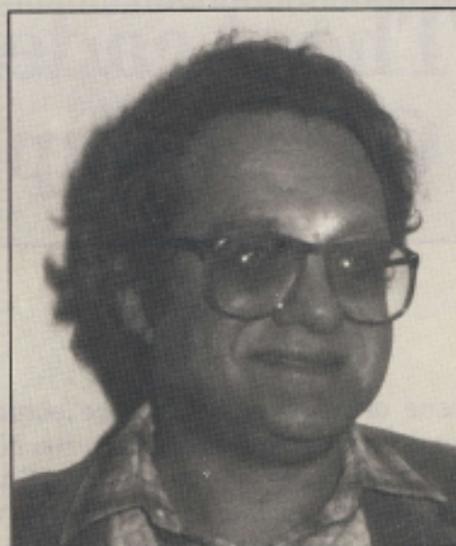


The Family in Distress

S Levenstein

Summary

The author explains how family distress can be the cause of patients' illnesses. The general practitioner should recognize this, understand the interdependence of individuals in the family and help a distressed family not to become a chronically distressed one. The difference between a family therapist and a general practitioner is discussed.



Curriculum Vitae

Dr Stanley Levenstein has been in general practice since 1972. He is Chairman of the Western Cape Region of the SA Academy of Family Practice/Primary Care and is a member of the National Council of the Academy. He is Founder President of the SA Balint Society and a member of the Administrative Council of the International Balint Federation. He is active in under- and postgraduate education in general practice. He has authored numerous publications and papers on topics related to general practice, one of which was awarded the Louis Leipoldt Memorial Medal in 1977 and another was the winning entry in the British Balint Society Essay Competition in 1982.

KEYWORDS: Physicians, Family; Physician-Patient Relations; Family Practice; Family; Family Health; Family Therapy; Life Change Events; Interpersonal Relations; Marriage; Neonatology; Personality Development.

All individuals whom the general practitioner has to treat, are or once were, members of families. This fact, though self-evident, has important implications. It underscores the reality of *interdependence* of individuals on biological, psychological, and social levels, throughout the developmental cycle, although the form that it takes and the degree of dependence vs independence which is healthy or appropriate will necessarily vary from one developmental stage to another.

The earliest dyadic or 2-person relationship is that between the mother and the new-born infant. (Perhaps one should qualify this by referring to the mother's relationship with her unborn infant in utero, which is earlier still). This mother-infant dyad could be regarded as the most basic family unit, as it is essential for the baby's survival and thus, more broadly for the entire human species. The new-born infant is of course *totally*

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IF ONLY I COULD GET A GOOD NIGHT'S SLEEP

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dependant on its mother or a mother-figure for the fulfilment of *all* its needs. The famous analyst, Winnicott, once said that there is no such thing as a new-born infant, only a mother-child relationship. In the first 3 months of its life, the baby is unaware of its

***The reality of interdependence
of individuals in a family
should not be underestimated.***

mother as a whole and separate person. He relates only to *parts*¹ of the mother *eg* breasts, arms, skin, mouth etc and often does not distinguish between mother's body-parts and his own. When his needs for feeding, warmth, closeness etc are being met, he feels himself to be in *possession* of mother's breast which is then experienced as *good*, while at times when he is experiencing hunger, cold, etc he may feel himself to have mother's *bad* (*ie* un-nourishing, un-gratifying, hurtful) breast within him. The infant's early experiences (or interpretation of his experiences) of the breast (or breast-substitute *ie* bottle) have been shown to have a life-long effect on his psychological development and inter-personal relationships. Thus, it is not surprising that the birth of a baby arouses strong feelings in other family members, as their own experiences of early infancy are unconsciously activated

by this event. This explains the high incidence of "post-partum depression" in mothers whose own experience of being mothered as infants and small children was very unsatisfactory. The birth of their own babies activates long-repressed longings for the love and nurturance they felt they did not receive from their own mothers, and they unconsciously wish that they were once again babies who could be given everything they need and want, without anything being demanded of them in return. The reality of the situation is, however, just the opposite *ie* they are now faced with the task of meeting all the baby's needs. This creates feelings of unconscious envy, anger, and even hostility towards the infant whom the mother at some level would really like to mother *her!* These hostile feelings in turn produce guilt which manifests as depression. These are often non-coping mothers, who typically present frequently to the general practitioner in the neo-natal period with various minor complaints about the baby, *eg* feeding difficulties, loose stools, blocked nose, restlessness, sleeping difficulties etc. By this time mother will often have been given liberal doses of re-assurance, and a few changes of milk brands recommended, with no effect. (During this time she may also have had a couple of changes of contraceptive pill at the Family Planning Clinic). There may also have been a few visits to a paediatrician who failed to detect any organic disorder and who may have told the mother to "stop worrying about your child, there's nothing wrong with him" or possibly diagnosed a mild milk allergy and recommen-

ded a soya-preparation. It is essential that the general practitioner recognize the mother's (and the family's) distress on these occasions and not become irritated or still worse, resort to simplistic advice and re-assurance at such times. Careful histories of marital and sexual problems will often be shown to date from the birth of a new baby, so that a general practitioner who fails to recognize and treat problems in the neonatal period will often be allowing an acutely distressed family to become a chronically distressed one.

It will be noted that I have referred to a distressed family in this situation and not merely a distressed mother and infant. As mentioned earlier, other family members may also regress and experience a sense of frustration and resentment which had not previously been apparent. The regressive behaviour of siblings after the birth of a new baby, eg bedwetting, nail biting, temper, tantrums, lack of attention to school work etc is well-known. However, father too often experiences a feeling of neglect and displacement at such times. Perhaps it is a reminder of how he felt when his mother gave birth to his baby brother or sister, or also of his own infancy and childhood. Thus it is that fathers tend to have a higher incidence of attendances at GPs for illness and requests for sick certificates at the time of their wives having new-born babies.

I have chosen to dwell on the neo-natal period for several reasons: one of them is that, as mentioned, I consider it a critical time in the development of malfunctioning in many families, which therefore presents a special challenge to the general practitioner; another is that it illustrates the interrelatedness of emotional problems within a family; yet another is that it also

The Infant's early experience of his mother's breast has a life-long effect on his psychological development and interpersonal relationships.

illustrates the crucial problem of rôles in the family. With regard to the latter point, the neo-natal period is the time when a woman has to adjust to the rôle of mother as well as that of wife, a man to that of father as well as husband, and a child to that of a sibling. Some women may have functioned very well as wives and sexual partners but fare less well as mothers, while in others the opposite is the case. Women who function better as mothers than as wives may become distressed when their children grow up and are ready to leave home. This may manifest as depression or with psychosomatic symptoms and may be dismissed as "menopausal symptoms". At such times, women require help in finding other outlets for their energies and talents such as community work, etc. Men too, may function better in one rôle than another, although their rôle as fathers is less crucial in the neo-natal period. In modern society², the expectations of spouses of each

other have become extremely complex. This is perhaps particularly true of women who are nowadays often expected to be warm and loving but also coldly efficient; assertive but also submissive; intelligent, talented, artistic, and imaginative but also conservative and conventional; sexy, but also motherly; wage-earners but also housewives. No wonder the incidence of divorce is so high in modern times! It must also be remembered that in addition to societal pressures, each spouse brings to a marriage his/her own set of expectations of how the other should behave based on their own childhood experiences of their own parents

The neo-natal period is a critical time for the development of malfunction in family life.

and siblings. A woman whose own mother was very submissive and passive for example, may expect her husband to be dominant and will resent the responsibilities this places on her if he is not. A man whose father was very authoritarian and strict may adopt the same attitude to his own children, or else may go to the opposite extreme as a reaction against it. Unfortunately it is all too seldom that spouses realize that their disappointment with and their anger towards each other is often based on unfulfilled expectations emanating from their very different homes of origin. It can sometimes be very helpful if they are enabled to see this and then be assisted towards developing more realistic expectations of each other.

Having stressed the importance of the neo-natal period both to individual development in later life and to the functioning of the family in the here-and-now situation, I now wish to return to it. At about the age of 3 months, the baby becomes aware of his mother as a whole and separate person and not merely as a collage of body parts. Initially, this is a terrible shock for the infant. He realises that he is not the centre of the universe, and that there are rivals for mother's attention, particularly father. When mother is not present he fears that she is dead and that he has killed her because of his attacks on her body which is how the infant experiences breast-feeding etc. This heralds the first experience of guilt feelings, but also the first experience of genuine love and caring for the mother, and a desire to repair the damage the infant imagines he has caused her. In favourable cases, the infant learns to tolerate ambivalence ie that he can experience both hate and love towards his mother at different times or even at the same time, without

Emotional problems within the family are interrelated.

destroying her or himself. He learns to tolerate frustration after discovering repeatedly that although mother is sometimes absent or non-nurturant, this is always followed by her returning and meeting his needs for food, warmth, love etc. Here again, this phase of an infant's life is crucially

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important in influencing his later development, particularly with regard to socialisation and the capacity to develop close, loving, intimate relationships. A male infant who has not developed caring, loving feelings for his own mother during this time may well turn out to be a cold, remote husband and father as an adult. He may marry a woman who is warmer than his own mother was, but because of his problem with basic trust, he will be too insecure and threatened to form a really close bond with her. She in turn may have had a father who was also cold and remote like her husband, but married this man in the hope of changing him, thereby fulfilling her long-cherished phantasised wish to change her own father. In the circumstances both partners are doomed to disappointment as husband is incapable of loving deeply and his wife has unrealistic hopes of his doing so. Such relationships may either rupture traumatically or else drag on in a mutually unsatisfying way with both partners clinging to their impossible demands of each other and not realising how much of the problem lies within their own respective individual psychopathologies.

In the normal course of development, the child gradually begins to separate from his mother and become more independent. He explores his environment, acquires skill and mastery in various areas, and gradually acquires increasing confidence in coping with life without the assistance of his parents, while still retaining the capacity for closeness and affection. This process then continues through adolescence and reaches its pinnacle in adult life.

Such a course of development requires an optimal state of family functioning. It is most likely to occur in families where there are close affectional bonds but where there is also ample scope for individual freedom and discovery. It is also favoured by families with clear, though not rigid, rôle-definitions, (eg children do not get drawn into marital squabbles, or be given responsibility for financial planning or disciplining other children), and families whose response to stress and conflicts is flexible and resourceful. However, it must be borne in mind that even in such families, certain events can disrupt the equilibrium which had existed, and cause the family to become dysfunctional. One such event is childbirth, which has already been discussed. At the other end of the lifespan is *bereavement* which is nearly always a traumatic event for a family even when the deceased is very old and the death was expected. The general practitioner once again has an important rôle here, not only to help the family to grieve their lost loved one, but also prior to that in preparing them for their impending loss. This will be more effective if the general practitioner has been able to observe the rôle the dying patient has played in the family in the past, eg was granny the peace-maker in her daughter and son-in-law's marital disputes? Was grandfather a special person to the 10-year old grandson?

Another, even more major source of family disruption is marital *breakdown and divorce*. Apart from being highly stressful to the spouses, it is invariably a devastating experience for the children, who very frequently

experience inter-alia strong feelings of guilt, blaming themselves for their parent's marital discord. In cases where divorce cannot be prevented, useful work can sometimes be done by counselling the parents to avoid using the children as a ping-pong ball in their disputes.

Other common causes of family dis-equilibrium are breadwinner's *loss of employment; financial disasters*; the occurrence of a serious *illness or handicap* in a family member; the emergence of a major problem such as *alcoholism* or *delinquency* in a family member; and dislocation of a family from its environment by *emigration* or even transfer by employers.

The above-mentioned situations all result in families in distress. How do such families present in general practice? Sometimes they present overtly with a precipitating event, such as bereavement. At other times the distress is less obvious and the general practitioner has to be on the lookout for it. One sign of distress in a family is a *high frequency of consultations*, either in absolute terms or relative to the previous consultation rate. Typically³, these may be consultations in which the mother has brought in one or more of the children with minor physical complaints, such as upper respiratory infections. If the general practitioner is listening carefully, tell-tale points will emerge in time eg little Johnny has dropped 10% in his school exams this term or Mary has started biting her finger-nails again. And "by the way, doctor, these children are impossible nowadays, I simply can't control them". The general practitioner must ask himself whether these children are reacting to some family distress, eg marital problems between their parents. In such cases the mother usually later starts complaining of physical symptoms such as tension headache, abdominal pain etc. If the general practitioner is on the alert, he may be able to recognise and deal with the underlying problems at an earlier and therefore more treatable, stage.

Another major manifestation of a distressed family is the *development of illness*, mental and/or physical. Earlier, I referred to major illness as a *cause* of distress in a family, but it is important to bear in mind that illness may also be the *result* of distress in a family. The increased incidence⁴ of illness, both physical and mental, in bereaved family members, especially spouses, as compared to a control population group, has been well documented. However, it is not only bereaved people who are at increased risk of becoming ill. There is also an increased incidence of illness at times of stress, eg the neo-natal period, and in families where there is a significant degree of marital discord. In the latter instance it is often one or more of the children who become ill, developing, eg severe chronic asthma or skin conditions such as eczema. These illnesses are not merely reactions to family stresses, they also serve the *purpose*⁵ of deflecting attention away from the more serious (from the child's viewpoint) problems in the family, such as the parents' marital discord. In one family in my practice one of the children seemed particularly accident-prone, having to be sutured or treated for injuries repeatedly over a short period of time. It later emerged that these "accidents" nearly always occurred when his parents were having a heated argument. The "accident" put an immediate end to the fight as all attention was now focussed on the child who had to be rushed off to the doctor! Similarly, an adult man

who does not wish to accept the responsibilities of being a father and husband may develop an ulcer, or become hypertensive, or diabetic. He is now regarded as "sick" and entitled to special dispensation with regard to family duties and tasks. This phenomenon has been described as the "illness solution".⁶ It is important for general practitioners to be aware of this and not to adopt a narrow, purely organic view of diagnoses and treatment. This is also true of less major illness events — examples from my recent experience include a child developing an ear infection a few days after his father was called away for military service, and a baby having recurrent episodes of infection soon after mother started a new job and had to leave baby in the care of his grandmother.

The question which now arises is "how should the general practitioner *manage* these situations?" To begin with, it is essential to recognise the distress signs, which, as discussed, can present in several different ways. The value of early recognition is that the problems can usually be worked with more effectively then. Crisis intervention⁷ therapists always try to see patients as early as possible after help is requested, as they maintain that this is the time when the patient(s) are most amenable to treatment, and also when they are most likely to be able to utilize their crisis to form new and more constructive ways of dealing with their lives as a whole. If too much time is allowed to elapse, the dysfunctional pattern of living which has arisen is inclined to become entrenched; the patient becomes increasingly resistant to change. This can result in much physical and mental pathology becoming chronic, or as Michael Balint³ put it, the illness becoming "organised".

Having recognised the distress signals, what does the general practitioner do next? It is of prime importance to attempt to establish *relationship* with the patient in which he/she feels free to express *any* feelings without fear of the doctor's disapproval or rejection. Moreover, the general practitioner needs to convey to the patient the value of being able to speak openly and not bottle all his emotions up. To return once again to the example of the neonatal period, the general practitioner can point out that *all* mothers have difficulty in caring for small babies, and that

In modern society spouses have extremely complex expectations of each other.

it might be helpful for her to talk about her problems as well. It can be of considerable help to mothers of small infants to be able to talk about negative feelings eg hostility, rejection towards their babies without feeling that they are being condemned as monsters. This is also an important time to see her husband as fathers are inclined to be forgotten figures at such times. The father can be helped to understand that his wife's irritability, short-temperedness etc is not to be interpreted as a personal rejection of him, even though he may be coming in for a good deal of criticism, but should rather be seen as reflecting her feelings of inadequacy as a mother etc. It can be pointed out that he has a valuable supportive rôle to play towards her at this time. These interventions can often serve to break the vicious cycle of attack and

counter-attack which often arises between spouses after the birth of a child. As the baby gets older and sleeps for longer periods etc and mother feels under less pressure and more confident, things can return to normal between her and her husband. However, in many cases, especially where there has been no therapeutic intervention, severe or irreparable damage may have been done to the relationship in the interim. With regard to the general practitioner's counselling rôle in this and other situations, I would like to caution strongly *against* the use of excessive re-assurance and the wholesale giving of advice. These expedients are not only usually useless, but are often harmful too. It is far more important for the general practitioner to *listen* and *observe* as closely as he can, and then try to help the patient to find his/her own solutions to their problems by helping them to understand their difficulties more clearly.

Spouses should realize that their different homes or origin may be the reason for feelings of anger towards, or unfulfilled expectations of, each other.

When consulting with *bereaved* family members, the general practitioner can play an important rôle by permitting and even encouraging the patient to express his/her feelings *eg* loss, anger, guilt etc verbally and non-verbally *ie*, by crying. I continue to be struck by the fact that some bereaved spouses are still suffering from the effects of prolonged, unresolved grief-reactions as long as 20 years after the death occurred! I recently saw a lonely, depressed, elderly woman, who at one stage during the consultation began to cry and said "my husband will have been dead 12 years on the 10th of this month". It is therefore important to realize that grief-work may need to be done with spouses or close relatives even when the bereavement is not a recent one.

With regard to illness as a manifestation of distress in a family, it is interesting to note that patients seem more able than their doctors to realize that certain stressful events may have "lowered their resistance" to certain illnesses, *eg* infections, or pre-disposed them to certain serious diseases

The GP must often ask himself whether children's complaints are due to some family distress.

such as ischaemic heart disease. By dealing with these stresses in the patient's family/work situation etc as part of his overall management, the general practitioner can avail himself of a valuable opportunity to improve his patient's overall well-being. In this way patients can be helped to gain a greater feeling of control over their own physical and mental health.

This paper has been concerned with distressed families, and to some extent I have drawn from the work and writings of family therapists in attempting to elucidate the ways in which the personalities and problems of individual family members affect and inter-act with all other family

Illness may be the result of distress in a family.

members. Family therapists work on the assumption that disturbance in one family member is virtually always an indication of disturbance of the family as a whole and they regard the entire family as the logical unit of treatment. Some family therapists refuse to treat patients unless the entire family is present. This approach has occasioned some of them to recommend to general practitioners that they always attempt to arrange family sessions whenever they are presented with disturbance in an individual family member. While recognising the applicability of several of the theoretical and therapeutic principles of family therapy to general practice, I would like to caution strongly against any attempt at a complete transplantation of the practice of a specialist discipline, such as family therapy, onto our discipline which is family medicine. Our terms of reference, while having similar aims, are in many ways different. To begin with, while we may regard ourselves as family doctors, we are committed to treating *individual* patients and establishing one-to-one relationships with them. Furthermore, it should be remembered that while most patients are members of families, each patient has his/her own *inner* world, which is at least to some extent un-related to their current family or

The GP should attempt a relationship in which the patient feels free to express any feelings without fear of the doctor's disapproval or rejection.

even their family of origin. The patient's inner world includes his fantasy life and his *irrational* attitudes, feelings, etc knowledge of which can be of considerable value to the general practitioner, but is unlikely to emerge in family- or even conjoint marital interviews. Besides this, there are often issues *eg* homo-sexual anxieties which a patient may be unwilling to discuss in the presence of his/her spouse.

In any case it is inadvisable for the general practitioner to rush into a combined marital or family interview until he has made some effort to discover what it is that is troubling the presenting patient.

This is not intended to discount the value of combined marital or family interviews in appropriate instances. Apart from being of definite therapeutic value in suitable cases,

they should also form a natural part of every general practitioner's daily work. By this I mean that general practitioners often have consultations where more than one family member is present, and on these occasions he (the gp) should make use of the opportunity to observe the interactions between family members, eg whether one spouse shows contempt for the other, or whether a mother answers questions which the general practitioner has addressed to a child. Also, when doing house-visits the general practitioner has a unique opportunity to gain a first-hand view of the family in their home. Moreover, even

Excessive re-assurance or wholesale giving of advice are often useless and even harmful.

when seeing individual patients alone, the general practitioner should be trying to build a mental picture of this patient's position in his/her family and the extent to which he (the gp) feels that the patient's view of his family and his position in it is a realistic one, for we are as much concerned with our patient's *perceptions* of reality as we are with reality itself.

It will be seen that our position is in fact much more complicated than that of the family therapist. While utilizing some of the concepts and techniques of family therapy, the general practitioner needs to modify and adapt them to his own situation, and also to bring to bear some of his own unique inputs to the problems which confront him. And indeed it is true that the general practitioner's contact with, and knowledge and experience of families exceeds that of any other health professional, including the family therapist. For is it not the general practitioner who is present at births and deaths, and deals with patients at the time of their marriages and sometimes

their divorces? Is it not the general practitioner who deals with patients in times of sickness and life-threatening disease? Is it not the general practitioner to whom patients confide their most secret fears, hopes and beliefs? Surely then it should also be from us that other disciplines should be trying to learn more about the nature of the family and its problems, rather than only us from them. Unfortunately most of our colleagues in the specialist disciplines do not see it that way and adopt a "teacher-pupil" attitude towards us. Even more unfortunate is that many, if not most, general practitioners, indoctrinated by their medical school training, seem to concur with this condescending or even downright contemptuous attitude towards our discipline. It is up to us to uphold the uniqueness and validity of our field of work. We have thousands of families in our practices who we can observe closely in health and illness as assiduously as any scientist working in a laboratory. We see distressed individuals and families presenting in numerous different ways, not least with physical illness. Who then are better placed than we to try to reach out to them in their suffering and to try to help them find ways, other than illness, to cope with the numerous problems which beset them?

BIBLIOGRAPHY

1. Segal H. Introduction to the work of Melanie Klein. New York: Basic Books, 1974.
2. Ackerman NN. The Psychodynamics of Family Life — diagnosis and treatment of family relationships. New York: Basic Books, 1980.
3. Balint M. The Doctor, His Patient and the Illness. 2nd ed. Old Woking, Surrey: Pitman Paperbacks, 1971.
4. Parkes CM. Bereavement: Studies of grief in adult life. London: Tavistock, 1972.
5. Minuchin S et al. Psychosomatic Families. Cambridge
5. Minuchin S et al. Psychosomatic Families. Cambridge: Harvard University Press, 1978.
6. Koos EL. Families in Trouble: New York: King's Crown Press, 1946.
7. Parad HJ ed. Crisis Intervention — Selected Readings. New York: Family Service Association of America, 1976.

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