STFM FAMILIES CONFERENCE * SAN DIEGO
CALIFORNIA March, 2000

BERMUDA TRIANGLES IN FAMILY MEDICINE: USING LITERATURE TO SALVAGE PATIENTS, FAMILIES, AND PHYSICIANS ENGULFED BY ILLNESS

I. INTRODUCTION (Pat)

A. Introduce presenters
B. Poems illustrating doctor-patient-family dynamics (J & P)
   1. "Irene"
      a. Who is present? What are their relationships?
      b. What is the triangle? (Dyadic enmeshment: doctor-patient against husband, who ends up excluded)
   2. "Foreign Body"
      a. Who is present? (illusion of dyad)
      b. What is the triangle? (closer to therapeutic alliance – rebalances relationship between father and son by extending system)
C. Purpose of presentation (P): To demonstrate how imaginative literature (ie., fiction, poetry, short stories, role-plays) can be used to teach about triangulation in the doctor-patient-family relationship
   1. Review basic principles of triangles as they apply to doctors, patients, and families
   2. Explore how concepts of narrative theory and therapy can be applied to doctor-patient-family dynamics
   3. Show how triangles and narrative constructs can be examined and elucidated through the use of literary materials
D. Obviously literature can be effectively used to teach about many aspects of families: structure, dynamics, "normal" vs. dysfunctional etc.
   1. For reasons we will expand on in a few moments, we have chosen in our teaching and in this presentation to focus on the concept of triangulation

II. UNIQUE ASPECTS OF OUR RESIDENCY THAT MADE US TURN TO LITERATURE (P)

A. Little exposure to actual families
   1. Limited continuity
   2. Competition for pediatric patients
   3. No family therapy clinic
B. Previous failed efforts to study family dynamics in more abstract, didactic forms

III. WHY TRIANGLES? (J)

A. We chose to focus on triangles in our work about families because:
   1. They are a good entry point for understanding families
   2. They are a frequently encountered occurrence in medicine

3. They allow the resident to relate to a given situation from the vantage point of a doctor, rather than as an imagined family member; so it is a safer, more familiar situation to explore

B. What is a triangle, relationally speaking?
   1. Definition: 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
   2. Bowen claimed the 3-person configuration is the basic building block of any emotional system
   3. Jay Haley referred to "the perverse triangle" (cross-generational coalition)

C. Triangulation occurs within families, but can also occur in therapeutic relationships as well
   1. 20 years ago, Doherty & Baird referred to the "illusion of the dyad" in the doctor-patient encounter
   2. They pointed out that family is "the ghost in the room" whenever the physician is interacting with an apparently solitary patient

D. Negative consequences of triangulation
   1. Patient, family (and physician him/herself) install physician as PPP - permanent perfect parent
      a. Physician then held responsible for success or failure of all subsequent events
      b. Other members of triangle engage in competitive struggles (sibling rivalry) for attention, loyalty, alliance with the new authority figure
   2. Dyadic enmeshment
      a. Two members of triangle become overly involved, protective of each other
      b. Ignore third, who is forced to assume outside position (exclusionary)
   3. Illicit coalitions
      a. Two members join together to attack a third
      b. Scapegoating – two members join together to blame patient
   4. Promotion of win-lose models (two-against-one)
      a. Triangle becomes stuck in repetitive, unproductive patterns
      b. Withdrawal common response to triangulation (losing)

E. Positive consequences of triangulation
   1. Triangles create more stability than dyads
   2. Triangles can expand the system to interrupt negative interaction patterns of dyads or triads within family
      a. Triangles are more fluid, dynamic relationships than dyads
      b. Encourage possibility of change and movement
   3. Create appropriate therapeutic alliance
      a. Successful triangle based on trust along all dimensions
      b. Mobilizes family resources on behalf of patient
      c. Doctor can support patient-family relationship
      d. Family can support patient-doctor relationship

IV. WHY NARRATIVE THEORY? (J)

A. Trained as a structural family therapist, but increasingly interested in what narrative constructs might have to say about our understanding of the interactions of patients, families, and doctors

B. Some interesting and relevant narrative assumptions
   1. Narrative is the natural way we organize experience, give it coherence and meaning
      a. We tell stories about illness to try to make sense from, and find meaning in the chaos and incoherence of these events
      b. Inevitably, these become stories about families and doctors as well as about illness (these are the characters that inhabit our illness stories)
   2. Because we are influenced by the dominant social discourse (the prevailing ideas about how things should be that have achieved the power of consensus), we do not always construct stories that are in our best interest
   3. We have the ability to construct alternative stories, and alternative endings
   4. In constructing a coherent story, we overlook unique outcomes, exceptional events, behaviors, thoughts, feelings from which a more favorable story might be constructed
   5. We are taught to internalize and identify with our problems, rather than viewing them as something separate from ourselves ("I am a shy person" vs. "Shyness is limiting me more and more")
   6. It is more useful to think of conflicting stories than conflicting people
      Corollary: A "compassionate misreading" of stories assumes that
      a. People generally are acting out of hurt, fear, or self-protectiveness rather than meanness and cruelty
      b. People are doing the best they can, but can be helped along to do even better

V. WHY LITERATURE? (J)

A. The uses of literature in residency education have many general goals
   1. Increase understanding of the doctor-patient relationship and the patient's illness experience
   2. Increase sensitivity to patient narrative, or stories
   3. Thereby increase empathy for patients and whole person understanding
   4. Reduces physician frustration, improves doctor-patient communication, and even aids in the development of new patient management strategies

B. Benefits of literature especially useful in understanding dr/pt/family triangulation
   1. Particularity – "We are able to understand and be moved by the meanings of singular stories about individual human beings" (Charon)… and their families
   2. Stimulates creative imagination – we learn to "imagine" ourselves into situations we have never been, or into aspects of situations that lie outside the explicit realm

3. Emotional engagement – literature requires that we *feel* as well as think, so it helps us become connected, helps us care about the situations portrayed
4. Point of view – particularly important because multiple perspectives simultaneously occurring; helps us to sort these out
5. Transitional object
    a. Successive approximation of reality – simpler to deal with than real life
    b. Safety – no direct clinical responsibility for fictional characters
    c. Freeze-frames complexity– helps us pin-down, examine complex interpersonal situations; not exactly fixed, because each time we examine we find more to understand; but not constantly shifting, as in actual interview

VI. STRUCTURE (P)

A. Overview of structure
1. 50 minute noon conference
2. Frequency –
    a. 3-4 times/year
    b. Coordinated with monthly behavioral science topic
3. Type of readings
    a. Generally brief
    b. Generally contemporary – more accessible
    c. Read on-site
    d. Role-plays or poetry
4. Value of oral reading
    a. Oral reading – communal tradition; more involving than silent or listening
    b. Forces reader to assume voice of narrator

VII. GENERAL TEACHING METHODS (P)

A. Open-ended discussion questions (packet)
B. Basic orientation questions (what's happening; speaker; tone)
C. Analysis and exploration of different points of view
D. Analysis of family dynamics; alternative viewpoints
E. Analysis of physician's role vis-à-vis family
F. Narrative approach –
    1. What's the problem?
    2. Unique outcomes
    3. Compassionate misreadings
    4. Alternative plots, stories, endings
G. Role of facilitator
    1. Establish ground rules
        a. No right or wrong answers
        b. Encourage differences of opinion
        c. Opportunity to explore emotional responses
    2. Create open, nonjudgmental atmosphere

3. Encourage playful speculation, imagination
4. Link to clinical experience

VIII. VIDEO DEMONSTRATION (P)

A. Difficult patient
B. Cross-cultural

IX. PARTICIPANT ROLE-PLAY

A. Cross-cultural

X. Q & A

OVERHEADS – STFM FAMILIES CONFERENCE

1. **BERMUDA TRIANGLES IN FAMILY MEDICINE: USING LITERATURE TO SALVAGE PATIENTS, FAMILIES, AND PHYSICIANS ENGULFED BY ILLNESS**

Johanna Shapiro, Ph.D., Pat Lenahan, LCSW
Department of Family Medicine, University of California Irvine

20th Anniversary STFM Conference on Families and Health,
San Diego, CA, March, 2000

2. **"Irene"** – poem

3. **"Foreign Body"** – poem

4. **GOALS OF PRESENTATION**: ***To demonstrate how imaginative literature –***
   * fiction
   * poetry
   * short stories
   * role-plays

can be used to teach about triangulation in the doctor-patient-family relationship

5. **SPECIFIC OBJECTIVES:**

   - Review basic principles of triangles as they apply to doctors, patients, and families
   - Explore how concepts of narrative theory and therapy can be applied to doctor-patient-family dynamics
   - Show how triangles and narrative constructs can be examined and elucidated through the use of literary materials

6. **ASPECTS OF OUR RESIDENCY THAT CAUSED US TO SEEK NEW TEACHING CONTENT AND METHODS**

   - **Little exposure to actual family units**
     - Limited continuity
     - Competition for pediatric patients
     - No family therapy clinic
   - **Previous failed efforts to study family dynamics with more abstract, didactic methods**

7. **WHY TRIANGLES?**
   - **Good entry point for understanding families**
   - **Frequently encountered occurrence in medical practice**
   - **Allow resident to retain safe vantage point as physician**

8. **WHY TRIANGLES?**
   WHAT IS A TRIANGLE? (find picture of triangle here)

   DEFINITION: *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*

9. **WHY TRIANGLES?**
   TRIANGULATION IN THE THERAPEUTIC RELATIONSHIP

   "Illusion of the dyad"
   "The ghost in the room" (picture of ghost)

   – W. Doherty and M. Baird,
   Family Therapy and Family Medicine, 1983

10. **WHY TRIANGLES?**
    NEGATIVE TRIANGLES

    PPP – Permanent Perfect Parent (Physician)
    (include sketch)

11. **WHY TRIANGLES?**
    NEGATIVE TRIANGLES

    Dyadic enmeshment
    (include sketches)

12. **WHY TRIANGLES?**
    NEGATIVE TRIANGLES

    Illicit Coalitions
    - **Scapegoating**

    (include sketches)

13. **WHY TRIANGLES?**
    NEGATIVE TRIANGLES

Promotion of *win-lose* models
Common consequence – withdrawal

14.WHY TRIANGLES? POSITIVE TRIANGLES

- **Create more stability than dyads**
- **Expand system to interrupt negative interaction patterns**
  - More fluid, dynamic than dyads
  - Encourage change, movement
    (include sketch)

15.WHY TRIANGLES? POSITIVE TRIANGLES

- **Create appropriate therapeutic alliance**
  - Trust along all dimensions
  - Mobilizes family resources on behalf of patient
  - Doctor supports patient-family relationship
  - Family supports patient-doctor relationship

  (include same sketch as in #15)

16.WHY NARRATIVE THEORY?

NARRATIVE ASSUMPTIONS

1. **Narrative (storytelling) is the natural way we organize experience to give it coherence and meaning**
2. **Because we are influenced by the "dominant social discourse"* we do not always construct stories that are in our best interest**
3. **We have the ability to construct alternative stories and alternatives endings**

* the prevailing ideas about how things should be that have achieved the power of consensus, cf. Michel Foucault

17.WHY NARRATIVE? NARRATIVE ASSUMPTIONS (cont)

4. **In order to construct a coherent story, we overlook unique outcomes****
5. **We are taught to internalize, identify with problems, rather than see them as something separate from ourselves**
6. **It is more useful to think of conflicting stories than conflicting people: "compassionate misreading"*****

** exceptional events, behaviors, thoughts, and feelings that contradict the prevailing story, cf. Michael White
***assumes that people generally act out of hurt, fear, or self-protectiveness rather than meanness or cruelty, cf. Michael White

18.WHY LITERATURE?

GENERAL GOALS OF LITERATURE

- **Increase understanding of doctor-patient relationship and patient's illness experience**
- **Increase sensitivity to patient stories**
- **Increase empathy, whole person understanding**
- **Reduce physician frustration**
- **Improve doctor-patient communication**
- **Aid in development of new patient management strategies**

19. WHY LITERATURE?
SPECIFIC UTILITY IN UNDERSTANDING DOCTOR-PATIENT-FAMILY TRIANGULATION

- **Particularity – "*We are able to understand and be moved by the meanings of singular stories about individual human beings*" – R. Charon, M.D.... *and their doctors and their families***
- **Creative imagination**
- **Emotional engagement**
- **Point of view**
- **Transitional object**
  - **Successive approximation of reality**
  - **Safety**
  - **Freeze-frames complexity**
  - **Encourages playfulness, risk-taking**

20. STRUCTURE AND CONTENT OF TEACHING

* **Format - 50 minute noon conference**
- **Frequency**
  - 3-4 times/year
  - Coordinated with monthly behavioral science topic
- **Type of readings**
  - Brief

    - Contemporary (greater accessibility)
    - Read on-site
    - Role-plays or poetry
- **Value of oral reading**
    - Communal tradition (more involving)
    - Forces reader to assume voice of narrator

21. GENERAL TEACHING METHODS

- **Basic orientation questions**
    - What's happening?
    - Speaker
    - Tone

22. GENERAL TEACHING METHODS

- **Questions about triangles**
    - Permanent perfect parent
    - Dyadic enmeshment
    - Illicit coalitions, scapegoating

23. GENERAL TEACHING METHODS

***Narrative questions**

- What's the story?
- What's the problem?
- Unique outcomes
- Compassionate misreadings
- Alternative plots, stories, endings

24. GENERAL TEACHING METHODS

ROLE OF FACILITATOR

- **Establish ground rules**
    - **No right or wrong answers**
    - **Encourage differences of opinion**
    - **Explore emotional responses**
- **Create open, nonjudgmental atmosphere**
- **Encourage playful speculation, imagination**
- **Link to clinical experience**

DOCTOR-PATIENT-FAMILY NARRATIVE DISCUSSION QUESTIONS

1. What is the dominant story here? What other stories might exist? How can those stories be brought out?

2. What are the unique outcomes, the exceptions to the dominant story that are apparent?

3. What is the main problem complicating this story? What strategies does the problem use to maintain its influence?

4. Where is this story stuck?

5. What could be a more "compassionate misreading" of this story?

6. How do you think this story will end? What other endings might be possible?

7. What characters or aspects of characters (ie., which voices) are not being heard? What might they be saying?

POINTS ABOUT TRIANGLES

A. DEFINITION: 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
   1. Bowen claimed the 3-person configuration is the basic building block of any emotional system
   2. Jay Haley referred to "the perverse triangle (cross-generational coalition)
B. Triangulation can occur within families, and can occur in therapeutic relationships as well
   1. Doherty and Baird (almost 20 years ago) "illusion of the dyad"
   2. Family is the "ghost in the room" when the physician is interacting with a solitary patient
C. Negative consequences of triangulation
   1. Competitive struggles (sibling rivalry) for attention, loyalty, alliance with the new authority figure
      a. Easy for patient and family to install physician in dominant position
      b. Hold physician responsible for success or failure
      c. Physician becomes the competent parent
   2. Dyadic enmeshment – two members of triangle become overly involved, protective of each other
   3. Illicit coalitions – two members join together to attack a third
   4. Scapegoating – blaming patient
   5. Win-lose models (two-against-one)
      a. Can become stuck in repetitive, unproductive patterns
      b. Withdrawal is common response to triangulation (losing)
D. Positive consequences
   1. Create more stability
   2. Expand the system to interrupt negative interaction patterns
      a. Triangles are more fluid, dynamic relationships than dyads
      b. Encourage possibility of change and movement
   3. Introducing even one new person into triangle creates possibility triangle will change
   4. Create appropriate therapeutic alliance
      a. dr. can use pt/family longing for approval to gain additional leverage
      b. successful triangle is based on trust
   5. Mobilize family resources
   6. Support patient-family relationship
   7. Get family to support patient-doctor relationship

BERMUDA TRIANGLES IN FAMILY MEDICINE: USING LITERATURE TO SALVAGE PATIENTS, FAMILIES, AND PHYSICIANS ENGULFED BY ILLNESS

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1

Irene

After the third stroke,
her words fell off
to a few soft syllables.
When I enter the room
and enter those red-rimmed eyes
that can't help
looking toward the left,
she cocks her jaw
and her cheekbones swell.
with what looks like weakness,
she wobbles
her left hand to my wrist,
but that grip is the grip of a woman
who clings by a root
to the face of a cliff.

2

Irene - 2

When she speaks, her words
are small stones
and loosened particles
of meaning
that tumble to their deaths
before my ear
is quick or close enough
to save them. *Irene,*
Tell me again, I say,
After the words
in her bits of chopped breath
are gone. But George
takes his cap from my desk
and puts it on his head, and says
her gulps don't make no sense.

-Jack Coulehan

3

Foreign Body

Foreign body:
something misplaced,
like a sliver in the thumb.

His thumb is red and sore
and he's sure
there's a piece of wood in it.

After the freezing kills the pain
I begin my search.
As he watches a drop of blood
grow large on his thumb nail,
he tells me of his other foreign body.

Something misplaced:
he calls it Father,
and drives long miles
over bad roads in winter
to find him
On the third floor.

4

Foreign Body - 2

"I usually arrive in time
to feed him late breakfast.
Crumbs and small bits of egg
catch in his stubble.
Breakfast over,
it's time for his shave."

"I've thought of shaving him first
and then feeding him breakfast
but he's too hungry for that."

"You ever give your father a shave?
The first time I did
I was surprised
by the smoothness of his chin.
Still wrinkled, but smooth."

5

Foreign Body - 3

"You know what bothers me?
When he shits himself."

"I remember him for so many years
bigger than I was,
stronger than I was.
Vigorous.
Now he does it in his bed
and doesn't even realize
the sheets are dirty."

I probe his thumb
One last time
And then abandon my search.
I can feel his pain returning.
My apology sounds
out of place.

-Vincent Hanlon

6

GOALS OF THE PRESENTATION:

To demonstrate how imaginative literature-

- *Fiction*
- *Poetry*
- *Short stories*
- *Role plays*

can be used to teach about triangulation in the doctor-patient-family relationship

SPECIFIC OBJECTIVES

- Review basic principles of triangles as they apply to doctors, patients, and families
- Explore how concepts of narrative theory and therapy can be applied to doctor-patient-family dynamics
- Show how triangles and narrative constructs can be examined and elucidated through the use of literary materials

WHY TRIANGLES?

- Good entry point for understanding families
- Frequently encountered occurrence in medical practice
- Allow resident to retain safe vantage point as physician

9

WHY TRIANGLES?

WHAT IS A TRIANGLE?

Definition:

Each of two opposing parties seeking 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.

10

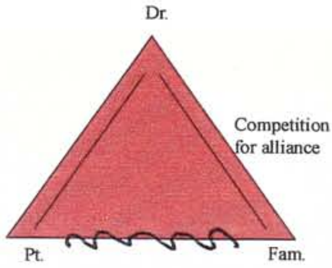
WHY TRIANGLES?

TRIANGULATION IN THE THERAPEUTIC RELATIONSHIP

- *"Illusion of the dyad"*
- *"The ghost in the room"*

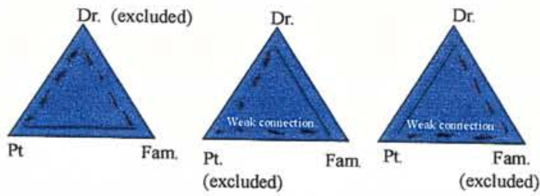
-W. Doherty & M. Baird
Family Therapy and Family Medicine, 1983

PERMANENT PERFECT PARENT (PHYSICIAN)

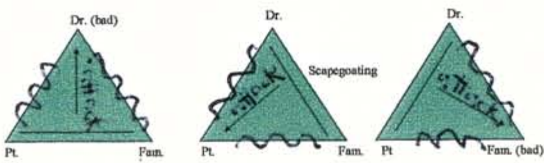


WHY TRIANGLES

DYADIC ENMESHMENT



Illicit Coalitions)



WHY TRIANGLES

NEGATIVE TRIANGLES

- Promotion of *win-lose* models
- Common Consequence: Withdrawal

WHY TRIANGLES?

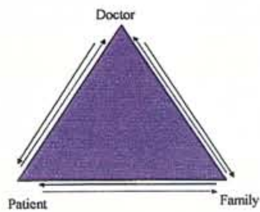
POSITIVE TRIANGLES

- **Create more stability than dyads**
- **Expand system to interrupt negative interaction patterns'**
  - ***More fluid, dynamic than dyads***
  - ***Encourage change, movement***

WHY TRIANGLES?

POSITIVE TRIANGLES

CREATE APPROPRIATE THERAPEUTIC ALLIANCE:



WHY TRIANGLES?

THERAPEUTIC ALLIANCE

- Trust along all dimensions
- Mobilizes family resources on behalf of patient
- Doctor supports patient-family relationship
- Family supports patient-doctor relationship

WHY NARRATIVE THEORY?

NARRATIVE ASSUMPTIONS

1. Narrative (storytelling) is the natural way we organize experience to give it coherence and meaning.
2. Because we are influenced by the "dominant social discourse"* we do not always construct stories that are in our best interest.
3. We have the ability to construct alternative stories and alternative endings.

*The prevailing ideas about how things should be that have achieved the power of consensus. cf. Michel Foucault

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WHY NARRATIVE THEORY?

NARRATIVE ASSUMPTIONS (CONT.)

4. In order to construct a coherent story, we overlook *unique outcomes***
5. We are taught to internalize, identify with problems, rather than see them as something separate from ourselves.
6. It is more useful to think of conflicting stories than conflicting people:

   *Compassionate misreading****

WHY LITERATURE?

General Goals of Literature

- ✓ Increase understanding of doctor-patient relationship and patient's illness experience
- ✓ Increase sensitivity to patient stories
- ✓ Increase empathy, whole person understanding
- ✓ Reduce physician frustration
- ✓ Improve doctor-patient communication
- ✓ Aid in development of new patient management strategies

WHY LITERATURE

SPECIFIC UTILITY IN UNDERSTANDING DOCTOR-PATIENT-FAMILY TRIANGULATION

- ✓ **Particularity –**
- ✓ **Creative imagination**
- ✓ **Emotional engagement**
- ✓ **Point of view**
- ✓ **Transitional object**
  - ***Provides successive approximation of reality***
  - ***Creates safety***
  - ***Freeze-frames complexity***
  - ***Encourages playfulness, risk-taking***

STRUCTURE AND CONTENT OF TEACHING

- FORMAT-50 MINUTE NOON CONFERENCE
- FREQUENCY
  - 3-4 times/year
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- TYPE OF READINGS
  - Brief
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  - Role -plays or poetry
- VALUE OF ORAL READING
  - Communal tradition (more involving)
  - Forces reader to assume voice of narrator

23

GENERAL TEACHING METHODS

- **Basic Orientation Questions**
  - ***What's happening?***
  - ***Speaker***
  - ***Tone***

24

GENERAL TEACHING METHODS

- **Questions About Triangles**
  - ***Permanent perfect parent***
  - ***Dyadic enmeshment***
  - ***Illicit coalitions, scapegoating***

25

GENERAL TEACHING METHODS

- **Narrative Questions**
  - ***What's the story?***
  - ***What's the problem?***
  - ***Unique outcomes***
  - ***Compassionate misreadings***
  - ***Alternate plots, stories, endings***

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ROLE OF FACILITATOR

- **Establish ground rules**
  - ***No right or wrong answers***
  - ***Encourage differences of opinion***
  - ***Explore emotional responses***
- **Create open, nonjudgmental atmosphere**
- **Encourage playful speculation, imagination**
- **Link to clinical experience**

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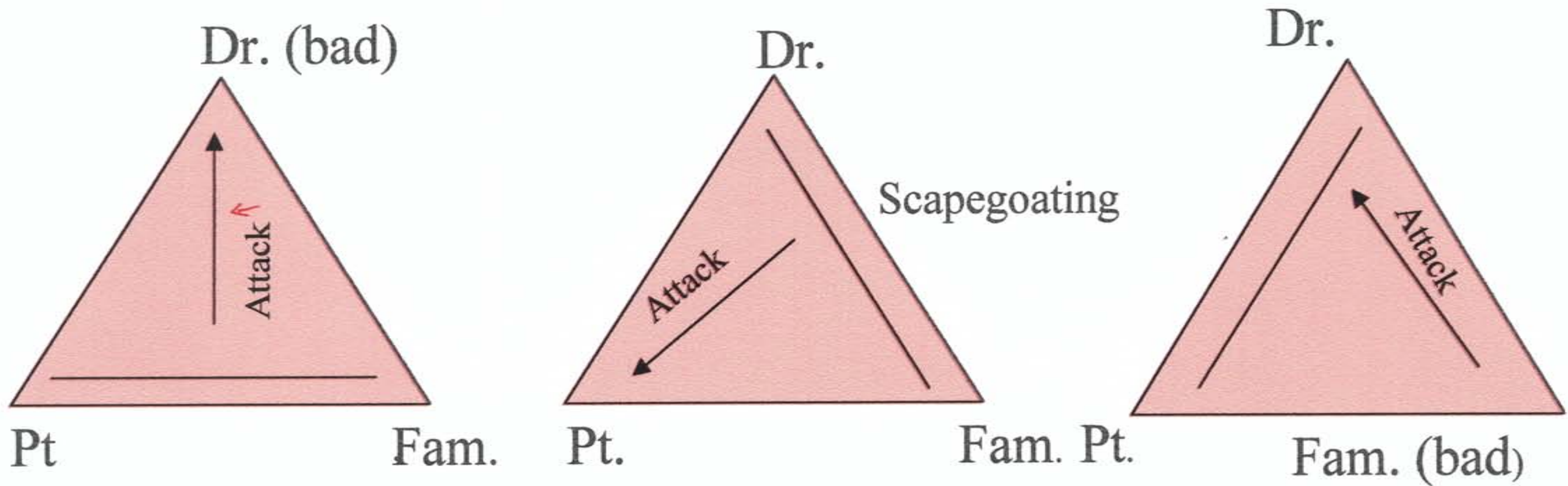
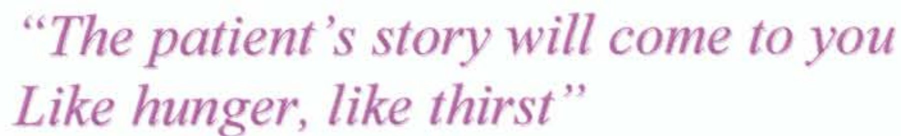
WHY TRIANGLES

ILLICIT COALITIONS



WHY STORIES?

- HUMAN BEINGS THINK NARRATIVELY
- NARRATIVE IS THE PARADIGMATIC MODE FOR HOW EXPERIENCE IS SHARED
- ILLNESS DISRUPTS ONE'S EXPECTED LIFE NARRATIVE
- STORIES REIMAGINE, MAKE SENSE OF CHAOS OF ILLNESS
- THERAPEUTIC POWER OF STORIES
    - SYMBOLIC
    - ACTUAL



"The patient's story will come to you
Like hunger, like thirst"

John Stone, M.D.

"Through my patient's stories, I learn how and why people suffer, and why they heal"

Harriet Squier, M.D.

"More stories, less theory!"

Robert Coles, M.D.

"Everything about being human is in poetry...I wonder then whether poetry is not therapeutic."

Rafael Campo, M.D.

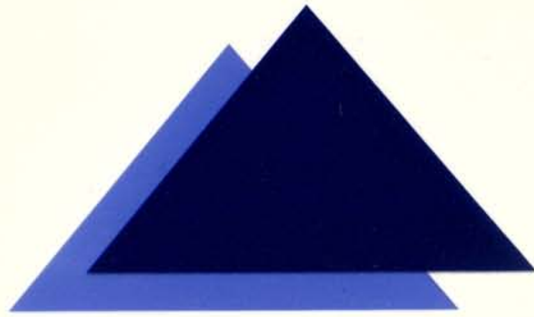
#C

WHAT IS A TRIANGLE?

Definition:

Each of two opposing parties seeking 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.

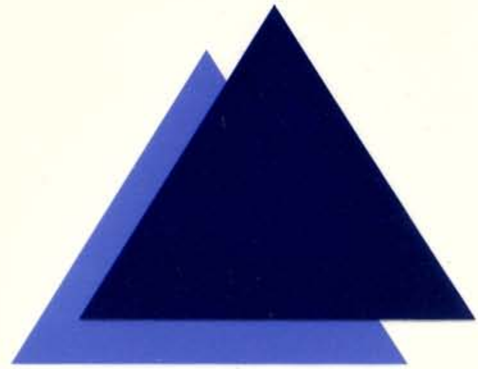
WHY TRIANGLES?



TRIANGULATION IN THE THERAPEUTIC RELATIONSHIP

- *"Illusion of the dyad"*
- *"The ghost in the room"*

-W. Doherty & M. Baird
Family Therapy and Family Medicine, 1983



WHY TRIANGLES?

- Good entry point for understanding families
- Frequently encountered occurrence in medical practice
- Allow resident to retain safe vantage point as physician

A MODEL FOR THE PRIMARY CARE OF FAMILIES

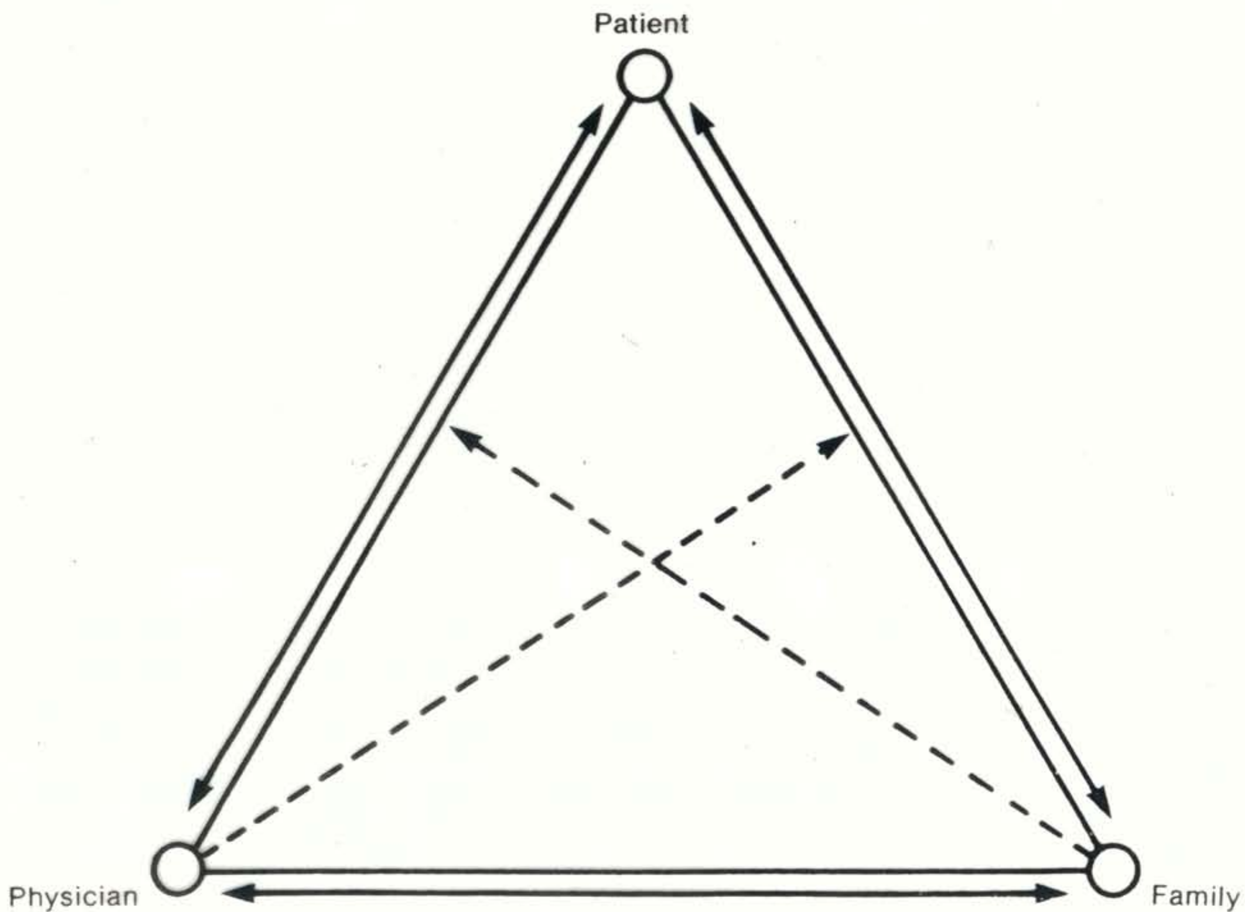
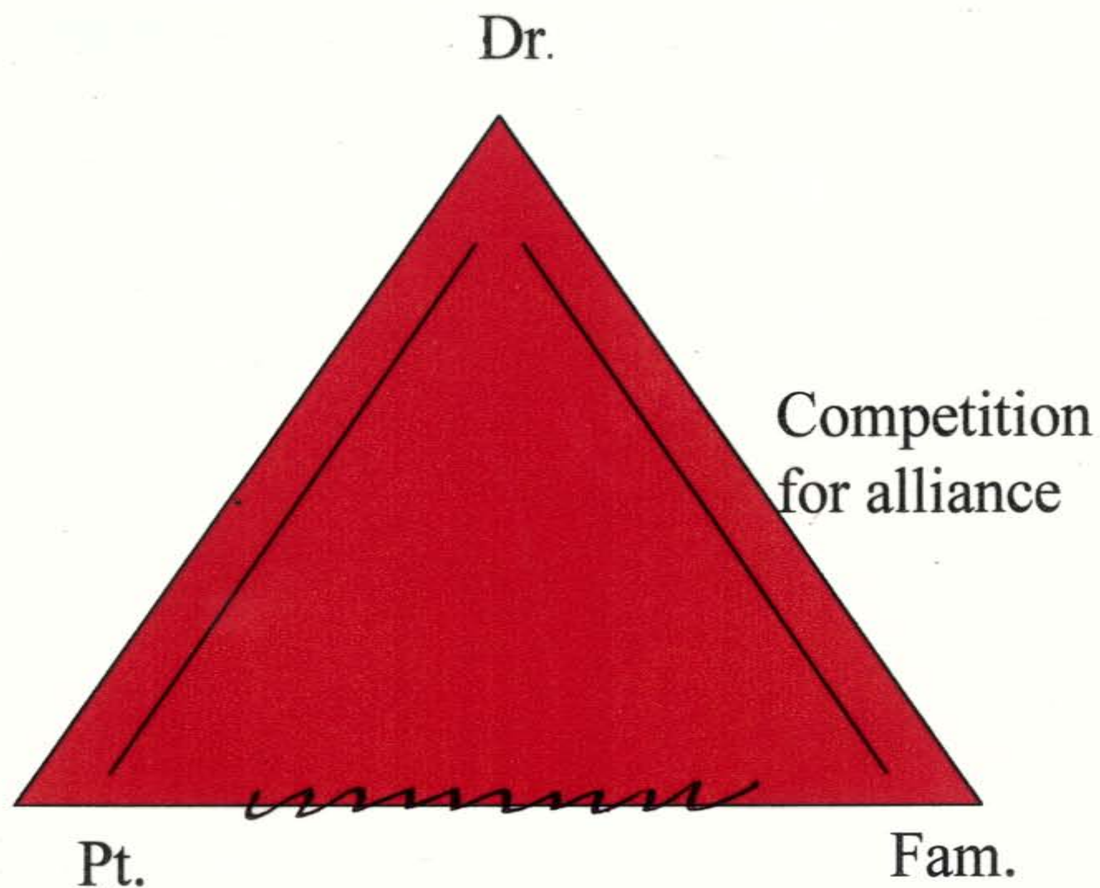


FIG. 2-1. THE THERAPEUTIC TRIANGLE IN MEDICINE.

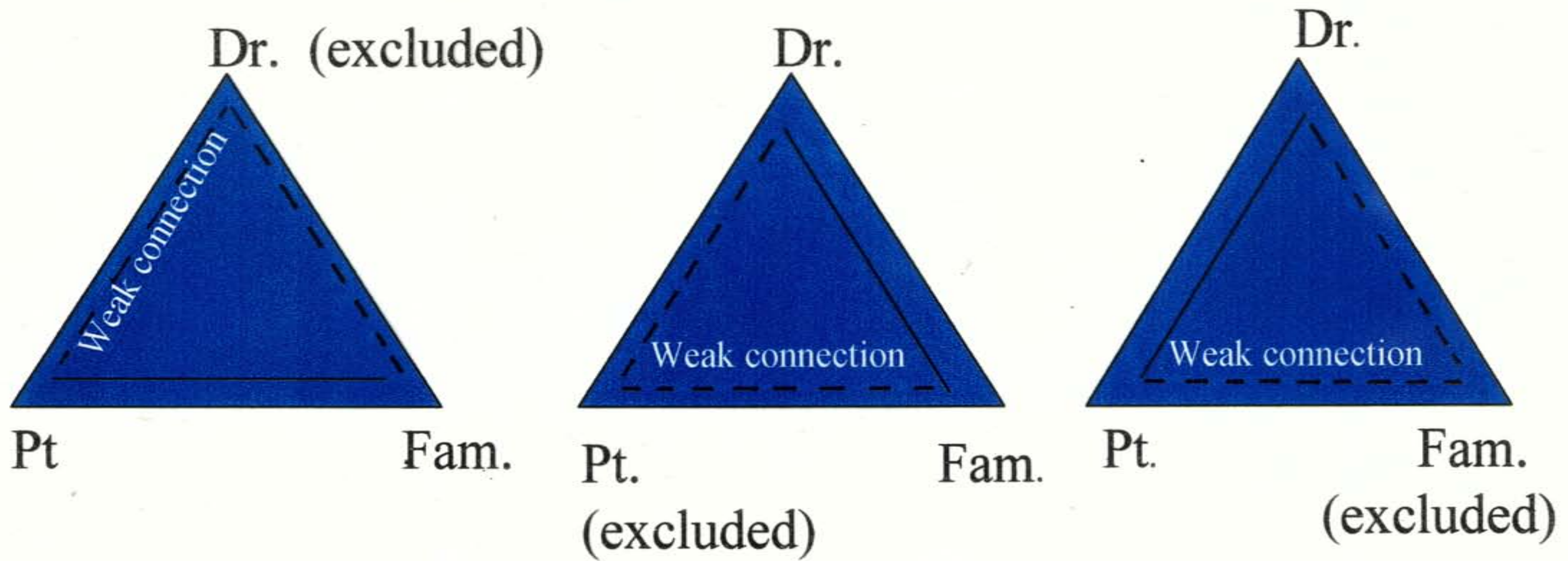
Doherty, W., & Baird, M.
Family Therapy and Family Medicine, 198

PERMANENT PERFECT PARENT (PHYSICIAN)



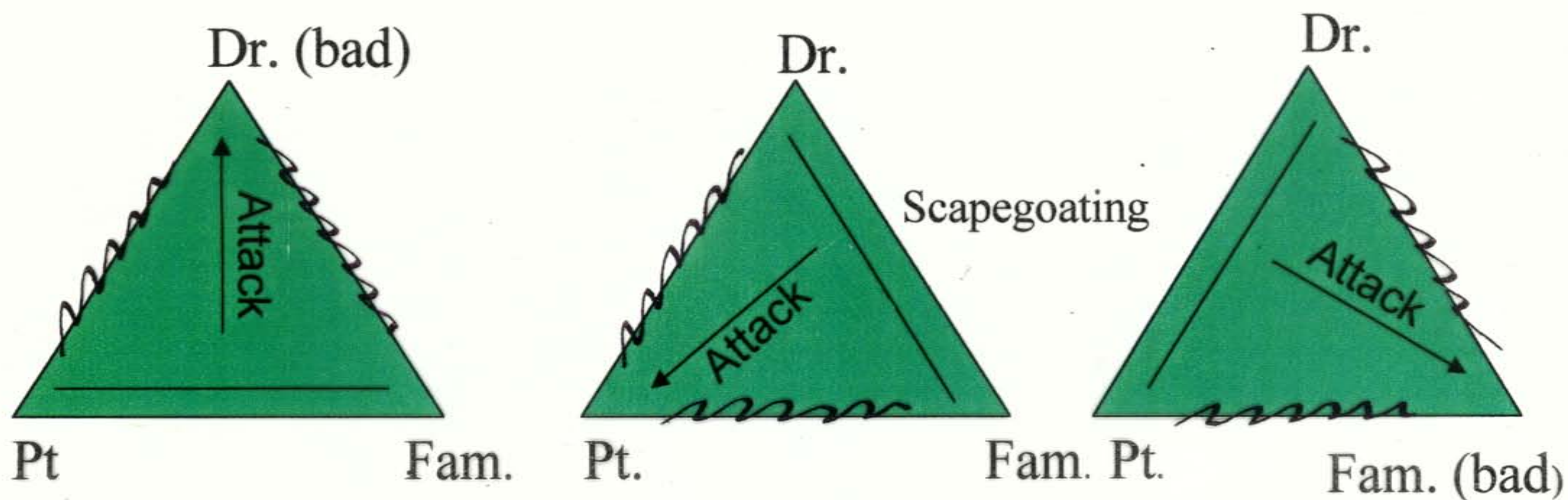
WHY TRIANGLES

DYADIC ENMESHMENT



WHY TRIANGLES

ILLICIT COALITIONS

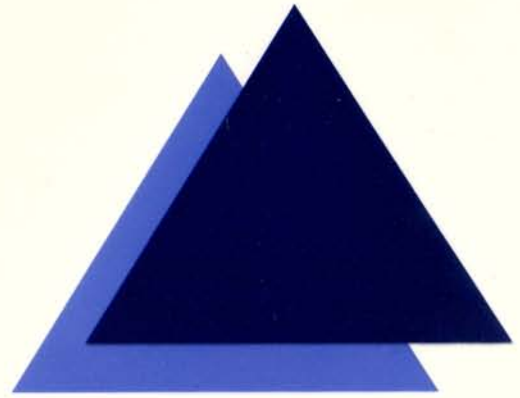


Why Triangles?

NEGATIVE TRIANGLES

- Promotion of win-lose models
- Common Consequence: Withdrawal

WHY TRIANGLES?



POSITIVE TRIANGLES

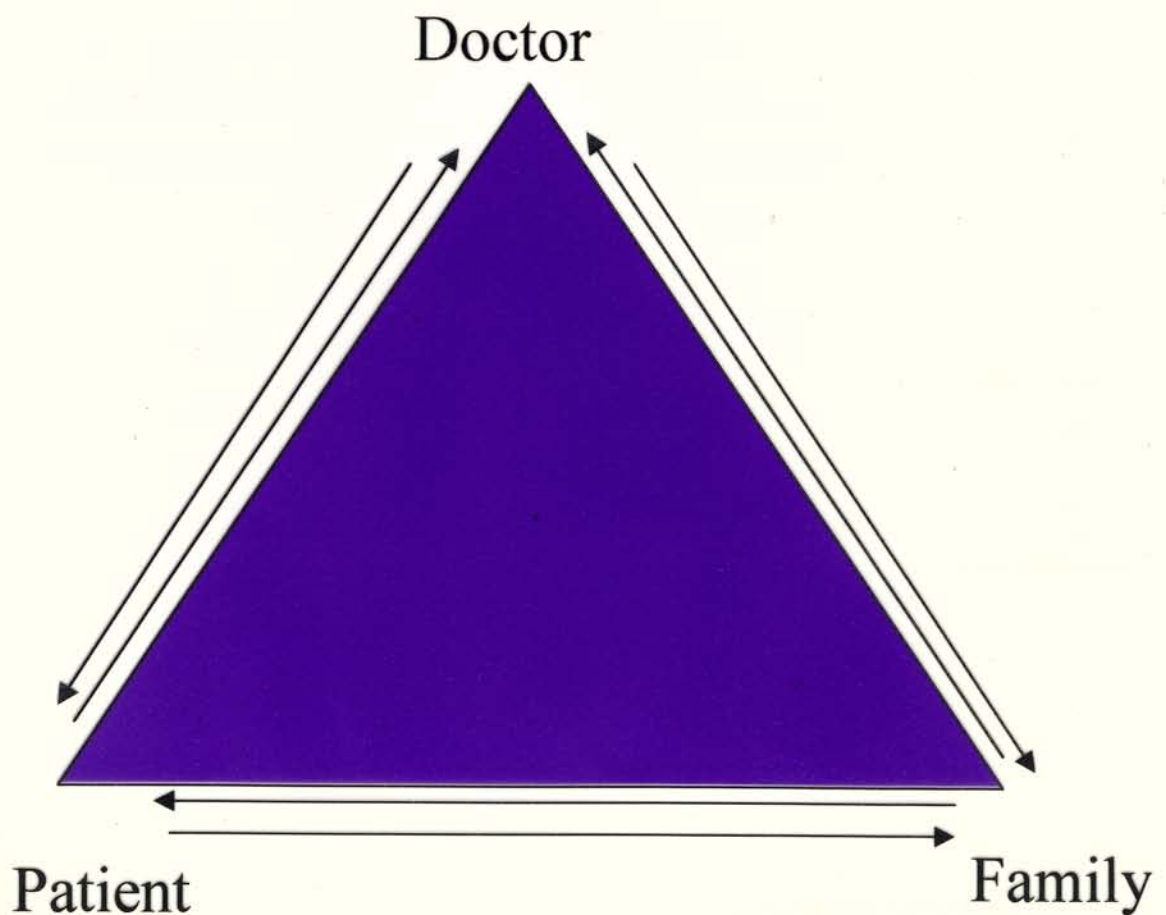
- **Create more stability than dyads**
- **Expand system to interrupt negative interaction patterns'**

  - ***More fluid,dynamic than dyads***
  - ***Encourage change, movement***

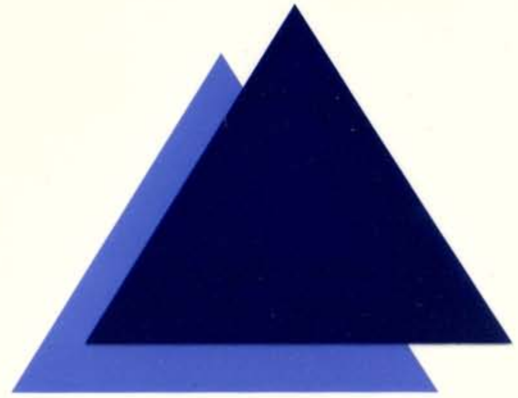
WHY TRIANGLES?

POSITIVE TRIANGLES

CREATE APPROPRIATE THERAPEUTIC ALLIANCE:



WHY TRIANGLES?



THERAPEUTIC ALLIANCE

- Trust along all dimensions
- Mobilizes family resources on behalf of patient
- Doctor supports patient-family relationship
- Family supports patient-doctor relationship

Useful Teaching Questions

USEFUL QUESTIONS FOR LITERATURE AND MEDICINE
BEHAVIORAL SCIENCE DISCUSSIONS

1. Basic Orientation Questions
    a. Who is the speaker?
    b. What is the point of view?
    c. What is happening?
    d. What is the tone of the work?

2. Thematic Questions
    a. What is the selection saying?
    b. What is the basic idea of the selection?
    b. How would you interpret the message or point of this selection? Do you agree or disagree?

3. Emotional Response/Empathy Questions
    a. What is the narrator (and other characters) feeling about his/her/their situation?
    b. How did you feel about the narrator, other characters, and/or opinions expressed in the selection?
    c. If you did not like the narrator, other characters etc., are there any circumstances under which you could feel more sympathetic to him/her/them?
    d. What would this story be like from the point of view of one of the other characters?
    e. Did you like or dislike the selection? Why?

4. Credibility Questions
    a. Is the passage true to human experience?
    b. Is it credible? Does it make sense?

5. Clinical Implications
    a. What message can you take back to clinical practice from this selection?
    b. What did it teach you that might be relevant to patient care?
    c. How would you feel about being this person's physician?
    d. If you were this person's physician, how would you try to act? What might you say and do?
    e. What have you learned about yourself as a physician from reading this selection?

DOCTOR-PATIENT-FAMILY NARRATIVE DISCUSSION QUESTIONS

1. What is the dominant story here? What other stories might exist? How can those stories be brought out?

2. What are the unique outcomes, the exceptions to the dominant story that are apparent?

3. What is the main problem complicating this story? What strategies does the problem use to maintain its influence?

4. Where is this story stuck?

5. What could be a more "compassionate misreading" of this story?

6. How do you think this story will end? What other endings might be possible?

7. What characters or aspects of characters (ie., which voices) are not being heard? What might they be saying?