

Using Triangulation Concepts to Understand the Doctor-Patient-Family Relationship

JOHANNA SHAPIRO, Ph.D.

Practical teaching about families remains an elusive and challenging educational goal. This article provides a brief overview of the concept of triangulation and shows how it can be easily applied to the doctor-patient-family relationship. Examples of both negative and positive triangulation are presented. Learning to recognize and work with triangles in the clinical encounter can lead to a more family-oriented approach in residencies, particularly for those lacking formal family intervention programs.

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Teaching about the complex interactions of family physician, patient, and family members to over-worked, stressed, and impatient residents can sometimes seem a daunting task. This is especially true for residents who train in a program like ours that has little systematic exposure to family units. It may be hard to understand the relevance of learning about the intricate dynamics activated in physician-patient-family encounters. In our residency

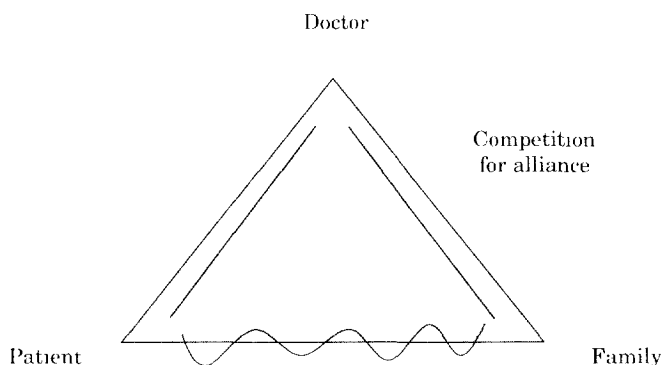
program, we have found that the concept of triangulation is a useful, easily graspable way of introducing ideas about such multifaceted relationships, and of illustrating certain classic dysfunctional patterns that may arise within interactions. This paper describes a conceptual model of triangles in primary care and a curriculum suggestion for small group conference formats.

BACKGROUND

In a relational triangle, "each of two opposing parties seeks to join with the same person against the other, with the third party finding it necessary to cooperate now with one and now with another of these opposing parties" (Aponte & VanDeusen, 1981). For example, a child and father in chronic conflict might both persistently compete for the support of the mother, who in turn tries to balance her favor between them. Murray Bowen, one of the founders of family systems theory, regarded the three-person configuration as the basic building block of any emotional system (Bowen, 1976). Jay Haley, another early family therapist, frequently referred to "the perverse triangle" (Haley, 1967) that can occur cross-generationally when two people in a family join together against, or to exclude, the third. Salvador Minuchin, a pioneer of structural family therapy, talked of the "rigid triads" formed when parents'

Johanna Shapiro, Ph.D., Department of Family Medicine, Rte 81, Bldg. 200, 101 City Drive South, Orange, CA 92668 (949) 824-3748; jshapiro@uci.edu.

FIGURE 1

Permanent Perfect Parent (Physician)

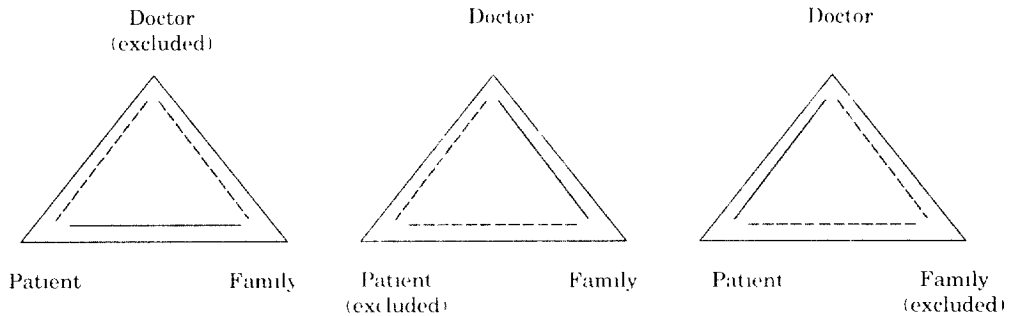
overt or implicit conflicts require their child to “choose sides” (Minuchin, 1974). The emotional intensity of such coalitions often contributes to physical and emotional symptomatology in the child.

Originally, the concept of triangulation referred to repetitious, and usually dysfunctional, patterns within families, but the term is also applicable to therapeutic relationships as well. William Doherty and Macaran Baird in their classic book *Family Therapy and Family Medicine* pointed out “the illusion of the dyad” in the encounter between the physician and an apparently singular individual, and famously referred to the family as “the ghost in the room” (Doherty & Baird, 1983). The revelation that the practice of medicine, seemingly rooted in the bedrock of the doctor-patient relationship, actually involved the (often implicit) operation of triangular relationships had a profound effect on the understanding of the medical encounter. Nevertheless, busy teachers of family medicine still struggle with how to distill practical applications from such theoretical insights and successfully convey them to even busier residents.

RATIONALE

We introduce our teaching about doctors, patients, and families with reference to triangles for the following reasons. First, triangles provide an excellent entry point for understanding families. Triangulation is a readily understood phenomenon, mastery of which often leads to curiosity about other aspects of family structure and dynamics. Secondly, once identified, triangles are a frequently encountered occurrence in family medicine. It is easy for residents to generate many examples of triangulation based on their own practices once they assimilate the basic concept. For example, in an introductory session on triangulation, one resident mentioned discovering late in a child’s treatment for recurrent otitis media the existence of a grandmother who was skeptical about the prescribed medical care. Another resident noted that her over-reliance on an adult daughter’s opinions might have contributed to the withdrawal and passivity of her 87 year-old patient. Finally, because triangles necessarily include the vantage point of the doctor, they

FIGURE 2

Dyadic Enmeshment

appear more relevant and applicable to residents' daily experience than abstract, theoretical discussions about families in general.

NEGATIVE TRIANGLES

Early family therapists suggested that triangles generally reflect or produce dysfunctional occurrences in the family (Bowen, 1976; Haley, 1967; Minuchin, 1974). One property of such negative triangles is that they lack flexibility and assume rigid configurations insensitive to altered circumstances or new developments among family members. Negative triangles also promote win-lose models among the various participants, usually in the sense of a coalition of two members oppressing the third, although occasionally one participant dominates the two. The most common consequence of a negative triangle is the withdrawal of one or more members from the relational context. To help make this concept more concrete, our teaching addresses three basic dysfunctional patterns of triangulation (Hoffman, 1981) that can commonly occur among doctors, patients, and family members.

Permanent Perfect Parent (PPP) (Figure 1). In this configuration, patient, family (and physician!) install the physician as the PPP, a permanently wise, all-knowing authority figure, a kind of throwback to *Father Knows Best*. In this role, the omnipotent physician is held responsible for the success or failure of all subsequent events concerning the patient. Occasionally, residents have trouble grasping why the PPP is a negative triangle. In this era of patient advocacy and virtually unlimited internet access to previously privileged medical information, residents may like the idea of patients who accede to their authority and expertise and who are obedient and compliant. However, residents quickly see that in such a triangle, it is easy for the other members to engage in competitive struggles, somewhat akin to sibling rivalry, for the attention, loyalty, and allegiance of the authority figure. Patient and family members compete to please the physician and to win his or her approval. Such glorification of the physician inappropriately weakens ties between patient and family, ignores internal family resources in deference to the supposedly unlimited powers of the physician, and

increases patient and family dependence on the physician. Further, while the elevated status can be flattering to the resident, it is highly uncomfortable to be unilaterally blamed when things go wrong in the care of the patient. In this triangle, the physician has too much power, the patient and family much too little.

Dyadic Enmeshment (Figure 2): In this situation, two members of the triangle become overly involved and protective of each other. They ignore the third, who is forced to assume the outside, exclusionary position. Three variants of this triangle exist. In the first, patient and family member form a strong alliance that virtually excludes the physician. Such an alliance can be based in shared health beliefs or skepticism about the doctor, as well as many other factors, including previously existing dynamics between patient and family member. For example, a physician recommends anti-hypertensive medication for a patient diagnosed with high blood pressure. In talking over the visit with her husband, both agree this doctor is a little too quick to prescribe drugs. They also believe that, in general, nonpharmacologic interventions are superior to medication. They quietly decide the wife will not fill the prescription but will try exercise and yoga instead. Because of the dyadic enmeshment, the physician does not learn of this decision for several months.

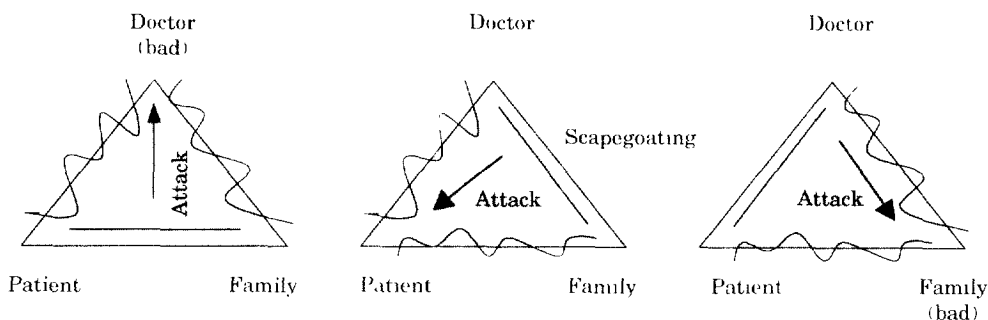
Dyadic enmeshment can also involve doctor and family member, to the exclusion of the patient. Such enmeshment is sometimes based on assumptions of the patient's decisional incompetence or perceptions of chronic noncompliance. Doctor-family member enmeshment often occurs in cases of pediatric illness, where the child may be old enough and/or mature enough to have a voice in treatment, but is systematically excluded by the interactions of parents and physician. For example, the parents and oncologist of a twelve year-old

girl with acute lymphocytic leukemia may opt for aggressive chemotherapy without soliciting the child's wishes or concerns. Such enmeshment also may occur at the opposite end of the life-cycle. In this case, decisions about elderly patients are made between physician and adult child. There is insufficient attention to the needs and desires of the patient, whose fluctuating mental competence may still include the ability to make choices about life values and goals.

Finally, doctor-patient enmeshment can lead to the erosion of meaningful involvement of family members. This typically happens in chronic illness situations, where patient and doctor develop a close bond based on shared knowledge and experience. Family members begin to lag behind doctor and patient in terms of the information they acquire about the condition, and eventually come to feel more and more excluded. In one instance discussed by a resident, a corporate lawyer developed amyotrophic lateral sclerosis (ALS). Although he avidly pursued information about the course and prognosis of the disease, he encouraged his physician to systematically join with him to "protect" his wife from detailed knowledge of the implications and long-term prognosis of his condition. The result was progressive withdrawal and alienation on the part of the spouse, who could otherwise have been an important source of support to this fatally ill man. In such cases, a crucial opportunity for support and guidance from family members is lost.

Illicit Coalitions (Figure 3): Illicit coalitions are enmeshed dyads carried to an extreme, with the addition of overt hostility toward and conflict with the excluded third. In the case of an illicit coalition of patient and family against the physician, these two members of the triangle are united in their perception of the physician as severely suspect, even

FIGURE 3
WhyTriangles
Illicit Coalitions



dangerous. An illicit coalition of patient and family against the physician is often the structural dynamic of a malpractice suit.

It is also possible for physician and family to form a faction against the patient, known as scapegoating. This type of coalition is distinguished from enmeshment by the overt rejection of the patient, as opposed to covert exclusion. A frequently observed example occurs when doctor and family agree that the patient is irresponsible and incorrigible. Sometimes this dynamic is found directed toward adolescent diabetic patients, whose behavior is evaluated by both parents and physician as self-destructively non-compliant. It is also easy for such scapegoating to occur with patients experiencing mental illness.

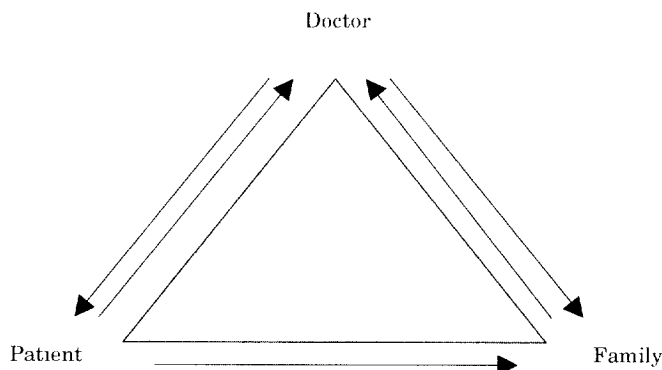
Finally, physician and patient can form a coalition against a family member. This situation has the potential to develop when the physician becomes convinced that the family member is undermining the patient's prescribed treatment regimen. For example, when a patient tells his doctor, "I can't lose weight or lower my cholesterol because my wife keeps cooking fatty foods," it is easy for physician and patient to join in identifying the family member as the

problem. Both perceive the family member as uncaring and uncooperative, and an obstacle to improved health.

It is important to distinguish enmeshments and coalitions from the temporary alliances that inevitably occur within triangles and which actually comprise the foundational strength of the triangular structure. Negative triangles are negative by virtue of their rigidity and inability to be responsive to changing circumstances or needs within the triangle. In other words, under certain circumstances, patient and doctor might reasonably form an alliance directed toward persuading a spouse to modify her meals in the direction of lowered fat intake. Such an alliance would be temporary and specific to a particular goal. It would degenerate into a coalition when, cross-situationally, the wife was evaluated as "bad" by both doctor and patient, and their efforts were directed less at systemic problem-solving and more at denigrating her behavior generally.

It is also important to note that negative triangles may be based on accurate perceptions. A wife *may* actually be cooking fatty foods for her husband with hypercholesterolemia; an adolescent patient

FIGURE 4

Appropriate Therapeutic Alliance

with diabetes *may* in fact feel self-destructive; and a physician *may* have made a mistake in the treatment of her patient. The problem with the formation of hostile coalitions as described above is not necessarily that they have misperceived reality (although this is also possible), but that they preclude cooperative action and problem-resolution. By excluding the “bad” third party, they decrease the likelihood that they can engage in constructive problem-solving as a functional unit. Once the third member of the triangle is ignored or labeled as “bad,” the resources, strategies, and potential of this individual are lost.

Positive triangles (Figure 4): Despite the existence of negative triangles, as Doherty and Baird (1983) astutely observed, the triangle of doctor-patient-family also can produce powerfully positive consequences as well. From a theoretical standpoint, triangles are considered to be more fluid and dynamic than dyads, because of the flexible options for combining and recombining that they offer. Precisely because of this fluidity, they are also

considered to be more “stable” than dyads. Triangles allow for the possibility of expanding a dysfunctional dyadic interaction to search for improved alternatives. For example, a patient who describes her son’s annoyance at her new exercise regimen to her physician may be encouraged to find ways to exercise during times when her son is not looking to her for attention.

In fact, the ideal therapeutic alliance is a positive triangle, in which all members support and guide the others, and in which the resources of all members are available to all. Such a successful triangle is based on trust existing along all dimensions or legs of the triangle. In such a triangle, physician and patient can mobilize family resources on behalf of the patient. The doctor can support the patient-family relationship, and family members can support the patient-doctor relationship.

TEACHING TRIANGLES

Teaching about triangles lends itself well to a noon lecture format. With appropriate visual support, the basic models of negative and positive triangulation can be presented

in twenty minutes, leaving a half-hour for presentation of case examples. For case examples, we typically ask residents to briefly present a scenario and describe the relationships among themselves, the patient, and other family members. We then consider to what extent the example fits one or more of the above models. In situations where residents have difficulty generating examples from their own practices, we often use supplementary literary resources, in the form of poetry or brief short stories that illustrate some aspect of the models described above.

INTERVENING WITH TRIANGLES

As in some situations in medicine, the concept of triangulation is sometimes easier to diagnose than to treat. Family physicians, especially residents who are still focused on learning their craft, usually do not have the time or inclination to be trained as family therapists. Therefore, complex prescriptions for change are usually not relevant. We have found that simple awareness of triangulation in itself sometimes leads to change. When residents understand the role negative triangles can play in promoting dysfunctional patterns, they become more likely to look for triangular patterns in relationships. Although we have yet to systematically assess this assertion, anecdotal evidence indicates that after just one or two presentations about the concept, participating residents later comment spontaneously about triangles and ask more family-oriented questions of behavioral scientists.

When a resident realizes he or she is enmeshed with or has formed a coalition with a patient or family member, such insight presents an opportunity to loosen the bond, to pursue greater flexibility within the triangle, and to reach out to include the excluded member. Awareness of enmesh-

ments or coalitions directed against the physician can lead to useful mini-family conferences that attempt to realign relationships in a more positive and productive manner. Following the prescriptions of brief and solution-focused therapies (Talmon, 1990), we encourage residents to focus on "changing something" in the triangular relationship and emphasizing the positive qualities or potential of the triangle. Frustrated residents have been asked to come up with *anything* they could change about a problematic triangle they had identified, without suggesting the nature of the change. A resident who feels excluded from a strong patient-family coalition may choose to move closer to patient and family; or the resident may decide to confront the coalition by disclosing personal frustration. In this philosophy, what initially matters most is initiating efforts to alter the dysfunctional power of a negative triangle. In terms of potential triangular strengths, residents can be encouraged to focus on what an excluded family member has to offer a patient in terms of resources and support, or on how their input regarding management of a chronic disease can help a distressed family.

One unexpected positive consequence of teaching about triangles in our residency has been increased knowledge of and sometimes more frequent contact with family members on the part of residents. The simple tool of the triangle appears to give residents a manageable way of thinking about family dynamics. As a result, they often become curious about how such concepts play out in real life. This curiosity in turn leads to increased gathering of family-oriented information, and at times more interest in learning about family members through increased interaction in the exam room and even home visits. In our residency, the study of triangles has helped promote a family orientation by

creating interest in the doctor-patient-family relationship that is inevitably activated in the presence of illness.

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