MEETING THE BIOPSYCHOSOCIAL HEALTH CARE NEEDS OF INDIVIDUALS AND FAMILIES PRESENTING TO THEIR FAMILY PHYSICIAN: A PHYSICIAN-SOCIAL WORKER ATTACHMENT PROJECT

BY

SHARON J. GOODYEAR

A Practicum Submitted to the Faculty of Graduate Studies
of the University of Manitoba in Partial Fulfillment
of the Requirements of the Degree of

MASTER OF SOCIAL WORK

WINNIPEG, MANITOBA

SEPTEMBER 1988

ISBN 0-315-54810-X

MEETING THE BIOPSYCHOSOCIAL HEALTH CARE NEEDS OF INDIVIDUALS AND FAMILIES PRESENTING TO THEIR FAMILY PHYSICIAN: A PHYSICIAN-SOCIAL WORKER ATTACHMENT PROJECT

BY

SHARON J. GOODYEAR

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

ACKNOWLEDGEMENTS

There were many persons who affected and greatly enriched the writing of this paper. My committee members, Dr. Kathryn McCannell, Professor Garry Grams and Dr. Barry Trute gently guided my learning through their teachings, supervision and support.

Doctors Glanzberg and MacDonald not only provided an opportuntity for this project to take place but were a pleasure to work with.

Dr. Dave Freeman challenged my thinking and encouraged my curiousity about human nature and the family, as a positive unit for change.

A warm thank-you to all.

Most importantly, I wish to thank my husband, Mitch, whose love, support and strength I drew on immeasurably over the past year; and my two sons, Shane and Tyler, who each day renew my appreciation of and belief in families.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Harmony comes from the ability of the various members of a whole to fulfill their roles, respect the other members, and be aware of their interdependence.

Anonymous

Building family strengths has always been an aim of the helping professions. Although the methodologies and techniques of working with families have undergone many changes throughout the years, the commitment to the healthy functioning of the family unit is unaltered and universal. Today, with the concern for comprehensive health care for the family, family medicine and social work are in increasing contact with each other (Candib & Glenn, 1983). Both disciplines have in common a desire to help others. Both place the family in the center of treatment. The family not only strongly influences the psychosocial well-being of its members but is the primary social context in which illness occurs (Yates, 1985).

The interrelatedness of health and the family has long been a concern of medicine and social work alike. There is a considerable volume of literature that demonstrates how important the family is to the individual's health. Additionally, there is supportive evidence showing a strong relationship between family function and health. "It is currently held that health and the family form a dynamic interrelationship with a change in one profoundly affecting the other" (Yates, 1985, p.7).

Problems encountered in family medicine are often assessed as being psychosocial in nature. Family physicians, however, do not always have the necessary time, orientation or expertise to effectively deal with these problems (Christie-Seely, 1981; Burbidge, Spasoff & Steel, 1982). Physicians tend to follow a biomedical model which focuses firstly on the disease and secondly on the individual (Engel, 1969; Fabrega, 1975). In addition, studies have shown that the general public sees only a limited role for the physician in the actual management of psychological difficulties (Geyman, 1982). Yet, family physicians are often found to be the primary resource for their patients' mental health problems (Mechanic, 1980; D'Arcy & Schmitz, 1981). This appears to be a result of the paucity of accessible professional counselling services, the stigma attached to those services, and the highly trusting patient - physician relationship.

Social workers, alternatively, do not always incorporate biomedical concerns into their practice. In their involvement with the psychosocial concerns a situation is presenting the social worker often forgets to give consideration to the physical aspects unless there is an extremely evident medical problem (Goldberg, 1973). This may be a result of the lack of interdisciplinary training between the two professions as well as their two differing models of practice -- psychosocial vs biomedical.

In my graduate year, however, I had the opportunity to participate in an attachment scheme which placed a masters level student of social work in collaborative practice with two private family physicians in Vancouver, British Columbia. This project, under the joint auspices of the University of British Columbia's School of Social Work and the Department of Family Practice, began in 1984 with the initial affiliation of a social work student with the two family physicians mentioned (Yates, 1985). At that time the social worker researched the project to examine the types of patient problems presented, the impact of the counselling service delivered to the patients and the usefulness of interprofessional collaboration to the family physicians. In 1985 - 1986 the attachment scheme was further explored by examining the obstacles which stood in the way of physician - social worker collaboration (Madigan, 1986).

During my nine month attachment to this project I researched and explored the utility of the biopsychosocial model in providing comprehensive primary health care. To this end I was referred for counselling those patients and their families assessed as experiencing problems psychosocial in nature. Regular consultations between the physicians and myself took place looking at the interrelationship between psychosocial and medical concerns, the referral process and interprofessional collaboration. Feedback from the client system was accumulated concerning their experience of the usefulness of this comprehensive system of health care.

This practium report looks at the experience from the doctors', patients' and social worker's perspectives. It further examines the usefulness of the biopsychosocial model in providing a more comprehensive system of health care.

The intent of this paper is to integrate relevant literature, research and theory with my practicum experience. Thus, Chapter 1 of this report begins with the problem under study: how to meet the biopsychosocial needs of individuals and families presenting to their family doctor. This problem is further explored in Chapter 1 through the literature review. Chapter 2 of the report then discusses this particular practicum experience and presents case illustrations. The final chapter is devoted to a discussion of implications for the fields of medicine and social work alike.

THE PROBLEM

There has been much written about the high prevalence of emotional problems amongst patients presenting in primary care settings (Coleman & Patrick 1978; Goldstein, Snope & McGreehan, 1980; Mechanic, 1980). Such problems often accompany disease or may be the primary concern frequently expressed indirectly through physical complaints.

As early as 1907, Dr. Cabot noted that 47 percent of medical patients had recorded diagnoses of psychiatric problems (Stoekle, Zola & Davidson, 1964). In a 1964 study by Zola and Davidson it was found that 80 percent of the patients attending the medical clinic reported psychological distress. Such distress was considered significant in their decision to seek medical aid. Further evidence of the large quantity of psychosocial problems in medicine was found through a questionnaire survey of family physicians in Washington State. Smith, Anderson and Masuda (1974) report that the responding physicians estimated that up to 30 percent of their patients had significant emotional problems of some sort. Another investigator, Fisher (1975), reached similar conclusions regarding the high prevalence of psychosocial concerns

in family practice. In reviewing the nature of the problems presented to general practitioners in the United States, Fisher discovered that 70 percent had physical problems compounded by social or emotional concerns. Due to the differences in classifying psychological and social problems the estimates concerning the extent to which psychosocial issues impinge on health vary widely. The estimates do reflect, however, the widespread agreement that social problems and psychological disorders are pervasive throughout the family physician's practice.

Although family physicians are frequently seen as resources for psychosocial difficulties, they do not have the necessary training, orientation, expertise or time to effectively cope with this large demand (Mechanic, 1980). A medical consultation typically lasts from six to ten minutes and the life problem may well be treated as an organic complaint, often through the prescription of drugs (Rowland & Irving, 1984). With the increasing developments in medical technology, physicians have before them a large task in acquiring and maintaining expertise in their specialty. Of concern is the viability in increasing the scope of the physicians's role to include managing psychological and social problems. While essential that family physicians see beyond the cause and effect nature of illness to include the mind, body and social components related to health and disease is it realistic to expect the primary care physician to deal with these problems? Mechanic (1980) suggests that is is unlikely that the functional demands of the

family physicians' practice allows for more than the ability to recognize the existence of psychosocial problems and to work with other professionals to resolve them. Likewise, Engel (1969), sees the role of the physician as including a general competence in the area of psychosocial concerns while relying on ancilliary disciplines for expertise in these matters.

The current system of health care supports a rerouting of patients with emotional problems to other sources of assistance, primarily psychiatric. In implementing this system the connections between symptoms associated with organic concerns and those associated with psychosocial concerns become lost. As well, it has been shown that patients rerouted to other helping professions typically do not follow through with the referral process (France, Weddingon and Houpt, 1978). Rerouting of patients primarily to the field of psychiatry poses other concerns including: length of waiting list for psychiatric services, stigma attached to those services, and appropriateness of service when the presenting problem is nonpsychiatric in nature. Additionally, studies have reported that the prevalence of patients diagnosed as experiencing a psychiatric disorder is significantly less than those with ordinary problems of living (Houpt, Orleans, George and Brodie, 1980). Mechanic (1980) points out that studies of the content of primary care suggest that psychotic disorders are relatively uncommon but 10 to 15 percent of

all patients are seen to suffer from moderate depression and anxiety. In evaluating the source of such problems, family physicians attributed them mostly to family life and occupational difficulties - yet referals to social services were negligible.

If primary health care is conceptualized as being a comprehensive service delivery system designed to respond to the biological, psychological, and social well-being of individuals and their families then optimal treatment involves a combination of biological, psychological and social interventions (Abroms, 1983). The problem remains, then, how best to meet the biopsychosocial needs of individuals and families presenting to their primary care physician.

LITERATURE REVIEW

The changing definition of illness

Of significant development in medicine today is a reexamination of the biomedical model of disease that has dominated western society for more than one hundred years (Engel, 1977; Kriesel & Rosenthal, 1986). The biomedical model seeks cause and effect singular solutions for complex phenomena predicating itself on a reductionistic view of reality. It assumes disease to be fully accounted for through an examination of organic variables (Engel, 1977). Thus the biomedical model leaves no room for a relationship between psychological, social and behavioral considerations and illness, demanding that disease be dealt with independent of its social context. In fact, since disease is considered only in relationship to the physical being, the medical model embraces mind - body dualism and demands that all behavioural aberrations be explained at the chemical and neurophysiological level. What cannot be explained though somatic processes is not considered a disease.

Since sickness is not desired, is socially disruptive and individually upsetting, we have exerted a tremendous effort in

understanding the cause of its occurrence. As a society we seem to have accepted the biomedical model not only for its scientific investigation of disease but for its very perspective about disease. To this end we have placed the physician in a highly revered position. In searching for cause and effect solutions to this undesirable phenomena we seem to believe that many of life's problems have a medical, biological explanation. The resultant effect of this perspective is its focus on the individual separate from all social context. In fact the patient ultimately becomes secondary to the disease.

The success and limitation of the current approach to health, predicated as it is on the biomedical model, is a subject of great controversy. The biomedical model has been inordinately successful in its treatment of illness (Fabrega, 1974). Today, we often read about miraculous medical discoveries and treatments unimaginable even a short time ago. With the proliferation of medical specialties in the 1960's, medicine has become even more technological, winning many battles over diseases and transforming the lives of many people suffering with crippling, chronic and often fatal illnesses.

However, there has much written about the central flaw of the model: its failure to recognize the person as a whole or to incorporate data of a psychological or social nature (Engel, 1977; 1980). The reductionistic and dualistic requirements of the medical model insist that all information first be reduced to biochemical deviations before it has meaning. The neglect of the whole

inherent in the reductionism of this model is largely responsible for the physician's preoccupation with disease and the corresponding disregard of the personhood of the patient. Society's scientific control of disease has also created new problems, an obvious one being an increased and aged population.

Many of the issues in contemporary medical care are outgrowths of the systems's noninclusive definition of disease. Studies have articulated that in neglecting the psychological and social aspects of illness and patient care there has been growing public dissatisfaction with the way health care is provided (Fabrega, 1975). People expect medicine to be socially orientated. Traditionally, we have utilized physicians and not other helping professionals as our general consultants, alluding to other concerns during the course of our appointments and revealing problems psychosocial in nature in roundabout ways.

In the 1960's a countermovement began against the specializing tendency and impersonality of biomedicine. The field of family medicine emerged to provide a more comprehensive approach to health care reflected by their policy statement: "the family physician is educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing comprehensive health maintenance and medical care to the

entire family regardless of sex, age, or type of problem, be it biological, behavioral or social" (Fosson, Elam, & Broaddus, 1982, p. 461).

Since its beginning as a speciality, family medicine has aspired to practice a biopsychosocial appraoch to health care. There is a profound epistemological difference between the orientation of the medicine just described and biomedicine (Doherty & Baird, 1983). Family medicine rests in the belief that the family--its history, function, development and structure is vitally connected to the most basic health concerns (Dym & Berman, 1985). The value of this model has been articulated by research studies which have shown that a significant percent of patient visits to primary care physicians include a primary or secondary psychosocial ailment (Williamson,Beitman & Katon,1981). As well, it has been well substantiated that the majority of patients with mental illnesses are treated by primary care physicians and not psychiatrists which may have been expected. Such patients utilize approximately twice the amount of non-psychiatric medical care as patients without these problems (Williamson, Beitman & Katon, 1981).

Engel (1980) and Fabrega (1975) discuss a model of health care which stresses the need to integrate biological, psychological and social concerns in the everyday medical care of patients and families. Engel (1977) sees the challenge of medicine as needing to broaden its conceptualization of disease to include the

intrapersonal and interpersonal dimensions of illness without sacrificing the proven utility of the biomedical model. To provide a basis for understanding the causal nature of disease and defining treatment for such, he puts forth that the medical model must also take into account the personhood of the patient; that is the patient, the patient's ecosystem, and larger systems such as the patient's physician and health care system. Thus the wholeness of the patient is intrinsically connected to health and impinges upon every episode of illness and every doctor - patient encounter.

Fabrega (1975) holds that an expanded model of disease which examines the relationship between disease, social behaviour and human adaptation is necessary. By offering a framework for understanding the relatedness between disease and social systems such a model could be utilized to examine contemporary issues including the organization and practice of medicine as well as its relationships with other systems.

A systems perspective

As early as 1945, Richardson, in reporting on an innovative study concerning the interrelatedness between illness and family wrote:

> The idea of disease as an entity which is limited to one person and can be transmitted to another fades into the background and disease becomes an integral part of the continuous process of living. The family is a unit of illness, because it is the unit of living.
>
> (Richardson, as quoted in Dym & Berman, 1985, p.22)

Thirty years later, Engel (1977) advocated for a scientific model which would take into account the missing dimensions of the biomedical model. He called this framework the biopsychosocial model of illness.

The vision of health care put forth by Richardson and Engel goes beyond the need for a more humanistic health care system. They question basic assumptions about what constitutes disease and how best to treat it. They are part of a growing attempt to apply systems concepts to the understanding of illness.

With the development of general systems theory (von Bertalanffy, 1956) and the integration of psychological and social concerns to the epistemology of family medicine, a radical shift of thinking in the medical world took place. This effort is represented through the development of Family Practice Medicine, a

specialty field grounded in the belief that family dynamics and physical health are most significantly interconnected, with a change in one greatly affecting the other. Family medicine shifts the treatment focus from the linear causal nature of disease towards viewing patients in terms of their contextual living ecology, the most primary one being the family unit.

General systems theory is a metatheory which promotes a way of looking at the world in terms of relatedness. It is a lens which organizes our perceptions as we seek to understand events through their interrelatedness. Systems theory examines entities in relation to what they affect and are affected by, rather than reducing the entity to its particular characteristics. In doing so it moves from linear, exclusive, analytic thought patterns to interactional, circular and inclusive thought (Schwartz, 1986). Thus a family physician, thinking systemically, would examine disease by considering its function and what it is a function of rather than solely reducing the disease to organic considerations. Such thinking attacks the basic boundaries and beliefs of biomedicine which regards disease as an entity in and of itself. The same disease greatly varies not only in its biological characteristics but in the way the patient experiences it and in the way families and professionals organize themselves around it. (Dym & Berman, 1985). The incorporation of systems principles in family medicine has underlined the relevance of pyschosocial issues in medical practice.

Family physicians, in conceptualizing disease systemically, utilize tenets presented by systems theory. General systems theory discusses the concept of nonsummativity which is the idea that the whole is greater than the sum of its parts. This concept suggests that all components of the system should be included to assess the total relational patterns and to affect change. A family physician working within a systemic framework can be compared to a technician with a zoom lens. The physician can reduce the area of study to examine the physical components of illness, but can also observe with a broader focus.

Systems theory posits that a change in one part of the system affects the system as a whole as well as its component parts. Every action in the change sequence is also seen as a reaction. Causality is thus seen as circular rather than linear. The finding, well documented in the literature and to be discussed at greater length later in this paper, that illness and the family are intrinsically linked and that a change in one vitally affects the other, truly comes to life when conceived through a systemic lens.

A natural living system is a whole that consists of interrelated and independent parts. It is a complex system consisting of all the levels of organization pertinent to the system. As in nature, organized systems are ordered on a

hierarchically arranged continuum with less complex smaller units subordinate to more complex larger units. Thus processes at a cellular level are subordinate to those at an organ level which are in turn subordinate to those at an individul or macro-ecological level (Engel, 1979). The individual is at the same time at the lowest level of the social hierarchy while at the highest level of the organismic hierarchy.

Each system, being organized at different levels, affects and is affected by each of the other levels (Schwartz, 1986). Hence each system, being a component of other systems is both a whole and a part, is functionally integrated and relatively independent while being interrelated with every other system (Buckley, 1967).

In general systems theory, living systems are bounded which allows for their autonomy and cohesive organization. These boundaries must be open to some extent to allow for the information and energy flow within and between component parts. The degree to which a system's boundaries are permeable determines in part its ability to adapt to new situations and to maintain a balance between its internal and external needs (Freeman, 1981). When considering the interrelatedness between the individual,

family system and health, one recognizes that the extent to which the system is open to new information and experiences helps determine its adaptive potential. Literature in family medicine abounds regarding the importance of permeating the boundaries of the family system such that the family can better adapt to the changes illness brings (Fabrega, 1975).

The structure, function and development of a system do not exist in static states but "are continuously played out in time through sequential actions in a social context that itself is evolving. Consequently, the patterns develop in ways that permit alterations in their structure without necessarily endangering the essential nature of the relationships in their system" (Aponte, 1976, p. 434). Systems work to establish themselves in a moving steady state as they respond to internal and external stressors. Such stressors may take place at a biological level such as viruses, pollutants, floods, and starvation or at a psychosocial level such as situational problems, transition points, and unexpected crises. The interactional patterns of behaviours that systems establish, albeit conscious or unconscious, are their way of coping with everyday living and this coping process is often unquestioned, highly valued, cultural and habitual. These patterns may or may not promote the health of the system or its ability to cope with change.

While undergoing changes, the system adjusts and adapts by altering its transactional patterns in an attempt to regain its steady state or equilibrium. Such a steady moving state may be maintained through the use of a number of homeostatic mechanisms, illness in a family member potentially being one such equilibrating mechanism (Bowen, 1976). The health of individuals and their families is sometimes a reflection of change, likewise, change in a family system is often a reflection of the chronic stress of illness.

Families maintain their steady state through recursive transactional patterns of behaviour. In a basic sense, the physician's attempts to do such things as influence people to take medicine, change everyday habits and modify their relations with others alter the very processes upon which family life is organized.

In presenting tenets consistent with all levels of analysis general systems theory allows for the use of a homogeneous conceptual framework when shifting frames of reference from one analytic level to another (Schwartz, 1986). The importance of multiple levels is a necessary and vital aspect of the systemic approach to illness. It is crucial to consider the many levels of illness from cellular to individual to community, from the biological through to the social systems.

For comprehensive health care to occur, it would seem necessary to have a model which would address the various levels; a model which would include all the levels of organization pertinent to health and disease; as well as a model which would focus on the relationship between these levels and not on entities in isolation. A more inclusive model of practice, advocated for by the field of family medicine and based on general systems theory is the biopsychosocial model. This model allows for a conceptual shift from one level of human reality to another, guiding the professional to the most effective working level.

The biopsychosocial model

Biopsychosocial health recognizes that good health is a product not only of good physical health but of good social health. As human beings we are cultural animals. We may become sick in body, in psyche, in both. Our physical and social being cannot be understood separately, rather they are to be evaluated as interdependent parts of a united whole. The systems oriented biopsychosocial model views health more broadly than usually conceptualized. It moves away from the reductionism and mind-body dualism perpetuated by the biomedical model. It replaces the linear thinking promoted by cause and effect diagnosis and treatment with reciprocal causal conceptualizations.

As espoused by systems theory, the biopsychosocial model conceptualizes health through the observation that, "nature is ordered as a hierarchically arranged continuum, with its more complex larger units superordinate to the less complex smaller units" (Engel, 1980, p. 537). Health and illness are, therefore, understood in terms of the relative autonomy and functioning of each component system at each hierarchical level of analysis. Thus the biopsychosocial model provides a framework for conceptualizing the intra- and interdependence of all natural systems from subatomic particles through molecules, cells, organs, the person, the family, the community and ultimately the biosphere.

The hierarchy of natural systems provides a guide to health care providers ultimately broadening perspectives whereby health providers from the outset consider all information in terms of system levels and possible usefulness of information from each level for the patient's further care. Overall health becomes understood in terms of a high level of intra- and intersystemic harmony. This harmony can be disrupted at any level. Congruent with general systems theory, the extent to which the resulting upset is maintained at the level at which it was initiated or whether other levels become greatly affected by the disruption is a function of the system's capacity to adapt to change.

Through a systemic lens one recognizes that each level in the hierarchy reflects an organized whole with distinctive properties and characteristics. Each system level exists in a specific frame of reference about which a high degree of consensus holds. Cell, organ, individual, and family require conceptual frameworks available to apply to each. Thus, the methods and rules utilized in studying cells are different than those applied to the study of the family. Similarly the methods utilized when identifying component parts of a system differ from those required to establish a system's wholeness.

When considering the hierarchy of natural systems it becomes evident that each system is at the same time a component of more complex larger systems. Hence, in the continuity of natural systems every unit is at the same time both a whole and a part. Cells are a component of tissues, organs and person. The individual is a component of the social hierarchy including family and community. Each system as a whole has its unique characteristics and organization; as a part it is a component of a higher-level system.

Appreciating the flow of the hierarchy underlines the significance of disruption at any system level for the intactness of other systems. One can readily visualize how events or circumstances at system levels above the person may in turn impinge on the person, and the implications for the stability of lower-level systems. The patient, therefore, is done a disservice when examined at any level exclusive of another. Ignoring the multiple levels of anaylysis will provide a potentially false and definitely skewed representation of illness. In Minuchin's words, "the region artificially segregated for study is in effect a creation of the investigator, for in reality it must always be part of a larger field, with which it interacts" (p.255, 1974). Such an inclusive approach considers all levels of organization that might possibly be important for immediate and long-term care.

When using a systemic framework the investigator recognizes that it is necessary to select one system level on which to focus or at least begin the work. For the family physician that system level is always the family. Thus the systemic physician does not limit his or her thinking to considering how the interrelationships between the biologic levels may contribute to illness. Of equal importance is how the illness may be affecting or might in the future affect the balance of other systems. The family systems

physician always has in mind the notion that the whole is more than the sum of its parts and that overall health is reflected by a high level of harmony within and between systems.

Biopsychosocial health considers not only the interrelationship between psyche and health but how such knowledge may be helpful in the patient's overall care. The patient's experience of illness is considered in relationship to the illness itself. And whether illness is cured or not, the model provides a framework for conceptualizing the impact of poor health not only for the patient but for the family and the community as well.

The biopsychosocial model can be shared by all who are involved in the care of the sick. In encompassing all the elements involved in health and disease, from the molecular to the pyschosocial, it provides professionals with a common conceptual framework. It is the systemic lens of the helping professional which promotes a way of thinking and organizing perceptions in terms of relatedness (Schwartz, 1986). The examination of health and illness in relation to the systems they affect and are affected by, rather than solely in relationship to particular characteristics, moves away from reductionistic linear thought to transactional thought. This examination broadens the field of enquiry and promotes the opportunity to think inclusively rather than exclusively when presented with a client system suffering from a health problem.

Adherence to a biopsychosocial model requires general competence for all health professionals in their ability to understand and assess the three levels of organization pertinent to health and disease - the biological, the psychological, and the social. Each level of organization requires equal attention. This posses many challenges and dilemmas for professionals involved in the health care system. Questions arise such as how can the biological, individual and interpersonal needs of our society best be met? What are the various roles of the different health professions in the care of the sick? How does the professional family interact in their efforts to provide optimal patient care? The remaining literature review will attempt to address these questions.

Family medicine and the biopsychosocial model

Since its beginning as a specialty family medicine has taken into account the biopsychosocial model of illness and has stressed the importance of integrating intra- and interpersonal factors in everyday health care (Geyman, 1982). The vision of health care held by family medicine is based on the belief that family dynamics are vitally connected to the most basic issues of physical health (Schmidt, 1978). "People's medical problems concern not only the

way their bodies function and malfunction but are also linked to vicissitudes of their social relationships and everyday lives" (Dym & Berman, 1985, p. 23).

The epistemological stance espoused by the field of family medicine, however, appears to differ from the functional reality of the physician's practice. In many family medicine practices and programs the individual rather than the family continues to be the focus of concern. Although most medical programs stress the relevance of whole person medicine the family as a system of health is not yet a primary concern (Christie-Seely, 1981). Thus despite the conceptual work in the field of family medicine attention to systems concepts remains only superficially applied. In fact not all residency programs include in their curriculum a behavioural component to address the interrationship between mind, body and social spheres. This leads to a situation where the physician is much more effective in diagnosing and managing organic problems than functional elements. For the biomedically trained physician judgements and decisions which affect their patients' lives commonly are made with a minimum of information about the persons and circumstances involved and with even less knowledge of the basic principles underlying intra- and interpersonal transactions. Such judgements largely rest on the physician's values, beliefs and intuitions rather than within the boundaries of behavioural sciences (Engel, 1980).

A recent survey by Cassata and Kirkman-Liff (1981), compared the practice habits of family physicians and other specialties. Both groups estimated that over one third of their patients had psychological or social problems as their fundamental diagnosis. Yet only two to four percent of their patient visits were for counselling or resulted in a referral to other professionals experienced in the area of psychosocial concerns.

While family medicine conceptualizes illness as a biopsychosocial process, the specialty does not appear to have integrated psychosocial concerns in its care of patients and families. As a result in many residency programs and family practices, the family unit may never be seen and as Geyman (1977) points out, there is a broad conceptual difference between caring for the individual as part of a family and seeing the family as the patient. He promotes a conceptual shift from the linear deterministic medical model with its individual focus to the cybernetic model where illness is seen as one piece of a much larger picture.

Despite accusations that humanism and empathy often go amiss in the technological medical world, one's family doctor is typically one's primary source of mental health care (Lee, 1974; Engel, 1977; Dym & Berman, 1985). It has previously been suggested that approximately one third of all patients who see their personal

doctor are experiencing a problem in daily living or a problem assessed as being more psychosocial in nature than organic. Psychosocial problems may accompany disease or they may be the primary problem frequently expressed indirectly through generalized complaints of poor health. Somatic illness (where emotional problems and psychosocial stress result in physical symptomatology) may be the only means available of seeking and receiving "care" from the health system.

In addition to their psychosocial problems, these patients tend to be high users of the medical system in general (Coleman & Patrick, 1978). In a series of studies of family practice in Great Britian and Wales from 1953 to 1981 a seven year follow-up showed a significant rate of chronicity and reoccurrence amongst those patients initially diagnosed as experiencing a psychological or interpersonal problem. These patients also showed a higher incidence of illness than the remaining patient population. The patient-physician consultation typically will last an average of six to ten minutes and problems are often treated as biological complaints (Winter & Whitfield, 1980). As a result, the condition being treated may become chronic, the problem of living unaltered, and visits to the physician increased. Apart from the obvious stress encountered by the patient system whose biopsychosocial needs are not being met, the health care system carries a huge

burden when one includes the general practitioners' time, pharmacists' salary, administration and packaging of unnecessary medication, hospitalization for those patients who have become drug dependent and the like.

When one considers the continuum of natural systems it becomes clear that families experiencing continuous anxiety from unrelieved problems of living or chronic illness are not only themselves at risk but can be a great disruption to their very community, culture and society.

Today's family physician is overloaded with expectations and responsibilities. They are expected to maintain current knowledge of technological advances in the medical world, be involved in patient education and management of health care, maintain a cost effective practice and be familiar with a wide variety of problems psychosocial in nature (Mechanic, 1980). The family physician faced with the multifaceted problems patients present is often limited in ability to effectively manage all levels of organization pertinent to health and disease. Some of these limits are a reflection of their medical training with its emphasis on biological concerns. Others are reflected by the lack of time, training, knowledge of available community resources, and motivation the physician brings to the process (Burbidge, Spasoff, and Steel, 1982). With the functional reality of needing to see

six to seven patients per hour to cover overhead, as well as the importance of maintaining expertise in managing organic problems, it is perhaps more realistic to expect the primary physician to obtain a general proficiency in assessing and managing problems psychosocial in nature rather than specializing in the treatment of such concerns. This suggests that the biopsychosocial physician have a working knowlege of the principles, characteristics and language of each level of organization rather than be an expert in all. Such a process does not add to the physician's workload, rather the biopyschosocial process promotes a way of thinking and organizing perceptions that enables that physician to act consciously in areas now excluded from a rational approach.

The family physician is in a unique position to view the developmental life cycle of an entire family unit. This unique position provides an opportunity for the professional to observe the family's biological, individual and social health over time and therefore to see more directly the development of problems and dysfunctional arrangements affecting the family's welfare. The physician, equipped with a biopsychosocial framework has the opportunity for assessing individual and family troubles at an early stage in their development. The process of this assessment may involve any or all of the following:

1) convening the family for further assessment or counselling about the problem;

2) specific treatment by the family physician;
3) further medical tests;
4) consultation with a specialist in the identified problem area; and
5) referral to a specialist in the problem area.

Due to the high incidence of psychosocial problems in primary practice, the decision to treat or refer confronts the family physician daily. Many patients experiencing problems in daily living are often resistant to a psychosocial diagnosis and fail to follow through with referrals to ancilliary helping professions. In a study conducted by France, Weddingon and Houpt (1978) it was found that only 10 percent of the 137 patients studied completed referrals to a community mental health centre. However, 87 percent followed through on the physician's prescription for a psychotropic drug. Physicians also express reluctance to refer patients partly out of their fear of alienating or losing the patient and partly from their lack of familiarity and comfort with the services offered (Yates, 1985).

Given this situation, one logical and rational option in responding to the biopsychosocial needs of patients would be to provide psychosocial services within the family care setting by

social workers who have specialized in this area of concern. The inclusion of a social worker in family medicine is one method of offering comprehensive health care involving the physical intra- and interpersonal worlds of the patient. This method calls for the collaborative and smooth interaction of professionals in their joint concern for the overall health of the family system.

Social work and family medicine

Since the introduction of social workers into medical practice by Dr. Cabot in 1907, social workers have performed a variety of functions in the health arena (Greene, Kruse & Arthurs, 1985). Historically, social work's contribution to health care has been to emphasize the relationship between social health and disease and to explore the social conditions seen to impact health. It was the social worker who first framed the patient as a member of a social group under stress.

The social worker initially affiliated with the medical profession in a hospital setting. This affiliation has since expanded to include involvement with public health agencies, public assistance agencies, departments of health and welfare, and to some extent primary care (Yates, 1985). By virtue of their training and epistemology, social workers are specifically equipped to deal with many problems presented in family practice (Burbidge, Spasoff &

Steele, 1982; Rosenburg, 1983). Working with families has long been part of social work intervention. The field of social work has traditionally viewed the family and not the individual client as the focus of concern. The family is considered to be the primary teacher of the individual and of our culture. It is also the primary context in which illness occurs. "Besides its reproduction, socialization, physical and emotional development functions the family is also the most important social context in which illness occurs...how illness and the family interface has long been the concern of medicine and social work alike" (Yates, 1985, p. 7).

To accept the dynamic relationship between family and illness is to realize that effective interventions must address the biological, psychological and interpersonal spheres. The same illness varies greatly not only in physical characteristics but in the way the individual experiences it and in the way the family and larger systems organize themselves around it. Such an orientation to health care emphasizes the role of the individual's primary social environment, the family, in determining the etiology and treatment of most health problems.

The comprehensive treatment orientation held by family medicine is philosophically congruent with social work's long held concern

for the biopsychosocial needs of people. Social work and family medicine recognize the connectiveness between the physical, psychological and social dimensions of human well-being. The concept of biopsychosocial health as a component of biosocial development suggests that overall health care is not a matter to be solely administered by physicians alone (Greene, Kruse & Arthurs, 1985).

The rationale for the development of family practice social work is further supported by the findings that today's major health concerns in primary care are chronic illnesses and their consequences, as well as the growing number of psychological ailments, stress induced health problems, and social diseases (Rehr, 1982). Family physicians claim that the six most common psychosocial problems presented to them are: depression, anxiety, obesity, marital discord, alcohol abuse and sexual problems (Greene, Kruse & Arthurs, 1985). These problems are commonly presented to and treated by social workers in other settings.

Tessler, Mechanic and Dimond have found that "persons who are distressed, or who otherwise face life problems with which they have difficulty in coping, deal with such situations in part by seeking medical care" (1976, p. 354). Medicalizing these problems has proven to be ineffective in achieving good overall health for both the patient and their family. Physicians are not equipped to manage the social component of illness and since "cure" is not

available for many chronic illnesses and injuries, effective health care may need to be judged largely in terms of physical, psychological and social functioning versus disease alleviation (Rehr, 1984).

Corney (1980) sees a role for social workers in helping people adapt to changes in life style imposed by their illnesses. An illness in the family forces a family to reorganize to meet the demands of the illness and to incorporate a larger system, the health care system, into its own structure. The family may respond to the medical crisis in a number of ways. Social workers are trained to help others access their own resources, grieve losses and work through a change process.

It has been estimated that 50 to 85 percent of all illnesses are stress related (Greene, Kruse & Arthurs, 1985). People with such problems often receive the bulk of their treatment in primary practice settings in lieu of a hospital. Compton (1983) believes that social workers with their understanding and training in the field of psychosocial matters have much to offer these patients. That social work can effectively help patients with stress has been noted by one physician as being a time saver as well as providing a much needed service (Williams, 1979). This implies a possible area of specialization for social workers working with family practitioners in private practice.

Corney (1980) suggests that a broader portion of the community would be accessed with the inclusion of social workers in primary practice settings as compared to clients served by social service agencies. This contention has been supported by studies of referrals showing that patients are more likely to complete an in-house referral to a social worker on a health team than to follow through with outside referrals (France, Weddingon and Houpt, 1978). Another advantage to the physician - social worker attachment in the primary practice setting is the ability for both formal and informal consultations regarding the referral process and intervention to take place more regularly. This has been shown to provide for a more successful attachment (Corney, 1980; 1983; 1984).

The inclusion of a social worker on a health team has also been shown to improve the psychosocial well-being of patients. In a 1975 study by Cooper, Harwin, Delpa and Shepherd it was found that patients treated by the social worker - physician team significantly improved in social functioning as compared to a control group of patients who were seen by the physician alone.

The advent of social work practice in health care is not new -- either in hospitals or in community based settings. What is new is the development of a new specialty in medical care -- biopsychosocial family medicine whose framework is congruent with family

oriented social work practice. Social works prior involvement within the medical arena has predominantly been connected to the medical problem rather than the psychosocial ramifications of the problem. To this end the social worker has primarily been involved in patient counselling, liaison services, advocacy and discharge planning.

Family medicine allows for a broadening of the social worker's role in the health arena. Retaining the biopychosocial frame of reference promotes a family oriented focus for both the family physician and the social worker. As a result of a social worker - physician affiliation the patient is likely to receive preventative, remedial and more comprehensive treatment in the primary care setting.

Social work and family medicine - common concerns

This section looks at concerns especially relevant to both fields. These common concerns are family life cycle, issues relating to loss and the impact of long term illness on the family. The integration of these frameworks in this practicum experience is later presented through the case illustrations.

Family life cycle

Social work and family medicine have in common not only their systemic lens, biopsycholocial foundation and family focus but their developmental view. Both disciplines study the family over time. The family life cycle, with its developmental phases and "normative" crises provides a structure for emphasizing the family within general practice (Authier, 1978). The life cycle perspective frames problems within the context of the family's history, present tasks and future goals.

Due to the nature of the physician's involvement with a family unit, the physician is in a position to observe the family's organization, natural resources, patterns of individual and family functioning, and adaptability in a longitudinal way for many years. This allows the physician, aware of the interrelatedness between health and the family, to intervene at an early stage in the development of problematic family processes (Bauman & Grace, 1977).

Knowledge of the different developmental stages in the family life cycle with their corresponding developmental and emotional tasks, potential difficulties and setbacks is of concern to the physician and social worker alike. It is a valuable diagnostic tool which aids the helping professional in the task of assessing

family problems and developing effective intervention plans at an early stage of dysfunctional family transactions. It provides the social worker and physician with a common language in their efforts to address the complex health needs of families.

All families in the course of their development have to be able to adapt to changes occurring over time which are related to the growth, autonomy, and developmental needs of individual members. In the life cycle model the family is seen to pass through a sequence of stages from birth to death which involve experiences such as coupling, raising children, leaving home, aging and eventually the death of the elder generation in the ongoing evolution of the family system (Rhodes, 1980).

Each of these stages has clearly defined characteristics and developmental tasks through which the family and its members co-evolve. As well, the family's movement through these stages involves the experiences of many generations. Meyer (1980) holds that this intergenerational connection is perhaps the major context and determinant of individual developmental achievement. Conceptualizing the family unit as an evolutionary process recognizes that family problems are not isolated events. Rather, they are connected to the family history and the developmental issues to be worked through.

The life cycle approach to families provides a general overview of family life which may assist the family physician and social worker in providing for the biopsychosocial needs of their patients. The recognition of the importance of developmental stages presents a useful framework for the helping professional in his or her psychosocial assessment of the patient. Each stage presents to the clinician hypotheses relating to potential areas of family trouble. For example, Haley (1973) suggests that adolescent schizophrenia can be seen as an extreme way of attempting to cope with the separation tasks particular to a family with adolescents. By exploring the developmental history of the family, and by researching hypotheses derived from this framework, the physician may more readily understand the nature of the family problems.

The shift to each new developmental stage in the life cycle can be described as a crucial transition point for the family. Haley (1973) states that many families in trouble appear to be stuck at some transition point in the unfolding family life cycle. Hence, information concerning the different stages and transition points may prove to be quite fruitful for the physician. Even if a developmental issue is not a major part of the initial patient problem, the physician should be aware of the interplay between illness and the developmental needs of individual and family members. Leahey and Wright (1985) state that there are predictable points of family stress when there is a chronic illness

in the family. If a symptom of the chronic illness conflicts with a normal developmental milestone, or if a particular developmental task is not met or delayed due to illness, they see stress as predictable. For example, a family might cope quite well with a disabled child until the child is six and unable to enter the school system at the usual time.

The common language of the physician-social worker team offered through the developmental view emphasizes the process of normal development. Developmental tasks and crises are seen to be universal and repetitive (Scherz, 1971). This normative view of families may encourage patients assessed as experiencing problems psychosocial in nature to engage in the therapeutic process and to be less concerned about change in their family. The physician-social worker team are in a position to reframe problem situations as difficulties in achieving a shift in the roles, functions and responsibilities of family members as they seek to adapt to their current stage of development. The problem, therefore, presents the family with an opportunity to tap their resources and achieve a more effective level of functioning.

Many transitions whether developmental, situational (such as job loss, separation, divorce), anticipatory, or unpredictable, involve losses. How these losses are worked through affect not only the individual and family but subsequent generations (Jordan, 1987).

The following section discusses some of the issues relating to loss and some thinking about the collaborative physician-social worker's ability to effectively intervene in this area and in some cases provide preventative mental health work.

Issues related to loss

Over the past fifteen years health care professionals have shown an increased interest in better understanding the complex phenomena of grief (Worden, 1982). Bowlby (1980) holds that much psychiatric illness is an expression of pathological grieving. Additionally, the literature points to a relationship between unresolved grief and physical illness. Studies suggest that the bereaved suffer from more depressive symptoms and physical distress than the non-bereaved and are more likely to take drugs for symptom relief (Clayton, 1974). People often seek medical care without necessarily recognizing that there might be an issue of loss underlying their particular physical symptom (Worden, 1982).

Grief is a very complex issue experienced by people in many different ways. It has been compared to physical illness..."the loss of a loved one is pathologically traumatic to the same extent as being severely wounded or burned is physiologically traumatic"

(Worden, 1982, p. 10). Both grief and illness take time to heal. Both involve the emotional, social and physical realms.

Historically, it was the family, church and neighborhoods which provided a support system to help people cope with loss. Today's mobile society no longer promotes this sense of community nor is the extended family unit as immediately available. Therefore, people now turn to the health delivery system for support and care. Others who have not sought counselling directly will often accept an offer of help (Worden, 1982).

Working through losses involves a natural and necessary process of mourning. This process has some predictable, interconnected phases and tasks which the bereaved must work through before mourning can be completed (Worden, 1982). Some of the generic characteristics of grief and the tasks involved in "grief work" are:

Accepting the reality of the loss

When a loved one passes away or we experience a significant loss there is always a sense that it has not happened. Although the process of denial has the initial functional property of protecting the mourner from their pain, it is important that, in time, this loss be realized. Denial takes on may dimensions including denying

the facts of the loss, the meaning the loss has for them and the irreversibility of the loss (Worden, 1982).

People rarely seek help for themselves in the denial stage. Concerned family members, however, may approach helping professionals for advice on helping a loved one come to terms with their losses. The ongoing relationship the family physician holds with the patient family often provides for an opportunity for the physician to assess the grief reaction and when necessary facilitate the process of working through the denial phase.

Experiencing the pain of grief

The pain of grief involves the emotional, behavioral and physical realms and if not worked through often manifests itself through some form of symptom (Engel, 1969). Although each person responds to their losses differently depending upon their unique coping abilities, past experience and preparation for their loss, it is impossible to experience a significant loss without some degree of pain (Turner and Shapiro, 1986).

The opposite of completing this task of working through the pain is not to feel. Different cultures show themselves to be more comfortable with expressions of feelings. Without a supportive

accepting social network the bereaved may attempt to cut off feelings and deny their pain to both themselves and others. Bowlby (1980) points out, however, that sooner or later those who avoid all conscious grieving break down and show their grief usually through some form of depression.

Adjusting to a changed environment

Adjusting to a new environment after a significant loss often means accepting that some dreams, whether idealized or real, will no longer be met. The loss of a spouse, patient, grandparent or child has many ramifications for the family unit. These ramifications include a role loss for the bereaved as well as the loss of emotional and sometimes practical support.

It is important that helping professionals appreciate the enormity of the losses a bereaved is experiencing and address the powerful emotional ties which prevent an adjustment to a new environment.

In the case illustration presented later in this paper a young woman only began to realize a year following her father's death the multiple losses his passing had brought to her life. This realization was incapacitating for her and was significantly upsetting the balance of her home life.

Withdrawing emotional energy and reinvesting it in another relationship

The final task of grieving involves withdrawing the emotional energy which the grief reaction has absorbed and reinvesting this energy into other relationships.

Sadness, anger and denial all require a tremendous amount of energy both to maintain as well as to let go of. Withdrawing the emotional energy from the loss means letting go of dreams and moving on.

Accomplishing this task is often defined by the ability to look beyond the past and invest more energy into present and future relationships. The bereaved should be able to discuss their loss with a less intense emotional response.

Anticipatory grief is distinguished from normal survivor grief in that many losses, particularily those concerning illness "occur with some forewarning and it is during this period of anticipation that the potential survivor begins the task of mourning and begins to experience the various responses of grief" (Worden, 1982 pg. 92). Studies have shown that coping and adapting to this specific type of loss are decisively affected by social and emotional variables (Mailick, 1979).

In this type of situation, the process of grieving begins in response to the multiple losses experienced by the family unit coping with the illness and involves the various tasks of grieving previously discussed. Different families adjust to and cope with the high anxiety and changes prolonged illness brings to their system in different ways. It has been suggested that coping abilities are greatly affected by the family's prior experience, developmental stage, adaptability and openess (Trute, 1987).

In looking at the significant losses which occur within the context of the family unit coping with chronic illness and perhaps the eventual death of a family member it is important to consider the impact of the loss on the entire family.

One common difficulty in this special area is that family members often begin to organize their relationships, roles and functions in the family around the "sick person". In order to lessen the burden for a sick family member, other family members may take on the person's previous roles and functions in the family. For example, in one of the case illustrations presented later, the mother, diagnosed with terminal cancer, found her children taking on her previous functions such as cooking, cleaning and shopping. Although the children were acting out of concern, the mother felt somewhat expendable and the young children were

becoming parentified. It was important that a professional intervention occur before the family became stuck in such a dysfunctional, unhealthy arrangement.

Sensitized to the wide variety of losses people experience including death, illness, separation, job loss and retirement, the physician is in a position to provide some form of early intervention to preclude an unresolved grief reaction. Bowen (1978) states that "knowledge of the total family configuration, the functioning position of the dying person in the family, and the overall level of life adaptation are important for anyone who attempts to help a family before, during or after a death (loss)" (p. 328). The specialized training of the social worker may aid the physican in the assessment of the grief reaction as well as providing the therapeutic knowledge and skills required to help the patient system adapt to their loss. The area of inquiry related to the special problems family systems need to work through as they accept and adapt to chronic illness in their family is an appropriate and fruitful one for the social worker. Recognizing that the course and outcome of illness is affected by psychosocial factors, appropriate intervention in this area has the potential to impact the way the illness develops, the manifestations of the illness and the way the individual and family adapt to it.

Social work - physician attachment schemes

The usefulness of social workers being involved in primary care has been explored through a series of studies in Great Britian. One such study revealed that over one quarter of their patient population seeking medical assistance required some form of psychosocial management of their problem (Collins, 1965). Since the 1970s the attachment of social workers to general practice in Great Britian has been quite high. In fact at least half of all general practices reportedly utilize the services of at least one medical social worker. These affiliations vary considerably from those where the social worker works either full or part time as part of the health care team to those social workers who provide more of a liasion consultative service. It is the former service which is considered more useful by physicians, social workers and patients alike (Corney, 1980). In reviewing the efficacy of such attachment schemes general practioners claim that the social worker's involvement provides for more preventative and remedial work, contributes to patient diagnosis and assessment, and allows for a more comprehensive service to patients.

In 1953 medical social work first moved into the realms of private practice in North America through an attachment scheme between a physician and a social worker (Bartlett, 1961). The

functions of the social worker included psychological case work, education to patients and consultations to the physicians involved. Since this time, medical social work has made other forays into the field of family medicine. In Canada, most experience between the two fields has taken place either academically or in group practices. Those attachments of social workers to family practices which have taken place typically are terminated at the end of the financial grant from which they were initiated (Yates, 1985).

Burbidge, Spassoff and Steel (1982) report on a two year project which took place in Kingston, Ontario. This demonstration project involved the equivalent of three and a half full time social workers who received referals from over forty physicians in the Kingston area. The service was seen to reach a population of patients not already involved with other social services. Some of these patients were seen as potential high system users had they not received social work services at this time. This suggests that the service has the potential to prevent the development of more serious psychiatric disorders and to alleviate some cases of chronic social and emotional distress.

A more recent study of physican-social worker collaboration has been documented by Scott and Wooley (1984). Social workers and general practioners kept records of each referral over the course

of their three year affiliation and recorded whether they felt the object of intervention to be successful. Counselling in the area of marital and family problems was the predominant social worker activity. There was an overall agreement that the involvement of a social worker was effective in 75 percent of all cases. Another study conducted in Great Britain compared the views and behaviours of clients referred to a general practice attachment scheme to those referred to a local social work intake team (Corney, 1983). In this study clients were interviewed who had been referred to one or the other scheme which covered the same area. Selected clients had had no previous contact with a social worker. The investigators found that there was a marked difference between the two settings on the referral agents involved, the reasons for the referrals, the style of social work carried out, as well as the client perception of the help given. Briefly, it was found that those clients attached to the attachment scheme were more likely to complete the referral process, experience practical help and emotional support through this process, and claim satisfaction with their involvement with a social worker (Corney, 1983).

In 1980, Corney reported on some of the factors which seem to increase the likelihood of success of social worker attachment schemes to general practice. These factors included: access for social worker to office space at the physicians' practice, regular consultations with the physicians through both formal and informal meetings and attachments where the social worker was involved full time.

An article by Goldberg (1973) describing the effectiveness of the physician-social worker attachment as percieved by the patient, practitioner and social worker presents the following conclusions. For the patient, it was an acceptable means of receiving help. It also provided access to social services at a much earlier stage in the patient's difficulties than would otherwise have been the case. For the physician, this form of collaboration enriched the health care they could provide their patients. Of significance is the finding that the more the physician valued the biopsychosocial approach to health care, the more the social worker's service was appreciated and the more satisfactorily both professionals were able to cooperate in the interest of the patients. Those social workers involved in these attachment schemes found the work rewarding and enjoyed the enormous increase in the range of their work.

An alliance between family medicine and social work continues to search for a place in the professions joint efforts to provide comprehensive health care. Literature has indicated that as the medical world's understanding of illness has broadened so has the role of social work in the medical setting. Research has further indicated the fruitfulness and utility of such an alliance for both the patient's well being and in the provision of service to an entirely new but needy population group. The logistics of the

physician-social worker attachment however have presented many stuggles for both disciplines as well as the health care delivery system. The following section briefly looks at some of the struggles yet to be worked through which are presently blocking the opportunity for our health care system to better respond to the physical, psychological and social needs of individuals and families.

Difficulties with the physician-social worker affiliation

Although the importance of collaboration between general practitioners and social workers is now well recognized and a number of social worker attachment schemes in primary care have proven successful, the general implementation of such schemes in North America has not taken place. This section explores the obstacles which are interfering with or barring interprofessional collaboration in the provision of biopychosocial health care.

Current literature discussing the difficulties presented by the social worker-family physician alliance is abundant. Survey after survey has shown that many family physicians do not seek help from social workers nor access social services available to them (Greene Kruse and Arthurs, 1985). In a discussion of problems pertaining

to the physician-social worker affiliation, Madigan noted that overall relationships between the two professions were poor (1986). There are many contextual differences which the physician and social worker need to be aware of. The physician's discipline is primarily a biophysical one which views biological processes alone to be responsible for health related problems. The realm of the social worker is psychosocial with emphasis on the social, psychological and behavioural dimensions of illness. Madigan states that, "by and large medical and social work training reflects a biomedical-psychosocial dichotomy with one end result being that exclusive patient care by either profession alone is much less than comprehensive" (1986, p. 6). Medicine tends to exclude the larger systems within which the individual is embedded while social work tends to forget that physical characteristics influence human behaviour. This exclusive focus has led to a situation where the two disciplines have difficulty working together (Kriesel & Rosenthol, 1986). The biopsychosocial approach to illness advocated by Engel (1983) provides connections among levels of systems such that collaborative practice between the two professions in treating dysfunction at whatever level it occurs becomes possible.

Physicians are action oriented, trained to listen to the patient's content, take charge of a problem and intervene quickly. Social workers are process oriented, trained to help clients access their own resources and usually work at their own tempo (Crane,

1986). A physician's practice is structured such that he or she sees many patients in an hour for the assessment, intervention and management of health concerns. In Bartlett's (1961) study of social workers in the health setting she notes that physicians are forced to quickly assess a situation and stick with their assessment. Given that our current system of health care is procedure based, that is doctors bill our medical plan for the procedure performed and not on the basis of time spent with the patient, time management becomes an economic reality for physicians. In North America, a doctor "needs" to see four to seven patients an hour to cover overhead (Madigan, 1986). Social work's concept of time is quite different from the medical professions. The social worker has been trained to understand the slowness of the change process and views assessment as part of the continuity of treatment. Bowen (1980) states that "it requires about three generations for the majority of people to hear and accept a new discovery, a new idea, or a belief that threatens a firmly held view of the world. Each generation hears and accepts a little more until the third generation accepts it as an established fact" (p. 16).

The conceptual differences related to time management have led to a situation where the social work profession often regards physicians as abrupt in their dealings with patients. Physicians, on the other hand, tend to question the social worker's approach to patient care as time wasting (Madigan, 1986).

Another difficulty is the differing perceptions the professions tend to hold of each other. As a profession, social work is often accused of being too broadly based in its attempt to provide a full range of services (Gross, Gross and Eisenstein-Naveh, 1983; Brieland, 1981 & Meyers, 1981). Gross and colleagues state that however difficult, defining the role of social work is a practical necessity, especially in contexts involving professional collaboration. This would move social work toward more specialization and standardization than its current role defines. One area of potential specialization for social work is family oriented social work practice in family medicine. Mandelbaum (1983) sees the success of social workers in family medicine being dependent upon role clarity. Social work's generic identity has contributed to its current role confusion and subsequent lack of credibility.

Receptivity of a new area of specialization for social work in family medicine will not come easily or without movement in thinking in both professions. Mechanic (1980) sees social workers as being defensive about their status, professional identity and perogatives. Physicians, conversely, view social work as being weak in the area of high status knowledge and resent impingement on their clinical domain (Lewis, 1982; Smith, 1985). It is imperative that the social worker come to terms with the fact that clients referred are <u>firstly</u> and <u>foremost</u> the physician's patients.

These patients will usually continue with the physician long after their connection with the social worker has ended. If the social worker is not comfortable with this power difference one could hypothesize that over time referrals for their services would subside. Thus accommodations are clearly needed on both sides for interprofessional collaboration.

Finally, in their attempt to form an alliance, doctors and social workers need to address logistic and financial issues. Office space for the social worker is a concern given the extensive use of the physician's office to cover high overhead costs. Of more concern, however, is the financial support for the service (Burbidge, et al, 1982) To date, social work attachments to primary practice in North America are primarily set up as experimental projects which are terminated at the end of the grant through which they were initiated (Yates, 1985). Social work services offered in primary care settings necessitate that health insurance plans and or client user fees cover the cost.

The following chapter of this report, Chapter 2, discusses the practicum experience and illustrates some case examples which brought to light, for me, some of the theory presented in the literature review.

CHAPTER 2

THE PRACTICUM

The setting

This practicum was conducted at the Pacific Coast Family Therapy Training Association's Institute (PCFTTA) in Vancouver, British Columbia. The Training Institute has been established by practicing family therapists, with a commitment to use family systems theory in their work with families, couples and individuals.

The institute has offered courses in family systems theory since 1982. It provides an intensive two year program in family therapy to working practitioners from different disciplines such as social work, medicine and psychology. As part of this training program, the institute offers a counselling service to families.

In 1983, the PCFTTA, in collaboration with the Department of Family Practice and the School of Social Work at the University of British Columbia began an ongoing research project designed to train social work therapists to work collaboratively with family physicians. It was with this project that I was involved.

The project involves the attachment of students to the private practices of two family physicians. During the

affiliation the physicians refer patients and their families assessed as experiencing psychological problems to the social worker for counselling. It is important to note that the institute is located across the street from the afore-mentioned physician's offices and was therefore within easy access to both the patients and physicians.

The clients

Twelve families were seen in this practicum. Several types of families were represented. They included one step-family, six single parent families, one adoptive family and four families in which the original spouses remained together. The families represented various stages of the life cycle including one single unattached adult, two families with preschool children, two families with school-age children, six adolescent families and one family in later life.

The general income of the families ranged from $15,000 to over $50,000. The single parent families all were experiencing a more limiting income than had been the case, for them, prior to their separation or divorce. One single female parent of three school age children was not receiving financial support from her former husband and was receiving income assistance. Another mother, with one child, was also not receiving child support and was living with her parents. The remaining four single parent

families were receiving some form of child support. Four of the single moms worked either full or part-time. All were unhappy in their work situation.

In three of the five two parent families both spouses worked full-time. The parents held a variety of jobs such as interior designer, architect, secretary, real estate agent, lawyer, business person, printer, housekeeper, salesperson, hairstylist and customs agent. Seven of the adults had university educations while the remaining had high school educations plus some additional vocational training.

The length of marriage of the spouses currently together was from seven to twenty years. The six single parents were women who had been separated or divorced from two months to ten years. The ages of the mothers ranged from thirty to fifty-eight years. The fathers ranged in age from thirty-two to sixty years and the children from two to twenty-one years of age.

Apart from five families who had moved to Vancouver from England, Montreal, the Caribbean and Ireland all families had some immediate family members in the city. All parents claimed to have ongoing contact through telephone, letters and visits with their extended family members.

For all but three families counselling was a new experience.

Other professionals involved with the families at the same time as myself were school counsellors, one psychiatrist, two income assistance workers and their physicians.

The problems

The presenting problems of the families who sought treatment included some unexpected life transitions such as separation issues, terminal illness, teen pregnancy and attempted suicide as well as some anticipated developmental factors including the death of a parent, adolescent problems and adoption issues. Most problems could be classified as problems of everyday living with which the social worker was experienced. Over the course of the practicum I researched and became more familiar with problems specific to terminal illness, cancer and depression. The physician as well as the clients were useful and expert resources for me in these areas.

All clients had discussed with their physicians some aspect of the presenting problem during the course of their medical appointment. Some patients approached their physician for help "not knowing where else to turn" while others were hoping that "some form of medication would ease the situation until things changed". One patient family was experiencing difficulty coping with and adapting to a family member's illness while another needed to reorganize roles and functions in the family while in

the process of grieving the mom's cancer. The physicians' biopsychosocial framework alerted them to the intra- and interpersonal dimensions of the client's problems and with patient approval a referral to myself was activated.

Procedures

I was available to receive referrals, meet with the physicians and see clients a minimum of two days and one evening a week. An important part of the project was the regular conferences between the physicians and myself which took place approximately biweekly and were scheduled to discuss referrals, treatment and facilitate communication. Informal contact between the physicians and myself was minimal, possibly more as a result of the separate office facilities than by choice. A nominal fee of $10.00 per session was charged to clients to cover the cost of video tape recording.

From my readings as well as prior counselling experience I had recognized that the referral process was of primary importance to the success of the project. The referral process was also one forum for the physician - social worker team to facilitate mutual learning. Therefore, I designed a series of questions whose purposes were to provide an understanding of the physician's view of the problem and intervention required as well as any medical concerns (see below).

Intake questions

1. What is the presenting problem as understood by the referring source?
2. Who is seen to be involved with this problem?
3. What are the medical concerns?
4. Who in the family does the physician care for?
5. What is the physician's thinking regarding membership for treatment?

In order for the two disciplines, family medicine and social work, to collaborate regarding their shared concerns, I saw as imperative the discussion of the following perceived conceptual differences: 1) models of practice: biomedical with its focus on the individual versus psychosocial model with its systemic centrality; 2) assumptions regarding practice principles; and 3) membership criteria for treatment. Thus, one part of this practicum experience is clearly seen to be concerned with larger systems issues.

Following the referral process I was responsible to contact the family and schedule an initial family session. The frequency and number of sessions was determined by the family's needs.

Duration

The duration of the clinical component of this practicum experience was from September 1986 to May 1987. I saw most of

the families weekly. Clients were seen an average of eight sessions. One client terminated following the first session as she wanted her adolescent son, the "identified patient", to be seen individually by myself. This client saw the role of a therapist as helping her son to change so that he would be different with the family. Although I attempted to broaden and reframe the presenting problem by addressing how concerns affect and are affected by the family as well as presenting the family as a resource for its members, the mother was more comfortable and familiar with individual therapy. She therefore decided to pursue school counselling until psychiatric help became available for her son. Another client facing terminal illness passed away during the course of therapy. This client was seen four times. Two families were seen throughout the attachment project, one on a weekly basis while the other was seen bi-weekly for an average of eighteen sessions.

Evaluation

Evaluation is an essential component of social work practice serving several important functions. It provides the practitioner with an objective, independent verification of a clinical assessment. Since the clinical assessment directs the practitioner's selection of intervention approaches, the outcome of therapy is critically linked to the accuracy of the assessment. Second, the quantitative measurement(s) of the

problem under study provides a baseline for evaluating the course of therapy as well as feedback to the client on his or her progress (Jehu, 1984). Third, systemic evaluation of clinical interventions provides information about the efficiency and effectiveness of those therapies available (Trute, 1985). Finally, it provides practitioners with a general body of knowledge regarding the effectiveness of selected intervention approaches with particular problems and client populations and the opportunity to provide feedback to the client (Jehu, 1984).

Clinical evaluation of family systems practice involves an examination of the assessment techniques which direct the change process. The use of instruments as assessment and evaluative tools should be complementary to the therapist's theoretical model and in this light provide an objective verification of a clinical assessment and a baseline for evaluating the progress and outcome of therapy. Such evaluation currently presents some practice difficulties, most notably being the time commitment involved. In addition, the availability of comprehensive measuring instruments which examine behaviour in the context of intrapsychic, family and community factors is limited (Trute, 1985).

For this practicum the Family Assessment Measure (FAM), a problem checklist and client feedback were used as quantitative and qualitative measurements of family functioning at the onset

of therapy and as measures of therapy outcome. Feedback from clients and physicians was also gathered to further evaluate the usefulness of the social worker - physician attachment for the client system and professional system.

FAM is a self report instrument based on a Process Model of Family Functioning developed by Skinner, Steinhauer and Santa-Barbara (1983). It is comprised of three questionnaires which provide information on family strengths and weaknesses from the following perspectives: 1) a General Scale which focuses on the overall functioning of the family system; 2) a Dyadic Relationships Scale which examines significant dyad relationships; and 3) a Self-Rating Scale which looks at the individual's perception of his or her functioning in the family.

The FAM is an evaluative tool which embraces the broader and more holistic dimensions of functioning as required by systems theory. All behaviour examined is understood in the context of surrounding social systems. The key concepts assessed by FAM are: task accomplishment, role performance, communication, affective expression, involvement, control and values and norms. Social desirability and defensiveness are also measured in the General Scale. Task Accomplishment is the successful completion of basic developmental and crisis tasks. This subscale measures the family's ability to adapt to changes in the family life cycle and maintain these functional patterns of behaviour even under

stress. Mastering basic tasks involves the appropriate distribution of roles and responsibilities in the family as measured by Role Performance. Functional families are seen to adapt to new roles as required in the development of the family and relevant to the task on hand. Communication relies on clarity and content of information as well as reciprocity of family members. The more a person is dominated by their emotional system the more inadequate the Affective Expression. This can be measured by the lack of affect the person may show and the reactivity of emotions relevant to the situation at hand. The transactional style or preferences for a type of interaction between family members is evaluated by their Affective Involvement with one another. Most families function within an average range on a continuum between somewhat overinvolved or somewhat disengaged subsystems. Control is relevant to the effective functioning of the family system. Critical aspects of control include whether the family is adaptable versus inflexible, supportive versus uninvolved, and consistent versus unpredictable. Finally, Values and Norms provide the grounding from which all other concepts flow.

Social Desirability and Defensiveness are important subscales useful when predicting the validity of client response. Social desirability measures the degree of response bias determined by the individual's desire to give the "correct" answer while defensiveness examines denial.

The FAM questionnaires were completed prior to the second session by individual family members over twelve years of age. The questions were in the form of statements one could make about their family, family relationships and the individual's understanding of his or her functioning in the family. Clients were requested to respond to each item by indicating whether they: strongly agree, agree, disagree or strongly disagree with the statement. It took approximately fifteen to twenty minutes to complete each questionnaire.

For the purpose of this practicum the student used the General Scale, comprised of 50 items and the Self-Rating Scale, comprised of 42 items. The decision to rely on these two scales as offering a comprehensive systemic analysis of family functioning, without incorporating the Dyadic Relationships Scale into the evaluation was made to prevent excessive taxing of the family's time and tolerance of the evaluation process.

Reliability of the FAM

Empirical analyses have shown that the FAM scales are reliable and differentiate significantly between clinical and nonclinical families (Skinner, Steinhauer and Santa-Barbara, 1983). The reliability estimates for the overall rating in the General Scale and Self-Rating Scale are .93 and .89 respectively (Ibid). This consistency, based on the degree of item

correlation is quite respectable. The reliability estimates of individuals when responding to items on the same subscale are adequate as well. Reliability estimates for the various subscales of FAM are also respectable with the exclusion of the Control and Involvement measures of the Self-Rating Scale. The authors indicate that the reliability estimates consider sources of measurement error at one point in time. Therefore the temporal consistency of the FAM needs to be further explored.

Validity of the FAM

The FAM scores of individuals from 131 clinical and 348 nonclinical families were used in a multiple discriminant analysis to provide evidence on its diagnostic power. Researchers were able to accurately identify group dispersement 84 percent of the time. Problem families in general were found to report family dysfunction in the subscales examining Role Performance and Affective Involvement. Children were more likely to report problems in the subscales measuring Values and Norms and Affective Expression than adults. Skinner, Steinhauer and Santa-Barbara also note that "the more congruence among the profiles of the various family members, the greater the likelihood that the scores are valid and the members share a common perception of their family" (pg. 8, 1983).

Weaknesses of the FAM

The FAM measures general areas of strength or weakness according to concepts in the process model. The scores cannot, in and of themselves, identify which specific variables within the subscales are a strength or weakness. Further evaluation would be required, for example, to determine if an elevated control score is due to style of control and/or failure to adapt to changing demands. In addition, FAM profiles do not necessarily show temporal reliability. The scores reflect family functioning at the time of assessment and may be influenced by the client's emotional state.

In this practicum many clients experienced the FAM as being rather cumbersome and lengthy to complete. In addition, on average, clients stated that they found this process to be of little value for themselves.

I found the FAM rather demanding of my time and question whether I would continue to use this evaluation tool in my own practice. On the other hand, though, the FAM did show client change in areas which concurred with my observations and client feedback.

The problem checklist

In addition to the FAM a problem checklist was administered to the families as a pretest prior to the first session. The post-test was administered to these families immediately following the termination session.

The problem checklist identifies specific areas of concern relevant to the client population in treatment. It was found to be a useful tool, easy and quick to utilize as well as being clinically relevant. It is a generalized self-report instrument designed to identify concerns across client groups rather than designed specifically for a particular client system (Trute, 1985).

The rating scale used in this practicum was a modified version of the Morrison Center Problem Checklist (see Appendix A). This scale records levels of satisfaction of family members as determined by a number of common problem areas such as family involvement, use of physical force, finances and parental, sibling and spousal relationships.

I found the problem checklist to be useful in broadening the initial presenting problem as well as providing a good index for change. Clients reported that the checklist was quite clear and easy to complete. They were very interested in hearing any

changes they had made.

Weaknesses of the problem checklist

The inherent limitation of this methodology is in its generalizability and lack of empirical strength (Trute, 1985).

Client feedback

Client feedback in the form of an interview process is a frequently used evaluation method in clinical work. Interviews generate a broad spectrum of information and have the advantage of being quite flexible. Such feedback can be excellent learning for the therapist as they hear what the client system a)perceives to have worked and not worked for them; b) would have liked to have happened differently; and c) would have liked to have had added to the therapy. In this light such qualitative research provides a knowledge building function, useful in gaining an understanding of certain phenomenon and in stimulating the development of ideas, thought processes and theories (Madigan, 1986). On the other hand however, client feedback can be prone to several sources of bias such as the interviewing skills of the therapist, the interpretation of client responses by the therapist as well as the desire on the part of the client to

comply with what they perceive the therapist would like to hear (Jehu, 1982).

For this practicum feedback from both the clients and the physicians was helpful in gaining an understanding of how best to meet the biopsychosocial needs of individuals and families. Perceptions of how each system viewed the experience were examined and will be discussed in more detail through the case illustrations and report recommendations.

CASE ILLUSTRATIONS

The A Family

This was a two parent family which consisted of Mary age 32, Peter age 32, and their daughter Sonya, age 2 1/2 years. There had been no other pregnancies. This couple had been married for seven years. It was the first marriage for both spouses. They had a long courtship period of approximately six years prior to their marriage. This was an upper middle class family whose annual income was above $50,000. Only one parent (Peter) worked outside the home.

The biopsychosocial approach

Mary had approached her physician with generalized complaints of feeling depressed. She claimed to be having difficulty sleeping and eating, was unmotivated to get out of bed in the morning and saw herself as lacking interest in both her husband and young daughter. Mary had been prescribed psychotropic drugs on her previous appointment but claimed to feel no better.

Although the A's family physician was concerned with the recent change in Mary's eating and sleeping routines, his biopsychosocial framework led him to explore areas which would

not normally be considered by adherents to the biomedical model. Hence the physician's conceptual framework allowed him to be curious about the person and family system and to assess the relative intactness and functioning of these systems. The physician's assessment, that Mary's physical complaints may be symptoms of some form of disruption in her family life precipitated a referral to the social worker.

The referral process

In presenting this family to the social worker the physician questioned the possibility of problems in the couple's relationship. The husband was seen to be very busy in his job and somewhat peripheral to the family unit. Additionally, the physician questioned the impact that Mary's father's death may have had on this family system. Her father had passed away the previous year, from terminal cancer.

The physician had no immediate medical concerns regarding this family at this time although he felt that Mary's depressive state needed ongoing observation. During his appointment with Mary he discussed the possibility that her general feeling of wellness may be nonorganic. It was then recommended that Mary and Peter take part in the counselling service offered through his office.

The family was then contacted by telephone and the presenting problem was further explored to determine who should attend the first interview. Mary claimed that she was mostly concerned with how "unmotivated" and "low" she was feeling. She was also unhappy with her present relationship with her husband. She stated that they were not having any parenting difficulties.

This family had never before sought help from a counsellor. Mary stated that they decided to follow through on this referral only because of the personal recommendation from their doctor. A first interview between Mary and Peter was scheduled. I chose not to involve the young child in the initial session as she was described as functioning quite well and did not appear to be part of the presenting problem.

The first session

In brief, my plan for the first session was: to discuss the presenting problem, its history as well as present concerns; to discuss the methods the family had already tried to alleviate their concerns; to address how the family would like to be following counselling and to contract with this family to work towards their change goals.

During the course of the first interview it became clear that the couple's problems were mostly connected to the loss they

had experienced of Mary's dad. Her father had passed away fourteen months ago from terminal cancer. The family had four months with the dad following his initial diagnosis of cancer until his death. Mary spent most of this time in Hawaii with her parents and ten month old daughter. She saw very little of her husband who had remained in Vancouver working during this time.

In assessing this problem further it became clear that Mary was stuck in a delayed grief reaction. The passage of time had seemingly allowed the remainder of Mary's family to work through some of their feelings towards her dad's death. Mary, however, had spent the four months prior to her father's death caring for him. She then took on the responsibility for the funeral arrangements and helped her mom through this difficult time. Mary sees her role in the family as often involving the care of other family members. Due to her mother's chronic history of mental illness Mary remembers herself as being very involved with her dad, cooking for him, socializing with him and caring for him.

Since her father's death, Mary stated that she had felt very apathetic towards her daily life. She saw as different her difficulty in getting up in the morning, lack of enthusiasm towards parenting, unhappiness in her relationship with her husband and feeling dissatisfied with herself. She claimed she was no longer involved in social activities and rarely felt

motivated to go out with her husband.

Peter, in turn, stated that he was very dissatisfied with his current relationship with his wife. He felt that their time together was poorly spent and felt frustrated with what he saw as his inability to change things. He also perceived that an argument he had had with his father-in-law prior to his death was getting in the way of their relationship.

Both spouses claimed that they were very invested in their relationship. They hoped that the process of counselling would help them find a way to enjoy their own selves and each other again. Mary, in particular, felt a need to get on with her life. This meant, to her, "taking part in the community again, enjoying my daughter, just feeling good about myself again".

The intervention

A primary role of counselling for this family system was seen to involve grief work. The therapist's goal was to help Mary and Peter accomplish the natural requisite process of grieving in a healthy manner. By reframing this process as natural and by "giving permission" to both Mary and Peter to continue to grieve their loss, both individuals described a feeling of relief. Mary stated that "its been such a while since

Dad has gone, I felt it was unfair to continue to talk about him".

Each session was used to talk about the deceased, their unique relationship with him and their respective losses. In time, the sessions began to include the couple's adjustment to a homelife in which Mary's father no longer played a part. Family of origin issues such as Mary's function in the family, and the gains and losses for her, of caring for her father, were also addressed. Over the course of therapy Peter began to look at his difficulty in connecting with Mary around this loss. Peter had grown up in a family of "doers". He remembers one of the values in his home as being "getting on with life no matter what". Not getting on was causing him considerable anxiety. His initial feelings of helplessness, anger and resentment began to dissipate as he began to see himself as being more in control of his part in their relationship. As well, as Peter became more aware that Mary's overriding sadness was not "caused" by him, he was more capable of being there for her without feeling as if he needed to make everything alright.

This couple was seen for six sessions. They described the process of therapy as being helpful for them. The couple was seen to become much more involved with each other and content in their relationship through the course of therapy. Mary was no longer taking her prescribed medication and stated that "life was

beginning to feel normal again". She claimed that she still missed her father and felt pain when she thought of him but she was no longer overwhelmed by her loss. Peter no longer felt threatened by Mary's grief and saw himself as being more able to support her around her sadness. He stated that the sessions had helped him value the expression of feelings and that this was something very different for him.

An evaluation of the attachment project for the A family

As previously discussed, the evaluation of the outcome of treatment was based on the differences between the FAM scores of family members at Time 1 and Time 2, changes in the levels of satisfaction on the problem checklist at Time 1 and Time 2, the therapist's observations, client feedback, and the physician's statements concerning their experience with the attachment project.

The FAM scores of family A at Time 1 for the FAM General Scale were higher on all subscales than the scores of the sample population. The scores at Time 2 on all seven scales indicated that the family had moved towards healthier functioning (see Figure 1).

The scores of both Peter and Mary at Time 1 for the FAM Self-Rating Scale showed both healthy functioning and some

problem areas. These scores were all within the average range at Time 2 (see Figure 1.1).

Insert Figures 1 & 1.1 about here

In reviewing the problem checklists, all problem areas showed either improvement or no change in levels of satisfaction. Most significant was the increase in levels of satisfaction regarding their relationship and Mary's good feelings about herself (see Tables 1 & 1.1).

Insert Tables 1 & 1.1 about here

The couple reported that they were very satisfied with their experience in counselling. Termination of the therapy took place after six sessions as both the therapist and the couple felt that the goals of therapy had been achieved. The final session with this couple was used to consolidate gains and gather feed-back regarding their experience in the attachment project. Of interest is this couple's impression that they would not have completed the counselling referral if their physician had not recommended both the service and counsellor as highly. The close location of the counselling space to their doctor's office was also seen as being helpful.

FIGURE 1

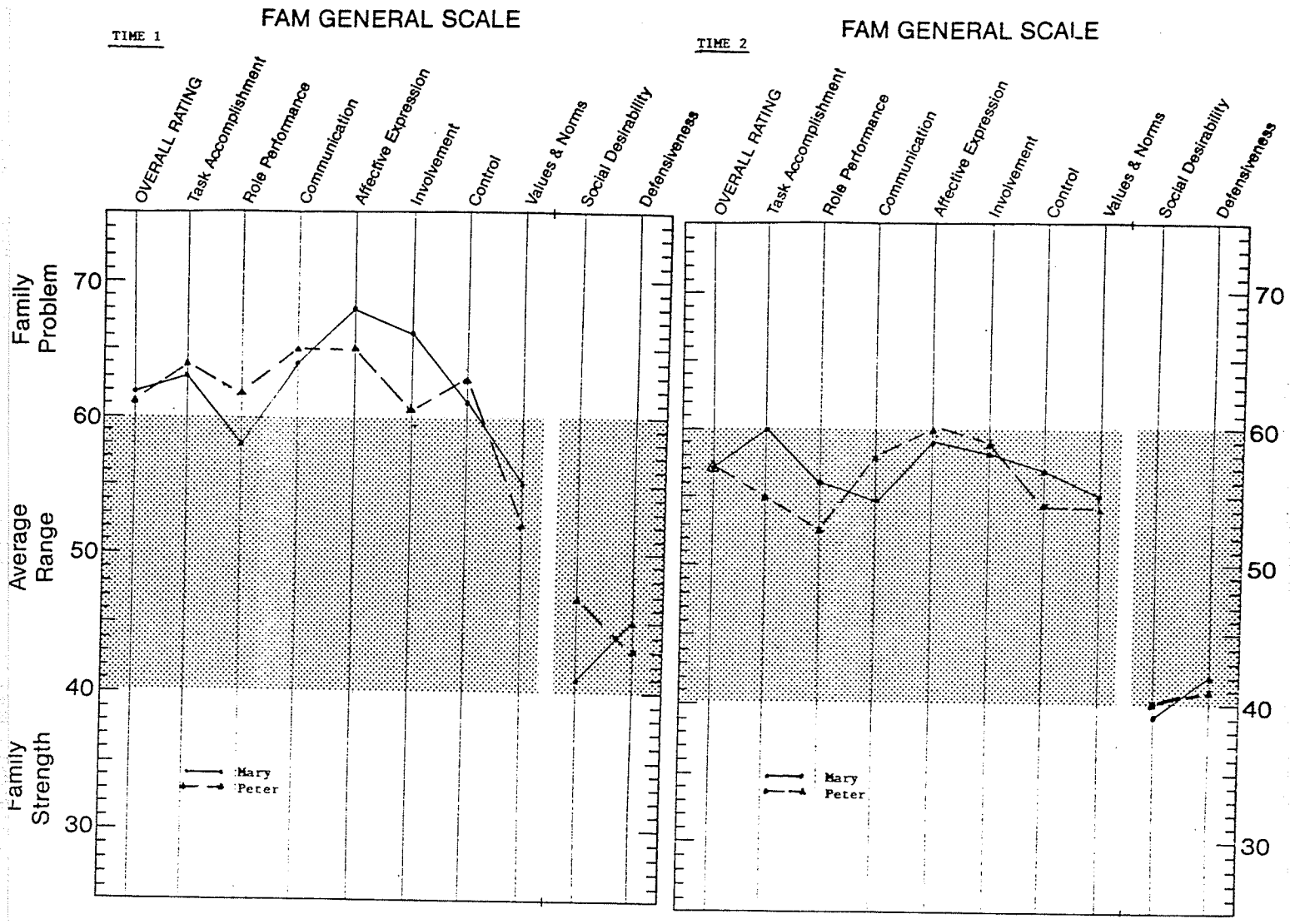

FAM GENERAL SCALE
TIME 1
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Mary
Peter
FAM GENERAL SCALE
TIME 2
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
70
60
50
40
30
Mary
Peter

FIGURE 1.1

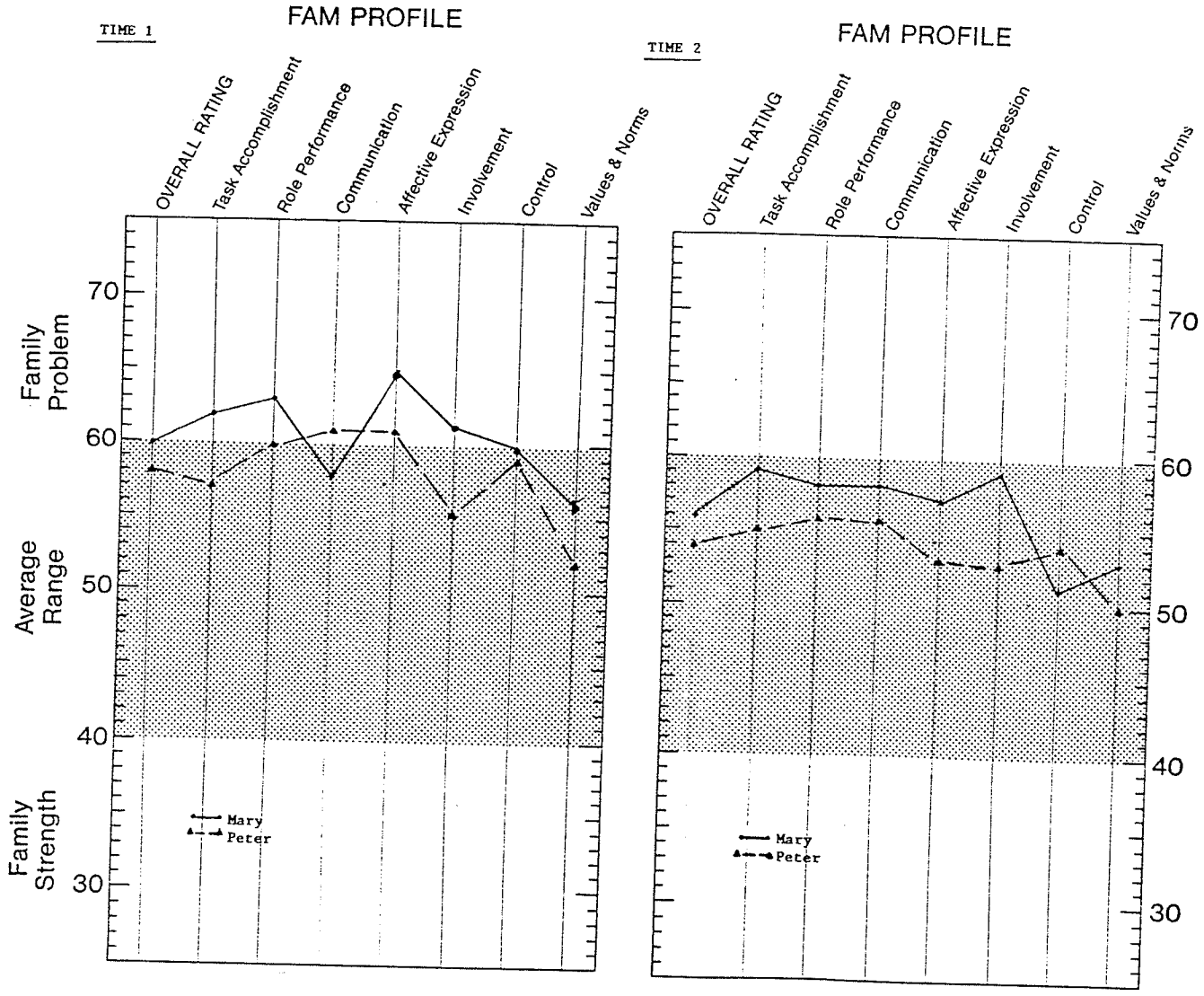

TIME 1
FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Mary
Peter
TIME 2
FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
70
60
50
40
30
Mary
Peter

TABLE 1
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Peter, Time 1
B = Peter, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			A	B	
2. Sharing feelings like anger, sadness, hurt		A		B	
3. Sharing problems with the family		A		B	
4. Making sensible rules				AB	
5. Being able to discuss what is right and wrong			AB		
6. Sharing of responsibilities			A	B	
7. Handling of anger and frustration			A	B	
8. Dealing with matters concerning sex		A		B	
9. Proper use of alcohol, drugs					AB
10. Use of discipline					AB
11. Use of physical force					AB
12. The amount of independence you have in the family			A	B	
13. Making contact with friends, relatives, church, etc.				AB	
14. Relationships between parents		A		B	
15. Relationships between children					AB
16. Relationships between parents and children					AB
17. Time family members spend together			A	B	
18. Situation at work or school				B	
19. Family finances					AB
20. Housing situation					AB
21. Overall satisfaction with my family			A	B	

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself			A	B	

TABLE 1.1
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Mary, Time 1
B = Mary, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		A		B	
2. Sharing feelings like anger, sadness, hurt	A			B	
3. Sharing problems with the family		A		B	
4. Making sensible rules				AB	
5. Being able to discuss what is right and wrong			A	B	
6. Sharing of responsibilities				AB	
7. Handling of anger and frustration		A		B	
8. Dealing with matters concerning sex		A		B	
9. Proper use of alcohol, drugs				AB	
10. Use of discipline				AB	
11. Use of physical force				AB	
12. The amount of independence you have in the family				AB	
13. Making contact with friends, relatives, church, etc.		A		B	
14. Relationships between parents	A			B	
15. Relationships between children				AB	
16. Relationships between parents and children			A	B	
17. Time family members spend together			A	B	
18. Situation at work or school N/A					
19. Family finances				AB	
20. Housing situation					AB
21. Overall satisfaction with my family			A	B	

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself		A		B	

The family physician was also pleased with the overall service offered to this family. He saw this family as being somewhat representative of his practice and was therefore gratified with their successful treatment experience.

Discussion

The social worker saw this as an appropriate referral for her services. One may hypothesize that had this family not experienced the death of a family member they may have continued to function relatively well. Mary's involved relationship with her father had found a place in the family system where it might have continued to work for both Mary and Peter. Her father's death, however, precipitated a crisis for the couple which they were having difficulty working through. Mary's central caretaking and nurturing functions in her family of origin had, in part, delayed her own experience of the loss. When she began to feel the pain of losing her father, the following year, her family became confused and anxious and were perhaps not as accommodating or understanding of these expressions of feelings as they would have been closer to the loss.

Following the death of Mary's father this system remained disrupted and in a heightened state of sustained anxiety. Their attempts to return to their former state of being were not successful. In fact, there could be no return to their previous

balance as things were no longer the same. Central to the biopsychosocial perspective is the understanding that every change becomes part of the history of each system, hence restored equilibrium is not the former state of health but a different intra- and intersystemic harmony with characteristics based on all system changes incurred through the disruption (Engel, 1979). It was necessary for the couple to adjust to a new way of being which no longer included the living presence of a father, father-in-law or grandfather figure.

This was a particularly gratifying referral to have in this practicum experience. The couple had not experienced therapy before and were not involved with a large professional helping network. The therapy, uncomplicated by larger systems issues was able to be quite clear. The couple was also quite open and available to counselling. Most importantly, however, was the fact that the physician's ongoing involvement with the family system and conceptual framework allowed him to assess the problem and intervene before the family was entrenched in their dysfunctional patterns of interaction. The form of intervention that the physician assessed as being most appropriate for this couple was the counselling service offered through the attachment project.

As Mary clearly states, "I don't know where we would both be if we hadn't had this counselling service made available to us.

I'm almost frightened to think about what would have happened to me...I knew it was getting to a point where we couldn't have gone on much longer but what were our alternatives?"

The B family

This family consisted of Ruth age 45 years, Ernie age 47 years and their two adopted children, Bryan age 15 years and Cindy age 11 1/2 years. Both children had been adopted at birth. This couple had been married 20 years it was the first marriage for both spouses. This was a two career family. Their varying work schedules provided the spouses with a minimum of time together during the work week.

The biopsychosocial approach

The precipitating event which brought this family to the attention of their family physician was Bryan's ingestion of poison. Bryan had taken some poison one evening and then took some more approximately two hours later when he still was not feeling sick. When he started to feel ill he began to have second thoughts and told his mother who then took him to the hospital. Following an in-patient assessment it was recommended that: Bryan engage in individual counselling through the Child Psychiatry Clinic and that some conjoint family therapy may also be helpful. Due to the clinics lengthy waiting list therapy was

not immediately available. The family physician, uncomfortable with the delay in counselling due to the nature of the presenting problem, referred the family for counselling services through the attachment project.

The referral process

In contacting myself the physician expressed his concerns regarding this family system. These concerns were: that Bryan may be a suicide risk and at the very least was in some way "asking for help" and that Bryan's parents did not appear to be as anxious regarding Bryan's recent behaviour as he considered normal.

Bryan had been referred for counselling the previous year by the same physician. The factors which precipitated this referral were his ongoing complaints of abdominal pains and sickness, which were assessed as being psychosomatic in nature. Bryan attended a boy's group at this time but stopped going after a few sessions. Although he informed his physician that the meetings were a waste of his time it was also noted that his complaints of abdominal pains had ceased.

The family physician did not have any significant biological concerns regarding Bryan and his family. The psychosocial concerns included: Bryan's poor self-image and apparent withdrawn

behaviour and the parents' seeming lack of involvement with their son.

In discussing the referral further with the physician I presented that I would most likely be including the whole family in treatment. The decision to include siblings in therapy who do not overtly appear to be part of the presenting problem is based on the theoretical principle that problems in the family affect and are affected by all family members. Had the therapist included only the symptom bearer and his parents in therapy she would have maintained an intrapsychic focus to the problem rather than broadening the therapy to look at how family interrelationships help to maintain or change family problems. Including the problem bearer in therapy while excluding others crosses family boundaries and implies that one family member is the dysfunctional one while others are functional and healthy (Freeman, 1981). Family members are seen to be a resource for one another in the change process. Siblings, in particular, have the capabilities of being a significant resource for one another over the course of their entire life span.

Upon contacting the family I asked Ruth if she could briefly tell me about the problem as she understood it, who lived in the home, who family members turned to for emotional support and whether or not any member of the family was involved with other professionals.

Ruth stated that she and her husband were completely surprised by Bryan's behaviour..."there were absolutely no signals to tell us that something was wrong". She wanted to bring her son in to counselling to ensure that this would not happen again. Ruth felt that her younger daughter should not exposed to the counselling process as "the whole thing is just too upsetting for her". She felt that if her daughter had been older there would be more reason to include her. As Ernie's work schedule was at odds with hers Ruth wondered if they could take turns bringing their son to sessions.

Ruth expressed that they were a very private family and did not discuss their problems with any other persons including extended family members. No member of the family was seeing any other professional although Bryan had had one brief experience in counselling the previous year. Ruth felt that the counselling had been helpful for him at that time.

This initial telephone conversation helped formulate some thoughts about mom being quite anxious regarding counselling and that it might be difficult for her to bring the whole family in to sessions immediately. Instead of fighting mom's energy regarding who to include and exclude in the therapy I saw as important the need to reduce her anxiety by helping her to engage in the therapeutic process. I therefore decided to invite the parental subsystem to the first session. This would then allow

the parents to meet with myself and experience a session prior to "exposing" their children to therapy. Inviting the parental subsystem to the first session has the additional dimension of defining to the family parental boundaries and hierarchy.

The first session

This was a very difficult session in that both parents were extremely anxious regarding what they defined as the presenting problem - their son's attempted suicide attempt. In their concern that this behaviour would not re-occur, father had read at great length about teenage suicide and was in the process of contracting with his son around not repeating this behaviour. Additionally, the parents had rearranged their schedules to insure that one of them was in the home at all times. They were also working on engaging Bryan in a variety of different activities with them such as swimming, playing chess and bowling.

Both Ruth and Ernie described Bryan as being a loner who spent a significant amount of time in his room alone, playing with his computer. Cindy was described as being much more outgoing than her brother. She had many friends and was involved in numerous extra-curricular activities. Cindy was presented as being "her father's girl" while Bryan was described as being most like mom. Neither parent had any concerns directly related to Cindy apart from her upset over her brother taking the poison.

Looking back, Ernie believed that Bryan's behaviour changed shortly after the family moved to Vancouver two years previously. Prior to this time Bryan was seen to have had some significant friendships and to be more outgoing. His parents also remember him as being more involved with the family during this time. In the last two years, however, Bryan had not formed any new peer relationships which the parents considered significant. Additionally, Bryan, once an average student, was now failing most of his academic work.

Much had changed for this family following their move to Vancouver. In leaving a rural community where they had lived for many years they left behind many long term connections and support systems. One of the benefits the parents felt that the small community had offered to them was a close network of support. For example, they believed they would have been contacted by the school system in their previous community regarding Bryan's deteriorating academic performance instead of discovering this at the completion of the school term. As well, due to the financial debt the family had incurred through their relocation, Ruth had returned to the workforce. Prior to this time she had been a stay-at-home wife and mother. The varying work schedules of the parents meant that they had minimal common time for each other or for the family. The move had been prompted by a transfer of offices and promotion for Ernie. He was finding his new job much more stressful and time consuming.

Both parents felt that they had made a joint decision two years ago, that their relationship could withstand these changes while they accumulated some financial capital. They could not remember having discussed this decision with their children.

When reflecting on the changes the family had undergone over the last two years Ernie and Ruth saw many losses. As Ernie put forth, "Ruth and I have been so busy we no longer talk. Not only do we not have time for each other we really haven't had much time to sit back and take a look at what's been happening to our family...this is one of the first times we have sat down and really talked in a long time".

The interview drew to a natural conclusion with the beginning of a reframe around the parent's initial thinking about the problem. Reframing Bryan's behaviour as serving a helpful function in the family in that it had brought together a family growing distant, not only broadened the problem area but allowed the parents to see some positives from this painful experience. The interview ended with the parents agreement to bring their two children to the next session.

The intervention

This family was seen throughout the practicum for a total of twelve sessions.

From my initial session with the parents as well as subsequent sessions which included both children I had formed some hypotheses around what may be going on in this family system. Some of my thinking which I then checked out with the family through the course of therapy was that:

- Bryan was experiencing difficulty adapting to the changes that the move had meant for him;

- developmentally, this move had occurred at a difficult time for Bryan. Adolescence is a period where the broadening of family boundaries to include influences from the outside world fosters a teen's independence. A family move, however, can establish a situation where family members become, at least in the short run, more dependent upon each other to meet their social needs. As well, Bryan's temperament appeared to be that of a withdrawing adolescent. Having no close friends from a prior developmental period to help him become an active member of a peer group, Bryan was acquiring the reputation of being an oddball. In fact, Bryan was often scapegoated by peers and had been beaten up at school on two occasions. The work of Chess and Thomas (1986) in exploring the role of temperament in personality development presents how a withdrawn adolescent, isolated from peer connections often acquires the reputation of being an oddity or a snob and that such labelling perpetuates the withdrawing behaviour with increasing fixity. This in turn often leads the teen to experience depression and to develop a negative self-image;

- being a very sensitive child Bryan had found a way to bring the family together;

- the parents were maintaining their spousal relationship through parenting, which was triangulating in different ways both of their children. Cindy had taken on the role of peacemaker in the family while Bryan was mom's confidante. This process was contributing to Bryan's inability to move in and out of the family system;

- both Ruth and Ernie had difficulty asserting their own autonomy in their relationship. Their emotional need to be together on all issues was usurping their need to establish some form of separateness and it was questionable how healthily they would be able to let their own children individuate.

The problem checklist pointed out that all family members saw themselves as having difficulty showing and sharing their feelings. The style of communication around both instrumental and affective issues was generally indirect and unclear. Ernie showed his concerns through expressions of anger which were seen to distance Bryan and mom while Cindy would take on a peacemaker role. Mom saw herself as expressing some of her worries to Bryan as well as exploding in "silent rages" by slamming cupboard doors and the like. This style of communication became a source of concern for the parents during therapy as they became more cognitively aware of the dysfunctional patterns it established in their family.

The ongoing sessions were broken down to include, at times, the whole family as well as the parental subsystem. In addition to the parents' concerns regarding their children they opened the door to explore their own relationship. Both spouses were concerned over the distance that had slowly permeated their relationship. They saw themselves as basically getting along, which meant to them, rarely fighting. Their involvement with their work and children to the exclusion of each other, allowed them to avoid looking at and dealing with their own needs for closeness and separateness.

Therapy with Ruth and Ernie took the form of helping them establish their differences by exploring beliefs, values, thoughts and feelings about issues. This allowed the couple to experience remaining connected while expressing their own individuality. Unresolved family of origin issues were seen to influence both adults' need to maintain peace in the home. Ruth, a middle child, saw her role in her family of origin as maintaining family harmony. She was the good kid who tried to keep everyone happy by helping around the home and not causing any upset whatever. Ernie presented that he had long ago made a decision to have a conflict free home. Life in his family of origin, especially during adolescence, had been very conflictual. In his efforts to raise his own family differently, Ernie had established, for himself, a situation where peace in his home was maintained no matter the individual or collective cost.

The intervention, that of helping the parents establish their own individuality then enabled them to allow their children to separate and individuate from the family while maintaining a healthy sense of belonging. Bryan, and soon Cindy, needed to be free to explore the world outside of the home, to be free to move in and out of the family system. Developmental theory suggests that the family system needs to be comfortable with the differences the adolescent will bring into the system. In this primary psychosocial stage between childhood and adulthood, as the adolescent searches for his or her own unique identity, family rules and regulations concerning privacy, control and responsibility often are challenged. At times, parents respond to this challenge by increasing the teen's dependency on them.

As the parents became less threatened by Bryan's need for independence he began to make some initial contacts with peers. Bryan was going out each night and had brought some of his friends to the home. As Ruth and Ernie saw Bryan become more involved in "normal" teen activities they became less concerned about any suicidal ideation on their son's part.

<u>An evaluation of the attachment project for the B family</u>

In reviewing the FAM General Score for the B family at Time 1 it was apparent that all family members saw themselves as having difficulty in the areas of communication, affective

expression and affective involvement. Ruth also indicated that the areas of task accomplishment and role performance were problematic. Additionally, Bryan showed elevated scores in the areas of control and values and norms.

At Time 2 all scale scores had lowered (see Figure 2). Bryan's scores in the areas of control and values and norms, though lower, remained above the "normal" level. Given that control and values and norms are recognized problem areas in adolescent development Bryan's higher scores in these areas were somewhat anticipated.

In reviewing the FAM profile for the B family at Time 1 it was again apparent that each family member saw themselves as having some difficulty communicating their needs as well as interacting affectively. Bryan's score in the area of control was also elevated.

At Time 2 all scale scores had normalized (see Figure 2.1).

Insert Figures 2 & 2.1 about here

The problem checklist at Time 1 showed overall family satisfaction to be highest in instrumental areas such as proper use of alcohol, drugs, discipline, physical force, housing situation and family finances and lowest in affective areas such

FIGURE 2

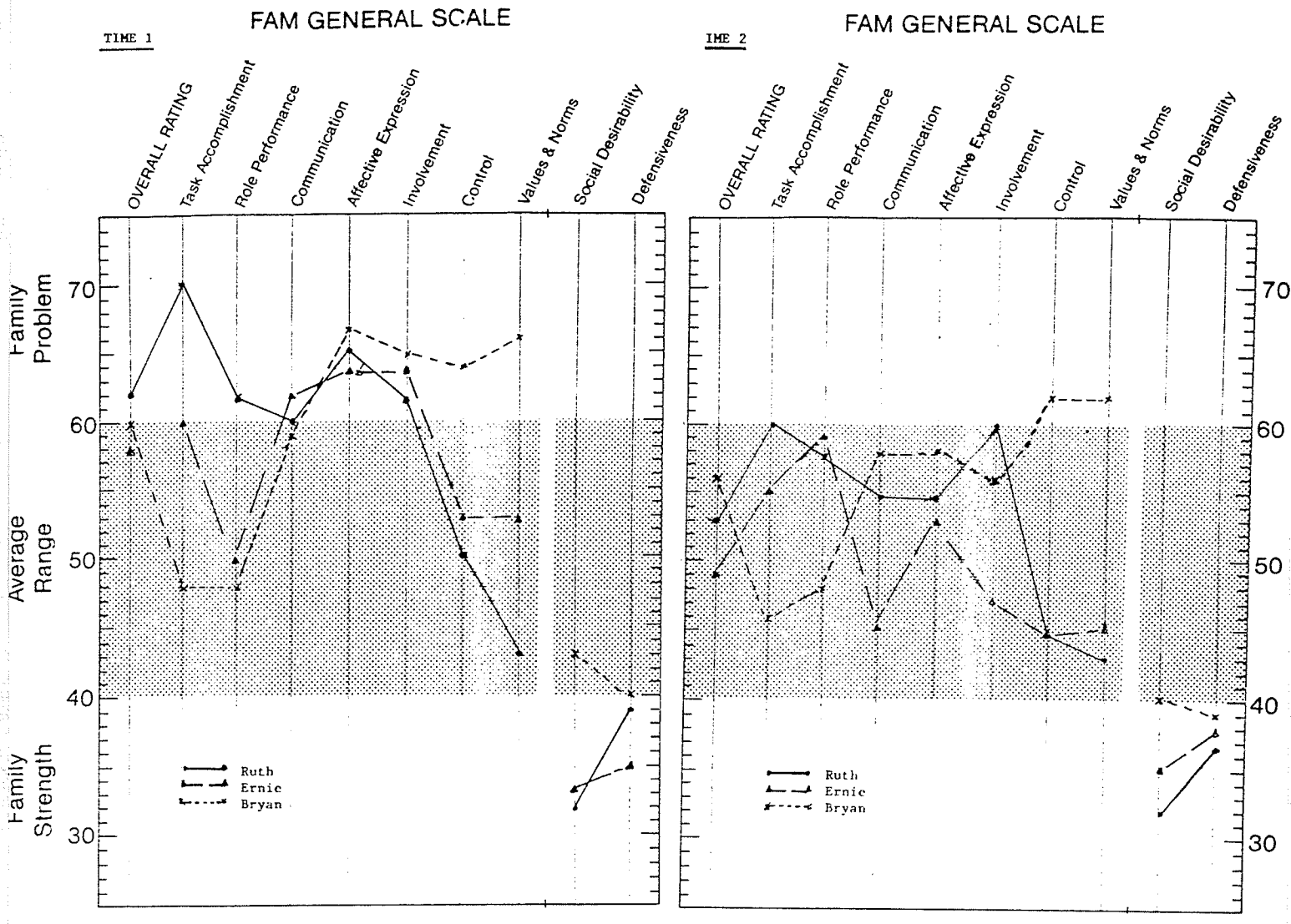
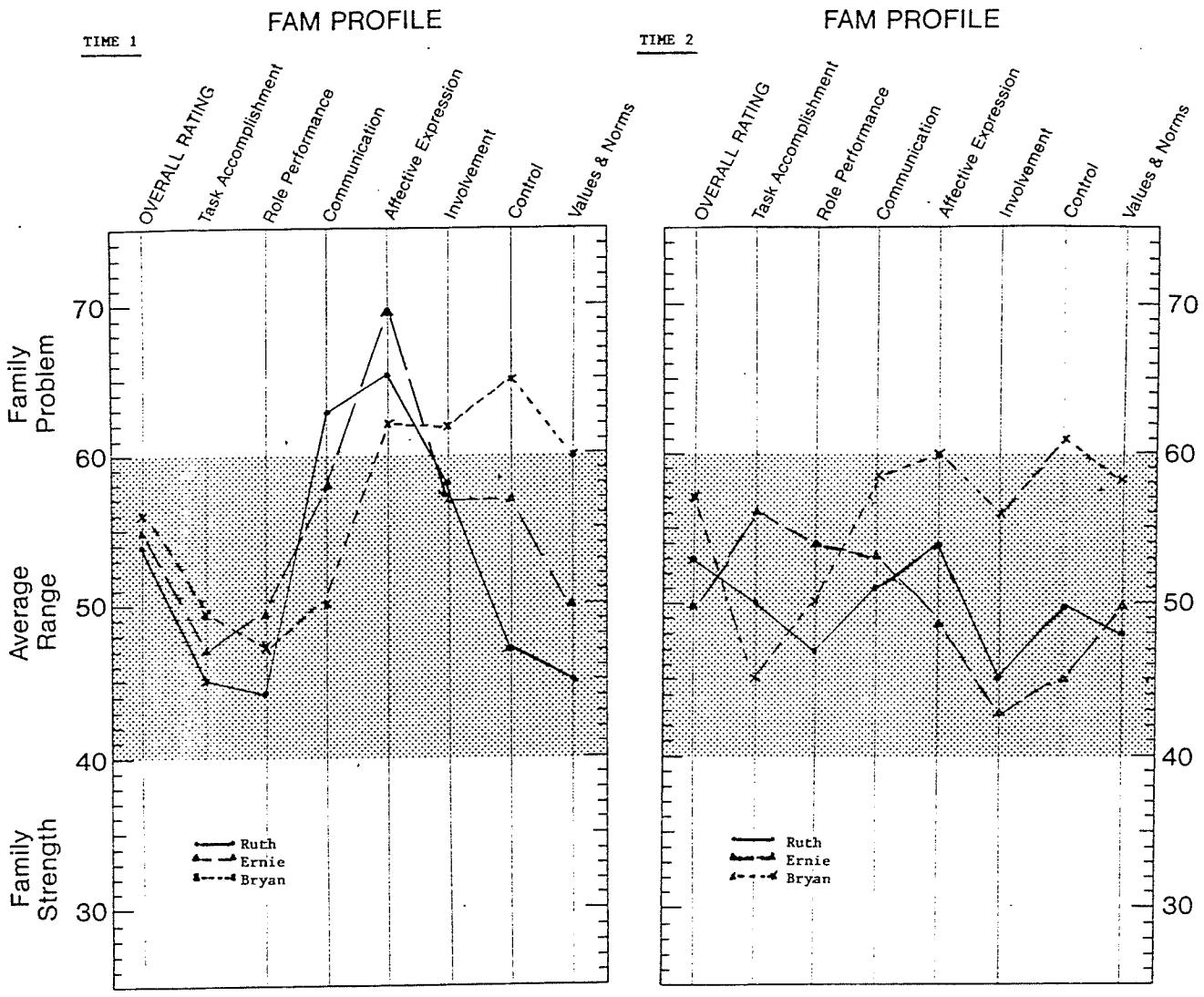

FAM GENERAL SCALE
TIME 1
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Ruth
Ernie
Bryan
FAM GENERAL SCALE
IME 2
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
70
60
50
40
30
Ruth
Ernie
Bryan

FIGURE 2.1


FAM PROFILE
TIME 1
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Ruth
Ernie
Bryan
FAM PROFILE
TIME 2
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
70
60
50
40
30
Ruth
Ernie
Bryan

as showing and sharing feelings, problems and family relationships.

At Time 2 overall family satisfaction was higher. Making sensible rules and amount of independence in the family were still low areas of satisfaction for Bryan. As well, Ruth scored in between in the area of sharing of responsibilities. This topic area was often addressed by the couple during the therapy. Ruth felt that the household responsibilities were not being equitably shared following her transition into the work force. She saw herself as having two full time jobs. Although there appeared to be some movement for the couple in this area it remained a source of discontent (see Tables 2, 2.1, 2.2 & 2.3).

Insert Tables 2, 2.1, 2.2 & 2.3 about here

Client feedback was mostly positive. Both Ruth and Ernie would have liked to have heard from a professional that their son would never again show any forms of self-destructive behaviour. They were, however, able to let their need of a diagnosis for their son go over the course of therapy. They also chose not to send Bryan to a psychiatrist which was a great relief for this young person. The parents strongly felt that involving the family in therapy had been helpful for everybody concerned.

TABLE 2
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Ernie, Time 1
B = Ernie, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				AB	
2. Sharing feelings like anger, sadness, hurt		A		B	
3. Sharing problems with the family			A	B	
4. Making sensible rules				AB	
5. Being able to discuss what is right and wrong				AB	
6. Sharing of responsibilities				AB	
7. Handling of anger and frustration			A	B	
8. Dealing with matters concerning sex				AB	
9. Proper use of alcohol, drugs				AB	
10. Use of discipline				AB	
11. Use of physical force				AB	
12. The amount of independence you have in the family				AB	
13. Making contact with friends, relatives, church, etc.			A	B	
14. Relationships between parents			A	B	
15. Relationships between children			A	B	
16. Relationships between parents and children			A	B	
17. Time family members spend together		A		B	
18. Situation at work or school				AB	
19. Family finances				AB	
20. Housing situation				AB	
21. Overall satisfaction with my family				AB	

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself			A	B	

TABLE 2.1
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Ruth, Time 1
B = Ruth, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				AB	
2. Sharing feelings like anger, sadness, hurt			A	B	
3. Sharing problems with the family			A	B	
4. Making sensible rules			A	B	
5. Being able to discuss what is right and wrong				AB	
6. Sharing of responsibilities		A	B		
7. Handling of anger and frustration			A	B	
8. Dealing with matters concerning sex					A
9. Proper use of alcohol, drugs				AB	
10. Use of discipline				AB	
11. Use of physical force					AB
12. The amount of independence you have in the family			AB		
13. Making contact with friends, relatives, church, etc.			A	B	
14. Relationships between parents			A	B	
15. Relationships between children			A	B	
16. Relationships between parents and children			A	B	
17. Time family members spend together		A		B	
18. Situation at work or school				AB	
19. Family finances			AB		
20. Housing situation					AB
21. Overall satisfaction with my family			A	B	
MAKE THE LAST RATING FOR YOURSELF:					
22. Feeling good about myself			A	B	

TABLE 2.2
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Bryan, Time 1
B = Bryan, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				A	B
2. Sharing feelings like anger, sadness, hurt			A	B	
3. Sharing problems with the family			A	B	
4. Making sensible rules			A	B	
5. Being able to discuss what is right and wrong			A	B	
6. Sharing of responsibilities					AB
7. Handling of anger and frustration		A		B	
8. Dealing with matters concerning sex					AB
9. Proper use of alcohol, drugs					AB
10. Use of discipline		A		B	
11. Use of physical force					AB
12. The amount of independence you have in the family			A		B
13. Making contact with friends, relatives, etc.			A	B	
14. Relationships between parents			A	B	
15. Relationships between children			AB		
16. Relationships between parents and children			A		B
17. Time family members spend together		A		B	
18. Situation at work or school			A	B	
19. Family finances	A		B		
20. Housing situation					AB
21. Overall satisfaction with my family			A	B	

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself			A	B	

TABLE 2.3
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Cindy, Time 1
B = Cindy, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					AB
2. Sharing feelings like anger, sadness, hurt			A	B	
3. Sharing problems with the family			A	B	
4. Making sensible rules				AB	
5. Being able to discuss what is right and wrong					AB
6. Sharing of responsibilities				AB	
7. Handling of anger and frustration				A	B
8. Dealing with matters concerning sex			A	B	
9. Proper use of alcohol, drugs	A		B		
10. Use of discipline				AB	
11. Use of physical force					AB
12. The amount of independence you have in the family				AB	
13. Making contact with friends, relatives, etc.					AB
14. Relationships between parents			A		B
15. Relationships between children			AB		
16. Relationships between parents and children				A	B
17. Time family members spend together		A		B	
18. Situation at work or school			AB		
19. Family finances				AB	
20. Housing situation					AB
21. Overall satisfaction with my family				AB	

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself			A	B	

The family physician was also satisfied with the course of therapy and agreed with the parents' decision not to follow through with the psychiatric referral. Exploring this family through the lens of developmental theory allowed the physician to see the parents struggle over their son's emerging independence. From a systems standpoint, one would anticipate that this reframe on the physician's earlier thinking about the parents' noninvolvement and possible disinterest in their son, would affect the patient- physician relationship.

Discussion

The B family initially became involved with the attachment project as they awaited their son's position for psychiatric counselling to become available. Prior to their termination from counselling it was agreed between the family, social worker and family physician that psychiatric counselling was no longer necessary.

The B family needed to address a number of developmental issues concerning the tasks families with adolescents need to master. These critical tasks included communication and boundary negotiation.

This case was also a challenge for myself in that the presenting problem of "attempted suicide" was, for me, difficult

to let go of. Yet, had I focused solely on Bryan I would have maintained an intrapsychic focus to the problem and not looked at the social relationships in the family which were, in part, maintaining this young person's troubles.

This case was also a good example of how family of origin issues impact subsequent generations. "The way we see ourselves, others and the world is shaped in the setting of our family of origin, the views we develop there stay with us throughout life" (Richardson, p. 1, 1984). Although both Ernie and Ruth had left their families of origin physically, they each brought into their family of procreation unfinished business which was getting in the way of their new relationships. In therapy, Ernie and Ruth began to reassess their own issues which were interfering with the process of letting their children separate and individuate from the family.

The C family

This was a single parent family consisting of Sandra age 39 and her two children, Michael age 11, and Donald age 9. Sandra had been an only adopted child in a two parent Irish, French Canadian family. Sandra and her husband Larry had separated one month prior to the referral. Sandra was presently working part time and was receiving financial support from Larry. In addition, Sandra had had a mastectomy six months prior to the referral.

The biopsychosocial approach

Sandra approached her physician with a number of concerns about herself and her children. She was having difficulty sleeping and was experiencing prolonged severe headaches. She also felt out of control with her eating. Her eldest son, considered to be hyperactive, was refusing to take his medication. Her youngest son seemed to be eating compulsively. During the course of her medical consultation Sandra discussed how her life had unexpectedly been disrupted when her husband decided to leave their twenty year relationship. Although she had been aware that they were experiencing marital problems she was not prepared for his leaving. Though Sandra did not present her recent fight with cancer as being an issue, her physician was aware that she had recently undergone a radical mastectomy and saw the longterm prognosis for Sandra as being poor. Given the larger picture the physician strongly believed that comprehensive health care, for Sandra, could best be provided if her individual, social and biological needs were attended to professionally. Thus, a referral to the attachment project was activated.

The referral process

In discussing this family with myself the physician expressed his concern regarding the poor longterm prognosis for

Sandra and the impact her fight with cancer and likely death would have on her and the family. The physician saw his patient's extended network for support as limited.

The physician was quite open regarding who to include or exclude in the therapy. He was in full agreement with myself that the tasks of counselling would include helping this family in transition to come to terms with and adjust to their losses, as well as connecting the family with their extended family members and friends, for support, whenever possible.

I then contacted Sandra who presented that she was having a lot of difficulty adjusting to the separation. She claimed to be "all tied up in feelings...and having great difficulty getting through each day". She saw her boys as suffering and was concerned that they were not sharing their feelings with her. The eldest son, Michael, was refusing to take his medication for hyperactivity. He was becoming increasingly more difficult to manage both at home and at school. He was also refusing to visit his father. Sandra was also worried about her other boy, Donald, who was described as eating large amounts of food somewhat compulsively.

Sandra hoped that counselling would help her sort through the emotional turmoil she was experiencing around her marriage and current separation. She also wanted a safe place for her

sons to go where they would be provided with an opportunity to talk about their own pain.

During the course of this conversation I made a decision to only invite Sandra to the first session. It was clear in talking to Sandra that she was overwhelmed with her loss and needed an opportunity to talk about what this loss meant for her. At this stage, this process was not seen as being therapeutic for her children. In order to provide Sandra with an opportunity to work through her grief reaction she needed to look at her own relationship with her husband. Parenting together was only one part of their relationship.

I also recognized that one of the tasks of therapy would be to help Sandra get to a place where she could hear her son's pain without needing to project blame onto their father for causing his pain.

The first session

The goal of this session was to hear from Sandra what the issues were for her, some of the history behind these issues, what the situation at home looked like at present, and what she was hoping to gain through therapy.

The presenting problem for Sandra was working through her

recent separation. She saw herself as being caught in an emotional web. At times she found herself feeling depressed and apathetic towards life. At other times she felt overwhelmed by her anger at having been placed in this position. Her most predominant feeling was anger towards her husband. Sandra saw herself as being a victim of her husband's decision to leave and felt powerless in this role. She states, "I was his doormat, I cooked for him, cleaned for him, did everything I could for him and one day when he was ready to leave I laid down so that he could walk over me."

Sandra was also angry at the pain her husband was causing his sons. She says, "he doesn't even care, he's off in this new relationship and has no time for us. He expects them to just get over this." Michael was apparently very angry with his dad and was refusing to visit him. Michael's behaviour had become significantly more difficult to manage during this period of separation.

Throughout the first session Sandra was very sad and weepy. Even her expressions of anger came through her tears. Although a part of her recognized that the marriage had not been good for her in many ways, it was much too early for her to accept this loss. The first session drew to a close with the therapist discussing with Sandra that such intense feelings were natural and part of a grieving process which she was now working through.

The intervention

I saw various groupings of this system weekly throughout this practicum experience. In fact, at Sandra's request and with the collaboration of her physician, it was arranged for counselling to be continued beyond the duration of the attachment project. At that time the family took on my fee for service.

Counselling with this family initially began with working through their grief around the separation. I encouraged family members to give some release to their feelings by talking to whomever they customarily went to for support as much as possible. I met with the family as a whole, with Sandra alone and on two occasions with the two boys.

In meetings with Sandra the work began with addressing the feelings and emotional ties which were keeping her from letting go of her relationship with Larry. Although their marriage had been very distant over the past year and Larry was currently involved in another relationship, it was difficult for Sandra to accept that the relationship was in fact over.

In working through the process of grieving with Sandra we explored the losses her changed circumstances meant to her. Feelings of loss included: a) letting go of the dream of the perfect marriage, b) loss of emotional and financial security,

and c) a loss of roles.

Sandra stated that she had been well taken care of and coddled most of her life. She saw herself as having a somewhat romanticized vision of married life, the reality of which her marriage did not meet. Over the years she had responded to this discrepancy by attempting to make things right. She "took on" the responsibility of making her marriage work by blaming herself for its problems and attempting to correct all the things Larry criticized. This became a self-defeating process.

During therapy, Sandra looked at many of the things she had given up in her efforts to maintain her vision of the perfect relationship. She began to acknowledge the many limitations of the marriage, for her, both historically and currently.

The loss of security for Sandra was at times paralyzing. She was afraid of the many financial and practical changes the family would have to make. Prior to the separation Sandra had been totally dependent upon her husband for income. Although she had some specialized vocational training her feelings of inadequacy were so large that she was certain she would fail in the working world.

As well as financial security, Larry's leaving had threatened Sandra's emotional security. He had been her

confidante, companion and support person for over twenty years. Although their marriage had been difficult in many ways it had also had some positive aspects which were very painful for Sandra to let go of.

Separation brings with it a loss of roles and a move to take on new roles. Sandra needed to work through all the role losses no longer being Larry's wife meant for her and her children. This loss of role also brought with it a loss of status and support, for Sandra, from relatives and mutual friends in their community. Sandra had been informed by Larry's family that they felt they should only see the boys through Larry. She was also convinced that many of their married friends would no longer be involved with her.

Articulating these losses made them less overwhelming and threatening for Sandra. Slowly, over the course of therapy, she was able to see and experience some of the gains which were born from these losses. For Sandra, the most rewarding aspect of therapy was her emerging independence as a person in her own right.

The grief work with the boys helped them address their very real anger towards both parents for not making the marriage work. Both boys experienced their anger and pain in many different ways throughout the time I was involved. Initially Michael denied the

finality of his parents separation and tried to help them reunite. At times each of the boys were used as intermediaries by either parent in their effort to maintain either more closeness or distance in the relationship.

In the fall the boys also took part in a group designed to help children work through their feelings around this specific type of loss.

Adjusting to the separation brought forward other problem areas common to families in transition. Areas of concern were redefining family boundaries, rules and roles as well as reducing the parents reactivity towards each other such that they could co-parent effectively. Although I attempted to engage Larry in the therapy at various times to discuss parenting concerns, he was not willing to attend sessions. It was clear from the content of the sessions, however, that both parents were, in part, acting out their relationship issues through the children.

The work in this area, with Sandra, involved helping her resolve her angry feelings towards Larry such that she was feeling less reactive and vengeful towards him; helping her become more cognitively aware of the danger of triangulating either child in their parents relationship difficulties; and maintaining the parental hierarchy such that neither child became parentified in the system.

A final significant aspect of the therapy with this family was adjusting to the emotional impact of Sandra's recent fight with cancer. Although Sandra hoped that all the cancer had been removed she was also aware that the spread of the disease had been quite advanced. In counselling Sandra began to let go of her need to be no different than before and began to accept that her illness had changed her and that she could no longer be the same. She also became more aware of the connection between the disease and the feelings of stress it brought to her life. As Sandra began to adjust to having had cancer she had less of a need to deny its existence and became more of a resource for her children and others.

As Larry had left the marriage while Sandra was in the process of chemotherapy, Michael was in part blaming the cancer for his parents' marital break-up. The different experience of openly talking about the cancer as well as promoting the expression of feelings about the cancer was seen to help the family better adapt to the changes it meant for them.

An evaluation of the attachment project for the C family

Only Sandra filled out the FAM questionnaire as both her boys were underage. At Time 1 the scores in the FAM General Scale indicated a high level of general family dysfunction. This was congruent with Sandra's description of family problems and my

observations. At Time 2 the scores remained elevated in many of the subscales although scores were no longer as high. Time 2 for this family, however, was not at the termination of therapy, as in other cases, but was at the conclusion of the attachment project. Thus, in this instance, the therapist utilized Time 2 in part to direct intervention. The scores were helpful in outlining the areas where significant changes had taken place and the other areas which remained problematic (see Figure 3).

The scores for Sandra at Time 1 of the FAM profile were extremely high indicating significant dysfunction in how Sandra perceived herself as functioning within the family. It was encouraging to note that these scores had greatly reduced at Time 2 (see Figure 3.1).

Insert Figures 3 & 3.1 about here

The problem checklist also showed many areas of dissatisfaction in Sandra's life at Time 1. Grieving the loss of her relationship with Larry enabled Sandra to emotionally and practically move towards feeling more satisfied about herself and her family as shown at Time 2 (see Table 3).

Insert Table 3 about here

FIGURE 3

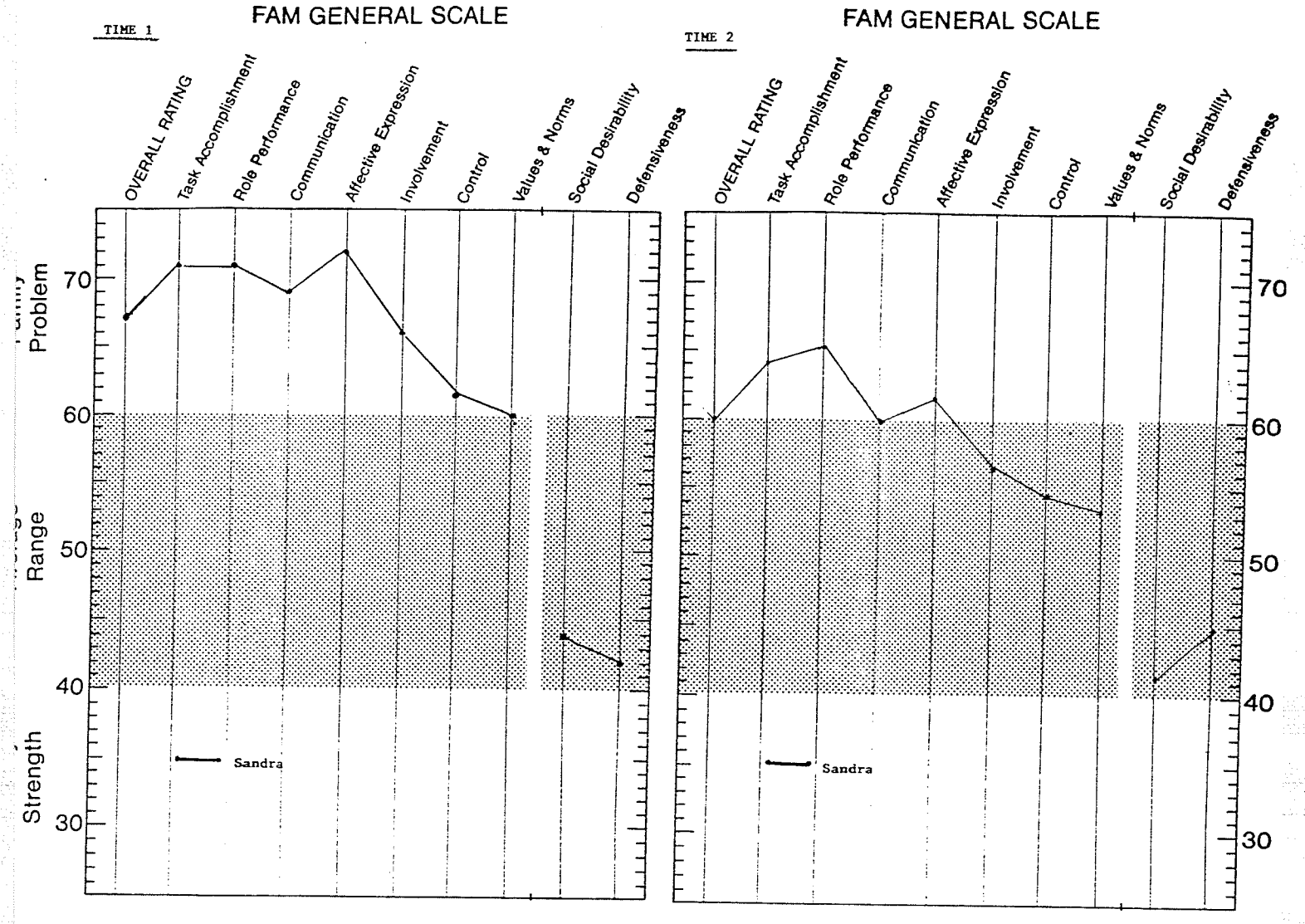

FAM GENERAL SCALE
TIME 1
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Problem
Range
Strength
70
60
50
40
30
Sandra
FAM GENERAL SCALE
TIME 2
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
70
60
50
40
30
Sandra

FIGURE 3.1

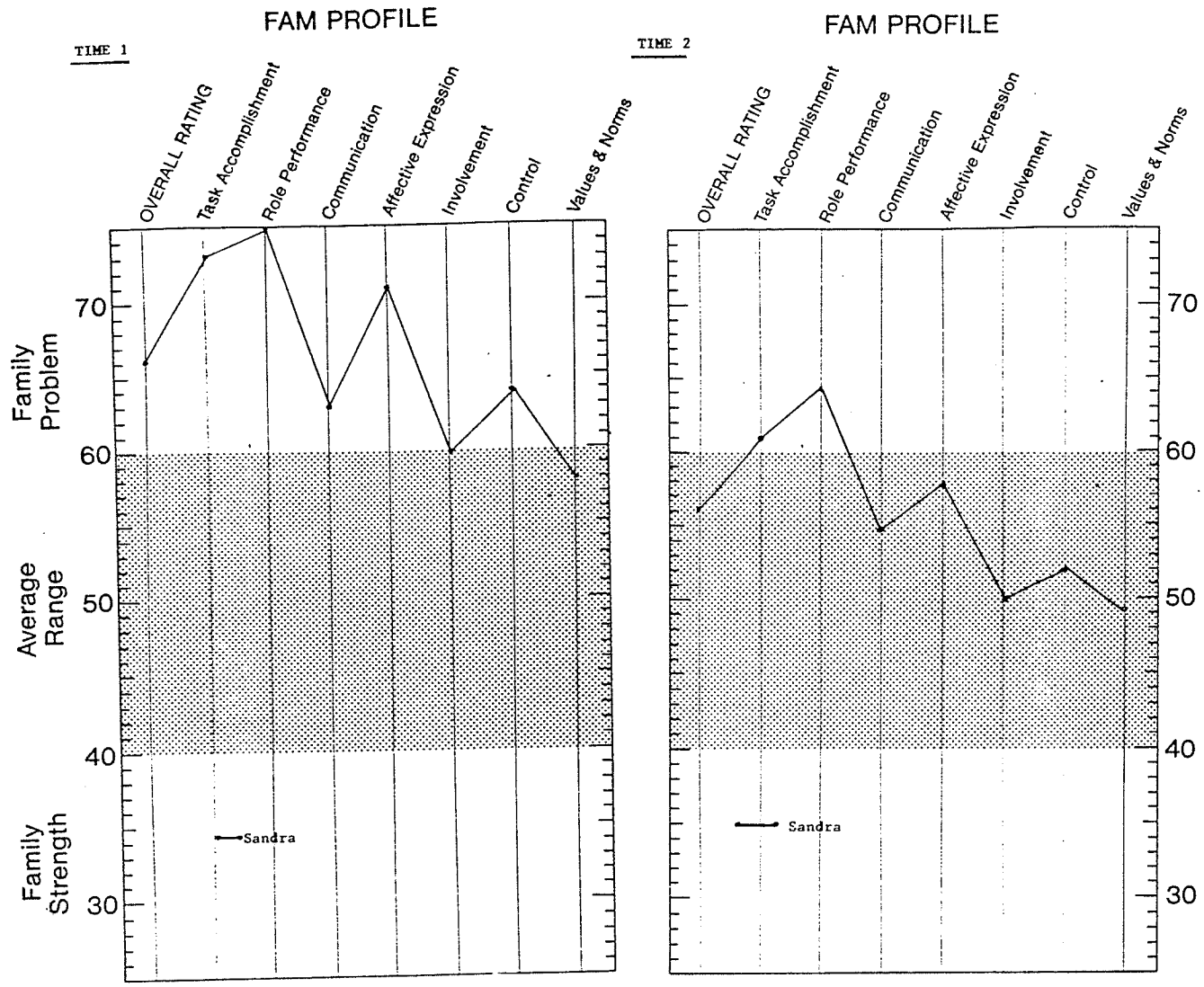

FAM PROFILE
TIME 1
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Sandra
FAM PROFILE
TIME 2
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
70
60
50
40
30
Sandra

TABLE 3
PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS. INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING NOW IN EACH AREA. PUT A CHECK (✓) IN THE BOX THAT SHOWS YOUR FEELING ABOUT EACH AREA.

A = Sandra, Time 1
B = Sandra, Time 2

	Very Dis-Satisfied	Dis-Satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)	A			B	
2. Sharing feelings like anger, sadness, hurt	A			B	
3. Sharing problems with the family	A		B		
4. Making sensible rules		A	B		
5. Being able to discuss what is right and wrong		A	B		
6. Sharing of responsibilities		A	B		
7. Handling of anger and frustration	A		B		
8. Dealing with matters concerning sex	A		B		
9. Proper use of alcohol, drugs				AB	
10. Use of discipline			A	B	
11. Use of physical force			A	B	
12. The amount of independence you have in the family		A		B	
13. Making contact with friends, relatives, church, etc.		A		B	
14. Relationships between parents	A		B		
15. Relationships between children		A	B		
16. Relationships between parents and children		A	B		
17. Time family members spend together			AB		
18. Situation at work or school		A	B		
19. Family finances		A		B	
20. Housing situation		A		B	
21. Overall satisfaction with my family		A	B		

MAKE THE LAST RATING FOR YOURSELF:

22. Feeling good about myself	A		B		

Throughout counselling Sandra verbalized how helpful she was finding the process for herself and her family. She particularly liked the link between myself and her doctor stating that she knew she was getting the best of care. Sandra verbalized many changes that she saw herself as making as she "shed the old protective layers to reach her true self".

Sandra's physician was also pleased with the results of his referral. He saw professional counselling as being necessary given all the life and health problems Sandra was facing. He was pleased he was able to recommend a service he believed in and had access to.

I learned greatly from my involvement with this family system. It was important for me to learn about the loyalty issues which come to the surface for children when they see a parent hurting or sick. It was helpful for me to be part of Sandra's working through her loss. Finally, it was important to translate some of the emotional issues this family was working through to their family physician who was also actively involved with this family.

Discussion

Once again this was a very interesting system to work with. The physician's ongoing contact with the family provided an early

opportunity for this system to receive help before the sustained stress they were experiencing created even more difficulties. As a treatment resource, the physician was invaluable. He was an extremely useful source of information regarding the patient, family system, as well as the medical aspects of Sandra's care.

When Sandra first entered counselling she presented herself as a victim of life and clearly saw herself as being powerless. Over the course of the year, however, she sold her house, returned to work and moved to an area in the city where she had always wanted to live. Sandra also became much more involved with her own extended family and visited her mother twice over the year. This was quite different for her.

The early sessions with Sandra and the boys all were filled with enormous sadness on their part and most of the sessions were spent talking about prior losses. Over time, however, as the family began to resolve and accept their losses the energy in the sessions became much more present and future oriented. Past experiences, holidays and other reminders of the way things used to be were being met with less pain and sadness and more distance. Although there were many unresolved issues for the boys regarding the separation throughout the therapy they too began focussing more energy on present concerns.

As previously mentioned, I continued with this family system

beyond the practicum experience. Over the past six months I began working with the family to help them accept Sandra's terminal illness. Sandra has now passed away and the boys are living with their father. I feel I was greatly enriched as a therapist in working with this woman and her boys. She had much to teach others about loss and about how from each loss there is always the potential for growth.

CHAPTER 3

DISCUSSION

> ...A woman in her early thirties goes to her family physician with a variety of physical symptoms. The woman is concerned about feeling quite sick and is spending a great amount of time in bed, although she has a toddler to care for. The doctor, however, can find no organic explanation for the woman's complaints. Following her third appointment with her doctor the woman discloses that she is having some marital problems and is still feeling greatly upset over the death of her father a year earlier.
>
> ...A 60 year old woman approaches her physician regarding her concerns for her daughter and family in their struggle with the daughter's terminal cancer. She hoped that her physician could refer her to a professional who could help the family better cope with the many changes the cancer had brought.
>
> ...A woman in her late twenties is losing weight very rapidly and complaining of severe headaches and sleep problems. During the course of his physical exam the physician questions the woman about her social life. The woman then becomes quite sad and relates that she has recently separated with her boyfriend.

Each of these patients approached their doctor looking for medical treatment and advice for what turned out to be a psychosocial problem. In most circumstances these problems would probably be dealt with during the course of the appointment, possibly through the prescription of medicine or a referral to another medical specialty. These particular persons, however, had the opportunity to take part in an attachment project which placed a social worker, specifically trained to deal with the life problems of individuals, couples and families in collaborative practice with their family physician.

When reviewing feedback from those who took part in this project it was clear that all clients strongly believed that such an attachment was useful. In fact two clients recommended this form of service to their friends who then approached their own family physician for a counselling referral to a social worker.

In all instances it was considered by the client very important that their physician knew the social worker and recommended her service. In fact some clients had had serious hesitation about a referral to a social worker as opposed to another mental health professional, such as a psychologist or a psychiatrist. These doubts were mostly related to the general lack of clarity surrounding the social work profession and services it offers. It was the social worker's connection with the physician which was most significant in helping the client decide to follow-through on the referral.

Seven of the twelve families felt that they would not have pursued counselling if the service had not been personally recommended by their physician. The remaining families were uncertain about the direction they may have chosen to help them resolve their concerns. Four of the patients who first approached their physician were initially looking for some relief via medication until things improved for them.

Although only two patient families had approached their

physician specifically for a counselling referral, none of the families were upset by the suggestion of counselling. Some comments of families were:

> "He explained your service so well and what you were offering truly seemed to fit the needs of our family".
>
> "We needed help right away. Some things are just too important to be put on a waiting list for. It was such a relief that this service was readily available. It's been so helpful".
>
> "I initially felt that a referral to a psychiatrist would make more sense for my son but when our physician so highly recommended you I thought I should give this a try".

In addition, five of the twelve families seen stated that they had used their doctor differently while in counselling. All stated that they were seeing their physician less frequently. Some were no longer on medication. One client expressed surprise that she had used her doctor less frequently stating:

> "It certainly hasn't been a conscious decision on my part but come to think of it I haven't seen him for over a month".

This was quite a different experience for this person.

All clients stated that they would attempt to find a similar service if they needed counselling in the future. Most hoped that their physician would again be in a position to recommend a social worker to them.

In looking at how this service could be made more available to the general population all clients suggested that the service should, at least in part, be covered by the provincial health plan. All clients felt that the service was truly valuable and did fill an existing void in the provision of comprehensive health care. Despite the clients' belief that the medical plan should cover this service, eight of the twelve families said they would have paid for the service, at the time of the referral, if necessary. The remaining four families felt that they were not in a financial position to incur the additional expense of counselling.

In addressing the physician's experience of the attachment project it was found that for the physician:

- it was of utmost importance that he knew the social worker to whom he was referring his patients;
- patient inclusion and exclusion in counselling was quite significant. The physicians' need to be made aware of who was involved in the counselling had mostly to do with their wanting to remain informed of the process of the counselling such that they could talk comfortably with patients and not appear "uninformed or disinterested" in a referral that they had activated;

- the regular meetings with the social worker were useful. In addition, the physicians felt that a report for their records on each client at the end of the intervention was desirable;
- they had felt unable to adequately meet the needs of the patients they had referred for counselling for many reasons, and believed that these needs had mostly been met through this service;
- the attachment of a social worker to their practice provided a necessary and fruitful service to their patients that they would not normally receive;
- they experienced no financial loss through this project; and finally,
- they saw a continued involvement for their own practice with this project. Both physicians highly rated their affiliation experience and felt that the social work attachment, provided a useful health service.

My experience with this project was extremely positive. Working collaboratively with the physicians in the provision of biopsychosocial health care expanded my own way of thinking about the mind-body connection. For too long I had perhaps not paid enough attention to my client's general physical well-being unless a health problem was quite visible. The physicians and clients were a wealth of information, for me, about health

concerns, their affect on the individual and family system and treatments. In turn, I think I was able to expand their thinking about life problems, developmental theory, the impact of sustained stress such as chronic illness on the family and the like.

It is my contention that social work's primary commitment to direct services, its expertise in working with the personal and social problems of individuals, families and groups as well as its enabling functions can largely contribute to the health care system in its efforts to provide comprehensive health care. A specialized field for social work in family medicine provides the opportunity not only to meet the psychosocial needs of patients but also the opportunity to intervene at an early stage, before dysfunctional family patterns become entrenched and very difficult to change.

An interesting follow-up study of a physician-social worker attachment would be to review the overall health care cost of those families referred to a social worker as compared to a control group assessed as experiencing psychosocial problems but, as is often the practice today, not receiving the attention of a mental health professional. It is my hypothesis, from my own experience, that the health care cost of the former group would be significantly lower than that of the control group. One may also hypothesize that patients not seeing their physician as

often are generally experiencing better health.

In their attempt to form an alliance, physicians, social workers and the health maintenance system must address the issue of payment. The three approaches to financing social work services in primary care most often presented are: 1) fee-for-services; 2) as a part of the overall operating expenses of a clinic or office; and 3) third party payment such as the medical services plan (Madigan, 1986; Yates, 1985).

Each of these approaches has an inherent problem. Social works's entry into private practice is being received by some resistance within the profession itself (Yates, 1985). The second approach, although commonly used in hospital settings is more financially difficult to establish within a physician's smaller practice and is also strongly subject to physician influence since the physician would be paying the fee. Finally, the implementation of third party payment would be a tremendous task to complete given today's restraint-minded government (Madigan, 1986).

Social workers to date, are not accustomed or trained to concern themselves with funding for their services. Consequently, they are not adequately prepared to develop and implement cost effective analyses of their work. This lack of orientation, as well as the methodological problems in evaluating

social work services, makes it difficult for the profession to establish its service and fiscal credibility. Nonetheless, if social work in family practice is to further develop, the issue of payment must be resolved.

CONCLUSIONS

What are the primary individual and social health problems of today? What brings people to their doctors? When we entered the twentieth century we were primarily concerned with infectious and communicable diseases. Research and technology have advanced at great rates in efforts to alleviate and prevent such contagious diseases. Today, the major health concerns are chronic illnesses and their impact, psychosocial problems including family troubles, social diseases resulting from lifestyle and environmental factors, and stress induced illnesses (Rehr, 1984). Each of these concerns tremendously impacts and stresses the individual, family, health care and social systems.

Todays family doctor spends a large amount of time assessing, listening, and responding to their patients' individual and social problems. The social worker-physician attachment provides an opportuntiy to redistribute this time and perhaps utilize it more efficiently. The physicians involved in this project suggested that the consultation process and

counselling service were, for them, potentially a time saver. This finding has also been reported in other attachments.

The need for social work in the health care arena has been well documented. Given the current health concerns, the need for such services is even greater. The psychosocial problems presented to physicians clearly come within the realm of social work expertise. Such problems are commonly presented to and treated by social workers in other practice settings. Additionally, it has been suggested earlier in this report that such an attachment would serve a wider portion of the community.

The findings of this project, supported by current literature, was that patients experience the attachment of social work services to their family doctor's practice as a positive component of comprehensive health care. Family physicians hold a highly valued, trusting, long term relationship with their patient system. This relationship places the physician in a position of trust and responsibility when referring their patients to other specialities. Of primary importance for the patients involved in this project was the physicians' personal recommendation of and close affiliation to the social worker involved. This association also enabled the doctors to entrust their patients' care to the social work professional with confidence.

The proximity of the social worker to the physician enhanced both professions ability to complete comprehensive assessments of the patient system and provide ongoing case consultation. This proximity was also helpful for the patients in conceptualizing and experiencing the social worker's involvement as part of their overall health care.

It was the experience of this attachment that the shared expertise of family medicine and social work was most effective in meeting the biopsychosocial health needs of individuals and families. The success of future affiliations rests on the ability of the professions to fulfill their roles, value one another and remain cognizant of their interdependence in their joint efforts to provide optimal overall health care.

REFERENCES

Abroms, E.M. (1983). Beyond eclectism. American Journal of Psychiatry, 140 (6), 740-745.

Aponte, H. (1976). Underorganization in the poor family. In Philip J. Guerin (Ed.). Family Therapy, New York: Gardner Press.

Authier, J. and Land, T. (1978). Family: the unique component in family medicine. Journal of Family Practice, 7 (5), 1066-1068.

Bartlett, H. (1961). Emotional elements in illness: responsibilities of the medical social worker. In Readings in Theory and Practice of Medical Social Work.

Bauman, M.H. and Grace, N.T. (1977). Family process and family practice. Journal of Family Practice, 4 (6), 1135-1137.

Bowen, M. (1976). Theory in the practice of psychotherapy. In P.J. Guerin (Ed.) Family Therapy Theory and Practice. New York Gardner Press.

Bowen, M. (1978). Family Therapy in Clinical Practice. New York: Jason Aranson.

Bowen, M. (1980). Key to the use of the genogram. In E. A. Carter and M. McGoldrick (Eds.) The Family Life Cycle: A Framework For Family Therapy. New York: Gardner Press.

Bowlby, J. (1980). Attachment and Loss: Loss, Sadness and Depression. 3, New York: Basic Books.

Brieland, R. (1981). Looking towards a social work professional definition. Journal of Social Casework, 261-266.

Burbridge, P.A., Spasoff, R.A. and Steel, K.O. (1982). Social work in family practice. Canadian Family Physician, 28, 1291-1296.

Candib, L. and Glenn, M. (1983). Family medicine and family therapy: comparative development, methods and roles. Journal of Family Practice, 16 (4), 773-779.

Cassata, D.M. and Kirkman-Liff, B.L. (1981). Mental health activities of family physicians. Journal of Family Practice, 12, 683-692.

Chess, S. and Thomas, A. (1986). Temperament in clinical practice New York: Guilford Press.

Christie-Seely, J. (1981). Teaching the family system concept in family medicine. Journal of Family Practice, 13, 391-401.

Clayton, P.J. (1974). Mortality and morbidity in the first year of widowhood. Archives of General Psychiatry, 30, 747-750.

Coleman, J.V. and Patrick, D.L. (1978). Psychiatry and general health care. American Journal of Psychiatry and Health Care, 68 (5), 451-457.

Collins, J. (1965). Social Casework in a General Medical Practice. London: Pitman.

Compton, B.R. (1983). Traditional fields of practice. In A. Rosenblatt and D. Waldfogel (Eds.) Handbook of Clinical Social Work. San Francisco: Jossey-Bass.

Cooper, B., Harwin, C., Delpa, C. and Shepherd, M. (1975). Mental health care in the community: an evaluative study. Psychological Medicine, 5, 372-380.

Corney, R. (1980). Factors affecting the operation and success of social work attachement schemes to general practice. Journal of the Royal College of General Practitioners, 149-158.

Corney, R. (1983). The views of clients new to a general practice attachment scheme. Psychological Medicine, 17 (20), 1549-1558.

Corney, R. (1984). The mental and physical health of clients referred to social workers in a local authority department and a general attachment scheme. Psychological Medicine, 14, 137-144.

Crane, D. (1986). The family therapist, the primary care physician, and the health maintenance organization: pitfalls and possibilities. Family Systems Medicine, 4 (1), 22-30.

D'Arcy, D. and Schmitz, J. (1981). Sex differences in the utilization of health services for psychiatric problems of health services for psychiatric problems in Saskatchewan. In D. Coburn (Ed.) Health and Canadian Society. Don Mills, Ontario: Fitzhenry & Whiteside.

Doherty, W. J. and Baird, M.A. (1983). Family Medicine and Family Practice: Toward the Primary Care of Families. New York: Guilford Press.

Dym, B. and Berman, S.(1985). Family systems medicine. Networker, 21-29.

Engel, G.L. (1961). Is grief a disease? A challenge for medical research. Psychosomatic Medicine, 23, 18-22.

Engel, G.L. (1977). The need for a new medical model: a challenge for biomedicine. Science, 196, 129-136.

Engel, G.L. (1979). The biomedical model: a procrustean bed? Man and Medicine, 4, 257-275.

Engel, G.L. (1980). The clinical application of the biopsychosocial model. American Journal of Psychiatry, 137 (5), 535-544.

Fabrega, H. (1974). Disease and Social Behaviour: An Interdisciplinary Perspective. Cambridge: MIT Press.

Fabrega, H. (1975). The need for an ethnomedical science. Science, 189, 969-975.

Fisher, J.V., Mason, R.L. and Fisher, J.C. (1975). Emotional illness and the family phsyician 1: identification and diagnosis. Psychosomatic Medicine, 10 (2), 626-633.

Fossom, A.R., Elam, C.L. and Broaddus, D.A. (1982). Family therapy in family practice: a solution to psychosocial problems Journal of Family Practice, 15 (3), 461-465.

France, R. D., Weddington W. W. and Houpt, J.L. (1978). Referral of patients from primary care physicians to community health center. Journal of Nervous and Mental Diseases, 166, 594-598.

Freeman, D.S. (1981). Techniques of Family Therapy. U.S.A.: Jason Aronson.

Geyman, J.P. (1977). The family as the object of care in family practice, Journal of Family Practice, 5 (4), 571-575.

Geyman, J.P. (1982). Public perceptions of psychosocial problems and roles of the family physician. The Journal of Family Practice, 15 (2), 225-226.

Goldgerg, R.L. (1973). The social worker and the family physician. Social Casework, 489-495.

Goldstein, H.S., Snope, F.C. and McGreehan, D.M. (1980). Family emotional health: a survey of family practice patients. Journal of Family Practice, 10 (1), 85-90.

Graham, H. and Sher, M. (1976). Social work and general medical practice: Personal accounts of a 3 year attachment. British Journal of Social Work, 6 (2).

Greene, G., Kruse, K.A. and Arthurs, R.J. (1985). Family practice social work: a new area of specialization. Social Work in Health Care, 10 (3), 53-71.

Gross, A.M., Gross, J. and Eisenstein-Naveh, A.R. (1983). Defining the role of the social worker in primary health care. Health and Social Work, 8, 174-181.

Haley, J. (1973). Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson M.D.. New York: W.W. Norton & Co.

Houpt, J.L., Orleans, G. and Brodie (1980). The role of psychiatric and behavioural factors in the practice of medicine. American Journal of Psychiatry, 137 (1), 37-47.

Jehu, D. (1982). Clinical evaluation of social work interventions. University of Manitoba, School of Social Work, Unpublished Manuscript.

Kriesel, H.T. and Rosenthal, D.M. (1986). The family therapist and the family physician: a comparative model. Family Medicine, 18 (4), 197-200.

Leahey, M. and Wright, L.M. (1985). Intervening with families with chronic illness. Family Systems Medicine, 3 (1), 60-69.

Lee, S.H., Gianturco, D. and Eisdorfer, C. (1974). Community mental health accessibility. Archives General Psychology, 13, 335-339.

Lewis, H. (1982). The emergence of social work as a profession in health care. In H. Rehr Milestones in Social Work and Medicine. New York: Prodist.

Madigan, S.P. (1985). Obstacles to doctor-social worker collaboration. Unpublished MSW major paper. University of British Columbia, School of Social Work.

Mandelbaum, E.K. (1983). The family medicine consultant - reframing the contribution of medical social work. Family Systems Medicine, 2 (3), 309-318.

Mechanic, D. (1972). Social psychologic factors affecting the presentation of bodily complaints. The New England Journal of Medicine, 286 (21), 1132-1139.

Mechanic, D. (1980). The management of psychosocial problems in primary medical care a potential role for social work. Journal of Human Stress, 16-21.

Medalie, J.H. (1979). The family life cycle and its implications for family practice. Journal of Family Practice, 9, 47-56.

Meyer, P.H. (1980). Between families: the unattached young adult. In E.A. Carter and M. McGoldrick (Eds.). The Family Life Cycle a Framework for Family Therapy. New York: Gardner Press.

Meyers, F. (1981). Issues in social policy and organization, Journal of Social Casework, 1981.

Minuchin, S. (1974). Families and Family Therapy. Cambridge: Harvard University Press.

Morrison, Center. Morrison Problem Checklist. 3355 S.E. Powell Blvd. Portland, Oregon.

Scherz, F.H. Maturational cries and parent-child interaction. Social Casework, 1971, 52, 362-369.

Schmidt, D.D. (1978). The family as the unit of medical care. Journal of Family Practice, 7 (2), 303-313.

Schwartz, G. (1986). The I - level classification system and a systems perspective. The level four anxious neurotic youth in a family context. Unpublished MSW major paper. University of British Columbia, School of Social Work.

Skinner, H., Steinhauer, P.D. and Santa-Barbara, J. (1983). The family assessment measure. Canadian Journal of Community Mental Health, 91-105.

Skinner, H., Steinhauer, P.D. and Santa-Barbara J. (1984). The process model of family functioning. Canadian Journal of Psychiatry, 29, 77-88.

Smith, R.D. (1985). From two monologues to one dialogue: The relationship between physicians and social scientists. Canadian Family Physician, 31, 14-16.

Smith, C.K., Anderson, J.C. and Masuda, M. (1974). A survey of psychiatric care in family practice. Journal of Family Practice, 1 (1), 39 - 43.

Stoeckle, J.D., Zola, I.K., and Davidson, G.E. (1964). The quantity and significance of psychological distress in medical patients. Journal of Chronic Disorders, 17, 959-970.

Stott, P.C. and Wooley, K. (1984). A social worker attachment to a primary care team. The Practitioner, 228, 1075-1078.

Tessler, R.D., Mechanic, D. and Dimond, M. (1976). Psychological distress on physical utilization: A prospective study. Journal of Health and Social Behaviour, 17, 353-364.

Trute, B. (1985). Evaluating clinical service in family practice settings. Canadian Social Work Review, 100-122.

Trute, B. (1987). Evaluation of family practice. Workshop conducted at University of British Columbia. Continuing Education Department.

Turner, S.F. and Shapiro, C.H. (1986). Battered women: mourning the death of a relationship. Social Work, 372-376.

Von, Bertalanffy L. and Rappaport, A. (Eds.) (1956). General systems theory in general systems yearbook of the society of the advancement of general systems theory. Ann Arbor: Barun Brumfield.

Williams, P. (1979). Social workers in primary health care: The general practioner's viewpoint. Journal of the Royal College of General Practitioners, 29, 554-558.

Williamson, P., Beitman, B. and Katon, W. (1981). Beliefs that foster physician avoidance of psychosocial aspects of health care. The Journal of Family Practice, 13 (7), 999-1003.

Winter, R.d. and Whitfield, M.J. (1980). General practitioners, counselling and psychotherapy. Update, 20, 637-647.

Worden, J.W. (1982). Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner. New York: Springer.

Yates, A.G. (1985). Patient, family and physician--is there any room for the social worker? Unpublished MSW major paper. Univeristy of British Columbia, School of Social Work.

APPENDIX A

Morrison Center Problem Checklist

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing <u>now</u> in each area. Put a check (x) in the box (1-5) that shows your feeling about each area.

	Very Dis-satisfied	Dis-satisfied	In between	Satisfied	Very satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8. Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right and wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistent with discipline					
18. Participation in family fun and recreation					
19. Making individual decisions					
20. Making family decisions					
21. Seeking help for family problems from friends, relatives, church, etc.					
22. Ability to provide help to friends neighbors, relatives, church, etc.					
23. Feeling good about our family					
Make the last rating for yourself:					
24. Feeling good about myself					