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

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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