Afterword: Challenges for Family Practitioners

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In the preceding pages, contributors have offered glimpses of families engaged in the growing activity of transracial adoption, strategies for working with family members in a medical setting, the use of diagnostic and intervention tools such as genograms, the changing nature of grandparenting, and recognizing the myriad roles family practitioners may play in influencing the course and content of the family intervention. All of these articles offer valuable information for those working with Michigan's 1.3 million families (National Center for Children in Poverty, 2004).

Throughout this issue, readers have been encouraged to place families within the numerous interacting contexts that give meaning to their lives. Without doing so, we risk designing interventions for families as we wish they were, rather than as they are. How might family practitioners address the changing realities of families whose life situations differ so much from their predecessors in historical and herstorical time? I suggest that the experiences of the families we have met in these pages leave us with three overarching questions that challenge our ongoing scholarship and practice:

- Where do we need to focus our energies as family practitioners and researchers who are mindful of the group, community, societal and global influences on family life?

- What or whom have we consistently neglected in our overall theory and practice endeavors?

- What roles might we play in improving the overall well being of families within their social, political, historical contexts?

Challenge 1: Where Do We Need to Focus Our Energies?

Even with the range of innovative practice methods available to family practitioners, some families and their members continue to experience major threats to their overall well being. Almost one-third of Michigan's 2.4 million children live in low-income families. Only 18 percent of those low-income families have unemployed parents. The majority (48%) of low income families has at least one adult who is employed full-time year-round (National Center for Children in Poverty, 2004). The consequences of this poverty were identified in the first example provided in the introduction to this issue. Associated with such poverty is an increased probability of homelessness and serious housing problems (National Low-Income Housing Coalition, 2004).

Parents who wish to work may find it extremely difficult to play an active role in their children's lives and meet the demands of the low-wage, service sector jobs our nation has been generating for the last 10 years (Malveaux, 2004). As our colleagues in family studies have demonstrated, children with supportive parents become healthier adults. We need to know how to increase the probability that parents will be able to provide the support their children need now in order to meet the future needs of the state and nation.

Offering some insight into this challenge, Bishof and his colleagues (this issue) identified four situations in which their medical family practice model can yield optimal results: (a) for those families combating chronic childhood illnesses; (b) for those whose spouses have chronic illnesses; (c) for family involvement in promotion/prevention activities; and (d) for the ongoing care of the aging. As the number of the aging increase in Michigan, considered by Tilove (2004) as one of the "Heartland" states, will we be cognizant that diverting major resources to the aging will leave us with fewer resources for children? For the 20 percent of Michigan's population whose families exist on incomes 9.2 times lower than those who represent the top 20 percent (National Center for Children in Poverty), attention to Bishof and colleagues' four effective practice entry points could make the difference between continued lives of ill health with lowered lifetime earning potential or a method of ensuring that even those without adequate health insurance could continue to live as contributing members of our society.

Challenge 2: What or Whom Have We Neglected?

Effective strategies for working with the chronically mentally ill and their families have been with us for decades (Test & Stein, 2003; Jackson, 2001). These intervention strategies require community-based practitioners and services. It is increasingly clear that during the last 15 years we have moved away from treatment for the chronically mentally ill, with the kinds of dire consequences outlined in the introduction (Lewis, this issue). Although the former Michigan Department of Mental Health has become the Department of Community Health, effective community based

interventions for the chronically mentally ill have never been institutionalized within the Department's practice priorities.

Gay, lesbian, bisexual, and transgender family members in families who have lost their domestic partner benefits since the November 2004 election also face a number of very problematic decisions. Michigan educators have long been concerned about the increased probability of suicide among gay and lesbian youth. Will mental health services and or programming geared toward suicide prevention for this population now also be eradicated, and with what consequences? Will only those people with heterosexual orientations have access to medical care? Given the level of misinformation in the nation in terms of understanding the range of sexual orientations, will those who have lobbied to have hate crimes on the basis of sexual orientation recognized and subject to criminal prosecution find that their efforts have been in vain?

The omission of rural families in our literature has long been of concern to those who work with them. With the exception of the Chavis article (this issue), all of our examples in this issue dealt with populations who were more likely to have access to cities and their resources for families. As noted in the introduction, the rural school shootings by young white males that have so shocked the nation almost became a reality in Michigan this year. Toppo (2004) noted that many school districts are still afraid of acknowledging the prevalence of troubled adolescents, a fear that is accompanied by a lack of effective interventions. At most, violence prevention is a focus. It is ironic that the "whistleblower" for the Michigan case hailed from another state. What will it take to implement some of the innovative interventions aimed at the systems of violence, such as Frank White's (2004) well-regarded program that has been adopted by the majority of Minnesota's school districts?

Challenge 3: What Roles Do We Play in Promoting Family Well Being?

The contributors to this issue have presented a number of roles open to family practitioners, including serving as advocates, educators, brokers, bridges between medical personnel and patients, and collaborators with multiple family self-help organizations. These roles require an understanding of social, political and historical contexts in order to be effective. They often require learning strategies more likely taught in other disciplines as well. As family practitioners, we can increase the extent to which we interact with our colleagues in other disciplines and collectively identify best practices instead of looking only within the "ways of knowing" afforded by our colleagues within our primary field. Family scholars' contributions to family interventions may also be improved by embracing the conceptual frameworks that provide a comprehensive and contextual view of family life. The ecological model of family life has been utilized in some disciplines for decades, and has resulted in some fruitful multidisciplinary collaborations (Phenice & Griffore, 2000; Barratt, 2000).

Learning more about how families live within contexts requires sharing the reality of those contexts with others. Our legislators (who are most likely to be found in the top 20 percent of our state's income range) can only learn about how much their lives differ from the other 80 percent of Michigan's families if those differences are pointed out to them. For example, if most families do not adhere to the model prevalent in the 1950s in terms of their structures and functioning, why are we still attempting to foist that ancient model on them? Who has benefited from this model in the past? Who benefits from it today? Is it ethical to have one more privileged group (in terms of access to resources) mandate behavior of less privileged groups without funding the mechanisms so that the desired behavior can actually be enacted by all of Michigan's families?

Boss and colleagues (2003) have demonstrated that family strengths can be utilized to enhance overall family well being even in extremely traumatic circumstances, such as the bombing of the World Trade Towers in New York in 2001. They learned that if they listened to what the families of the trade unions wanted, they could help families in communities along in their healing processes. In this case, listening meant that practitioners needed to be aware of their own cultural competence and knowledge of contexts, that they needed to expand their practice skill base to include facilitating multiple family groups, and that they would need to present their interventions in community-based settings. Their listening has paid off for those families in New York City. During this next decade, let us take up their challenge and commit ourselves to listening to the families of Michigan as we design and implement our family practice interventions.

Most importantly, family practitioners and scholars must support families in this country in their attempts to understand themselves and their internal and external complexities. Even those interventions designed to provide immediate behavioral or social change for the family can be viewed within the therapeutic alliance as being a part of an overall long-term plan for intervention. Such long-term plans recognize changes within family structures and functioning as normative and help families develop strategies for recognizing when external assistance is needed. To understand this complexity requires those interested in working with families to also incorporate–as a normative act–all of the systems influencing and being influenced by these families, including those that are historical, social, and political. In this way, family practice, family policy, and family research may more closely provide meaningful solutions to the real needs of families in the 21st century, including the ones of which we are members.

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