

The Soft Touch: Teaching "Families" in a Family Practice Residency Diploma Program

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Teaching Families is a 12-session course in the Family Practice Residency Diploma Program at the School of Medicine at Tel-Aviv University, Israel. It is taught jointly by a family physician and an expert in the specific field; in this case, a social worker and family therapist. The residents are called upon to use attentive listening and a broad view of the family as diagnostic tools, just as if these were blood tests or CAT scans. The challenge of introducing "soft" matters to new physicians, oriented toward quantification and medical technology, is compounded by the fact that the course cannot be graded. Processes observed during the course serve as a model for the developing relationship between family physicians and their patients. In this article, we follow the changes undergone by one participant, as observed by both teachers, and enhanced by reflection with a third family physician, herself a former teacher in the course.

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It was the third time we taught this one-semester course about families, and our tenth year of teaching residents in family practice. Yet, we could still taste the familiar flavor of anxiety, just as we did the very first time. Who will we have in our classroom? How will they react to the "soft" issues in medicine, such as insight, systems approach, or family life cycle?

At 5 P.M., 14 new, tired faces showed up for their weekly class. Ofira took the first minutes to introduce herself. She is a social worker in a primary care clinic, married and the mother of three children, teacher and tutor of psychosocial issues for residents for the last 15 years. Next, Andre introduced himself, a family physician, also 15 years in practice, father of three children, tutor and lecturer in Family Medicine with a special interest in somatization. Each of the residents then gave his or her name, the stage of their specialization, and expectations from the course. To our annoyance, they all expressed their interest in somatization. Their response made us realize that we should have confined our introduction to basic facts, so as not to provide them with a trigger for their answers. Most of them did not know what to say at all, but specified the importance of learning about families as a requisite to pass the specialization board.

We presented our objectives: (a) understanding the influence of families in illness and health and the impact of illness

in families; (b) learning about passages in the family life cycle and normative family stress; and (c) family dysfunction and its assessment. We explained that at the end of the course we would like them to "talk" families and understand why family practice without families is just another clinical one-on-one general medical practice. We told them, from our experience, the best way to implement our objectives is to hold the seminar as an open discussion group. The work would be based on articles that we would distribute regarding specific themes: the genogram, family life cycle, symptoms of families in crisis, stressful life events, evaluation of families and dysfunctional families, and family resources and coping mechanisms. We planned to use role-play to practice family-interview skills including referral. We left the last two or three sessions open to allow residents to bring families and problems from their own clinics in order to consult with the group.

After the first session we chose to observe one participant, Boris,* for any changes that might occur throughout his participation. He was neither the most talkative nor the quietest participant. We decided that after each session, each of us would record our impressions of his participation. Boris was unaware of our observation; had he been aware of it, he might have changed his behavior. In this article we present a summary narrative of each session, our observations, and our feelings.

Still in our first meeting, we presented a family that had been in Andre's care for 15 years (Matalon & Mazor, 1999), mostly through home visits. We described the difficulties and pleasures in the management of this family. In describing their follow up, we demonstrated the principles of systemic care and the main characteristics of family

practice: continuous, comprehensive, and coordinated care.

The case discussion of a home-bound octogenarian highlighted the difficulties of diagnosing angina pectoris when chest pain occurred while eating. Boris' only response was to suggest a referral to hospitalization or, at the least, to perform an isotope cardiac scan with dipyridamole and thallium. The anxiety of a mistaken diagnosis seemed to lead him—and other young physicians—to lean on tests and hospital investigations where responsibility is diluted and shared by others. None dared to try an anti-anginal drug before meals. We decided to restrain ourselves from comments, as we were in the phase of creating a learning alliance. Instead, we chose to close the session, pointing out that insights for treating families come after a few years of practice, and that what they had just heard was the beginning of "thinking" and "talking" families. We asked them to read a paper on genogram (Crouch & Davis, 1987) for the next session. We felt we had touched them.

The second meeting began with a disappointment—no one had read the article. Boris was not present that day. We repeated our concept of the course: rather than teach we wanted to discuss papers and incorporate our clinical experiences. We preached a bit on "adult learning," and then asked them about the reasons for doing genograms. It did not take long before the board was covered. We felt they had made progress, and moved on to difficulties in eliciting a genogram. Again the board filled quickly, so we asked them each to obtain a genogram from the colleague seated next to them. Although the board was full again, they now became aware of their own emotional barriers and boundaries, and their fears of intruding upon the privacy of another person's life. At this point, we could feel and "touch" their first lesson in insight. We asked them to prepare their own genogram and bring it to the next session.

*Throughout this article, names of all residents and patients are fictive and patients' stories were modified to protect confidentiality.

We came to the third session fearing that they would not bring their genograms, and were relieved to find that they did. The first to present his genogram was Salim, an Arab doctor who has a large family with many links between family members. It was a good beginning. There were no psychiatric problems, no major diseases, and Salim was the only doctor in his village. This gave us the opportunity to talk about living and doctoring in the same community (Matalon, Yinnon, & Cohen, 2000). It was also a natural opening to the topics of cultural differences in doctoring, the position of the doctor in the Arab community, and the position within his own family, as Salim was the oldest child. We commented that he was a vivid realization of the Arab proverb "When your older son grows up, make him your brother." He proudly agreed.

Next, Marian presented her family, a typical Ashkenazi Jewish family. She told us her family story as detailed as she felt comfortable. After listening to these family stories for a while, we and all of the participants felt at ease.

The last to present was Boris. He told us about his grandmother and his parents who did not want to come to Israel when he did, and still had not. There were no special diseases in the family, except for a recent discovery, 2 or 3 months earlier, of possible angina pectoris in his mother. The genogram revealed that Boris had come to Israel 5 years ago, his younger brother 1 year ago, and his youngest sister 3 months ago. Ofira brought up the possibility that his mother had a "broken heart" with the departure of all her children to Israel. Boris immediately added that she had changes in her electrocardiogram, to which we just replied, "But why now?"

This session was extremely important from our point of view. We felt a closeness, a sense of unique togetherness, between us and the class and within the class itself. The exercise allowed the residents to think of their roles as family members and doctors,

and how listening to family stories helped participants feel at ease. We told them that this is the way patients (and doctors) often feel after taking a genogram. We respected their family stories and encouraged their feelings. We showed them at this stage that this was again a lesson on insight, on changing the focus toward themselves, and on identifying their own emotions.

In the fourth session, Ofira discussed the stages of the family life cycle (Carter & McGoldrick, 1980; Duvall, 1977; Smilkstein, 1980). We then developed one of the principles of Family Medicine: the continuity of care. The family life cycle model refers to sequential predictable passages throughout life (Sheehy, 1976), and notes the stress related to them (e.g., the transition from single to married status or the adaptation of a couple to the birth of their first child). When we needed clinical examples, we asked the class to remember their own upbringing, their marriages, and other life passages. They brought up stories in which we were able to distinguish between normative and nonnormative responses, such as difficulties in creating the adequate distance and barriers between the two families after marriage, the adaptation to "being" a mother, and the fatigue of the first months after giving birth. Boris brought in his own distress and feelings of loneliness while observing the distance kept by his wife's parents after the birth of their first child.

We felt that the session was off-track, and we wanted to return the focus to clinical care. We suggested that the insights gained by looking at their families and their own life passages would enable them to better understand their patients, discern normative and abnormal behavior, and promote reassurance when appropriate. Reflecting on this session, we thought that maybe we had talked too much. Maybe *we* were those in need of reassurance?

The discussion of family life cycle and children in school continued in the

fifth session. We discussed an assigned chapter from a novel about an Iranian-Jewish family in Israel (Rabinian, 1999). The chapter describes the birth of a baby girl and her stillborn twin brother. It tells how her sisters used to tease her about his death, how she felt that she lived with an inner ghost, and the development of attention deficit disorder. We talked about the feelings and the people behind the diagnosis, the history of a diagnosis, the family story, and the culture and beliefs surrounding the diagnosis. Each disease and each diagnosis has its own narrative. We could almost feel ourselves adding the personal, individual, familial, and cultural spices to their evidence-based medical record. We could not find the answers about why our trainees were not very cooperative that day. Boris seemed more involved than the others, and Ofira noticed the ease with which he gave examples and shared his own experience.

Next session was devoted to mid-life crisis and to gender differences in symptom presentation. Between the ages of 45 and 55, people may experience loss and separation: children leaving home, empty nest, parents passing away, friends getting sick, menopause and loss of fertility or virility, and feelings of being at the edge of the last opportunity to make a life change and fulfill inner wishes and desires. Boris presented us with a dilemma from his morning clinic. A 50-year-old woman married to a 55-year-old man, suffered from long-term intermittent migraine headaches. She came to the clinic to receive a note for her employer, confirming her illness. While waiting for the note, she repeated her request for new pain killing medication. She was full of expectations from Boris, who had only been at the clinic for a month. He, however, was intimidated by the size and bulk of her medical record. They had little time to talk, and Boris was distracted by the noisy crowd waiting outside his door. He quickly revised all the drugs she had

received and suggested a beta-blocker for preventing the attacks.

As the woman was putting the prescription in her wallet, a picture of a young man fell out. Boris asked who the man in the picture was, and learned that he was her 26-year-old only son. He thought that what the woman said next exemplified our discussion: she was the only worker and provider at home and she was tired, very tired. Her husband had been unemployed for the last 2 or 3 years, and her son had just decided to leave home to live with a girlfriend of whom she disapproved. At the end of the consultation Boris felt a strong need to help the woman, and at the same time, felt powerless to do so. He was quite sure she would not take the medication he had prescribed. He also felt frustrated that he did not have enough time to spend with her. He asked us for suggestions about how to help.

Ofira was delighted with this story; she remembered Boris' fears and difficulties in integrating psychosocial issues into clinical reasoning during his first year of residency. She felt encouraged to tell him so and pointed out his progress, specifically how he had asked for the identity of the man in the photograph. His question elicited an emotional response and opened the family issue, which might be the crucial one for her headaches.

We also had the opportunity to deal with his feelings of impotence, which were based on an assumption that he must give her a "medical" treatment for her symptoms, despite the fact that she had already received all kinds of pills. We could also see that his feelings of helplessness came from his compassion for her. We showed him that just being present for her, and listening to her story could be a powerful medical treatment and we suggested that he had given her help. We also used this case to empathize with the huge amount of information residents need to process about new patients (many of whom had come

just to see the new doctor), and their fear of making mistakes. We felt that listening to the residents' stories about beginning work in a new clinic was a parallel process and could serve as a model for empathic listening with patients.

The seventh session was on aging, on facing death, and on the death of the spouse as one of the most important health risk factors. We noted the special needs of the aging patient, reiterating the main characteristics of family practice: continuous, comprehensive, and coordinated care, and how greatly needed they are in geriatric care. Residents told stories about their grandparents and we ended our session with a shared feeling of being part of a big family.

The next two sessions were on models of family functioning. We elicited ideas about the characteristics of healthy families and the overt and the covert signs of dysfunction. We relied on Rakel's *Textbook of Family Medicine* (1984), which unfortunately no longer includes the models and characteristics of each phase of the family life cycle. The Circumplex Model of family functioning was somewhat difficult to teach, but it provided the opportunity to talk about cohesion in families, enmeshment or disengagement, rigidity or chaos, and rules and coalitions (Olson, Sprenkle, & Russell, 1979). It turned out to be difficult to discuss these theoretical issues, since residents expressed greater concern about misdiagnosing coronary heart disease in a clear case of panic disorder.

For the discussion of Smilkstein's psychosocial stressful life events, we presented the case of a newly divorced computer director who had relocated after divorce (Smilkstein, 1995). The residents asked to role-play a similar situation, and one of the trainees played the stubborn patient solely concerned with his symptoms of panic disorder. At the end of the session, Boris remained with Ofira and Andre for another 15 minutes. The role-play reminded

him of a female patient of his, a woman with panic disorder. We worked together, helping him understand her and giving him tips to manage her care.

Families' assessment tools and support systems were the topic of the tenth session. We were again faithful to Smilkstein's APGAR and SCREEEM model (Smilkstein, 1978, 1980), but also taught Kobosa, Maddi, and Kahn (1982) and Antonovsky (1987). The class was especially interested in stress management and prevention. They all felt stressed by their residency. They felt out of control, did not have a strong feeling of commitment to the HMO they were linked to, and had not yet developed a commitment to their patients. Most of them were still in hospital training, and the challenges of primary care were, as yet, remote. They felt lost; they did not understand the connection between their learning and their future, and it was left to us to make that connection and to show how theories turn into practice. We asked two residents to bring family problems from their own clinics so that we could consider them along the lines of the theories we discussed in class. Joseph presented one of his difficult patients. His presentation was well organized as he went through the family genogram, the connections between family members, and implications for the patient's symptoms and health behavior. All the residents were very involved in the story and we could feel their interest and integration of the learned material. Ofira and Andre exchanged looks of satisfaction.

For the next session, we wanted to reach a synthesis of all the material learned, and chose an article by Cole-Kelly and Seaburn (1999) on the five areas of questioning to promote a family-oriented approach to primary care. We were quite astonished when we realized that all the residents had read it. This article truly attracted them—they found the five questions logical and inevitable, but did not feel able to integrate them easily into the interviews.

Particular attention was devoted to the question of how to elicit patients' and families' explanatory models and health beliefs after one of the residents divulged that her mother and sister performed many ceremonies to protect themselves from the evil eye. The fact that her eldest daughter was about to be a doctor did not change any of the mother's rituals, although she felt ashamed of them. However, she did not tell her doctors about these rituals—she did not believe in her doctors and did not take the medication they prescribed. We were grateful to this doctor for sharing her secret with us, and agreed that in order for her to be a better doctor and understand the mother, we had to explore this area and make her feel comfortable with herself and her beliefs. Boris had problems in assimilating these questions in his day-to-day medical history taking, and found it very difficult to ask his patients the question on recent changes in their family. How could it be related to their symptoms? Do family changes generate symptoms? How can one make patients understand that their symptoms are "all in their heads?"

In the twelfth and final session, Boris described a patient who was a problem for him. He was over-visited by Rebecca, a wealthy, beautiful 74-year-old lady, who had pain all over her body and suffered from several other functional somatic symptoms. She herself had even suggested that her symptoms were a consequence of insomnia and stress over her husband's increasing sexual demands. She said he wanted her sexually every other night and they spent hours quarreling over it. Boris did a good job describing the family genogram and the connections between the family members. It was obvious to all of us that she had formed a coalition with her oldest daughter who lived nearby, and who was herself clearly dissatisfied with her marriage to an unemployed man. We could see how the intergenerational coalitions affected this family. Boris did not have

much information on the husband, since Rebecca would not allow Boris to invite him to talk about their problem. Boris felt trapped. All the medications he prescribed either did not seem to help or created new symptoms that called for more visits.

We tried to understand the behavior of her 80-year-old husband and his great interest in sex. We ventured the possibility that he might be at the early stages of Alzheimer's disease, characterized by release of inhibitions. Boris reacted to this by suggesting a mini mental test. But then his face lit up, and he felt "a stroke of magic" when we suggested that the husband might simply be jealous or reacting to feelings of rejection. Boris then told us a story that Rebecca had told him about a friend of hers, who spent long evenings at their home playing cards. Rebecca had mentioned that he was a very nice man, behaved very politely toward her, and that the two of them had quite a lot of common interests.

We could now hypothesize that she might exhibit some narcissistic and histrionic personality traits, perhaps living in a vicious cycle of seduction and rejection. We also suggested to Boris that he himself might be a "victim" of her seduction and trapped in her net. He then told us that at her behest, he had twice escorted her home after work, something he had never done with any other patient. He just could not refuse her, after she had disclosed such intimate descriptions of the sexual assaults by her husband. Boris felt very confused by her, totally out of control emotionally, and relieved in presenting this to the class.

We discussed establishing healthy, professional boundaries and regaining control without evoking feelings of rejection in her. Boris was able to recognize the unconscious ways in which she had used her symptoms ("being terribly ill") to reject her husband and to open the hearts of special people—her doctor, for instance. With the help of all participants he then

worked out a plan of seeing her once a week for a limited time. During these sessions he would listen to her but also set boundaries. We also suggested that one of his future objectives might be to have the husband join them, or refer the two of them to couple therapy with the clinic social worker. It is never too late.

The residents wanted to continue discussion of some of their difficult families. We chose one, leaving the last half-hour to receive feedback on the course. The feedback pleased us. They were very grateful, and felt that the course had theoretical and practical implications for their work. They felt more at ease when talking to patients about their families and felt that they better understood how to provide support during times of illness. They used the genogram as a diagnostic tool, as they would a laboratory test or X-ray. Boris reported that he was more ready to receive and to elicit his patients' stories and would not hesitate to trace genograms in those cases when he must deepen his knowledge of the family. He felt more at ease when asking questions that were not "strictly medical."

Ofira smiled in satisfaction with his progress. She had met him 2 years earlier, at the beginning of his residency. He was then a newcomer medical doctor from Russia, with very limited educational exposure to psychosocial issues. At the beginning of our course he was especially concerned with the clinical issues of accompanying a person through life. By the last session he felt at ease to the point of talking about his confusion with some patients, and of his occasionally feeling out of control of his emotions. He could then understand healthy boundaries and how to achieve them professionally and regain control, without evoking feelings of rejection. We felt that the course had provided him with the appropriate keys to open the doors and hearts of his patients and of himself.

One year after the course we met with him again to ask him to comment on this

article. He had just passed the board examination and was now a specialist in Family Medicine, dealing with a little boredom after the intense preparation for the examination. After the first moments of astonishment, he was very satisfied and proud to be our central figure, had no changes to make, and supported our wish to publish it by reassuring us that when reading it, new insights came to his mind. But, this is another story....

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