Family therapy

by C Pretorius

Many disciplines have for long been involved in providing services directed towards the health and welfare of families (social workers, psychologists, sociologists, anthropologists, etc.).

In the historic sense, the focus of intervention has been upon the individual in the family, rather than the family as a whole, as a unit of treatment.

More recently, there has been a need for change from the individual to the whole family unit. In other words, there is a growing realisation that the individual family member cannot be considered as separate from the social context in which he lives.

David H Olson has this to say: "Although there was initially considerable resistance to the idea of clinically treating more than the 'identified patient', the pressure to conform to a one-to-one therapeutic model has progressively diminished in the last decade. This shift in treatment was a gradual move away from working with an individual to working with the total family unit."

Theoretical framework

Systems Theory

Talcot Parsons and Robert Merton conceived of the family as "the smallest social system within a complex web of social systems which define its environment." The internal family system is composed of individual members who define both the family as a whole, and the various subsystems within the whole — ie husband/wife, parent/child, child/child sub-systems.

Further, the family is a boundary-maintaining system which is relatively open to transactions with its environment. In other words, it permits certain things from inside out, and from outside in, while restricting the exchange of other things (permeability).

Thus, for example, a family may, in the context of our present economic and Western standards, have too many children, with father as the sole source of income, and as such do not have enough means of bringing up their children, whilst the wife is still child-bearing.

Despite all these, they may be strongly opposed to contraception — for promotive and preventative purpose.

Finally in the interchange between the family and the other social systems, which define its environment, individual family members are viewed fundamentally as reactors, rather than actors, who are subject to influences and impingements from the greater social system.

Thus, the family is placed in a position of having to adapt to changes or pressures from the environment in such a manner that it re-establishes its stability or equilibrium.

Equilibrium of the family

Equilibrium or homeostasis is the capacity to maintain effective functioning under constantly changing conditions. It does not mean to "stay the same", but is a dynamic process of continual adjustment to stimuli, involving the ability to adapt to new, often stressful events, and to be creative in identifying new solutions.

The family repeatedly modifies its activities to maintain a steady state, just as the body perspires to maintain a steady body temperature.

This stability of the family is necessary to fulfil one of its major tasks, namely, that of nurturing the growth of its individual members and ensuring their successful integration into the community.

The family stability can be disturbed by anything — like a teenage daughter

who becomes pregnant. The family may treat it as a crisis and respond by expelling the daughter in an attempt to maintain family stability.

A new family is then created with redefined expectations, lingering guilt feelings, and less stability than might have been gained by a more open-minded and conciliatory response to the situation.

Families that show stability and can withstand stress, exhibit inter alia:— **Love** — which provides an atmosphere of warmth, acceptance and support; **discipline** — which provides guidelines for acceptable activity as well as the stability to save and prepare for future needs; **tolerance** — which allows for individual freedom and development; **adaptability** — which makes it possible to adjust and respond to sudden or relatively unexpected changes; and **free communication** — which contributes to the consistency of honest and open relationships amongst members.

Family categories schema

This schema is used for the training of physicians in Family Medicine (McMaster program) and they focus on the following areas in family therapy:

(a) Problem-solving
Here one looks at the manner in which the family approaches solutions to its problems. Some approaches (which are often used by some families) are much more effective than others and families can be helped to develop patterns of solution appropriate to their family system.

(b) Affective expression and involvement
The manner in which the family system deals with the wide range of human feelings is of basic importance to its well-being. For example, some families have their emotions and internal conflict suppressed, whilst others exhibit their emotions overtly with arguments and demonstrations of affection.
The expression of emotions and involvement must be studied with the aim of developing appropriate methods that would facilitate optimal funtioning within the family systems.

(c) Communication
There is a dire need to understand communication — verbal and non-verbal between people. According to Virginia Satir, the word "communicate" is generally understood to refer to non-verbal as well as verbal behaviour within a social context. This "communication" can mean "interaction" or "transaction". "Communication" also includes all those symbols and clues used by persons in giving and receiving meaning.

People must communicate clearly if they are going to get the information which they need from others. Without communication we, as humans, would not be able to survive.

For example, if we look at simple verbal communications, they can create great difficulties. The same word can have different meanings, different denotations.

If a person is asked: "What class are you in?", it is not clear whether he is being asked what he is taking at school or what social standing he has. This elementary "meaning of words" aspect of communication is very important because people so often get into tangles with each other simply because A is using a word in one way, and B received the word as if it meant something entirely different. Communications such as "everybody is like that", are very unclear, and generalized, instead of saying something like "many people, at least the ones I have known, seem to be like that".

A person who communicates in a functional way can: firmly state his case; yet at the same time clarify and qualify what he says; as well as ask for feedback; and be receptive to feedback when he gets it.

Dysfunctional communicators also send incomplete messages and rely on the receiver to fill in: "He isn't very ..... you know"; "As you can see ..... well it's obvious."

A person simultaneously communicates by his gestures, facial expression, body posture and movement, tone of voice and even by the way he is dressed. All this communication occurs within a context. When does it take place? (does a child have a temper tantrum when he is refused something) Where? (in public) With whom? (when the mother is present and not when father is present) Under what circumstances? What is the contract between the persons carrying on the interchange?

All these dysfunctional media of communication are found within family relationships and can cause marital dysfunction.

Most families presenting with severe problems communicate in a masked and indirect fashion, in a hostile, destructive and undermining emotional environment. Skills of helping families in these areas are of inestimable value to the practising family physician.

Role behaviour:
Families differ as to how they share power authority, responsibility, accountability, etc. Although the father is traditionally the dominant individual, this authority may be in the hands of a hidden or more subtle member, eg a quiet wife who is the power behind the throne or a hyperactive child who manipulates the whole family. Scape-goating is another example where blame is assigned to one person in the family. This is also an area to be explored.

Autonomy:
Families differ in their capacity to grant autonomy to their members. This capacity seems to be related to the level of healthy functioning in a given family. This could be evident, for example, in a case where a child has a physical handicap and the mother becomes too protective and interferes with its autonomy or children who reach adolescence and parents do not accept their becoming adults and therefore the need for some autonomy.

Behavioural control
Family units demonstrate much variation controlling behaviours of their members. Some patterns seem more conducive to satisfactory functioning of the family system, and the individual members, than others.

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Family members should be aware of these relationships and should be helped to evaluate and, if necessary, change their patterns of behavioural control.

Treatment process

Family problems usually present indirectly. It is rare that a family member is "hurting" sufficiently on an emotional level to seek help openly as a result of what is happening at home. Instead a symptom is presented such as tiredness, headache or sadness, which has its origin in a disordered system — in this case the family. If the physician gives the patient an opportunity to express his feelings, the patient may often suspect the origin of the "pain".

In the handling of organic problems the physician's role is usually that of an authoritarian person spelling out the diagnosis and directing or carrying out the treatment. With family problems the role of the physician changes to that of assisting the family in labelling problems, agreeing upon reasonable goals, and then changing the necessary behaviour patterns.

The decision to involve the rest of the family in addition to the "identified patient" and then for the family to agree to the therapy sessions, depends upon the severity or degree of "hurt" of the current problems, the motivation of the family to reduce the discomfort, the rapport with the family physician and his comfort level and skill in therapeutic intervention.

Many therapists would like the children involved in the family therapy, but will determine as to whether it is necessary first, then ask the parents to tell the children they are joining them for therapy and maybe have them for two or more sessions and later continue with parents alone, child(ren) alone, or one parent and one child, etc., depending on the nature of the problem.

Often the initial suggestion of therapy is rejected either by the patient or his family, only to be accepted at a later date, because the "hurt" is greater or on-going. This is not different from the patient who rejects an operation, but after recurrent difficulty either suggests or agrees to surgical intervention.

If the family agrees to participate in therapy, then one of the tasks of the initial interview is clarification of the therapist's expectations of the family, and their's of him (contract).

During on-going sessions it is essential that goals and progress are regularly reviewed. Therapy is terminated when the family or the physician feels that sufficient change has occurred, or conversely, that the sessions are not productive. If the physician feels the problem is beyond his capacity, then he can refer it to a psychiatrist.

Summary

In summary we see the following special values of Joint Family Interviews. Research has been done in this area and Elizabeth H Couch gives the following results:

1 Increased speed and accuracy of diagnosis — joint and family interviews are of diagnostic usefulness and also have a tendency to accelerate diagnosis as compared with exploration through the use of individual interviews alone.

2 Improved understanding of family members and their interactions. This helps in evaluating the individuals within the family and their interactions, eg ways of relating, interacting and adapting — iow the therapist learns through these interviews about the verbal and non-verbal interaction, constructive and destructive patterns of behaviour and the marital or familial balance.

3 Attitudes towards the marital difficulty — this gave each partner the chance of stating his view of the problem in front of his partner and a better understanding of the problem by the therapist.

4 Patterns of leadership, control and role allocation — this will reveal such things as: the respective roles of various family members and role failures where they existed; who assumes the burden of responsibility within the interview situation or whether there is a mutual sharing or one of the partners prefers to remain relatively uninvolved. They also reveal the role each is fulfilling in marriage and whether this is a source of dissatisfaction to one or both. Further, one can also detect who shows leadership, who is the stronger of the two, who is dominant or controlling, who uses manipulation, who is passive, submissive or dependent.

5 Patterns of communication — in this way one can see whether each partner is free to present the situation as he sees it. Does the other partner really listen, or look out of the window in impatience? Do the complaints only come from one side? Is there uneasiness about being revealed in front of the other?, etc.

6 Extent and nature of conflict — the interviews reveal both overt and covert patterns of mutual hostility and destructiveness and for casting light on the actual areas of conflict. The extent and manner of the children's involvement in the marital conflict — like playing the one parent against the other.

7 Operation and effectiveness of mutual defenses — it gives one a chance to observe the types of defenses or method of coping with anxiety, their appropriateness and their degree (e.g. projection denial, etc.).

8 Socio-cultrual patterns and values — not only is an understanding of the couple's and family's cultural patterns and values important, but also that the therapist understands clearly whether and in what ways their culture (ie the family) and value system differ from his own — which will promote a better understanding and acceptance on the part of the therapist.

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Curriculum vitae

Connie Pretorius

Connie Pretorius completed her BA (Social Sciences) in 1968 at the University of the North. She went on to do her BA Hons (Psychology) in 1974 at the University of Zululand and her MA Clinical Psychology at Unisa (1977).

Connie started work at Groothoek Hospital as an intern clinical Psychologist in January 1977 and left in December of that year to join Weskoppies Hospital in the same capacity. On 1 August 1979 she joined the Department of Family Medicine at Medunsa as a lecturer in Social Work.

Study of the pharmacokinetics of gold

A pharmacokinetic study has shown that levels of intracellular gold accumulation are lower in orally administered auranofin (triethylphosphine gold) than in injectable gold compounds. For this reason the risk of toxicity in auranofin is reduced.

RW Mason et al Toxicology Research Unit (Medical Research Council of New Zealand), University of Otago Medical School, Dunedin, New Zealand, reported on the results of their pharmacokinetic studies with gold sodium thiomalage (sodium aurothiomalate) in rats and monkeys, and compared some of their findings with pharmacokinetic data reported for auranofin.

They noted that high tissue gold concentrations were observed in the kidneys, liver, and spleen of monkeys given intramuscular injections of aurothiomalate. In contrast, oral administration of auranofin resulted in relatively lower tissue gold levels.

In the case of these orally administered gold compounds it has been suggested that the concentration of gold in the tissues may be controlled by the rate of gastrointestinal absorption rather than by renal elimination as in the case of the injected soluble gold complexes such as sodium aurothiomalate and aurothioglucose. The extent of intracellular accumulation and possibly the risk of toxicity may thus be reduced."

Mason et al, concluded that studies on the binding of gold to cytosolic proteins showed a significant incorporation of gold into renal metallothionein which might play an important role in the sequestration and localisation of gold.

Protection against chronic gold toxicity might be conferred by pretreatment with low doses of gold and/or other metals eg Zn^{2+} which stimulate metallothionein synthesis. The interactions of gold with intracellular protein alter the cytosolic binding of Cu and Zn which provide support for the suggestion that the therapeutic action of gold complexes might be mediated to some extent by its effects on the metabolism of these essential metals.

Confusion over insulin prescription cleared up

The suppliers of Lentard (Proinsulin Freed) Insulin have notified doctors throughout South Africa that the product has been withdrawn to eliminate prescription confusion.

In a statement issued by Novo Industries it was noted that a recent survey had confirmed that many doctors who prescribed "Lentard" intended their patients to receive Lentard MC (Monocomponent), but owing to the omission of "MC" on the prescription, the patients had been receiving the less pure product.

The statement added: "We realise that we have been partly responsible for the confusion and therefore intend to correct the matter as soon as possible.

"Furthermore, in keeping with Novo's policy of providing only the purest insulins for diabetic patients, we cannot justify continuing to market a product which does not meet the monocomponent specification.

"To ensure that patients receive the purest available insulins, we are therefore withdrawing Lentard P I F from the market with immediate effect.

"Lentard MC has the same duration of action as Lentard P I F, which means that most patients should not require dosage adjustments. In rare cases where patients are on high doses of insulin, a decrease in the daily requirement might be experienced.

"When prescribing Lentard MC to a patient previously on Lentard P I F, the patient will receive a different colour pack from the chemist. We would ask you to reassure the patient on this aspect and to explain that the purer insulin could only be of benefit in the long term."

For further information contact Novo Industries, (011) 783-7275.