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EDITORIAL STAFF

Editor: Shannon Sauer-Zavala Ph.D.,
ssz@uky.edu

Associate Editor: Stephanie Jarvi
Steele, Ph.D., sjs11@williams.edu

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PRESIDENT'S COLUMN

Reflections on the Importance of Our Work as Clinical Psychologists

Elizabeth A. Yeater, Ph.D.

 Happy New Year! I hope you had a happy, safe, and joyous holiday season. This is my first article in *The Clinical Psychologist* as President of the Society of Clinical Psychology (SCP). I wanted to begin this entry by introducing myself; it is my hope that I get to know more of you during the coming year! As incoming President of SCP, I follow on the heels of many illustrious psychologists, which is quite an honor, yet the role also feels, at times, like a daunting endeavor! As a graduate student at the University of Nevada, Reno (UNR), I never dreamed I would lead such a prestigious organization, especially one that I perceived to be the place where the most important conversations were happening in the field (I was a graduate student when the infamous Chambless list was released!). My training experiences, both at UNR and later under the mentorship of Richard McFall at Indiana University (IU) Bloomington, shaped irrevocably the clinical psychologist I am today. My mentors were quintessential psychological clinical scientists, and they imbued in me a true passion for clinical work, both within the research laboratory and the therapy room, work that would lead ultimately to a reduction in human suffering. That passion continues to fuel me today, in my research, as Director of Clinical Training at the University of New Mexico (UNM), as a clinical supervisor for a rather large group of doctoral students, and as the incoming President of SCP. In a word, I love being a clinical psychologist and have never regretted my career choice!

While I find most aspects of clinical psychology fascinating, three areas are my intellectual and emotional "bread and butter." The first is my programmatic line of research. I have spent the past 18 years examining the cognitive, interpersonal, and behavioral risk factors for sexual victimization among college women. This basic work has informed my applied work; that is, the development of preventative interventions to reduce victimization risk among more vulnerable women. It seems like every other day we hear another media account of sexually violence, happening typically to children, women, and other marginalized groups, and committed most frequently by people who are in positions of power over the victims. Sadly, despite the development over many years of preventative interventions aimed at decreasing the prevalence of sexual violence, rates of victimization have

remained steady over several decades. Moreover, these interventions, while reasonably effective at changing attitudes, have been relatively ineffective at changing behavior (Anderson & Whiston, 2005; Ellsberg et al., 2015) and have been implemented often as static, one-time preventive interventions with limited focus on the contextual and dynamical processes linked to victimization risk, which to date, remain relatively elusive. Several years ago, the country of Kenya developed a rape prevention program that targets reducing men's sexual aggression as well as women's self-defense skills. Older men mentor young men and model positive masculinity and respect for women. To date, rates of rape have decreased by 50% in Nairobi, Kenya. Kenya, a third world country with few resources, has been successful at accomplishing what the United States, with all of our resources, has been unable to do. We must do better to solve this public health problem – for our children, women, and other marginalized groups who are commonly the victims of sexual violence. In short, we need to transform our cultural context such that sexual violence is neither accepted nor permissible, regardless of environmental context.

When I have my clinical hat on, I supervise students who treat clients suffering from PTSD from sexual trauma (rape, child sexual abuse). Most of these clients wait many years before accessing treatment. Notably, the literature shows that less than half of women who experience an act of sexual violence meeting the legal definition of rape acknowledge their experience as such (Bondurant, 2001; Kahn, Mathie, & Torgler, 1994). Moreover, women who have difficulty labeling their experience appropriately experience greater difficulty recovering from the psychological sequelae of rape (Kahn et al., 1994; Bondurant, 2001; Littleton & Breitkopf, 2006). In our current sociopolitical climate, which I observe as not being particularly affirming to women (not to mention other marginalized groups), women who are victimized may be even more reluctant to come forward to report a sexual assault or to ask for help dealing with the effects of these violent acts. Some in the field have argued that there is a significant cost to our science and practice (and, hence, to victims themselves) when we fail to inquire about possible traumatic experiences (e.g., Becker-Blease & Freyd, 2006; Yeater, Miller, Rinehart, & Nason, 2012). Thus, to be silent about sexual violence is to support tacitly such acts; thus, it is incumbent upon us to inquire about possible acts of sexual violence among our clients. I communicate this often to the students that I supervise.

The second “bread and butter” issue that intrigues me has to do with dissemination and implementation of the treatments that work into our communities and, consequently, to the people who need them the most. We have a good number of treatments that range from extremely effective (e.g., CBT for panic disorder) to moderately effective (e.g., CBT for depression) for a variety of disorders, and research that shows that psychosocial interventions are superior to psychotropic medications for a good handful of disorders (e.g., Hollon, Stewart, & Strunk, 2006). Yet, we know from the literature that practicing clinicians are not, on average, using those treatments. Some have argued that for clinical psychology to have a “place at the table” in health care, we need to demonstrate the relevance of what we do, including our treatments’ efficacy, effectiveness (i.e., generalizability), cost-effectiveness, disseminability, and reach (Baker, McFall, & Shoham, 2009). We have struggled to find a place at that table, partially, I think, because we disagree about some of the fundamental principles in clinical psychology, such as how to train clinical psychologists, what the aims and goals of treatment should be, and how much common factors versus the active ingredients of therapies account for treatment outcomes. Unlike the medical profession, which has a more unified and standardized way of training doctors, clinical psychologists are trained in programs that emphasize to greater or less degree, the importance of research and the use of empirically based interventions. I suspect that confusion about our own training goals and desired outcomes for clinical psychologists has contributed to what some have called the “poor public face of psychology” (Lilienfeld, 2012). That is, we need to do better educating the public about what it is that we do, how we do it, and the empirical basis for ameliorating psychological/behavioral problems. As noted by Lilienfeld (2012), the public face of psychology should not be Dr. Phil or Dr. Laura! We need to do better by draining our motes and getting out of our silos!

My third “bread and butter” issue pertains to diversity, broadly defined, including topics of gender, race/ethnicity, intersectionality, inclusion, and social justice. I live and work in a minority-majority state and direct a doctoral training program in clinical psychology that has a Multicultural Diversity Emphasis, as well as a host of other diversity-related training opportunities (including clients in our clinic). I often take where I live and work for granted, and in my daily context, appreciation for diversity is a given. I remind myself continually that this is not a given outside of my context, and many marginalized populations experience a

variety of hardships, including (but not limited to) discrimination and health disparities (both mental health and medical treatment). The demographics of the United States are quickly changing and becoming more racially/ethnically diverse, yet the face of clinical psychology does not yet reflect that diversity. We need to do more to make our field more inclusive to those from diverse populations.

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Where are Siblings of Children with Specific Health Care Needs in Family-Centered Care?

Kristin A. Long, Ph.D.

Department of Psychological and Brain Science,
Boston University

Melissa A. Alderfer, Ph.D.

Nemours Children's Health System
Sidney Kimmel Medical College at Thomas
Jefferson University

 *"My mom, she sent us a picture, they were drawing blood from his arm... I wanted to be with them at that moment, but I had to stay here because I had to go to school. So there was no way I could go, but the next weekend we went and everybody was there. Relatives came to visit us, church members, my cousins who live over here, and from other parts. They cheered us up ... [but] I missed him. He was there, and I had to stay here... We wanted to be together, because a separated family is not the same."*

- 15-year-old brother of a child with acute myeloid leukemia

Family-centered theories emphasize the interconnectedness of family members and highlight the role of families as advocates and partners in policymaking and service provision (Bamm & Rosenbaum, 2008). These theories suggest that changes in any part of a system (e.g., a serious illness in a child) will influence the functioning of the family as a whole and that of each individual family member (Kazak, 1989; Epstein et al., 1978). However, applications of family systems theories in family-centered care initiatives often adopt a narrow definition of "family" that includes only the child with the specific health care need and a parent. This narrow definition misses other family members' roles as informal care partners, their influences on the family's ability to manage treatment regimens for the child with the specific health care need, and their emotional experiences of adapting to a serious illness or disability in their family member. Here, we will review the rationale for expanding the practice of family-centered care to include siblings of children with specific health care needs and offer an agenda to advance sibling research and care. Although applicable across families of children with various specific health care needs, we will highlight the example of families of children with cancer.

Family-Centered Pediatric Health Care

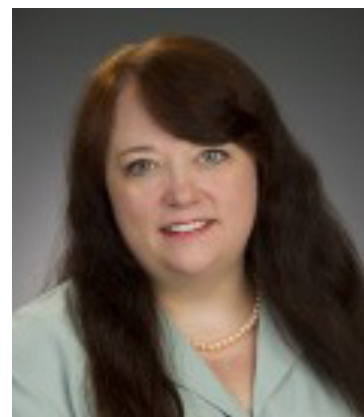
The family plays an important role in the health and well-being of its children, and the health of children influences

the functioning of their family unit and the well-being of other family members (Alderfer & Stanley, 2012). In the context of childhood chronic medical illnesses, it is well documented that adherence to treatment and medical outcomes are better when the family is good at problem-solving and integrating treatment regimens into daily routines, and poorer when communication, oversight, and monitoring are poor and when family relationships are characterized by conflict, hostility, and emotional over-involvement (Alderfer & Stanley, 2012). Similarly, in the context of autism spectrum disorder, family-related protective factors such as greater parenting self-efficacy and parent well-being are associated with better child outcomes, while family-related risk factors such as higher parent stress and lower parent responsiveness can lead to more pronounced autism symptoms and behavioral problems and can reduce or eliminate the benefits of autism-related interventions (Karst & Van Hecke, 2012).

At the same time, a child's medical diagnosis, developmental disability, or mental health condition has an impact on the family unit and individuals within the family. These effects are often described as negative, but positive outcomes are also notable. For example, a child's medical diagnosis is often distressing for family members and can lead to family conflicts and shifts in family roles and responsibilities, but also greater family cohesion and more positive outlooks regarding others and the future (Christofferson et al., 2019; Long & Marsland, 2011; Van Schoors et al., 2015). Similarly, aspects of a child's intellectual or developmental disability are associated with higher parenting stress and risk for challenges in parent mental health, physical health, or marital functioning, but also positive outcomes such as increased family closeness, positive parenting experiences, and acceptance of human difference (Glidden et al., In Press; Karst & Van Hecke, 2012). As



Kristin A. Long, Ph.D.



Melissa A. Alderfer, Ph.D.

disabilities persist across the life course, it is important to take a process-oriented view of understanding how these family effects and roles change across the life course and are influenced by culture (Blacher & McIntyre, 2006; Glidden et al., in press; Magaña & Smith, 2006). In sum, the development, health, and well-being of children are inextricably tied to the health and functioning of the family system.

Acknowledging the family's influence on the functioning of children with specific health care needs has led to many years of family-led advocacy efforts and federally-supported initiatives focused on improving the health care system for families. From these efforts, professional policy statements have emerged describing our current standard of pediatric health care: family-centered care delivered within a medical home (Alderfer, Kazak, & Canter, 2019). There is currently no universally agreed-upon definition of family centered care (Kuo et al., 2012), but there is general consensus on its key principles. These principles emphasize conceptualizing health care as a partnership between the provider and the family; respecting diversity, differences, and care preferences; providing care and support in the context of the family, home, and community; and recognizing and building on the strengths of the family (Bamm & Rosenbaum, 2008; Kuo et al., 2012). Health care providers practicing family-centered care recognize families' vital role in ensuring the development, health, and well-being of children and acknowledge that emotional, social, and developmental support of all family members and the family as a whole are integral components of health care (American Academy of Pediatrics, 2012). Psychologists play an important role in family-centered care initiatives for children with health care needs, including working within primary care and specialty medical settings to increase patients' access to care, foster multidisciplinary collaboration among providers, and target behavioral aspects of care such as adherence (Kazak et al., 2017).

What is often missing from policy statements and descriptions of family-centered care is a definition of "family." Most organizations, such as the Institute for Patient- and Family-Centered Care, hold that the patient and family defines their family (Institute for Patient- and Family-Centered Care, n.d.). Models of family-centered care developed in different care contexts have different perspectives regarding which family members should be included. Some argue for a more limited approach to family-centered care that focuses exclusively on caregivers, while others suggest that family-centered care should, by definition, include all family members (Kokorelias et al., 2019). In each of these contexts, siblings are rarely mentioned. Siblings frequently assume informal caregiving roles, and they are both affected by and influence (directly or indirectly) aspects of the treatment and outcomes for children with specific health care needs. Thus, we

argue that explicitly incorporating siblings into models of family-centered care is aligned with the principles and goals of family-centered care.

Why Attend to Siblings in Family-Centered Care?

Over 80% of children grow up with at least one sibling (King et al., 2010). A sibling relationship can endure across the life course, often making it a person's longest-lasting relationship (Feinberg et al., 2012). The salience of sibling relationships is often even stronger in families with more pronounced familistic cultural values (Updegraff et al., 2005). During childhood, siblings spend extended amounts of time together as play partners, companions, teachers/socializers, protectors, or competitors (McHale et al., 2012), and sibling relationships are one of the most influential forces on behavior and development (Kramer et al., 2019). Positive sibling relationship quality promotes social competence and positive well-being (Feinberg et al., 2012), and aspects of the sibling relationship (more warmth, less conflict, and less differential treatment by parents) protect against the emergence of both internalizing and externalizing problems in children and adolescents (Buist et al., 2013). Similarities within sibling pairs likely reflect a combination of modeling or reinforcement as well as common environmental and genetic influences (Feinberg et al., 2012).

The sibling relationship may hold additional importance if a child has a specific health care need, where there may be shifts in egalitarian versus complementary aspects of the sibling relationship and where siblings often assume additional roles (e.g., supporter or caregiver) (Orsmond & Long, in press), though the nature of sibling involvement varies by culture (Kao et al., 2011). Furthermore, there are reciprocal influences between siblings' functioning and the management of the illness or disability. For example, siblings enhance each other's adjustment by providing support to one another. In turn, improved child adjustment allows parents to devote more resources to meeting the demands associated with the diagnosis or its treatment. Siblings also may provide emotional support to parents and provide instrumental support in meeting the challenges that the family is facing (Kramer et al., 2019). If siblings have pre-existing problems or difficulties adjusting to a stressor within the family, they may exacerbate family or parental stress in the face of challenges (Patterson, 2002). Thus, siblings may be an important resource to bolster the family's ability to meet the challenges associated with a child's diagnosis and treatment, and they also could add to the challenges that the family is facing (Patterson, 1988; 2004).

In addition to family-level adjustment, siblings engage in an individual process of adjusting to the unique experiences of having a brother or sister with a medical illness or disability. Siblings of children with intellectual or developmental disabilities report both

positive and negative emotional reactions. These siblings have an increased risk for emotional and behavioral problems, functional impairment, stress, and psychiatric diagnoses, particularly in the presence of sociodemographic risk factors (e.g., lower income), but they also report higher mean levels of empathy, compassion, sense of responsibility, and awareness of others (Orsmond & Long, in press; Rossiter & Sharpe, 2001). In the context of chronic medical illness, meta-analytic findings show that siblings of children with medical illnesses are more likely to experience higher levels of internalizing and externalizing symptoms, along with lower levels of positive self-attributes (e.g., self-esteem, sense of competence) than siblings of healthy children (Vermaes, van Susante, & van Bakel, 2012), though positive outcomes are also frequently highlighted in qualitative work (e.g., Christofferson et al., 2019; Long et al., 2018). Finally, there is variability in the functioning of siblings of children with mental health concerns, though these siblings have elevated levels of psychopathology, poorer quality of life, and greater emotional or behavioral problems (Barnett & Hunter, 2011; Kilmer et al., 2008).

Despite their contributions to family adjustment in the face of illness- or disability-related stressors and their elevated risk for poor psychosocial outcomes, siblings are seldom considered as part of family-centered care. Siblings' absence from family-centered care initiatives is a missed opportunity to ensure health and well-being at the level of the whole family. It also introduces the possibility of increased burden on parents or families if siblings show adjustment difficulties. Finally, it misses an opportunity to recognize and engage siblings as part of the family system working together to support the child with the illness or disability, which is particularly important for some cultural groups. This oversight is notable given that siblings are often informal caregivers and, across the life course, may assume formal caregiving or primary support roles for their brother or sister.

Exemplar: Incorporating Siblings into Models of Family-Centered Care in Childhood Cancer

Although family-centered care approaches are applicable across families of children with various health care needs, we focus here on siblings of children with cancer for both conceptual reasons (i.e., the pronounced effects of a sudden diagnosis of this life-threatening illness) and practical reasons (i.e., the larger literature base from which to draw conclusions). Treatment regimens for childhood cancer are often prolonged, complicated, and intensive, which can disrupt the entire family system both functionally and emotionally (Alderfer & Kazak, 2006). Families must coordinate frequent hospitalizations and clinic visits, administer home-based medication regimens, minimize exposure to germs, manage the many side effects of treatment (e.g., mood swings, nausea, susceptibility

to infection), and monitor treatment response through repeated blood draws, bone marrow aspirations, and lumbar punctures. In addition, families must adapt to the unpredictable and uncontrollable course of cancer treatment and face the possibility that the child may not survive or will develop serious late effects. Thus, cancer-related stressors affect quality of life not only for the child with cancer, but for the whole family (Long & Marsland, 2011), including siblings (Long et al., 2018).

Although most families facing cancer have more than one child, the focus on family-centered care in pediatric oncology has rarely extended to siblings. Siblings feel the effects of their family's need to renegotiate roles and routines to accommodate cancer-related treatment demands. This might require siblings to assume more responsibilities for household management, provide childcare to younger siblings, or assume an active role in administering home-based cancer treatments (Long et al., 2015). Siblings also report having surrogate caretakers while parent(s) assume primary responsibility for the child with cancer, along with disruptions to their day-to-day activities (Samson, Rourke, & Alderfer, 2016). A cancer diagnosis also affects the parent-sibling relationship, with disruptions exacerbated by parents' decreased physical and emotional availability. Decreased parental availability can be particularly disconcerting in the context of siblings feeling scared and confused, having limited information about cancer, and forming misconceptions about cancer treatment and prognosis (Long et al., 2015; Pariseau et al., in press). Notably, siblings have different experiences of cancer compared to other family members; they are observers rather than participants in the medical process, and they often have less interaction with the hospital, first-hand exposure to cancer-related cues, and access to support (Long et al., 2017). Together, siblings' unique experiences can contribute to feelings of isolation and disconnection from their families.

Given these cancer-related family changes at a highly emotional time, it is not surprising that siblings have elevated risk for poor psychosocial adjustment outcomes. In one study, two-thirds of siblings of children with cancer reported moderate to severe levels of cancer-related posttraumatic stress, and a quarter met full diagnostic criteria for posttraumatic stress disorder, which is far higher than the rate of posttraumatic stress reactions for children with cancer (Kaplan et al., 2013). In addition to elevated posttraumatic stress, a recent systematic review of 102 sibling studies showed that siblings frequently report strong negative emotions, school-aged siblings display poorer academic functioning and more absenteeism than peers, and adult siblings engage in more risky health behaviors and have poorer health outcomes than comparisons (Long et al., 2018). Psychosocial risks appear to be greater for siblings who identify as ethnic or racial minorities or who come from families with fewer

economic resources. At the same time, many siblings show resilient outcomes and report elevated maturity or compassion compared to their peers (Long et al., 2018).

Despite their clear needs, siblings of children with cancer consistently report unmet needs related to social and emotional support, access to cancer-related information, and cancer treatment involvement (Gerhardt, Lehmann, Long, & Alderfer, 2015). These unmet needs can have persistent negative consequences for both sibling- and family-level adjustment to cancer.

Reimagining a Service Delivery Model that Includes Siblings of Children with Cancer

A broad initiative within pediatric psycho-oncology was recently undertaken to ensure that the psychosocial needs of families of children with cancer are met across pediatric oncology treatment settings. The resulting evidence- and consensus-based Standards for Psychosocial Care for Children with Cancer and their Families were published in 2015 (Wiener et al., 2015). One of these standards focused on the provision of psychosocial services to siblings of children with cancer (Gerhardt et al., 2015). However, a cross-sectional evaluation of the delivery of psychosocial care within 144 pediatric oncology programs nationwide reported the sibling-focused standard of care is among those least likely to be met (Scialla et al., 2018). A follow-up study suggested that siblings almost never receive psychosocial screening or assessment systematically or directly (i.e., psychosocial screening tends to be sporadic and rely on parents proactively raising concerns), dedicated sibling support is not routinely offered within hospitals, and community-based referrals are poorly coordinated and have unknown follow-through (Long et al., 2020).

Despite siblings' well-documented unmet needs, there has been relatively little consideration of how to address barriers to providing psychosocial care to siblings. Sibling-specific barriers differ from more general barriers to providing psychosocial care to children with cancer and their parents and occur at the level of the family, health care center, and larger medical community. At the level of the family, frequent separations and emotional strain inhibit exchange of information about cancer and influence siblings' emotional reactions to cancer. For example, siblings are reluctant to disclose coping difficulties or ask parents for emotional support either to avoid further burdening parents and/or in response to parents' subtle messages about the importance of siblings being strong, positive, or helpful in the face of cancer and their lower tolerance of siblings' negative emotions (Pariseau et al., in press). Thus, siblings' needs are often unknown to parents. Furthermore, siblings often are not present

in the hospital or clinic setting and therefore are inaccessible to hospital-based psychosocial providers and unable to attend sibling-focused programs (Long et al., 2017). Even when siblings are present in the hospital or clinic, aspects of the health care center are not conducive to offering sibling services (Gerhardt et al., 2015; Long et al., 2020). Health care center barriers include limited staff availability to attend to siblings' issues, as hospital-based resources are generally allocated to patients and parents; questions about compensation for work with siblings, particularly in programs in which psychosocial staff are salaried and do not bill for services; and questions about documenting sibling screening/assessment outcomes, concerns, or treatment notes within electronic medical record systems. Practical barriers are exacerbated for families who do not speak English or who have lower levels of literacy, for whom existing educational materials (e.g., handouts, videos, etc.) are less accessible. Finally, sibling initiatives are thwarted by a general lack of awareness and appreciation of siblings' needs. Even the larger medical community, including the pediatric oncology community, has low awareness about siblings' needs (Buchbinder et al., 2018).

It is clear that hospital-based support is not currently feasible for siblings of children with cancer, and yet, models of family-centered care suggest that supporting all members of the family is integral to high-quality health care (American Academy of Pediatrics, 2012). In line with principles of family-centered care, oncology care teams (oncologists, psycho-oncology providers) need to be aware of siblings within the families they serve and ask about siblings' well-being and role within the family as related to the patient's care. Oncology care team members can educate families about the impact of cancer on siblings and encourage families to enlist support for siblings within their social networks. Raising awareness about siblings' support needs should begin in the hospital but emphasize linkage to community-based resources such as extended family, friends, neighbors, school personnel, or pediatricians – individuals who know the sibling well and who are available to provide developmentally-appropriate support to siblings in addition to that provided by the immediate family. Cancer-specific sibling programs also are available in the community, offered through national non-profit organizations (e.g., SuperSibs powered by Alex's Lemonade Stand Foundation or pediatric oncology camps) and may help provide basic information and support. Additionally, when siblings are at clinic appointments or visiting the hospital, the oncology team should acknowledge siblings and answer any questions they have.

Within the hospital, we further recommend that systematic protocols be put in place with a point person from among the oncology care team who ensures that siblings receive psychosocial screening, preferably

using validated screening instruments, at multiple points after the cancer diagnosis since siblings' distress often emerges months or even years later. These screenings should form the basis for further tailored assessment or specific clinical recommendations. Here, it can be helpful to use a stepped model of care such as the Pediatric Psychosocial Preventative Health Model (Kazak et al., 2015), where level of psychosocial risk within the family maps onto level of care: universal, targeted, or clinical care. This stepped approach ensures that hospital resources are used efficiently. Families with universal levels of sibling risk may benefit from education about common sibling reactions to cancer, general support, and referral to community-based programs as described above. Those with targeted or clinical levels of risk may benefit from more intensive mental health treatment and referral to psychosocial providers within the community. Importantly, the hospital-based oncology care team and community-based school personnel, medical providers, and psychosocial providers must communicate; whereas community-based supports will have more knowledge of the individual sibling, the hospital-based care team will have more knowledge of cancer-related considerations.

Conclusions & Future Directions: Integrating Sibling Research & Clinical Care in Childhood Cancer

In sum, decades of research findings highlight the important role of siblings both in typical child development and in the context of childhood illness or disability. Siblings of children with illnesses or disabilities frequently serve as informal caregivers, supports, or socializing agents. Although there is wide variability in psychosocial adjustment, these siblings have elevated risk for poor psychosocial outcomes and commonly report unmet psychosocial needs. Yet, the reality of siblings' sustained interconnectedness with their brother's or sister's symptoms and/or treatments lies in stark contrast with common care models that exclude siblings. This mismatch is a missed opportunity to realize the tenets of true family-centered care that emphasize how all members of a family system are affected by and contribute to the management of a child's illness or disability.

The absence of siblings from family-centered care is exacerbated by characteristics of our service delivery system that create systematic barriers to serving siblings, and therefore, we need to reimagine an innovative service delivery model that begins in the health care setting and emphasizes linkage with community-based supports (e.g., schools, community agencies, and mental health providers) and that better accounts for diversity within families. Substantive questions remain regarding the mechanisms underlying sibling risk and resilience and treatment targets and

timing. Since mechanistic and treatment research findings have limited applicability outside of a system of care that supports implementation, a sibling research agenda must prioritize the development of innovative approaches to service delivery. Given the relatively low base rate of many childhood medical illnesses, these efforts can be catalyzed by centralizing sibling-focused research efforts to create a systematic approach to sibling screening and support that can be developed with input from medical centers, families, and communities, and then adapted and disseminated widely. This model of centralized clinical and translational research has a long tradition in childhood cancer, where the Children's Oncology Group has coordinated national clinical trials for cancer treatment, the findings from which have led to drastically improved childhood cancer outcomes (Children's Oncology Group, n.d.).

Community-based research approaches will ensure that members of the community, including families and providers, are informing all steps of the research process, including articulation of research priorities and research questions, approaches to recruitment and data collection that reduce bias, and interpretation and application of findings (Israel et al., 1998). One particular way in which community-based approaches can be advantageous is to address a limitation of the existing sibling literature: the insufficient consideration of how cultural, economic, linguistic, and family-structure diversity might influence siblings' experiences and needs in the context of a brother's or sister's specific health care need. For example, it remains unclear how cultural values affect siblings' involvement in home- or hospital-based cancer treatment, engagement in additional household responsibilities, access to accurate cancer-related information, and interpretation of messages about how to cope with cancer-related stressors, family changes, and strong emotions. Thus, future sibling research should enroll diverse samples from the earliest stages of program development to ensure that the resulting protocols are culturally-acceptable and equitable for families from diverse backgrounds. Together, these integrated research/treatment approaches will move us closer to the ultimate goal of better serving all members of the family when a child has a specific health care need.

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Update on APA Coalition for Psychology in Schools and Education (CPSE)

Wendy Grolnick, Ph.D.

Frances L. Hiatt School of Psychology, Clark University, Division 12 representative

 Psychologists often interact with schools in the work they do with children and undoubtedly have a plethora of information to help children, teachers, parents and other school professionals to provide an environment that facilitates children's adjustment and achievement. APA's Coalition for Psychology in Schools and Education (CPSE <https://www.apa.org/ed/schools/coalition/index>) seeks to bring psychological principles and knowledge to pre-K-12 education to facilitate student adjustment and success. The Coalition brings together representatives from 17 APA divisions and multiple affiliate groups (e.g., Committee for Children, Youth and Families, Committee on Ethnic Minority Affairs) who have interest and expertise in youth and education. I currently serve as your Division 12 representative. The group convenes twice a year to plan and work on projects and resources that can be of use to teachers, parents, children, and other school professionals. Among the most disseminated projects is the TOP 20 Psychological Principles for Pre-K-12 Education (<https://www.apa.org/ed/schools/teaching-learning/top-twenty-principles.pdf>). This document describes important psychological principles in 5 domains: Thinking and learning, Motivation, Social-emotional learning, Classroom management, and Assessment. The document is being used by schools, teacher training programs, psychology courses, and practitioners in the US and abroad. It has been translated into 10 languages, with others on the way, has been adapted for Early Childhood Education and Creative, Talented and Gifted students and is currently being adapted to Special Education populations. A project in which I have been heavily involved is the development of Mental Health Primers to help teachers identify and respond to concerning behaviors exhibited by children in their classrooms (<https://www.apa.org/ed/schools/primer>). These brief primers are not meant to diagnose but to help teachers know how to intervene and when to seek out additional resources. Completed primers include those focusing on stress, sadness, low self-esteem, crisis, inattention/distractibility, shyness and social withdrawal, trauma, bullying, and exploring gender identity, with several others in development. Other projects include a guide for parents in choosing a high quality preschool, a survey of teachers to help identify areas about which they would like to receive further education, preventing violence directed toward teachers, reducing educational disparities, and

identifying motivational myths that would have implications for working with students. If you are interested in learning more about the Coalition or have questions about our work, please feel free to email me at wgrolnick@clarku.edu. 

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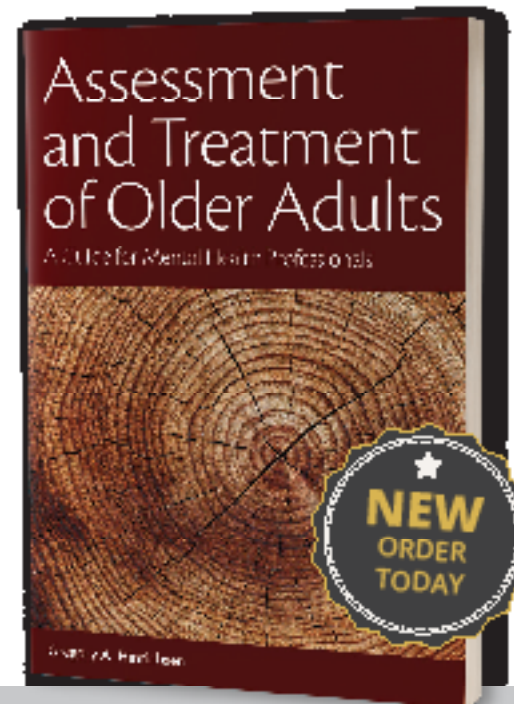
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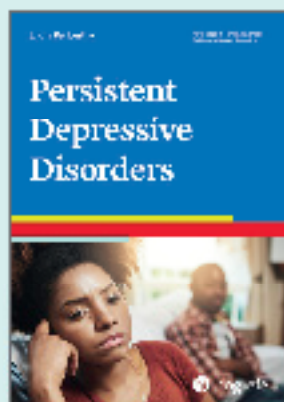
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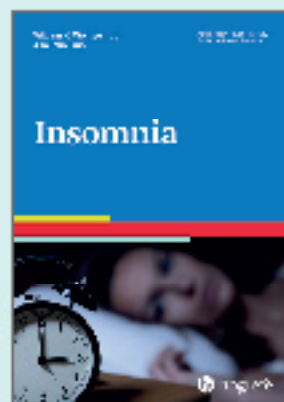
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