Families in Context

Conceptual Frameworks for Understanding and Supporting Families

Marci J. Hanson

"A family is a circle of caring."

—Anonymous

"The family is the association established by nature for the supply of man's everyday wants."

—Aristotle (as cited in Tripp, 1970, p. 209)

"Man is a knot, a web, a mesh into which relationships are tied. Only those relationships matter."

—Antoine de Saint-Exupéry (as cited in Tripp, 1970, p. 536)

"Call it a clan, call it a network, call it a tribe, call it a family. Whatever you call it, whoever you are, you need one."

—J. Howard (1978)

Families come in all shapes and sizes. Regardless of the configuration, the one universal descriptor is that families are diverse in nature. They vary along all dimensions, such as structure and membership, size, beliefs and values, culture, languages spoken, roles and functions, and living arrangements. The concept of family is largely a personal concept. Individuals view their families through their own lenses; members of the same family may offer quite different accounts and perspectives on the workings of their family.

However, families do not exist in a vacuum as a separate unit. Rather, they are embedded in the complex webs of their larger communities, including extended kinship networks, friends, neighbors, work environments, educational organizations, faith communities, and other social networks. Families and the individuals within them influence these communities; in addition, the larger beliefs, values, and practices of these communities affect and define the families within. Service systems and service providers are integral components of these communities, particularly for families whose

members experience biological or environmental conditions that affect their abilities to meet individual and family goals and support all family members. The service methods used by practitioners can inhibit a family's ability to function. These practices also can support and enhance the strengths and resources that families can marshal to meet their own needs.

Theoretical and conceptual models provide organizational frameworks for defining the concept of family and understanding how families operate and change. Several key frameworks are highlighted in this chapter because of their influence on the shaping of clinical models of support and services for families: the family systems framework, bioecological models, and models of coping and/or adaptation to stress. These frameworks have been applied extensively to the study of families of children with disabilities and risk conditions and have been instructive in identifying and understanding the effect of disability or risk on the family as a whole.

Following this discussion, the transactional model of human development is reviewed in an effort to examine the reciprocal influences within the family context on the development of the individual. This perspective allows one to analyze the more direct influences on the individual's development and the active role of persons in constructing their own trajectories. The concepts of risk and resilience also are considered to further the understanding of why certain factors and contexts constitute risk for some individuals and families but not for others. Finally, implications for interventions that are designed to support families to function effectively in meeting their own goals and needs are outlined at the close of the chapter. The frameworks selected for these discussions focus on emphasizing and enhancing family strengths and resilience.

WHAT IS A FAMILY?

When asked to portray the family with whom she was working for a class assignment, a graduate student responded as follows:

> The family structure . . . reminds me of the days of diagramming sentences. Each clause has its own nouns and verbs, but they all connect to form a complete sentence. What makes this family a complete sentence is the fact that they consider and define themselves as a family.

She continued on to describe this family as including a husband and wife, their children (both from their marriage to each other and from previous marriages), the grandmother (the wife's mother), the grandmother's brother, and the wife's sister and her fiancé. The whole family lived with the grandmother with the exception of the wife's sister and fiancé, who had recently moved out of the home but were considered part of the household. The affiliations among these family members came from blood ties, bonds of marriage, and a shared commitment. Other class members volunteered similar observations; their definitions and descriptions of families varied considerably in terms of the number of people within the family, types of family arrangements, and, in some cases, the formal relationships (e.g., marriage, cohabitation, stepparenting) among the family members. Although these varied descriptions appear to defy the establishment of a common definition, they all contain these common elements of a family: 1) a set of individuals bound together and 2) a shared understanding or commitment to one another among family members.

Many theoreticians and researchers also have attempted to define the core concepts that demarcate a family. Individual family members may have strong ties and relationships to individuals in their larger social networks and view them as "like family."

However, White and Klein (2008) identified four features that differentiate families from other social networks, such as friends and coworkers:

1. Families usually last for a longer period of time than other social groups.
2. Families are intergenerational.
3. Relationships among family members include both biological and affinal (e.g., legal) relationships.
4. Relationships among family members link them to a larger kinship network.

Children typically join family units at birth, and the family members in these units constitute the children's caregivers. For most children, entering into and belonging to the family is involuntary. These ties remain in some form over time and link children to a larger network of people (relatives) and family history and traditions (White & Klein, 2008). These features serve to distinguish families from other types of social groups, such as friendship networks. Families may include married partners with children, nonmarried partners with children, single parents with children, adults bound by marriage or other contractual commitments, groups of adults and children living communally, and so forth. Even when a child and his or her parents have all died, relatives such as the child's grandparents may remain bound together in some fashion as a family.

This exercise of attempting to define family underscores the breadth of family possibilities and the range of issues that must be considered by service providers when working with families. Just as the many variations among families must be appreciated, the various contexts in which families reside must be recognized. The functioning and development of the family can be understood only in this broader social context.

CONCEPTUAL MODELS FOR UNDERSTANDING FAMILIES

Several prominent theories and conceptual frameworks have aided the understanding of how families operate and interact within their larger communities. Setting aside the issue of whether these frameworks constitute viable theories, they will be examined as useful models that have greatly influenced ways in which families are viewed and services are construed and implemented. Insights for structuring policies and interventions to support families are derived from these perspectives. Several frameworks are highlighted in this text to explain and interpret the effects of disability and/or risk on the developing child within the family: the family systems model, the bioecological framework, and models of coping and adaptation to stress.

Family Systems Model

The family systems model is one of the predominant theoretical perspectives in family studies and family therapy (Braithwaite & Baxter, 2006; Broderick, 1993; Whitchurch & Constantine, 1993; White & Klein, 2008). This view of the family as an interactive system of individuals also has been advanced as a framework for understanding the roles and relationships among family members as they care for an individual with disabilities or developmental risks (Turnbull, Summers, & Brotherson, 1984; Turnbull & Turnbull, 1990, 1997).

The family systems perspective is based on four fundamental assumptions (White & Klein, 2008). The first assumption is that all parts of the system are interconnected, which implies that all family members are integrally linked with one another. Second,

the family as a system only can be understood by viewing it as a whole, rather than in terms of its individual parts or members. In essence, the whole is considered to be greater than the sum of its parts. Third, the family system both affects and is affected by its environment. This notion focuses on feedback–the outputs of the family system and the inputs to that system. The fourth assumption is that the system is not a reality but rather a way of knowing about the family. It is a way of understanding the organization and experiences of families rather than an actual physical phenomenon.

The family is considered, like other social systems, to be a goal-seeking system (Broderick, 1993; White & Klein, 2008). Each family has its own goals and priorities; family members select and mobilize support to meet these objectives. These goals are not static and will be modified as families strive to meet tasks and demands at various points in the life cycle, such as the birth of a child or care for an aging parent. Families likewise differ in the degree to which the individuals within the family jointly define and act together to implement these priorities. Families also are characterized by boundaries that affect their interaction and the flow of information–that is, "permeability" between the family and the outside environment. For instance, families differ markedly in their openness to include or interact with outsiders. All families have their own unwritten internal rules for making changes or transformations and for maintaining and regulating the interactions among family members. Examples include how a husband and wife communicate and treat one another or how parents relate to and discipline their children.

Some families have very rigid rules or codes of behavior for the members (e.g., strict religious beliefs, codes of behavior for how children relate to their elders), whereas others maintain flexible rules and adapt readily to change. Another concept often applied to the systems approach is the notion of equilibrium. Family systems tend to maintain a homeostasis. Like the human body's own internal thermostat, families adjust to inputs or environmental demands to maintain the sense of balance. These practices may govern how the family responds to an outside stress or intervention. Because the family is likened to a system with interacting parts, tremendous variety occurs in the ways in which they adapt to changes and in the feedback loops.

The parts or components of the family also may be understood by an awareness of the subsystems within the family. Subsystems may include the parents, siblings, marital subsystem, parent–child subsystem, extended family members, and so on. An individual's ability to function and meet role obligations in one subsystem (e.g., the parental subsystem) does not necessarily predict one's ability to function comfortably and successfully communicate in another (e.g., the marital subsystem).

A glimpse at the life of Amanda and her parents, Barbara and Roger, will help us examine the family systems model in an attempt to appreciate the complexity of family interactions as well as the many factors that influence families. Through this case study, we enter the life of a couple as they become new parents with their first child.

The Morgan Family

Barbara and Roger Morgan tried for many years to have a child. As time passed and Barbara watched her younger sisters deliver healthy babies, her anxiety about parenthood was amplified. Finally, Barbara and Roger became the parents of a baby girl,

Amanda. Their devotion to Amanda was fueled by their intense desire to have children and Barbara's efforts to become pregnant.

Amanda was born prematurely and experienced a prolonged period of hospitalization after birth. Amanda's difficult delivery and birth experiences necessitated that Barbara take a leave of absence from her job as a nurse at a local university hospital. The round-the-clock care and frequent medical appointments created by Amanda's chronic illnesses and developmental delays became a full-time job for Barbara. The loss of Barbara's income became a source of concern to the family as they struggled to maintain their home mortgage and move from a dual-income to a single-income family. The long hours required by Roger's job were only increased by his need to advance.

The birth of their child also altered the lifestyle that Barbara and Roger had come to expect in their 8 years as a married couple. Their exercise routines, concert going, and outside interests were put on hold as they adapted to having a new baby and meeting her medical and caregiving needs. Family members' and friends' responses to the family's altered circumstances varied. Most were supportive and offered to grocery shop, babysit, and assist when needed. However, several individuals appeared to feel awkward and quit communicating with Barbara and Roger. One friend even suggested that they consider "out-of-home" care for their baby. Although Amanda's birth brought Barbara and Roger tremendous joy and relief at their fulfillment of parenthood, it also brought concerns, lifestyle changes, and new demands.

The family systems model helps us to understand the dynamics of families such as the Morgans. This family is comprised of Barbara, Roger, the new baby Amanda, and extended family members (grandparents, aunts, and uncles). The family's primary subsystems include Amanda and her parents (parent–child), Barbara and Roger together as the marital subsystem, and Barbara and Roger with their parents and other family members (parent–extended family).

As discussed previously, families have boundaries–in other words, their degree of being open or closed to outside influences. Families also differ and have their own rules for operation or change; these rules represent how family members communicate and relate to one another, such as how a husband and wife behave toward one another and make decisions. Barbara and Roger, for instance, were open to adjusting to their new responsibilities by altering their work schedules and commitments, as well as their lifestyles. They were thankful that Barbara's parents could help out occasionally with babysitting and household tasks. Both Barbara and Roger started their marriage as partners who worked outside of the home and shared equally in family responsibilities. Following Amanda's birth, they were able to communicate effectively with one another and adapt (although not without ambivalence and some difficulties) by shifting roles and relationships (e.g., Barbara quit her job to care for Amanda at home). They rearranged their work schedules and outside interests to support the other needs of the family after Amanda's birth. The decreased family income and the increased caregiving demands were counterbalanced by cutbacks in the family's recreational and social activities and expenses.

The family systems approach presupposes that families are influenced by feedback from the outside, such as societal norms to behave or conform in particular ways. In this case, Barbara and Roger responded to the expectations of the medical community and their own parents' judgments about the situation, as well as to feedback from other sources such as their employers and friends. Key important concepts in the family systems model as embodied in this case study are the dynamic and ever-changing influences

on the family and family member's interconnectedness and the internal structures that bind them together in responding to these influences.

Application of the Family Systems Approach to Risk/Disability The family systems approach has been synthesized with special education concepts and applied in work with families of children who are at risk for or have disabilities. Turnbull, Summers, and Brotherson (1984) proposed such a framework, which consists of four components (see Figure 3.1): family characteristics, family interaction, family functions, and family life cycle.

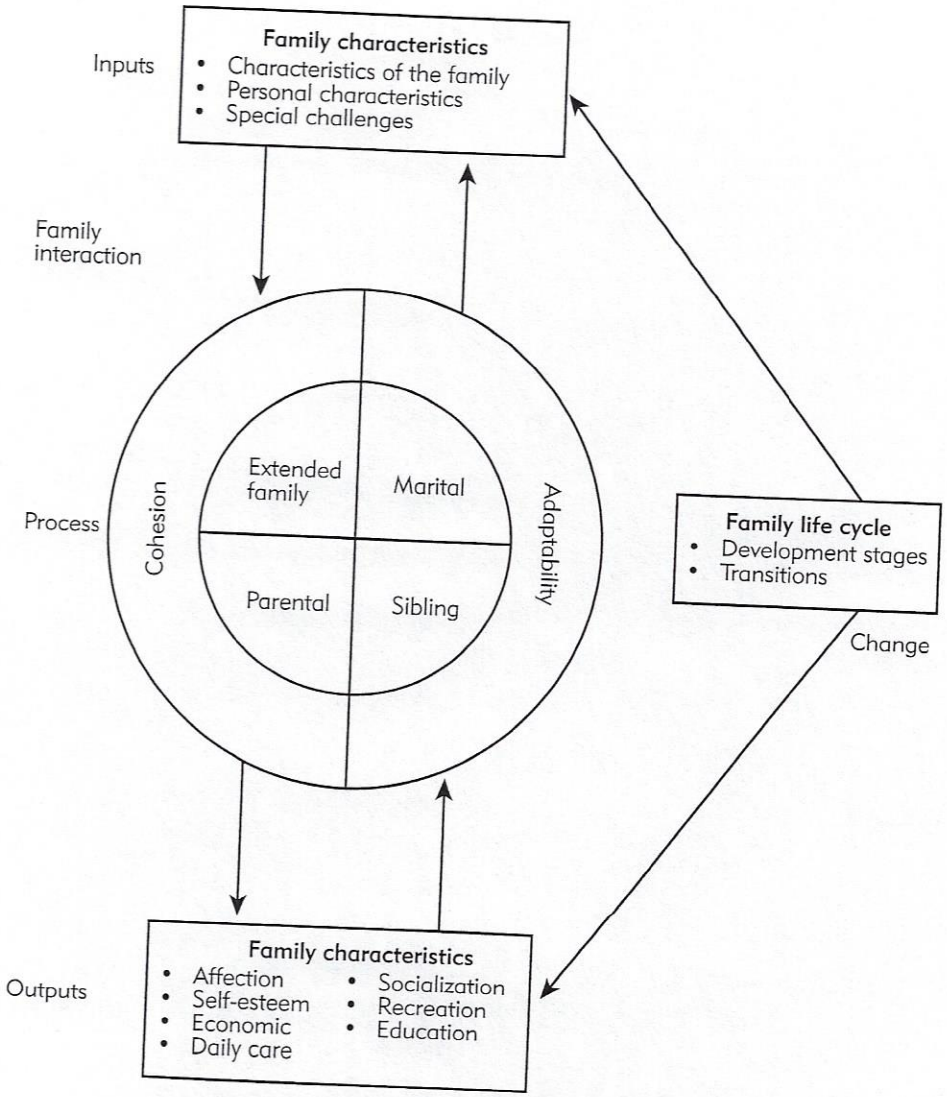


Figure 3.1. Family systems framework. (From Turnbull, A.P., Summers, J.A., & Brotherson, M.J. [1984]. Working with families with disabled members: A family systems approach. Lawrence, KS: RTC/IL, University of Kansas; reprinted by permission.)

Briefly, family characteristics include the personalities of family members, their values and beliefs, cultural background and perspectives, socioeconomic status, disability, health status, and family resources, to name a few. These characteristics are viewed in this schema as input variables into family interaction. The relationships among family members and family subsystems are considered through the component of family interaction. Relationships vary in terms of their adaptability to change in response to stressors or outside influences and also in terms of their cohesiveness (i.e., degree of bonding among members and each member's maintenance of independence within the family). The outputs of family interaction address the fulfillment of family needs through accomplishing family functions. Family functions include meeting economic needs, physical and health care needs, recreation and socialization needs, the need for affection, self-identity needs, and educational/vocational needs. Finally, the family life cycle component addresses the developmental and nondevelopmental changes that affect families over time. These life cycle events may include births, deaths, divorce, change in employment, and change in residence, among others.

Returning to the example of the Morgan family, this framework can be used to understand the family's current roles and relationships. With respect to family characteristics, Barbara and Roger bring to the family their own individual personalities and interests, marital relationship, economic resources and demands, educational backgrounds, and coping styles. Amanda brings her own characteristics, including her personality, temperament, appearance, and developmental challenges and needs. These characteristics or inputs influence the family's interaction and the relationships among members within the various subsystems (e.g., husband–wife, parent–child, extrafamilial subsystem–extended family, others). For instance, these variables have had an impact on the relationship Barbara and Roger have with one another and on the relationships they have with their parents, siblings, and their professional colleagues. These relationships or components of family interaction, in turn, have influenced the family's ability to meet basic needs or functions of the family, such as economic provision, recreational, affectional, social, medical, and so forth.

Although the Morgan family will change as it experiences various transitions and shifts through its family life cycle, this glimpse at life just after Amanda's birth demonstrates the alterations that already have occurred in response to the infant's birth. The family's characteristics are changed by the introduction of a new family member and by the needs of that child. The family's functions are altered in that Barbara must go on leave from her job, and the family's economic resources are reduced although economic demands are increased. The ability to meet these family needs or functions will be determined by interaction variables related to Barbara and Roger's relationship and their relationships with others. This brief example demonstrates the complex interconnections of families and the fact that the family is much more than the sum of its parts.

Implications for Intervention The family systems model provides a useful focus to both the unit of intervention and to the approach. In this framework, the family is viewed as a whole and members are seen as an interacting unit (Broderick, 1993). Meaningful supports must consider this whole unit and the parts within, in so far as family members affect one another and in turn are affected by outside forces. Simply put, service providers will likely have limited success in implementing any service intervention unless the whole family is considered. This family systems perspective also underscores the recognition of differences among families in their goals, priorities, and means of attaining

their objectives, as well as variability in the ways that the family members interact both internally among themselves and as a family with the outside world.

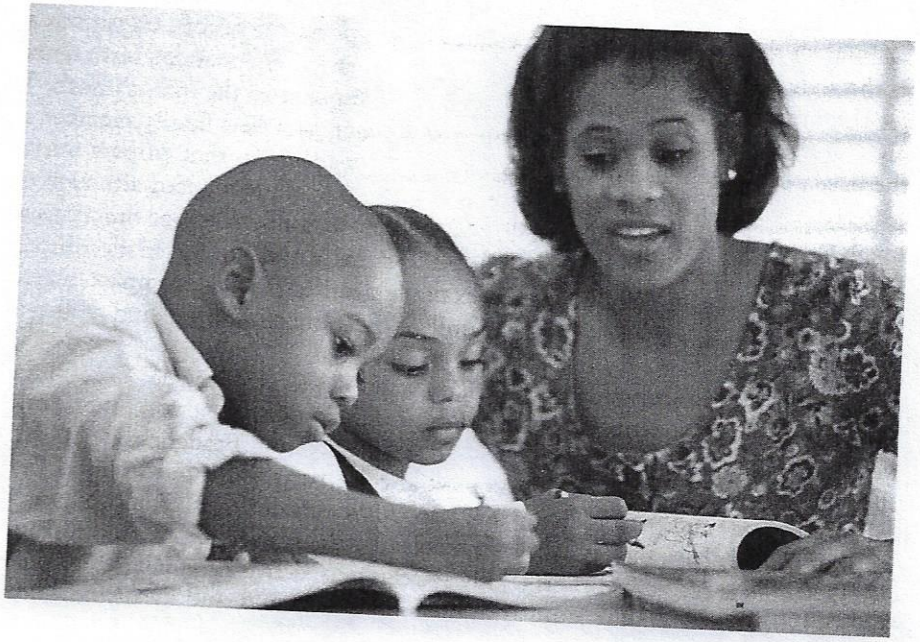
Bioecological Systems Models

Families do not exist as an insular unit. Rather, they are situated within other contexts, such as their communities and the broader societal network. Bioecological models focus on these contexts; emphasis is placed on how individuals and families adapt to changing conditions. White and Klein (2008) outlined the key assumptions of the ecological perspective:

1. Individuals and groups are both biological and social in nature.
2. Humans depend on their environment for survival.
3. Humans are social in nature and depend on others.
4. Human life is finite and time can be seen as both a constraint and a resource.
5. Interactions are spatially organized.
6. Human interaction can be understood at different levels–both at the population level and at the level of the individual.

These tenets underscore the social nature of development and the crucial importance of environmental interactions. The family is typically the primary context for the child's development and that of other members, but this unit is greatly affected by the external contexts with which it interacts.

The ecology of human development postulated by Bronfenbrenner (1979, 1986, 2005) provided an influential model for understanding the relationships between the developing person and the environment. The family is viewed as one component or



ecosystem withi
ecological syster
context of the e
ronment. This n
have disabilities
on families and
& Siegel, 1994;
al., 1996).

Bronfenbre
structures or sy
tem, mesosyster
is "a pattern of
ing person in a
fenbrenner, p. 2
microsystems n
interrelationshi
children, these
home and scho
series of micros
children may i

The exosy
person as an a
by, what happ

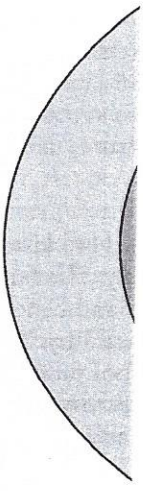


Figure 3.2.

ecosystem within the ecological systems described by Bronfenbrenner (1979). This ecological systems framework also provides a model for placing families in the broader context of the ecosystems within which they must interact and the broader social environment. This model is particularly appealing for the study of families of children who have disabilities or are at risk in that it enables one to describe the range of influences on families and the interactions among systems over time (e.g., Beckman, 1996; Bernier & Siegel, 1994; Berry, 1995; Hanson et al., 1998; Kazak, 1989; Odom, 2002; Odom et al., 1996).

Bronfenbrenner (1979) described the ecological environment as a nested set of structures or systems that interact with each another. These structures are the microsystem, mesosystem, exosystem, and macrosystem (see Figure 3.2). Briefly, the microsystem is "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner, p. 22). For the young child, the family is the primary microsystem. Other microsystems may include child care environments and early education programs. The interrelationships among these microsystems are termed the mesosystem. For young children, these relationships may occur between the home and child care program, home and school, and home and hospital, to name a few. Thus, the mesosystem is a series of microsystems and encompasses the immediate systems with which families and children may interact.

The exosystem level is "one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (Bronfenbrenner,

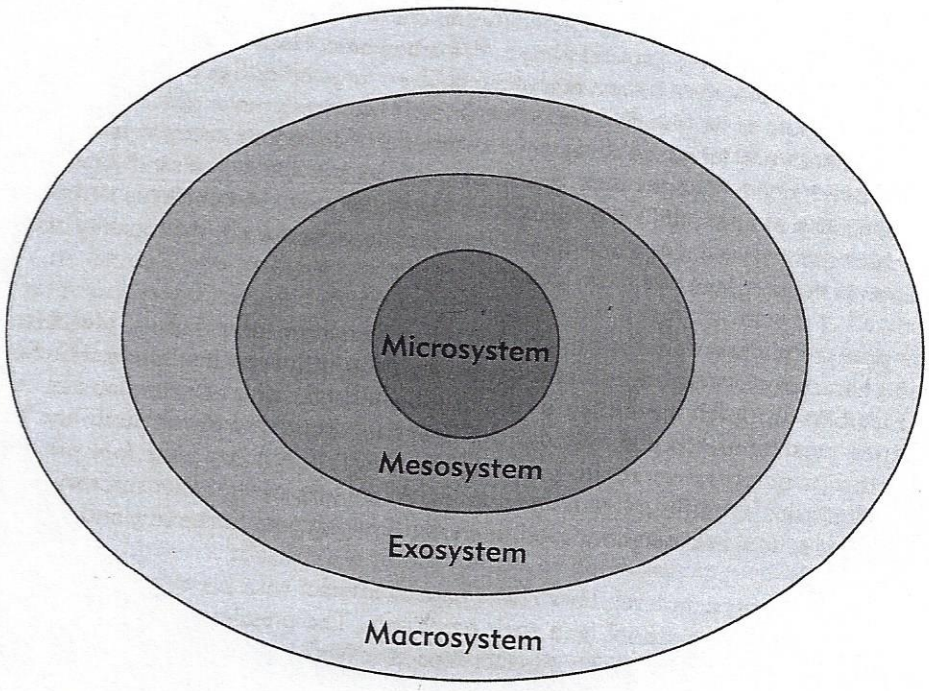
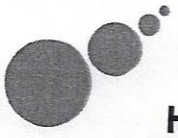


Figure 3.2. Ecological systems framework. (*Source*: Bronfenbrenner, 1979.)

1979, p. 25). Examples for young children include the policies of the child care and education programs and institutions, neighborhoods, families' social networks, parents' employers, and employment policies–all networks outside the family that can have a direct impact on the child and family. At the broader systems level, or macrosystem, are societal and cultural beliefs and values that serve to shape and influence the lower order systems. For the young child, societal and cultural views on child-rearing patterns, early education, the meaning of disability, and health and education intervention philosophies and policies (e.g., philosophy of inclusion) all can be found at this macrosystem level.

This model was further expanded to describe the impact of the individual's personal characteristics and the influence of time on development (Bronfenbrenner, 1999, 2005; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 1998, 2006). The variable of time can be appreciated both in terms of the effects of the timing of an event on the individual's or family's development and the cumulative effects of an event over time on development. The bioecological systems framework is illustrated through the following discussion of Hwa Hwa and his family.



Hwa Hwa

Hwa Hwa is a 4-year-old boy with Down syndrome who lives with his mother, father, and sister in a city with a large Asian population. The family moved to the United States several years ago from the People's Republic of China. Both of Hwa Hwa's parents work in blue-collar jobs (one works during the day and one works at night) to provide for their family and to meet the high cost of living in this urban area. Hwa Hwa attends a Montessori preschool program; he was one of the children targeted as a good candidate for inclusion because of his friendly personality. One of Hwa Hwa's major developmental needs is speech and language development. Although the program recognizes Hwa Hwa's speech and language needs, and these goals are stipulated on his individualized education program (IEP), the one speech-language pathologist available to the preschool speaks only English and Spanish (the languages spoken by the majority of the children in the program).

The primary microsystem for this child is Hwa Hwa's immediate family. Hwa Hwa's own characteristics (e.g., age, disability, personality) influence his family. His family members also each bring their own personal characteristics of values and beliefs, abilities, personalities, and knowledge and concerns about Hwa Hwa's disability. The other major microsystem at this point in Hwa Hwa's life is his preschool program with its particular philosophy and resources. As he gets older, other microsystems, such as his school and neighborhood, increasingly will come to the fore and exert an impact.

At the mesosystem level, Hwa Hwa's parents interact with his preschool program, his sister's elementary school, and their employers. The preschool program not only welcomes parental involvement but in fact expects it. No one on the staff at the program speaks Cantonese, however. This has a significant negative impact on the communication and relationships between the family and the preschool staff members.

At the exosystem level, several school and employment policies are used to demonstrate this ecological model. The school system that operates the preschool is a strong advocate for inclusion of children with disabilities. Hence, Hwa Hwa is given an opportunity to participate in a neighborhood school with his typically developing peers even though he shows marked developmental delays. The school's lack of employee experience with the Cantonese language, however, affects Hwa Hwa's ability to participate and learn in that environment. Thus, the school's policies and hiring practices have a direct impact on the ability or inability of the program to address or meet Hwa Hwa's developmental and educational needs.

Exosystem issues are evident for the parents as well. Neither parent is allowed time off from his or her job to attend school functions, thus making it difficult for both parents to stay informed regarding the education program and to participate in school activities.

Examined from the broader macrosystem level, this family lives in a community with a large Asian population, and many supports are available to families from this ethnic and linguistic background. Furthermore, the community is known for its liberal policies and support for diverse populations, including people from non–Anglo-European backgrounds and those with disabilities. Although the values and beliefs espoused in the community provide a supportive environment for this family, these beliefs and values have not been enacted for the betterment of the family at the other systems levels through the use of interpreters for the child and family or through involving the parents through culturally appropriate approaches.

This story of Hwa Hwa and his family allows us to examine the interconnections and influences among systems described in this framework. Hwa Hwa and his family are nested within multiple contexts that are interrelated and that exert a profound influence upon one another.

The bioecological systems framework provides a structure for examining and appreciating the broader societal context in which families must function. The family is the primary microsystem for its members. Members are nurtured and cared for in the family home. The family is connected to other microsystems such as schools, community programs, child care programs, and health care systems. These interact with and influence the family and its individual members. These systems, in turn, are influenced by the broader policies and structures of other systems (exosystems), such as the parents' workplace, the medical care system, the education system, and insurance programs, among others.

At the still broader macrosystem level, societal values and policies influence the other priorities, policies, and resources in other systems. Examples include public policies related to diversity (immigration, language supports) and disabilities, including federal legislation pertaining to education and disability rights such as the Individuals with Disabilities Education Act (IDEA) of 1990 (PL 101-476), the Individuals with Disabilities Education Improvement Act of 2004 (PL 108-446), and the Americans with Disabilities Act (ADA) of 1990 (PL 101-336).

Viewing families through the lens of the bioecological systems framework provides a vehicle for examining the multiple and interconnected influences on the family. The family, however, remains the prime context of development particularly for the young child.

Family Niche in Social Systems Families occupy an important niche in social systems. They are part of a larger kinship network and the family group or system is embedded within the larger ecological culture in which these groups function. The

family microculture has been acknowledged and studied as a crucial developmental niche for the child who enters this system with her or his own biological makeup but is influenced by the cultural and social construction of the family environment with its daily routines, activities, priorities, child-rearing practices, beliefs, and caregiver characteristics (Super & Harkness, 1997).

Weisner's (2002, 2005) ecocultural niche perspective expands on the concept developmental niche and focuses on the cultural unit of the family. This ecocultural model is conceptualized around the ways that families interpret meaning and share culture through interactions among caregivers and children in the activities and practices of their everyday routines. This model has been applied to the study of families of children with developmental delays and has been used to examine the ways in which families meet the challenges of these circumstances, accommodate to the needs and demands, and perceive their situations (Gallimore, Weisner, Bernheimer, Guthrie, & Nihira, 1993; Nihira, Weisner, & Bernheimer, 1994; Weisner, Matheson, & Bernheimer, 1996; Weisner, Matheson, Coots, & Bernheimer, 2005).

Implications for Intervention By the very term *bioecological,* this perspective shines a lens on the family within the larger ecology or context of community and society and reveals the multiple influences upon the family. Emphasis is placed on the interaction of the family unit with the broader world that is construed as dynamic and changing. This perspective also highlights the importance of interactions within families and the cultural influences on family members through family routines and practices, as well as the means by which families address the demands and needs related to risk or disability circumstances. Intervention philosophies and services for families are embedded in these systems in the family's ecology and can exert major influences through the types of services provided and the professional practices implemented.

Adjustment and Adaptation Models for Coping with Stress

The birth or later diagnosis of a child or family member with a disability, illness, or other type of risk condition typically necessitates changes for the family. Most clinical professionals view this change as producing stressful family outcomes. Conceptual models have been proposed for examining families' adaptation and adjustment to these altered life circumstances through the use of coping strategies (Berry & Hardman, 1998; Blacher & Hatton, 2007; Turnbull et al., 1993). These frameworks have been developed to understand the meaning of stress and how it operates in families' lives. Psychological stress has been defined as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19). This definition underscores the interaction between personal variables and environmental variables in defining stressors and their impact. It also highlights the importance of the individual's cognitive appraisal of the circumstances.

ABCX Model A predominant conceptual model designed to understand the impact of stressful events is the ABCX model advanced by Hill (1949, 1958; see Figure 3.3). In this model, factor A refers to the stressor event. Factor A can include both normative stressors (e.g., family adding a new member through the birth of child) and nonnormative stressors (e.g., birth trauma, child's specialized medical needs). Factor B refers to the family resources to meet the stressor, and factor C is the family's appraisal

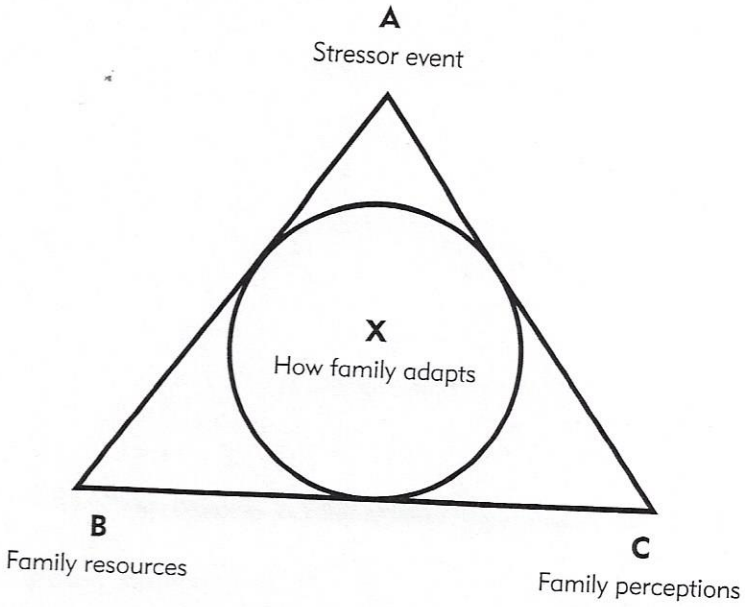


Figure 3.3. The ABCX model. In this model, factor A (the stressor event) reacts with factor B (the family resources available to meet the stressor) and factor C (the family's appraisal or definition and interpretation of the event) to produce X (the response to the crisis). (*Sources*: Hill, 1949, 1958.)

or definition and interpretation of the event. According to this model, factor C interacts with factors A and B to produce factor X, the family's response to the crisis. To understand how this model is used to look at family adjustments, the example of Judy, Kevin, and their daughter, Samantha, is presented.

Judy and Kevin

Judy and Kevin's second child, Samantha, was born 12 weeks prematurely with the umbilical cord wrapped around her neck. Samantha experienced anoxia and was rushed to the neonatal intensive care unit (NICU) shortly after her birth. Judy and Kevin went home but continued to visit Samantha daily. Judy was able to express milk to bring to her baby and got to hold Samantha in the NICU. Although terrified and saddened by their baby's trauma, Judy and Kevin relied on the support of the professionals and their family and friends, and they longed for the day when they could bring baby Samantha home. This support enabled them to remain confident of Samantha's recovery. The information that they received from professionals also gave them options for services and supports that they could use in the future as needed.

In this case, factor A is the premature and high-risk birth; it includes both normative (birth of a child) and nonnormative (premature birth and illness) stress factors. Factor B, the family's resources, includes the support Judy and Kevin provided each other as well

as that given by friends and family who lived close by, good medical care in a facility with a NICU, and sufficient health insurance. Factor C, which is the primary emphasis in this model, is the family's appraisal or interpretation of the stressor event. Because of the supportive resources of the care institutions and family and friends, Judy and Kevin were optimistic about Samantha's future.

Double ABCX Model McCubbin and Patterson (1982, 1983a, 1983b) expanded the ABCX model in their work with families of children with disabilities and chronic illness. This expanded model is typically called the double ABCX model. In this model, more emphasis is placed on the family's appraisal of the event (the C factor) and also the interactive and additive nature of events. In this expanded model, aA refers to the original stressor and to the pile up of other stresses and strains, and bB denotes the perception of resources. Factor cC alludes to the family's perception of the original stressor event and their appraisal of the demands and their own capacity for managing or meeting these challenges. This model also introduced the concept of sense of coherence (based on Antonovosky, 1979), which refers to the family's ability to balance trust and control (i.e., their ability to know when to trust other authority figures versus when to take charge with their own resources). Consider this model as it relates to the story of Judy and Kevin.

Right before Samantha's birth, Kevin was laid off his job in construction. Judy anticipated that she would not return to her job as a teacher until her children were old enough to go to school. Now she had to consider going back to work to make ends meet for the family. She also worried about Samantha's caregiving because she realized that her daughter might have special needs. The couple's other child, 3-year-old Joshua, had recently been diagnosed with asthma, which had produced new challenges for the family in terms of procuring health services and modifying their home environment to support Joshua's health needs. Thus, Samantha was born into a family that was already grappling with some stressors. Her traumatic birth situation multiplied the concerns of the family (factor aA).

Judy and Kevin sat down and analyzed their situation. They decided that they had enough health insurance to get by and that they could borrow some money from Judy's parents if needed. They also felt comfortable with the medical care and regimen for Joshua. He seemed to have adjusted well to medication and his condition was under control. Kevin met with a friend who promised to help him get a job with another construction company. Both parents recognized the resources they had (factor bB) and planned for how to deploy these resources. They were confident that although times would be tough, they would get through this together and provide the needed care for their children (factor cC). Judy and Kevin felt that they had the abilities and resources to meet the additional challenges that Samantha's condition might produce.

Family Adjustment and Adaptation Response Model A related model that is useful in understanding families' adjustment to stressors is the Family Adjustment and Adaptation Response model (FAAR; Patterson, 1988, 1989). This model represents an expansion over the previous models in that it examines the family's adaptation and adjustment over time. Thus, the emphasis is placed on the adaptation rather than the stress. Emphasis also is placed on positive, or salutogenic, outcomes. The term *salutogenesis* was coined by Antonovsky (1979, 1993) in his analysis of the study of disease. This term is intended to capture a more constructive orientation to developing

healthful (as opposed to disease) states and contrasts with more traditional approaches with a pathogenic orientation to the study of disease.

Like the previous models discussed, the FAAR model stresses the cognitive appraisal or the role of the meanings families assign to events as they shape their responses and adaptation to the crisis. Two different levels of meaning used by families in the adaptation process are considered: situational meanings and global meanings (Patterson, 1988, 1989). Situational meanings include the immediate situation and how a family defines the demands and assesses their capacity to meet them. For instance, the family may have a child who is very sick. Their expectations for how to care for the child, what the child's needs necessitate, and what their resources are all fall into this category. The family's cognitive coping strategies can be used to meet the situational demands. When demands supersede the family's capability to manage them, the family will experience stress. Examples of cognitive coping include recognition of one's self-esteem or efficacy (i.e., knowledge and confidence that one can handle the situation), knowledge that physical resources exist to alleviate the demand (e.g., money, insurance, caregivers), and awareness of characteristics of the individual child and/or parents that may be helpful, such as a responsive or warm personality, assertiveness or perseverance, or the family's ability to work together.

Global meanings, however, transcend the specific situation and refer to a more stable set of beliefs and values. Patterson (1993, p. 227) referred to this as the "family schema." The family schema can be characterized by five dimensions based on the beliefs and meanings reported in research with families of children who were medically fragile.

1. *Shared purpose.* The family has reordered priorities with a greater focus on people and commitment to life.
2. *Collectivity.* The family focuses on working closely together and with others, such as doctors, in meeting the demands of the child.
3. *Frameability.* The family has a new, more optimistic focus or outlook on the characteristics of the child or family as a whole, such as being grateful for what they do have.
4. *Relativism.* Family members feel more tolerant, flexible, and less judgmental.
5. *Shared control.* Parents realize that they have less control over life than they previously thought and often acknowledge a "higher power" in their lives.

The FAAR model includes both the adjustment and the adaptation phases of response. It is in the adjustment phase that the family makes first-order changes in response to the demands (e.g., mother or father takes time off work, couple hires a new caregiver). When the crisis continues, second-order changes are required. During this adaptation phase, the family system is restructured and changes may occur in family roles, functions, or boundaries. For instance, the mother or father may decide to quit employment outside of the home to care for the child. Clearly, this signals a change in family roles and resources.

As families are able to adapt, they may attain a positive perspective of the situation (salutogenesis). Research with families of children who were medically fragile revealed that parents often reported positive aspects of raising their children that included the child's warmth and responsiveness, the tenacity and perseverance of the child (which

made the parents want to invest more effort), the family's closeness in pulling together as a unit, the assertiveness skills parents developed and the ability to deal with multiple providers and third-party payers, and the empathy and growth witnessed in their other children (Patterson & Leonard, 1993). These perceptions relate to the situational meanings. At the level of global meanings, family members may believe they are better able to draw from their previous experiences in managing a situation, have confidence in their abilities to be assertive and communicate effectively with other care providers, and are able to amass their resources and supports quickly and effectively (e.g., calling on a neighbor or family member).

The changes that families make in their beliefs and in their behaviors to manage the demands of a disability/illness occur within the "social context of relationships" (Patterson, 1993, p. 235). One can debate whether behavior changes cognitive meanings, cognitive meanings change behavior, or both. Regardless, families of children with disabilities or other special needs may be faced with increased stressors and demands in their lives. These demands by definition can create the need for changes or adjustments. The capacity to change varies across individuals and from family to family. Clearly, not all families have the same resources or the abilities to adapt and thrive. Real limits exist in the degree to which families can change the world in which they live. The emotional reactions of individuals, the behaviors of family members, family members' cognitive beliefs, and the family's external or physical resources all play a role. One can only conclude and appreciate that, in the words of Patterson (1993, p. 236), "Families are complex social units and they vary widely in their adaptive capacities."

Implications for Intervention Although models aimed at explaining and understanding families' adjustment and adaptation to disability, illness, and risk stem from a view that these factors pose negative sources of stress for families, they have been influential in underscoring the merits of developing systems of support for families. Support has been conceptualized along a broad spectrum from the informal support provided by family, friends, neighbors, and other important persons to the family, to formal systems

of support such as early intervention, social services, psychological services, and health services. Increasingly, this support has been construed as aimed at enhancing family members' self-esteem and sense of efficacy in meeting any challenges of their altered situations.

Summary

Regardless of the framework that is used to understand family dynamics and change, all perspectives share a common focus on the importance of interactions with the environment. Each family member brings his or her own personal characteristics, needs, beliefs, values, and culture to the family, and each family develops its own tacit way of operating. The interactions that family members and the family as a group have with the larger world contribute markedly to shaping the family's practices, outcomes, and trajectory. This malleability can offer a hopeful outlook when families encounter challenges, as all families do.

TRANSACTIONAL MODEL OF DEVELOPMENT

Everything is a transaction; everyone and everything is affecting everyone and everything else (Sameroff, 2009). Contemporary theorists and researchers agree that development is a highly complex process that is influenced by the dynamic interplay between biology and environmental experiences (nature and nurture). Interactions are at the core of this notion. The transactional model helps us to understand these influences and dynamic interactions between biology and experience.

The developmental process is characterized by the mutual reciprocal effects of both the context on the individual and the individual on the context. Although the development of individuals occurs along different pathways, human relationships play an essential role in optimal development and are the building blocks for the development of the young child (Shonkoff & Phillips, 2000). The quality of the home environment and family resources (e.g., basic needs, socioeconomic, psychological and emotional, learning opportunities) exert crucial influences on child development (Shonkoff & Phillips). A strong research base supports the importance of the family context and the active contributions that individuals make to their own development.

The argument for a transactional nature of development was presented in seminal articles by Sameroff (1975) and Sameroff and Chandler (1975). In the latter, these researchers examined developmental outcomes for infants with respect to medical and caregiving risks. This extensive literature review on biological risks and the "continuum of caretaking casualty" (Sameroff & Chandler, p. 218) documented the myriad of risks to the infant from biological problems, including premature delivery and anoxia (i.e., a lack of oxygen delivered to tissue), as well as factors associated with social conditions, such as poor socioeconomic conditions and mothers' physical and mental health. Sameroff and Chandler described and contrasted different developmental models that sought to explain child outcomes according to these factors. They described the main effects model (often called the medical model) that explains development primarily in terms of the individual's constitutional characteristics (e.g., presence of biological damage) or environmental factors (e.g., neglect). In this model, a risk condition (e.g., a birth defect or trauma) is considered to be causally linked as a determinant directly to a developmental outcome. The main effects model was contrasted with models that focus on interactional effects.

A transactional model of development was postulated as the optimal model through which to view development. This transactional model recognizes the "continual and progressive interplay between the organism and its environment" (Sameroff & Chandler, 1975, p. 234) and views the contributions of the individual to his or her own development. In other words, individuals are not viewed as static entities but rather seen as actively engaged in constructing their own worlds. In this sense, the characteristics of a person both transform and are transformed by interactions with the environment. For example, if a baby actively engages her parent by smiling and reaching for her mother's face, the mother will likely feel drawn to the infant and continue the interaction by looking back at the baby, smiling, and talking. Over time, the infant learns how to engage the mother's attention and care and learns to feel secure in that attention, and the mother delights in the baby's responsiveness; these continued interactions will likely foster the baby's competencies in social interaction and communication and also cement the mother's feeling of competence as a parent. For most children and adults, their primary world is their family. Thus, the family and caregiving environments are both affected by the individual family members' characteristics and likewise serve a primary role in shaping their development.

Viewing child and family development through a transactional perspective allows one to understand the complex interactions and transactions that occur. This perspective also guides notions of early intervention goals and focus (Sameroff & Friese, 1990). Using the main effects model, the birth of a baby with biological risks or a genetic anomaly would lead to linear predictions of developmental risks and characteristics. The implications and predictions when using a transactional lens are entirely different and more dynamic. To demonstrate these different explanatory approaches, we will use the example of an individual born with Down syndrome.

Prior to the 1960s, physicians often counseled parents to institutionalize a child with Down syndrome, predicting that the child's developmental prognosis and life expectancy were poor (a viewpoint represented by the main effects model). Today, individuals with Down syndrome attend school, star in television programs, are featured as models in clothing catalogs, work in restaurants and businesses, and write books. What happened? Down syndrome was not cured, and the genetic mysteries that produce Down syndrome have not been solved. Rather, these children and families are given early support that fosters positive transactions. Children now typically begin participating in early intervention regimens in which they are helped to develop more fully and at an advanced rate. These programs foster increased skills whereby children can interact with their environment through more competent and complex communication, exploration, and social interactions. This increased child competence also may affect the parent's own feelings of competence and raise parental expectations for their children's developmental potential. Like an upward spiral, these positive effects lead to positive transactions that, in turn, change the opportunities and expectations in the next phase of development. As individuals with Down syndrome are seen participating in society, the community has more opportunities to develop greater understanding of individuals with Down syndrome and higher expectations for them. As is evident from this example, educational policies, intervention services, and societal expectations can and do enhance the early developmental potential and opportunities of children and their families. Although opportunities are not without bounds or limits, the transactions create a dynamic context for the developing child.

These perspectives are further underscored by research in neuroscience that documents the impact that early experiences (both positive and negative) or the absence of appropriate stimulation has on brain development (Shonkoff & Phillips, 2000; Shore, 1997). Greater understanding of how experience acts on the nervous system to shape early brain growth and development has focused increased attention on identifying the most beneficial learning environments for young children (Bruer & Greenough, 2001). Although these investigations have documented the dynamic interplay between nature and nurture and increased our understanding of brain plasticity, these findings are only beginning to be translated into policy implications and recommendations (Shonkoff & Phillips; Young, 2002).

RISK AND RESILIENCE

Scarcely a day goes by that the news media does not feature a story about risk–children at risk for school failure, toxins released into the environment that constitute health risks, deviant behavior explained in terms of poor parenting, risks of abuse or neglect encountered in an individual's early years, and risks of physical violence in our communities. To be sure, these factors all constitute major risks to human development. As such, it is tempting to focus attention in education, health care, and the social services on what can and does go wrong. However, many things also go right in human development and within families.

What do we mean by the terms *risk* and *resilience?* Researcher Emmy Werner (1990, p. 97) posited the following: "The concepts of resilience and protective factors are the positive counterparts to the constructs of vulnerability (which denotes an individual's susceptibility to a negative outcome) and risk factors (which denote biological or psychosocial hazards that increase the likelihood of a negative developmental outcome)."

In discussing the concept of risk, Rutter (1996, 2000) explained the importance of differentiating between risk indicators and risk mechanisms. Risk indicators are broadly defined variables that are statistically associated with risk. Poverty and homelessness are examples of risk indicators. Although they are strongly associated with risk, these factors do not necessarily in and of themselves create risk for the individuals. Risk mechanisms denote how risk works or the risk process itself that results in the disorder; for instance, a child may be born to a family living below the poverty level and in difficult circumstances (risk indicators). Whether those circumstances lead to actual risks to the individual's development will depend on the risk mechanisms; these mechanisms may include the family's access to medical and health care, the family's extended family and friendship resources, the parent's resourcefulness and support networks, emotional availability of family members, supportive learning opportunities, and other types of resources and supports.

According to Rutter (1996, 2000), the risk process also is greatly influenced by the individual's response to stressors. Each individual responds differently. Rutter cautioned that protection from risk might derive, in some cases, from exposure to risk rather than avoidance of the risk if the individual is able to successfully cope with the event. He likened this process to the effects of inoculations used to build resilience to infections. Some experiences can be seen to have a steeling effect. For example, Rutter observed that, in families growing up in the Great Depression, older children who were given early responsibilities and those who performed these responsibilities successfully fared better in the long run in their capabilities.

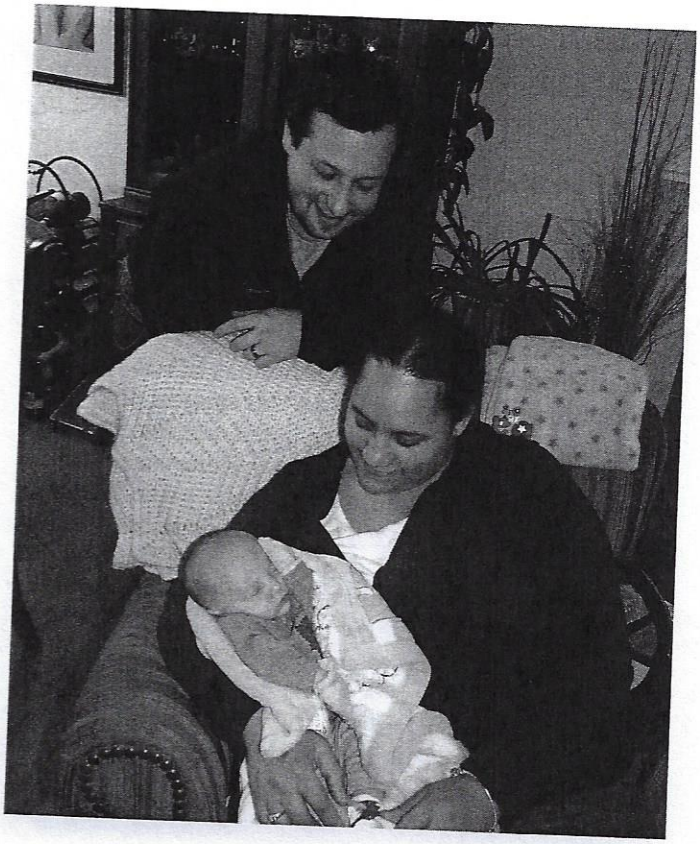
Rutter (1996, 2000) also noted that protection from risk is affected by prior experiences and that different factors may operate differently at different periods during the lifespan. For example, experiencing early malnutrition or subnutrition is associated with developing heart disease in later life, whereas being overweight in mid-life increases risk for disease. Rutter (1996, 2000) explained that a particular event might constitute a risk for one person but a protective event for another. For example, adoption usually protects a child from a poor, nonnurturing environment; however, in some cases it may constitute a psychological risk.

Rutter (1996, 2000) highlighted the transactional nature of development by underscoring the need to focus on individualized aspects or experiences rather than broad categories of risk factors. People's characteristics, such as temperament and coping abilities, and attitudes or appraisals of their own abilities, can greatly affect their resilience to risk factors. The importance of an individual's interaction and contribution to his or her own development is evident from this research, as is the importance of the individual's social context in posing risk or providing protection and support.

Families clearly are an important social context for all individuals. A risk condition within the family, such as marital discord or parental mental illness, may exert a profound influence and may affect the members within the family differently, depending on each one's ability to cope with the stressors. Societal influences also can play a major role in supporting both families and the individuals within them.

Several researchers have examined supportive factors, termed *protective mechanisms* by Rutter (1990, 1996) and *protective factors* by Werner (1990). Rutter (1990, 2000) examined different types of protective mechanisms that promote resilient responses to potentially stressful factors. First, he described reducing the risk itself, such as children who are able to distance themselves emotionally from a mentally ill parent or an acrimonious divorce situation. Other examples include parents who avoid drawing a child into a marital conflict, as well as parents who provide adequate parental supervision and monitoring to prevent their children's exposure to or continuance of risk from danger, such as the influence of a negative peer group.

A second protective mechanism was termed by Rutter as preventing or reducing "negative chain reactions" (Rutter, 2000, p. 672). For instance, hostile family exchanges may escalate when hostile comments are made by one of the members. Teaching family members to use humor or other coping strategies to diffuse the situation may lessen the hostility cycles that are likely to occur otherwise. Using effective coping strategies and avoiding damaging coping strategies, such as the use of alcohol or drugs, are other ways family members can reduce negative chain reactions. Third, Rutter described the importance of promoting self-esteem and self-efficacy in individuals. Factors that produce self-esteem and self-efficacy include secure and supportive personal relationships, successful accomplishment of tasks or responsibilities, and the successful use of coping strategies when encountering stresses. Fourth, the act of opening up positive opportunities may be protective, such as in the case of when families with teenagers move to a new town or school and away from high-risk peer groups. Other positive opportunities may include educational and career opportunities, broader choices of relationships with others, and even a change in home environment. Finally, a fifth protective mechanism identified by Rutter is the individual's method of cognitive processing–in other words, how the individual accepts negative experiences and reframes them around positive concepts. Rather than dwelling in denial or deception, the individual with this protective mechanism in place accepts and focuses on the positive aspects of the situation or the experience.



The work of Werner and colleagues (Werner, 1990; Werner, Bierman, & French, 1971; Werner & Smith, 1977, 1989, 1992) also examined risk and protective factors from a transactional perspective. Their core research is based on a landmark longitudinal study of children in Kauai from their prenatal period to adulthood. Findings from this investigation documented that poor developmental outcomes were associated with perinatal assaults (i.e., difficulties or trauma associated with the birth or delivery), particularly when paired with poor environmental conditions. Children who were reared in more favorable environments, however, fared better even if they began life at greater biological risk. Werner and Smith (1992) attempted to identify factors over time that had served as protectors. These general factors (listed from early childhood to later childhood) include the following:

- Birth order (being first born)
- Activity level (having a high activity level)
- Individual characteristics, such as absence of distressing habits associated with eating and sleeping
- Responsiveness to people
- Ability to display affectionate or cuddly behaviors
- Autonomy

- Positive social orientation
- Advanced self-help skills
- Adequate motor and communication skills
- Strong problem-solving abilities and achievement scores
- Ability to focus attention and control impulses
- Positive self-concept
- High regard for school and future expectations

In addition to individual characteristics, family variables were examined in the Kauai study (Werner & Smith, 1992). The factors that served a protective function were parent's educational level, attention paid to the infant, positive early parent–child relationships, care by other kin, adult coping styles, family coherence demonstrated through shared values, and adult structuring and rule setting at home. Factors outside of the family also served as protective influences, such as the support of other family members, teachers, neighbors, community leaders, and friends. These studies demonstrate the dynamic interplay between the personal characteristics of individuals and families and the broader environment in which they grow and live. Both the immediate family environment and the communities in which families are nested exert a tremendous influence on the children and families.

This research highlights not only areas of influence but also intervention arenas for fostering resilience. The concepts of risk and resilience apply not only to an examination of child development but also to family development and functioning (Singer & Powers, 1993). Families' resilience in adapting to challenges, such as the birth of a child with a disability, has received less attention in the literature than have the risks to family functioning posed by such events. A review of the literature by Patterson (1991) sheds some light on resilience and adaptation in families of children with chronic illnesses. Patterson noted that resilient families

- Maintained their family boundaries and control over their family decisions in the face of interactions with outside forces, such as professionals
- Were able to openly and assertively express feelings and convey communications competently
- Ascribed positive meanings to difficult situations and remained flexible in their roles and tasks
- Demonstrated teamwork within the family and maintained the family as a unit
- Engaged in active problem solving and coping skills
- Maintained social integration through friendships and participation in social networks and activities
- Developed collaborative relationships with professionals

This work identified the importance of the family's responses to demands associated with the illness. Patterson's work also elucidated the importance of a partnership or alliance between family and professionals as the basis for supportive interventions.

IMPLICATIONS FOR SUPPORTIVE INTERVENTIONS FOR FAMILIES

The family support movement has received great attention both nationally and internationally from policy makers and clinicians. Family initiatives also have been brought to the forefront of disability rights and services. These initiatives have raised awareness of the importance of the family as the primary context for children's development. The family unit is now viewed as the major focus of intervention and support services.

Contemporary approaches to family support center on recognizing family strengths and resources. These notions are often in sharp contrast to more traditional approaches or services for families that were characterized by "residualism, professional dominance, and pathology" (Singer & Powers, 1993, p. 4). In other words, supports were traditionally given to a small, residual number of families who were viewed as unable to function without such services (e.g., the traditional welfare system in the United States). Approaches were professionally driven so that families were fitted to the services rather than the reverse. These services were developed around a pathological or problem-oriented approach and interventions were focused on "fixing" families.

The shift in perspective to family support has been applied and expanded to families of children with disabilities (Dunst, Trivette, & Deal, 1988; Singer & Irvin, 1989). Family support is construed in a broader social context and the family unit is recognized as being embedded in other social networks in the ecological framework. Family competencies and capabilities are stressed and the role of professionals has shifted to support, rather than control, over family goals and decisions.

Using a social systems perspective, Dunst, Trivette, and Deal (1994) outlined six principles that reflect this family support philosophy based on views of family competency:

- Enhancement of a sense of community
- Mobilization of resources and support
- Shared responsibility and collaboration
- Protection of family integrity
- Strengthening of family functioning
- Proactive practices in the human services

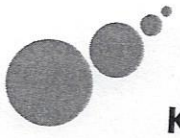
In this perspective, interventions build on the family's interactions within its community and focus on the resources and informal supports, such as family members and friends, inherent in that family. Interventions are conducted in a manner that enhances families' competencies, recognizes families' values and life ways, and maximizes families' control over decision making and services. This approach allows for a more individualized and flexible system of service delivery that is responsive to the particular needs of families and their cultural and linguistic heritage and preferences. Collaborative partnerships between family members and professionals are at the heart of all interventions delivered in this manner.

This consumer-driven approach to services has been termed a *family-centered approach*. Dunst, Trivette, and Deal (1988, p. 48) identified four essential intervention principles associated with this approach:

1. To promote positive family functioning, focus intervention efforts on "family-identified needs, aspirations, and personal projects."

2. To meet the needs identified by the family, capitalize on family strengths and capabilities as they mobilize their needed resources.
3. To ensure that the family obtains resources to meet their needs, emphasize strengthening existing social support networks and identifying other potential sources of information and assistance.
4. To enhance the family's ability to become self-sustaining in meeting their needs, use helping behaviors that promote the family's ability to gain and use its own competencies and skills to obtain needed resources.

These principles not only provide the nexus of a philosophy of service delivery, but they also offer direct benchmarks for practice. Service providers can examine their own methods and approaches to serving children and families by reflecting on these principles. The story of Kasheen and his family illustrates these principles of family support.



Kasheen

Kasheen was adopted when he was 6 months old, and his parents later discovered that he had been born early and prenatally addicted to drugs. The first years were difficult for his parents as they adapted their home to provide a calming and consistent environment for Kasheen, who was easily excited and difficult to console. At first, they were barely able to leave home without him crying intensely, but over time they were able to participate in neighborhood and family events. Kasheen was able to attend a preschool program at their church when he turned 3. A special education consultant for the school district provided on-site consultation for children with developmental delays. Given his delays in communication and in meeting cognitive developmental milestones, Kasheen qualified for services. Then, suddenly, when Kasheen was only 3½ years old, his father died of a heart attack. At that point, Kasheen and his mother, Nonda, moved in with Nonda's mother to save money on rent, allowing Nonda to have supportive child care when she was at work during the day.

Kasheen's grandmother became a tremendous source of support for both Nonda and Kasheen. Nonda's two sisters, her brother, and their families also lived in nearby communities, and the whole family and neighbors chipped in to provide child care and to take Kasheen to and from school and other appointments.

Now, Kasheen is 6 years old and attends his neighborhood kindergarten. During the early months of the school year, his teachers requested that Kasheen be tested for learning disabilities because of his inability to master early literacy concepts and difficulties following directions and focusing his attention. His teachers reported that even during recess, Kasheen shifted from activity to activity and playmate to playmate without sustaining attention in any one place. The kindergarten teachers were convinced that Kasheen "had learning problems." Nonda followed through with these recommendations, at which point Kasheen was identified as having attention-deficit/hyperactivity disorder (ADHD). The teachers believe that their suspicions were confirmed by the educational psychologist's diagnosis.

Although Nonda welcomed the assessment to learn more about Kasheen's needs, she has found it demoralizing to be told that Kasheen will always have "problems" and that she should ensure that he has a male role model integrally involved in his life. She feels like she is doing the best that she can. This diagnosis came as a blow to Nonda on top of the previous disappointments and challenges that she has experienced.

What types of support have Nonda and Kasheen needed throughout Kasheen's lifetime? What service approaches have and have not been helpful? First, when Nonda and her husband adopted Kasheen, they were faced with caregiving challenges (e.g., crying, inconsolability) that they had not anticipated. Nonda reported that their strong marital foundation and the support of their own families helped them to meet Kasheen's needs. The teachers and other service providers in the preschool early intervention program and preschool helped Nonda by providing her with practical tips and educational information for supporting Kasheen's development at home. They made home visits and actively included Kasheen's grandmother in all planning and delivery of services.

The family also benefited from participating in early intervention services during which teachers and an occupational therapist provided them with information on how to hold and feed Kasheen and how to structure their home environment so that they would be less likely to overtax his senses. Nonda felt less professional support when Kasheen was in kindergarten, however.

If this family is viewed through the lens of the service provider as "the expert" and dispenser of services to individuals in need, one may see a single parent, a child without a father, a child with learning difficulties, and other risk conditions. If one views the family through a different lens that is based on a family-centered approach, different phenomena become apparent. Through this lens, one can see that Nonda and Kasheen have many strengths and resources. Kasheen is able to participate in his local school program and make friends. Nonda is employed and able to support her family. She is also quite capable of gaining access to community resources and services for Kasheen. Furthermore, the family has a tremendously close network of family and friends who are an active and integral part of their lives. Nonda also relies on spiritual guidance from her faith and her faith community. She is confident in that guidance and in her own abilities to see the family through whatever challenges they may encounter. Those teachers, therapists, and other service providers who acknowledged these strengths were able to provide the most support for Nonda and Kasheen. They answered Nonda's questions, provided the specific technical information that she requested to manage and address Kasheen's needs, and helped her to obtain information on school programs in her area. They also told Nonda about a parent-to-parent support network in her community for parents of children with similar needs. Nonda has found this to be another valuable resource for child-rearing tips as well as an avenue to broaden her own friendships.

SUMMARY

When viewing families from various perspectives, the choice is not unlike that posed in the old cliché of viewing the cup as either half empty or half full. Each view leads to a different approach to our lives and/or our work. The approach advocated in this text is to examine the many possibilities for supporting families to fulfill their roles as primary contexts for growth and nurturance for each individual within the family.