CHAPTER 3

Family Systems Theory In Medical Practice

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In medical practice some patient presentations are not adequately explained by the usual textbook descriptions of pathophysiology. Understanding the interactions in the patient’s family, for example, is essential for evaluating and managing the presenting problem in a family where a 10-year-old with asthma seems to be the focus of a power struggle between parents; or when the parents in a reconstituted (step) family appear overly involved with an 11-year-old with headaches; or when a 30-year-old woman with increasingly frequent headaches feels isolated from her working husband, overwhelmed by the demands of caring for three small children, and fails to recognize the impact of her mother’s death upon her life.

Problems such as parent–child conflicts, alcohol abuse, sexual dysfunction, and psychosomatic illness often present with one family member as the identified patient, but the whole family is involved in the illness (1–4). Exactly how the family is involved and what constitutes proper management may not be clear. It is helpful (as explained later) for the clinician to formulate a diagnosis that locates the problem in the context of the family and the circumstances under which the symptoms occur.

The relationships between family dynamics and the health and illness of family members are studied in the disciplines of sociology, medicine, family therapy, social work, psychology, and anthropology. Family therapists and other systems-oriented clinicians have written a great deal about the family and illness (5–13). How the principles of family systems theories can best be applied in medical practice is the subject of this chapter (4, 14–20). The first example emphasizes the added dimension of understanding that such an approach affords the physician.

Clinical Example #1

Mrs. Jones, presented Nicholas, her 11-year-old son, for a checkup. Mrs. Jones told the physician that Nick had severe asthma, which required numerous emergency room visits and changes in medications. They have changed doctors several times because of his “delicate condition,” according to Mrs. Jones. She requested that Nick be placed on “steroids” immediately. She stated that he has always been her
“sick child” and that the three older boys were never this much of a problem. While Mrs. Jones described Nick as a sick patient, he smiled and bowed his head.

After Mrs. Jones left the room, the clinician talked with Nick and discovered a pattern of symptoms. Nick noted that his worst symptoms often occurred when his father was angry and/or vocally critical of him. He also thought his asthma worsened when his father and mother began to argue. While discussing these issues with the clinician, Nick appeared somewhat sad and afraid, and his breathing was more rapid and shallow.

Later that day, the clinician received a telephone call from Mr. Jones, who said he just learned of the office visit by Mrs. Jones and Nick and wanted to set the record straight. He stated that there was nothing seriously wrong with Nick, except for laziness, and that his mother was overprotective. He said that he has told Nicholas over and over to just calm down. Mr. Jones also described Nicholas as bullheaded and uncooperative.

Later in the day, a second telephone call came from a friend of the Jones family who expressed concern about Mr. Jones’ drinking pattern. The family friend said Mr. Jones denied being an alcoholic, but that during the past two years he had become quite verbally abusive at home during frequent drinking binges. The friend was concerned that Mr. and Mrs. Jones were discussing sending Nick to military school so that he could learn better self-discipline.

The Jones family example challenges the description of Nick as the only patient and asthma as the only problem. What diagnoses encompass the medical problem and its context? Is it accurate to describe Nick’s problem as just asthma, and does such a diagnosis acknowledge the situation surrounding his symptoms? What will it take for Nick’s asthma symptoms to improve? Should a plan of management include not only an optimal regimen of medications, but also attention to the family interaction pattern, which seems to influence the symptoms? If Nick felt less anxiety and were not caught in the middle of a parental struggle, would his symptoms improve and the need for medications decrease? How is Mr. Jones’ drinking behavior related to the whole issue and how can it be addressed effectively? How is Mrs. Jones maintaining the cycle of symptoms and office visits? There are many reasons why family systems theories should be of interest to physicians. The above example touched on a few of these; other reasons are explained below.

Rationale for Learning How to Work with Families

Families Are the Settings in Which Most Patients Live

Most individuals are products of family interactions—genetic and social. Families are complex organizations with observable behavior patterns and structure (such as when and how to eat, sleep, play, work, express emotion, etc.). Most patients are active members of family systems, with ongoing interactions with other members of their nuclear and/or extended families. In caring for patients, most physicians must deal with the family to some extent. To effectively relate to and work with other family mem-