BRIEF INTERVENTIONS: FAMILY COMMUNICATION PROBLEMS

BI-PED PROJECT (BRIEF INTERVENTIONS: PEDIATRICS)
Emotional Health Committee Maryland Chapter American Academy of Pediatrics

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COMMUNICATION and RELATIONSHIP BUILDING: Parents often become embroiled in conflicts with their children. The following are some approaches that families can utilize to improve communication:

(1) Active Listening: Parents can be encouraged to engage in "active listening" with their children and teenagers. This approach entails listening to their child and empathetically feeding back what the parent perceives to be the underlying concern. Parents may be most effective by really *listening* and refraining from the impulse to *interrupt, lecture* or *fix* the problem.

For example:

Child: "I hate school. My teacher yelled at me because I wasn't paying attention."

Parent: (active listening) "It sounds like you are really upset because your teacher yelled at you" versus "maybe you do need to pay more attention" or "perhaps if you sat closer to the teacher, you could better pay attention".

(2) <u>"I" versus "You" Messages:</u> "I" messages allow parents to frame concerns in a way that does not put their child or teenager on the defensive. When using an "I" message, the parent is basically stating that "I feel ___ when you ____because_____" . "You" messages tend to be attack messages and are more likely to lead to conflict.

For example:

Parent: ("You" message:) "I am sick and tired of your getting home late when you are out with your friends".

Parent: ("I" message:) "I am <u>*upset*</u> … (*scared, worried, sad, disappointed*) <u>*when you*</u> get home late <u>*because*</u> I am concerned that something bad may have happened."

During the meeting with the child and parents, the practitioner can have the family practice these techniques with each other (e.g. "can you say that to your daughter directly using an "I" message?")

(3) <u>Open Ended Questions</u> :

- **Parents can keep a conversation moving by asking open ended non-judgmental questions such as "…and then what happened?" or "tell me what you think about that" to keep their child engaged. Asking judgmental or close ended questions such as "why do you always do that?" or "do you really want to fail?" shut down communication**

(4) Conversation Extenders

- **Once a parent has established their concern with their child, they may wish to continue the conversation by asking the child permission to further talk about it. For example, "I am really nervous when you go to a party without parental supervision because I am concerned that you could drink too much and get hurt. Is it ok if we talk about this?"**
- **Parents should also seek to discover the best time for dialog. Some kids prefer morning, afternoon or bedtimes. Meaningful conversations can also take place during a drive to or from school**

- **Sometimes parents can open a dialog of communication by sharing a story ("you won't believe what happened at work today…")**
- **Some kids will talk about what seems like trivia (who said or wore what) but these conversations can often lead into more substantial conversations that provide insight into the child's life if parents are willing to remain patient and listen**

(5) Changing the nature of arguments:

- **Sometimes changing the circumstances of the argument can reduce conflict. For example, the parent and teen may wish to *schedule an "argument"* at a specific time or by email**
- ***Humor* can be a powerful way to reduce tension. They can try putting on funny glasses when arguing. Parents can send a note to the child from the garbage can- "Dear Joe: Please take me out"**
- **Parents may also simply wish to give themselves a "*time out*" and leave the scene or take a break if embroiled in an argument that is starting to escalate**
- ***Ground rules*: parents should expect *respect* from their kids. Ground rules for conflict should include the condition that parents will not be verbally abused by their children. Parents also need to treat their kids respectfully**
- ***Special Time*: parents can also be advised to go on a "date" with their child or teen, selecting something to do that they both enjoy. The underlying stipulation is that they are *not* to argue during this time. These kinds of activities can improve the parent child relationship and reduce conflict**

(6) Recognizing good behaviors:

- **Parents should recognize when their kids and teens have engaged in appropriate behaviors. A simple acknowledgement can go a long way to reinforce positive behaviors (e.g. "thanks for calling before you left the party", " I appreciate your coming home on time last night", or " I am glad to see that you are trying harder in school")**

PROBLEM SOLVING and the ART OF NEGOTIATION: "What do you need?- What do I need?- How do we get there?"

Parents and child/teen can be encouraged to reduce conflicts by problem solving in a systematic way. Conflict between parents and teens typically stems from *different agendas*: parents are concerned about safety and good decision making; adolescents are concerned about autonomy and creating distance. It is helpful to point out to parents and teens how these different agendas lead to conflict.

(1) Identifying the problem:

- **Simply identifying and listing out problems can lead to unproductive reciprocal blame games. On the other hand, using a "*solution focused*" approach helps direct the discussion towards a more productive endpoint. The problem and goal should be defined by observable behaviors**
- **Family members have a tendency to blame each other in vague or negative ways when asked to identify the problem e.g. "she needs to stop talking back" or "my parents need to just leave me alone"**
- **A solution focused approach encourages the family to *think about what each member will be doing differently* when the problem is solved, focusing on *positive* action. The clinician can ask "what will each of you be doing differently when the problem is solved?"**
- **The "*miracle question*" is another way to get the family to focus on positive solution focused action. The clinician can ask "if I could wave a wand and a miracle occurred, what would you be doing differently when the problem is solved?" Another approach is to ask "if I was to review a video tape or if I was a fly on the wall, what would I see you doing differently?" or "what will others see you doing that will let them know that things are improving?" For example, instead of describing the problem as "she needs to stop talking back", the solution focused approach could redefine the problem as "when I speak to her, she needs to speak back to me in a calm voice and remain polite". "My parents need to leave me alone" can be reframed as "when I need to be left**

alone, I can politely let my parents know that I do not wish to talk right now but that I will seek them out later in the day to calmly discuss the matter"

- **For most families the identified problem is not occurring all of the time. It is therefore helpful for the practitioner to have families think about what is going on when the problem is *not* occurring. These "*exceptions*" allow the family to think about "what already works?" The clinician can ask "are there pieces of the miracle that are already happening?" or "what is going differently when the problem is *not* occurring or when things are going well?" This approach allows the family to focus on what they are already effectively doing to avoid conflict**
- **For younger children, the problem can be identified by *externalizing* it (e.g. name the problem or draw a picture of the problem so that it can be *attacked*). For example, the clinician can ask the child with anger issues "how will you "*tame"* the anger monster…. , the sloppiness bug….or the screaming jeebies…?" or for the child with anxiety "how will you shrink the fear troll?" Externalizing the problem allows the child and family to view it as something that can be controlled and resolved through action**

(2) Brainstorming:

- **Once the problem and goal are defined by observable behaviors, the family can be asked to come up with potential solutions that will lead to the desired result. At this stage, all suggestions no matter how outrageous should be listed. The practitioner can also make suggestions, but it is best to let the family take the lead so that they remain invested in implementing the devised plan**

(3) Selecting and Implementing a Solution: What do I need? What do you need? How do we get there?

- **At this stage, the family should select a solution that they are willing to implement. This should be done when everyone is calm. The plan should be kept simple and a *compromise* should be adopted that everyone can live with and agree upon. Parents should be clear about their**

expectations but should listen seriously to their child's perspective. A solution should be sought that embraces a spirit of compromise- "I am willing to do___ if you in turn are willing to do___".

- **In addition, *consequences* for a breach of the agreement should be clearly spelled out. "If you do X, then Y will occur (e.g. "if you come in 20 minutes late from the party, you will need to come home 20 minutes early next time") (see discipline module)**
  It is also reasonable for parents to acknowledge that they cannot realistically monitor their teen's behavior outside of the home and to say "I cannot be everywhere to make sure that you are following the agreement so I am placing my trust in you and ultimately it is your choice. However if I discover that you have broken our agreement, there will be consequences". Consequences need to be realistic and *enforceable.* (e.g. do not ground a teenager for 6 months)
- **Parents and their children and teens should also discuss how *loss of trust* can be hard to repair. In fact, disappointment and loss of trust is a natural consequence of misbehavior and can be particularly effective if the parent and child/teen have a good relationship. For example, "You came in really late and I am disappointed. I am not sure I can let you use the car again until you have demonstrated that I can trust you and you can come in on time"**
- **Contingency plans should be discussed to consider what the family will do if the plan does not go smoothly. If there is an infraction of the agreement, the family should again discuss the consequences that will be applied**

CLINICIAN INPUT: MISCELLANEOUS INTERVENTIONS:

(1) Physician Input:

- **Clinicians should try to let the family provide solutions. However, it is often helpful for the clinician to make suggestions as well. The clinician can ask permission to make suggestions or tell a story about a family that faced similar problems and how they solved them. The clinician can also use the *third person* approach "many of my families have found …... to be helpful in dealing with this kind of problem"**
- **The practitioner can conclude with an expectation for successful change with a statement such as "I know you are a caring parent and want to do the best for your child so I am sure that you will make the right decisions to help your child" or "I know that despite the arguments you do care about your parents so I am confident that you will give this plan your best effort"**

(2) Reframing:

- **Sometimes the clinician can reframe the problem to allow the family to look at it in a fresh way. For example, in a family struggling with bed wetting, the practitioner can point out that the problem behavior takes place for several seconds of a very long day. If those few seconds can be corrected, the problem can be solved. This reframe recasts what is perceived as a pervasive problem to one that only occurs briefly each day**
- **The clinician can also point out (if appropriate) that the problems causing conflict only occur during a fraction of the day or week and that most of the time, the family is doing fine. Encourage the family to think about the things that are going well and what they are doing successfully during those times**
- **The identified problem can also be *reframed and redefined* in a positive way. For example, the child with an attention deficit disorder can be redefined as a child who needs to focus more. The child who is failing school can be redefined as a child who is not passing *yet*. The child who is angry can be redefined as a child who needs to gain control over his anger. The child with enuresis can be redefined as the child who has not**

learned to stay dry *yet.* These types of redefinitions move the identified problem from simple labeling towards an implicit statement of what needs to occur for the problem to be solved

(3) <u>Working with Parents:</u>

- **In some families, one parent appears to be *over-involved* in dealing with the problem while the other parent is more *peripheral*. The clinician can help to correct the imbalance by advising that the more peripheral parent pick up some additional responsibilities such as taking the child to school, putting the child to bed, enforcing consequences for misbehavior and giving the over-involved parent some regular time off**
- **Parents can also be advised to try to find time to go out together on a regular basis doing something that they enjoy as a way to reduce family stress**

<u>Follow-up and Referral:</u>

- **A follow-up meeting should be set up to evaluate how the plan is going and to make any necessary revisions**
- **The practitioner should refer the child and family to a mental health consultant under the following circumstances:**
    - **♦ Child or parent has significant psychopathology**
    - **♦ Significant marital discord**
    - **♦ Patient or parents request a referral**
    - **♦ Poor response to primary care mental health interventions**
    - **♦ Primary care clinician is uncomfortable managing the case**

REFERENCES:

Family-Focused Behavioral Pediatrics **(2nd ed.) , William Lord Coleman M.D., American Academy of Pediatrics, 2011.**

Family –Focused Pediatrics: Issues, Challenges and Clinical Methods, ed. William Lord Coleman M.D., ***Pediatric Clinics of North America,*** **February 1995.**

Family-Focused Pediatrics: Solution-oriented techniques for behavioral problems, William Lord Coleman M.D., ***Contemporary Pediatrics,*** **July 1997.**

Family-Focused Behavioral Pediatrics: Clinical Techniques for Primary Care, William Lord Coleman M.D. and Barbara Howard M.D. , ***Pediatrics in Review*** **Vol 16 No.12 December 1995.**

Parent/Teen Breakthrough: The Relationship Approach**, Mira Kirshenbaum and Charles Foster, Plume, 1991.**

Childhood Unbound: Saving Our Kids' Best Selves- Confident Parenting In a World of Change **, Ron Taffel, Free Press, 2009.**

Why Parents Disagree and What You Can Do About It**, Ron Taffel, Avon Books, 1994.**