
- Kazak, A., Segal-Andrews, A., & Johnson, K. (1995). Pediatric psychology research and practice: A family/systems approach. In M. Roberts (Ed.), *Handbook of pediatric psychology* (2nd ed., pp. 84–104). New York: Guilford.
- Kazak, A., & Simms, S. (1996). Children with life threatening illnesses: Psychological difficulties and interpersonal relationships. In F. Kaslow (Ed.), *Handbook of relational diagnosis and dysfunctional family patterns* (pp. 225–237). New York: Wiley.
- Kazak, A., Simms, S., Barakat, L., Hobbie, W., Foley, B., Golomb, V., & Best, M. (1999). Surviving Cancer Competently Intervention Program (SCCIP): A cognitive behavioral and family therapy intervention for adolescent survivors of childhood cancer and their families. *Family Process, 38*, 175–192.
- Kazak, A., & Sorkin, S. (1997). Competence Encouragement Tokens (CET): Two illustrations of an innovative behavioral technique in family therapy. *Families, Systems and Health, 15*, 321–331.
- McDaniel, S., Hepworth, J., & Doherty, W. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York: Basic Books.
- McKernon, W., Holmbeck, G., Colder, C., Hommeyer, J., Shapera, W., & Westhoven, V. (2001). Longitudinal study of observed and perceived family influences on problem-focused coping behaviors of preadolescents with spina bifida. *Journal of Pediatric Psychology, 26*, 41–54.
- Micucci, J. (1998). *The adolescent in family therapy: Breaking the cycle of conflict and control*. New York: Guilford.
- Minuchin, S., Rosman, B., & Baker, L. (1978). *Psychosomatic families*. Cambridge, MA: Harvard University Press.
- Mullins, L., Gillman, J., & Harbeck, C. (1991). Multiple level interventions in pediatric psychology settings: A behavioral systems perspective. In L. Siegel, J. Wallander, & E. Walker (Eds), *Stress and coping in child health* (pp. 377–399). New York: Guilford.
- Quittner, A., Espelage, D., Opiari, L., Carter, B., Eid, N., & Eigen, H. (1998). Role strain in couples with and without a child with a chronic illness: Associations with marital satisfaction, intimacy and daily mood. *Health Psychology, 17*, 112–124.
- Resnick, R., & Kruczek, T. (1996). Pediatric consultation: New concepts in training. *Professional Psychology, 27*, 194–197.
- Roberts, M., Carson, C., Erickson, M., Friedman, R.,

- La Greca, A., Lemanek, K., Russ, S., Schroeder, C., Vargas, L., & Wohlford, P. (1998). A model for training pediatric psychologists to provide services for children and adolescents. *Professional Psychology: Research and Practice, 29*, 293–299.
- Spirito, A., Brown, R., D'Angelo, E., Delamater, A., Rodrigue, J., & Siegel, L. (in press). Society of Pediatric Psychology Task Force Report: Recommendations for the training of pediatric psychologists. *Journal of Pediatric Psychology*.
- Wysocki, T., Harris, M., Greco, P., Bubb, J., Danda, C., Harvey, L., McDonnell, K., Taylor, A., & White, N. (2000). Randomized, controlled trial of behavior therapy for families of adolescents with insulin dependent diabetes mellitus. *Journal of Pediatric Psychology, 25*, 23–33.
- Seagull, E. (2000). Beyond mothers and children: Finding the family in pediatric psychology. *Journal of Pediatric Psychology, 25*, 161–169.
- Simms, S. (1995). A protocol for seriously ill children with severe psychosocial symptoms: Avoiding potential disasters. *Family Systems Medicine, 13*, 245–257.
- Simms, S., & Kazak, A. (1998). Family systems interventions in pediatric neuropsychiatric disorders. In C. E. Coffey & R. Brumback (Eds.), *Textbook of pediatric neuropsychiatry* (pp. 1449–1464). Washington, DC: American Psychiatric Press.
- Waters, D., & Lawrence, E. (1992). *Competence, courage and change: An approach to family therapy*. New York: Norton.

