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The Impact of Family Therapy in Hospitalized Children with Chronic Diseases

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Abstract **– The purpose of this study is to provide a scientific contribution to the evaluation of family therapy in patients with chronic disease. The findings of the study are based on previous researches and existing theories. Researches were made on professional literature related to various chronic diseases. Many chronic diseases are very difficult to be emotionally managed because of the limitations that the disease causes, therefore some of them should be put under complicated procedures. Hospitalization as a stressful situation that presents a series of real or imaginary threats to children as well as to the family. The main purpose of family therapy is the examination of levels of disease as in organic aspect as well as emotional, also analyzing the difficulties of the family to build and separate therapeutic targets necessary to promote the welfare of each family member. The targets of this therapy include reducing feelings of anxiety, anger and sadness. Encouraging communication with all members of the family. Working with the sense of competence and autonomy at the diseased child.**

Keywords **– Children, Chronic disease, Family therapy, Hospitalization.**

I. Introduction

Chronic disease may prevent normal development of self-esteem and sense of autonomy "The chronic disease is the experience which includes parameters deviated from normal, caused by pathological changes" (Cameron & Gregor, 1987). The hospitalized child should receive special attention through communication, based on his age and cognitive condition.

Chronic diseases have a great importance, not because of the frequency but because of the duration and difficulty of their treatment. Numerous epidemiological studies and extensive clinical data that include kids have been used to examine reports of unexplained symptoms. These studies are consistent in their findings.

Gender is reported to be constantly associated with the change of reports: girls feel more symptoms than boys, and girls report more symptoms during adolescence. In most of the studies it's been found that the reported symptoms from girls incur an upward scale during the adolescence while the level of reports from teenage boys lowers during this time. So it is noticed that when boys grow up they tend to consistently report less physical symptoms. Puberty is associated with increased reporting of symptoms in girls.

II. Main Text

Several factors that appear to be consistent over many studies are reported. Foremost among these factors are the conditions or psychological conditions, perhaps most pronounced, anxiety and depression.

Young children's difficult behaviors are also associated with more complaints about the symptoms. Temperamental factors in children are also identified as relevant with features as anxiety characteristics like perfectionism and as a conscious being are reported in many clinical studies. In many studies those who perceived their self esteem as low has been seen to have high levels of symptoms. So stressful familiar and social situations such as lack of parental harmony, increases symptoms the same way as acute stresses in life do.

It has been suggested that genetic factors may play a role in sensitivity to pain and other bodily sensations, although very little strong evidences exist. Previous experience in life cut in half and poor parental care are also associated with increased reporting of symptoms and are found in the history of the adults more unexplained symptoms.

A. Factors that affect in unhealthy behavior

Even the kids themselves even at a young age are far-called unimportant contributors to unhealthy behaviors regardless of the relative importance of the parents choices on how children's complaints are managed.

In descriptive studies, children from a very young age (5-6) show a sense of compulsive behaviors, so they notice that the ways of behaviors are different at those who are sick, that even showing some of the behaviors someone could indicate at others that he is sick and the works he has to do should be taken from him.

However, an understanding of the role of the patient is taken by children as part of family life, although this will severely be influenced by parental level. Children raised independently show a wide space of unhealthy behaviors.

B. Family and parental factors

Parents or caretakers are those who decide on responses to children's symptoms and behavior diseases, and they decide whether the complaints of a child are severe enough to let him be deemed as sick and if so whether he or she has to skip school, to be given medication or go to a professional doctor. But for some parents who are responsible and careful and may not have any parental difficulties in other ways, these decision-making processes could become more difficult, resulting in problems for encouraging a child to ignore his or her symptoms and return to daily activities.

Similarly, Rangel & Garralda (2000) have shown that parental belief in a physical cause for the chronic tiredness symptoms in children is associated with a poor prognosis.

Having a parent who has a chronic physical illness, it is likely to have children with somatic disorders later in life. (Garbe, Zeman & Walker, 1990; Hotopf, Chidgey, Addington-Hall, & Ly, 2002).

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Moreover, theory's can predict that family systems that have a child with an apparent disease may help avoid family focus from other family problems. In this context, family members can redefine their role to focus on avoiding potential conflicts of family life or materials, by concentrating on the sick child. Children who often get somatic illness have families who are often anxious and depressive (Garber, Zeman & Walker, 1990).

Bad parental health (mental or physical) may be associated with a difficulty in believing that the child is healthy or has only a slight illness, and anxiety about the health of the child, with a distorted or pessimistic analysis of the situation. Parental Depression and anxiety can increase the likelihood of consultation by parents for both, themselves and for their children in primary and secondary care (Garralda & Bailey, 1986).

Children with (chronic medical illnesses) can not be developed at the same rate as healthy children due to neurocognitive development (development of knowledge) delayed, disorders in education and limited social experiences. For example, a 15-year-old chronically ill teenager can function at the level of the age of a primary school child. Similarly, consultations for adults who have chronic diseases since childhood should be seen in the earliest hospitals and medical practices to enable a thorough understanding of the current level of development.

C. Family Therapy

Functional Family Therapy focuses on high reliefness of parental collaboration levels in solving problems related to adolescent behavior management; obvious hierarchies of generations between parents and adolescents, warm family support relationships; plain communication, and plain family rules, roles and routines.

Within functional therapy the family assumes that if family members can be helped collectively to change the problematic patterns of communication and if the lack of supervision and discipline within the family has changed, the child's behavioral problems will improve. This assumption is based on finding that vulnerable families are characterized by a higher level of protection communication and lower levels of supportive communication compared to families of non-dangerous youth and also have weaker practices of surveillance. In functional family therapy, all family members attend therapy sessions. Initially, family assessment focuses on identifying patterns of interaction and beliefs about the problems and solutions that sustain the youth's behavioral problems.

Within early sessions of therapy, for parents and adolescents, communication skills development, problem solving skills, and negotiation skills get easier. There is a wide use of reshaping to reduce adolescents blaming by parents and help parents see devious behavior as a result of situational factors. In the later stages of therapy, we focus on negotiating contracts in which parents provide adolescent privileges in exchange for respecting the rules and taking responsibilities.

While, functional family therapy focuses only on factors' change within the family system in such a way to improve enduring behavioral problems, multisistemic therapy, besides addressing factors among adolescents and within the broader social system, effective multisistemic therapy offers individual intervention packages that target behavioral problems -factoring factors within multiple social systems in which the teenager is a member (Curtis, Ronan & Borduin, 2004;. Henggeler et al., 2003).

These multiple systems include ones themselves, family, school, colleagues the group and community. Multisistemic interventions integrate family therapy self-regulating self-training skills into adolescents, school-based educational and entertainment interventions. In multisistemic therapy, it is assumed that if internal factors of adolescents, family, school, group members, and the community maintain the problematic behavior, then interventions can focus on changing these factors and thus reducing the problematic behavior. After multisistemic assessment where adolescents' family members are interviewed, they enter a unique intervention program, which includes specific subsystems that are responsible for adolescents' difficulties.

In the early stages of therapy, the therapist contacts, with the members of system, and later the interventions focus on understanding the problem by members of other systems or restructuring the ways they collaborate around the problems. Interventions can only focus on adolescents, family, schools, group or community members. Individual interventions usually focus on the assistance given to young people to develop their social and academic skills. Improving communication with family members and supervising abilities and disciplination of parents are the goals of family intervention. Facilitate communication between parents, teachers arranging and setting appropriate educational interventions common with the intervention of the education schedule.

Interventions with group members may include diminishing contact with devious colleagues and increasing contact with non-deviant colleagues. In contrast to family functional therapy, which focuses only on the family system, or multisistemic therapy, which addresses, besides family factors, also individual factors and the broader social network, treatment for encouraging caution towards related behavioral problems. In the treatment of fosters, foster parents, were selected and trained extensively, in collaboration with adolescents the therapists provided a nursing care structure for a few months in a foster family environment (Chamberlain, 2003, Chamberlain et al., 2003). The treatment aims to modify behavioral problems, preserve internal factors of children, family, school, peer group adoption, and other systems by temporarily placing the child within a family in which foster parents have been trained to use strategies to change deviant behavior of adolescents.

Treatment of adolescents' caretakers usually takes a multisistemic intervention package to modify the behavioral problem - including teenagers themselves, the biological family, school, group members, and the wider community. These are similar to those described for multisistemic therapy and with biological parents so that when treatment is completed it will be continued by

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biological parents, so they will be able to continue working on the treatment of foster parents when they are visited by teenagers or back home for a long time. The purpose of foster care is to prevent long-term separation of adolescents from their biological family in order to spend more time with the natural family and less time in custody treatment. In terms of service development, it may be more efficient to provide services for adolescent behavioral problems in a permanency of care (Brosnan & Carr, 2000, Chamberlain and Rosicky, 1995).

Less severe cases can be provided with functional family therapy up to 40 sessions over a one-year period. Moderate severe cases and non-responsive to therapies cases can be provided with multisistemic therapy up to 20 hours per month over a period of up to four years. In extremely severe cases and those who do not respond to multisistemic intensive therapy may undergo treatment under guardianship for a period of up to a year and this may be followed by ongoing multisistemic intervention. It will be essential because the service involves high levels of supervision and reduction of clinician consumption.

III. Conclusion

In the pediatric consultation and epidemiology studies, it has shown that parents with more physical and mental health problems are more likely to have children with functional somatic symptoms than parents who have no such complaints.

Doctors need basic knowledge of physical norms, language development, the development of knowledge, sexual development and emotional development in children with chronic diseases in order to distinguish normal reactions to stress from harmful responses. Understanding the child's cognitive ability to process information is essential when communicating with him or about his / her illness.

While children generally go through similar stages of knowledge, clinicians can not assume that chronological age is equivalent with the mental age.

Functional family therapy aims to reduce the overall level of disorganization within the family and in this chaotic way to modify family routines and communication patterns, which hold non-social behaviors (Alexander et al., 2000).

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