FAMILY PRESENTATION

I. What is a Family?(OVERHEAD) ✓

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
      a. Spousal - mutual support, skills of complementary, accommodation
      b. Parental - nurture, guide, control
      c. 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) ✓ - young couple - think of other's needs
C. Developmental tasks at each stage (OVERHEAD) ✓ - young children - setting limits
   1. Both normative, predictable and
   2. Unexpected - serious illness, financial loss, rape, divorce, crime

III. What happens to a Family when Someone Becomes Sick?

A. Family health and illness cycle (OVERHEAD) ✓ – APPRAISAL (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

H. Coping mechanisms - (OVERHEADS x 2)

F. 1. Appraisal - illness viewed as threat, loss, or challenge (OVERHEAD)

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

G. Goals of coping - maintain sense of family membership for ill person, family reorganization, reestablishment of emotional baseline, restoration of family functioning (OVERHEAD x 2) G1. Stages of Coping

H. Transgenerational patterns of response

H. Effective coping strategies

I. Negative coping strategies

IV. Family/Professional Relationships (OVERHEAD)

A. Professionals may define parents as patients, rather than as colleagues or resources
   1. May 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) (OVERHEADS)

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

C. Genograms (HANDOUTS; OVERHEAD) Hx of family illnesses
   1. Should be 3-generational
   2. Presents overview of family as a unit

3. Identifies key nodal events (normative crises and catastrophic events)

D. 10 important questions to answer (OVERHEAD)

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 (Overhead)

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. When to Intervene with a Family (OVERHEAD) ✓

A. When asked
B. When family is in crisis
C. When developmental transition occurs (preventive, educational) juvenile diabetes
D. When abuse (substance, physical, sexual) is present
E. When family member is at serious risk

X. Basic Communication Skills

A. Therapeutic core qualities and listening skills (HANDOUTS) (OVERHEAD) ✓

1. Listening Skills (OVERHEAD) ✓
2. Common Mistakes (OVERHEAD) ✓

1. Respect
2. Genuineness
3. Empathy

B. Five stages of coping and appropriate responses (HANDOUT and OVERHEAD)
   1. Denial
   2. Anger, guilt, blaming
   3. Bargaining(Hope)
   4. Depression
   5. Acceptance, understanding

XI. General Approaches in Working with Families (OVERHEAD)

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, within family, and between family and outside world)
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

XIV. Basic Techniques: Wellness Interventions (OVERHEAD)

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): (OVERHEAD)

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 (OVERHEAD)

1. Identify something new and positive that happens in your family life that you want to continue to happen (families 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 (families 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 engage in the behaviors associated with the complaint (family members tend to view their problem behavior as compulsive and beyond their control)
4. A lot of people in your situation would have… (families tend to assume that what they are doing in response to their problem is the only logical thing to do)

XV. 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

XVI. Common Problems/Quick-Fix Solutions (OVERHEAD)

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

XVII. Structural Family Interventions

A. Complaint raised and family assembled (OVERHEAD)
B. Interactions of family members observed
C. Problematic patterns of interaction identified
D. Goals mutually established
E. Therapeutic contract (all affected family members sign)
F. Assignment of therapeutic tasks (to strengthen boundaries, realign subsystems; challenge conflict avoidance, modify family roles etc.)
G. Task completion and progress monitored at follow-up
H. Restructuring the family (OVERHEAD)
1. Cross-generational enmeshment
2. Detouring
3. Undermining grandmother
4. Chaotic family

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 – medical science doesn't have all the answers; then support their ideas
   6. Disengage child from parents, return patient to child subsystem, strengthen spouse subset – Lessen their responsibility
   7. Focus on siblings as well as the pt.

LEARNING OBJECTIVES - FAMILY PRESENTATION

1. Be able to define functions and unique characteristics of the family unit
2. Be able to identify various stages of the family life cycle and normative developmental events associated with each stage.
3. Be able to describe how a family is affected by and responds to illness
4. Know how to conduct a brief clinical assessment of a family system, including strengths/resources, roles, power locus, rules, and structure
5. Know how to construct a family genogram
6. Define common terms used in family intervention such as subsystems, triangulation, detouring, enmeshment, and disengagement
7. Identify distinguishing characteristics of various types of dysfunctional families (dominated, chaotic, enmeshed, disengaged)
8. Be able to differentiate between working with families vs. family therapy on the basis of objectives and skills
9. Demonstrate basic communication skills and therapeutic core qualities
10. Describe brief techniques of "working with" families, including wellness interventions, behavioral approaches, and simple structural family therapy strategies

WHAT IS A FAMILY?

STRUCTURE – VARIABLE

Definition: Network of interpersonal relations characterized by continuous interchange between members, and reciprocal causal effects.

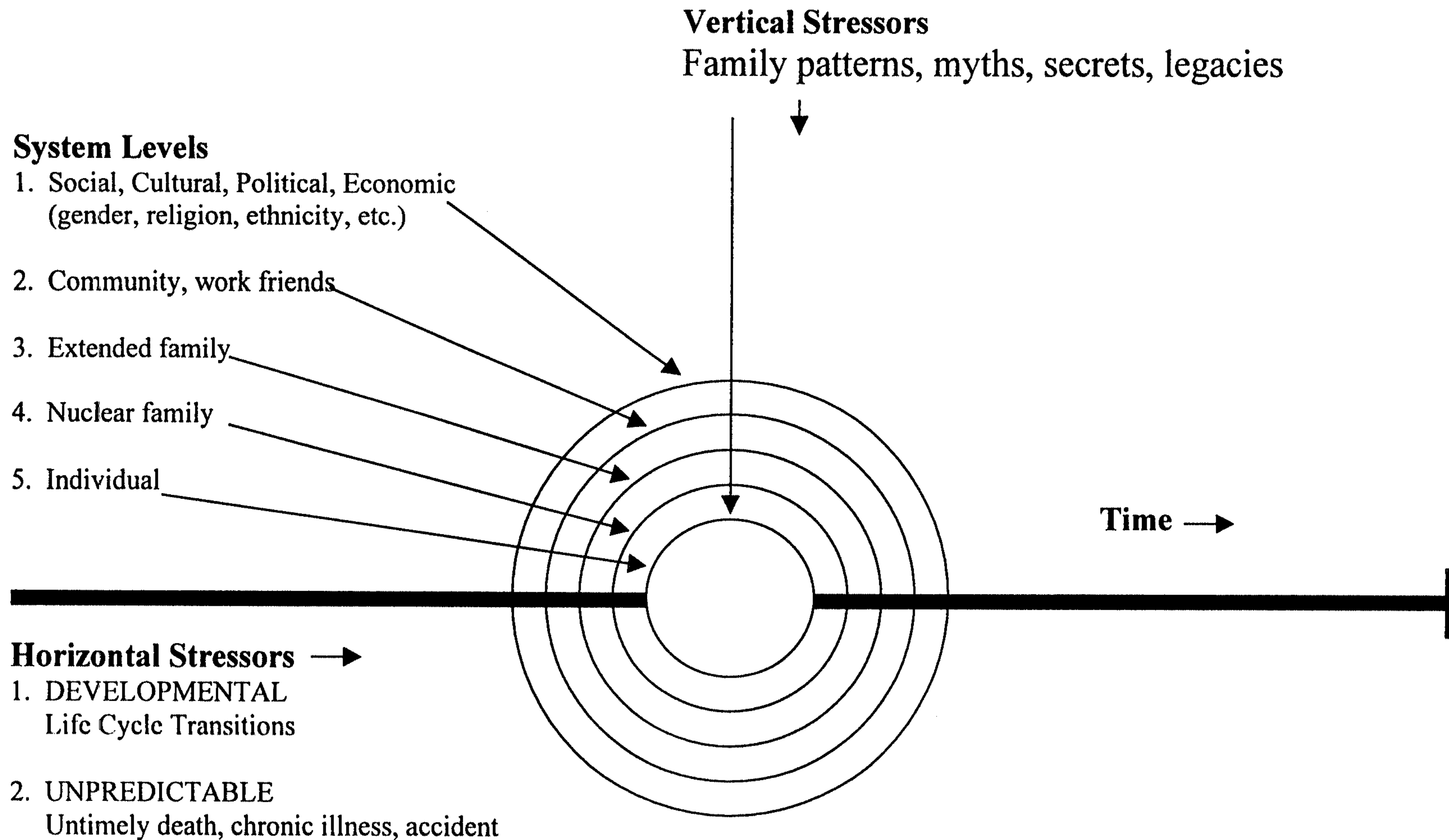
- Homeostatic
- Capable of transformation

FUNCTIONS

- Physical Needs
- Emotional Needs
- Navigation of developmental changes, stress
- Socialization

THE STAGES OF THE FAMILY LIFE CYCLE

STRESSORS-ADAPTIVE AND MALADAPTIVE RESPONSES



FAMILY EFFECTS

NEGATIVE

- SENSE OF PARENTAL INCOMPETENCE
- MARITAL DYSFUNCTION
- SIBLING DIFFICULTIES
- LACK OF COMMUNICATION
- FINANCIAL STRESSORS
- SOCIAL ISOLATION
- INFRINGEMENT ON WORK/LEISURE

POSITIVE

- FAMILY UNITY
- PERSONAL GROWTH
- COMPASSION AND TOLERANCE
- RELATIONSHIPS

GOALS OF FAMILY COPING

General

- RESTORE HOMEOSTASIS
- CONTROL IMPACT OF STRESSOR ON FAMILY FUNCTIONING
- MAINTAIN FAMILY INTEGRITY
- PROMOTE MEMBER INDEPENDENCE, SELF-ESTEEM, POSITIVE OUTLOOK
- DEVELOP AND UTILIZE RESOURCES

EFFECTIVE COPING STRATEGIES

- ACQUIRING AND USING SOCIAL SUPPORT
- COMMUNICATING EMOTIONS
- DEVELOPING SKILLS OF PROBLEM-SOLVING AND INFORMATION ACQUISITION
- BEING FLEXIBLE IN THE CHOICE OF COPING STRATEGIES
- USING HUMOR
- CAPACITY TO GRIEVE LOSSES
- RECOGNIZING AND ACCEPTING BOTH NORMAL AND DEVIANT ASPECTS OF THEIR CHILD
- IDENTIFYING MEANING AND PURPOSE IN THEIR LIVES

PROFESSIONALS VS. PARENTS

Health Professionals	Parents
Parents are extensions of patients	Parents are experts on their child
Prefer passive, cooperative parents	Challenge professionals to ensure welfare of child
Labeling	Labeling
Child unidimensional	Child multiple social roles
Child one case among many: objective, impartial	Only interested in their child; subjective, partial
Linear approach	Systemic approach
Powerful, controls information, resources	Powerless

TEN IMPORTANT QUESTIONS ABOUT FAMILIES

1. Outward Appearance
2. Resources
3. Repetitive, Non-Productive Patterns
4. Family Roles
5. Power/Decisions
6. Subsystems and Boundaries
7. Triangles
8. Rules
9. Enmeshment/Disengagement
10. Phase of Life Cycle

TROUBLED FAMILIES

- Dominated
- Conflicted
- Chaotic
- Closed
- Perfect
- Enmeshed
- Disengaged

WHEN TO INTERVENE WITH A FAMILY

- When asked
- When family is in crisis
- At developmental transitions
- When abuse is present
- When a family member is at serious risk

LISTENING SKILLS

1. Have a compassionate, caring concern for the patient/family
2. Cultivate a respectful, nonjudgmental attitude toward the patient/family.
3. Take your time-periods of silence can be useful and healing.
4. Use attentive nonverbal behaviors, such as eye contact and posture, to keep exclusive focus on the patient/family.
5. Use touch in an appropriate, reassuring manner.
6. Pay attention to your voice tone; the speed of your words; as well as these aspects of the patient/family's communications.
7. Encourage description and elaboration through WH questions
8. Help the patient/family to clarify and express feelings through the use of minimal encouragers and open-ended questions.
9. Note discrepancies between verbal and nonverbal communication
10. Attend to, and be willing to make observations about, nonverbal behaviors of the patient/family.
11. Express your own desire to understand the other, as well as, when appropriate, your own feelings of sadness, confusion.
12. Clarify – through paraphrasing and restatement – to make sure you are hearing what the patient/family is saying.
13. Be aware of, and willing to comment on, the emotional as well as the content message of the speaker; Validate by acknowledging that the feelings, thoughts, confusions of the speaker are genuine; it is OK to express emotion.
14. Listen for the questions behind the questions.
15. Provide information and explore alternatives.
16. Encourage patient/family to set goals and plan activities toward those goals.
17. Be willing to set limits with patient/family based on your own abilities, skills, and resources.
18. Summarize and review significant points of the communication.

FIVE STAGES OF COPING

1. Denial

2. Anger, guilt, blaming

3. Bargaining (Hope)

4. Depression

5. Acceptance, understanding

TABLE 4.3

Questions to Elicit Patient's and Family Members' Illness Perceptions

For the patient:

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a long or short course?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?
9. Should we expect complications?
10. What has been your extended family's experience with illness?
11. Has anyone else in your family faced an illness similar to the one you have now? If so, what was its course?
12. What is your and your family's past history of recuperation?
13. What might make healing now a struggle for you?
14. Do you see yourself as having much to live for?

For family members:

15. What changes in family responsibilities do you think will be needed because of the patient's sickness?
16. If the patient needs care or special help, what family members are going to be responsible for providing it?
17. If the illness is already chronic or appears likely to become chronic, what are the patient's and family members' plans for taking care of the problem over the long term?

Source: The first eight questions are taken from Kleinman, Eisenberg, and Good (1978). Questions 9 and 10 are adapted from Seaburn, Lorenz, and Kaplan (in press). Questions 11 through 14 are adapted from Friedman (1991). Questions 15 through 17 are from Shields, Wynne, and Sirkin (1992).

WELLNESS INTERVENTIONS
SOLUTION-ORIENTED APPROACH

"That's the question, now what's the answer?"

Answer lies within family

- What have you done in the past?
- What do you think you're doing now that might help solve the problem?
- What do you think might work?

Answer lies within others

- What do other families do?
- One family I know did ____________.

  Could this work for you?

COMMON PROBLEMS/ QUICK FIX SOLUTIONS

- ♦ Untangling Enmeshment

- ♦ Counteracting Disengagement

- ♦ Behavior Problems

- ♦ Communication Problems

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   1. Successive approximation
   2. Never ignore desired behavior
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XVII. Structural Family Interventions

A. Complaint raised and family assembled

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THE STAGES OF THE FAMILY LIFE CYCLE

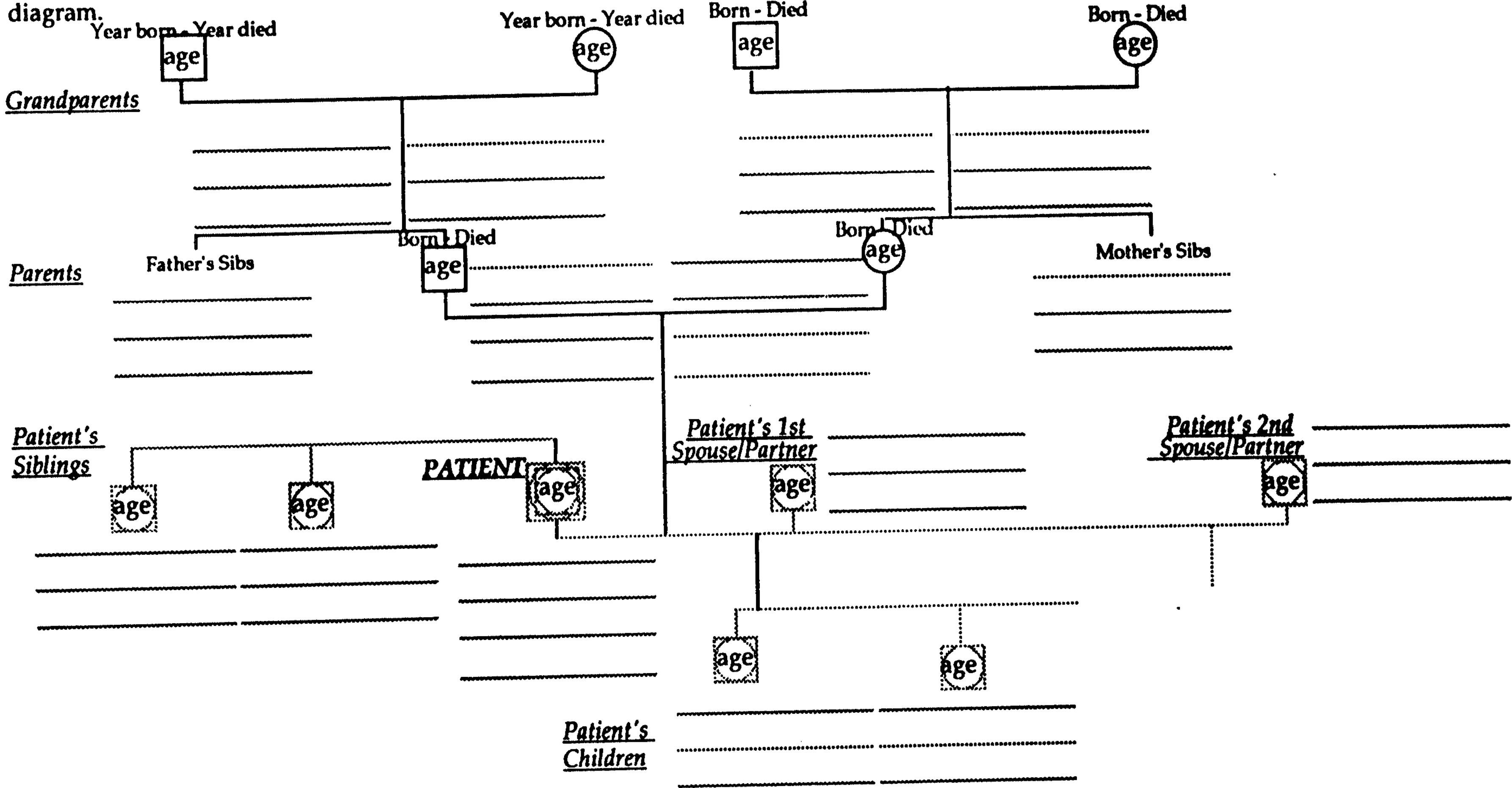
Family Life Cycle Stage	Emotional Process of Transition: Key Principles	Second-Order Changes in Family Status Required to Proceed Developmentally
1. Leaving home: Single young adults	Accepting emotional and financial responsibility for self	a. Differentiation of self in relation to family of origin b. Development of intimate peer relationships c. Establishment of self re: work and financial independence
2. The joining of families through marriage: The new couple	Commitment to new system	a. Formation of marital system b. Realignment of relationships with extended families and friends to include spouse c. Role assignments d. Negotiation of interpersonal boundaries e. Change from self to other oriented perspective f. Satisfactory sexual adjustment g. Skills in conflicts and management
3. Families with young children	Accepting new members into the system	a. Adjusting marital system to make space for child(ren)-competition of marital and child subsystem b. Joining in childrearing, financial, and household tasks c. Realignment of relationships with extended family to include parenting and grandparenting roles. d. Coincides w/career establishment
3a. Child-rearing years	Balancing authority and affection; socialization to larger world	a. Differentiation of role function b. Discipline c. Transmission of values d. Develop self-esteem
4. Families with adolescents	Increasing flexibility of family boundaries to include children's independence and grandparents' frailties	a. Shifting of parent child relationships to permit adolescent to move in and out of system b. Refocus on midlife marital and career issues c. Beginning shift toward joint caring for older generation
5. Launching children and moving on	Accepting a multitude of exits from and entries into the family system	a. Renegotiation marital system as a dyad b. Development of adult to adult relationships between grown children and their parents c. Realignment of relationships to include in-laws and grandchildren d. Coping with physical changes e. Dealing with disabilities and death of parents (grandparents) f. Beginning of disengagement process
6. Families in later life	Accepting the shifting of generational roles	a. Maintaining own and/or couple functioning and interests in face of physiological decline (sexual accommodations) b. Support for a more central role of middle generation c. Making room in the system for wisdom and experience of the elderly, supporting the older generation without overfunctioning for them d. Shift from position oriented to person oriented e. Dealing with loss of [illegible]ouse, siblings, and other peers and preparation for own death. Lif[illegible]view and integration.

Patien Name ________ ________ Date completed: ________

Last name First name

FAMILY H ...TH DIAGRAM INSTRUCTIONS*

Directions: Ask the patient about the ages and health problems of their family members. Ask the name of each member and then inquire: "W... physical or emotional health problems do (did) this person have?" Conclude with inquiring specifically about cardiovascular disease, cancer, depression, suicide, substance abuse, obesity and prolonged disability. If this diagram is not appropriate for your patient/family, please turn this sheet over and draw your own diagram.



TOP

Place Immediately Behind Problem List

Significant Medical History	Significant Psychosocial History
1.	1.
2.	2.
3.	3.

*Developed by Department of Community Health and Family Medicine, University of Florida, Shae Graham Kosch, Ph.D., Larry Kravitz, M.D. and John G. Reiss, Ph.D.

FIVE STAGES OF COPING (GRIEF)

Parents or families of children who have a developmental disability progress through five stages. These five stages are in response to the loss of an expected "normal" child.

The rate at which parents pass through these stages depend upon a number of factors (e.g., their coping mechanisms, spousal relationships, available support outside the family, culture, etc.).

Parents may and frequently do pass through these stages again when they have to cope with a new problem, crisis, or stress. For example, parents may experience these feelings or stages during the following times:

- Diagnoses
- Hospitalization
- Marital stress
- IEP
- Dealing with individuals outside the family
- Placement
- Puberty

The following pages outline the stages of grief, provide a brief description of some of the characteristics you may observe.

Stage	Characteristics of Parents	Possible Support
Bargaining (Hope)	• Having hope is a natural aspect of being human. However, "excessive" or "unreasonable" hope can drain energy, create stress, and set a person up for failure • Parent searches for a "miracle" cure • Parent participates in "alternative therapies" which promise results, but have not documented the process or the validity of the results • Parents shop around for physicians, therapies, programs, services, etc. • Parents devote an enormous amount of time to child, usually to the detriment of spousal and family relations • Parents make "unreasonable" demands of professionals, formal and informal support structures.	• Listen to parent • Explore their feelings and expectations • Be sensitive to whether they are very confident in their expectations or asking for feedback • Provide information about programs/therapies which come from a source other than the program which they are considering • Help them digest and understand this information, and advise consistent with your own knowledge and expertise. • Explore other priorities, responsibilities in their life
Depression	The characteristics of this stage may be mild or severe, but include: • Sadness • Loss of interest, energy • Isolation from others • Crying • "Not caring anymore" • Feeling of inadequacy or worthlessness • Felling helpless, ineffective	• BE THERE • Encourage parent to share feelings • It's OK to feel sad and cry • Reassure parent they are not alone • Support and encourage acceptance of the disability • Allow parents the freedom and emotions to come to terms with the situation • Be alert for suicidal tendencies
Acceptance	• Parents accept themselves and their child • Feel comfortable with parent-child relationship • Parent feels comfortable in dealing with other people, professionals regarding their child • Parents deal more in the present regarding their child	• LISTEN (and learn) • Provide support in areas where parents need it • Realize this parent may again pass through previous stages in times of stress
Understanding	• Sense of being enriched, strengthened by the child's presence • Desire and ability to help others • Attitude of fulfillment • Feeling of having grown as a person	• None: we can learn a great deal from these parents.

FAMILY THERAPY AND FAMILY MEDICINE

I: INTRODUCTION:

A. CONCEPT:

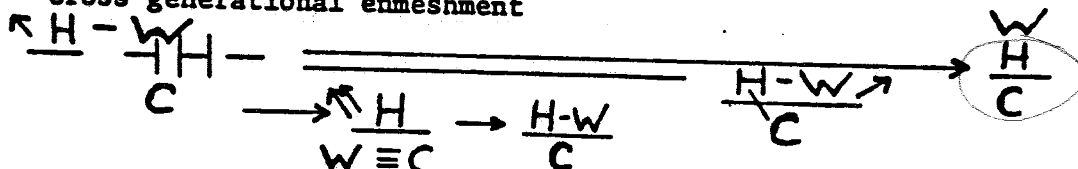
1. In many children psychomatic illness, conduct disorders, emotional disturbances, and poor adjustment to physical disease originate and persist because of dysfunctional patterns of interaction within their families.
2. These patterns are rigidly and incessantly adhered to when the family is assembled.
3. Once familiar with the more common dysfunctional patterns, the health professional can quickly identify these in families presenting for assistance.
4. Then simple strategies can be employed to modify the identified dysfunctional pattern and extinguish the presenting symptom.

B. HOW TO LOOK:

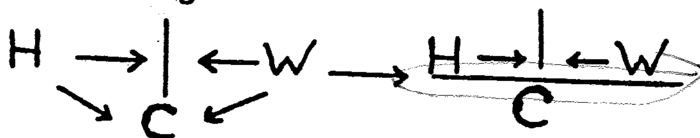
1. You must attend three channels of communications, verbal, paraverbal, and nonverbal.
2. The verbal channel is used by the family to communicate to you the problem they have identified and the various home remedies they have attempted.
3. Small bits of information received through the paraverbal channel can be synthesized to reveal the relationships of the various family members.
4. Communications through the nonverbal channel usually disclose the affective state of the individual. The affect should be congruent with the content of the discussion.

C. HOW DO YOU FIX THEM:

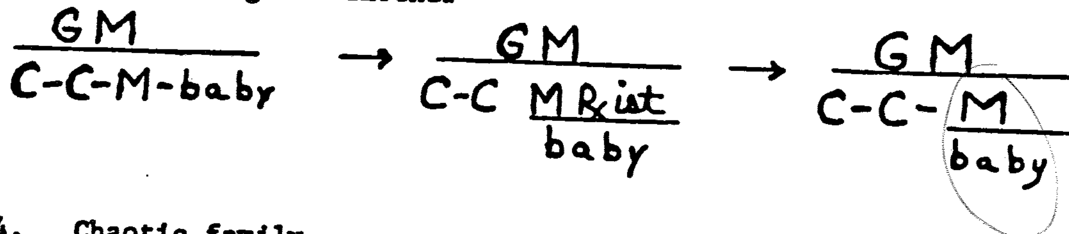
1. Cross generational enmeshment



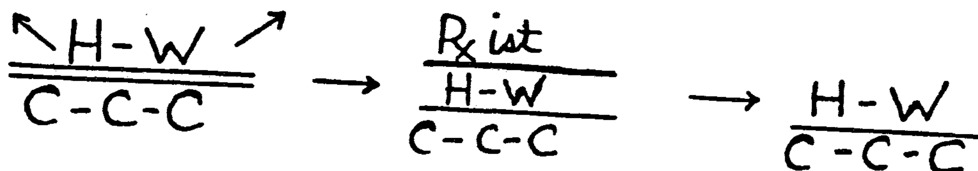
2. Detouring



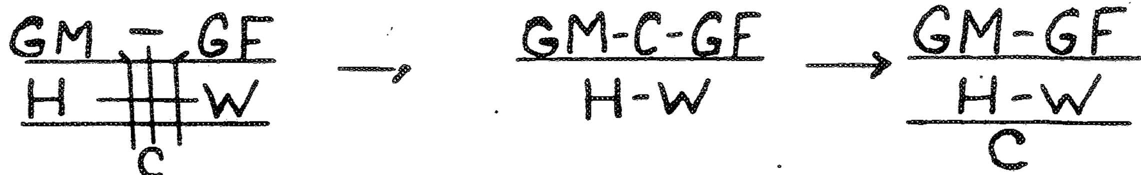
3. Undermining Grandmother



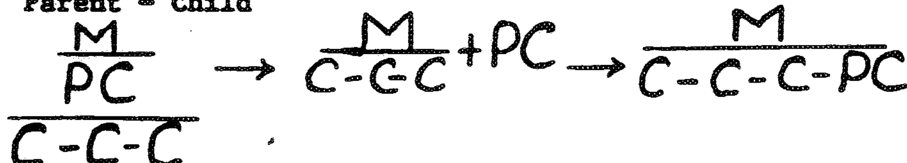
4. Chaotic family



5. Three generational enmeshment



6. Parent - Child



III. SUMMARY:

Rather than recapitulate a trunkated version of this discussion, I shall direct your attention to the two patterns of dysfunctional family interaction which are most important in clinical medicine. Firstly, children often present with physical complaints when they are overly close to their mother and their father is absent or little involved. The intervention in these cases is interposing the father between the mother and the child, enticing the mother out of the close relationship by interesting her in other people or activities and giving her permission to feel guilty about leaving her child. These two therapeutic maneuvers failing, one should push the mother and son closer together and hope the mother's exasperation will distance them. Secondly, the child will present with physical symptoms when these serve to draw the family's attention away from a marital conflict. The child thus supplies the parents a common interest and temporarily detours their emotional energies. In this situation the therapist extricates the child from the conflict, assuring him that he is neither responsible for nor powerful enough to bring about reconciliation. The marital conflict is then either dealt with directly or by referral to an outside resource. Further discussion and practice on how to make the necessary observations, identify patterns, and motivate families to implement directives will be forthcoming in the small groups which follow this presentation.