

CHAPTER 8

Psychotherapeutic Intervention: From Individual Through Group to Extended Network

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THERAPEUTIC PERSPECTIVE

In Chapter 2, we were introduced to the biological, psychological, and social aspects of Kevin, Helene, and Mary, and we learned the benefit of using a wide angle lens to let us see the total picture of their lives. In the same way, the perspective selected by the psychotherapist influences the therapist's therapeutic direction, as well as the therapy outcome.

In the case of patients with HIV infection, it becomes almost impossible to narrow the lens. They are embedded in their social networks and cannot be viewed from a purely individual perspective. However the issues are presented, the AIDS patient's significant others are inevitably involved. This involvement may be limited to their concerns about their own vulnerability to infection or extend to their feelings about losing someone they love. In addition, this disease involves significant responses from the community. Community agencies, self-help groups, and medical care providers have become intensively involved. Patients may also be connected to the legal system or be a member of a political action group.

Why should the psychotherapist be concerned about these systems at the clinical level? Although Mary's therapist saw her alone, it was impossible to view her without considering her children, her mother, her boyfriend, her socioeconomic background, her hopes and dreams. It was crucial for the therapist to understand these multiple systems levels, regardless of what form of clinical intervention was to be used. In the same way, Kevin's main

concern was the care of his mother after he was gone. He hoped his spouse/lover would continue to be a son to her. Kevin also dreamed about leaving a legacy to the community. He wanted to contribute to AIDS prevention and education—but not at the cost of those he loved.

How can we as therapists understand enough and deal with all the systems levels that concern our patients? In Helene's case, the therapist's sensitivity not only to her nuclear family system but also to her extended family and cultural background became critical. If we apply the model described and diagrammed in Chapter 2, we can more easily identify the systems of which we need to be aware in order to provide her with good clinical care. Following the diagram, and starting with (i) the biopsychosocial level, we expand to (ii) the level of the natural support system: Helene's nuclear family, extended family, boyfriend and intimate friends; her student colleagues and work system; her minister and religious community, and her primary medical care system (family doctor), and her community agency support (AIDS community service, AIDS Hotline). This brings us to (iii), the level of ancillary or artificial support system: the specialty AIDS Clinic, Helene's nurse and psychiatrist; her group therapist, and the group members in the AIDS Women's group within the psychiatric service.

In Helene's case, in order to obtain a truly ecosystemic view,¹ we need to consider the next level. Level (iv) includes cultural, spiritual, and philosophical world views and incorporates world events at economic, political, geographic, and even geological levels. For Helene her cultural tradition was extremely important, and her migration away from her traditional context was motivated by political/economic factors.

In certain cases, issues pertaining to membership of minority groups (either gay, racial, or ethnic), disenfranchisement, and prejudice may need to be addressed. These issues impact at a political and economic level as well as at a personal level; failure to consider them may lead to failure of therapy. Patients might also be discriminated against for their behavior patterns, such as substance abuse, (which, of course, is a very high-risk behavior for transmitting the disease). Substance abusers are engaged in self-destructive behavior and have frequently given up hope at the social levels. Risk of HIV infection, or the disease itself, requires attention to the special characteristics of substance abusers and their families in contrast, for example, to those who are at risk or have acquired the disease through blood transfusion. The issue of vulnerability in self-destructive behavior is best viewed from a larger systems perspective and will be discussed below.

Not only the disenfranchised (although this group is perhaps most vulnerable), but anyone facing the possibility of HIV infection feels guilty, deserving of blame, and shamed. These feelings make it difficult for patients to engage in therapy and particularly difficult for them to bring their significant others into therapy sessions. In the pages to follow, we will

present a number of methods and techniques for working with the resistance and for successfully engaging the extended system.

Joining the extended family system, both literally and figuratively, of patients with HIV disease becomes critical for many reasons. These are patients facing chronic illness and death. Despite the frequency of apparent cut-offs, connection to family takes on an urgency. Time is compressed for AIDS patients and their families—development and resolution of relationships that should take many years need to occur in a very short period. The disease also distorts, even to the point of reversal, the natural family life cycle. Children become critically ill before their grandparents and parents, often leaving their children to be cared for by the elders of the family. Even the future of the next generation may be threatened, if an only child is infected with HIV and cannot continue the family line by producing descendants. This signifies far more than the loss of an individual for it may be the loss of an entire family's future. Reconnecting the family's transitional pathway across generations, while looking for meaning in their value systems and contributions, becomes essential; helping them to deal with issues of death, dying and the loss to be suffered by survivors is key.

Therapists are not usually trained to deal with the imminent loss of young patients unless they have specifically worked in the area of oncology or Medical Family Therapy.^{2,3} They may also not be attuned to dealing with the family following the loss of their patient or to helping the patient and the family plan for the death of the patient and placement of his or her children. Where does the responsibility of the therapist lie? With whom is the primary relationship? Where are the boundaries? Does the therapist visit the patient in the hospital? At home? Who attends the funeral and who helps the family after the death? When does involvement in these activities become overinvolvement, or excessive countertransference?

The threat of loss colors every aspect of the therapy. It is usually perceived in terms of its negative consequences. However, there may be major positive effects of this time compression and urgency of reconnection. If the therapist is open to engaging the extended system to its full capacity, a great deal of healing across the system becomes possible.

All of these issues can be addressed within a systems approach to therapy. The model detailed below is an adaptation of the Rochester Family Therapy Model which, in line with the seminal work of Speck and Attneave,⁴ applies network theory as an effective means of change. Unlike Speck and Attneave, who used family networks as a component of therapy, usually as a "last resort," the Rochester Model considers it the method of first choice.⁵⁻¹⁴ Similar to Speck and Attneave's conclusions, we've found that the more extensive the network, the more effective the treatment. Also, the earlier the involvement of the larger network in therapy, the more rapid is the healing process. Various other network therapy approaches have

developed over the years, following Speck and Attneave's work.¹⁵⁻¹⁹ However, the following pages reflect the use of the Rochester Model.

THERAPEUTIC PRINCIPLES AND TECHNIQUES PART I. OUTLINE OF THE THERAPY SESSION

1. Joining and Determining the Level of Intervention

Therapists need to be particularly sensitive to generational hierarchies, non-traditional family constellations and issues of gender when working with these clients and their families. We find it helpful to encourage all present to greet each other by physical touch, which normalizes the process and helps it resemble everyday social exchange. Joining techniques such as utilizing one's position in the room and the sequence of handshakes and verbal participation are also useful.

The complexity of levels that become evident during the joining process and bear consideration when treating people who are infected with the HIV virus is further illustrated by the case of Amy:*

Amy was a 39-year-old woman who abused cocaine and was diagnosed as being HIV positive. Amy presented for therapy stating that she was severely depressed and experiencing great difficulty in managing her teenage children. Shortly into the session, Amy revealed another purpose to her visit when she produced a disability form, which required urgent signature as she was out of funds. Her economic crisis had arisen because, being only HIV positive and not diagnosed with AIDS, she had no access to medical care.

As Amy's personal history unfolded, it became apparent that her case could easily have confounded an individual therapist committed to the confidential psychiatric care of his or her patient. It could also have stymied the enthusiastic therapist committed to the immediate resolution of the patient's problems. Amy's situation raised questions of what level to intervene at, which treatment systems to include, what priorities to set, how to identify manageable goals for treatment, and how to design the process to achieve the desired outcome of therapy.

History revealed that both Amy and her fourth husband, Brian, had been heavily implicated in the cocaine trade. Both of the children hated Brian and blamed him for bringing cocaine into the house.

*Therapist, Ann Zettelmaier Griep, M.D.; supervisor, Susan McDaniel, Ph.D. This case was treated in the Family Therapy Training Program of the University of Rochester.

Violence had become a common occurrence in the home and the children had also witnessed their parents' involvement in outbursts of violence in the streets.

Amy's own family lived in Europe and was not easily accessible to her. Her move was partially an attempt to expand her family support by including the children's own father and his extended family who were from the area. She wanted to ensure that the children would be taken care of in the event of her death. Her contact with her ex-husband had been minimal, however, and when she arrived in upstate New York she found that he was no longer living there.

Mental health status examination was essentially normal, with evidence of some anxiety and depressed mood. There was no sign of major depression or suicidality, nor was Amy psychotic. Her cognitive functioning was normal and there was no sign of neuropsychiatric problems.

From the above, the therapist determined that the issue of psychiatric disability was marginal, particularly since HIV infection was not then seen as qualifying the patient for disability. In order to resolve the therapeutic dilemma, the therapist decided to employ the patient's motivation for disability to aid her in the therapy. The therapist insisted that she was unable to make a clear determination without the assistance of Brian and the children. The therapist was now involved at both the individual/biopsychosocial and nuclear/relational family levels.

2. Establishing Strengths and Resources

Amy, Brian and the two children presented for the second session. Shortly after the therapist had developed rapport with Brian and the children, and reconnected with Amy, the session commenced with Brian's statement, "Doc, here I am, HIV positive. It's a bitch to be dying of AIDS in the 80s."

The therapist hastened to look for positive metaphors and reframes to establish what strengths the family had to draw upon to help them deal with the overwhelming events. Families facing infection with HIV are invariably anxious, fearful, and somewhat depressed. They have frequently given up hope and feel responsible and guilty, or blamed, for their predicament. Many AIDS families belong to devalued, disenfranchised, or denigrated groups. These include the gay population, minority groups, inner-city lower socioeconomic families, substance abusers, and people who sell sex. They are already acutely aware of the manner in which they are viewed by society; AIDS only intensifies the self-denigration, guilt, rejection, and inevitable blame. Their cups are always half empty and it is dif-

difficult for them to envisage a future. Thus they are less likely to seek external resources that could assist them with their problems. Helping them to view their difficulties from a more positive perspective allows them to uncover options that may not have occurred to them.

A caveat is that positive reframes and metaphors intended to assist families must always be reality-based and the therapist needs to believe in them. An empty Pollyanna promise is of little benefit, since it undercuts the credibility of the therapist and prevents the building of a trusting relationship, an essential for successful therapy. In looking for a positive perspective to share with families, it is useful to explore the relationships prior to the current problems. Helping family members to get in touch with the positive aspects of their earlier relationships helps them to gain motivation, self-confidence, and hope for dealing with current problems.

Brian was Amy's fourth husband; they had been married for one and a half years. Amy said that this had been her longest relationship since the dissolution of the abusive first marriage to the children's father. Amy had fallen in love with Brian, a likeable, funny disc jockey living a very glamorous fast life, who provided her with constant excitement. They were both facing the loss of this lifestyle and confronting the real possibility of their death. The therapist reframed Brian's earlier statement by suggesting that they all work out a formula not for "dying with AIDS in the 80s" but for "living with AIDS in the 90s."

This created an immediate mood shift in the therapy session by focusing their attention on living one day at a time and gaining as much enjoyment as possible from those days.

In addition to helping the immediate family gain a more positive perspective, it is important to use a multigenerational perspective. The intergenerational models of family therapy have stressed the importance of the family context through time, generally including at least three generations.^{20,21,22} With AIDS cases, it is particularly crucial to provide such a perspective, since both patient and support system could be easily demoralized if they looked only at the immediate situation. The rationale for this will be described in more detail later in this chapter in Part Two on the explanation of the therapy model.

We have found that the further back one goes the greater the positive information one derives. An effective method for allowing patients and families access to their own competence is encouraging them to look for strengths and resources across the multigenerational extended family and the natural support system. In order to do this, we ask them to list family strengths that have come down to them across time from previous generations and that they would wish to have perpetuated in their children and grandchildren. A list of family strengths developed by Emily's family may

be seen in Table 8-B later in the chapter. The list of strengths may be compiled during the initial phase of the session as part of the joining process and then expanded during the mapping process or it may be elicited during the mapping process. In either instance, it may be added to throughout the process of the therapy.

3. Mapping the Natural and Artificial Support Systems

Extended family and natural support system. Another method for assisting the family in the development of a multigenerational perspective is through the construction of a genogram, which is a graphic display of the extended family over at least three generations.²³ This allows us to explore births, deaths, marriages, separations, and divorces across the extended family system and to gain an impression of multigenerational patterns. Genograms provide ". . . a quick gestalt of complex family patterns and a rich source of hypotheses about how a clinical problem may be connected to the family context and the evolution of both problem and context over time."²³ The method and symbols we use for our genograms are those developed by Bowen²⁴ and detailed by McGoldrick and Gerson.²³ An example of the genogram may be found in Emily's case, in Figures 8-1 and 8-2, later in the chapter.

We then expand the genogram into a transitional map, further examining and diagramming the many facets of change across time and how they may be connected to present difficulties. In an attempt to determine how the wider context may have interfaced with family life-cycle events depicted on the genogram, we include, for example: culture and country of origin and any changes over time; changes in values, traditions, rituals, religion or spiritual culture; geographic moves; major economic or political changes; natural disasters and any other major events.

Once these have been added to the genogram, we explore with the family whether there have been any family life cycle stages or other transitions that have been difficult for them, and whether these difficulties have been repeated over time across the generations or across sibling and cousin subsystems (i.e. vertically or horizontally on the genogram). If these appear, we mark them with the symbol for transitional conflict. This stage of mapping Emily's family will be found in Figures 8-3 and 8-4.

Since we generally use a color code to simplify the interpretation of complex lines, we have divided the genogram and transitional map of Emily's family into four figures to demonstrate the stages of their development (Figures 8-1 through 8-4). The color code we use in order to consolidate the transitional mapping process into one diagram is: black for all factual information, family members, and members of the natural support system; blue for natural support system relationship lines; red for problem areas or symp-

toms, as well as for members of the ancillary support system and their relationships to the family; and green for all transitions and transitional conflict lines.

Once the transitional map is drawn, the interpretation is completed by discussion of the strengths, resources, patterns, and themes that appear across generations. This allows the family to realize the inherent assets of their traditions, heritage, and values, seeing how these may have extended across generations and reaching a blame-free understanding of current events.²⁵⁻²⁹ The information is then consolidated into a time line, which provides a clear graphic of the coincidence of time-events and how they impact on the current situation.³⁰ Emily's time line may be found in Figure 8-5.

During the session, we have found that the easiest way to include the family in the mapping process is to use a large sheet of paper attached to an easel. This can then be brought to subsequent sessions for review, addition, or interpretation.

Through mapping, using the methods described above, the therapist was able to discover many strengths and resources in Amy and Brian's family, despite the obvious difficulties they faced. She began by praising them for their move, emphasizing that they had brought the children to a place of safety. The therapist then extended the transitional map to include both Brian and Amy's extended families, as well as that of the children's father. The therapist identified an apparent cut-off between Brian and his family as an area to explore later in the therapy.

In dealing with AIDS families, the process of mapping the family and exploring the strengths and resources of the extended system raises several issues of particular importance. In particular, unresolved grief, loss, and apparent cut-offs are common and deserve the therapist's special attention. The inclusion of members of importance in the support system, beyond the extended family, was also necessary in the case of Amy and Brian.

Amy had two very close friends living in the area, and one of these became her major resource during this time. Amy, Brian, and the children lived in the friend's home and the friend took very good care of them. If one fails to include the friendship network in one's questions, important information and resources may be missed. In addition to friends, inquiries should be made about linkages with other natural support system resources such as family doctors, clergy, neighbors, employers and work colleagues, and community support agencies. Amy had not had time to make these connections, and, in fact, had not even found a primary care physician by the time she presented for psychiatric help. The therapist was able during

the mapping process to identify this deficiency and took responsibility for linking her with the local AIDS clinic.

Ancillary, professional, or artificial support system. Although Amy had not had time to connect with an ancillary professional support system, her application for disability was steering her in this direction. It had begun to activate the relevant social support services. In dealing with HIV disease, therapists and counselors generally find that multiple services and professional helpers are involved during the course of therapy.

Healing losses, apparent cut-offs and unresolved grief: Amy appeared to have very little contact with her family in Britain, with the least contact occurring between Amy and her mother. Amy had left her mother, a prescription addict and alcoholic, in anger 20 years before and had no idea how to bridge the gap. The lack of contact had reached a stage of almost total cut-off between them. She had, however, maintained contact with her brother, thus keeping up with family events. She knew that her mother had cancer and was dying.

Amy's capacity to remain informed about family events despite her apparent cut-offs is not unusual. Research into substance abusers who appeared to be totally out of touch with their families has shown us that cut-offs are often more apparent than real. The substance abusers maintained detail knowledge about important family occurrences through a roundabout route of communication.³¹ In our clinical experience, the same applies within the gay population and with others at risk for this terminal illness.

Therapists may be pleasantly surprised if, in exploring this issue, they initially refrain from asking about close contact, instead asking about important family events such as births, deaths, illnesses, graduations, and marriages. Then, the inquiry can pursue the means by which this knowledge was acquired. Once the therapist has allowed the patient to express concern for the family and for its individual members, the patient will find it easier to deal with resolution of the cut-off. This is of particular urgency in HIV disease, since people die unpredictably and time for resolution and healing is limited.

Amy expressed intense guilt about the cut-off from her dying mother and sadness that she was unable to afford a trip to Britain or even a phone call. While facing her own death, she realized that she would never have contact with her mother again.

4. Establishing Treatment Goals and the Therapy Contract

When dealing with people who are overwhelmed and feeling unsure about being able to make any positive changes in their lives, it is useful

to establish clear treatment priorities and goals. Instead of identifying problems as such, the family may be encouraged to convert them into specific goals. Drawing upon the strengths and resources identified earlier in the session, the therapist might ask the patient and family, "What would you like to achieve using the multiple strengths that we have discovered?" Patients and families are frequently able to identify particular strengths that would be useful in achieving objectives that earlier in the therapy session seemed out of their reach.

Amy and Brian identified two primary goals as part of this process: their children's safety and ensuring that the children would be taken care of after their death. They were also able to express their wish, with some uncertainty as to how they would achieve it, to reconnect with their families. In addition, they agreed to work on their own issues with death and dying. Another goal was to maintain a sense of living life to the fullest while facing death.

The challenge for Amy and Brian's therapist at this stage was how to help them develop a realistic plan to deal with their request for disability and when (and even whether) to take on the issue of their substance abuse, since the latter was not listed among their goals. The therapist made several decisions about therapeutic choices and directions. She elected not to take on Brian and Amy's drug use at the initial family session, feeling that this would ensure their not returning for further therapy, especially since drug treatment was not their immediate priority. It was necessary to join the family and allow them to achieve some concrete sign of success in their stated goals before the other problems could be tackled. However, even if a family does not deal with an issue of this magnitude fairly early in the therapy, the addiction, and whatever other problems are being denied, will eventually have to be confronted. From the clinician's standpoint, it is primarily a matter of timing.

5. Enactment

In order to show the family that they are capable of meeting their goals, and that the strengths and resources that they have identified will enable them to do this, it is useful to employ the technique of *enactment* in the therapy session.³² Patients are encouraged to identify a primary goal, to state clearly which strengths they will be drawing upon to achieve it, and to start practicing how to do it right there in the session. If this is not done and the first attempt at home fails, they may lose their confidence in themselves and in the therapist. It may be extremely difficult for the therapist to help them regain at a later stage the feeling of competence that they have lost. When one is determining the goal for enactment, it is advisable not to choose the entire goal, but rather to identify a smaller, realistic component

of it, so that success may be ensured. A little success is far better than a major failure. In Amy's case, the goal that she and Brian identified as their first priority was reconnecting with their families. They both felt that the most urgent agenda was getting in touch with Amy's dying mother.

The therapist suggested that Amy call her mother immediately from the session. Amy was too frightened and did not feel ready, so the therapist assisted Brian in working with Amy to help her prepare to make the call at the next therapy session. Once she had become more comfortable with the idea and had successfully role-played the phone call, Brian was asked to practice again with Amy at home. Amy felt better as a result of the in-session enactment, supported by the homework, and was able to speak with her mother. The healing had begun.

6. Homework

Once the enactment is successfully concluded, homework tasks need to be set, again based on goals, strengths, and successful enactment.¹⁴ In Amy's case, the homework was an extension of the in-session enactment, drawing upon the strength of the marital relationship and the couple's determination to resolve relationships for the sake of their families of origin and their children. Homework needs to be circumscribed, realistic, and highly likely to succeed. For this reason, basing it upon the in-session enactment that the therapist and family have seen succeed is very helpful. Should the family return feeling bad about failure, the therapist needs to take full responsibility for having set unrealistic tasks. In Amy's case the therapy proceeded successfully. Amy had been able to have a meaningful talk with her mother and to resolve their cut-off in a warm and loving way during the in-session enactment. It appeared that she and Brian would be capable of following up the family networking and reconnecting outside of the therapy sessions.

The principles outlined above form a useful outline for both the first and subsequent therapy sessions. Again, it is important to establish strengths and resources early in the session, during the joining phase and while constructing the maps. Doing this makes it far easier for the family to establish realistic goals with hope of a good outcome. It is also useful to ensure that closure of the session is formalized.

7. Session Closure and Formalized Greeting

During formal closure, repetition of some of the joining techniques are very useful. For example, shaking hands with AIDS families takes on far more meaning than in other contexts. It is important during both the opening and closing joining to ensure contact between all members of the group

present (including patient and therapeutic systems). This formality also assists in normalizing the session by helping families to feel the similarity between this ritual and those of other normal family events (such as financial distress, relocating, career planning, births, weddings, and funerals).

THERAPEUTIC PRINCIPLES AND TECHNIQUES PART II. EXPLICATION OF THE THERAPY MODEL

The previous section provided some specifics for organizing the first therapy session. It gave a feeling for how treatment is initiated and for some of the particular interventions we use with such cases. This section presents the major components of the Rochester Model that apply to the treatment of HIV disease:

1. Cooperation across systems and the engagement and building of a therapeutic team
2. Explicating the transitional pathway.
3. Resolution of unresolved grief, loss and cut-offs.
4. Recognizing scripts, themes and issues of loyalty.
5. Exposing secrets.
6. Resolving transitional conflict and its sequelae.
7. Sensitivity to issues of culture and gender.

1. Cooperation Across Systems and the Engagement and Building of a Therapeutic Team

If one is thinking systemically, one has to be aware of all of the levels of the system and their impact upon each other. In HIV disease this is crucial because the biological component will have a major impact at all levels and will cause significant stress across the system.

If therapists remain unaware of the patient's connections with other individuals and systems, they may find that their work is apparently being undercut by others. This may not be intentional, but if communication is incomplete, goals and directions may not be synchronized. As a result, despite the best of intentions all around, people may end up working at cross-purposes. At best, resources that are not pooled may be missed; yet, these cases need all the support they can get.

When one first engages the patient, it may be difficult to persuade him or her to attend the first session with other members of his or her significant network. At the same time, the further the therapy goes, the more difficult it becomes to engage these others. At the least, the therapist should make a careful effort to list all the other members of the extended family, natural

support system, and professional system interacting with the patient at a significant level. One may easily achieve this by asking the patient, "Who cares about you and what happens to you? Whom do you see regularly? With whom are you in contact by phone, letter, or visit?" It is often helpful to persuade the patient that we as therapists do not have a history with them, we haven't raised them, and care as we might, we can never love them as their family does. Stressing that we need help in order to provide the best possible therapy assures our patients that we will not blame or scapegoat beloved family members.

Patients may resist involvement of their family members in order to protect them from the horror of the disease. Many of these patients (particularly those with a history of substance abuse, but also those whose families have experienced major losses through time) are scripted to die early,³³ are extremely protective of their families, and are resistant to their coming to therapy. They may be scripted as the saviors of their families, which makes them even more protective.³⁴ Convincing them that the family will not be harmed, judged, or blamed, but used as a major resource, with acknowledgment of their inherent strengths, lessens the patient's resistance to involving family members in the therapy. Ascribing a noble role to their resistance aids in this process.³¹

While one is engaging key members of the system, however, the other members of the natural and professional support system need to be included in the planning of the therapy. Minimally they should all be contacted; as many as are relevant should be included in the therapy team. Therapists may be surprised by the readiness of the family doctor, the employer, the teacher, the close friends, and others to become involved in helping the patient. This may take considerable effort on the therapist's part, but the result makes the effort worthwhile.

In contacting members of the professional network, one of the basic questions is how the medical team can best work with the mental health providers, the patient, the natural support system, and the rest of the professional support system, including the therapist. In AIDS there are important medical questions, such as the side effects of AZT and DDI, that the entire team needs to take into consideration. There are negotiations with all members of the team about how involved each member should be and how roles should be delineated. Who should be informed about medical complications, or about emotional stress? Where should boundaries be drawn? If consultants are involved, how much should they be included in the intimate family information?

These issues are particularly important for mental health professionals such as psychiatric nurses, social workers, psychiatrists, psychologists, and counselors, all of whom have had some training at various levels in medical science, but who through their identification with behavioral issues may

not be regarded by the medical team as legitimate team members. We need to be cooperative team members, without being intrusive or unintentionally undercutting the medical treatment. At the same time, we need to assist the team in being aware of, and sensitive to, the patient's personal, social, and psychiatric situation. A constructive approach is to remind the medical team members of their inherent knowledge of psychiatry and families, thus drawing upon their expertise, rather than lecturing to them.

Stanton, Todd and associates describe many effective techniques for engagement of drug abusers and their families that may easily be applied to this population.^{31,35} In addition, Table 8-A provides a listing of frequent resistances to involvement of both natural and professional support systems and some possible responses to them.

TABLE 8-A
Engaging AIDS Patients and Their Families

RESISTANCE	RESPONSE
<i>Logistics & Geography</i>	
"My family lives too far away; I haven't spoken to them in years."	"Well maybe we can just involve them on the telephone."
"I don't know where they are."	"It must be very hard not having them know the children. Maybe I can help you trace them."
"We live so far away and I'm afraid to drive."	"Well maybe your Dad will make this trip when he knows how important it is."
"They're too old to make that trip."	"Wouldn't they be hurt if you didn't give them that choice?"
"My husband couldn't possibly take a day off work."	"How about meeting after work next time?"
"He's in prison."	"Why don't I speak to the warden and we can all meet there."
"They don't even speak English."	"Well, we're fortunate to have an interpreter in the hospital" or "Could you or your wife translate?"
"My doctor/minister/therapist is far too busy to come."	"Why don't I give it a try and see if we can coordinate something?"
"Don't call my counselor/doctor. I haven't seen him/her for years."	"It would be really helpful to catch up on some of the details of your earlier history in light of the present."

Secrecy, Privacy & Protection

"They don't know about . . . my being gay . . . an addict . . . the rape . . ."

"Well, why don't we just start by asking their advice about the things they do know? You and I can decide together when it's time to share the rest with them."

"I don't want to hurt them."

"Maybe they're not as fragile as you think. When your kids are grown, would you want to be excluded from something this big?"

"Our family doesn't talk about things."

"Well, maybe this happened to create something so important that it had to be talked about."

"My mother is critically ill with heart disease. My father's been sober for so many years this would drive him back to drink and kill my mother."

"Wouldn't it be more likely to hurt them if they find out only after your death, and you're not there to help them through it?"

"This man is my family and he would be hurt if I asked my parents in."

"Doesn't he love you enough to want what's best for you? I'm sure you have enough love for them all."

"I don't know who or where my father is."

"Let's invite in the others who played a fatherly role in raising you to help me help you. Maybe they also know where we can start looking for him."

"How can you make him suffer in his dying days, why can't you let him die in peace?"

"Since we can't guarantee his dying before you, do you really want him to have to deal with this alone?"

"I don't want my children to know. I want their last days with me to be happy."

"Perhaps it would be kinder to the children to have the mother they've always relied on to help them through tough times be there for them to deal with this? It's the toughest situation they've ever faced. Let's not let them do it alone."

"My father would never forgive me if he knew. I don't want him to know. I don't want to see him because he'd find out."

"Maybe he'd rather hear it from you than from others. Are you so sure he'd never find out? I can help you share it with him in a gentle way."

"I want them to remember me as I was."

"Didn't your parents change your diapers and clean your vomit when you were small? Don't you think they'd regret missing precious time with you? Would you not visit them if they were frail and smelly?"

"My family would never be able to go back to church."

"Isn't that the best place for them? Is it not a truly Christian/Jewish/Muslim place of forgiveness, community and friendship? Isn't that where they'd receive their best help after your illness? Have no sinners ever been forgiven there?"

"We live in a small town, everyone will know."

"Yes, that is hard. But it can also be a relief when everyone knows and the secret is finally shared. It will also make it easier for the family to have support through this hard time."

"My father/husband/wife will lose his/her job if they find out."

"Isn't it more important to give him/her an opportunity of protecting himself/herself?"

"My kids will have trouble at school."

"There are very few good teachers who wouldn't want to know what the kids were going through so they could help. Why don't you start by sharing with the teacher that you're critically ill, and let's take it step by step from there?"

"They've lost so much, why drag them in to suffer more?"

"Aren't they going to suffer more by being excluded and having to deal with it all of a sudden? Including them now will allow you to help them get used to it all gradually."

"He really wouldn't want to see me after all these years. He wouldn't want me to see him like that."

"Wouldn't he want to make his peace with you?"

"He thinks I don't know that he's gay/IV drug abuser/was in prison . . ."

"Secrets in families are never really secret. The fact that you know shows that. He realizes as you do that people who love each other always get the news somehow."

"I don't want my mother to know my baby has AIDS."

"Don't you want your mother to be able to protect herself from infection? How can she do that if you don't tell her? Is there anyone to help you tell her?"

"We'll tell them he has cancer, they're too young to understand."

"Well maybe that's a start."

"They'll just talk about their problems and not listen to his . . . it'll be more painful for him."

"I have a lot of experience with family sessions like that, and you'll be pleasantly surprised at how they'll tune in when they realize how important it is to him."