Chapter

Family Therapy: New Intervention Programs and Researches: Systemic Family Approach in Health Care

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Abstract

Talking about family practice is talking about family systemic approach. There are many cues that are so important to understand how the family functions. This is the scope of systemic family approach, where the health is influenced by all the systems a person belongs. In this chapter, we will discuss how a family interacts and the roles of every person in the family—as individuals and as part of the context. And most of it is how this interaction influences the health of every member of the family. Based on the systemic theory, we will run over some tools that will allow to assess the family and discuss how to ease the communication and to help the family to face their difficulties.

Keywords: systemic thinking, complexity, systemic family therapy, intervention tools

1. Introduction

There is a huge evolution on the health care, medicine, nursery, psychology, pharmacy, and many others fields of care, but most of it has been based on traditional science that analyzes details, but it misses the context.

Many authors had emphasized the need to understand how things are happening and why there are differences between individuals. That is where we find out a new paradigm which is emerging from everywhere but specially in the health field. As the evolution of scientific research in the field of health is more focused on the biomedical model, the emergence of a new paradigmatic movement proposes the reading and understanding of the health/disease interface through the multidetermination of the elements that compose it; according to Khun [1], p. 126, "Scientific revolutions begin with a growing feeling, then also restricted to a small division of the scientific community, that the existing paradigm no longer functions properly in the exploration of an aspect of nature whose exploitation previously driven by the dominant paradigm."

The disease is no longer understood only from the biological point of view, and today it has a very complex conceptual expansion, involving physical, psychological, social, cultural, spiritual, and ecological dimensions.

Systemic thinking does not deny the importance of traditional research, but it is realized that it is not enough to answer the differences between individuals and does not answer many questions about why people suffer of something. So it is necessary to open the mind for these paradigms, where things are complex and complexity will allow the recognition of how to understand and help people and their context to face the challenges life is presenting.

Since 1975, Bertalanffy [3] had introduced the systemic thinking in health assistance, but it was Morin in the beginning of the 1970s who had started to talk about complexity and its implication on modern science. From these time and forward, many authors had produced research over these fields, and one of them—Ian McWhiney, a family doctor—had pointed that there is a need of a new approach to offer a health assistance that allows a view of the entire system and to recognize that the ill and illness are part of lifestyle, relations, and social conditions.

Simultaneously, the biopsychosocial model had been proposed by Engel in 1977, and the family theory had started to produce its first researches. The new paradigm recognizes that there are no observers that are out of the system, and it means that their own knowledge and life story will have some influence in the results. That is a major change in the research field and shows one of the big challenges to everyone who works on this field.

2. Systemic family thinking

As long as it is accepted that the family is a system, part of the society where it belongs, many issues appear to be of concern—first is that any system desires to keep its functionality. As a living system, they want to discover their own rules to work, the society rules that allow interaction with other families and organizations of this community. But also they have to admit that each member has their own necessities and will develop according to their possibilities.

That system needs to grow and differentiate to survive, and any movement in every part of the system can challenge the role of the system. This concept shows the complexity to work on this field, but it opens the possibility to understand why people suffer and in the meantime can have some illness or even if nothing can be done can develop an ill.

Life is very complex; we deal with changes in our body, during the time and with the relations with our family—creating a huge challenge to adapt each one with these. But few persons are aware with these challenges. Mostly, they say that is a phase or a crisis, and they do not realize that each moment can stress the system and can develop some noise on the relation.

Every system has roles that must be assumed by their members, and as long it is well divided, it will work more easily; but most of the time, this task division is unfair for some of the members, and it can create stress factors. Every member of the system has some expectations about the others members, and generally it is not clear for everyone what is expected. Members of any human group will interact based on their feelings, but also over the expectations of their counterparts, but they used to understand the others by reflecting over themselves.

This is the field where a systemic professional must work. And there is much more: every person has been built based on the roles that they found early in their lives, as long as they saw the childhood of their mothers and fathers and how the adults related to each other—everyone brings these in their personality, and the ability to face this challenge is the key to the family success (**Figure 1**).

The fortress that every person possesses is based on the skills developed during the childhood: ability to feed, to bond to each other, to organize life, to be protected and to protect others, to find their own limits and to define others' limits, and how to drive their own feelings in any direction. Their learnings are essential for a person to relate with the world that surrounds them. But friendship, affection, and sexuality are also developed in this environment [3].

It is clear that knowing about the family development allows the professional to have a better understanding about the difficulties that have been faced

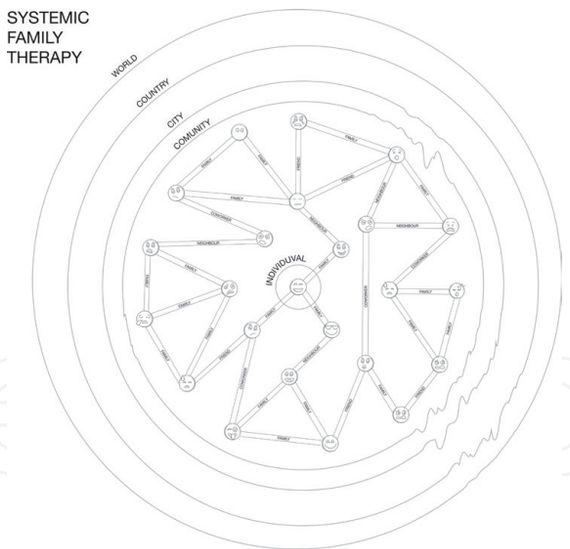

Figure 1.
Schematic functioning of the family system.

by individuals and groups. And the way to describe these situations needs to be understood in order to allow a therapeutic approach and offer some paths to people to have a better life.

3. The steps to working with families

Working with families can be divided into different steps in a different way for better explanation and understanding [6]. The use of these steps depends on the given situation and the needs of each family served. The following phases can be identified schematically: association, evaluation, health education, facilitation, and reference.

3.1 Family connection

Associating with the patient and their family is a fundamental requirement for the construction of the therapeutic process that should be actively pursued. The interaction of the professional with the patient is rich when the former can respect the reality and beliefs of the latter, which is often very difficult. The reality of people's lives is very diverse and demands from the professional a careful observation not to slip into attitudes centered on their own way of seeing life and to believe in solutions based on their core of knowledge. Almost all people receive good advice when they reflect their way of seeing and feeling an item; the attitude of the professional to perceive the situations by their angle of vision can put him in confrontation with the patient and his family, leading to a break in the relationship between them.

Often the professional's lack of practice in working with families leads to the difficulty of understanding why it is necessary to meet with family groups or even to visualize the feelings of each patient. Freire [7], in one of his several texts on pedagogy, approaches in a very clear way the need for the perception of personal experiences in the construction of effective communication. For this communication to take place, it must be based on the lived reality and be of adequate complexity to the person to be reached.

The professional who intends to perform his task of promoting the health of the community where he serves should be able to seek association with patients and their families. In order for this attempt to be achieved, there are some important steps to remember:

1. The moments of contact with the patient and his family are all precious; sometimes a relationship established over time can be broken by disrespecting family beliefs or hierarchies.

2. When it is proposed to contact a patient's family, it is often difficult to see the professional (who is not clear about why a family interview is being conducted) or the patient (who fears losing his status with the professional when the other family members participate).

3. There are pitfalls that this type of intervention can easily expose the professional: family members try to triangulate with the professional, lateralization of communication with one of the family members, the use of language inappropriate for that family group, and disrespect to the group hierarchy and their communication times.

4. The association with the patient and his/her family is the key to making primary health care no longer just a health model, a fad, but actually promoting an improvement in the health and life of the communities served.

The association is initiated when the patient brings to the professional a situation where the family (or the group with which it interacts) interferes directly or indirectly in the process. Often the role of the identified patient is compromised by a clinical or social intercurrence, necessitating adjustments in the family structure, which is a very rich moment to establish a partnership with the group.

3.2 Evaluation

Once the bond with the family has been built, it is important to evaluate it through analysis tools that allow, in a more objective way, to perceive the functioning of the group being studied. These tools seek to explain the power and decision lines of the family, their way of perceiving the health and disease process, their natural resources, and their internal and community support [8]. It is from this analysis that the intervention plan will be proposed, recognizing the belief of the family in the process of becoming ill and negotiating with it an action plan that respects their way of life.

The evaluation of the family group, a clinical task of situation analysis, allows the primary care professional to understand the ways in which the different health conditions arise, such as why alcoholism has a high family incidence or why a patient with hypertension has difficulty controlling their hypertension. Minuchin [9] describes the situation of identical twin sisters with diabetes mellitus who had unequal control of their disease; when analyzing the family relations of these girls, it is found that the one who had a bad control of the disease was the one that triangulated with the parents in their problems of relationship—whenever they fought she made a crisis in their diabetes. It is common to comment in classes on hypertension that if the patients follow the professional's guidelines, they would not have consequences of their disease, but unfortunately the hypertensive patient is very difficult to deal with. This frustrates the results even though the new medications available are highly effective.

The proper evaluation of the role that the person carrying the disease has in his/her family structure (how this illness is perceived by the various components of the group, in what things they believe or like to do) gives the professional an intervention power that increases in the proposed intervention. The use of alcohol in family rituals and their insertion into happy times said by the family lead people to have difficulty understanding it as a health hazard or to glimpse the frequent drinking situation as an initial step

toward addiction. Any intervention that proposes to face the problem of alcoholism should consider its symbology for the target group and use the lines of force of this group to obtain an adequate result in the prevention and treatment of the pathology.

Coping with chronic diseases such as hypertension [10] should understand how the patient and his family understand the disease, translating into their language what hypertension is and how the modification of habits can influence the evolution of the process. This type of negotiation is only possible if the process of association and evaluation has occurred satisfactorily, which will allow more consistent and long-lasting results in the follow-up of any patient.

Among the evaluation tools that we can use in primary care, we will list some that are particularly useful, focusing briefly on its use and application. Beginning with the genogram [8, 11], which is an auxiliary graphic instrument in the identification of patterns of repetition of pathologies and behaviors, allowing a quick visualization of the actions to be developed by the study family.

The family life cycle [8, 12, 13] is another powerful tool that identifies situations where the onset of dysfunctions is more frequent. It is in the transition phases where the family is challenged to structure a new pact that stress grows, allowing the emergence of diseases. The life cycle analysis allows the family to assist in understanding the tasks that must be fulfilled in order to cross these transitions.

A third instrument is the social network [14], which allows us to glimpse the support and beliefs of the family. It makes it easier to see who are the key people for the search for support and on what cultural basis we will be interacting with the family. The richness of contacts and community structures allows the search for solutions from the very core, creating the bases for self-care.

Fundamental Interpersonal Relations Orientations (FIRO) [8, 15] is an instrument that analyzes the family from the dimensions of inclusion, control, and intimacy. Inclusion is the starting point—what is to be understood in the levels of group structure, beliefs that provide the behavioral guidelines of the group, and the roles to be played by each member for the harmony of the group. Once included the individual develops some type of control within the group and established the type of control conditions are created for the development of intimacy. FIRO provides conditions to understand the meanings of the different processes that occur in the study group, helping in the planning of the action.

There are a number of other family assessment instruments that can be used in accordance with the training and preparation of the primary care professional, and this chapter does not aim to exhaust the various instruments to exhaustively detail those mentioned. In bibliographical references, suitable material can be found to study these and other instruments.

3.3 Health education

The next step in working with families is, through proper communication, initiate a health education process that leads to the development of self-care and healthier lifestyles [6, 16]. Constructing a moment of health education and anticipation of situations that allows the family and the patient to understand the process of becoming ill and how this can impose changes and restrictions on their lives is one of the central points of the professional primary health care.

One of the key moments in introducing concepts of health education is when the family or the patient seeks the health team to solve a problem. At this moment, an adequate explanation about the process of becoming sick that gave rise to the demand takes the client in a very receptive situation to deal with the information. This is, in fact, one of the principles of adult education—adults only learn new knowledge when they make sense in their lives.

At this stage, it is necessary to remember that culture is not something learned only in schools, but the living and doing of the population are also expressions of it, and that to perceive this culture is the best way to promote any change that is intended to develop. The limit is given by the community itself, which has its parameters and beliefs, on which the professional should work. In order to promote any change, it is necessary to level the information to the customer's perception capacity, help him to perceive the situation, allow him to take the step of growth, and only then provide new data or present them with greater complexity. Health professionals are often seen blaspheming the community for not following their guidelines and thus not improving their health status. These professionals forget that it is not the community's lack of capacity to listen to them that hinders them but their own inability to give meaning to the information they wish to convey.

Working health education is the initial step for the community and its sick members to change their focus and habits in dealing with illness or risk situations to get sick. Since it implies a change of habits and attitudes, this education must be based on the history and experience of the people that one wishes to benefit. This is one of the fundamental principles of "working with families," because the basic goal is to help them find their ways and promote healthier lifestyles. The strategy of this education is to pay attention to the information that the community brings us, valuing the "tips" that are said in a veiled way and respecting the power lines of the community. If, for reasons of lack of training or fears of going into certain subjects, these moments are lost, the opportunity to provide alternatives is lost. Not realizing influential people in the community and how they see and deal with health issues will often lead to opposition from the proposals put forward. The correlation of forces, in most cases, is unfavorable to health teams.

3.4 Facilitation

Another basic element of working with families is the facilitation of communication among their members, a task that requires an adequate understanding of the family hierarchy and the way the group presents itself [6]. According to systemic theory, people tend to maintain, through their negative control mechanisms, the rules and positions they occupy in the structure. This often leads to communication blockages, which form the basis of stressful situations triggering the process of becoming ill. The primary care professional, because of his unique position in the community, can identify these blocks and through programmed actions allow an adequate exchange of information and feelings that facilitate the maintenance and recovery of the family health under study.

One of the great keys to the success of communication facilitation is the FIRO tool, which allows us to perceive the structure of families and their power relations and exchanges of feelings. With this knowledge, it is possible to identify the allies and impediments for communication to flow, as well as the determinants for the perpetuation of pathogenic situations. Always remembering the systemic theory, communication can be stimulated by participating in the communication rings of the family, discussing the determinants of the life processes of that family group and making an arc of reflection in which they perceive where they come from, where they are, and where they will go. This arc of communication projects the family a sense of unity and direction, allowing the health team to be valued as a link to foster family growth, gaining credibility and efficiency in health promotion.

Communication in situations of illness or conflict requires the primary care professional to take care of the perception of feelings of guilt and the situations of balance that the group presents. An interesting strategy may be the assembly of familiar sculptures, where the team reproduces the family grouping in a stylized

way, trying to see who is leaning on whom and how the modifications can produce disturbances in the dynamics of the family group. Working with families is rewarding but requires professional dedication and commitment. The lack of perception of the family dynamics can compromise the effect of the intervention and lead to unsatisfactory results in family communication, without the expected improvement of the process. Situations of serious illness or impending death tend to put the family in a great stress, with the communication being made in a choppy way and filled with guilty silences. The work of facilitating communication enables people to explore their feelings and clarify their doubts, reducing the "silence pact" that is associated with depression and the worsening of pre-existing illnesses.

The construction of this proposal involves the discussion of the framework, with respect to hierarchies and lines of communication of the family, considering their taboos and without failing to clarify the process and the causal agents of the process. Important people in the family structure, even if not belonging to the grouping, should be invited to participate in the process so that the communication reaches the desired level of exchange. This avoids the persistence of shadows in the communication, which can make it less satisfactory. The attitude of the professional during these family gatherings should be to stimulate the exchange of feelings and expectations between the components, in order to facilitate the interaction and to clarify the doubts that exist about the pathology and its progression and the available treatment alternatives for the case.

3.5 References

In cases where it is necessary to refer the family or their patient to more complex levels, the technique of working with families also proposes a more interactive way: the reference is made explaining the reasons why the case is being addressed and which one's results are expected from this reference. In addition, contact is made with the referenced professional in order to accompany the patient and give subsidy on the situation experienced by the family during illness. This communication process increases satisfaction with referral, in addition to allowing more satisfactory results, because it gives confidence to the patient and his family, guarantees information to the reference professional, and enables the primary care professional to follow up the case on a continuous basis. This follow-up also allows for the clarification of the results obtained with the consultancy, in clearer terms to the patient and his/her family.

A final characteristic well emphasized by Papp [17] is teamwork. The view of several professionals about a given situation allows a better perception of the case under study, guaranteeing a broader vision and a result closer to the aspirations of the community. The shared look glimpses the various faces of the familiar kaleidoscope, which facilitates the understanding of the process of becoming ill, increases the capacity of identification of community resources to support the case in question, and prevents pathological attitudes in the relationship of a professional with the family group.

4. Genogram

In follow-up and family studies, understanding their natural history and patterns of illness may potentiate the action of health professionals. In this way the need arises to be able in a simple and objective way to create an instrument that shows graphically the structure and the pattern of repetition of the familiar relations.

This instrument is developed in North America to facilitate the understanding of families, based on the model of the heredogram, therefore called "genogram." Its basic characteristics are to identify the structure of the family and its pattern of relationship, showing the diseases that usually occur—the repetition of the patterns of relationship and the conflicts that lead to the process of becoming ill.

The instrument, useful to the health team, can also be used as an educational factor, allowing the patient and his/her family to have a sense of the repetitions of the processes that have been occurring and how they are repeated—facilitating the insight necessary to follow up the therapeutic proposal to be developed.

As long as the family has been drawn, they can realize its connections, strengths, and the pitfalls presented by their history, a very useful tool to start a communication process and to build up partnership.

5. Development of the family and the individual from the systemic perspective: family and individual life cycle and the impact of the illness

The systemic perspective for individual and family development is based on the concept of the life cycle, formulated by the sociological theory of the family, where the family life cycle and the individual life cycle fit together through interrelations of circularities and recurrence.

According to Graham [2], the family systems development model emphasizes changes in the developmental cycle of the family and individual life cycle, introducing a very important perspective in understanding the events of family life.

The concepts of ecology and the modern orientation of biology comprehend these developments in an interrelational and interdependent way, building maps of intersubjective for understanding the family and its members. Graham [2] highlights an important lesson of the ecological view "that no matter how conscious we may be, and how our actions may be deliberate, our acts become a part of a pattern whose form and effect generally exceed our understanding. An important point is that if this change happens within each individual and its subsystems, it will produce second-order changes that will, in the process of intercommunication, reverberate throughout the whole system, producing a kaleidoscopic rearrangement of each member."

In the systemic perspective, family and individual relational life is mediated by the passage of time and in the biological-social-cultural-psychic-political developments and transformations arising from this complex phenomenon.

Hoffman (in Graham) [2] argues that development is not a continuous process but characterized by transformations, second-order changes, and sudden emergence of simply nonexistent, more functionally organized patterns.

Not being considered in a linear fashion, as concatenated cause and effect events, the development of the family and the individual incorporates the notion of the dynamic interrelationship and the processes of recursion and equifinality for elements that belong to complex systems.

Graham states that "The family life cycle is not a linear event, it does not begin with a phase nor end with the deaths of members of a specific generation. Indeed, because death can happen at any stage in the family life cycle, it is not an event of life cycle but a life-changing event. That is to say, death is an event that happens within the context of the life cycle and can affect its evolution profoundly" [2].

Proposals on the definition and identification of family and individual life cycles contribute to the development of understandings about bio-psycho-social-cultural events in these moments of change, with the concept of crisis as a propelling event for cycle changes.

The energy of the crisis is understood in these evolutionary models as a propulsive force, occurring when the previously efficient adaptive mechanisms are not enough to maintain the stability of all intra- and extra-familiar movements, being necessary the application of new resources for its internal restructuring.

According to Wynne [18] there is a methodological problem in the study of the family life cycle, which would be to not reach an agreement on the number of stages that should be recognized. According to this author, the family life cycle has been subdivided by different authors, between 4 and 24 stages.

The interrelational versatility of the human being is an efficient destabilizer for the normalizations; in this way, every age of family and individual development presents new possibilities for solving the continuous process of belonging and individuation, perpetuating the task of maintaining and producing our personal and family histories, so that new stages and crises are redefined and localized.

One of the proposals used is related to the inter- and intra-oscillations [2], between periods of family closeness, periods of naturalness and entanglement, non-problematic periods, and periods of family distancing. This author finds four oscillations during life about events in an individual's development: birth, childhood, adolescence, and adulthood.

It also emphasizes that from the perspective of the family as a system, it understands these oscillations as having the function of providing a basis for the practice of intimacy relations and ego updates, in experiencing different levels of maturity and in the different tasks that the individual develops in the family.

Another proposal is the one used by Monica McGoldrick and Bety Carter [12], emphasizing the importance of a growing and integrative expansion of cultural-social-political-gender-racial differences in the understanding and manipulation of the life-cycle concept.

"We are born into families, our first relationships, our first group, our first experience with the world, happen to and through our families, we develop, grow and hope to die within our family context. a socio-political culture, takes shape and movement involved in the matrix of the family life cycle." McGoldrick and Carter [12], p. 1.

The authors understand the phases of the American family: becoming an adult, leaving the house, becoming a couple, family with young children, transformation of the family during adolescence, casting the children and moving on, and families in the late stage. Each of these events is accompanied by emotional processes characteristic of their transition and by expected developments for the second-order changes necessary for family development.

Galano [19] proposes the understanding of the family and individual life cycle through complex epistemology, taking into account differences and regularities, promoting the idea of dialogic experiences with family and individual events and their significant pluricontexts.

In this way, it uses the intergenerational, multidimensional, and multicontextual contingencies for the management of the family and individual life cycle with all its constituent elements.

"Intergenerational because the evolution of the family interferes and disrupts all members, both the nuclear family that is being constituted and the family of origin of the couple. Pluridimensional because functions, roles, values, feelings are subject to change and these do not always occur in the same way at the same time. The moments of passage from one stage to another face conflicts of interest, both 'within' members and 'among' family members. Cultural, religious, moral, racial, ethical, socio-economic contexts". Galano [19], p. 223

In a study that is closer to our Brazilian reality, which is so rich in values and cultural characteristics, the research carried out by Cerveny and Berthoud [20], recognizing the singularities of our Brazil, makes a cut for the study of the life cycle by the middle-class family of São Paulo.

"We do not feel very comfortable when we talk about the Brazilian family, for example. The diversity of models, the breadth of the territory, the different settlements, the miscegenation, the immigrations, the monstrous socioeconomic differences that exist in our country make it difficult to the generalization of a Brazilian family. The impression is that we have many Brazilian families, which are not only defined geographically, but which suffer many other influences". Cerveny and Berthoud [20], p. 33

This author organizes the middle-class São Paulo family in four phases: the family in the acquisition phase, the adolescent family, the family in the mature phase, and the family in the last stage.

Through the temporal perspective, this instrument organizes and constructs the history of the family and the individual and makes the understandings about the changes caused by the impact of difficult circumstances experienced by the family and its members, which are better defined, according to the possibilities, functions, potentialities, and limitations of each phase.

The concept of life cycle is an extremely useful tool in understanding the intense complexity that surrounds the developing family and individual life and its interrelationships with the environment; I consider one of the central elements of the systemic theory, for understanding the developments of the family.

6. Working based on the family system

The development of the family and individual life cycle, in its interrelations with social, cultural, psychological, biological, religious, gender, and geographical circumstances, produces coping resources for crises whose purpose is to deal with the problem of disease by protecting the system of any threat in its interactive dynamics.

The understanding of family dynamics with the lens of systems theory makes it possible to understand the interactional phenomena through the Morin [21] complexity theory proposal, understanding in this way that there are several significant events in family and individual life that must be understood from a perspective of difference and belonging.

Illness is part of one of these complex family interactions, which mobilizes various sectors of our society and culture and causes intense transformations in family and individual life and throughout its life cycle.

"In the arena of physical disease, particularly chronic disease, the focus of concern is the system created by the interaction of a disease with an individual, family, or other biopsychosocial system. From a familial point of view, family system theory has to include In order to place the unfolding of chronic disease in a developmental context, it is crucial to understand the interweaving of three evolutionary lines: the disease the individual, and the family life cycle thinking in an interactive and systemic way at the interface of these three lines." Rolland [22], p. 143.

This author posits that a serious illness happens as a blow to the family and turns into a point of reference by constructing or revitalizing interactions, from this moment on. Some diseases dismantle the future predictability of family and individual life in terms of the medium and long term.

Families in their multigenerational relationships have had experiences with illness and loss and also use these experiences and beliefs as an aid and guide in coping with the disease in the present time.

In this way, clinicians and families need a more effective way to work in the field of clinical consultations, applied to the development of any disease, which makes it possible to look at the future in a more collaborative way by updating the actions developed in other moments of the cycle vital part of the family.

"A scheme that conceptualizes chronic diseases and their relevance to psychosocial interactions is necessary, introducing into the biological world a common metalanguage that transforms or reclassifies the usual biological language. Chronic diseases need to be reconceptualized to some extent, this would organize the similarities and differences of the course of the disease, so that the type and degree of demands relevant to psychosocial research and clinical practice is highlighted in a more useful way." Rolland [22], p. 145

Rolland proposes for this planning the need for coevolutionary understanding of three structures: the disease, the individual, and the life cycles. It is necessary to consider the changes that occur, through the intercommunication between the life cycles in the family and individual life.

In the systemic understanding of this model, there is an interaction between the structures, the disease, the individual, and the family life cycle. Two main concepts are important for a more objective understanding of this interaction: the life cycle already discussed above and the structure of life.

By structure of life, Rolland understands as being those underlying patterns that are taught and form the family, the way they live and how does the family function at any point in the life cicle. Its main components include profession, love affairs, marriages in the family, functions coordinated by the family in various social situations, relationships between individuals and individuals with themselves, and the helper functions. The family life structure forms a barrier between the family and its members and the environment governing and mediating their relationships.

The structure of life is present throughout the life cycle and attaches importance to significant events during the changes required in each phase.

The key issue is that there is the notion of development in the life cycle sequence, including individual, family, and disease structure. This will have great influence of the cultural, socioeconomic, gender, ethical and racial diversity context.

To systematically think about the interface of these three lines of development, a common language and the organization of some concepts to be applied are necessary, considering the three structures simultaneously.

Two main steps are based on this model: (1) The need for a bridge between the biomedical and psychosocial worlds, a language that allows the chronic disease to be characterized in terms of psychosocial and longitudinal, and each of these conditions has specific characteristics and during the vital cycle appears with different demands. (2) Need to think simultaneously about family and individual development.

Rolland believes that a major impact on the relational life of the couple and their lives occurs in the event of a chronic illness. It proposes the family systemic model for work with diseases in interface with families and individuals. It is also a preventive work, which offers a framework for assessment, intervention, and support for families who are involved in the problem of chronic disease and living conditions being threatened.

This model is based on the systemic interaction between family and disease throughout the time. A good relationship between the demands of the disease and the family style of functioning and capacity building of the family are important determinants for the success or the location of dysfunctional resources and difficulties of adaptation.

Rolland points to the interface scheme between chronic disease and family and states that the variation of family conditions include the family and individual life cycles, the relationship with the life cycle and the stages of the disease, multigenerational legacies referring to the disease and loss, and the belief system. Not believing that it is possible to understand all the factors that compose the chronic disease problem and the family life cycle through the medical model emphasizes the intense importance of the social context of diseases and disabilities.

Family experience of illness and disability is strongly influenced by the dominant culture and health system affected by this culture.

In these conditions, he cites the incidence of diseases, the course of illnesses, the question of quality of life, and several other causes of suffering as produced by social discrimination. In the less privileged groups, it states that chronic diseases may be more prevalent and may occur earlier and in a more intense way, with a more difficult course due to problems with medical care and limited access to treatments.

Due to the technological advance, one can live a lot with a chronic illness, but this situation is often not experienced in the most deprived social strata, affecting both the family's capacity to organize resources for survival in prolonged periods of care and the individual development of its members in relation to all the demands produced by the chronic disease.

There are difficulties in integrating psychosocial work with traditional health services.

Today, many families can organize social network resources to help care for people with disabling problems, but never without spending extreme energy and effort, causing significant changes in their daily lives.

Rolland proposes the construction of a psychosocial typology of the diseases, organized in such a way that it contributes so that the family and clinicians have a form of understanding and action directed toward the integration of the preventive and curative structures.

These phases take into account the idea that diseases have a very significant temporal development peculiarity, just as each phase of the life cycle brings about the necessary relationships and behaviors, in the same way the disease in its development requires the mobilization of conduits within the cycle of individual and family life before healing or dead.

The first of these phases is the onset of illness: according to Rolland, diseases can be divided into those that occur suddenly and those that appear gradually, such as Alzheimer's disease. For sudden illnesses, emotional changes and more practical behaviors are required in a very short time, requiring the family a fairly rapid mobilization in the management of skills. Families who can tolerate explosive affective discharges, flexibility in changing roles, problems solved efficiently, and using external resources have more advantages in dealing with sudden illnesses. Gradual onset diseases such as Parkinson's require a longer adjustment period.

The second phase is the course of the disease: the course of chronic diseases have three general forms of progressive development, constant or with sporadic episodes.

Progressively, the family encounters a member with a constant symptom, in which the disability occurs gradually. Rest periods are rare due to the demands of the disease. The family lives in an ongoing process of change of function and adaptation due to disease progression. Increased exhaustion and effort of caregiver members occur because of increased demand for disease symptoms, and often the inclusion of new caregivers should occur.

Family flexibility, in the sense of internal reorganization of functions and ability to use external resources, is an excellent feature.

With the constant course of the disease, the occurrence of any event is followed by a stable biological event, for example: heart attack or severe pain in the spine. After a recovery period, the chronic phase is characterized by a period defined by a deficit or limitation. Returns to phases can happen, but the individual and the families face semipermanent changes during the course of life, so the possibility of family exhaustion exists, no matter how much effort new functions demand over time.

Relapses, or acute episodes such as asthma or disk problems, are distinguished by periods of stability and acute reactions. Families may return to more stable

periods, but the spectrum of relapse always remains. Relapses require families to have different attitudes toward the adjustment process. The family is called to order in periods of exacerbation of crisis brought about by the disease. The tension in the family system is caused by the frequency and transition between periods of crisis and normalcy and by the uncertainty of when a new crisis will occur.

The result in these circumstances is the profound psychosocial impact that chronic, fatal, or episodic disease causes in the course of life. The most crucial factor is when the disease can be a sign of fatality.

In the continuum of the history of the disease, there are those that do not affect the period of life as much as arthritis (at the other extreme, there are progressive and fatal diseases such as cancer metastasis) and, in the intermediate area and in a more unpredictable category, those that shorten periods of life, such as cystic fibrosis or heart attack, and those with the possibility of sudden death, such as hemophilia.

The major difference between these three structures for the family is the experience of anticipatory losses and the effects of these circumstances during family life.

The future expectation of loss may cause difficulties in the family with the management and control of future perspectives. The family is almost always struggling between maintaining intimacy and keeping the sick member away from the occurrences of family life.

Varied, expected emotional reactions are important and can distract the family in its role of maintaining actions to solve problems that would maintain family integrity. The family, prior to the death of the sick member, or their responses to the disease situation are difficult and can lead to ill-adapted interactions, thereby withdrawing the sick member from the problem-solving space and responsibilities previously obtained.

Isolation of the diseased limb occurs in these situations, and in most cases this situation is related to a lack of medical management to inform the family about possible management for the continued treatment of the disease. When the loss is imminent or certain, it provides a fertility of emotional reactions and familiar verbalizations. Being able to create relationships varies between overprotection and secondary gain for the sick member. This situation is more relevant in situations of juvenile diseases such as hemophilia and diabetes.

When disability occurs, it may involve cognitive impairment such as Alzheimer's disease, sensory impairment such as blindness, impairment of movement such as paralysis, impairment in endurance such as heart disease, mutilation such as mastectomy, and conditions associated with social stigmas such as AIDS. The type and timing of disabling illness imply significant differences in the degree of family stress. The combination of one or more disabilities requires the family's intense reorganization of functions.

In some diseases the disability starts less severe and can go slowly worse, which gives the family conditions to organize functions and gives the sick member participation in planning as well. Combining types of disease onset, course, outcome, degree of disability, similarities, and differences in psychosocial patterns and their demands are crucial to offer a good care.

The question of uncertainties, for Rolland, refers to the degree of predictability and unpredictability of each disease, the specificity of each path, and what will be its consequences; all these doubts produce in the family often interrelationships and constructions of ambiguous beliefs.

For diseases with an unexpected course such as multiple sclerosis, the resources that the family can develop or already have, and their ability to adapt, especially future plans, are delayed or can be redone due to anticipatory anxiety and the inconstancy of events.

Families who can build long-term perspectives and jointly work with uncertainty, sustaining hope, are more prepared to avoid risks of exhaustion or dysfunction. Frequency, complexity, and efficacy of treatment, all situations involving the hospital and the cause in the patient's care, as well as the frequency and intensity of symptoms, are important issues, differing for each disease in terms of their characteristics and which should be considered from an evolutionary and systemically oriented perspective.

In most discussions about resources to fight against cancer, disability management, or agreements with how to situate the disease in everyday life, the understanding of the disease appears through a static form rather than the perception of the disease having a process over time.

For Rolland, the concept of temporal phase for each disease enables the clinician and families to think longitudinally and understand chronic disease as a process, with situations that transpire over time and with expected limits, transitions, and changing demands.

Each disease presents distinct phases, with psychosocial demands, and the development of attitudes, concerns, and tasks that require effort and changes for the family. The main themes related to the natural history of the disease can be described in three major phases: crisis, chronic, and terminal.

Crisis phase includes any symptomatic period prior to diagnosis and the initial period of readjustment after diagnosis and initiation of treatment plan. This period brings together a significant number of skills and tasks that must be developed and/or already exist in the family and the sick member.

Rolland informs about some universal practices that must be learned to coexist with chronic disease problems: understanding and learning about coping resources for symptoms and disability, adaptation to the treatment site, and establishment of a productive working relationship with the treatment team. The family must create meaning for disease that maximizes a sense of competence. Family members must face the mourning of life they had before the disease appeared in their lives. They need to understand illness as permanent while maintaining a sense of continuity between their past and their future. They need to organize together coping resources for the eminent crisis situation. When the crisis is about to happen, they need to develop flexibility in the face of future projects and reorientation of dreams and hopes.

Chronic phase, whether long or short, is the period of the cycle between the initial diagnosis and the readjustment and construction of the family's actions for the care of the sick member, where the questions about death and terminal illness predominate. This area is marked by episodes of constant progress or episodes of change. It is the day to day with chronic illness, those difficult moments that drag on for months or years.

The family and patient must build coping reactions and/or use the strength they have in organizing permanent changes and organize attitudes and behaviors that lead to a more comfortable day-to-day life for all of their members. The family's ability to keep matters current with chronic illness is the key to living through this period. If the disease is fatal, it is a very dense, difficult period where the passing of days is slow and intense commotion. For progressive and debilitating chronic diseases, the family feels tired having to deal with an exhaustive and endless problem.

In the terminal phase, the inevitability of death becomes apparent and dominates family life. The family deals with issues of separation, death, mourning, and the question of the reconstruction of family life after the loss. A sign of good transition happens when the family succeeds in letting go, emotional opening, seizing the opportunity to share time together, talking about unfinished business, and saying goodbye. Decide with the sick person about situations or objects for the family to live better, how far medical conduct, about the death at home or at the hospice, and

the wishes on the funeral. These conversations, in fact, should be made in advance if there are progressive illnesses.

Rolland calls the clinical transition the transitions in the phases of illness that refer to the periods lived at each moment and its consequences and circumstances. There are periods in which the family reassesses their competence in the period prior to illness, in view of the demands of the disease in the current phase. Situations that have not been resolved during the previous phase can hinder or block transitional phases. Families and individuals may get frozen in structures that have been built in unsatisfactory survival ratio.

Each period has its specific task independent of the type of disease. Each type of disease has specific supplementary tasks.

This way of understanding chronic illness and family impact, through the choice of the systemic model, produces very useful clinical implications because it facilitates understanding and intervention in families with serious health problems along with the possible psychosocial disorders that accompany these circumstances.

Rolland draws attention to the following questions related to the characteristics of the diseases: aspect at the beginning of the illness, course, results and consequences, and inability. Acute diseases require a high level of adaptation, problem solving, function reorganizations, and balanced cohesion. Under these circumstances, helping families to maximize flexibility may be an important therapeutic interaction for a more satisfactory adjustment.

Each period of a disease delineates a characteristic type of psychosocial development; each phase has the development of its own abilities. It is important for families to be informed of their successes and know how to recognize them, to maximize the continuum of adaptations in the daily life of chronic diseases. Attention to the period and its requirements helps clinicians to access family strength and vulnerability in relation to the present and future stages of the disease.

These actions clarify the treatment plan by locating family characteristics relevant to the type and stage of the disease, sharing the information with the family, and helping to build objectives in a realistic way, giving the family a sense of power in their care journey of a member with chronic disease. Producing a pedagogical interaction with the family about the important signs of the illness, and re-orientation of the objectives in the treatment if necessary.

Rolland advises on the conditions of the family and the resources they have available if they combine with the transition points of the life cycle of the disease. Helping to approach the illness and the person who suffers it, and to develop an economic planning in terms of prevention.

During family living with the disease situation, it is extremely important to take into account, according to Rolland, the family beliefs about the meaning of the disease for the family, the family medical plan in a crisis situation, the family's ability to conduct in-home treatments, family communication when disease-oriented, problem solving, the reorganization of function, emotional involvement, social support, and the use and feasibility of social support.

For Rolland, the transition phases are the most vulnerable, because previous structures of the family, individual, and disease life cycle can be reintroduced in the form of new developmental tasks, which requires greater discontinuity in interactions rather than minor changes.

Often illness and disability tend to force the process of individual and family developments into transition and increased cohesion.

For example, in the period of education of children, if a disease happens at this stage, or shortly after this stage, a derailment may occur in the natural course of family development. A disease or disability in young or adolescent adults can develop relationships of extreme dependence and return the family cycle to the childhood care phase. The construction of autonomy and independence is in danger.

Parents need to review their plans in the social sphere to organize more care in the care of the sick person. As disease occurs in certain stages of the life cycle, it is likely that this moment may suffer from an extension in its manifestation.

When the disease appears in one parent, their ability to stay in course in the development of care and interaction with their children is severely affected.

In a more serious situation, the impact of the disease is like the arrival of a new child in the family, who has special needs and will compete with the children present; this situation can cause quite significant psychosocial changes, interfering in obtaining resources for help.

The illness captures the sick parent, and his relationship with the children is compromised. In many cases the family does not have the resources to function simultaneously with the demands of the disease and with the care of the children.

Often older children are called to share responsibilities along with other family members. All of these structural changes may be familiar supportive features, and clinicians need to be careful not to pathologize these interactions.

In this way, there is an intense interaction between the characteristics of the diseases, the circumstances in which they appear in the family and individual life cycle, and the consequences affecting all involved in this context.

Severe antisocial behaviors may occur more in adolescents, in the form of reactive or more constant peaks, worsening school performance, and reactions of isolation with the pairs of friends and with the members of the family; there may also be beneficial situations such as reorganization of sibling functions, increased sense and belonging and responsibility, restructuring in family relationships for more beneficial and rewarding interactions.

Qualifying and monitoring the solutions found by families is one of the great therapeutic resources in the follow-up of families with chronic, disabling, or fatal illnesses.

7. Social network

In the same way that illness and situations of extreme family and individual vulnerability cause suffering to the person and their significant family members, these situations also cause loss of reference in the community and society.

Systemic theory comes in the rescue of all cultural (wich look at relations, communication, and believes), communitarian, social, economic, religious, experienced and transmitted by families and their members for generations, and after transformed through the creative process in actions in the world for the development of the process of living. These singularities lost during this process of paradigmatic domination are rescued and qualified by the network concept.

For Sluzki [14], the 1990s were an evil decade, a time of medicalization of emotions. The repercussions of this model will be present in a deep and continuous way in this health/hospital interface; the effort of including the practice of interlacing relationships is daily, in all dimensions of this context, from the research to the administrative area.

Sluzki [14] defines network as the sum of all relationships that an individual perceives as meaningful or differentiates them as belonging to their interrelational context. This network corresponds to the interpersonal niche of the person and contributes substantially to his own recognition as an individual and to his self-image (**Figure 1**).

The network is formed by virtuous circles, having the function of protecting the health of the individual, and, consequently, the health of the individual maintains the social network. It is also formed by vicious circles where the presence of a family difficulty substantially affects the social network of the family and its individual

members, a retraction in the maintenance of interactions with the significant community, and in the same way, this detachment appears in the network environment, occurring a process of reciprocal retraction.

According to Vasconcellos [25], the network provides sustenance support for families and individuals; for this author, the network is a distinction of the observer and, in this way, constructs spaces of interventions very useful in health work, because it expands the field of observer's view of the effects and limits of team performance and includes other contexts in the planning of therapy: the families of the people being served and the resources of the community. Producing collaborative actions in this way.

The disease event in the individual and family life, with all the resulting multi-interventions, alters the daily structures minimizing the maintenance of the networks of these systems, due to the social isolation produced by some diseases that diminish the interrelated possibilities affecting the health processes of the family and individual.

"The presence of a disease especially in the case of a chronic disease, usually debilitating or isolating, has an impact on the interactions between the individual, his/her family and the wider social network through different interrelated processes." Sluzki [14], p. 81.

The disease, as an event that involves crisis emergencies, causes a temporary immobilization in people's capacity to produce new relationships and to maintain relationships as usual, reducing the quality of the network and also reducing the possibility of people reaching their goal of quality of life.

According to Sluzki [14], the disease has an aversive interpersonal effect, restricts the mobility of the sick person and his family, reduces the activation initiative of the social network, and reduces the possibility of generating reciprocity behaviors.

A dramatic moment as a disease can generate virtuous circles in the already existing individual and family network, in the co-construction of new networks between families, sick people, health staff, and spaces in the community and society composed of people with capacity both material and emotional.

Sluzki [14] stresses that social support is the raison d'être of numerous self-management and self-help groups of patients and families suffering from chronic physical or emotional disorders; partial hospitalization or day hospital programs contain as one of its most important components the possibility of fostering the development and consolidation of a stable network of informal relationships and the learning or relearning of the skills needed to establish, nurture, and maintain active social relationships.

According to Vasconcellos [25], the network reduces the stress caused by the diagnosis, increasing a cycle of healthy feedbacks, not a vicious cycle of isolation and stigmatization, distancing, social asymmetry, and weakness.

Vasconcellos also points out that network maintenance effort is responsible for a system's resiliency capability. Work across the network values contextual and multi-contextual content, qualifying differences, enabling interacting people to become learners through situations that occur between people and the reported experiences of conflict resolution experienced.

8. Evaluating a family with the FIRO model

The disease is the consequence of a series of factors, involved with people's life choices and their genetic background and living conditions [5, 15]. Communication plays a fundamental role in human relationships, and it has a fundamentally self-referential view—and we always communicate [23]. So when the illness happens,

a reflection is needed, "why does this happen at this moment?" "What leads to the emergence of this specific situation?" And still more the question: "how can we help this person or this family to find a better way to deal with your challenges?"

Schutz [24] in 1958 proposed the FIRO model (Fundamental Interpersonal Relations Orientation) for the study of small groups. In 1984 Doherty [24] adapts this model to systemic health care. According to Schutz the groups can be studied in three dimensions, namely, inclusion, control, and intimacy. Years later he rewrites about the method, and in 1977 he describes FIRO B—in which he develops work scales for group study.

8.1 Inclusion

When you are part of a group, the first question to be resolved is to be accepted by it; as long as we do not feel part of the group, we are going to act insecurely and generate attitudes so that they see, perceive, and recognize us. In a family this is also critical. The more I feel part and important, within the family nucleus, the more I feel free and able to fully develop within this context.

But it is not enough to be in the family; it is important that the space and the forms of communication are clear and acceptable so that I feel included. Doherty [4] raises the need to perceive what space and role we occupy within the family structure—and using Sluzki's framework [14], we can say that the more central we are within the family structure, the more knowledge we have about the rule and family designs for its members. Wilson [7] poses the issue of communication and subliminal issues—which often cloud our view of communication occurring within the family. And yet in this item, questions about how we share acts and things make the complexity of this component.

The issue of inclusion is so impotent that it is a cornerstone in the systemic structural therapy proposed by Minuchin [9]. And how does inclusion work? Before interacting in a particular group, you need to know what our space and what capacity for influence we have. A child tests boundaries uninterruptedly to find out this, teenagers question rules and limits family and adults try to assert their positions—all this is inclusion, but not just this.

The agreed rules in each group are part of this component, where issues often escape the external observer and will only become apparent with systematic pursuit—family secrets, entrenched beliefs about health issues, and accepted or non-accepted behaviors. So detailing in a map of questions about what and how the person and his family perceive the health situation makes us able to better understand their positions and provides the appropriate condition to propose valid interventions. The family's communication style and the way they determine their roles and functions within the family provide a very rich material to be worked on.

8.2 Control

The second component of the FIRO model is control, and it is the second component because without knowing its space and being accepted in a certain group, it is impossible to have some type of control. The exercise of control can be done in different ways—direct and indirect—and will depend on the family structure and its power lines.

When assessing a family, the observer often has difficulty understanding the chains of command, which are exercised either by economic power, personal leadership, or structural family issues. When entering within the scope of the family, it is basic to discover how it reacts to situations of stress and of the decision processes, because the different types of control become apparent.

Classically Wilson [8] divides the control into dominant, collaborative, and reactive. But the nuances of these components are more complex and require special attention from the observer. Dominance may be in some areas, and the way of exercising it varies greatly, with different results. The same goes for the other modes of control.

The understanding of these behaviors shows its importance in the adhesion of the patients to the different treatments, particularly when talking about chronic disease. Dominant people within a social nucleus if they do not understand the pathology and the proposal of intervention can hinder adherence to the treatment and the changes of the necessary habits.

Some family therapy schools base their actions on this component, such as the strategic school developed by Haley.

8.3 Intimacy

The third component proposed by Schutz is intimacy. When I recognize myself as part of a group, I know my place, and I have some kind of control within it; I am ready to establish exchange relationships, and I am able to share emotions and feelings.

More subtle within the work centers, the knowledge of affective relationships and loyalty is a powerful way to gain adherence and support the people to whom attention is given.

Also some family therapy schools are based on this component as the humanistic school of Satir.

Working on it is simple. The model was designed for working with groups within social settings; the adaptation proposed by Doherty [5] and later by Wilson [8] brings the tool to the family and supports the treatment of family and support for clinical interventions.

The instrument can be used in individual care by taking a person-centered approach. In this context the approach explores the knowledge it has about the health situation and how this is influenced by its environment. How much of their autonomy is affected by the situation, who defines the searches and priorities of care and the changes and treatments to be performed. Finally with whom in the group he/she shares his/hers doubts and complaints.

Used in this way, the FIRO is simple and broadens the dialog, favoring adherence to the treatment besides narrowing the patient doctor relationship.

In situations where changes are difficult, people have difficulty adhering to treatment or the results fall short of the goals proposed the use of a family interview with the support of the methodology can be very useful.

In these cases, the interviewer should listen to all members and care about absent members, or who refuses to participate is crucial because they generally play an important role within the family structure and may render the approach ineffective. An interviewer considering FIRO should listen to the family's understanding of the health situation, their beliefs, and previous experiences with similar situations. Next identify the key people in the family hierarchy—providers, tasks and spaces of each member, forms of communication, and people who are considered "scapegoats" of the family.

At a later moment, one can seek to explore the power lines within the family, identifying who actually decides and how people collaborate or resist the proposals of people who have some control within the family. This will identify how the family facilitates, or creates, difficulties in controlling the case.

Example: attending a family with diabetes and the generally inadequate control generated a family interview to understand the difficulties in following the

guidelines regarding lifestyle habits and therapeutics. It became obvious that the family greatly valued the use of the drugs that were used properly, with the consumption monitored by the team as planned. But the person who made purchases and took responsibility for food had a low understanding of what diabetes would be, as well as feeding a person with the disease. During the approach it was made clear to all that food would always have sugars and that the fractionation of the diet and the use of foods with slower release of sugar would be fundamental to the control. The target patient of the activity put how much she felt taken care of by the relatives, who did many things for her—but also did not perceive clearly the dietary error. After the interview there was a 30% reduction in glycemic levels, without the family losing the affective link and improving the understanding of the health team's concerns about the patient on the screen.

The use of FIRO can be taken to improve care by inviting people, families, or groups to talk about the dimensions in which the instrument was studied—people are invited to talk about themselves and to perceive themselves within their context. This improves understanding of the processes and by itself is already therapeutic.

The professional who understands the dimensions of belonging, control, and intimacy can transform the dialog with patients in a process of growth and review of situations, which makes the interview rich and motivating. The key question is, the perception of how central to each element is how your life is organized, how it perceives the interpersonal relationships in your group, and how it influences their lives.

For most people, exchanging information in a quiet dialog can reshape their sufferings and difficulties without requiring any intervention by the therapist—only the flow of dialog and openness to encourage people to talk about their expectations and difficulties within the relationship.

By understanding the concept of a biopsychosocial model, it is clear that a group interactions are an important part of the health-disease process. By establishing a thoughtful conversation, people begin their journey of recovery.

9. Conclusion

A family system approach is now a concept that is well developed and, despite its challenging way to think, allows the health professional to have an open, broad comprehension of the context. Based on that, it is possible to help people to better understand their situation and find a new path to have a healthier life.

Most of the time, the blindness attached to a lack of comprehension of the facts linked to any situation is the cause of suffering and may be one of the key points to the development of any ill that will emerge in the future.

This approach to families turns blindness into understanding and can be a pathway for the development of new languages among families and health professionals. New indicators of well-being would be recognized by increasing the quality of life of families and communities.

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