The Individual in Family-Orientated Care: A Paradox?

Van Deventer, C
MB, ChB (Stell), BA (UNISA) MCFP(SA), MFamMed (Medunsa)
Senior Lecturer, Dept of Family Medicine, Medunsa

Address for correspondence:
Department of Family Medicine
PO Box 222, Medunsa, 0204
Tel: 012-2523311
Fax: 012-2531610
E-mail: domdox@lantic.net

Keywords: Individual in family therapy, Narrative therapy, Systemic worldview, Circular questioning, externalising

Abstract

Although the presence of all family members is the ideal, if one works within the framework of systemic thought and understands that this is the key to interacting with an individual with all the "shadows" that he/she brings, there is no paradox in becoming involved with someone in a stuck situation whether all the role players are present or not.

It needs a commitment by the family physician to think systemically all the time and to become skilled at methods that assist this worldview.

Many of these skills fit well within a narrative way of dealing with family problems.

S A Fam Pract 2000;22(4): 6-8

Introduction

A changing worldview

In family medicine there has been a significant shift from disease-centredness to patient-centredness. Different models[1] reflect the search to replace the biomedical (mechanical, reductionist) model which has been used since the early 1900's, when linear thinking was hailed as the only truly objective and thus scientific worldview. The new approach had as aim "to understand the patient's expectations, feelings, and fears.... Understanding patients in this way also requires in the physician certain qualities not usually emphasised in medical education: self-knowledge, moral awareness, a reflective habit of mind and a capacity for empathy and attentive listening."[2] McWhinney continues to say that this clinical method is a transformed rather than an additive one because "first, it requires a radical change in the physician's character and perception, and second, it requires a change in the epistemology of medicine."[3]

There is therefore a specific way to look at and understand patients, which could help under difficult circumstances.

Subsequent to the debate about the transformed approach to patients, there was a concerted effort to understand not only the presenting individual but that person in his/her context. This led amongst others to the concept of the family as patient. There has been a great deal of resistance to this idea. "There may be two principal reasons....The first is the conceptually difficult transition from the linear....to the cybernetic model of the family as a system, in which the pattern of interrelationships is seen to have impact on health and disease... The second problem is confusion between the skills of a family physician working with families and those of family therapy, a separate discipline."[4] Christie-Seely explains systems theory and the importance of recognising homeostasis and feedback systems in family relationships. It remains however a reality that "A family physician with a system orientation will still see individuals in his office 95% of the time. He or she may be more aware of 'the family in the patient', will know all members of most families in the practice, and will respond to cues indicating the need for a family interview."[5] She however limits the family physician's role to assessing the family and **deciding when to refer** to a family therapist. McDaniel, Campbell and Seaburn concur but say: "Biopsycho-socially orientated physicians observe the interaction between themselves and their patients. In that sense they understand themselves as part of a circular process in which their behaviour contributes as much to what transpires as their patients."[6] They have a wider concept of the family physician's role than Christie-Seely does but fairly frequently do suggest referral of patients at a certain point, especially for alcohol and drug-related problems and child abuse. This solution is not a satisfactory one for me in my context as there are almost no possibilities for family therapy related referrals.

I would therefore examine the dilemma of a family practice where most patients come as individuals with a wide range of presenting needs and the possible options that can be utilised within a holistic worldview. This encompasses not only inter-familial relationships but recognises the interactions between the family and the therapist, the relationships of society, of nature, of all the possible things that can influence one's decision-making. It would be the difference between giving an antibiotic to a baby after the mother's umpteenth visit and spending some time listening to stories about her family and life in general.

The dilemma of caring for the individual systemically in family practice

*Mrs Netshiavha** makes an appointment for intractable left chest pain which she has had for months and which has not responded to medical or homeopathic treatment. When she walks in, she sinks to her knees in a foetal position and groans. During our discussion, a very insecure marital relationship is revealed. She is convinced that her husband is having a string of affairs and does not love her any more. I ask that her husband accompany her to the next session. When she arrives at the next meeting, she says that she had requested him not to come because she was afraid he would just sit and lie about the relationship and also that he might become aggressive later at home. Her family and friends had advised her that this was the better way to go! Her pain had disappeared but I felt that we were nowhere near the possibility of attending to the actual problems.

*Mrs du Preez** has been a number of times to see me about physical complaints but also because she has an alcohol problem. She has been institutionalised before and refuses to go again. She is extremely ill by the time I see her and needs medication to support her through the withdrawal symptoms. Each time she manages to overcome the dependency in the short term but does not come back with her family to work through the problems of having been abused as a child, aggression in her marriage, an episode of infidelity eight years ago etc. Two weeks before her daughter's wedding, she presented with severe anxiety and tremors and was drinking about 9 beers in the evening and also drinking throughout the day. I called her husband urgently and insisted on a series of consultations to try and work at the problem. The first consultation was cancelled because he was working late, the second and third never materialised!

*Mrs Nemaduluni**, a nursing tutor, seeks me out late when there are no other patients around. She is covered in bruises. Her husband has beaten her because she took R4.00 and did not first discuss it with him. A terrible story emerges of a husband who has lost his job, is drinking heavily and because of his aggression, the family find themselves fleeing the house at night." But he's a wonderful person when he's not drunk." I negotiate all manners of possibilities e.g. asking him to come and join us to discuss their child's frequent abdominal pains or his wife's hypertension, which is difficult to control, as possible entry points to the deeper problem. He doesn't come. This is the pattern in my practice. Although I see families, they usually emerge as individuals at different times. There is the advantage in this that a jigsaw puzzle slowly comes together over time, which is possibly just as valuable as having the whole family together over one or two sessions. However, the interaction of relationships cannot be observed.

The most absent person in the family jigsaw is normally the male partner. It may be in my case, that my gender causes this bias. That however is not an answer to my attempt to practice interactively.

It is important to realise that the therapist/family physician's role is as integrally a part of the system as is the patient.

The potential in an eco-systemic family practice

I recognise that each individual, who presents with a problem, is bringing his/her system (or shadow family) with him/her. As an individual speaks and tells a story, and I become part of the conversation, there is already a system functioning.[7] The system is obviously limited if no other role-players are present, but it remains workable. There are a number of methods whereby the discussion can be broadened e.g. the use of circular questioning, genograms and ecomaps, the utilisation of metaphors, the art of reframing, all these techniques of the narrative approach to counselling. These will be discussed later. However, it is how the family physician sees his/her role and involvement that remains the most important factor.

It is important to realise that the therapist/family physician's role is as integrally a part of the system as is the patient. The family system then can either change in response to the inputs and observations by the family physician or resist them.

Practical considerations

Whilst one can appreciate the unity of a person in relationships and whilst one can understand a worldview which theoretically permits one to become part of the universe of a patient, there are practical methods which "fit" with this worldview, which can be utilised. All these fall within a narrative way of thinking.

Circular questioning

*Gideon**, a man with an alcohol problem has been rejected by his sister after his mother's death. I can ask "Why do you think your sister is doing this to you? What do you

think she will do if you go and try to make peace? How is her husband reacting in the situation? Why do you think her husband is treating her like this?" In this way the presenting person's ideas about how his family reacts are brought into the discussion and become part of the interaction. One cannot observe the "interactions of interactions" but there is the opportunity to stir things and to reframe, (put matters in a different light) with the individual.

Michael White has refined these questions by emphasising "unique outcomes" in abused children i.e. occasions when the child felt the he/she was experienced positively e.g. "What do you think it is that your teacher noticed about you that your ...(abusing adult) was blind to?"[8] With this skill of circular questioning, one can bring worlds of creative imagination into the system.

Reframing and metaphors.

If frames are "like templates placed over our experiences so as to give them meaning."[9], then reframing implies a reorientation which leads to changed ways of doing things. Capps highlights a number of practicalities in the process of reframing.[10] In summary: recognition of the original frame is essential; things may be reframed in more than one way; and relatively small alterations can produce dramatic change. For example if the patient says that her husband has closed the door on her, one could mention that every door has a key and what are the possible keys that she can identify which could open the door again. Here the "patient" can reformulate without the therapist taking the initiative. It is especially in the last of these that the patient's metaphors can be facilitated by the family physician to redirect the thoughts or relationships of a person.[11] Metaphors are often offered in the conversation and have within them the potential to help in reframing. Capps relates to the parables as strong metaphors for reframing, in a pastoral situation.[12] Biblical or other parables are therefore a strong resource to be accessed.

Externalising the problem.

By allowing the problem to develop a life of its own, individuals can no longer be blamed or treated as if they were the problem. Alcohol could for example take on its own personality and then ways would have to be found to trick it at its game or to become strong enough to frighten it off when it becomes troublesome. Visualising the problem as a monster or goblin or something else socially understandable works as well with adults as with children!

Narrative therapy as underlying thought process.

In any clinical situation, a patient comes with a **story** of something that has happened, which needs change in one form or another. It is therefore very appropriate to think of the narratives of people as a way of facilitating change. "The text analogy proposes that meaning is derived through the "storying" of experience; that it is the stories that persons have about their lives that determines the meaning that they ascribe to their experience."[13] Michael White has constructed a theory around stories that have become "problem-saturated". Working with this theory, he describes how the identification of unique outcomes in the past, present and future of a person/people can lead to an opening of "space for persons to re-author or reconstitute themselves, each other, and their relationships, according to alternative stories or knowledges."[14]

Conclusion

Although it needs time and some measure of hands-on training, the ideas around narrative family therapy make sense to me as a family physician. In my context where **individuals** often present, I can hope to be a catalyst of change through certain techniques. There is also the extremely important understanding of my role in becoming part of the patient's system whenever we engage in conversation. I therefore may become a part of the newly created story of the patient, which often leads to his/her healing.

** Not the patient's real name*

References

1. Henbest R. Time for a Change. New Perspectives on the Doctor-patient Interaction. J Fam Pract January 1989;8-15.
2. McWhinney IR. Are we on the brink of a major transformation of clinical method? CMAJ 1986;135:873-878.
3. IBID
4. Christie-Seely J. Teaching the Family System Concept in Family Medicine. J Fam Pract 1981;13:391-401.
5. IBID
6. McDaniel S, Campbell TL and Seaburn DB. Family-Oriented Primary Care. A Manual for Medical Providers. New York. Springer-Verlag; 1990.
7. Anderson H, Goolishian HA. Human Systems as Linguistic Systems: Preliminary and Evolving Ideas about the Implications for Clinical Theory. Fam Process December 1988;27:371-391.
8. White M. The externalising of the problem and the re-authoring of lives and relationships. In Dulwich Centre Newsletter, Summer; 1988/89.
9. Stone HW. Brief Pastoral Counselling: Short-term approaches and strategies, Minneapolis; 1994.
10. Capps D. Reframing. A New Method in Pastoral Care. Fortress Press; 1990.
11. IBID
12. IBID
13. White M. The externalising of the problem and the re-authoring of lives and relationships. In Dulwich Centre Newsletter. Summer; 1988/1989.
14. IBID.