FAMILY PRESENTATION

I. What is a family?
   A. Structure - variable; mom, dad, two kids, a dog; two moms; blended families and step-parents; single parents; adoptive; non-blood who consider themselves a family; multigenerational; single person with no living relatives who still has memories and influence of family
      1. Formal Definition: Network of interpersonal relations characterized by a continuous interchange between members, and reciprocal causal effects
      2. Homeostatic: It is a homeostatic system, tending toward equilibrium, that cannot maintain a perpetual state of imbalance or crisis
      3. Capable of transformation - able to grow, change, evolve
   B. Functions
      1. General -
         a. Provide for physical (and emotional) needs of members
         b. Establish reasonable level of functioning (non-chaotic)
         c. Capacity to help members navigate stress, life stages
         d. Socialization of family members for roles in family and other groups
      2. Subsystems
         e. Spousal - mutual support, skills of complementary, accommodation
         f. Parental - nurture, guide, control
         g. Sibling - skills of cooperation, competition
   C. Unique characteristics of family (contrast to other organizational systems)
      1. Membership virtually permanent
      2. Relationship primarily affectional in nature
      3. Committed to guaranteeing survival and developmental needs of its members

II. Life cycle of the family
   A. Families have specific beginnings and endings
   B. Distinct sequential stages (OVERHEAD)
   C. Developmental tasks at each stage (OVERHEAD)
      1. Both normative, predictable and
      2. Unexpected - serious illness, financial loss, rape

III. What happens to a family when someone becomes sick?
   A. Family health and illness cycle (OVERHEAD)
   B. Interaction of family and illness - family responds to and is affected by illness
   C. Effects: chronic stress, distortion of family life - throws family into disequilibrium (OVERHEAD)
   D. Responses -
      1. Shock, disappointment, guilt, grief, resentment, anger, anxiety;
      2. Positive - increased closeness, growth
   E. Roles must be reallocated - requires adaptation
   F. Coping mechanisms - (OVERHEAD)
      1. Appraisal - illness viewed as threat, loss, or challenge

2. Defense, denial, information-seeking, requesting reassurance, emotional support, escape/distraction, learning specific skills, setting goals, finding meaning, acceptance, making positive life changes (OVHEADS - 2)

G. Goals of coping - (OVERHEADs - 2) maintain sense of family membership for ill person, family reorganization, reestablishment of emotional baseline, restoration of family functioning

H. Transgenerational patterns of response

IV. Family/Professional relationships

A. Professionals tend to define parents as patients, rather than as colleagues or resources
   1. Prefer passive, cooperative parents who agree with expert
   2. Negative labels ("angry," "demanding," "lazy," "manipulative") create distance between professional and parent
   3. See child as more unidimensional
   4. May see child as one case of many; objective, impartial
   5. Has power, because has control, information, expertise, access

B. Parents' perspective
   1. Boundary issues- family private, personal; becomes territory of health care provider
   2. Has no choice about "becoming an expert," entering the professional's world
   3. See child as having multiple social roles
   4. Parents only interested in their child; expect expression of emotional concern
   5. Powerless, fear of retribution, desire to please, save face

C. Linear vs. systemic models

1. Linear - most commonly applied in patient care; individual is identified patient and primary focus

2. Systems - every part seen as influencing and being influenced by other part; interactive and reciprocal

V. Family Assessment (When is there a problem?)

A. Myths about families (HANDOUT)

B. What is a dysfunctional family?: hard to say, except we all know we come from one

C. Genograms (HANDOUTS; OVERHEAD)
   1. Should be 3-generational
   2. Presents overview of family as a unit
   3. Identifies key nodal events (normative crises and catastrophic events)

A. 10 important questions to answer
   1. Outward appearance of family
   2. What are the family resources? (problem-solving skills, emotional expression, ability to deal with crises, financial, social support etc.)
   3. What are the family's repetitive, non-productive patterns?
   4. What are the family roles? (scapegoat, high achiever, good parent etc.)
   5. Who carries the power in the family? How are decisions made?

6. What are the family subsystems, and boundaries between subsystems? (may be based on generation, sex, interest; each member belongs to several different subsystems)
7. What dysfunctional triangles do you observe? (Dysfunctional in that they offer stabilization through diversion rather than through resolution of issues)
8. What are the family rules ?
   a. Don't want to violate unintentionally
   b. Both explicit ("Curfew is at midnight") and implicit ("Men in our family don't share their feelings")
9. Where does the family fall on the enmeshment/disengagement continuum? (OVERHEAD)
   a. Enmeshment - poor boundaries; very reactive
   b. Disengagement - ties between members weak, no structure; disconnectedness
10. What is the phase of the family life cycle?

VI. What's the problem?: Troubled Families

A. Dominated: one powerful authoritarian parent, often emotionally or physically abusive; little or no closeness
B. Conflicted: parents unable to share power; struggles for control
C. Chaotic: disorganized, isolated, may seem bizarre
D. Closed: may be chaotic or rigid, but little interaction with outside world
E. Perfect: appearance of close, open relationship, but in reality distance, anger among family members
F. Enmeshed: no parental leadership, lack of boundaries between family subsystems; individuality discouraged
G. Disengaged: lack of warmth, support, guidance

VII. Working with Families vs. Family Therapy (OVERHEAD)

A. Theoretical basis, objectives, and skills
B. Working with families - emphasizes maintenance, strengths, resources; techniques emphasize reinforcement of positive patterns, optimism regarding change, and reframing
C. Family therapy: emphasis is on dysfunction, pathology; active change skills (altering reinforcement contingencies, confrontation, restructuring)
D. Levels of family involvement (OVERHEAD)
   1. Minimal emphasis on family - only contact with individual patients
   2. Work with families through individual -
      a. Ongoing medical information and advice
      b. Discuss medical information with more than one family member
   3. Discuss feelings and support needs with family members; examines psychosocial impact of illness
   4. Systematic assessment and planned intervention
   5. Family therapy

VIII. Is Family Intervention Effective?

A. Randomized controlled clinical trials of family intervention in physical illness (OVERHEAD)
B. Family stress
    1. Numerous studies have demonstrated an increase in morbidity and mortality after death of a spouse
    2. Separated and divorced individuals have poorer health and higher death rates than single, married, or widowed persons
    3. Mothers of disabled children report poorer physical health
C. Family and social support
    1. Low social support results in higher mortality; family members are the most important source of social support
    2. Importance of spousal support in effecting behavioral change such as smoking cessation, dietary change associated with heart disease and obesity, and hypertension
D. Family enmeshment
    1. Family enmeshment is the component of family functioning most consistently related to poor health outcomes
    2. Characteristic of families of children with brittle diabetes, severe asthma, anorexia nervosa

IX. Basic Communication Skills
A. Talk to both parents together (or parent and support person)
B. Use accurate, nontechnical language
C. Show acceptance and optimism regarding child
D. Encourage parents to explain child's problems to others
E. Help parents to learn about child's needs
F. Help parents to understand how their attitudes affect the child
G. Avoid presenting excessive information
H. Make sure parents feel they have something practical and specific to do when they leave the office
I. Educate about availability of community resources if appropriate
J. Five stages of coping and appropriate responses (HANDOUT)
K. Therapeutic core qualities and listening skills (HANDOUTS)

X. When to Intervene with a Family
A. When asked
B. When family is in crisis
C. When developmental transition occurs (preventive, educational)
D. When abuse (substance, physical, sexual) is present

XI. General Approaches in Working with Families
A. Maintenance: keep things as they are overall; work within family framework; emphasize positive
B. Stress: accentuate tension (paradoxical intention, confrontation)
C. Repair: offer family chance to modify itself (behavioral strategies, restructuring)

XII. Medical Family Therapy Techniques (OVERHEAD)

A. Recognize the biological dimension
B. Solicit the illness story (OVERHEAD)
C. Respect defenses, remove blame, accept unacceptable (negative) feelings
D. Maintain communication (with family, and within family)
E. Attend to developmental issues (help ensure illness does not supplant normal developmental tasks)
F. Increase sense of agency in patient and family (emphasize patient input; recognize patient's right to decide whether and how to comply with treatment recommendations)
G. Leave door open for future contact

XIII. A Family Intervention Sequence (OVERHEAD)

A. Complaint raised and family assembled
B. Interactions of family members observed
C. Problematic patterns of interaction identified
D. Goals mutually established
E. Tasks assigned to family members
F. Task completion and progress monitored at followup

XIV. Basic Techniques: Wellness Interventions

A. Education
B. Reinforcement/encouragement (cheerleading)
C. Resource identification
D. Empowerment of patient and family - power-over vs. power-in-relation
    1. Inclusion of parent as empowered partner, often expert
    2. Emphasize flexibility and collaboration in approach
    3. Value parental perspective - empathy for parent point of view
    4. Encourage parental activism and advocacy
E. Optimism/hope (crisis as opportunity)
F. Reframing (look on the bright side)
G. Theory of natural consequences (step out of the way; life is a teacher)
H. Solution-oriented approach (that's the question, now what's the answer):
    1. Answer lies within family (what have you done in the past?; what do you think might work; what existing resources do you have that you can bring to bear on the problem; what are you doing now that sometimes works?)
    2. Answer lies in others: new suggestions to break out of old patterns (one family I know approached the problem by…)
I. Brief Interventions

1.Identify something new and positive that happens in your family life that you want to continue to happen (patients tend to focus on the perceived stability of their problematic patterns; this focuses on the possibility that positive change can occur spontaneously in the family unit)

2. Do something different (patients tend to believe they have used up their repertoire of available responses to the problem; this shows them other options exist

3. Pay attention to what you do when you overcome the temptation to perform the behaviors associated with the complaint (patients tend to view their problem behavior as compulsive and beyond their control)

4. A lot of people in your situation would have… (patients tend to assume that what they are doing in response to their problem is the only logical thing to do)

XV. Common Problems/Quick-Fix Solutions

- A. Untangling enmeshment
  1. Reinforce boundaries, autonomy, structure
  2. Help members develop own identities, recognize own needs
- B. Counteracting disengagement
  1. Structure contact (family activities, physical affection)
  2. Modify roles
  3. Encourage expression of feelings, reinforcement, interest in other family members
- C. Behavior problems
  1. Family contracts to alter contingencies to reinforce desired behavior
  2. Set limited, achievable goals
- D. Communication problems
  1. Establish basic rules of communication
     a. No rudeness, name-calling, bad language
     b. Clear, specific communication
     c. I statements (When you, I feel)
     d. Paraphrasing and clarifying
  2. Establish set times for family interaction

XVI. Structural Interventions

- A. Therapeutic contract (all affected family members sign)
- B. Assignment of therapeutic tasks (to strengthen boundaries, realign subsystems; challenge conflict avoidance, modify family roles etc.)
- C. Restructuring the family (OVERHEAD)
  1. Cross-generational enmeshment
  2. Detouring
  3. Undermining grandmother
  4. Chaotic family

XVII. Behavioral Interventions

- A. Contextual issues
  1. Trust, unconditional positive regard
  2. Realistic expectations for child
  3. Parents uncomfortable with parenting role (friend vs. parent), setting limits
  4. Parental unity
- B. Identify target behavior (more of/less of)
- C. Functional analysis: antecedents, behavior, consequences
- D. Strengthen existing behavior - skills already within repertoire

1.Positive reinforcement, rewards
2. Proximity to desired behavior is important
3. Reinforcing agent - prestigious person

E. Developing new behaviors

1. Successive approximation (intermediate steps, increasing accuracy, longer intervals of good behavior, increasing effort)
2. Never ignore desired behavior (ignoring extinguishes behavior, attention encourages)
3. Modeling the good example
4. Role-playing - behavioral rehearsal

F.Extinguishing undesirable behavior

1. Ignoring
2. Substituting positive behavior
3. Consequences

XVIII. A Special Case: Somatizing Families

A. Somatization - patients in difficult life situations present not with anxiety, depression, but with numerous physical symptoms; often deny emotional component
B. Family members may share same somatically fixated health beliefs; express frustration at traditional medical system for not curing loved one's symptoms
C. Family factors in the development and maintenance of somatization
   1. Alexithymia - inability to express emotion
   2. Children receive attention for physical pain, but not for emotional pain

D. Health professional feels frustrated (OVERHEAD POEM), engages in dysfunctional interaction cycle with patient (OVERHEAD)

E. Symptoms may be attempt to solve or avoid other family problems (achieve intimacy if cannot attain through more direct means; reduce conflict)

F. Family often becomes organized around symptoms

G. Family may be characterized by enmeshment, overprotectiveness, rigidity, lack of conflict resolution

H. Triangulation of sick child detours spousal conflict

I. Treatment
   1. Acknowledge physical, biological dimension
   2. Avoid psychologization of symptoms
   3. Mix of empathy and boundaries
   4. Focus on function, rather than symptoms
   5. Transfer of responsibility back to patient and family
   6. Disengage child from parents, return patient to child subsystem, strengthen spouse subset
   7. Focus on siblings as well as the pt.