

PSYCHOSOCIAL INFLUENCES AND ADJUSTMENT : FAMILY AND HEALTH CARE SYSTEMS

CLARE BRADLEY

Department of Psychology, University of Sheffield, Sheffield (UK)

Over the past few years I have become increasingly aware of physicians talking of the need for family therapy for families of young patients who have problems with diabetes management and of comments in the literature suggesting that families are frequently the cause of problems in managing diabetes which family therapy may solve. Researching the literature on families in preparation for my IDF talk I came across an interesting paper by Coyne and Anderson (1988)¹ which put forward a good case that the much cited systems model explored by Minuchin Rosman and Baker in their famous book *Psychosomatic Families*² has been given more credence than the experimental evidence warrants. Minuchin and colleagues' pioneering work with families led them to propose that 3 factors are necessary for the development and maintenance of what they termed "severe psychosomatic illness" in children.

1. The child is physiologically vulnerable eg the child has diabetes.
2. The child's family has the following 4 transactional characteristics:-
 - i) enmeshment; ii) overprotectiveness; iii) rigidity; iv) lack of conflict resolution
3. The child plays an important role in the family's patterns of conflict avoidance and this role reinforces the child's symptoms.

Preliminary physiological data were provided in support of the observations described in (3) above. Free fatty acid (FFA) levels were reported to rise in the "psychosomatic diabetic children" during discussion of family conflicts while parents' elevated FFA levels were reduced when the child entered into the discussion. Minuchin et al put great emphasis on the importance of these FFA data in supporting their model of the family's role in developing and maintaining "severe psychosomatic illness" and the data and the model have been extensively cited.

Psychosomatic Families is a brilliantly written book which inspires confidence in the ideas presented and the transcripts of therapy with anorexic children and their families make gripping reading. But no evidence was provided to support the view that enmeshment, overprotectiveness, rigidity and lack of conflict resolution were features of the families with "psychosomatic diabetic children". The FFA findings were, as Coyne and Anderson pointed out, presented in a misleading manner and have nowhere been reported in full. If the readership had not been so eager to accept the ideas, a good deal more convincing evidence and systematic description of methodology would have been demanded. Happily Coyne and Anderson's critique stimulated two of the authors of the original book, Rosman and Baker, to analyse their data statistically and provide some more appropriate supportive evidence for their ideas³.

Coyne and Anderson in their critique also expressed concern about the way Minuchin, Rosman and Baker's² ideas have been used by others. "Phenomena that are more appropriately seen in terms of difficulties in interactions between families and health care systems are misconstrued as structural defects of families"¹. I would add that some researchers have been

too ready to label families as enmeshed, rigid and overprotective when they might more reasonably be seen as involved, organised and concerned, e.g.⁴. In those cases where families do get into terrible difficulties with managing diabetes for whom family therapy may be extremely valuable, the family may not have caused the problems in the first place. Interestingly Minuchin et al² did not claim that the family was the original source of the child's problems but that the family interaction served to *develop and maintain* the "psychosomatic syndromes". Indeed the influence of extrafamilial stresses was given explicit mention in the model though what these might be and how they might operate was, understandably, not a focus of a book concerned with family systems and family therapy. The problem is not that *Minuchin et al* focused on the family in their particular work but that other health professionals have done so in a manner that is neither appropriate nor constructive and have cited Minuchin et al to justify their actions.

An explanation in terms of family pathology has far more immediate appeal than an explanation in terms of deficiencies in the health care system to overworked diabetologists dealing with a continual stream of time-consuming, frustrating and disturbing clinical problems. Attribution to family pathology may serve to protect the doctor from feelings of self blame and depression but such an attribution is, in practice, unlikely to be constructive and may be damaging to all concerned. Figure 1 offers a model which recognises the importance of family influences on adjustment to diabetes. It also recognises that attribution of problems to family pathology may in itself be the cause of family conflict. Poor adjustment to diabetes and poor glycaemic control may more constructively be attributed to problems with the health care system including inadequacies in the education and training of patients and their families. Intervention at this point could serve to *prevent* problems with diabetes *before* disastrous family conflicts develop needing family therapy. Attribution of adjustment and control problems to family pathology focuses attention on things that few physicians or nurses can do anything about. Few diabetologists have access to family therapists to whom they might refer difficulties. Even more importantly perhaps, attribution to family pathology deflects them from a more constructive course. By criticising the family, health professionals may reduce their own disturbing feelings of personal responsibility for patients' control and adjustment problems and a dead end is reached. The brick wall is included in the figure to represent both the dead end and the defence against burgeoning problems with the organisation and functioning of the health care system. When we look at the kind of psychological research that doctors want to do and are prepared to fund and publish, it tends to focus on what it is about the patients and their families that causes problems with diabetes control and adjustment and is rarely concerned with the personality, beliefs and behaviour of the doctor and the influence of these doctor variables on the patient. What little research has been done is illuminating and thought provoking and has practical implications for constructive intervention. Two examples of such research are given below.

Heszen-Klemens⁵ examined doctors' behaviour when faced with patients' non-compliance with treatment. The doctors studied had various specialist qualifications but all dealt with patients who had chronic illnesses. Analysis of tape recordings of 30 physicians dealing with obvious examples of non-compliance and interviews to elicit reported attitudes and behaviour of a second

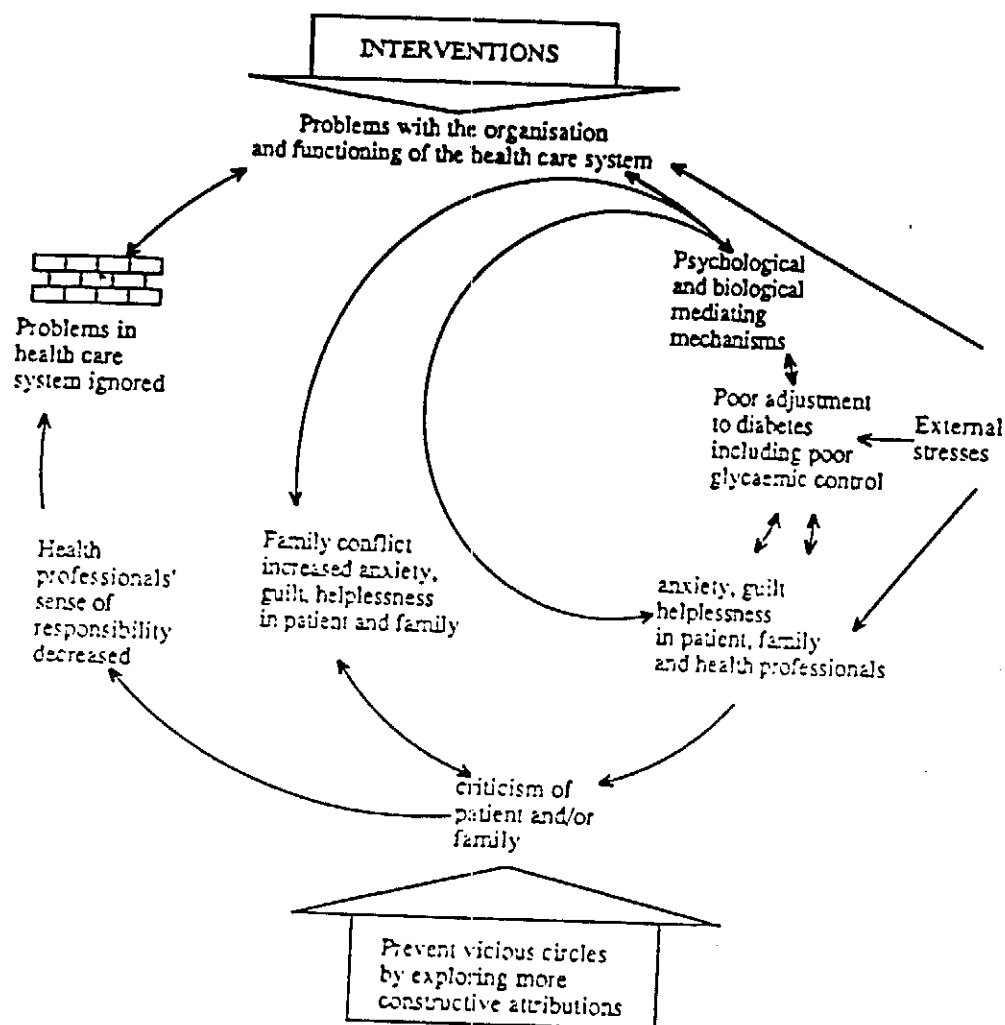


Figure 1. Model of poor adjustment to diabetes illuminating opportunities for constructive interventions by the health care team

group of 63 physicians resulted in the identification of 11 different tactics used in dealing with non-compliance. The most frequently used by both groups was medical threat. Other tactics commonly used were; carrying their point in an indulgent atmosphere, authoritarian tactics, providing medical information, and withdrawal. Interestingly, none of the doctors in the first study attempted to enlist family support and only 2 in the second study reported use of this tactic. Only 2 doctors in each study tried or reported trying to determine the causes of non-compliance. Heszen-Klemens considered the findings in the framework of frustration theory and categorised the tactics used as either task-oriented (aimed to help solve the non-compliance eg trying to determine the causes of non-compliance, giving the patient information) or ego-defensive (aimed to reduce the tension caused by frustrating events eg authoritarian tactics, medical threat). In both groups of doctors studied, 38% of doctors applied task-oriented tactics and 62% applied ego-defensive tactics. Thus doctors' actions were more often aimed at defending professional self esteem and reducing emotional tension than at finding solutions for non-compliance.

In several studies conducted by my own research group we have focused on the attributions people make when accounting for things going well with a person's diabetes management and

when accounting for diabetes-related problems. In two studies we have compared attributions made by clinical staff and patients^{6,7}. We have found that clinical staff vary considerably in the kind of attributions they make. Some make constructive, encouraging attributions seeing positive outcomes as attributable to the good judgement and efforts of the patient and staff and negative outcomes as due to temporary or surmountable difficulties or bad luck. Others make discouraging attributions which deny the patient any credit for positive outcomes and see the patient as responsible for negative outcomes. A number of significant differences were apparent when the ratings of clinical staff were compared with those of a comparison group of patients. Of particular interest in the present context was the finding that staff rated chance factors as more important in explaining positive outcomes than did patients, and staff rated patients as having less personal control over positive outcomes than the patients rated themselves. Such patterns of attributions from the staff are likely to undermine patients' feelings of personal control or self efficacy yet a sense of self efficacy is vital to the successful management of diabetes. Credit should be given where it is due when patients manage to control their diabetes well.

In a study of real life consultations⁷, the doctor rated medical factors as more important in causing positive outcomes than in causing negative outcomes. However when the consultations were structured to help doctor and patients to make their attributions explicit, this self serving bias was erased. The doctor changed her attributions for the problems being discussed to match more closely the attributions suggested by the patient. It would be expected that as the doctor takes account of the patient's view of the causes of the problem under discussion then any treatment recommendations the doctor makes are likely to be more appropriate and make more sense to the patient who will consequently be more likely to follow them.

The above studies^{5,6,7} demonstrate how doctors' needs to defend their own self esteem may lead them to deal with patients in a non-constructive way. The model outlined in Fig.1 shows how an ego-defensive, critical stance towards patients and their families not only exacerbates the problems the patients and their families face but also serves to reduce the perceived need for interventions to improve the organisation and functioning of the health care system. There is no shortage of possibilities for constructive interventions which have been described in detail elsewhere^{5,6,7,8}. An essential first step is to recognise the dangers of adopting ego-defensive strategies and recognise the need for positive collaboration with patients and their families to deal with the task of managing diabetes.

REFERENCES

- 1 Coyne JC and Anderson BJ (1988) *J Marital Family Ther* 14 No 2: 113-123
- 2 Minuchin S, Rosman BL and Baker L (1978) *Psychosomatic families. Anorexia in context*. Harvard University Press, Cambridge, Massachusetts.
- 3 Rosman BL and Baker L (1988) *J Marital Family Ther* 14 2 : 125-132.
- 4 Hauser S T, Jacobson A M, Wertlieb D et al (1986) *Health Psychol*, 5, 273-296.
- 5 Heszen-Klemens I (1987) *Soc Sci Med* 24 No 5 : 409-416.
- 6 Gamsu DS and Bradley C (1987) *Curr Psychol Res Rev* 6 No 1 : 69-78
- 7 Gillespie CR and Bradley C (1988) *Brit J Clin Psychol* 27 : 67-76
- 8 Shillitoe R W (1988) *Psychology and Diabetes*, Chapman and Hall, London.