Family Context in Pediatric Psychology from a Transactional Perspective: Family Rituals and Stories as Examples

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Received April 2, 1996; accepted September 5, 1996

Reviewed the transactional model as applied to the family context of pediatric psychology. A three-part sequence of child behavior, parent behavior, and family interpretation was used to describe developmental adaptation and transitions. It was proposed that families are regulated by practices that are proximal to the child's experience and representations that are more distal to the child's experience. Family practices are examined through family routines and rituals. Family representations are examined through family stories. Case examples of low birth weight premature infants and an adolescent referred for repeated hospitalizations due to diabetic ketoacidosis were presented to illustrate the model. Guidelines for the practicing pediatric psychologist are presented to assess family organization through family rituals and family meaning-making in the telling of family stories.

KEY WORDS: family regulation; family stories; family rituals.

Over the past 10 years there has been increasing recognition that families play an important role in understanding child health. A variety of theoretical models have been proposed connecting family factors to child health and well-being including social learning theory (e.g., Schafer, McCaul, & Glasgow, 1986),
family systems theory (e.g., Kazak, 1989), biobehavioral family models (e.g., Wood, 1994), and transactional perspectives (Fiese & Sameroff, 1989). There has been a call to consider pediatric issues within the context of expectable and normative family functioning (Kazak, 1989; Roberts & Wallander, 1992). However, developmental theory has often been implicit and rarely explicit in theories of family adaptation to childhood illness. Furthermore, these theoretical models have failed to provide specific guidelines for the practicing pediatric psychologist. This paper reviews the transactional model as it applies to the family context of pediatric psychology. This approach emphasizes the regulation of family behavior over time and the child’s influence on family adaptation. It is proposed that families are regulated through their daily practices and representations. Family practices may be examined through family routines and rituals. Family representations may be examined through the family’s verbal account of experiences captured in family stories. Case examples of pediatric conditions are provided to illustrate the transactional model and to provide evaluation guidelines for the pediatric psychologist.

TRANSACTIONAL MODEL

The transactional model originally presented by Sameroff and Chandler (1975) proposed that the child’s current condition can be seen as the result of a series of bidirectional interactions between parent and child embedded in several different ecologies (Bronfenbrenner, 1977). The child’s effect on the environment was seen as just as important as the environment’s effect on the child. Thus, caretaking experiences are affected by child as well as parent characteristics. An understanding of the child’s current condition is abstracted from variables proximal to the child’s experience, such as interaction between parent and child, and distal variables, such as the parent’s family-of-origin experiences. Proximal variables such as parent-child interaction patterns have been found to be related to disease management (e.g., Hauser et al., 1986). Distal variables such as the mother’s family-of-origin experiences have been found to be related to the adjustment of high-risk infants (e.g., Zeenah, Mammen, & Lieberman, 1993).

To illustrate the transactional model, consider language delay as a potential outcome of low birth weight premature birth (Figure 1). Low birth weight premature infants have been described as fussy and difficult to engage (Field, 1984). Frequently parents overstimulate the infant in an attempt to get the infant to respond. In response to intrusive interaction, the infant may turn his or her head away to decrease the stimulation. The infant’s gaze aversion may be interpreted by the mother or father as a sign of rejection based on his or her own caregiving experiences. The parent is then less likely to initiate sustained interaction with the infant. The infant may be temporally soothed. If this pattern persists, there is limited opportunity for reciprocal turn-taking and vocalizations. The alteration in
interaction patterns then creates an environment that is less conducive to verbal play and may ultimately lead to a delay in language development. Was the cause of the language delay the prematurity of the infant, maladaptive parent–child interaction, parental rejection, or low rates of verbal play? According to the transactional model, there is no single answer.

Transactional processes are not restricted to maladaptive outcomes but are central to our understanding of adaptation at any point in time. Returning to Figure 1, it is possible to enter the process at multiple points and predict a positive trajectory. Interactional coaching aimed at increasing parent sensitivity to infant cues may prevent interpretations of personal rejection (McDonough, 1993). Interventions aimed at distinguishing current relationships from past harmful relationships may increase positive interactions and a richer language environment (Liberman & Pawl, 1993).

Although the transactional model has been useful in identifying trajectories of maladaptive outcomes in large-scale research projects (e.g., Sameroff, Barocas, & Seifer, 1984) it has been less accessible to clinicians. A more careful examination of the interplay between proximal and distal variables suggests that how families organize their behavior on a daily basis and represent their family experiences over time are integral parts of the transactional process. Family practices and representations are embedded in developmental regulation. A brief overview of developmental regulation is warranted and provides the foundation for clinical applications of the model.

FAMILY REGULATION

Developmental Regulation

Current conceptualizations of the family life-cycle recognize that the developmental demands of the family are set in a social and cultural context that influences not only the definition of family but expectations of what constitutes
healthy family functioning (McGoldrick, Heiman, & Carter, 1993). Current family functioning must also be considered in a generational context as family-of-origin experiences often influence choice of marital partner (Wamboldt & Reiss, 1989), the types of traditions created (Fiese, 1995), and the interpretation of parent–child relationships (Crowell & Feldman, 1988). It is tempting to consider the developmental forces at work as centered on the age of the child referred for treatment. Certainly it is crucial to understand age-related developmental tasks. When considering the family’s contribution to a particular developmental period, it may be useful to consider family transitions as an important marker of family development.

The points at which families transition from one phase to the next may be pivotal in understanding family adaptation. Transitions involve reorganization and stress. The transition to parenthood has been identified as a period of increased risk for marital distress (Cowan, Cowan, Heming, & Miller, 1991), the early school years have been identified as a period of risk for developing antisocial behaviors (Dishion, French, & Patterson, 1995), early adolescence brings challenges to medical adherence (Anderson, Auslander, Jung, Miller, & Santiago, 1990), and adolescence has been identified as a transition period associated with increased risk for substance abuse (Zucker, Fitzgerald, & Moses, 1995). Because all families must reorganize around transition points, how families organize their behavior on a daily basis and make sense of transitions becomes important. It is proposed that these points of transition can be accessed through an evaluation of the family’s beliefs and practices.

The Represented and Practicing Family.

Reiss (1989) proposed that family regulation can be detected and observed through the study of family representations and practices. The represented family highlights the internal representation of relationships and how working memories provide a sense of stability in dyadic relationships. Working models of relationships are developed within the context of the family, are retained in memory, and guide the individual’s behavior over time. The study of the represented family includes how families impart values and make sense of personal experiences. The practicing family, in contrast, stabilizes and regulates family members through observable interaction. The interaction patterns are repetitive and serve to provide a sense of family coherence and identity. Family life resides not only in the minds of individuals but comes to life in the observed coordinated practices of the group. It is proposed that the practicing family may be accessed through the study of family rituals and that the represented family may be accessed through the study of family stories. These two aspects of family regulation may be useful in understanding how families organize their behavior when
one member has a medical condition and also how the family comes to understand the meaning of illness.

**Family Stories**

There are a variety of ways in which family stories may regulate child development. First of all, it is important to distinguish between family stories and the act of storytelling. Storytelling as a family activity may be more closely linked to the practicing family than to the represented family (Reiss, 1989). Furthermore, it can be argued that families differ considerably in their active use of stories. Some families, as cultures, may be relentless storytellers whereas other families may use storytelling more sparingly. As an indicator of the represented family it may not be the frequency of storytelling that is essential but rather the thematic content and process by which personal information is shared among family members.

Definitions of family stories are slippery at best. For the purposes of this paper, family stories are considered to be verbal accounts of meaningful experiences that are not necessarily a factual accounting of person, place, and time but are part of a constructive process where past events are viewed in light of current context. Stories may be used as a vehicle for socializing children as well as a reflection of the meaning that the child’s illness may have to the family (Patterson & Garwick, 1994). Furthermore, developmental transitions may be determined as stressful, or not, “depending on who is asked to describe the experience and how societal values . . . are integrated into the meaning that an individual and family make of the event” (Kazak, 1992, p. 121).

Family stories may be considered from at least three different vantage points: (a) as a socialization process, (b) as a link between generations, and (c) as a healing strategy. As a process of socialization, the thematic content of family stories has been found to be related to developmental stages and as a means of imparting family values. Storytelling may be associated with family transitions, increasing in frequency according to the age of the oldest child (Fiese, Hooker, Kotary, Schwagler, & Rimmer, 1995). The expressed message of family stories may also alter with age of children in the family. Parents tend to tell younger children family stories focusing on affiliation and nurturance and tell older children stories focused on themes of autonomy and achievement.

Within a generational context, family stories link current experiences with family-of-origin experiences. Families often tell stories during the history-taking portion of a clinical interview. In an interview of a family whose adolescent had been hospitalized for recurrent diabetic ketoacidosis, a story was told about the aunt’s brittle adult-onset diabetes that “could not be medically treated.” The adolescent’s condition was seen as equivalent to the aunt’s although there were
striking medical differences. The story was used as a way for the parents to understand their daughter's condition as expectable and that little could be done to monitor her regimen adherence, given the “family history.” Byng-Hall (1988) pointed out that families employ scripts linked to legends in their families and are related to symptom development in children.

Stories have been identified as facilitating the curative process in patients with pain associated with chronic illnesses (Brody, 1987) and reveal the patient’s understanding of the course of their illness (Coles, 1989). As one aspect of the represented family, storytelling about past events may aid health professionals in understanding how medical conditions are interpreted. In this regard, the family’s story about when the child was diagnosed will include not only factual information but interpretive biases linked to behavior and adaptation.

**Family Rituals**

Family rituals may range from highly stylized religious observances such as first communion or bar mitzvahs to less articulated daily interaction patterns such as the type of greeting that someone makes when they return home. Rituals mark the beginning and end of the family life-cycle but also regulate behavior on a daily basis. Families can easily identify the routines that they perform on a daily, weekly, or annual basis (Fiese, Hooker, Kotary, & Schwagler, 1993; Wolin, Bennett, & Jacobs, 1988). Family rituals are composed of several features that include role assignment, affect, regularity, expectations of attendance, planfulness, and the symbolic significance associated with the ritual. The multiple aspects of family rituals have been summarized into the dimensions of routines and meaning (Fiese, 1992, 1995). Families differ in regards to the flexibility of their practices and the extent to which family rituals are a meaningful part of their life.

Family rituals may be particularly useful in understanding how families reorganize their behavior around periods of transition. In a study of family rituals during the early stages of parenthood, it was found that families with preschool age children report the practice of more rituals and ascribe more meaning to their dinnertime and weekend activities than families whose oldest child is an infant (Fiese et al., 1993). The transition to adolescence often involves reorganizing family rituals to allow for autonomy and involvement with the peer group (Lax & Lussardi, 1988). As children are able to take on a more active role in the family, daily practices are reorganized to incorporate the child’s participation. Over time, these practices come to have meaning for the family and aid in the creation of a family identity.

For families raising a child with a medical condition, the routine aspect of family rituals may need to be altered to conform to the medical regimen. The
timing of meals, allowable distance to travel from home, adjustments that need to be made when away from home, all call for variations in family routines. Points of developmental transition may affect disease management through the disruption of mealtime routines and often involve a renegotiation of family roles (Hauser et al., 1986). The flexibility with which rituals are practiced may play a key, although at times paradoxical role, for children with medical conditions. Rigid ritual practice, with little affective involvement, has been found to be related to heightened levels of anxiety and somatic symptoms in adolescents (Fiese, 1992). However, a lack of routinization has been found to be related to poorer medical compliance in adolescents with diabetes (Wertlieb, Hauser, & Jacobson, 1986). These two findings may be reconciled by examining how families come to define their rituals and how meaning is ascribed to family activities. Bush and Pargament (1996) report that family adaptation to chronic pain may be eased by the practice of family rituals. For the patient, the regularity of family routines provided a sense of predictability associated with positive adaptation. For the spouse of the patient, the meaning of the ritual was linked to feelings of family competence, suggesting a sense of belongingness and preservation of family relationships in the face of caring for someone with chronic pain.

The practicing family of a child with a medical condition may organize around routines that are predictable and provide stability for the identified patient. A sense of group membership based on family shared activities may allow individuals to create definitions of themselves outside of a medical condition. Indeed, it has been found that the ability of the family to create rituals distinct from illness may protect offspring from the harmful effects of alcoholism (Fiese, 1993; Wolin, Bennett, Noonan, & Teitelbaum, 1980). Wolin et al. (1980) made an important contrast between ritual practices that may be distinct from the disease process and those that are subsumed by it. In a sample affected by parental alcoholism, it was found that offspring of families that are able to keep their rituals distinct from paternal alcoholism were less likely to develop problematic drinking or to marry an alcoholic. Offspring of families where the rituals were subsumed by the alcoholism were more likely to develop alcoholism and/or to marry an alcoholic.

**Linking Family Practices and Representations to the Transactional Model: A Case Example**

Given an overview of the practicing and represented family, it is possible to apply these concepts to the transactional model using a case example. Rachel, 16 years old, was referred for psychological treatment following multiple hospitalizations due to diabetic ketoacidosis (DKA). Rachel's parents were divorced and
she had one older sister. Several family transitions had occurred in the previous 6 months; Rachel's sister had recently left home for college, her father became more involved in the family's daily routines, and her mother returned to school for advanced training. Rachel's hospitalizations occurred 2 days prior to Christmas and when her mother was away on a business trip. The mother's central concern was Rachel's ability to be independent and self-reliant. Rachel interpreted her mother's encouragement of independence as rejection. Rachel's mother interpreted Rachel's sullenness as lethargy and a lack of motivation, personality characteristics also ascribed to her ex-husband. Echoes of the mother's past relationships became intertwined with mother–daughter interactions marked by screaming matches. Following such incidents Rachel would overeat. The overeating would lead to increased monitoring and harshness on the part of the mother which led to binge eating and hospitalizations for DKA.

From a transactional perspective the following scenario can be constructed and is presented in Figure 2. Several transitions were occurring in the family including Rachel's normative striving for independence and her sister's departure for college. Rachel's autonomy-seeking was unconditionally accepted and endorsed by her mother who was beginning to see a new period in her life. Rachel interpreted her mother's enthusiasm for independence as rejection and altered her interactions with her mother. Her mother then reacted to Rachel's behavior as part of a long-standing stubbornness seen in Rachel and her father. The mother's recognition of this generational pattern led to increasing pressures on Rachel to take personal responsibility for her diabetes care. Rachel interpreted her mother's monitoring as an insensitivity to her adolescent needs and engaged in overeating. The overeating led to negative parent–child interactions which led to binge eating and DKA.

Within this cycle there are several instances of the practicing and represented family. The represented family is evident in the mother's reaction to Rachel's behavior as similar to her ex-husband's personality. Rachel, on the other

Child

Parent

Fig. 2. Transactional model predicting sequence of maladaptive interactions in adolescent with diabetes.
hand, is attempting to create a definition of who she is distinct from the family but at the same time relying on support from her mother. The practicing family is evident in the cycle of increased negative affect and alteration in daily eating routines. It is interesting to note that Rachel’s hospitalizations occurred during times of alteration of routines (sister leaving home, mother away from home) or intensification of routines (Christmas). The relationship between mother and daughter was redefined within the current context of a developing adolescent and the mother’s transition into a new period in her life. Rather than consider parent–child involvement as restrictive, it was redefined as positive attention and an opportunity to reorganize daily routines. The disposition of the case included good diabetic control, Rachel’s understanding of the pattern of binge eating and rejection, and the mother’s understanding of supportive independence.

EVALUATION GUIDELINES

Evaluation guidelines may be developed to access represented and practicing family in clinical settings. These recommendations may be integrated into existing clinical interviews.

Identifying Transitions

After determining the developmental issues central to the presenting problem, the clinician should consider what transitions have occurred in the family. As part of the clinical interview the following issues should be addressed: (a) Change in family structure. Have there been any marriages, divorces, births, or deaths in the past year? (b) Change in family roles. Has any family member taken on new responsibilities in the past year? Have there been any job changes in the past year? (c) Plans for the future. Are there any plans for changes in structure or roles in the next 6 months? Are there any plans for adding family members to the household, job changes, or school changes? Attention to family transitions allows the clinician to evaluate the degree to which important family members have entered or left the family and the degree to which families deliberately plan for family transitions.

Practicing Family

Family rituals may be assessed through self-report questionnaires (Fiese & Kline, 1993) or semistructured interviews (Fiese et al., 1993; Wolin, Bennett, & Jacobs, 1988) and interpreted along the dimensions of routine and meaning. Routine aspects include how often the ritual is practiced, the degree to which
roles are assigned, and the degree to which the routine has remained stable over time. The meaningful aspect of family rituals include the degree to which the family considers this an important event or whether it is fairly routine. An example of a meaningful family ritual would be "dinner is a special time for us to get together and catch up with everyone." An example of a family ritual with little meaning would be "Dinner is a time to get fed and get on with other activities." Meaningful family rituals are anticipated and deliberately planned for. Meaningful rituals may also incorporate symbolic objects such as photographs of absent family members.

The following questions may be used as part of a clinical interview: (a) Occurrence. Are there any events or gatherings that you look forward to on a daily or weekly basis? Do you eat meals together or find a time during the week to come together as a family? (b) Routine. Are specific roles assigned at these gatherings? Are there expectations that the events will occur at a specified time or on a regular basis? (c) Meaning. How would you describe this event so I would know it was a gathering with your family and not other families? Would you describe this gathering as a special time or a time to accomplish something and move onto other activities?

Represented Family

When the represented family is accessed through the use of family stories and the interpretation of important family events then central features of narrative analysis become important. Narratives may be evaluated along several dimensions including the coherence of the narrative, the style in which the narrative is told, and the implicit beliefs in the narrative. Coherence refers to how well the individual is able to construct and organize a story. The coherence of a narrative has been found to be related to attachment relationships (Main & Goldwyn, in press).

The act of storytelling may reveal how the family works together in constructing an image of their family life. Markers of relationship functioning identified in marital interaction studies (Gottman & Levenson, 1992) such as attentive listening, turn-taking, and affirmation of affect, can be evaluated as part of the narrative process. These markers have been found to be related to adult health and physiology (Gottman & Levenson, 1992).

The implicit beliefs about relationships may also be accessed through family stories. Several themes may be identified when families recall family events. Pediatric psychologists may want to attend to how the family perceives the medical community, availability of social support, and adaptation to illness. The following case examples, drawn from stories told by mothers of premature infants, highlight these themes.
The first case illustrates how the narrative reflects beliefs about the medical community.

Oh, I went into labor early... It was pretty nasty labor, five minutes apart. And they knew something was wrong before I had her. They knew they were going to have to have the pediatrician right there in the delivery room. They did, and when she came out, she wasn’t really breathing that well. They took her right over to that corner and started working on her and just wrapped her up and basically said, “here is your daughter” and they were walking away with her. And we didn’t get to see her until six the next morning and she was in an incubator, IV’s and tube and monitors, and it was pretty nasty. I was kind of upset with the doctor cause I think he kept. Honestly to this day I think it could have been prevented because they knew the day before something was wrong and I think he could have done something right then instead of waiting so long.

In this narrative the mother’s distrust about the medical community is evident. Under these circumstances it would be important to evaluate the family’s current relationship with the medical community and the degree of trust between the family and health professionals.

In the next case, lack of social support during a medical crisis is a strong theme.

I woke up about four in the morning and didn’t even know I was in labor. This huge pain woke me up out of a deep sleep and I tried to wake up my boyfriend and he just went back to sleep. So he thought I was just kidding and he rolled over and went to sleep and I got up... I was doing the dishes and trying to forget about the pain... I was doing my breathing exercises and they seemed to help and I went to see my boyfriend’s mother and asked her and she was getting ready for work... my boyfriend had already left for work... and I asked her, what does labor feel like... And she goes why? And I go, well I have been having these horrible pains for six hours and she goes you better call the doctor. So I called the hospital and left a message at my boyfriend’s work for him to come home immediately and his mother... and this is the funny part... she asked me if she could stop off on her way to taking me to the hospital to pick up her check and then cash it at the bank and I said OK... fine... you know because I didn’t think I was going to have the baby then... and then my boyfriend asked to get his check cashed and could we stop for a burger along the way?

In this narrative, the mother’s medical condition takes a back seat to more mundane daily routines such as cashing a check and grabbing a bite to eat. The clinician would have to wonder whether under other stressful conditions there is a consistent lack of social support.

In the last example highlights how even in the face of adverse conditions, positive resolutions are possible.

Pain... and I felt happiness because like she was... she was the second one [of twins]... the first one, when I had the first one it was like an hour apart you know. I felt kind of bad because that baby didn’t make it you know... it didn’t develop right... and they was telling me in my earlier months that one of the babies wasn’t going to make it but they was going to be small... when I seen her I... I just I was like hurt but then again I was feeling joy because like I said one of my babies made it... I was like one of my babies had made it because she’s been through a lot, too... she had an operation and had to stay in the hospital until she gained six pounds... then she needed an operation two months
Fiese later. . . right now she has asthma. . . it's just like everything been going wrong with my baby so she's growing out of it and I'm happy she's here you know.

FAMILY CONTEXT AND THE PEDIATRIC PERSPECTIVE

A focus on family regulation in developmental context suggests that there are multiple influences on child adaptation. An evaluation of family practices and representations is ecologically valid and developmentally sensitive. By using the family's own description of their beliefs and practices the psychologist is able to gain a fresh perspective on family adaptation outside of the health care setting. Previous research and theoretical models have done a commendable job in identifying aspects of family process and organization that are related to child health. Broadly defined family characteristics such as conflict, warmth, and support have been linked to disease management and adaptation (e.g., Hauser et al., 1986). These efforts have strongly argued for the development of intervention strategies targeted to decrease family conflict and increase family communication. Intervening at the level of family organization in a way that is meaningful to the family may provide an avenue to reach families that have been less receptive to treatment. By listening to the family's stories it may be possible to create meaningful metaphors for change (White & Epston, 1990). The pediatric psychologist is then poised to identify family competencies and aid in the negotiation of expectable and unexpected transitions. From this perspective, the child is not a case of an illness but rather an active member of a family that changes over time to meet new challenges through family transactions.

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