FAMILY SYSTEMS THEORY, PHYSICAL HEALTH AND ILLNESS

Family Systems Theory, Physical Health and Illness

Many patients seeking a therapist's assistance with their emotional distress also have a wide variety of physical complications, such as fibromyalgia, Parkinson's, cancer, asthma, M.S., etc. A question is how to incorporate with the therapy process the awareness of these physical concerns. Thinking about how these connections work is still very much alive, with a long and often barbaric history. Treating the body to improve emotional and cognitive functioning was in vogue in much of the 19th and 20th centuries. For example, purging the body was a practice to treat melancholy (Abraham Lincoln). Castration and other sterilization methods were an early 20th century practice to cure aggression, epilepsy, "mental disease," and "feeblemindedness."* Prefrontal lobotomies were being recommended by leading psychiatrists as recently as the 1950s. Yearly refinements in ECT are predictably reported. Classification systems reflect efforts to label and conceptualize the mind/body symptoms—from psychosomatic to the current "functional somatic syndrome."

From the other side, there are theories that focus on the use of psychotherapy for treating physical symptoms and diseases, such as cancer, "fibromyalgia," and for an extreme example pruritis ani. A more moderate approach recommends support groups for patients with certain illnesses, which still assume that emotions are contributing to the "cause" of the illness. There is still some lingering thinking that the physical symptoms are "all in your head."

Much of the above is driven by and the search for linear reasoning; that the illness or problem is *caused* by one (whatever), and if this cause is addressed the problem will disappear. Much of the drug industry is characterized by such cause/effect thinking. One can always avoid asking about long-term effects of a medicine by issuing a black box label.

* In North Carolina between 1929 and 1973, over 7,600 people were sterilized for these causes.

How does the clinician think about these issues? When does one step into A causes B assumptions? When does the clinician shift from a focus of *managing* of what is on one's plate to a focus of what is on the plate?

In March 1985 Dr. Bowen was invited to do a one-day conference in Massachusetts on "a family systems approach to physical health and illness." Two letters are included, one explaining to the conference organizers how he would structure the sessions, and his thinking behind his efforts (January 30, 1985). A second letter is to a conference sponsor and Georgetown student in response to the conference; what he did, his thinking about it, and how the audience reacted (March 26, 1985).

A third letter is this section is a letter from Dr. Bowen responding to a colleague who has been recently diagnosed with a melanoma cancer (March 14, 1981). Where does one direct one's efforts to when there is no "solution?"

4903 DeRussey Pkwy
Chevy Chase, MD 20815
January 30, 1985

Dear

I will be doing my best to make March 1, 1985 into a significant day for those who attend the meeting. From Georgetown you will receive a bibliography, a biography, and a photograph.

The overall format will focus on "A Family Systems Approach to Physical Health and Illness". The development of somatic symptoms is an extension of the broader aspects of human adaptation as defined by Family Systems Theory. Through knowledge of the variables in theory, the physical symptom appears as part of the total configuration. The best in Family Systems Therapy requires that the therapist know the family as a multidimensional system, that he/she respect the medical consequences of the symptom, and that he never lose sight of the fact that the family plays a part in most situations of health and illness. When family pressure can be modified, the patient does better and chronicity is often avoided. There are numerous subtle points between the usual orientation of medicine, the different orientation of family systems thinking, and helping the patient make responsible decisions about the difference.

The first session might be titled, "Family Systems Theory and Somatic Problems". It will involve a lecture type presentation with chalkboard diagrams. It will involve the total family configuration, the individual development of physical illness as part of the whole, and ways the family can alleviate the dysfunction in the patient.

The second session might be titled, "The Function of the Family Therapist in Families with Somatic Problems". It will include about ½ hr on the role of the therapist, followed by a long period of discussion with the audience about the entire morning.

The third session with be a videotaped demonstration. It might be titled "Videotape Presentation". Introduction of the tape plus the tape itself, will take too much time for much discussion.

The fourth session can be the longest. A title might be "Summary and Discussion of the Day with the Audience". We can decide on written comments and questions at the time. Written comments provide additional latitude for focusing on broad issues, including those made too brief during the day. Second thought—the third

session could more accurately be called *"Video Presentation of Family Therapy"*. Theory is absolutely necessary for good therapy but people are usually more interested in therapy. Discussion of the 3rd session could take up much of the time for the 4th session.

My goal is to present voluminous material in a single day, and to make it interesting and informative to all levels of clinical expertise. The audience usually wants more time than the program permits. If your schedule allows flexibility, I can start early, reduce the time for lunch, and go later.

The only audiovisual aids I will need are a large chalkboard, a clip on microphone which can move about when I do, and equipment for a ½ inch VHS videotape. I do not use xeroxed "hand-outs for broad subjects such as this. People are inclined to read it and act as if they know the detail. My effort is more to stimulate life long inquiry than suggest answers for complex issues. You may xerox any of the bibliography you wish.

The Continuing Education form you sent has been the difficult part that has delayed this letter. In my 30 years of working at this, I have never been as concise as I would like, or to pretend to know the final word in anything. When I am trying to raise the issues rather than provide answers it collides with the specificity of CE programs. I have completed the outline on the CE page, but I would like you to simplify it with comments from this letter. The March 1 meeting should be as helpful to those who have already wrestled with the problems of physical illness, as it will be in providing new vistas for those less familiar with the problem.

I expect to arrive at the Boston airport the early evening of February 28, and to leave for Washington the early evening of Friday March 1, 1985. I will be in contact with Dr.   about final travel and lodging arrangements.

Sincerely yours,

Murray Bowen, M.D.

March 26, 1985

Dr
Lynn, Massachusetts

Dear

Your letter provided some good feedback on the recent mtg. It sounds like you have been dealing with questions pretty well.

The session I did with the family with MS was not a typical interview by anyone's imagination. MS is not that kind of an illness. A goodly percentage of physical illnesses are more determined by psychological or emotional malfunction, and psychotherapy can be effective in relieving, or even alleviating the problem. Not so with MS, as far as we know.

MS appears to be a neurological degenerative disease, more genetically determined, that leaves the thinking system relatively intact, and that follows its lifelong slow progress toward oblivion. I started my experience with Multiple Sclerosis over 40 yrs ago, and I have never modified the inexorable progress of the process with anything called psychotherapy. IT IS COMPLETELY DIFFERENT FROM THE MAIN STREAM OF PSYCHOLOGICAL PROBLEMS. The main stream can be modified to a degree by psychotherapy. NOT MS. I tried hard in Topeka some 40 yrs ago, with the focus on the patient. MS marched on. I tried again at NIMH, with the focus on the family. MS marched on. I hoped that psychotherapy might make the disease process slow down. I never found positive evidence for this. Most MS slows down all by itself anyway, while the basic process marches on.

Most of your questions come from people who view MS in the same category as all other physical illnesses. IT IS NOT. At the meeting, there was one "on point" question about continuing family sessions, an "on target"question from a "far out" viewpoint.

MS might well be THE ONE DISEASE, with the clearest distinction between the soma and the sesorium. The soma is not reversed. The patient knows and accepts that WHILE family feelings boil. If the HOPE gets too extreme, in the family, or in family therapists (your mtg was pretty much in that bag), the patient can go into a clown like, rose colored silliness, about life. It befuddles everyone. Denial is extreme.

Someday we will understand MS, Huntington's Chorea, hemophilia, and all those other inexorable conditions. The patient knows and respects the process. I could go on and on, but I won't. My session with the family with MS was COMPLETELY DIFFERENT from what I would ordinarily do with the big bulk of physical problems. The patient is FACTUAL and beyond hurt. I merely tried to use my imperfect knowledge to help the family, and the audience to relate to "what is". With another problem I might have been quite different. Your audience could not hear. Suggest they get into simple problems like schizophrenia and cancer.

It is fortuitous that 2 days before your mtg, we had done a session on MS and ALS at Georgetown. ALS (Antero Lateral Sclerosis) is sort of like MS, except ALS runs its course in 3 to 5 yrs. It is kinder and quicker. Maybe your audience was fortunate in being bathed in MS, when they are still young.

Have to go before this page runs out. Thanks much for your letter.

Sincerely,
Murray Bowen, M.D.

4903 DeRussey Parkway
Chevy Chase, Md. 20015
March 14, 1981

Dear

There have been a few hundred thoughts about you in these weeks since your telephone call and the last letters. I enclose a thing about radiation therapy for a Sunday supplement a couple of weeks ago. You may have seen it if the L.A. papers have a Parade Magazine supplement on Sunday.

Another story. I am currently seeing a Professor of Oncology whose marital problems began a couple of years ago. His work situation played a part in it. In medical school he was excited about the future of Molecular Medicine. He went all the way. There was an exciting 10 or 15 years in which leukemia and other forms of childhood "cancer" was apparently conquered. Now that field has "leveled off". Now the field has moved toward long term rehabilitation and long term relationships. He says he is so tired of being "father" to so many, he is ready to give it up. In addition, he is being "torn apart" by those who relapse and die in early adulthood. The percentage on this is low but when it does happen, he and his wife react as if this was their own child. Maybe I can help them to the point they can do better with the "rehabilitation" and react less to those who die years later. First time I have had experience with a high level physician who has been on the firing line so long.

As I know it, melanoma is one of those borderline things with cells that respond to a combination of chemotherapy and radiation. It is sort of like Hodgkin's and retinoblastoma, if I know it. Now the cure rate with Hodgkin's is as good as leukemia and and enucleation of eyes is no longer automatic with retinoblastoma. Your melanoma might be one that is not going to melt away but the total field is hopeful and the percentages get better each year. From your standpoint, you have the responsibility of coaxing your body to do all it can to reject the melanoma cells.

I think it is healthy to have more urgent projects than you can complete in a lifetime. That was one of the things I liked about . He had a lung cancer with an estimated 100% mortality rate. He refused palliative treatment lest it mess up his head and prevent him completing his book. He was asking for just another month, and another month, etc, to complete the book. He made that book, plus another two books before he died of heart complications abut 2½ yrs later. I think it was his goal directed energy that put his cancer in abeyance. Others cannot do it the way did but I think that somewhere there is an "easy does it" way to help the body deal with cancer cells.

I will be thinking about you and pulling for you.

For now,

Murray Bowen