The Nurse Practitioner–Patient Relationship
Family-Focused Clinical Practice: Considerations for the Nurse Practitioner

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INTRODUCTION

As nurse practitioners we interface with the patient at the point of care and often neglect to consider the individual in the context of a family unit. It is our moral and ethical obligation to consider the health of families throughout their life cycle. Despite changing demographics, most patients live with family members, and these relationships can strongly influence the health and illness of its members (Bray & Campbell, 2007). It is imperative that we consider family background, structure, and level of function when caring for the individual patient. The information that we glean from the patient will have a significant affect on the health and well-being of the patient, and it has the potential to improve the health of the family unit when the nurse practitioner collaborates with and involves the family in the framework of the treatment plan.

FAMILY THEORY

Family health has been studied by a variety of disciplines, including but not limited to psychology, sociology, medicine, anthropology, and economics. Most family theories important to advanced practice nursing have been developed by other disciplines.
but have been used effectively by nurse practitioners. We do not often think that we are using “theory” when taking a family history or conducting a review of systems in the examination room, but if we study the components of theory, we are better able to understand its practical application in the clinical area. The usefulness of a theory is based on its ability to systematically describe the wide range of relationships between variables in order to generalize the findings (Loveland-Cherry, 2004).

As nurse practitioners we are continually striving to explain the relationships between symptoms in patients to develop a differential diagnosis. In a simple example we consider the relationship between chest pain on exertion, back pain, palpitations, and dizziness to help us draw conclusions about coronary heart disease in an individual patient. Similarly, we can use family theory to help expand this differential diagnosis by asking about family risk factors and hereditary causes to assist us in completing the framework of what appears to be coronary heart disease. During the past several decades, the nursing literature has emphasized the importance of “family” in nursing practice. Catch phrases such as “family health promotion,” “family healthcare nursing,” “family interviewing,” and “family systems nursing” helped to define family-centered nursing care as an important part of practice (Wright, 2009).

According to Denham (2003), a family theory that is meaningful and useful for nurse practitioners must:

- Describe and explain family structure, dynamics, process, and change.
- Describe interpersonal structures and emotional dynamics within the family and the transmission of distress to individuals.
- View the family as the liaison between the individual and culture.
- Describe the process of healthy individuation and differentiation of family members.
- Predict health and pathology within the family.
- Prescribe therapeutic strategies for dealing with family dysfunction, grief, and illness.
- Account for stability and change when viewed within the family’s developmental life cycle.

Most of the propositions above have been developed out of family social science theories and can be useful for practice.

Application of Macrosystem Family Theory to Clinical Practice

The macrosystem can be described as the larger world in which the family lives and interacts. This can influence the family’s overall development and well-being.
across the family lifespan. The macrosystem includes social expectations, legal and moral perspectives, and cultural traditions that affect the ways individuals treat and are treated by others. Race, ethnicity, religion, gender, social class, and age may alter the ways individuals and families view themselves and others. The macrosystem serves as a social framework that has unintentional influences on values, attitudes, and behaviors through time. On the other hand, the family’s microsystem consists of extended family members as well as those in the nuclear family and the roles and expectations that the family holds for its membership.

Structural Approach

All theories, whether at the macrosystem level or microsystem level, have applicability to practice. When the nurse practitioner uses the structural approach to assessing the family unit, he or she is considering the position or status of the family in society. Each position has associated social norms or expectations for society. For example, in most societies a woman in the kinship position of “mother” is expected to act in a nurturing manner toward her child. A social role implies the cluster of expectations or norms for any status position (White & Klein, 2008). An individual may occupy several positions or roles at the same time across the life span. The mother may also be a sister, teacher, wife, volunteer, and daughter simultaneously, which can lead to role strain and conflict.

Interactional Approach

The interactional approach views the family as being constructed by culture and societal norms. Individuals establish their roles and communicate them within the family and to the external environment. It is the way individuals in a family unit frame their behavior. For example, transition to parenthood can be conceptualized when parents form their beliefs about their contributions to parenthood. In a study, new fathers were found to have a greater number of social accounts to justify non-involvement with childcare activities than the mothers had (White & Klein, 2008).

Developmental Approach

The developmental approach considers normal family changes and experiences over the members’ lifetime; this framework assesses both individuals and families as a whole unit. The developmental framework has three major theoretical components: (1) individual life span theory, (2) family development theory, and (3) life course theory. All of these components influence each other and must be considered together. Individual life span theory focuses on the genetic development of the individual and factors that affect that development. The family development
theory focuses on the systematic and patterned changes experienced by families as experience stages and events of the family life course. Life course theory examines the event history of an individual and how earlier events, such as marriage, influence later outcomes, such as birth or adoption of a child (White & Klein, 2008). The developmental approach emphasizes dimensions of time and change in the membership structure of the family including the change in content of social roles in the family. These events and roles do not necessarily proceed in a given sequence, but rather constitute the sum total of the individual’s actual experience.

Application of Microsystem Family Theory to Clinical Practice

Family Systems Approach

Health professionals have applied general systems theory, introduced in 1936 by von Bertalanffy, to the understanding of families for a number of years (Wright, 2009). The general belief of systems theory is that all parts of a system are interconnected. Any change in one family member will affect all family members, and understanding the family is only possible by viewing the whole. The nurse practitioner (NP) that is skilled in collecting and analyzing family data within this framework will consider boundaries within the family and external environment, rules of transformation within the family, positive and negative communication patterns, equilibrium in the family unit, and what the relationships are like within the subsystems of the unit, such as sibling to sibling or parent to child (White & Klein, 2008).

Family Stress Theory

Family stress and individual stress must be assessed by focusing on both the individual and family resources and coping skills. The study of stress has emphasized significant events or a pileup of stressors in the individual and family history. Certain normative events such as buying a house, becoming a parent, and changing jobs may occur at the same time as unexpected events such as the death of a parent, infidelity, or divorce. The normative event may be stressful enough; when the compression of unexpected events occurs at the same time, the family unit can become compromised. The NP must consider the general family stressors, specific stressors, and family strengths as identified by the family.

Change Theory

It is well known that systems of family relationships undergo progressive change. However, a French proverb states, “The more something changes, the more it remains the same.” This paradoxical relationship highlights the dilemma frequently
faced by families in need of both stability and change (Wright & Leahey, 2009). Changes in family behavior are dependent on the perception of the problem and may or may not be accompanied by insight. The NP must understand that facilitating change is necessary to help stabilize the family unit in the face of major life events such as death, disability, divorce, natural disasters, and addictions.

**FAMILY RESILIENCE AND CAPACITY MODELS**

Resilience is the process of “bouncing back” from life’s adversities and difficult experiences. It does not mean that individuals and families do not suffer or experience grief when faced with hardship, but it is a quality that can be learned and developed. In the past decade, Americans have witnessed terrorist attacks and random acts of violence on communities. Out of these disasters we have seen individual and community efforts to build capacity in order to heal.

**Resilience**

Resilience is defined as an individual’s or family’s abilities to function well and achieve life’s goals despite overbearing stressors or challenges that might easily impair the person or family unit (Mullin, 2008). Felten and Hall (2001) define resilience as “the ability to achieve, retain, or regain a level of physical or emotional health after devastating illness or loss” (p. 46). Wagnild and Young’s Theoretical Model of Resilience describes resilience as an enduring personality characteristic that persists through the human life cycle and moderates the negative effects of stress and promotes adaptation (Wagnild & Young, 1993). This model describes five themes that constitute resilience: equanimity, self-reliance, existential aloneness, perseverance, and meaningfulness (Wagnild & Young, 1990). Resilience has also been studied from developmental and environmental perspectives. Environmental factors that influence resilience include social support, which can be described as interactions between the individual, family, and environment (Tusaie & Dyer, 2004). Most researchers agree on the basic nature of resilience but use different terms to define it. The most accepted terms connected to the concept of resilience are adversity, stressors, adaptation, coping, risk factor, and protective factor (Mullin, 2008). Resilience is sometimes conceptualized as the ability to withstand a crisis that is brief in nature, but most often, it is associated with the ways that an individual or family faces a pervasive social condition such as poverty or a devastating illness or injury.

Resilient individuals preserve hope and construct a meaningful account of their situations (Druss & Douglas, 1988). Resilience is the process of identifying
or developing resources and strengths to manage stressors flexibly and gain a positive outcome (Haase, 2004). When they need assistance, resilient individuals reach out to others including their family, their community, their society, and health professionals (Rabkin, Remien, Katoff, & Williams, 1993). In addition, researchers have identified contributing factors to resilience (Dyer & McGuinness, 1996; Rabkin et al.). Patients with AIDS, for example, have identified social support, excellent medical care, personal resources (e.g., intelligence, education), and access to supplementary services (e.g., visiting nurses, home health aides) as contributing factors to resilience (Rabkin et al.).

In a descriptive correlational study of 71 African-American females with type 2 diabetes, the researcher found that high levels of resilience were significantly correlated with low glycosylated hemoglobin levels, suggesting that resilience may play a role in positive health outcomes (DeNisco, 2011). NPs have an opportunity to consider resilience in the care of minority populations with a chronic illness such as type 2 diabetes. Clinical implications based on the findings of this study include preventing complications of poorly controlled diabetes by recognizing holistic approaches to care that integrate not only the physiological aspects of care but also the psychological aspect of the person, including interventions to help build individual resilience (DeNisco).

Figure 2-1 depicts a theoretical model of resilience showing the effect of resilience on physiological stressors.

**Family Resilience**

The system-based Resilience Model of Family Stress, Adjustment, and Adaptation based on the work of McCubbin and McCubbin (1993) is concerned with family development and the family's ability to negotiate change and adapt to stressful life events over time, particularly to stressors such as illness (Kaakinen, 2010). An approach like this is useful in clinical practice as it analyzes interactions between family members, the family system, and the community or environment to shape the course of family resilience and adaptation. Germain and Bloom (1999) wrote that families are more resilient when there is a “fit” between the family and the environment. They note that specific protective factors or positive characteristics of an individual or family help moderate risk factors or negative characteristics that easily become problematic (Germain & Bloom, 1999).

Resilience was identified recently by the Committee on Future Direction for Behavioral and Social Sciences as a research priority for the National Institutes of Health (Singer & Ryff, 2001). The committee addressed the significance of behavioral and psychosocial processes in disease etiology, well-being, and health promotion. Singer and Ryff point out the need for the increased study of
correlates of resilience including protective factors such as optimism, meaning, purpose, as well as social and emotional support.

Since the 1970s, research on resilience has shifted its focus from the study of personal qualities that predicate positive outcomes to studying the process of resilience in order to foster this in all individuals and to develop interventions to promote health (Peterson & Bredow, 2004). The helping professions have been seeking ways to understand the reasons that one individual or family faces insurmountable problems and continues to function well, while others do not. The search to identify the factors of resilience was begun by researchers who focused specifically on children, adolescents, and the elderly (Garmezy, 1993; Gilligan, 2004). Resilient children were seen as having positive temperaments and being easily lovable, autonomous, and intelligent. They were generally seen to have benefited from close relationships with supportive adults or extended family members and others in the community (Garmezy, 1993; Gilligan, 2004).

In a meta-analysis of 24 studies examining the sense of self in children with cancer and in childhood cancer survivors, Woodgate and McClement (1997) found similar themes. Most studies evaluated the psychological functioning of

FIGURE 2-1 Theoretical model of resilience.

children including self-esteem and the effect on family functioning and adjustment. It was found that the majority of children with cancer do not have significantly lower self-esteem scores than healthy children (Woodgate & McClement).

Other studies have focused on resilience in children with asthma (Svavarsdottir & Rayens, 2005; Vinson, 2002). In a descriptive correlational survey study of 235 children with asthma, Vinson found positive correlations between family environment and child characteristics, as well as between the dependent variables of appraisal, coping, quality of life, and illness indices. The researcher also reported that cohesiveness and adaptability were positively correlated with competence and optimism.

Researchers have also investigated resilience in children with cancer. Hockenberry-Eaton, Kemp, and Dilorio (1994) studied 44 children with cancer receiving outpatient chemotherapy. In this descriptive correlational study, the relationship between the independent variables of childhood cancer stressors (protective factors) and the dependent variables of physiologic and psychological responses to stressors experienced during cancer treatment were examined. Findings revealed that family environment, global self-worth, and social support are protective factors that may influence resilience.

The concept of resilience has also been studied in adolescent populations. In a descriptive correlational study, Rew, Taylor-Seehafer, Thomas, and Yockey (2001) explored relationships among resilience and selected protective factors and which factors were the best predictors of resilience in a convenience sample of 59 homeless adolescents. In another descriptive correlational study, the relationship between adaptive and maladaptive coping correlates to health and illness outcomes in 404 female adolescent athletes who have experienced high levels of stress recently (Yi, Smith, & Vitaliano, 2005).

Resilience has been studied in elderly populations in order to describe characteristics of resilience. In a qualitative study of elderly women over 85 years of age, nine emerging themes were identified as characteristics of resilience: frailty, determination, hardship, access to care, culture, family support, self-care activities, care of others, and efficiency (Felten & Hall, 2001). The researchers concluded that resilience has implications for healthcare providers to facilitate these traits in order to prevent frailty and disability.

Three other studies were conducted to measure resilience in elderly populations (Adams, Sanders, & Auth, 2004; Becker & Newsome, 2005; Hardy, Concato, & Gill, 2004). In a descriptive qualitative study of 38 African-American participants between the ages of 65 and 91 years, it was found that values such as independence, spirituality, and survival were important factors that shaped responses...
to chronic illness. Thus, resilience may be a culturally important tool as ethnic minority people age (Becker & Newsome).

A descriptive cross-sectional study of resilience in 546 community-dwelling older adults found that higher stress levels were negatively correlated ($r = -0.48$, $P < .001$) with lower resilience scores (Hardy et al., 2004). Resilience scores were negatively correlated with depressive symptoms. The authors concluded that more research was needed on the relationship between resilience and future health and functional status as a predication of recovery (Hardy et al.). According to Adams et al. (2004), in a study of 234 elderly participants living in a retirement community, loneliness was seen as a risk factor for depression and associated with a smaller social network.

The following case study represents a model case study of resilience.

**Ellen’s Story**

Ellen Collins is a 63-year-old Jamaican female who has a history of chronic physical problems including type 2 diabetes mellitus, hypertension, asthma, and hyperlipidemia for which she is on numerous medications. Ms. Collins also has a history of depression, but she has maintained well on an antidepressant for a number of years. She visits her primary care provider regularly for the above problems. Ms. Collins cares for her 87-year-old aunt who has a polymorphic adenoma of the salivary glands. Ms. Collins was also awarded custody of her 13-year-old grandson because her son and daughter-in-law are drug addicts and unable to care for their child. Ms. Collins, youngest son is dually diagnosed with bipolar disorder and alcohol abuse, has had legal problems related to domestic violence, and is currently hospitalized for decompensation of his mental illness.

Despite the myriad of adversities, Ms. Collins has a good outlook on life, and she seeks out the support of her healthcare provider and community services. Her chronic health problems are well controlled. She continues to care for her aunt, son, and grandson with a positive attitude and sees hope for the future. She owns her own home, and continues to work with the Department of Children and Families providing foster care for troubled adolescents. She enjoys gardening, raises money for HIV research, and is looking forward to taking her grandson to Niagara Falls this summer.
Family resilience or relational resilience has been defined by Walsh (2006) as having three domains: beliefs systems, family organizational patterns, and communication processes. Walsh redefined resilience as having “reparative” potential on family functioning. The following individual, family, and social factors contribute to family resilience:

- An internal locus of control or the belief that the individual or family is empowered to influence the environment
- Spirituality that fosters personal meaning and a sense of purpose in life
- Downward social comparison
- Positive social supports including emotional support, informational support, social companionship, and instrumental support

When a nurse practitioner encounters an individual in the healthcare system, the following theoretical assumptions should be kept in mind:

- Some individuals recover or “bounce back” better than expected when faced with an adverse condition (Dyer & McGinness, 1996).
- Positive health outcomes (both physiological and psychological) include the absence of disease or low levels of symptoms or impairments (Heinzer, 1995; Hockenberry-Eaton et al., 1994).
- Resilient individuals have inherent personality characteristics that are protective factors in the face of illness or adversity (Haase, Heiny, Ruczone, & Stutzer, 1999; Jacelon, 1997; Polk, 1997; Woodgate & McClement, 1997).
- Nurse practitioners can be helpful in fostering resilience within individuals, families, and communities (Drummond, Kysela, McDonald, & Query, 2002; Hockenberry-Eaton et al., 1994).

Family Capacity

One of the greatest challenges for many healthcare providers is to address the need for family capacity; if a family has not realized their “capacity” or capabilities, they can face significant obstacles in their day-to-day living. Family capacity-building involves increasing the families’ competence in implementing strategies to enhance their development and build their problem-solving skills while increasing their confidence that they are able to do so.

Family capacity can be defined as the extent to which the family needs, goals, strengths, capabilities, and aspirations can meet the family’s ability to function to its fullest potential (Dunst & Trivette, 2009). It is the nurse practitioner’s responsibility to assess the family’s capacity to support the family’s health and wellness, as well as...
prevent illness risks, treat medical conditions, and manage tertiary care needs. Similar to resilience, family capacity can be viewed as the family’s ability to adapt and change. The family capacity model is presented in Figure 2-2.

Traditionally, the literature considered children and families as having deficits and weaknesses that needed treatment by healthcare professionals to correct problems, whereas the capacity-building literature believes that families have varied strengths and assets, and the focus of interventions is on supporting and promoting competence and other positive aspects of family member functioning (Dunst & Trivette, 2009). To understand family capacity, the nurse practitioner needs to understand family, structure, function, and roles.

FAMILY STRUCTURE, FUNCTION, AND ROLES

There are many clinical family assessment models that the nurse practitioner can use to assess family structure, function, and roles. Some of the popular models are:

1. The Calgary Family Assessment (CFAM) (Wright and Leahey, 2009)
2. The Family Assessment and Intervention Model (Kaakinen, Hanson, & Denham, 2010)
3. The Friedman Family Assessment Model (Friedman, 1998)
All three models may have different approaches in their theoretical underpinnings, scope, data collection methods (quantitative or qualitative), and unit of analysis, but they have many similarities. Broadly, these assessment tools are available to expand the clinician's understanding and management of family-wide threats to both physiologic and psychologic health.

There are five key goals of family life:

1. Pass on culture (religion, ethnicity).
2. Socialize young people for the next generation (to be good citizens, to be able to cope in society through going to school).
3. Exist for sexual satisfaction and procreation.
4. Serve as a protective mechanism for family members against outside forces.
5. Provide closer human contact and relations.

**Family Structure**

The nurse practitioner may use a genogram or “family tree” to gather much of the information regarding family structure. A detailed discussion of the genogram will take place later in this chapter. Family structure can be defined as the organizational framework that determines family membership and the way in which a family is organized according to roles, rules, power, and hierarchies. There is no typical family form in the 21st century. Nurse practitioners need to expand their definitions of the traditional nuclear family (or biological family of procreation) to include alternate forms of family life: the single- or sole-parent family, blended families including step-children, grandparents raising grandchildren, communal families, and the lesbian, gay, bisexual, queer, intersexed, transgendered, or twin-spirited (LGBT) couple or family (Wright, 2009).

Whether or not you are using a pictorial representation of the family structure such as the genogram or ecomap, the following components should be included in the interview data collection regarding family structure (Bomar, 2004; McGoldrick, 1999, 2003).

1. Family constellation: Who is in the immediate family, who lives in the house, how are the individuals related, relationship to extended family, and boundaries
2. Family constellation changes: Permanent (birth or death), temporary (illness, hospitalizations, co-parenting in divorced families, homelessness)
3. Individual family members: Age, gender, sexual orientation, ethnicity, race, health problems, occupation, educational level, and cultural/religious beliefs
Family Function

According to Wright (2009), family functioning can be defined as the processes by which the family operates as a whole, including communication patterns and manipulation of the environment for problem solving. Each family possesses a distinctive operating system, and it can influence healthcare outcomes. Some specific areas to assess include:

- Activities of daily living: Eating, sleeping, common tasks including family participation in leisure activities and family rituals
- Nutrition: Food insecurity
- Communication patterns: How family members communicate (Is there one spokesperson when articulating healthcare issues?)
- Family perceptions: How illness affects each family member, concerns for other family members, care-seeking behaviors
- Family members’ mental health history: Includes substance, tobacco, and alcohol use
- Problem-solving abilities
- Influence and power: Who is dominate, subordinate, controlling, abusive, guilt-inducing, the scape-goat, etc.

FAMILY DEVELOPMENT

The nurse practitioner must also consider the developmental life cycle for each family that he or she encounters in the clinical setting. Families are shaped by people who share a past and future history together. As contemporary families move through time, there is a normative sequence by which families develop and change. McGoldrick and Carter (2003) have done extensive work on the family life cycle by describing the underlying factors that influence family development as the family expands and contracts by variables such as birth, death, marriage, divorce, adoption, poverty, and catastrophic illness. These events typically cause realignment of the family system to support the entry, exit, and developmental changes of family members through time. Major life-cycle transitions are marked...
by fundamental changes in the family system itself (second-order changes) rather than rearrangements within the system (first-order changes). McGoldrick and Carter (1999) have designed a classification system of normative stages that typical middle class American families go through across the life cycle. When reviewing these “normative” stages of the family life cycle, the nurse practitioner must take into consideration societal influences and sweeping changes in the way the family functions. In this day and age, it is hard to conceptualize what is considered a typical family when there are gay and lesbian couples, sole-parent adoptions, dual-career families, grandparents raising grandchildren, cohabiting couples, military families, and foster families.

In the Calgary Family Assessment Model, Wright and Leahey (2009) propose that family developmental assessment includes an overview of the stages, tasks, and attachments that are important to each stage. The nurse practitioner must also keep in mind common health issues that may accompany each stage. The nurse practitioner must also keep in mind common health issues that may accompany each stage.

**DIVORCED FAMILIES**

According to the U.S. Census Bureau, in 2008 there were over 10.5 million single-parent families in the United States, accounting for 29.5 percent of all households with children under the age of 16 (U.S. Census Bureau, 2012). This is higher than the reported rates in Canada, Denmark, France, and Japan. Children living with a parent who divorced in 2009 were more likely to live in a household headed by their mother (75 percent) than in a household headed by their father (25 percent). Additionally, children living with a parent who divorced in 2009 were more likely to be in a household below the poverty level (28 percent) compared with other children (19 percent), and they were more likely to live in a rented home (53 percent) compared with other children (36 percent) (U.S. Census Bureau, 2012). While the divorce rate fluctuates given geographic location, population, income and educational status, single-parent and divorced families are common in our society and have unique challenges.

The term *divorce* invokes a series of images of bitter custody battles, financial hardship, broken families, vulnerable children, hostility, resentment, and failure to live up to commitments. While these images may be true of some divorces, research shows that most families will experience short-term, moderate effects postdivorce (Bowen, 2012; Demo, 2010). However, it is true that families experiencing divorce are under significant emotional pressure during the transition and must fulfill the same developmental tasks as the two-parent nuclear family.
but without all the means. Shortages in time, money, and energy can cause single parents to experience self-doubt and often feel guilty for not meeting societal expectations of living in a two-parent family (Wright and Leahey, 2009).

**NONTRADITIONAL FAMILIES**

If we consider society a generation ago, the average American family might be defined as a married man and woman with two biological children. Divorce rates were lower, optional single parenthood was rare, and surrogacy and in vitro fertilization by sperm or egg donation were not available. The gay and lesbian community had little hope of raising their own children. Grandparents and extended family members played a supportive role during holidays, special events, and illness, but did not have major responsibility to the nuclear family. Adoption was closed if available (Lantz, 2012). While societal perceptions of the “traditional family” may still be a certainty for some, this is clearly dependent on age, gender, education, religious beliefs, socioeconomic status, and geographic location. The reality is that less than 25% of U.S. households are considered “traditional.”

**Single-Parent Families**

Single-parent families are recognized as the most common nontraditional family; in 2006, the number of single-parent households increased to 10 million, accounting for 26% of families with children in the United States. Father-only families are on the rise, accounting for 2 million families or 5% of all family structures (Kaakinen, 2010). Single-parent families by divorce or death are under significant pressure for time, space, adequate finances, social control, and tension management. Single parents typically have the ultimate responsibility for paying the bills, disciplining, and caring for the children’s physical and emotional needs. This can be especially challenging for the parent who does not have the financial resources, support of the biological parent, or extended family support. Single-parent mothers and fathers also experience societal pressure to live in a “normal family” and feel like failures in meeting expectations of friends, neighbors, and their extended families (Wright & Leahey, 2012). In working with single-parent families, it is important for the NP to help the parent explore his or her feelings, develop coping mechanisms, and find community and financial resources to support the parent through issues of custody, visitation, social networks, and effective parenting.
Same-Sex Couple Families

Until recently gay and lesbian families have been “invisible” in our culture. With changes in the laws recognizing the legal union of same-sex couples, more attention is being focused on these relationships, their structures, challenges, strengths, and issues. In 2010, the American Community Survey (ACS) results showed that 19.4% of households were headed by same-sex couples with children. By conservative estimates, there are at least 400,000 to 500,000 gay or lesbian parents living with children in the United States. Of these families (Lofquist, 2011):

- 72.8% reported having biological children from previous heterosexual relationships or artificial insemination.
- 21.2% reported as having step- or adopted children.
- 6% reported having a combination of biological, step-, and adopted children.

While research studies on children raised by gay and lesbian parents are still relatively new, to date the majority of evidence suggests that children who grow up in families headed by same-sex parents fare as well as children who grow up in families headed by opposite-sex parents. In addition, children who have gay, lesbian, bisexual, or transgender parents do not appear to differ from children who have heterosexual parents in terms of psychological health, social relationships, or cognitive or emotional functioning (Burkholder & Burbank, 2012). State laws and rights of same-sex parents and children vary widely. It is important for the nurse practitioner to understand these differences in order to assist the family to navigate a complicated legal system that may not support the family, or one that may place legal limitations on the family. Child custody issues, adoption rights, and a variety of other rights and benefits offered to married couples, such as insurance coverage and spousal benefits, are not available to same-sex couples. The NP must gain expertise in assessments and interventions that address the unique needs of these families in order to help parents and children to deal with social stress from being perceived as different by other children, or as problematic and threatening by other parents.

Foster Families

Other types of nontraditional families include foster parenting and grandparents raising grandchildren. In the United States, 30%–60% of children residing in urban school districts live with caretakers that are not their biological parents (Lantz, 2012). The nurse practitioner must be cognizant of the intensity of the health and emotional issues that a child residing in foster care may present with;
many children have been victims of emotional and physical abuse and have special medical and physiological needs (Lenora, 2009).

In a descriptive study of physical examination findings of 5,181 children taken into protective custody, the researchers found that nearly half (44%) had an identified health problem, including acute infections (otitis media, sexually transmitted diseases), anemia, and lead poisoning. In addition, approximately 5% of the children evaluated for physical abuse were found to have occult fractures not suspected by their caseworkers (Chernoff, Coombs-Orme, Risley-Curtiss, & Heisler, 1994). In another large study of 2,419 children assessed shortly after placement in foster care almost all (92%) had at least one abnormality on physical examination, including disorders of the upper respiratory tract (66%), skin (61%), genitals (10%), eyes (8%), abdomen (8%), lungs (7%), and extremities (6%). Nearly one-quarter (23%) of younger children failed a developmental screening, and 22% of older children were already receiving special education services before placement. As a result of these evaluations, 53% of the children were referred for further medical services (Flaherty & Weiss, 1990).

Because of the high rate of physical, mental, and developmental problems in foster children, they often require more frequent healthcare visits than most children. Many states require that children newly placed in foster care have a comprehensive health assessment within 30 to 60 days of placement (Simms, 2000). The clinician needs to negotiate a management plan with the foster parents and their children to ensure timely routine health maintenance visits including close developmental screening and mental health interventions as appropriate. This plan needs to be updated with each patient care encounter, and communicated to the caseworker and the foster family. NPs play a significant role in coordinating services for foster children and ensuring they receive care in a timely manner.

Grandparents Raising Grandchildren

Recent U.S. census reports show that there are more than 4.5 million children being raised in grandparent-headed households (Conway, 2011). The phenomenon of grandparent caregiving is prevalent among African-American and Latino grandparents: African-Americans and Latino grandparents have a 38% and 13% chance respectively of becoming caregivers for their grandchildren (Conway, 2011).

The increase in the numbers of grandparents in caregiving roles parallels the increase in the growing number of older adults. According to the federal Administration on Aging (AOA, 2011), it is estimated that the number of older adults age 65 and older will make up 20% of the population in the year 2030 as compared to 12% in the year 2000. The grandparenting role is a stressful one; typically the caregiver attains responsibility for the child secondary to a family
crisis where the biological parents cannot effectively care for their child. Factors that may contribute to the shift in parenting include substance abuse, mental health issues, lack of money, incarceration, death, and abuse or neglect of the children. These unexpected life events can cause significant emotional and financial strain on the grandparents as they assume new parenting responsibilities for children.

Grandparents who are primary caregivers usually face a number of challenges, including higher rates of depression, health problems, and fatigue, as compared to noncaregivers or to others their age (Kaakinen, 2010). Grandparents often are dealing with their own chronic health issues, may be raising their own adolescent children, and are often providing care for their aging parents. Grandparents report having less time for themselves, experiencing social isolation, and increased financial pressures, especially if they need to reduce their hours at work or draw on their savings in their efforts to provide a home for their grandchildren. Grandchildren are affected, too; research shows that these children have higher rates of asthma, decreased immunity, poor eating and sleep patterns, physical disabilities, and hyperactivity compared to children in parental households (Kaakinen, 2010).

The nurse practitioner plays a key role in assisting the grandparent to seek out and use existing community resources and social supports to prevent social isolation, ease financial burdens, and promote the health and well-being of the family unit.

**STRUCTURAL ASSESSMENT AND FAMILY INTERVIEWS**

Structural assessment tools are helpful to discern the internal and external functioning of the family. Family interviews can be gathered by drawing a genogram, ecomap, or family pedigree. The genogram is essentially a diagram of the family constellation, while the ecomap displays the important contacts that are external to the immediate family. The family pedigree is a risk assessment tool for conditions that have familial genetic predisposition.

The relationship between family history and health risks has long been recognized. Indeed, family history is a risk factor for many pediatric and adult onset diseases and disorders. It represents genetic susceptibility, shared environment, common behaviors, and the interactions between and among the family members. The genogram and ecomap are tools that can assist the nurse practitioner in assisting a family as a whole system, as well as assisting the individuals within the family system. The therapeutic relationship between the nurse practitioner and
patient can begin in the waiting room, the examination room, or at the hospital beside. When using a genogram or an ecomap, it is impossible to differentiate between its value to the nurse practitioner–patient relationship, or on the quality and quantity of information acquired and its effect on that family or individual. At the most superficial level, either of these tools gives family members a new framework with which to understand themselves as individuals and as an active part of a system (Denham, 2003).

The family pedigree is another interview tool that includes a three-generational assessment of medical conditions in each relative, including specific genetic disorders, birth defects, Down syndrome, and questions about certain behaviors (e.g., alcohol, substance abuse, and tobacco use), as well as questions about consanguinity and ethnicity (Yoon, 2003).

Genograms

A genogram is an assessment tool or clinical method of taking, storing, and processing family information for the benefit of the patient and the family. It is displayed as a graphic representation of family members and their relations over three generations (McGoldrick, 2008). The three-generation family genogram was developed primarily out of the family systems theory and is a popular tool among social workers, psychologists, physicians, and nurses. According to Bowen (2012), people are organized into family systems by age, generation, sex, or other similar features. Where the person fits into the family structure influences the person’s functioning, relational patterns, and type of family he or she forms in the next generation. It is also believed that sex and birth order shape sibling relationships and individual characteristics (Rakel, 2007). Families repeat themselves over generations in the phenomenon called the transmission of family patterns; what happens in one generation repeats itself in the next, so that the same issues are played out from generation to generation (Bowen).

The information collected for the genogram may include genetic, medical, social, behavioral, and cultural aspects of the family.

Because the process of creating a genogram involves extensive interviewing, it is a way for the nurse practitioner to establish a therapeutic relationship with the family. Families tend to become engaged in the process of developing the genogram and often gain insight into their potential health issues and missing support systems (Schilsin, 1993). Despite the clear advantages the genogram offers, many primary care clinicians often neglect to use it as it can take up extra time in an already overburdened office schedule (Schilson). The genogram does not have to be completed in one sitting but can be started on the initial visit and completed
on subsequent visits. While some primary care clinicians may not feel skilled at delving into psychosocial issues and sensitive family matters, nurse practitioners by virtue of their education and experience are poised to assist families to identify strengths as individuals and in a family unit to promote their mutual support and growth. Some key indications for the nurse practitioner to develop a family genogram are represented in Table 2-1.

Process of Developing the Genogram

The manner in which a genogram is taken is perhaps more important that what is elicited and the technique of recording. The nurse practitioner needs to be sincere, open-minded, interested, and nonjudgmental, and even occasionally prepared to share anecdotes of his or her own family to put the patient at ease. It is a mutual scientific inquiry with members of a family and they often get enthusiastic about drawing their “family tree” and want it be accurate, complete, and relevant. You may use a flip chart, or in a hurried practice setting a pad of paper or progress note. The diagramming of a family genogram must comply with the use of specific symbols to assure that the family and the nurse practitioner have the same understanding and interpretations of the genogram. Authors may vary on symbols used for different nodal events, but all genograms are similar in terms of gathering information on family membership, structure, interaction patterns, and other important information. The genogram does not have to be completed in one session; in general, nurse practitioners working in a primary care setting will see patients and their families over time, and data can be collected and added as a continuous process.

See Table 2-2, Table 2-3, and Table 2-4 for the three types of family genogram interview data: factual events, expanded events, and relationships.

<table>
<thead>
<tr>
<th>Table 2-1 Key Indicators to Develop a Family Genogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Somatic problems (e.g., headache, abdominal pain, chest pain)</td>
</tr>
<tr>
<td>Frequent office visits</td>
</tr>
<tr>
<td>Poor school or work attendance</td>
</tr>
<tr>
<td>Behavioral problems</td>
</tr>
<tr>
<td>Problems between family members</td>
</tr>
<tr>
<td>Step-families with problems</td>
</tr>
<tr>
<td>Obesity, smoking, alcohol, substance abuse</td>
</tr>
<tr>
<td>Nonadherence to treatment regimen</td>
</tr>
</tbody>
</table>


# Structural Assessment and Family Interviews

## Table 2-2 Family Genogram Interview Data: Factual Events

- **Family composition**: Who is the immediate family? Who has the identified health problem?
- **Who lives with the immediate family, and how are they related?**
- **Dates of births, miscarriages, abortions, and stillbirths**
- **Dates of any adoptions**
- **Dates and causes of deaths**
- **Major illnesses and dates**
- **Dates of marriages, separations, divorces, remarriages, retirements, and relocations**

## Table 2-3 Family Genogram Interview Data: Expanded Events

- **Religion, ethnic factors, occupations, social class, education, military service**
- **Additional births, abortions, miscarriages, adoptions, and infertility**
- **Congenital abnormalities, mental disabilities, learning problems**
- **Illnesses similar to presenting illness**
- **Cancer, heart disease, hypertension, asthma, hyperlipidemia, diabetes, depression, alcoholism, substance abuse**
- **Common causes of death in that family**
- **Family secrets**
- **Troubles with the law, incest**

## Table 2-4 Family Genogram Interview Data: Relationships

- **Who is close to whom? Is there too much closeness? Are there “favorites” or “isolates”?**
- **Relationships and alliances between:**
  - **Marriage partners**
  - **Siblings**
  - **Children and parents**
  - **Children and grandparents**
- **Boundaries between family members:**
  - **Permeable**
  - **Loose**
  - **Rigid**
- **Power and patterns of avoidance**
- **Patterns of friendships and relationships with work colleagues**
- **Matters that cannot be talked about in the family**
Understanding and Interpreting the Genogram

Discussion of the completed genogram can offer alternatives to the family for their current behaviors, and it offers a chance to escape from repetitive family patterns if the family views this as helpful. Furthermore, a genogram will help the family make sense of unexplained fears and anxieties about family patterns and illness.

In the Hucks/Rizzo genogram shown in Figure 2-3, you can see that Althea Rose suffered from postpartum depression, and her mother Althea Susan also suffers from depression. Interestingly, Althea Rose’s daughter, who is 6 years old, has a history of attention deficit disorder, which can in part be explained by the family history of mental illness. Christopher Nugent Huck’s grandparents have history of esophageal and prostate cancer, and Christopher’s diagnosis of basal cell carcinoma shows in part a predilection for cancers on that side of the family tree. If you look further at Christopher’s health problems, he is at risk for coronary artery disease and diabetes, based on his history of hyperlipidemia and obesity, as well as his father’s history of a cerebrovascular accident and his mother’s history of diabetes.

One of the challenges for nurse practitioners is to take the vast amount of information collected during the interview process and consolidate the data into categories that can be analyzed for repetitive relationship patterns between generations. Categorizing the data groups can assist in the identification of the most pertinent family problem that needs immediate attention. In a family where emotions can be neither recognized nor displayed, distress may present as somatic symptoms resulting in frequent office visits; for example, you may recognize a pattern in the above genogram that when Christopher binge drinks, his daughter’s attention deficit disorder symptoms may worsen. Table 2-5 lists themes in a family genogram that should raise a red flag and help you identify problems and patterns that may affect family functioning and individual family members’ well-being.

Family Pedigree

Similar to a genogram, a family pedigree is a graphic representation of a person’s medical and biological history and is often referred to as the “family tree.” Like the genogram, the pedigree is a family history assessment tool developed in an interview with a patient; it includes three generations and involves the use of standardized symbols, which clearly mark individuals affected with a specific diagnosis to allow for easy identification (Yoon, 2003). Advances in genetics and genomics have brought pedigree analysis from the traditional prerogative of genetic specialists into mainstream primary care practice. When appropriately used, a pedigree generated from a family history can be one of the nurse
FIGURE 2-3 Sample genogram.
practitioner's most powerful clinical tools for health risk identification, diagnosis, and intervention, yet it provides little insight into family dynamics or the complex context of the patient and family in the community.

Nurse practitioners need a comprehensive, three-generation pedigree that records a patient's medical, social, and environmental history, thereby communicating an expansive scenario for holistic primary care practice. Such a tool can guide the identification of risk factors to inform the patient and family clinical decisions regarding care management strategies, psychosocial support, and education for reproductive decisions, risk reduction, and the prevention, screening, diagnosis, referral, and long-term management of disease. The family pedigree should indicate the age of individuals; if deceased, the age and cause of death; and any relevant health history, illnesses, and age of onset. If any genetic testing has been performed on family members, the results should be indicated on the pedigree. The ethnic background of each grandparent should be listed as well as any known consanguinity. A general inquiry about the more distant relatives should be made in case there is a possible X-linked disorder or autosomal dominant disorder with reduced penetrance (National Genetics Education and Development Centre, 2012).

While the genogram focuses on the family relationships and communication patterns, the pedigree is a collection of the family health history and an assessment of disease risk factors. It is used to develop a differential diagnosis for identified familial traits. Family history plays a critical role in assessing the risk of inherited medical conditions and single gene disorders. Certain types of cancer, such as

Table 2-5 Family Genogram Red-Flag Themes

<table>
<thead>
<tr>
<th>Red-Flag Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetitive patterns between generations, such as alcoholism, drug addiction,</td>
</tr>
<tr>
<td>divorce, or mental illness</td>
</tr>
<tr>
<td>Chronological coincidences, such as births, marriages, and deaths</td>
</tr>
<tr>
<td>Similarity of names, possible personality resemblances, or identity in upbringing, such as family favorites, family scapegoat</td>
</tr>
<tr>
<td>Cultural, educational, ethnic, and religious backgrounds—differences and similarities</td>
</tr>
<tr>
<td>Family patterns from husband’s and wife’s relations—similarities and differences</td>
</tr>
<tr>
<td>Family secrets, such as abortions, adoptions, or secret affairs</td>
</tr>
<tr>
<td>Significance of nicknames</td>
</tr>
<tr>
<td>Too much closeness between generations (absence of boundaries)</td>
</tr>
<tr>
<td>Poor or loose contact between the generations, as in cut off</td>
</tr>
<tr>
<td>Inappropriate alliances</td>
</tr>
<tr>
<td>Fighting and domestic abuse</td>
</tr>
</tbody>
</table>
breast cancer and colon cancer, appear more frequently in some families, as do some adverse birth outcomes. Coronary artery disease, type 2 diabetes, depression, and thrombophilias also have familial tendencies (Yoon, 2003). The U.S. Surgeon General’s Family History Initiative was launched in 2004. The goal of this initiative is to educate both healthcare providers and patients about the value of collecting a family history as a screening tool and to increase its use and effectiveness in clinical care by simplifying the collection process and analysis of the family history (Office of the Surgeon General, 2012).

Over the past 20 years, the Human Genome Project has afforded us a better understanding of the effect of genetic variation on health and disease. This has furthered research in identifying genotype–phenotype correlations and enhanced the ability to predict those at risk of developing inherited medical conditions (National Genetics Education and Development Centre, 2012). With increased awareness of the importance of using the family history as a screening tool and of the value of preventive measures and increased surveillance, there is hope for improved outcomes.

Although it may be best to take a systematic approach to enquiring about each branch of a family, sometimes this may not be possible in a busy primary care practice. There are some useful general questions, however, that can help the NP to gain a quick overview of the medical conditions in a family. Answers to these questions may trigger a need for drawing out how the people with the condition are related to each other. This would inform a preliminary assessment of whether there is an increased genetic risk that warrants further investigation, a detailed family pedigree, or specialist referral. Table 2-6 provides some key questions to ask individuals about their family history.

### Table 2-6  Key Questions for a Family History Warranting a Detailed Pedigree

<table>
<thead>
<tr>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td>Do you have any concerns about diseases or conditions that seem to run in either your or your partner’s side of the family?</td>
</tr>
<tr>
<td>Does anyone have a major medical, physical, or mental problem?</td>
</tr>
<tr>
<td>Has anyone ever needed treatment in a hospital?</td>
</tr>
<tr>
<td>Has anyone ever had any serious illnesses or operations?</td>
</tr>
<tr>
<td>How old was he or she at diagnosis?</td>
</tr>
<tr>
<td>(Avoid just asking “Is everyone well?” as past medical history may not be offered!)</td>
</tr>
<tr>
<td>Have any adults, children, or babies died?</td>
</tr>
<tr>
<td>How old were they, and what was the cause of death?</td>
</tr>
<tr>
<td>Have there been any miscarriages or babies who were stillborn?</td>
</tr>
</tbody>
</table>
Figure 2-4 and Figure 2-5 show the process of drawing a family tree and the symbols used.

More samples of pedigree diagrams for healthcare professionals can be found by visiting http://www.geneticseducation.nhs.uk. A PowerPoint presentation showing the process of creating a pedigree as well as exercises to practice making family histories and pedigrees can also be found on this website.

**Family Risk Assessment Tools**

The screening tool selected should be tailored to the practice setting and patient population, taking into consideration patient education level and cultural background. Whether a pedigree diagram or questionnaire is used, it is important to review and update the family history periodically for new diagnoses within the family.

**FIGURE 2-4** Drawing a family pedigree.

*Source: Genetic family history pedigree images, printed with permission from the NHS National Genetics Education and Development Centre.*
Family assessment and family interviews

A family history screening tool will allow the healthcare provider to stratify levels of risk (Centers for Disease Control and Prevention, 2012). Moreover, the use of a family history screening tool (pedigree or questionnaire) has been shown to increase by 20% the likelihood of detecting a patient at high risk of developing an inherited medical condition compared with medical record review alone (Yoon, 2003). Table 2-7 lists red flags for genetic conditions that may warrant referral to a genetic specialist (National Coalition for Health Professional Education in Genetics, 2012).

**Ecomap**

Similar to the genogram, the ecomap is a pictorial representation of a family’s contact with larger systems. These systems can include school, work environment, place of worship, healthcare agencies, social support agencies, courts, recreation, housing, and friends. The ecomap is used to clarify reciprocal relationships between family members and the broader community. It provides a way of assessing resources and strengths of family relationships with significant others, organizations, and institutions (Reed, 1994; Bomar, 2004). The ecomap

**Figure 2-5** Other pedigree symbols.

*Source:* Genetic family history pedigree images, printed with permission from the NHS National Genetics Education and Development Centre.
allows the nurse practitioner to view both the nurturing aspects of the families’
world and the family’s stress-producing connections. Often the ecomap shows
deprivation of resources, which can assist the nurse practitioner in developing an
adequate plan of care for the family (Wright, 2009).

Typically a simplified version of the genogram is developed first and can be
placed in the center of the ecomap circle. Outer circles represent significant peo-
ple, agencies, or institutions in the family’s context. Lines are drawn between the
circles and the family members to depict the nature and quality of the relation-
ships and to show what kinds of resources are moving in and out of the family.
 Straight lines denote strong or close relationships. Wider or thicker lines show
stronger relationships. Straight lines with slashes show stressful or strained rela-
tionships. Broken or dotted lines show tenuous, weak, or distant relationships.
 Arrows are drawn to indicate the flow of energy and resources between people
and the environment. The ecomap provides the nurse practitioner with a more
integrated perception of the family situation and can be helpful in assisting the
family to define goals and increase its use of community resources (Kaakinen,
2010). A sample ecomap is shown in Figure 2-6.

### Table 2-7  Red Flags for Genetic Conditions

- Family history of a known or suspected genetic condition
- Ethnic predisposition to certain genetic disorders
- Close biological relationship between parents (consanguinity = blood relationship of
  parents)
- Multiple affected family members with the same or related disorders
- Earlier than expected age of onset of disease
- Diagnosis in less-often-affected sex
- Multifocal or bilateral occurrence of disease (often cancer) in paired organs
- Disease in the absence of risk factors or after application of preventive measures
- One or more major malformations
- Developmental delays or mental retardation
- Abnormalities in growth (growth restriction, asymmetric growth, or excessive
growth)
- Recurrent pregnancy losses (> 2)

**Source:** The National Coalition for Health Professional Education in Genetics (NCHPEG).
Available online at [http://www.NCHPEG.org](http://www.NCHPEG.org)
FIGURE 2.6 Sample ecomap.

**Hucks Family Ecomap**

- **Work at General Electric**
- **Home projects and ETOH**
- **Church**
- **Playgroups**
- **Professional organizations**
- **Nursery school**
- **Extended family**
- **Church**
- **Friends**
- **Recreation time as a family**
- **Josie the family dog**
- **Allie the au pair**
- **Isabella the au pair**
- **Catechism**
- **Extracurricular activities**
- **School and teachers**

**Structured Assessment and Family Interviews**
FAMILY PROBLEM LIST

Following careful assessment of the individual in the context of the family unit, the nurse practitioner must develop a comprehensive prioritized problem list. The Problem Oriented Medical Record (POMR) and the “problem list” date back to the 1960s; they were developed by Dr. Lawrence Weed as a simple way to document and manage important health problems facing a patient (Holmes, 2011). Today the problem list still exists as an acceptable model of documentation in both paper and electronic medical records. The contents of the problem list may vary from one healthcare organization to the next and may vary depending on the healthcare provider’s preference. In general, nurse practitioners and other primary care providers agree that the problem list should contain the following general information:

- A list of chronic diseases or illnesses
- An ongoing or active problem that you are working on with the patient
- A summarization of the most important things about a patient

There is some debate about what diagnosed illnesses are worthy of the problem list. Currently the decision of which problems are included or excluded remains largely up to the judgment of the practitioner. Some practitioners will exclude certain information as it may “clutter up” the record with extraneous information (e.g., lab results or “sensitive issues” such as sexually transmitted infections or mental health issues). Primary care nurse practitioners provide integrated, accessible healthcare services and are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community (DeNisco & Barker, 2012).

In caring for the individual patient in the context of the family unit, it is important for the nurse practitioner to maintain clear documentation of the family’s healthcare needs. At minimum the problem list should include the following elements: acute self-limiting problems, routine health maintenance issues, allergies, family planning, social problems, and chronic health problems.

Acute self-limiting problems are problems that may be acute or short term. For example, streptococcal pharyngitis is an example of an acute self-limiting problem. Nocturnal leg cramps, upper respiratory infection, and contact dermatitis are other problems that fall into this category. Routine health maintenance refers to health promotion and screening activities that are needed by the patient per age and risk factor analysis. This includes but is not limited to mammograms, annual physical examinations, pap smears, immunizations, and well-child care. Allergies would include allergies to medications, food, dust, and mold. Family planning
would address contraceptive needs of the family including infertility issues. Social
problems take into account the toxic history of the patient or family members
(e.g., tobacco use, substance abuse, alcohol use). Chronic health problems include
long-standing diagnoses the healthcare provider is following (e.g., hypertension,
type 2 diabetes, hyperlipidemia, asthma, migraine headaches).

The other category is a net to catch all other problems that may be important
to remember as you care for the patient. This may include family problems (death
of family member, mental health issues, school truancy), financial problems
(unemployment, entitlements such as food stamps), sexual preferences, and so on.

There are many issues complicating the maintenance of a patient problem list.
If the list is messy, unorganized, or partially completed because the healthcare pro-
vider did not have time to add problems, the list will not be used effectively. The
usefulness of problem lists in the care of the individual patient and family is based
on the ability of nurse practitioner to articulate patient problems (when identi-
fied) and follow consistent guidelines that ensure the lists are current and useful.

The family problem list includes these categories:
- Acute self-limiting problems
- Routine health maintenance
- Allergies
- Family planning
- Social
- Chronic problems and other

**Family Problem List/Case Study Exercises**

Read the following cases and develop a comprehensive problem list for each case.
If you do not have enough information to develop a list for each problem cat-
egory as described above, propose what questions you would need to ask the
patient and family to gather the information you need.

**Case Study One**

Ms. Belcher is a 48-year-old married white female and has children
and three grandchildren. Ms. Belcher has a long history of schizoaf-
fective disorder and also has chronic medical problems including type 2 diabetes mellitus, hypertension, coronary artery disease, and so
Ms. Belcher has resided at the same low-income housing project for many years. Her husband, who is African-American, also suffers from schizoaffective disorder and has a multitude of chronic health problems and has been hospitalized recently for renal insufficiency. Ms. Belcher’s daughters, age 19 and 15, reside at home and are very important in Ms. Belcher’s life. The youngest daughter was hospitalized last year for a new diagnosis of bipolar disorder, and Ms. Belcher was very concerned about this. She was worried that Department of Children and Families would take her daughter out of the home.

Despite these adversities, Ms. Belcher has an optimistic view regarding her family life and does her best to care for her husband and daughters. She does have moments were she becomes very somatic and visits her healthcare provider frequently for reassurance. Ms. Belcher reaches out to her psychiatric visiting nurse and her primary care provider for support when the going gets tough.

Case Study Two

Ms. Dora Roman is a 50 year-old Hispanic female who resides in her car on the streets of Bridgeport. She relocated to Connecticut 1 year ago after she left an abusive relationship with her husband while residing in Florida. Ms. Roman is educated as an LPN and has worked in long-term care settings in the past. She has a history of sarcoid and other chronic medical problems. She seeks medical care at the local community health center since relocating to Connecticut and had her medical records sent to Connecticut so she can have continuity of care. Ms. Roman has a sister in Connecticut and uses her house occasionally in the bitterest cold nights, but mostly sleeps in her car and uses the public beach bath house for hygiene purposes. Since relocating to Connecticut, she has worked seasonally at a Halloween store in the local mall.

Ms. Roman has filled out applications for subsidized housing and Medicaid entitlements for health care, but for unknown reasons
Ms. Tamika Jenkins is a 30 year-old African-American single mother of three children and resides in an economically disadvantaged housing project in the inner city. She frequently visits the health center with a multitude of complaints typically focused around injury. In the past 6 months, Ms. Jenkins has been seen for a miscarriage, a fractured wrist related to a fall while rollerblading, and a head injury related to an altercation with another woman for unknown reasons. Ms. Jenkins states that her husband is incarcerated and she has no family support; her mother died of HIV when she was a teenager, and she doesn’t speak to her father. When she presents to the health center she is anxious and despondent and seeks pain medication. She seems to have little insight into her problems. She is currently being investigated by the Department of Children and Families for child neglect.

Seminar Discussion Questions

1. Describe the characteristics that constitute a healthy family.

2. Develop a three-generation family genogram on a partner and build a comprehensive problem list for one family constellation.

3. Draw your family ecomap, and outline the various family relationships to institutions, leisure activities, and agencies. Define which relationships are stress producing and which foster support. Discuss how the individuals in the family are linked to significant people and how they engage in social support.

4. Consider the family capacity model when reading the case of Dora Roman, and outline family strengths, function, needs, goals, and supports needed to maximize the family potential.
REFERENCES


ADDITIONAL RESOURCES


