Family Process And Family Practice

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This paper describes the importance of family process concepts, and proposes some ways in which the family physician can enhance the effectiveness of health-care delivery and allow him or her to serve as a physician for the entire family. The essential change which is proposed is one of conceptual approach, whereby symptomatic patients are viewed in relation to their home environment and the group of intimates with whom they share their life – their family. Concepts are illustrated by both personal and research insights.

There has been a movement in the medical field away from the term "General Practice" and toward the term "Family Practice," which is a reflection of more than simply a change in name. Significantly, it means that the physician can focus on the *family* as a unit of treatment, as opposed to the individual. From the practical standpoint this means that the physician, who is on the front lines of continuous medical care of people in the community, can redefine the problems he or she sees in an individual as being manifestations of a disturbance in the patient's family unit. The basis for this concept is that the person who is ill is often the symptom-carrier for the whole family, and thus acts as a signal that the entire family relationship is in distress.[1,2]

For the past 20 years there has been a movement in the behavioral sciences to investigate the interpersonal worlds in which the patient lives. This has led to the development of Family Therapy, which takes into account the patient *and* the significant others with whom he/she is concerned.[3] The meaning of this has been quite significant inasmuch as the focus on the symptom-carrying patient has been reduced, and now involves the entire family. This allows for inclusion of both the effect of the patient on the family and of the family on the patient. The purpose of this paper is to examine aspects of family practice to see how some of the insights of family therapy can be advantageously applied (by the physician treating the illness) in the context of the family.

Unique Role of the Family Physician

The family physician can investigate the processes within the family structure and the way in which each person's behavior affects the others. The family physician is in a unique position to observe the life process of an entire family unit – from the birth of the family (at the time of marriage), through the introduction of children, during the growing-up process and, eventually, the leaving of home to establish a new cycle in perpetuating that family history.

Because of his/her long-term relationship with the family unit, the family physician is in a position to observe the effects of the family's function, in a longitudinal way, for many years. This is a particular advantage not shared by most other clinical specialists, since they usually have contact with the family in an episodic manner and for only a limited period of time. They are unable, therefore, to see directly the development of problems and processes that affect the family relationships. The family physician, however, is in an advantageous position to intervene at an early stage in the development of pathological family processes, thus frequently preventing long-term psychiatric therapy and/or psychosomatic concomitants.

Some Basic Concepts

We are discussing a change in the family physician's conceptual framework by which he/she views the person identified as the patient. In traditional medical terminology, we have been instructed since medical school days to treat the "whole patient." The general practitioner of the past has modified and enlarged this concept to include the individual's family as the background which, somehow, has a relationship to him/her and his/her illness. The new concept which we propose as being an integral one for the practicing family physician is that of viewing the entire family as "the patient," and the individual as merely a symptom-carrier whose behavior, thoughts, physical state, and response to illness are influenced as much by the family with whom he/she lives as the disease process with which he/she is burdened.[4]

All families exist in a homeostatic balance in which the behavior of each member is integrally involved with the others.[5] This means that a physically ill member can upset that homeostatic balance and affect the other family members, or, conversely, that disturbed family relationships can result in illness in an individual family member.

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Illness has a major effect on the symptom-carrier's life, but in a larger way it affects the functioning of a spouse and/or children. A previously well-functioning family unit may have to realign relationships, abruptly change role expectations, financial aspects, and total activities of all family members. This has the effect of producing major stress due to the rather immediate and long-range changes that all family members must make.[6]

Paradoxically, the onset of illness may often serve to stabilize a disrupted and strife-torn family situation. This "beneficial" effect of an illness can be exemplified by a low back injury which not only unites a family emotionally (by supporting or protecting the injured party), but may also serve to "justify" a disturbed sexual relationship between the spouses. In addition, individuals who have a long history of relating to one another as a unit are sensitive to the subtle needs and changes of the other members. Because of this, physical illness may often be an indication that one member of the family – being sensitive to the needs of another – reacts by developing symptomatic behavior to evoke change in or to control other members of the family.

It has been observed that children develop temper tantrums in an attempt to distract the parents away from a heated argument. Often, so-called "accidental" poisonings of children who see the disruptive behavior of parents may be an attempt by the child to affect the parents' behavior. This may be an unconscious act or may be deliberate.

Attempts have been made in recent years toward assisting the non-symptomatic family member(s) in such conditions as depression, alcoholism, schizophrenic behavior, and other psychosomatic illnesses. The effect of these investigations has been to point to the significant role of the "well" members of the family: they may sustain, or precipitate, the problem in the symptomatic member. Indeed, there is a rich and varying field waiting to be explored by the curious and dedicated family physician. Discoveries and increased knowledge of the ramifications of the illness on other family members may provide more adequate care for the entire family, while considering the needs of each individual member.

Application of Family Process Concepts in Family Practice

By "family process" we mean an understanding both of interrelationships among family members and of the way individual behavior affects the other members of the family unit (even though it may be beyond the awareness of the individual member). This includes the understanding of verbal and nonverbal communication, of reciprocal feelings of need, and of family dynamics.

More effective care can be given by evaluating the effects of physical illness on the needs of each family member. The onset of physical illness often marks a major crisis in the functioning of the family. In addition to financial stress, a change occurs in the behavior of all family members because of the change in family homeostasis. When a mother or father is hospitalized, other members of the family may have to forego some activities and take on the duties of the absent member. Children are affected by the separation and are often in the difficult position of being unable, or finding it difficult, to express frustration or anger related to these changes. A family member may often resent the added burdens assumed, yet find it difficult to express, socially, feelings regarding his/her position. The role changes evoked by the illness may have varied effects on the prognosis of the symptomatic individual. These feelings may cause an eruption of symptomatic behavior – both physical and emotional – in other family members. By talking periodically with the family and helping them to express feelings, the physician may prevent destructive actions and feelings, and prevent morbidity in the entire family.

The physical illness of one member of a family is often complemented by an emotional component of major proportions in another member. This may go undetected because the physical symptomatology often predominates, directing attention away from the (sometimes) more *debilitated* member or member whose problems are less obvious. These other family members often feel reluctant to express their feelings because they feel that the physically symptomatic member is in more significant distress, and because they have not been given permission to move into the sick role.

Major disorders of a physical or emotional content may go undetected until a rather abrupt crisis, or eruption of symptoms, draws attention away from the "ill" member of the family. The family physician who is aware of the concepts of family dynamics can open areas for more productive ventilation of feelings by simply commenting on the probable existence of such feelings as frustration or anger.

There are many advantages which can be realized when the family physician develops an increased awareness of family dynamics and cares for the family as a unit. Several of the more important advantages can be outlined here.

More Effective Therapeutic Intervention

The alert and sensitive family physician may well be able to intervene in areas of the patient's life which have not been previously amenable to physician intervention. He/she may at the same time gain a greater understanding of previous treatment failures. Specifically, in times of crisis, the attuned family physician can intervene in ways which will direct the family toward more positive resolution of problems and more productive functioning. From a practical standpoint, this may mean seeing "unaffected" family members on occasion to gain insight into their responses and feelings about the "sick" member. At other times, the entire family may be present for short interviews; parents or children may be seen separately, and together as a unit.[7]

Other advantages of working with the entire family as the treatment unit include added insight into the etiology of the illness, determination of family strengths regarding prognosis and chronicity of illness, and support for the total family while enlisting their aid in carrying out a successful treatment plan.

Clarification of Communication and Instructions

A visit to a physician is often fraught with anxiety and tension. Even when the physician gives clear and concise instructions, the patient may not adequately perceive or remember what he/she was told because of needs

or anxieties. This can lead to the improper carrying out of instructions or treatment at home. When the spouse asks, "What did the doctor say, dear?" the response of the identified patient may be colored by his/her emotional needs and by the response he/she wishes to elicit from the family. This may lead to a minimization or accentuation of the nature of the illness, leaving the family without adequate perception of the degree of seriousness of the problem. This points to the advantage of involving the family after the examination, instead of leaving them in the waiting room. Thus a closer approximation of reality may attend the instructions and treatment the patient receives at home. It also avoids any manipulation or distortion of the instructions to favor the individual at the expense of the family.

An individual who has difficulty in changing the direction of role-relationship may use a situation involving illness as a fulcrum or wedge to change the direction of the family. For example, the diagnosis of allergy may be used as an excuse to plan a long-opposed move to another location, or the diagnosis of mild or moderate angina pectoris may be used by a dependent individual to manipulate or control functions of the family, levels of aggression, or sexual relationship.

In illnesses of the gynecological or urogenital systems, it is frequently important to have both members present. Among other reasons, minor problems may be used by one or the other to "solve" a long-standing or difficult sexual relationship. For example, a woman who has a problem with sexual dysfunction or inhibition of sexual response may use a diagnosis of mild vaginitis to prolong her lack of sexual involvement with her husband, and continue to ignore the fact of an emotional problem. A joint interview in this situation may prompt the husband to ask questions or offer information that could clarify or illuminate the immediate situation. The presence of both persons also obviates possible seductive behavior on the part of the patient.

Avoiding Entangling Alliances

Another advantage to involving the family by dealing with single illness as a *family* problem may be the avoidance of collusion and hidden alliances between the physician and one family member. By seeing a single patient, the physician may inadvertently upset the homeostatic balance of the family and precipitate adverse consequences which are not in the family's best interests. Such an inadvertent pitfall is one in which the physician becomes involved with the "ill" member of the family in a supportive and therapeutic manner, because he/she sees only that person's side of the problem. By seeing other members of the family, the physician may have a better grasp of the realities, and may become a sounding board or ventilation place, thereby receiving an entirely different perspective.

Parents may use their private interview, after their child has been seen, as a means to punish or control their offspring's behavior. What "the doctor said you should . . ." may never have taken place; because it was a private interview, the youngster is not in a position to refute the parents' position or direction. The physician may initially gain insight into this process by questioning the children regarding what they have been told about the ill member of the family.

Facilitation of Expression of Feelings

A family physician who is concerned about the nonverbal, indirect, and process-elements of family life may develop an uncanny ability to sense the feelings which patients are experiencing but not expressing. The progenitors of psychosomatic illness may often be noted by the attuned physician long before the ulcer or other physical concomitant surfaces. A subtle intervention – in allowing patients to ventilate feelings or work through their hostility before the problem is converted into a physical symptom – may prevent the onset of more severe physical illness. This is the essence of preventive medicine in the broadest sense. The family physician is in a position to follow the life history of the family unit, to become aware early of the tensions developing in potential illness, and to take remedial or preventive action.

Discussion

The implementation of these concepts does not necessarily mean that the entire family is seen by the physician on each visit, although it is often found essential to see the family as a unit on at least one occasion. Subsequent visits may include individuals, pairs, or even extended-family members (such as grandparents), or other significant persons in the family. The essential feature is that the clinician see the individual embedded in the matrix of his/her family, while at the same time, encouraging the differentiation of individual family members from this matrix and allowing this to occur with a minimum disruptive effect on other family members.

In order to facilitate the introduction of the family physician to an understanding of family process and dynamics, it is imperative that current teaching programs develop effective ways of teaching young physicians the basic concepts of family therapy. The programs would not be designed to teach the physician to treat emotional illness, but rather to understand the family dynamics that are operational in all patients. It is important to start such training early, not only in a residency training program, but in the undergraduate curriculum of family practice. A major problem today in implementation is the insufficient teaching force of family physicians who are conceptually oriented in family dynamics such that they can impart this knowledge to future family physicians.

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