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Family Therapy and Family Medicine: An Interdisciplinary Epistemology

by

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ABSTRACT

The problem which this dissertation addresses is the current absence of an inclusive epistemology for Family Medicine and Family Therapy. While biomedicine requires the empirical method to establish diagnoses, Family Therapy often embraces entirely subjective perspectives which deny the existence of norms. This poses problems for the integration of Family Therapy into health care and medical education.

My research involved the examination of clinical cases. I utilize Bernard Lonergan's Transcendental Method in which I reflect on my experience as a family therapist and family physician. Describing the whole of reality was initially defined by Three Ways of Thinking which evolved into four quadrants as described by Ken Wilber. A critique of family systems theory allows a more inclusive epistemology to be derived.

With this approach I find that both the objective and subjective dimensions of knowing can be retained. The world is mediated by meaning. Objectivity is the result of authentic subjectivity. Therapy is seen as progressing towards a good of order. The assumptions of both client and therapist are taken into account.

Reflection upon my own process of coming to know leads to an inclusive epistemology which encompasses ascending levels of consciousness, starting from attention to the data, and

progressing to the deriving of intelligent hypotheses through the use of questions, to the making of judgments about which hypothesis most likely fits the data of my research. Responsible decisions can then be made based on these judgments.

With an inclusive epistemology defined, one can more clearly recognize the limits of the biomedical model, the biopsychosocial model, patient-centered medicine and systems theory. The place of spirituality and alternative medicine can also be more clearly described. This epistemology is supportive of problem-based learning.

My conclusion is that an inclusive epistemology can be described which allows the integration of science and non-science into the medical school curriculum. It provides a basis for interdisciplinary education and a foundation for the philosophy of medical education.

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Thank you one and all.

Russ Sawa
Calgary
August 13, 1998

DEDICATION

This dissertation is dedicated to my wife, Nancy.

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INTRODUCTION

Precis

In Chapter One I recount the history of my developing questions about the relationship between Family Medicine and Family Therapy which this dissertation seeks to answer. I also define some of the key concepts which will be necessary to understanding the five remaining chapters, namely the Transcendental Method of Bernard Lonergan, his Critical Realism and my own Three Ways of Thinking. A brief chapter outline follows.

Background

After nearly 20 years as a practicing family physician and family therapist, I find the two halves of my professional life growing farther and farther apart. Over these years I have played a role in expanding the boundaries of Family Medicine to include the context of the patient and the family as a necessary component of good care. But in Family Therapy, some theorists are moving in a direction that I have found increasingly difficult to accept, even incompatible with the basic ethics I have to maintain as a physician. What is the cause of this incompatibility, I wonder. Why are the two fields that I know best, fields that should be united by the common concern for the health of individuals and their families, becoming increasingly unable to communicate with each other? The search for the solution to this dilemma moves me

to do this dissertation. Finding a way to reunite these diverging fields and discovering a way for them to dialogue are my goals.

In order to provide a clear understanding of this situation, I must begin at the beginning, by describing some of the limitations I encountered when I first became involved with Family Medicine, limitations that led me into Family Therapy. The first such incident occurred in the summer of 1975. I was in the first assignment of my family practice residency, a pediatrics rotation at the Hospital for Sick Children in Toronto. On that lovely summer day I collided with the boundaries of the biomedical model and found they were not wide enough. I was observing a pediatric gynecologist that afternoon, and her patient was an attractive, teenaged girl. It was explained to me that she had already seen four consultants in other specialties for problems of pain, but they could not figure out what was wrong. The patient looked perfectly healthy to me, and test results were all negative. How can this be? Why are all these specialists needed? Why no answer? What I had done though I had not yet realized it, was to try to solve a medical problem within the parameters of a theory, the biomedical model, that was too confining.

While still a resident, I asked my supervising family physician if he could explain to me how the family of the patient might provide an understanding of the problems I was

seeing. He handed me a book by family therapist Salvador Minuchin, a book that seemed to be about another, incomprehensible world from that of Family Medicine. That was the end of our discussion; so I resolved to see if I could find somewhere to learn about families. I chose to go to McMaster University for an elective year in Family Therapy.

Later, when I was practising Family Medicine, I saw another patient, similar to the one I had encountered in my pediatric rotation during residency. She was also a teen-aged girl. I saw her again and again for what appeared to be non-existent medical reasons. I knew there was something which had to be sorted out, but nowhere in my medical training had such situations been discussed. Physicians were supposed to see sick people, whose symptoms and test results led to medical interventions that fixed the problem.

Although it was not clear to me at the time, I had arrived at the realization that the family of the patient might somehow provide some answers. Upon reflection, I see that the necessary insight was that the biomedical model taught to me in medical school had to be expanded to include the family. The biomedical model poses criteria for what is acceptable data for the attainment of knowledge. Anything not within its empirical parameters is excluded. In my medical training I was taught to think in a dualist fashion, to distinguish what is organic from what is psychological. The biomedical approach is to first rule out the physical; what

remains must be considered as psychiatric.

What I found upon later experience, however, was that these two young women mentioned above were somatizing. They were expressing their psychological stress in terms of physical pain, and my biomedical education was too narrow to explain their problems. Some practitioners of this model might say that these patients were not of concern to the doctor who deals with "real" medical problems; they should be seen by a psychiatrist or psychologist or social worker. But I was not satisfied with that position, and resolved to find a way to take care of these patients in my own practice, not to treat them as if they were split in half.

These clinical experiences initiated the journey which is the foundation of my present research. Upon reflection, I now see that my earliest introduction to this general theme was laid out by C. P. Snow in his 1959 essay, 'The Two Cultures,' which I first read in an introductory English course at the beginning of my undergraduate training that focused on both philosophy and biology. This essay laid out for me the dualistic split that plagues our intellectual community, a fact that has fascinated and challenged me ever since. When I read Snow in 1964, I did not realize that he laid out for me the agenda of a lifetime, that is to say, the integration of art and science into a new paradigm which encompasses them both.

Family Medicine

Family Medicine is the practice of primary care. Primary

care medicine involves the first contact a patient has with the medical system. The doctor will either be able to deal with the problem or refer the patient to consultants for more specizalized interventions. In the past General Practice was the discipline most often involved in primary care. Family Medicine began in the 1960's and has become the discipline which is now viewed as the primary care medical health specialty. It is also a body of knowledge which represents a world view about problems encountered by Family Physicians.[1] Among the principles of Family Medicine are a commitment to the person, an understanding of the context of illness, prevention and health promotion, and an emphasis on the doctor-patient relationship. Family physicians are a community-based resource to a defined population.[2] To some Family Medicine means a unique clinical discipline about the family and health.[3] Family Medicine integrates concepts and practices from many disciplines, including Family Therapy.

Family Therapy

Family Therapy is considered by some to be a type of psychotherapy which is based on systems thinking[4] and often meets with the whole family. As a form of therapy it seeks to solve relationship issues and many emotional problems.[5] Often, but not always, two or more generations attend therapy sessions together.[6] The goal is usually to change the family system.[7] Family therapists today treat a wide assortment of mental illnesses.

As a family physician trained in Family Therapy, I saw Family Therapy moving into a realm which is farther and farther away from the empirical world of medicine. My purpose in this thesis is to describe interdisciplinary thinking to help integrate concepts from Family Therapy into Family Medicine and vice versa.

Important Concepts

Transcendental Method. I have come to recognize that my own methodology has been strongly influenced by my study of philosophy, and that I needed concepts which I found in the writings of Bernard Lonergan to find solutions to the questions I was asking. In brief, Lonergan's Transcendental Method has four steps. I look at the data of my experience from which questions arise. I form hypotheses about these questions. I then reason as to what the correct hypothesis is. Once I have made a judgment about what is a reasonable hypothesis, the decisions I make can be responsibly made in light of that knowledge.

I chose Family Systems Therapy as the field from which I worked out the principles for deriving an integration between Family Therapy and Family Medicine. I developed a hypothesis which is my integrative vision. The final step in Lonergan's Transcendental Method is to make decisions in conformity with one's hypothesis. One decision I made was to try it out. I did so initially in teaching undergraduate medicine.

Critical Realism. The cognitive theory of Bernard Lon-

ergan has been called **critical realism,** which is a form of moderate realism.[8] Critical realism invites us to answer the question, "What am I doing when I am knowing?" by attending to ourselves as subjects. In preparing this dissertation, I had to reflect on my own experience of coming to know in order to identify the steps I took in coming to know. The first step in this process was to reflect on my experience and recognize that I experienced data which was both outer (from my senses) and inner (from my interior consciousness). I thus experienced the data which I have described in this dissertation.

The second step was to consider the meaning of the questions which the data evoked in my mind and to come to an understanding of it, through insight. I describe such experiences throughout this study. I formed hypotheses about my understanding of the data. It was as a family physician with a background in philosophy, who had learned some models of Family Therapy and psychotherapy, that I was coming to this understanding. I had to ask myself, "Does my understanding fit the facts, or is there a flaw in my collection of the data or the questions I have asked about it?"

I then gradually moved to the third step in coming to know: I made judgments. I decided whether my hypothesis fit the data which I had come to understand. I realized that my viewpoint may be quite different from that of a psychiatrist or some other specialist. I decided that knowledge is the result of my experience of the three levels of coming to know,

namely experience, understanding, and judgment. In the following chapters, I discuss all of these levels in relation to my personal and clinical experience.

Throughout this study, when I speak of realism, I do not speak of a naive realism, in which knowing is a matter of taking a good look, in which objectivity is a matter of seeing what there is to be seen, a reality that is given in immediate experience.[9] Rather, I speak of a critical realism in which our world is mediated by meaning in which

> The objects to which we are related immediately are the objects intended by our questioning and known by correct answering.[10]

The object of our knowing is being, both inner and outer. Being or the real, which I have just referred to, is known in judgment. When we objectify, through speaking and writing, our acts of understanding and formulating, of reflecting, weighing the evidence, and judging and deciding we come to understand the impact of meaning on our coming to know. Since meaning is influenced by our historical context in which our statements are formulated, they are always relative to their historical context. Since each person draws on that context of meaning, we also construct our knowledge of the real, which is known by correct answers to our questions.

Three Ways of Thinking. When I began teaching about Family Medicine to medical students and residents in 1978, I encountered the need to integrate the physical and non-physical, the somatic and psychological, the material and

spiritual realms. I found that the usual view to be a hinderance, the view that mind and body must be seen as separate entities, (check out the body, then if you don't find the problem, check out the psyche). I needed to integrate these realities so that I could teach about relating to patients as persons.

I did so with my model of Three Ways of Thinking,[11] which I conceived in the late 1980's. In this model, with the person as the starting point, reality can be understood in three different ways: the empirical, the systemic, and the personal. I came to this understanding by reflecting on my own thinking when solving clinical problems. I realized that sometimes I reduce the data in an empirical fashion (reduction), sometimes I attend to developmental sequences (organic or systems thinking), and sometimes I relate to a person as a person, aware of spiritual, symbolic, and unconscious factors. I became aware that I switch freely among these three ways of thinking. When I am working as a physician, I came to realize, it is as a person in relationship to other persons that I participate in healing in the non-physical domain. My discussions with students and my personal reflections led me to identify these Three Ways of Thinking, but I still needed a way of accounting for the differences we each experience subjectively.

Outline of Chapters

In Chapter Two I discuss biomedicine and explain its philosophical limitations, as well as some of the problems it has solved. I then discuss the development of Family Medicine as a response to these limitations. In Chapter Three I discuss Family Systems Therapy and the philosophical limitations of its development. I review the development of Family Therapy and focus on systems theory as it has been developed by family therapy theorists. I focus on key issues which led me to do this dissertation.

In Chapter Four I discuss philosophical concepts which can lead to an integration of the empirical and the systemic ways of thinking. In Chapter Five I propose an inclusive epistemology which can be used to integrate the various models with which clinicians work on a day-to-day basis. In Chapter Six I discuss an integrative vision of medical education and Family Therapy and its implications on interdisciplinary education and ethics. I begin each chapter with a precis.

CHAPTER TWO

THE BIOMEDICAL MODEL

Precis

This chapter explains the biomedical model and the limitations which have led to the development of broader models. The biomedical model can be seen to have taken on the position of dogma which is not open to being reformulated as conflicting data emerges. The medical model assumes a mind/body dualism. Other models, including the biopsychosocial and patient-centered models seek to allow a broadened perspective by clinicians. This is necessary since physicians providing primary care (i.e., family physicians) do not restrict the kinds of problems they see in practice and thus require models which are adequately comprehensive. Family Medicine incorporates aspects of many disciplines, and thus needs interdisciplinary thinking and an integrating vision. This chapter also provides the rationale for seeking an epistemology which can be used to allow science to be incorporated into a broader perspective and to provide a framework for integrating principles from one discipline into another.

Background

The great advances of modern medicine have occurred through the use of the biomedical model. In sociological parlance, a model is a complex, integrated system of meaning used to view, interpret, and understand a part of reality.[12] The biomedical model is a systematic mode of interpretation of

social deviance from a norm. In medicine, the norm is what we call health, and a deviance (sickness) will have a place or be considered by the model if it is seen as non-voluntary and organic, if its treatment is appropriate to the role of the physician, and if the condition falls below some socially defined minimum standard of acceptability, namely health.[13] This model defines the sick role as being exempt from some normal responsibilities due to the sickness, thus removing culpability, an important function of the model. The model places the sick person in some sense under the control of the medical professional. This explains why the cases I referred to in the first chapter could not be dealt with within the biomedical model. In those cases, diagnosis of a sickness or disease could not be made.

Characterized as organic, sickness can be distinguished from other forms of deviant conditions: psychological, social and cultural. The model presumes an internal-external, physical-mental dichotomy and is based on reductionism, which reduces phenomena to a single primary principle, or in the case of biomedicine, that we can understand and treat the human body by breaking it down into its constituent parts.

The model assumes that the language of chemistry and physics will ultimately suffice to explain medical phenomena. With chemistry and physics as its ideal method, the model has adopted an empiricist view of the nature of knowledge.

> From the reductionist point of view, the only conceptual tools available to characterize the experimental tools to study biological systems are physical in nature.[14]

George Engel suggests that the biomedical model has attained the status of dogma. While in science a model is revised or abandoned when it fails to account adequately for the data, a dogma requires that discrepant data be forced to fit the model or be excluded. The biomedical model requires that all disease, including mental disease, be viewed in terms of underlying physical mechanisms.[15]

Science and medicine have adopted an empiricist view, as articulated by such writers as Locke, Berkeley, and Hume, culminating in logical positivism. This empirical stance defines the task of the physician as distinguishing health from disease, and it views diseases as entities in themselves.[16]

> ... towards the end of the century it was generally accepted by the medical profession that medicine was a branch of natural science and that disease processes must be explained in anatomical and physiological terms. The so-called mechanical model of disease...became an important component of the paradigm of clinical thinking, and clinical medicine at the time entered a stable productive phase which in Kuhn's terminology may well be called a period of normal science.[17]

The biomedical model assumes a mind/body dualism, which is most frequently attributed to Descartes.[18] Such a dualism leads to the adoption of the metaphor of the body as a machine, with the doctor's task being the repair of the machine.[19] This dualist view is learned implicitly by many physicians in premedical science education and is reinforced

in medical school.

The biomedical model has been very successful, especially in the areas of internal medicine and surgery. It is also very helpful in many psychiatric areas of health and illness. The first case illustrates that the biomedical model is still considered the authority in distinguishing health from disease. The second case illustrates how effective the biomedical model can be in some conditions.

Cases

In Case 2.1 a mother and her son came to see me in order to have their insurance forms filled out for an accident that had occurred about one year previously. Both patients were new to me. They had both seen a chiropractor for their injuries, and he had followed them from the time of the accident until the present. However, the insurance company would not allow the chiropractor to complete the forms since he is not a medical doctor.

In Case 2.2 an eight-year-old boy is having very serious problems in school. He is not finishing his work and doing poorly on his tests. He is diagnosed as having Attention Deficit Disorder and prescribed Ritalin. His change is viewed as nothing short of miraculous both by his teachers and his single parent mother.

Case 2.1 demonstrates that the biomedical model is central to our health care system at this time. It illustrates the power which a physician has in determining who falls

within the model and who does not. In this instance, the chiropractor is not accepted as an adequate testifier to the data of the accident and the rehabilitation process.

Case 2.2 is a powerful illustration of how beneficial the biomedical model is when it is able to diagnose a condition which can be treated by a specific medication. There is no need to cite many references or to build a case, since all of us have experienced being treated by a medication and being cured. The next case illustrates the limitations of the biomedical model.

Case 2.3. This a case of somatization. Somatization is the experience of body complaints which cannot be explained by any known general medical condition. The patient, whom I will call Debbie, came to me as her family physician. In the first interview I came to the conclusion that her pain may be due to somatization. Not long after I first met her, she came into the emergency department when I was not on call. She came in what appeared to be excruciating pain. She was described as lying on the floor in a fetal position. The physicians on call believed that she had renal colic or some other condition yet to be diagnosed. When I heard their report on Monday morning I suggested to them that it might be somatization. The doctors were sceptical. I went to the ward and found that despite a fairly large dose of morphine, the patient was in pain. Her husband was with her. Through our discussion she came to recognize that she had been in conflict with her

husband and was unable to talk about it. With the discussion the pain began to resolve. In about twenty minutes she was feeling fine, and we agreed that she did not need to be in the hospital. I discharged her and followed her as a family doctor. We discussed how specific stresses, such as one at work with her employer, caused her bodily pain. She was able to admit this to herself and again, talking relieved the pain.

Her story is interesting, because for years prior to seeing me she had been treated by a number of physicians, often in emergency rooms, with narcotic analgesic medications. She recounted how her experience of pain began when she started to remember sexual abuse by her father that occurred when she was a young girl. Her mind had repressed these experiences, because it was too difficult for her to live with these memories in her awareness. Her body was the first to regain the memory through its symptoms of abdominal and pelvic pain. She had tried therapy with a number of individuals, some of whom showed no interest in determining whether or not she had undergone real trauma.

We formed an ongoing relationship as doctor-patient, during which I determined if her current symptoms were due to conditions which I should treat. This is difficult because a person who has learned to somatize in order to remain unaware of past trauma will experience normal physiology in an intense manner.[20] Our ongoing relationship of trust facilitated her not using narcotics, not coming into hospital or the emergency

department, and living a fairly normal life. The issues of sexual abuse were being dealt with. Since such individuals are very often skilled in self-hypnosis, as they learn to dissociate in order to survive, I taught her self-hypnotic skills by which she could relax herself when she became anxious in order to help her deal with flashbacks.

The fact that this patient, like many other similar patients, spent years of her life being investigated and reinvestigated for a disease entity demonstrates that many physicians continue to function in a reductionist manner, trying to exclude physical disease before moving to a psychological approach. (Note: This case will be further discussed in Chapter Five.)

Remaining in a reductionist model in the practice of medicine leaves certain problems solved and certain problems unsolved. Reductionist thinking allows us to distinguish diseases which can be treated with medication. Depression, Attention Deficit Disorder, Panic Disorder, among others, can be treated as a disease with chemicals. However, chronic illness, substance abuse, and somatization are examples of conditions or problems which cannot be solved by the biomedical model. In fact, a continued search for disease actually worsens somatization until it becomes nearly impossible to treat.

As Weston and Brown point out

> Medical training indoctrinates students to see patients' problems as derangements of "the body

> machine" and to be concerned about missing some rare but deadly disease...Physicians, when stressed or overwhelmed by the problems of a patient, often will revert to a simplistic focus on conventional medical diagnosis even if they have learned and have used a more sophisticated and comprehensive patient-centered approach.[21] [quotes the authors']

Different models are necessary in medicine in order to practice clinically. Initially, students learn how to do a complete history in order to solve a medical problem with a physical basis, as well as to document the health status of the various systems of the body. This method is used to record information on a patient's chart when coming into hospital for an operation or for the treatment of some disease. It reduces the whole patient into a series of systems and describes the function of each system. This reduction is implicit in the method. Students are often overwhelmed by the amount they have to learn about physical medicine and see the psychological aspects as "soft" or somehow less important. But when they go into practice they learn how important the emotional aspect of medicine really is, especially if they pursue Family Medicine.

Problems Unsolved by our Current Biomedical Model.

A critique of the medical model involves a recognition that a dualist and reductionist approach to illness and disease is not adequate today, especially in primary care. In the first place, physicians use much more than empirical data to decide on their hypotheses. The appearance, tone of communication, responses of the patient to questions, the

patient's story, as well as specific signs and symptoms are used to draw conclusions about the data and arrive at the facts of the specific case. Many of the problems we see as family physicians do not have specific diagnoses. Ian McWhinney points out that in some studies only half of patients seen in family practice with chest pain have specific diagnoses and only thirty percent of abdominal pain received pathology-based diagnosis.[22]

Lack of social support leads to higher mortality from all causes.[23] Such support, aided by support groups or family physicians, help patients to become agents of their own healing.[24] The separation of mind and body fails to solve the problem of somatization. This is a clue that this model in itself is inadequate to deal with all the problems brought to the physician.

Some problems do not fit in the biomedical model. When people are expressing their emotional pain through their bodies by somatization, differentiating between disease and non-disease gives patients the message that their problem is 'in their head' or psychological. (Unlike psychosomatic illnesses, somatization does not have physical findings.) They view this judgment as showing a lack of empathy and understanding on the part of the clinician. Also, people with the problems associated with chronic disease may feel dismissed by clinicians who make the diagnosis and view the many associated problems (such as the impact of the illness on

their families and the impact of their families on their illness) as being beyond their scope of practice.

Different medical specialties are competitive with one another for time in the medical curriculum. Surgeons may not want the ambiguity which family physicians deal with on an ongoing basis. Psychiatrists are often uncomfortable with the ongoing medical illnesses which may accompany emotional illnesses. Internal Medicine does not deal directly with the emotional component of illness and thus relies on laboratory tests and other technologies for diagnosis, usually excluding the kind of cues which family doctors use to address the undifferentiated problems which they treat.

Medical education is split into competing camps, perhaps fostered by the lack of integration in which a general method is outlined and taught. The specialties, with surgery and internal medicine on one side of the mind/body dichotomy, and psychiatry on the other, is reflective of our split thinking.[25] At the same time it must be acknowledged that there is a tremendous amount of material to cover in medical school and not enough time for all those who wish to include topics in the curriculum.

Family Medicine's Approach to Broadening the Biomedical Model

There have been a number of approaches to broadening the biomedical model. The biopsychosocial model[26] and the development of the theoretical foundations of Family Medicine are most pertinent. A third approach is the development of the

'Family in Family Medicine' movement of which I have been a part. This movement is represented by an integration of the family context into Family Medicine.

The biopsychosocial model is built on systems theory, and it attempts to integrate experience and data at the biological, psychological, and social levels. I have previously described systems theory in the following way:

> Systems theory views reality as composed of ascending and descending levels of systems. Each system is a component of the system above it and is made up of the components of the system below it. The theory sees any one of these systems as more than the sum of its parts. At the smallest end are subatomic particles while the biosphere is at the large end. Natural systems include the molecule, organelle, cell, tissue, organ systems, nervous system, person, couple, family, community, culture, society, and biosphere.[27]

In opposition to the reductionist biomedical model, the biopsychosocial model proposed by Engel,[28] seeks to expand the context of problems until all their significant relationships are included. Emotional, family, and social adjustment problems are important. In time, a disturbance in one level will result in some disruption on nearly all levels. Where the major disruption can be confined to one or a few levels, the levels immediately above or below can be called into play to readjust or remove the locus of disturbance.

A major problem with the biopsychosocial model is that it is founded on systems theory, which as shall be seen in Chapter Three, poses many difficulties for its integration into the practice of primary care or Family Medicine. It is

my position that systems thinking is essential, but systems theory cannot be an overall framework for the integration of the biological, psychological, and social domains of knowledge which are required in medicine because it views systems theory in which the person is submerged into an impersonal system as foundational. Family Medicine on the other hand has adopted a patient-centred approach which views the patient, and by implication the person, as foundational.

Family Medicine arose in response to the needs of the population. Its development is well described in McWhinney's A Textbook of Family Medicine. As McWhinney notes, family physicians have a common clinical experience and a common epistemology. It also overlaps with many disciplines and integrates into itself aspects of other disciplines which fit. For instance, the integration of the behavioral sciences required some family physicians to master aspects of this discipline. This integration occurs in practice, as McWhinney also notes.

The behavioral sciences are especially important in Family Medicine because so much of what is seen in the family doctor's office is in the emotional realm or are physical issues which have an emotional impact. In order to integrate this or any other field into Family Medicine, it is important to clarify the assumptions of that field to see which aspects of that field fit with the assumptions of Family Medicine.

Since the late 1970's, a small number of family physi-

cians world wide have set out to expand the medical model to include the emotional domain. They did so by becoming family therapists as well as family physicians. I have been one of these physicians. As discussed in Chapter One, I saw the family, or the context in which the patient presents, as the key to enlarging my perspective as a clinician. I learned to think systemically, or to view patients and their problems in the context of their relationships. Throughout my career as a family therapist, I have maintained the perspective of a family physician. As Family Medicine developed, a patient-centered approach has been a response to the narrowness of the traditional model. I myself have tried to integrate the insights of Family Therapy, as it evolved, into my practice of Family Medicine. It is through this experience that I found the need to clarify method at a philosophical level, so that I could articulate to my students and myself what fit and what did not.

Family Medicine has developed a patient-centered clinical method[29] which differentiates between disease (the pathological process physicians use as an explanatory model for disorders) and illness (the patient's personal experience of a physical or psychological disturbance). This approach includes understanding the whole person, finding common ground with the patient about the problem, including prevention and health promotion, and the doctor-patient relationship.[30] The method involves the physician's attending to the patient's

expression and non-verbal cues, as well as intuitions from previous experience and forming hypotheses from these cues. The physician then tests these hypotheses by a selective collection of data from the patient's history, from the physical exam, and from lab investigations.

It goes without saying that patients have their own assumptions about any problem they bring to the doctor. As McWhinney notes,[31] if there is a difference in expectation between the doctor and the patient, the physician must attempt to reconcile the two views. The physician responds to the cues given by the patient and sensitively explores feelings. The patient's cues and the doctor's responses determine the flow of the interview. Symptoms are viewed as ways in which the patient expresses his or her experience of illness. The clinician tries to grasp the meaning of the symptom presentation, which is seen as an attempt to communicate an experience which might be an expression of disease.

Family physicians also try to classify the patient's illness into its correct disease category. This classification is a reduction to disease entities. In doing so, the clinician can predict the outcome of disease and treatment, make inferences about causation, and communicate with other clinicians about specific diseases. In Family Medicine the entire encounter between the doctor and patient may be therapeutic. Therapy occurs because of the caring relationship between doctor and patient and because of the trust the

patient gives to the doctor.

Epistemological Issues

When we ask, "What am I doing when I am knowing?" the answer has to do with cognitional theory. When we ask, "Why is that knowing?" our answer expresses our epistemology.[32]

The epistemology of Family Medicine assumes that data can be both empirical and transempirical. It assumes that there is a spiritual and healing quality to the relationship between doctor and patient. Family physicians are asked to help patients with any problem. They do so by forming hypotheses, sometimes over time, and deciding on the best hypothesis. They then test this hypothesis by their history, examination, and investigations.

> When presented with a problem, the clinician responds to cues by forming one or more hypotheses about what is wrong with the patient...The clinician then embarks on a search (the history, examination, and investigation) to test the hypotheses. In the course of the search, he or she looks for positive (confirming) and negative (refuting) evidence. If the evidence refutes the hypothesis, it is revised and the search begins again.[33]

This general approach is consistent with the Transcendental Method of Bernard Lonergan.[34] My approach to this dissertation, however, is to examine the philosophical foundations of clinical method which would allow an understanding of systems theory as it has developed in Family Therapy so that it can be integrated into medicine. The biopsychosocial model accomplishes much of this, but does not address the inherent contradictions which can occur when

everything is reduced to a system. I find that McWhinney, a most respected thinker in Family Medicine, like the systems theorists I will discuss in Chapter Three, sees no difficulty in regarding a person as a level of system.

> The immune system "talks" to the nervous system on the same level of the vertical hierarchy. Social systems - family, community, culture - relate to each other on the same level, and a person can be a component of all three. If we think in terms of human systems, a person is at the highest level of the organismic hierarchy and at the lowest level of the social hierarchy.[35] [quotes, the author's]

It is my belief that medical education requires more than systems theory, as I will explain in Chapter Three. Medical education requires an exploration of the underlying philosophical issues with respect to the attainment of knowledge. Since Family Medicine relies on the behavioral sciences, it is imperative that there be a language and conceptual map in which the differing assumptions of distinct disciplines can be recognized. This is important because these assumptions define the different cultures of these disciplines.

I have described the integration of the family into Family Medicine in other past works.[36] [37] The integration of Family Therapy principles into Family Medicine requires concepts, assumptions, and beliefs about clinical practice which are compatible with the assumptions of Family Medicine.

Family Medicine solves many of the limitations of the biomedical model by adding to systems thinking the concept of patient-centered care. However, the field of Family Medicine does not currently resolve the problems caused by the inte-

gration of systems thinking into the medical model. It simply posits that we can add the concept of person to systems theory. In the next chapter I will examine how systems thinking in Family Therapy has made systems theory its starting point, and in so doing has not been inclusive enough to contain the concept of person.

CHAPTER THREE

FAMILY SYSTEMS THERAPY

Precis

Family systems theory reduced systems and individuals to objects or "It." It subsequently moved to an epistemology which is entirely subjective. Both positions have ethical and epistemological limitations. Adding contradictory concepts to either position is not an adequate solution. Rather, a higher viewpoint which includes both is required. Family Therapy has sought to solve this problem through the use of the question. The cases in this chapter illustrate the wide variety of problems brought to clinicians which cry out for an integrated epistemology. The concepts of good of order, horizon, and a recognition of assumptions which are often hidden, as well as the use of the question help us to move toward an integrative vision which seeks to resolve this situation. Ethical problems in Family Therapy are discussed.

The Evolution of Family Systems Therapy

Family Therapy evolved as a reaction to the limitations of traditional psychiatry at a time when psychoanalysis was the dominant model. Other precursors include psychosomatic medicine (Weis, Cannon, Binger, Linemann), early cybernetics (von Forester, Weiner), and early communications theory (Dewey, Bently, Reusch, & Bateson).[38] Other influences[39] were Sullivan and his interpersonal psychiatry, Ackerman with his approach to child psychiatry, and Fairbairn's object

relations theory. Mother-child attachment theory (Bowlby, Mahler, Rosen, Hill) and the Rejecting Mother theory (Bowen, Fromm-Reichmann) were early influences as well. The psychological theories of Adler, Fromm, and Horney, who were all psychoanalytically trained, are also at the roots of the development of Family Therapy.

Many of the early influences of Family Therapy come from psychoanalytic experience. The discipline of Family Therapy may in fact have arisen due to a perception that it was therapeutically limiting to work in the psychoanalytic manner only with individuals. The philosophical root of psychoanalysis is a Cartesian/Newtonian reductionism.[40] This reductionism is based on an empiricism which would reduce the workings of the mind to empirical data. Freud tried to make his new theory into a science so that it would gain acceptability in the context of his intellectual milieu. To counter this situation and its psychoanalytic foundation, Family Therapy had its roots in an opposition to empiricism and reductionism. Since all of medical science at the time shared in that reductionistic framework, Family Therapy distanced itself from an integration with medical science.

General systems theory was pioneered by the work of von Bertalanffy,[41] and it originated out of the thinking of mathematicians, physicists and engineers. Systems theory holds that the whole system, such as a family, is more than the sum of its parts. Indeed, the relationships themselves

constitute a part of the system. To understand a system one must engage with it as a whole. At the same time, change in any part of the system affects it in its entirety. Feedback loops allow the system to remain within healthy or functional parameters. The endocrine system in the human body is a good example of a system. The study of corrective phenomena in systems is called cybernetics.

All of these principles are a part of systems thinking. I learned to think in systems terms by assessing and treating families with the use of the McMaster Model of Family Function[42] and by reading von Bertalanffy. Once I had the insight into how family function differs from individual function, I was able to think in systems terms from then on.

Gregory Bateson applied systemic ideas to human interaction.[43] Bateson suggested that we are rule-governed systems. He posited systemic determinism, and rejected the notion of persons in favour of the concept of mind, which is connected through feedback loops with the universe. He believed that systems were related to one another as systems within systems, starting with atoms and moving up to galaxies. As a system, a human person is like any other system.

Ken Wilber, in A Brief History of Everything[44] describes the universe as having four aspects (see Figure 3.1, page 31). This can be viewed as a square that is equally divided into four quadrants. Reality is composed of all four quadrants simultaneously. The left side (also called the Left Hand) of

Interior **Left Hand Paths**		**Exterior** **Right Hand Paths**
Subjective		*Objective*
truthfulness sincerity integrity trustworthiness		*truth* correspondence representation propositional
INDIVIDUAL	I / it	**INDIVIDUAL**
COLLECTIVE	we / it	**COLLECTIVE**
justness cultural fit mutual understanding rightness		*functional fit* systems theory web structural-function-alism social systems mesh
Intersubjective		*Interobjective*

Figure 3-1[45]

Wilber's Four Quadrants of the Universe

the square is further divided into two equal squares which together represent the inside, conscious, interior aspect of the universe. Within the Upper Left Hand, the individual interior quadrant are emotions, symbols, and concepts as subjective experiences. The Lower Left Hand is the interior collective. In the Lower Left Hand are interior meanings, such as explanatory models of illness, which are shared amongst a group of individuals. Interior meanings, values, and world views which are shared collectively by groups (culture) are contained in this quadrant.

The right side (also called the Right Hand), is also divided into two equal squares; the Upper Right Hand and the Lower Right Hand. Both the Upper and Lower Right Hand represents the exterior, empirical, and objective aspect of the universe. The Upper Right Hand represents the exterior individual. In the Upper Right Hand are contained atoms, molecules and the nervous system including the human brain, all of physical reality. In the Lower Right Hand is the exterior collective. The Lower Right Hand is the social domain in its exterior or material aspects. This would include forms of community, families, nations, and other social systems.

Since the right side has no interiority, it cannot be personal, subjective or 'I'. Rather, as objective it represents the impersonal or 'It'. When we view systems from this impersonal perspective, all systems are reduced to objects.

Systems theory, when it views relationships as reciprocal patterns, is in the Lower Right Hand.

These four quadrants can be reduced further to 'the Big Three-I **We** and **It**.'[46] **I** is the Upper Left. It includes consciousness, subjectivity, sincerity, truthfulness, and self expression. The Lower Left is **We**, and it includes world views, ethics and morals, culture, intersubjective meaning, mutual understanding, and appropriateness. The Right Hand is **It**. This includes objective nature, empirical forms which include brain and social systems. Wilber believes that the Enlightenment acknowledged only the Right Hand. He contends, and I agree, that systems theory had collapsed into an **It**.

> This flatland reductionism is all the more insidious if you are a systems theorist, because you think you have covered all the bases in your great it-system. You think you have all of reality, you think [sic] have captured the whole, you think you are on the way to sanity, whereas you are literally out of your mind.[47]

Family Therapy, which sought to avoid the reductionism of the empirical sciences, fell into a **systemic reduction**, where people become objects within a system. Therapists who apply systems theory sometimes try (unsuccessfully, in my opinion) to resolve this problem by adding onto this set of philosophical assumptions the existence of persons, with choice, freedom, responsibility, accountability, and an ability to have intimacy.[48] [49] Persons have choice, and at least some degree of free will. Systems theory reduces families and persons into objects which are determined by the forces of

system.[50]

Family systems are seen to govern themselves like a cybernetic system. This governance is viewed as automatic by systems theorists, thus removing the effect or even the concept of free will. Homeostasis (at least in the early systems theorists' views) is a component of each system as a governance mechanism. There is no choice, norms, justice, or truth, only the laws of system. Nor is there subjectivity or intersubjectivity in Wilber's terms.[51] It could be argued that intersubjectivity is what systems theory is all about. However, as I see it, intersubjectivity is in fact seen as patterns, not the extension of relationships between persons. Systems theory is not interested in persons as such, but in the patterns of interaction between subjects.

My hypothesis is that **systems theory (Wilber's Lower Right), while being widely accepted by family therapists, is too narrow a conceptual field in which to understand the full breadth of human interactions.**

I must make it clear that I am critiquing systems theory in itself, not individual therapists, who may well be very personal in approach, and may not agree with any of the theory I outline in this dissertation. The therapist who takes a personal and caring approach, may do so regardless of the theory he or she espouses.

In Family Therapy, unclear language and the masking of meaning due to contradictions between verbal and non-verbal

cues, often increase with dysfunction in relationships, as will greater defensiveness, flight from insight[52] or unconscious factors. Communications difficulty is not clearly captured in the biomedical DSM-IV (Diagnostic and Statistical Manual Fourth Edition) reductionist categories.

Systems theorists (again, not necessarily practitioners) distanced themselves from an acceptance of the concept of truth. This frees a family from having one member impose his or her meaning on other family members. Rather, it seems to me, the therapist might make it clear that deciding who is right and who is wrong in a specific situation is not what is important. Rather, what is important is how we treat one another.

This is how a too-narrow view, which excludes some of the relevant data, can lead to false hypotheses and thus false judgments and the construction of false theories. The explanation that is needed (unconscious phenomena) is rejected, out of bias I believe, in order to support the theory which is being promoted, as well perhaps to distance the theorist from analytic theory. This is not how science ought to proceed. What is required is the construction of a new theory which does not contain this contradiction. Genuine science does not try to repress contradictions. Rather it regards them as a demand for a new and better theory.[53]

This prompts a question: **Can a theory, such as family systems theory or the biopsychosocial model (which holds for**

a systems framework), hold simultaneously within itself contradictory concepts and assumptions, such as both the personal and reductionist view of human beings? Or, does the principle of non-contradiction prohibit opposing assumptions within the same horizon?

Lonergan's concept of **horizon**[54] is a metaphor which applies to the way we see life. If we stand on a mountain looking out in all directions, we will have a particular view. As we move down the mountain, the shape and contour of all the surrounding objects would change. If we were to move to a second mountain, again the shape and the total expanse of the horizon would change. What I can see relates to where I stand. Where I stand in the way I see the world is associated with deep, fundamental assumptions. These are often unknown, even to myself. How much I see depends on the breadth of my experience (or mountains I climb). Each person has his own horizon which delimits the scope of his knowledge. So, too, does one's scope of knowledge and the range of one's interest vary with the period in which one lives, one's social background and milieu, as well as one's education and personal development.

Horizons may have assumptions which are complementary or opposed. In order to know if my horizon is opposed to another's, I must first know the other's horizon, or a particular aspect of it. If I stand with any fundamental conviction, belief or judgment, and this conviction, belief or

judgment would be untrue if the opposing conviction, belief or judgment of another were true, then with respect to this conviction, we hold opposed horizons.

The question of how to reconcile reality with an entirely subjective view (which will be discussed later in this chapter) as expressed by the family therapy theorists is a major challenge for this dissertation to answer. The reason that this is a challenge is because I believe that systems thinking must be a part of a clinician's horizon as well as the empirical and reductionist. I do not believe that an entirely subjective systems theorist and an empiricist can be in the same horizon if the systemic is also a denial of reality, as this would be an intrinsic contradiction in the same horizon.

Systemic theorists developed the theory of the Double Bind, which was derived by watching a schizophrenic mother giving contradictory messages to her son, one at a verbal and the other at a non-verbal level. A request not to do something is contradicted by a second message at a more abstract level. Both messages have implied punishments for not obeying them, and a third message prohibits the child from leaving the field or family (because at some level, survival in the system, whether the family or work system, would be threatened by leaving the field to get out of the bind).

Systems theorists concentrate on the relationship between persons as seen in patterns of communication. The subjective is not adequately accounted for. By subjective I mean the

inclusion of the psychic, emotional, conscious and unconscious, as well as the spiritual dimensions of the whole person. The subjective is approached by the systems thinker from the viewpoint of what one person thinks another person thinks. In such instances the therapist is obtaining personal information in an indirect manner through a family member. This highlights differences in perceptions.

The fact that the subjective dimension itself is often a dynamic interaction of the external system in subjective consciousness is not attended to. This in itself is a reduction, just as empiricism is. The reduction is to patterns which are things, not persons.

Having ignored interiority and subjectivity as data in understanding human systems, the systems theorists turned to language as a source of data. As Maturana summarized:

> Every reflection, including one on the foundation of human knowledge, invariably takes place in language, which is our distinctive way of being human and being humanly active. For this reason, language is also our starting point, our cognitive instrument, and our sticking point.[55]

It is important to note this shift from system to language[56] as a cognitive basis for Family Therapy. This was done in order to avoid people being categorized by the language of someone who is in authority.[57] This shift is a very significant one, in that language itself is so open to interpretation. The position taken by Maturana is a form of scepticism, in which objective knowledge is not attainable. I disagree with Maturana. I hold for a critical realism in

which language is not the foundation of human knowledge. Human knowledge is a matter of judgment about what is or is not, based on hypotheses arising from the data of experience (of the senses and of consciousness).[58] Language can be as much a vehicle for confusion, distortion, lies, and psychotic experience as it is for knowledge. An acceptance of language as the criterion for knowledge follows from the denial of authentic subjectivity.[59] This illustrates how a downward spiral of consciousness[60] can move away from truth due to bias. General bias is the tendency of common sense in practical affairs to avoid the exercise and implementation of sustained intelligence and reasonableness.[61] The bias here is the erroneous assumption that systems thinking contains an adequate and comprehensive understanding of reality.

Maturana's thinking leads to creative ideas. But this creativity is due to insight prior to judgment. This is, I think, what the Romantics were talking about,[62] the creative insight.

> As the basis for our knowledge of the real, the Romantics, as it were, substituted the artist's point of view (ideas about the "true," the "good," and the "beautiful") for the rationalist's mind and the scientist's empirical method. Neither rationalism nor empiricism leave any room for affectivity (feelings, emotion). The productive spontaneity of the imagination (an artistic activity which combines elements of experience in a way that is not given in experience) underlies all experience, the Romantics said, and particularly all cognitional activity (knowing).[63] [quotes, the author's]

In other words, therapists who are artists (in the broad sense of the term) may be able to use techniques founded on data

prior to judgment about reality and get good results. It opens new space for the client. Owen[64] sees open space as necessary for transformation of individuals. He states that love is the open space between acceptance and challenge. This space can be new alternative interpretations of events, or challenging acceptance, which is the love others freely give. The results, however, have more to do with other factors than epistemology. Healing occurs at a personal level as the therapist accepts, challenges and loves. It includes the person of the therapist him or herself, as well as their ability to have intuition and creative insight. This is both relationship and art.

Major Issues in Systems Theory

Issues of Causality. Systemic thinkers distanced themselves from the idea that any person in a system is a cause of any effect. Rather, they argue for circular causality. In circular causality, A influences B which is seen to simultaneously influence A. There is no starting point, and thus no primary or final cause. It could be argued that the goal of therapy in general is to have people act more freely. Thus, circular causality merely shows how in the family one person's actions (or thoughts or beliefs) influence another person's actions, thoughts or beliefs. This helps the therapist to remain free of blaming. This is valid in its own right, but is not adequate grounds for denying linear causality, or that sometimes a person does things which have direct

consequences for which they are responsible.

Linear causality is understood as laying blame or pathologizing by systems theorists. The denial of linear causality does not agree with the data of my experience. I do in fact experience at least some degree of free will and choice. Moral or ethical value is derived from our choices. Knowledge of reality must be transformed into prudent decisions. This transformation occurs in stages. These stages are deliberation, judgment and decision.[65] Prudence is the virtue of making good choices, according to Pieper. To be prudent we must have the data.

> For the virtue of prudence resides in this: that the objective cognition of reality shall determine action; that the truth of real things shall become determinative.[66]

Ethical growth occurs as we reply, in each case, to the reality of the situation in which we find ourselves. To educate persons in how to make good choices, we must help them learn to understand or become aware of this reality and to transform this understanding into concrete decisions. There must be desire for good in general in a person in order to discover what is prudent. Since the content of prudent decisions is determined by **ipsa res**, or by reality, ethical awareness requires a distinction of what is real, or what the facts are, and what is not real. Therapists require an interior collaboration of prudence and caring.

In many of the cases presented in this dissertation, we observe data and the activity of a therapist. If there were

no distinction between what is real and what is not, what then is the standard of ethical practice? Is it to make the client feel good? Is it to answer the questions the client asks without distinguishing what is real from what is not?

Good of order. Good actions are the basis of what Lonergan calls the **good of order.**

> It consists in an intelligible pattern of relationships that condition the fulfilment of each man's desires by his contributions to the fulfilment of the desires of others and, similarly, protect each from the object of his fears in the measure he contributes to warding off the objects feared by others.[67]

If we are all determined by a system of feedback loops, then how can we be empowered in any way?

The evaluation of the importance of the question. The Milan Group. The Milan Group, which clarified and disseminated its ideas starting in 1979,

> has been the most systematic in articulating and operationalizing the application of systems theory to family therapy, particularly as proposed by Bateson in his later writings.[68]

This group used paradox to disarm family members' resistance. Paradox is defined in Webster's Dictionary as a self-contradictory conclusion by valid deduction from acceptable premises. The Milan Group describes paradoxes as situations in which the discontinuity between a class and its members are not respected.[69] For instance, the Milan therapists would give an injunction that the family not change from its counter-productive functioning in order to have them rebel against the therapist and then change.

When reviewing the Milan method from a philosophical perspective, an interesting parallel to Lonergan's method emerges. The "Milan method" developed a systemic explanation of the family's current dilemma. This parallels the gathering of data and coming to an understanding or insight regarding the data. From this data hypotheses are formed about the possible origin of the problem and the way in which the problem reveals dysfunctional or functional aspects of the family's relationships.

In the intervention the hypothesis judged to be correct (or more therapeutic) is reframed in a positive manner while often prescribing the symptom-producing interaction. Intervention includes or implies a judgment about the correct hypothesis. The therapist tells the family not to change, but rather to continue to maintain the problem. This paradoxical manoeuver gets around the family's resistance.

The session is designed to change (at one level) and yet at another level (the communication from the therapist) the family is told not to change. This puts the family into a hypnotic suggestion in that if it changes, it violates the therapist's request yet conforms to the therapist's intention to change the family through meeting with them. If they do not change, the family still supports the therapist's request not to change. The therapist, either way, is in control, not the family.

The Milan Group, which went through six distinct phases

in their theorizing between 1979 and the present,[70] through their experience and, I presume, reflection on their experience, shifted their method and began giving the question more credit for producing change.[71]

Postmodern Therapy.

> The Milan Associates' shift away from imposing forceful interventions and toward simply helping families explore their predicaments marks the advent of the postmodern era in family therapy. The original group split at that point, and the two male members...pursued their interest in the questioning process and in constructivism.[72]

Luigi Boscolo and Gianfranco Cecchin, the men of the Milan group, cultivated the art of questions (in the early 1980's) which raised questions to family members and thus stirred the cognitive process in those members. The Milan Associates introduced a type of interviewing called circular questioning, developed further by Karl Tomm,[73] [74] which generates the kind of systemic information that enabled families to see their problems differently.

Circular questions make connections among actions, beliefs and relationships within the system. For example, a therapist might ask, "When your wife shows appreciation rather than irritation at your suggestions, what impact does this have on your time together?" Such questions allow the couple to become more aware of what is happening in their interactions with one another, by which the therapists gather their data. The question is the basis by which knowledge comes to us.

Questions can be used to suggest as well as to elicit information.[75] By "hooking" the family into actually asking the question for themselves, the process which moves towards insight is begun indirectly through the question. The basic method involves asking questions that highlight differences among family members or that define relationships, rather than asking for beliefs or feelings of any one family member without reference to another.[76]

In Milan-style interventions, the use of the question is the key to understanding change. It is also the key to any new insight, including changes needed in a relationship. This is also true in medicine. Data provokes our questions. Families can figure out and change some things on their own if the right questions are asked.[77]

This creative process of asking questions to stir one to think of new hypotheses is essential in the progress towards knowledge. The Milan team used their questions to obtain data from which they would hypothesize. From this they would come to decisions to act by delivering an intervention, which was often a dramatic speech. They sought to find the function of the symptom within the family system. They were looking for the pattern which, once revealed, would help the family to change.[78]

Although its proponents may not agree, in the Milan method is contained a cognitive theory which moves from data (the family's story and problem), to the question or questions

posed which seek understanding - what in Aquinas' theory is called the agent intellect. Although implicit, this derivation of hypotheses must however be followed by judgment as to which is the most likely hypothesis.[79] To conclude that all hypotheses, or the hypotheses of all the different family members have equal validity is to destroy the meaning of judgment and pervert the process of coming to know into a relativism which abandons the notion of truth and knowledge. Knowledge comes with the judgment of which hypothesis in question best fits the data and is therefore the best hypothesis.

Current Developments

The move to Constructivism. When the Milan Group split into two groups, family therapy theorists called some basic tenets of systems theory into question. Paradox[80] [81] [82] was now seen as technique.[83] Theorists blamed the belief in objectivity as a flaw in thinking and proposed the adoption of Maturana and Varela, that people have no direct experience of their environment. Observers were seen, as in quantum physics, to have an effect on the systems they interpret.[84] Von Glaserfeld took a most radical position by proposing that we can never know the real world, only our internal images of it.[85] I, on the other hand, agree that pure objectivity is impossible. But this does not imply that there is **no** objectivity. Some systems theorists went too far and threw out the baby with the bath water.

Critical realism admits the existence of a sensible world of reality.[86] The naive realist

> ...knows the world mediated by meaning but thinks he knows it by looking. The empiricist restricts objective knowledge to sense experience; for him, understanding and conceiving, judging and believing are merely subjective activities. The idealist insists that human knowing always includes understanding as well as sense; but he retains the empiricist's notion of reality, and so he thinks of the world mediated by meaning as not real but ideal.[87]

In an attempt to escape the difficulties involved in deciding which family member, if any, has a correct understanding of reality, some theorists have reacted against a naive realism to move into Constructivism.

> Constructivism asserts that reality doesn't exist 'out there,' but instead is a mental construction of the observer. The implications for therapy of the constructivist position are that therapists should not consider what they're seeing in families as existing in the family. Instead, they should understand that what they are seeing is the product of their assumptions - about people, families, and problems - and of their interactions with the family.[88]

Family Therapy, in moving towards Constructivism, is attempting to integrate what Lonergan calls the world as mediated by meaning.[89] It is groping to incorporate the subjective pole of cognition.[90]

<u>The move to a more personal approach</u>. I believe that family therapy theorists are, like myself, now delving into the Personal Way of Thinking.[91] Meanings, values, dialogue, respect for others are all personal. Family Therapy theorists have extended the horizon of their thinking from the tenets of

systems theory and are now engaged in a new enterprise. They have broadened their horizon out of necessity, just as physicians are forced to go beyond the empirical method into the personal and systemic ways of thinking, while perhaps not realizing that they have extended the biomedical model.

Narrative Therapy. Language which might identify a person or family as 'not normal' can be oppressive. In response to this, the reality which needs to be dealt with in the post-modern context has become "the story." It is made into an entity, as something which can be handled and changed, thus externalizing what might otherwise be called pathology. Responsibility for the reality of the situation is, by implication, avoided, thus removing resistance in the client. This may help to engage a very defensive family member, but is it truthful? Is this ethical? Having been relieved of responsibility and made a passive spectator of the problem, is the client justified in feeling no obligation to change the situation? Or is it a device to engage clients, so they can face responsibility?

> In this sense, families with problems present a story about themselves that is, in White's words, 'problem saturated'; it focuses on their impotence and frustration. By externalizing the problem and asking family members to focus on 'unique outcomes,' that is, times when the problem did not defeat them, White helps people identify how they were able to triumph. In the process, people are able to separate from the problem-saturated story that had been shaping their lives and, thereby, see alternative aspects of themselves that lead them to 'reauthor' themselves in a new, empowered story. In the 1990s White has become increasingly post-modern in the political sense due to his interest

> in the late philosopher Michel Foucault.[92] [quotes the author's]

Systems therapy had moved the field away from the "I" and "We" into the realm of "It." Narrative Therapy is an attempt to rediscover a personal way of being with clients and patients. The story is by nature interpersonal communication. When the story is about oneself, it is a communication of our world view, our experience, our values and intentions. When we listen to what the meaning of a person's story is to him, we are engaging in his meaning. In Family Medicine, a person's meaning connects us to the person in a new way. Language is no longer a matter of information so that we can make a diagnosis. As Freedman and Combs state:

> Instead we try to put ourselves in the shoes of the people we work with and understand, from their perspective, in their language, what has led them to seek our assistance. Only then can we recognize alternative stories. Connecting with people's experience from their perspective orients us to the specific realities that shape, and are shaped by, their personal narratives. This sort of understanding requires that we listen with focused attention, patience, and curiosity while building a relationship of mutual respect and trust. In spite of all our education telling us what we know, we try to listen for what we *don't know*.[93] [Italics the authors']

The narrative approach seeks to remove the preconceived idea of what knowledge should be obtained in the interview so that the patient's meaning emerges, in whatever shape it comes. The therapist adopts a "not-knowing" position. Through a lack of preconceived notions it is hoped that new possibilities will occur to the client through conversation.

Listening itself is seen as therapeutic. But the listening is attentive, just as it is in Family Medicine.[94] It is also a listening which does not reify or intensify the negativity in the stories, but rather a **deconstructive listening** which attempts to open new and positive spaces in the story which can be healing. Through listening to people's 'realities', these 'realities' change in the process. The narrative externalizes meaning rather than leaving the person to be identified with the problem. The listening is done in reciprocity, in conversation, in which no one person's opinion has authority over another's.[95] These theorists are describing a safe, non-judgmental space for therapist and client to talk. This is similar to the privileged relationship between doctor and patient.

The development of Narrative Therapy is a natural and valid response to the context of society, and is especially useful in treating those who have internalized negative messages and live by these as scripts. This of course does not represent the entire population of those who need therapy. It is therefore my strong suspicion that Narrative Therapy is a new model among many, and in time it will be replaced by another. Like those models which precede it, its proponents and the entrepreneurs who market it suggest it is the final answer. Again, such a claim is a philosophical claim, since it is addressing the universe of situations and contexts rather than the particular context in which the model has

arisen and in which it is applicable.

Part of the reason I believe Narrative Therapy does not represent a new paradigm is that, at least in some instances, it maintains a purely subjective assumption without an adequate epistemology to move the therapist back into the real world in which the client functions. This is well illustrated in an excellent exposition of Narrative Therapy in which the therapist writes a letter for the courts. She states:

> It became apparent during the course of therapy that the depression and feelings of anger, frustration, and hopelessness were caused by mistreatment by her former employer during the entire course of events leading up to and including her being fired. The very real consequences of this job loss included the financial jeopardy, loss of a home, and disruption in schooling and security for Ms. Wilson's children.[96]

This is a therapist who also proposes that reality is constructed by each person and that truth is relative and language an instrument of oppression. Nonetheless she appears to appeal to objective evidence when she writes this letter to a judge.

There is a bracketing of reality in the therapeutic situation, but an acknowledgement that there is a reality outside of the therapy room. This raises a further question. **Do those who propose entirely subjective epistemologies act as if their underlying assumption was that reality does exist in the everyday world? And if they do, does this mean that impli-citly their purely subjective position is limited to the world of therapy?**

The creation of differing stories about an event is not, in my opinion, addressing the issue of whether or not we can be in contact with being and thus come to knowledge of the facts. It does not address the fact that sometimes there is no room for different interpretations; either this airplane is flying above the ground or it is not! Stories about the trip may differ, but the plane actually took off or it did not. It is when theorists make claims about reality, not stories, that they are speaking in philosophical terms, not therapeutic terms.

What Problems Does Family Therapy Solve?

As has been discussed above, systems theory has changed and evolved since I first learned to do Family Therapy in 1977. I learned to think systemically through seeing hundreds of families. In this way I came to recognize that systems thinking was a new way of thinking for me. My interviews with families gave me data which could only be understood when I integrated the different facets of family function and synthesized this data into a comprehensive, systemic understanding of the family. I learned to formulate understanding of the entire family as a whole, as a system.

Family therapy has adopted systems theory as an essential requirement for doing family work.[97] A supervisor must demonstrate an ability to think systemically in order to be approved to train other therapists.[98]

I have observed systems theory develop in ways which

countered the "resistances" of family members. By incorporating systemic thinking into my medical practice I am able to understand the context of my patients and their problems. This is important since social support is necessary for health, especially during times of stress. Stress can be expressed through our bodies as somatization through bodily symptoms, and the stress usually if not always affects the relationship system or is affected by that system. However, I realized from my medical training that I must include individuals in my understanding of families, since I worked in a medical context and mainly saw individuals, as do most family therapists.

Family therapy solves some of the problems which are not addressed adequately within the biomedical model.

> Marriage and family therapy is more efficacious than standard and/or individual treatments for the following patients, disorders, and problems: adult schizophrenia; depressed outpatient women in distressed marriages; marital distress; adult alcoholism and drug abuse; adolescent conduct disorders; adolescent drug abuse; anorexia in young adolescent females; childhood autism; and various chronic physical illnesses in adults and children. Additionally, involving the family in engaging alcoholic adults in treatment is more efficacious than just working with the individual adult.[99]

> By both therapist and client reports, marriage and family therapy is an effective treatment which results in positive outcomes, including marked improvement in individual, family, work, and social functioning.[100]

Data about which therapies work suggest that they all do.

> Despite some superficial evidence apparently favoring some orientations over others, no orientation is yet demonstrably superior to any other.[101]

Even though there is evidence that no orientation is better than another, it is my experience as a therapist that engagement sometimes requires different approaches, that not all orientations can fit with my culture as a physician or my personality, and that some approaches are more appropriate than others in a given context. What is more, some therapists gain special expertise with a specific problem such as sexual abuse, and are appropriately referred more of these cases. The following case histories will illustrate some of the kinds of problems which are brought to physicians and therapists.

Cases

In Case 3.1 a woman, Brenda, brings her problem to her family doctor (not myself). Both she and her husband are highly educated, intelligent and competent. As is so often the case in midlife, her husband is tied up in his work, and he does not try to include her in his interests.

The problem is marital. There is a lack of satisfactory intimacy for either partner. While the wife wishes to shore up her marriage, the husband is not sure initially if he wants to stay in the marriage. He is sceptical that marital therapy has any merit.

In Case 3.2 a woman, whom I shall call Gail, was referred to me by her family doctor because he believed there was some underlying stress which was causing severe headaches. She had seen a neurologist and had a CT scan and an EEG, and her doctor's diagnosis was tension headache with strong overlay of

psychoneurosis. The patient herself said that her marriage and family were good, and that she worried a lot about her parents. My initial hypothesis was that she had stress-related headaches.

In the second session I did some work in which she sat in a chair and imagined her mother was in a chair opposite her. This is a form of psychodrama in Gestalt Therapy called 'the empty chair.' In such experiences a discussion is dramatically enacted as if the other party were present, and emotions which have been repressed are often evoked. In this session she told her mother that she believed her mother never loved her, and that she had never been able to talk to her because of it. She had repressed her sadness about this for thirty years. With our discussion her sadness became unlocked, and she expressed her feelings freely. Her husband was invited to comfort her, and he did.

At the next session she disclosed that she was able to distinguish herself from her mother. She said she felt freer, more calm, and more at peace. She was also able to discuss spiritual issues in the first and next to last session. There were only four sessions, but the major work was done. I went on sabbatical a few weeks after the final session. At that final session she said she was now free of having to take care of her mother. She felt that the Gestalt chair session had cured her in that her headaches had ceased from that session.

Case 3.3. A middle-aged man, Cal, along with his wife,

Beatrice, has been a medical patient of mine for fifteen years. When I came back from my sabbatical in the summer of 1997, they both came to see me. Beatrice was depressed, and I prescribed antidepressants. Her response was dramatic, and she realized she has been depressed for years without realizing it.

Cal came in for counselling. He told me that he had an affair, and that he was very troubled by it. He felt he wanted to see someone else other than myself as a counsellor. He ended up seeing a family therapist who told him, according to his wife, that he should make love to his wife one week and to his mistress the next week, and continue this way. He was very upset by this suggestion according to his wife, whom I saw for depression.

An indirect approach. In Case 3.1, Brenda with the marital issues, the data told me there was a problem in the marriage, and both spouses readily agreed. The major issues included engaging the couple for therapy, since the husband was dubious, perhaps from some previous experience with therapy, either for himself or for someone he knows. The next issue was assessing in some way whether he was willing to agree with his wife's desire to strengthen the marriage. This assessment would have been done directly or indirectly. The next issue was helping them with their mutual goal to improve their marriage. One hypothesis which occurred to me was that in this case one could choose either a reality-based method or

an entirely subjective method of Family Therapy. The approach could be direct or indirect.[102]

Since a direct approach might be viewed defensively, it could annoy or disengage the husband from marital therapy. If the therapist were convinced that this would happen should they try to look at reality together, then perhaps an indirect approach would be preferable. A therapist could initiate this session in some indirect or entirely subjective model in which the stories of the individuals are discussed, or they are interviewed as internalized-other. In such an internalized-other interview, each partner answers questions as if they were their partner. I usually ask them, in this role, to tell me what is necessary to make this marriage satisfactory. This gives me and the partner data about the couple's understanding of each other. The judgment that this strategy should be pursued might be based on the idea that the decision to make the marriage work will be the energy which allows them to accomplish the task.

Once the couple engage for therapy, they will face their reality together in order to change what needs to be changed. In this sense, a purely subjective view may be a false statement of their position. One cannot move towards the change of an existing situation if one is not in contact with the real, if one has no agreement with one's partner as to what has to change, and even more, if one has no idea as to what a functional (normal) marriage would look like. There really is no

ethical neutrality for the couple, because they are in a position where they have to make choices, and choices are, by definition, in the moral order.

Hidden Assumptions of Therapists

Therapists who claim to be value free may be deceiving themselves and thus may be biased without recognizing it. If their values are not explicit, then they may be implicit or even unconscious. Such hidden values in marital or any other therapy could be any of the following:

1. The assumption that success of marital therapy involves saving the marriage.
2. The assumption that women are oppressed, and the job of the therapist is to help them realize this and help them liberate themselves from their oppression.
3. The assumption that change is what is needed, and any change is successful therapy.
4. The assumption that any movement in the session toward some small goal the couple can name in the session is successful therapy.
5. The assumption that as long as the couple walk away happier than when they came in, the session is a success since they may come back again or tell their friends they liked the therapist.
6. The assumption that everything is relative, and that success with this couple involves re-storying their lives.
7. The assumption that there is likely something wrong with

the husband (or wife or both) and that this pathology needs to be fixed in individual therapy.

8. The assumption that to take a moral position with regard to the couple is to act with violence by imposing the therapist's values on the clients. This assumption would mean not naming what the therapist knows to be false assumptions on the part of either partner. It could mean a lack of understanding of the nature of marriage or the developmental tasks the couple are struggling with. Thus the reality of the couple is accepted as healthy reality; their context of meaning is accepted as unchangeable, or to provide a new perspective is viewed as an intrusion.

9. The assumption that there is a good of order in marriage and in relationship and that this good of order can be known and moved towards.

These are some of the possible hidden assumptions or agendas of the therapist. A non-confronting approach may be seen as a way of avoiding any of these value positions. The avoidance of confrontation may be due to lack of comfort of the therapist, lack of skill, lack of interior freedom, or a conviction that one or more of the above world views or value systems is correct and should be applied in all situations. Much of the skill of therapy is knowing when to confront and when not to.

A reality-based approach. As opposed to an indirect approach as discussed above, in a reality-oriented episte-

mology, the goal of therapy is to bring into the conscious awareness of family members present, the reality of their situation. The therapist works to help family members state clearly what is bothering them so that all present become more clear about the issues. The entire process acquaints the family with its reality. If reality is perceived as threatening by the family members, then there will be resistance. If this process is too painful, the family members may disengage and not return for the next session. It is the job of the therapist to provide adequate safety and support for family members so that they can endure the ordeal if it is painful. On the other hand, if the family is healthy enough, the process itself brings healing and relief.

In marital therapy, given that the couple are intelligent, competent, with good ability for insight, a reality-based approach is highly **ethical** and perhaps ethically desirable, because it empowers them, acknowledges their individual and collective right to make the decision of what is best for them, and teaches them the skills for solving future problems. It is respectful of their own competence. Eventually, such a position will have to be taken, but perhaps in a metaphorical form initially. This is because the couple will have to come to the necessary insights to change their behaviour or, perhaps much more importantly, come into contact with reality. Such contact will have them functioning in Wilber's Left-Handed path,[103] where the validity of each

partner is recognized by truthfulness, sincerity, integrity, trustworthiness, justice, mutual understanding, and rightness.[104]

In Case 3.1, because the husband is healthy enough to take in new information and benefit from discussion, he is likely healthy enough emotionally to be confronted with reality as reality. If that were not the case, a purely subjective position would open up new possibilities, and in a marriage which may end unilaterally if no intervention were to occur, this is desirable. In Case 3.1 the goals of the therapeutic relationship are ambivalent, because only the wife clearly wishes to save the marriage. Therefore, a primary goal exists prior to the wife's wishes, and that is to engage the husband in marital therapy. Confrontation may or may not work, once engagement is secured. I use indirect or purely subjective approaches, at least initially, when I believe that a straight-forward or reality-based approach is highly likely to end in disengagement. The use of circular questioning, embedded questioning, Milan-style interventions, metaphor, difference questioning are all indirect in that they do not confront clients with the reality of their situation. But the reality is suggested by the question itself, and it is left for clients to discover the reality on their own.

The **meaning** of the marriage to each of the spouses is important. So are their hopes and expectations for the future. These are more significant than any objective factor,

and this may also account for my reasoning that an indirect or purely subjective approach is also appropriate. In either case, therapy would involve looking at the family of origin to understand the current issues of both spouses. It could also shed light on the capacity of the husband to commit himself. He may be in a flight from insight.

Case 3.2, Gail, who had headaches, illustrates that the uncovering of unconscious material can have dramatic effects if a person is disposed to face reality. Gestalt work takes place at a certain depth of consciousness which is not readily accessible. It brings material dramatically into consciousness when the person speaks for the person imagined in the chair. Gestalt chair work certainly does not always produce such dramatic results, but it often unlocks repressed feelings around events that were perceived as traumatic in childhood. In this case my engagement was enhanced by the fact that the patient's family doctor, whom I was supervising in family therapy, was with me in the room. The client and I engaged as persons. Such engagement is aided by truthfulness, sincerity, integrity, and trustworthiness, all aspects of Wilber's Lower Left Hand. These are traits in the subjective or interior domain which foster inter-subjective fit or intimacy.[105] When I asked the family doctor what she (the doctor) learned from me during her observation of my therapy, she commented that I "have wisdom" and I am "always truthful." I would suspect that these qualities are necessary to gain the trust

of clients and do the kind of work required. (Note: This case will be further discussed in Chapter Five.)

I believe that therapy involves work at different levels of consciousness. Fritjof Capra quotes Stanislav Grof who discusses research experiments in which it is evident

> that there is a definite continuity, a successive unfolding of deeper and deeper levels of the unconscious. On this inner journey, a person may first move through a Freudian phase, then pass through a death-rebirth experience that can be loosely referred to as Rankian, and the advanced sessions of the same person may have a mythological and religious quality that can best be described in Jungian terms.[106]

Therapies are designed to work at different levels. It is the intuition of the therapist and the nature of the problems encountered which determine what depth of consciousness is necessary. In marital or Family Therapy intuition also determines the approach taken.[107]

Case 3.3 illustrates that there is an inevitable ethical dimension to our actions as therapists. In this case the therapist did not know Cal well enough to realize how deeply Cal was offended by his therapist's suggestion that he share himself with his wife and a mistress. (He told his wife he thought the therapist was 'crazy'). The therapist did not clarify the assumptions of his client.

<u>The Task of the Postmodern Family Therapy Theorist</u>

It is my belief that the task of the postmodern theorist in psychotherapy is to map out which therapies are fit for which circumstances. A way to confirm our intuition is to

note what works. There are many variables, but the experienced therapist is able to draw on his or her own experience and self-knowledge to determine what the next move in therapy of the client should be. This is the art of therapy.

I have found that systems thinking, work with the family of origin, the marriage and/or family, and unconscious factors which contribute to relationship problems in the present, cover the range of consciousness (as in the Grof quote above) which I must consider as a therapist. I use specific models to do this, and acquire skill in knowing when to use which approach. It is not required that a huge number of approaches and models be used. Work at a systems level itself may lead to changes in other levels and is often adequate.

Thinking in systems terms is essential to both of these cases. The first one illustrates that family therapy provides approaches which can help without confronting the clients' defenses directly. The second illustrates how family systems therapy can integrate well with other approaches, including those which involve the reality of unconscious material which is blocking development in the present.

<u>The move toward integration</u>. Nichols and Schwartz cite Kuhn's suggestion that there are three developmental phases in an emerging discipline.[108] Before the discipline develops a 'paradigm'[109], there are competing schools, each of which approaches the subject differently while claiming its own approach as the best way.[110] Kuhn suggests that this

first stage remains until there is a major breakthrough which becomes the dominant model. One might say that systems theory had become a dominant model in Family Therapy, but with the emergence of Narrative Therapy, which may be a reaction to systemic reduction, it remains to be seen what the dominant model of Family Therapy will be. Further, Narrative Therapy is not a synthesis of models, it is a new direction for family therapy, while at the same time it is as old as the Jewish mystical tradition.[111] I suspect that Narrative Therapy will be incorporated into the dominant model when it emerges. I would further agree with Nichols and Schwartz that the next phase of development will be one which utilizes *all* the models. This is referred to as an ecological theoretical stance.[112]

Unresolved Problems in Family Therapy

The question for Family Therapy theory at this point is, "What are the guidelines for what is to be accepted as true?" My observation over the years is that practical experience as to what works and what does not work has been the major guide for Family Therapy. In Family Therapy when a new model is being touted, it quickly becomes the rage. With time the therapists use it and find out what is useful and what is not. For instance, when Milan interventions were adopted by our major family therapy unit in Calgary for a time, some families went away angry. This may have been because families did not understand what was going on in therapy, and they may have

felt manipulated through paradoxical and hypnotic language. I learned this from a colleague therapist who was working with me in teaching medical students about the effect of alcoholism on families. She told me that she saw the "fallout" from the Milan approach; families were angry.[113] Further, we both agreed that the Milan approach used by the Family Therapy Unit at that time would not be appropriate with alcoholics, perhaps because healing alcoholics required enhanced awareness or consciousness about having the problem and reaching out for help from another person, perhaps even God, as occurs in the Twelve Step Program.

The therapists were likely aware of this, and no doubt became more and more aware of it with time. Further, people do not necessarily like to be mystified in their therapeutic experiences. It is very much, in the parlance of transactional analysis, a one-down position from the therapist in which clients feel themselves to be inferior. In other words, clients may not have been able to engage themselves as persons.

<u>The breakdown of systems thinking as a coherent theory</u>. Many theorists have tried to save systems theory as the foundational premise for family therapy. Rather than recognizing that it is one theory among many, they tinker by adding new, often contradictory assumptions, as mentioned above. For instance, theorists and practitioners recognize that concepts of development, person and intimacy are necessary to under-

stand clients. Yet they would argue that one can just tack on these essential missing features to systems theory.

It is my position that one cannot add principles which contradict the underlying philosophical assumptions of a theory in order to fix what is lacking in it. One has to move to what Lonergan would call a higher viewpoint which will explain the data without the inconsistency. The systems model itself needs to be reduced to a more limited theory with limited application, and a more comprehensive theory be found which encompasses both the truth in the old theory and that truth which the old theory could not contain. The problem is not with Family Therapy itself but with its uncritical adoption of certain forms of contemporary thinking as its theoretical basis. Its adoption of Constructivism and pure subjectivity does not lead to coherence, but rather to modes of thought and action which are confused and at times self-contradictory. This philosophical deficiency is what needs to be addressed so that a coherent model can be developed. To quote Robinson:

> In the absence of one comprehensive *theory*, all these issues can be subsumed within a *systems framework*, by the inclusion of elements drawn from various theories, although it is necessary to be aware of the theoretical discrepancies which may result.[114] [italics, the author's]

This theoretical incongruity, in my opinion, may reflect an all too uncritical acceptance of circular epistemology as the one and only epistemology which is creative and helpful when relating to troubled and emotionally defensive family

members.

> This *concept of circular epistemology, the recursive way through which we acquire and develop knowledge*, is a central idea of the systems approach, and has far-reaching implications for the study of the family.[115] [Italics, the author's]

While I agree that circular epistemology is useful in working with dysfunctional family systems, it is not usually necessary when dealing with relatively normal families. This raises the question, **Can both circular and linear causality and epistemology exist in the same horizon, or are they mutually exclusive?** It would be a contradiction in logic to assume the correct epistemology to be one which states that there is no such thing as objectivity, truth or correctness, but only individual constructions or conversations. How can this new 'truth' claim to be correct when it claims there is no truth or correctness?

Certainly there are situations in which families do not appear to relate to the real world in a realistic fashion. But it is a major leap to suggest that therefore we cannot know the world of everyday activity. Just as the world of sub-atomic physics does not provide the appropriate approach for studying human behaviour, the abandonment of the real world on the basis of our understanding of highly defensive family behaviour does not provide an adequate understanding of the world in which health care is provided. When theorists reject objectivity by stating that we are mapping a world which does not exist independently of ourselves, or that there

is no truth, or that reality is continually reinvented,[116] this does not fit with my experience.

Because Family Therapy has adopted philosophical ideas such as Constructivism, which in my opinion is a form of scepticism, I have been motivated to pursue this dissertation. I have been disturbed by what appears to me to be anti-intellectual and anti-educational theory. By this I mean theory which claims that all information is relative and that the individual becomes the sole criterion for what is true or correct. I am not convinced that those who claim to espouse these positions are aware of their implications.

For instance, Constructivism holds that our nervous systems are so constructed that we cannot know what is really out there. Theorists are asked to change from an observed system reality, which proposes that we can know some objective truths about others and the world, to an observing system, which proposes that individuals can only know their own construction of others and the world.[117] From their constructivist position, if there is any certitude in knowing, it comes from the agreement of a group of observers. This means that individuals, acting by themselves, can never know what is real. It is only by consensus that we come to knowledge.[118]

Such a position ignores that one can indeed come into contact with the real through insight into data, understanding, and judgment. Truth, according to Lonergan, is to be found in the conformity between the data and judgment. Moral

goodness is conformity between knowledge and decision, and genuine objectivity is the fruit of authentic subjectivity.[119] In working with couples and families, I believe we are helping them to become more authentic and more responsible, more caring of themselves and other family members. This is indeed a call for transformation, but this transformation rests on a shared reality that has some objective foundation. Sharing of reality could be construed as sharing an interpretation of meanings. This is true, but these meanings are either derived from the data or they are not. Ethical behaviour rests on decisions made according to judgments of value, which in turn rest on insight into the relevant data.

Family Therapy has moved away from the therapist being in the superior position towards therapy being viewed as a collaboration. In doing so, theorists also reject the notion of objective criteria for health and psychopathology.[120] In this balanced, power-sharing position, the therapist is viewed not as doing something to or for the client, but rather they construct, by conversation or dialogue, a shared meaning which co-evolves between the therapist and client.[121]

As therapists, especially in tertiary care or highly specialized centers, work in teams (called the observing system), they view therapy as constructing a meaningful process which develops a life of its own.[122] Notions of objectivity are dispelled and in its place, reality becomes a

product of changing dialogue.[123] It becomes the role of the therapist to help the client articulate meaning and in doing so, move in the direction of healing. Not to do so runs the risk at times of further burdening the client with guilt.

This raises a huge ethical question of when we clinicians are imposing our values and when we are being responsible. For instance, I recently saw a woman who was having an affair. She was troubled. Her lover had moved to England, and he had made no commitment to her. She was torn between leaving her husband and following this man, or making her marriage a more fulfilling one. In such a case, what is the ethical obligation of the therapist - to free the woman from her guilt, or to help her become more authentic and loving in her marital relationship? Is the latter case an imposition of value by the therapist, or is it being congruent and authentic? Can the therapist remain value free? Does the therapist have an obligation to help her become more free and loving?

Some systems theorists propose that our problems do not objectively exist in reality, but only in terms of meanings.[124] There is a sense in which this is true, and a sense in which it is not true. In the first place, this or any sentence can only be judged true or untrue by an appeal to some external criterion, or a judgment based on real data. In the second place, meaning does not necessarily imply lack of objectivity, since true objectivity is a consequence of authentic subjectivity, according to Lonergan.[125] By this,

Lonergan means being attentive to the data, being intelligent about the possible hypotheses or guesses which spring from the data, and being reasonable in choosing which hypothesis best fits the data.

Meaningful conversation becomes defined as conversation which is based on mutual respect and understanding which involves dialogue. This dialogue evolves around the reason for the conversation, knowledge of the situation which led to the conversation and what the participants hope to accomplish.[126] Meaningful conversation involves intentionality, and intention is open to creativity.

> The heart of therapeutic communication is still essentially a process of people trying to understand one another...."[127]

The current situation in family and systems therapy may be characterized as follows: lack of integration between models, an apparent continuous array of new models, a lack of critique or method of critique between models, two competing epistemologies which are logically incompatible, the application of systems theory in larger systems in which the model of systems is **I - It**, and the ethical confusion which results when theory denies the possibility of truth, leaving either scepticism or moral relativism as the only possible consequence. Further, there is a real threat to quantitative research as the postmodern academics insist that a purely subjective position is the only view, and they threaten to disqualify empirical studies from the academic curricula.[128]

> Since they believe there is no such thing as objectivity, skeptical postmodernists contend that research is used to bolster established knowledges and marginalize alternatives. They believe that since each theory or model is just another story about families or therapy, none better than any other, there's no point in trying to compare or test them.[129]

What is perhaps most important is that any form of scepticism strikes at the heart of education.

Ethical Problems in Modern Family Therapy

1. Competition among different levels of system. What is good for the family as a whole is not necessarily good for family members as individuals. Because of this, family well-being may be counter to the interests of at least one member. Family members are free (in varying degrees) to choose what they perceive as their own good. In our culture, the pursuit of this good is the right of every individual. This presumes that the choice is not something which violates the rights of another, such as the right of freedom from physical or sexual abuse. This is usually overcome by improving the function of the family in family interventions. There is, nonetheless, a serious potential ethical problem with an exclusively systemic perspective for anyone dealing clinically with primary care health issues.

This potential conflict was made clear to me early in my medical career. I had a very sick man on the ward with multi-system failure. The intensive care physician was opposed to admitting him because he believed that the patient would not survive even with an admission to the Intensive Care Unit.

The patient was no longer mentally competent, and I met with his wife whom I did not know. She favoured not proceeding further with highly invasive interventions, such as intubation and resuscitation. Only after the patient died did I find out that the wife had taken a lover and thus had interests which might have been in conflict with the interests of her husband. This situation clarified for me that the wishes of the patient supersede the wishes of the family and that the family's role in these cases is simply to convey the wishes of their ill member should the patient be unable to state them.

In order to deal with these issues ethically, we are required to introduce the notion of good of order and norms governing action, neither of which are congruent with systems theory in which persons are reduced to being a member of a system. A personal approach which allows meaning and value is necessary.

2. Relativism. For some systems thinkers, the system to be treated contains those who are together using a language context about a problem, with therapist and client becoming collaborators in solving it. It is here we clearly see the abandonment of any notion of objectivity.

> ...the therapist and client(s) engage in a collaborative venture rather than the therapist as being a diagnostic expert. This implies that any assessment or diagnosis must be developed together and can no longer be based on so-called objective notions of health or psychopathology.[130]

This relativism is problematic if one is working in a health care system with medical illness, and one is required to

diagnose for treatment or for billing purposes.

3. Criteria for judgment. One might therefore ask if the constructivists, in imposing normlessness, are not breaching their own imperative of not imposing value (normlessness is itself a value), and are thus undermining their own position. What then is the role of the therapist in a constructivist framework? It is to try to enable everyone's private reality to be understood, to check out hypotheses developed by the therapist, and to promote self-questioning in the clients by using circular, future oriented, reflective questions, or questions with embedded suggestions.

One might wonder how such interventions can be value free. However, when it comes to the safety of a child at risk of violence, therapists must consult their own belief system and that of the agencies they work for, which no doubt would have a policy on what to do when a child is at risk of abuse.[131] Thus it seems to me that systems therapists use norms and values and an appeal to common sense. Therapists are not value free. They must maintain their integrity and their own values and the code of ethics for their profession when selecting an appropriate intervention.

4. The personal. One of the potential moral problems of the systems model is that

> ...the *indiscriminate* selection of such a focus can diminish the value and therefore the rights of the individual, and an awareness of the context of such practice is important. Because the systems model is an evolutionary one, which originally derives from the mathematical theory of cybernetics (that

> is, control, regulation and information exchange and processing from the sciences) which the anthropologist Gregory Bateson (1967) recognized also had relevance in the understanding of human relationships, the language may appear mechanistic and is sometimes criticized as dehumanizing.[132] [italics the author's]

In recognizing that an indiscriminate application of systems thinking can threaten the rights of the individual, we are brought to the realization that there is another, ethically higher viewpoint, and this is the recognition of the personal domain.[133]

5. Objectivity. A methodology, cognitive theory, and philosophical framework which would have Family Therapy as an integral part of the intellectual and health care delivery communities require the recognition of both subjectivity and objectivity.[134] With a disrespect for the objective dimension of our knowing comes the loss of norms and the undermining of common value. Norms have been viewed by systems writers as impositions of one person's mind on another. Margaret Robinson quotes Epstein's and Loos' concerns in this area:

> Normative views of what constitutes a family, what characterises healthy interaction or what defines appropriate communication represent an imposition of moral values with disrespect for the other's position.[135]

Thus, objectivity and truth are done away with, but respect for others and their viewpoints is introduced, without any discussion of how systems theorists can maintain a determinist philosophy while still respecting persons and their

position. The confusion which should result from such a position appears to be ignored and the communicative process itself is made into reality by the systems theorist. This position would be a hard one to support if a judge were confronting a therapist for not reporting a child whom he or she believed was being abused, and the defense of the therapist was that the judge and the judge's norms were simply one conversation, and the therapist had another conversation that didn't match the judge's. I believe that in such a position, we do not really have the whole picture, because the epistemology and ethic do not encompass a wide enough horizon.

6. Common sense. It is my belief that family and marital therapy are in a difficult transitional state, where the theory espoused by those working in rarefied academic centres sometimes conflicts with the common sense of those therapists on the front line.[136] By common sense, I mean in this case what appears obvious. For example, it would appear obvious to most people that a young child should be protected from abuse, and that epistemological positions should not interfere with this obvious right of the child to protection when it is necessary.

7. Inherent contradictions. Systems theory, as it has developed in its application in Family Therapy, is an incomplete model with inconsistencies and contradictions. As Robinson states,[137] there are some blind alleys and contradictions in using systems thinking as if it were intrinsically coherent

and adequate to do the job on its own. But I believe systems theory, without the personal way of thinking (and thus spirituality) of itself is insufficient as a model because it lacks an adequate basis for the comprehension of human persons. The theory treats persons as objects. It is left to the therapist to make up for the deficit in the theory. I would suggest that the language of systems theory in itself is not the problem, but it is the inadequacy of the model on its own; it lacks a higher viewpoint that would integrate the personal as foundational.

The above seven problems in systems theory call into question the adequacy of this system of thought to account for ethical conduct in therapy. Yet systems thinking is essential for working with clients. We will now discuss some theory and experiences which help to integrate the split between objective reductionist empiricism on the one hand and subjective systemic reductionism on the other. Such integration is necessary if systems theory and Family Therapy are to be integrated into our health care system.

CHAPTER FOUR

TOWARD INTERDISCIPLINARY THINKING

Precis

The integration of Family Medicine and Family Therapy requires interdisciplinary epistemology. Such an epistemology, which integrates the subjective and objective domains is described in this chapter. The source for the ideas which support this integration is found in the realm of philosophy. The important ideas of various philosophers are briefly discussed. Clinical cases illustrate the need for an approach that will permit the consideration of both subjective and objective data. Principles which support the development of interdisciplinary thinking include the unity of the universe, reality as knowable both subjectively and objectively, and the nature of truth. Using Critical Realism, the Transcendental Method moves past empiricism and entirely subjective thinking to a new and more inclusive epistemology. Purely subjective theories can now be described as creative thinking which frees the client from oppressive language, judgmentalism and pathologizing. The need for the transformation of the therapist, the inadequacy of a single model, and the need for an inclusive epistemology are discussed.

Looking to Philosophy for Answers

The task of this dissertation is to create the basis for interdisciplinary thinking which links the purely subjective theories of Family Therapy with reality, while allowing for

what is helpful and practical in these theories. This raises the major question for this dissertation: **Can an inclusive epistemology be described which integrates the field of Family Therapy and Family Medicine?** It seems at first glance that such interdisciplinary thinking would be faced with violating the principle of non-contradiction. The contradiction which must be addressed is the following: either the universe is real, and there is an objective as well as a subjective dimension to our knowledge; or the world is not real/not knowable/ not objective, and instead is either unknowable or entirely subjective. Or both of these two propositions are true at the same time. It is my contention that it is not the place of the behavioral sciences or Family Therapy to answer this question. It is a question of philosophy, and in particular of cognitive theory.

The need to think about method occurred to me while I was in my studies in philosophy. Through the ancient Greeks, I saw knowledge and questions highlighted as issues to be thought about in themselves. I saw how Plato went about coming to know through reasoned questioning, with the implication that knowledge already existed and just had to be defined through the intelligent question.

Aristotle analyzed the process of coming to know and described internal functions to explain how it is that we come to know universals, such as the concept of triangle. He explained change and permanency by positing matter and form,

invisible realities that would be so important yet not accessible to anyone who does not study philosophy. But more important to me, he said 'the knower becomes the thing known.' I could not understand the implications of this, but it set up for me knowledge as a highest value. On closer inspection, it set up being as the highest value, and equated knowledge with being. Perhaps this hints at the insights of the existentialists, who held that we create our essence through our choices.

But how did Aristotle contribute to my method? Firstly, he applied his great mind to everything in sight. Implicit in this is the assumption that the world is knowable. Secondly, Aristotle analyzed the act of knowing. This is the foundational experience of epistemology for me. The questions, if not the answers, were formulated for me by Aristotle. What is it to know? How do I know that what I am doing is knowing? What is it that I know when I am knowing? How do I know that this is knowing? Do I know a world out there, objectivity? These questions framed my entire intellectual journey, even to the present moment.

During the mid-1960's I read the works of Teilhard de Chardin, including The Phenomenon of Man[138] and Martin Buber's I and Thou.[139] These books profoundly influenced my thinking and my intellectual and moral development. The Phenomenon of Man showed me the creativity which is sparked when a man becomes an expert in several fields, such as palaeontology and philosophy. Although Teilhard was not a

professional philosopher or theologian, his education as a Jesuit made him at least competent in these subjects. His education and experience as a paleontologist made him an acknowledged expert in his field. Teilhard's personal integration of these fields resulted in his theological poetry and creative philosophical works.[140] It is now clear to me that Teilhard, writing in mid-20th century, was making fundamental contributions to the more organic and interdisciplinary paradigm that has evolved at the end of this century. Teilhard de Chardin continues to be quoted by contemporary philosophical thinkers.

The idea of integrating several fields, as Teilhard did, offered me a whole different way of looking at life. The idea that biology could be the source of a new paradigm influenced me to study biology, and then medicine rather than physics, which was at that time the standard for science and the philosophy of science. It was clear to me that medicine had to be a part of my path.

Martin Buber influenced me philosophically and theologically by his powerful description of relationship in <u>I and Thou</u>. He defined the standard of relationship, the saying of Thou to another. He also introduced a personal way of thinking to me, by describing relationship. This became the standard by which I came to judge relationship. It meant intimacy, intimacy that had not only psychological and psychosocial implications, it also had profound theological and

spiritual implications. This began to shape the path which I took that resulted in my becoming a marital, family, and individual psychotherapist.

At Gonzaga University in Spokane Washington, I was extensively exposed to the thinking and method of St. Thomas Aquinas. I was especially excited by reading how Aquinas answered questions. His texts were the source of information for my studies in metaphysics, ethics, and rational psychology. His cognitional theory was presented to me as the most legitimate epistemology available.

I learned from Aquinas, not by focusing on his content or his conclusions, but on his process of coming to know through asking himself questions and answering them in a rigorous manner. Aquinas always started with a question. He looked at his data, the purported knowledge which was available to the western world at his time. He informed the reader of the answers which the Greeks, the Arabs, and other thinkers known to have an opinion, had given to his question. He would then analyze critically the answers of all these authorities. In so doing Aquinas exposed me to the use of logic, and the use of fundamental principles of reasoning. He was showing me how to look at data through the question, how to induce the possible hypotheses through intelligent research, how to use reason to evaluate the hypotheses, and how to judge which hypothesis fits the data best and why. As I read his Summa Theologica, I was unconsciously absorbing and integrating his

method. Lonergan later described and refined Aquinas' method in his own Transcendental Method.

In the study of medicine I learned the theory of medicine and then applied it in clinical situations. Method was implicitly taught. I learned the meaning of bodily signs and symptoms, and about therapeutics. I learned how to examine the body and how to elicit symptoms and signs of illness, the connection between these symptoms and signs and their possible underlying pathology. I came to realize that knowledge is readily available to me through careful listening, observing, examining, hypothesising, questioning whether or not there is an illness or disease present, diagnosing or judging which is the most likely hypothesis, and acting accordingly. This is similar to Aquinas' method. Data strikes up interest, and the mind forms a question; the question leads to understanding and the formation of hypotheses. Examine the hypotheses, decide which one fits the facts best.

Important Concepts: Horizon. A further refinement of method came to me as I sought to integrate medicine and Family Therapy. In so doing I found Lonergan's concept of **horizon** essential.[141] [142] In order to understand our own horizon, we must reflect on our experiences of coming to know. We can come to know our inner meaning and values by the expression of these meanings and values in language. I would disagree, however, with the postmodernists who argue that language itself is our sole inner experience. At a deeper level there is

symbol and image[143] and with an understanding of image and symbol comes an understanding of self, our whole selves. This understanding allows us to see why there are such different views about reality, and why there can be views that differ and yet represent the facts to different people. This insight is critical in Family Therapy.

Three Ways of Thinking. I analyzed my own **horizon** when I wrote about the Three Ways of Thinking and three kinds of data which I discerned in my clinical activity.[144] Through my reflection on my own inner thoughts I discovered that I think in empirical, systemic, and personal ways. Each is distinct, looking at data from a specific perspective. Indeed, there are three kinds of data: data obtained through reduction (empirical), through attention to interconnections and relationships (systemic), and data which unfolds meaning and values (personal).[145]

I came to this distinction of ways of thinking (and ways of being or kinds of data) in order to understand the differences between the **empirical** method as modelled by physics and biomedicine, the **systemic** method as modelled by ecology and family systems theory, and the **personal** method as modelled by philosophy, psychology and spirituality. Philosophical method pertains to the entire universe. My quest has been to understand how the universe can be understood or known. The Three Ways of Thinking which I came to distinguish, I later discovered, were discussed by John Macmurray

in his book, Interpreting the Universe.[146] As a systems thinker, I came to realise that there is a fourth category. This is **systems thinking** in which an entirely subjective epistemology is espoused and used as its theoretical base. My clinical experience informs me of the need for an integrated vision which contains systems theory and empirical method, in which the personal is the starting point. The following cases illustrate how all three ways of thinking are required to deal with the multidimensional issues which patients bring to clinicians. They also lay out the issues which are central to this dissertation.

Cases

Case 4.1 involved a family who was concerned about their child, Billy. The data suggested that the child may have an Attention Deficit Disorder, perhaps with Hyperactivity. As a therapist, this posed the problem as to whether the child or the family or both needed help. As it turned out, the family was fairly healthy.

Case 4.2 involved a seventeen-year-old woman named Sarah, who had multiple physical problems and who was referred to me for a second opinion. She experienced fatigue, a feeling of unreality (depersonalization and derealization), problems with concentration, and dizziness. She stated that she had episodes where she lost consciousness but had never fallen down, that she had negative thoughts all the time, periods of anxiety, and problems with sleep. She described periods of

weakness at school which required her to sit. She also had low blood pressure. There were ongoing troubles in her relationship with her parents. She took Prozac which helped her control her rage. She had a CT scan of the skull, an EEG (electroencephalogram or brain wave test), and an Echocardiogram, a test to look at the structure of the heart, all of which were normal. The neurologist suggested she should see a psychologist. The neurologist said that she did not have chronic fatigue syndrome, but a number of factors were interfering with her sleep. The neurologist had her read Seven Habits of Highly Effective People "in the hopes," as he said, "that the family dynamics can be optimised to support her through this troublesome time." The neurologist suggested regular exercise, aerobic conditioning, and the avoidance of caffeine. He recommended to her primary physician a drug called Florinef, a steroid medication.

In the counselling session, I found out Sarah had been estranged from her father since age thirteen. I also noted that she had a number of the descriptors of somatization. This included fatigue, shortness of breath, dizziness, blurred vision, episodes of unreality, periods in which she could hear but could not react for a few minutes. She could not concentrate. Also she felt sad and alone, with negative thoughts all the time. Further, she had been having suicidal thoughts off and on for the past year, and was not working at school.

In inquiring about her family, I learned that her parents

made her quit piano, which she had enjoyed. There was no family history of depression. It seemed to me early on that there were developmental issues which were affecting her physical health.

I discovered that she did not know where her life was going, and she felt completely alone. She feared for her future, and that she would end up alone. My intervention would have included working with father and daughter, but he declined family counselling.

Case 4.3. In this case, which is unique in my experience because of the personal and spiritual elements involved, a couple with several very young children presented for marital therapy. At first, the husband felt stifled in the relationship. Then he left his wife for another woman, came back briefly, and left again.

When the wife had completed her psychological and family work, and was in great grief over the loss of her husband, I discovered that her spirituality was very important to her. I believe that this approach helped her to not only to merely cope but to grow through a very difficult time. This is because spirituality provides meaning to suffering when it appears to be illogical or simply destructive. It provides support beyond that of therapy or friends.

Case 4.4. In this case two very intelligent professionals, Barry and June, (a psychologist and an architect) were referred to me with long standing, serious marital prob-

lems. He was seeing a Jungian analyst while seeing me for therapy with his wife. He was a charismatic individual, and he was also highly involved in the New Age culture. He had several affairs during his marriage, and his wife noted that he would always come back to her for security. He felt that she did not share his world adequately with him. Her background was Lutheran, and she did not feel attracted to his New Age views. It was disclosed after time that he was in fact having an affair while coming to marital therapy.

Marital therapy in this case failed to keep the couple together. I believe that the moral issues in the husband's self deceit which led him repeatedly to deceive his wife, in spite of his working to become aware of unconscious issues and the problems with his marriage, precluded a successful outcome.

Case 4.5. In this case a woman, Suzie, was not working because of somatic (bodily) complaints. She had seen a number of specialists, and their conclusion was that there was no underlying illness which could be disabling her. She was referred to me by her family doctor, whom I was supervising in a therapy elective. The doctor was present at the session. It was clear to me from reading the consultants' reports and from talking to her physician that this woman was somatizing, and that this somatization could not only prevent her from working, it could become the centre of her life.

Discussion of cases.

In Case 4.1 a diagnosis is required for medical treatment. A brief family intervention which ignored data about the child's behaviour would be inappropriate. Nor would family narrative approaches be of any value. A narrative approach which focuses on restorying the patient's story would ignore the essential problem being brought to me as a therapist who is also a physician, namely, "Is this a medical or biological problem, a family problem, both, or neither?

In order to address the question coming from Case 4.1, I adopt what seems the only alternative, the use of a critical realist epistemology. This means I take for granted that I can indeed come to know a real person and a real family, and judge whether each fits within norms or not. If I were to try to take an entirely subjective position I could not address the issue of whether the child or the family is functioning adequately or is in need of help. At the same time family systems must be a part of my horizon or method or I would not be able to properly assess the family. My horizon became broader as I integrated the methods of different disciplines and broadened my experience. I discovered that the systemic way of thinking is radically different when one adopts the person as foundational (**It** becomes personal or a **We**) as opposed to a reductionist way in which people and families become objects - **It**.

To recognize the patient or person without thinking about

the family system is inadequate. The function of the family very much affects the function of individuals in the family, especially the children. As a physician seeing the child, I recognize the importance of the family in assessment and treatment. A therapist must not ignore the possible physical problem, because it has ramifications on family function, and a physical problem could be disregarded if the therapist gets involved in family issues. Family therapists have been trained in a systems perspective, which has been viewed as an antithesis of a biological reduction into labels and diagnoses. Thus the DSM IV has been ignored until relatively recently. At the same time, the therapist, in this case myself, must collect enough data to determine if the family is at this point healthy or not. I say this because a stress such as Attention Deficit Disorder with or without Hyperactivity could at least temporarily destabilize a family. Because Ritalin definitely helps ADD in my experience, and a diagnosis is necessary before it can be prescribed, norms must be used to make the diagnosis of ADD. Helping these people required a discerning family assessment.

A horizon which is strictly adhered to and is too narrow to collect all the data needed to intervene appropriately is problematic and inadequate. If a clinician has such a narrow paradigm so as not to include both the biological, the systemic and the personal, this situation is unsolvable by that clinician. Further, if the clinician is working from a para-

digm that is too narrow to include realism or normality in its horizon, then the necessary biological intervention will not occur.

A biopsychosocial model which integrates all of the above requires that a therapist must work with a medical doctor, must determine that the family is or is not healthy and in need of help, and must be able to instruct the family about the attention deficit diagnosis once it is made. The therapist needs to recognize the need for the involvement of a physician, and the physician must recognize the need for the involvement of a therapist for the family. An integrated paradigm would have both the doctor and therapist working together, or a psychiatrist who functions beyond the reductionist approach and is able to work with the family as well.

In summary, data must be collected on the following levels: the biological level for assessing the child, and the family level to assess how the family functions with respect to either healthy or dysfunctional interactions, whether or not the family's function (or dysfunction) is disturbing the child or indeed, whether or not the family is disturbed by the child's behaviour. In the case of this normal family, they will not be pathologized **because** there are norms within which the therapist can claim them to be healthy or normal. If there were no norms or distinctions about what is good function and what is not, the family could well be or feel blamed or partially blamed for the child's condition. These distinc-

tions are not easy, given how the illness can so readily become interwoven into family dynamics and even become the centre around which a family organizes itself.[147] Also, a psychoeducational approach is needed to help the family learn how to deal with a child who has ADDH.[148] Specific approaches are necessary for specific problems.

Given the above, my first hypothesis from the data is that **norms** must be used, at least in the case of Billy (Case 4.1) and Sarah (Case 4.2), to distinguish whether or not the child or family or both are healthy or unhealthy. Subjecting a family to family therapy when they do not need it would be abusive and unethical and would serve to pathologize them. Alternate hypotheses would suggest that there are no norms, or even no real world of children and families, but only alternative stories. However, such hypotheses would make the biomedical model meaningless. This is counter to my medical experience. I use norms all the time in both medical and counselling settings. Based on this experience I would go even further, and make a judgment that this hypothesis best fits the data. In other words, **any integrated model or paradigm must have within it the objective dimension of reality. It must also include systems function from a critical realist position. An approach must include a personal relationship with the family in order to engage and work with them.** A personal approach will take into account the family's perceptions, fears, and expectations, as well as their explanatory

model. An explanatory model takes into account the world view of the person whose model it is. If a person believes that there is no such thing as ADDH, or that drugs are always harmful, or that the family is not important in maintaining health, such views will affect the outcome of any intervention.

In Case 4.2, Sarah's situation illustrates how family dynamics can interfere with physical health. While we wonder what might have happened at age thirteen, it is not unusual for a father to become distanced from a daughter when she goes into puberty. It is quite normal. She is no longer 'daddy's little girl,' but is becoming a young woman.

From pre-distributed forms,[149] I learned that none of the family members requested family counselling. The 17-year-old viewed herself as isolated both inside and outside the family. It may be that she has a primary depression and that this is a major cause of the difficulty. Depression increases sensitivity to physical symptoms and often accompanies somatization. Also, there may still be some physical basis to this young lady's problems, given that the parents' marriage is perceived by all those involved as stable. At this time, all that can be done is to reassure them that, while there is no obvious answer to her problems, having her renegotiate a relationship with her father may help.

In this case, a developmental problem, possible physical problems, and a family relationship problem occur which are

not amenable to intervention at this time. This is not an uncommon situation. I have heard family therapists and other psychotherapists complain that at times half of their cases do not show up for appointments. This may reflect the reality of resistance.

The family physician is in the ideal position to monitor the situation and seek further help as matters clarify over time. The role of the family doctor in primary mental health care is underlined by this case. In this case Sarah's family doctor who referred her to me is sensitive and diligent in insuring that all that can be done is being done. Individual counselling may be appropriate for the 17-year-old as she negotiates her next phase of development, that of leaving the family.

Sarah's case also illustrates the importance of the unity of mind and body and how they interrelate with one another. Stress affects both mind and body. Medicine helps us to understand the physiological determinants of mind-body action. It further illustrates that we make choices, such as the father in this case did in not pursuing therapy for himself.

The data of these cases illustrate that in order to make clinical decisions, we must make judgments. Judgment is required to distinguish between health and non-health, in several of the above cases, for example, between a healthy child, or between an individual with a medical illness, such as Attention Deficit Disorder. In the first case all four of

Wilber's four quadrants are useful, as well as all Three Ways of Thinking. The subjective is perceived in how each individual is affected by the impact of the illness on his family.

Case 4.3, in which a husband leaves his young wife, is an illustration of the fact that marriage and family therapists can integrate spirituality into their counselling. In fact, many certified family therapists are also ministers of various churches. The role of priests and ministers and the role of the therapist or marriage counsellor often overlap. Some people bring spiritual issues to counsellors; others bring psychological or interrelational problems to priests and ministers. Hypothesis: **an integrative vision is incomplete without an awareness and understanding of the spiritual domain.** This has been brought home to me by the Twelve Step programs which are often so successful. These programs require that the client recognize his or her own helplessness and the need to reach out to a higher power in order to be healed.

In Case 4.4, Barry and June, I saw that there was an ethical problem. While the therapist's neutrality is generally recommended as essential in therapy, this is a case where I thought at one point that the husband was quite confused about how to make an ethical decision. I used a brief outline of Lonergan's Transcendental Method to explain to him the basis of ethical decision making. I saw his wife, June, individually and also taught her the steps in making moral

decisions by explaining Lonergan's Transcendental Method. I found it necessary to bring ethical decision making into the counselling arena because there was an ethical block. It was not for me, but for them to study the data and draw their own conclusions.

This case also illustrates that when there is subjective lack of truth, lack of sincerity, lack of trustworthiness, the grounds for authentic intersubjectivity are absent. The intersubjective (**We**) involves morals and ethics, world views, common contexts, intersubjective meaning, justness, mutual understanding, appropriateness, and culture.[150] There can be no mutual understanding, rightness, justness, and cultural fit; there can be no **We** when there is intentional deceit in the fundamentals of a relationship. While ethics, morality, and spirituality are often ignored in psychotherapy and family therapy, they can nonetheless be at the core of the problem. Culture (i.e., the culture of different environments, not ethnicity per se) may differ between persons (Wilber's Lower Left Hand). This will cause conflict. Any model which truly works with persons to help them with their own subjectivity and intersubjectivity must include these domains in order to accurately diagnose the problem and assist those seeking help to find solutions.

There was a wide divergence between Barry and June on spirituality, religion, and a New Age versus Lutheran culture. Lonergan's Transcendental Method was employed to help clarify

the steps in consciousness to become responsible ethically. Meaning and the context in which the client's problem emerged was integral to understanding the situation, including spiritual values. The goal was seen by both clients and therapist as improving or saving the marriage. The husband needed to become aware of how his infidelity was jeopardizing his chances of saving the marriage and his own happiness, not to mention his wife's.

Case 4.4 illustrates the hypothesis that **therapy is not morally neutral. Both the client and the therapist bring their assumptions and values into the therapeutic relationship. The therapist must make his biases clear to the client, and not infringe on the values of the client or impose his or her values on the client.** However, in this case, it may be counterproductive to try to facilitate a spouse staying in a marriage in which the partner is actively unfaithful and dishonest. Thus morality and spirituality were an important component of therapy.

Mind-body split (Somatization). In Case 4.5, Suzie cannot work because of somatization. Somatization represents a problem which conventional medicine has difficulty helping because of the mind/body split or the Cartesian dualism in which medicine is still trapped. This is one situation where philosophy (by avoiding the dualism which occurs when ruling out the physical before checking into the psychological) is an aid to intervention. In fact, it is central to defining the

problem and the solution. The intervention which I have devised and have used successfully has a number of steps. These are:

1. Explain to the patient that where pain is concerned, I do not believe in or make a distinction between mind and body. I say that I believe that people are unified beings, and when they hurt, they hurt. This intervention **removes duality as an assumption.**

2. I tell the patient that the pain is real. This is because it **is** real.

3. I then explain that all of us can experience bodily symptoms when we are under stress. We can get headaches, stomachaches, or backaches among other symptoms. I might ask if the patient has ever noticed this. In this intervention I **normalize** the experience. This is not just a technique to make the patient feel better; it is the truth. When people realize that what they are experiencing is normal, it can often be a healing experience, often the only intervention necessary. When people are told that they are not normal, or the patient believes it is being implied that they are a psychiatric case, a personality disorder, there is a way in which these labels **can** be pathologizing or counter-therapeutic when made judgmentally. Psychiatrists who are family therapists are especially sensitive to this form of pathologizing. This has been one of the incentives for family therapy theorists to move away from and dissociate themselves from

biomedicine.

4. Then I ask about the current stresses in the patient's life. Patients are often resistant to this and say everything is fine. With skilful questioning however, I usually find that there is stress from fears that they may be seriously ill, if from nothing else. When they admit to themselves, or have the **insight** (i.e., stop the flight from insight) that they are under stress and that they do feel stress at times and that their body is having symptoms, or that they are not aware of the stress but their body acts up when their lives have increased stress, then the healing connection or insight has occurred.

In certain cases, insight leads to healing. It is likely not the only factor which leads a person to psychological conversion, but it is the key. Conversion always involves a radical or ongoing turning away from that which is destructive and death-producing, toward that which is constructive and life-enriching. These conversions can be intellectual, moral, religious, and psychological.[151] Growth in knowledge of the psyche and of the whole domain of affections can result from psychological conversion or from normal developmental processes.[152] Insight builds upon insight. A person comes closer and closer to the truth about themselves. They become more truthful. As Wilber points out, "truth, in the broadest sense, means being **attuned** to the real."[153]

We can be either in touch or out of touch with the real.

This woman, Suzie, is out of touch with the real. Suzie believes that her body has a disease which prevents her from working. In fact, there are stresses in her life which are expressed as pain.

5. I then ask the patient if there are any current stresses that need talking about. I explain that when these stresses are discussed, often pain will decrease. I explain that the talking can be with the family doctor, a therapist, or a person who is close.

In Case 4.5 the patient was not ready at the time of the session to accept the truth. She was annoyed, because I had come too close to, or in fact had zeroed in on the truth. The truth is, she is able to work. She has many stresses, some of which were obvious to me, for instance, she had a lesbian partner, which may pose some stress in our society. In this case, a single-session interview was not adequate to engage her. The family physician is the appropriate person to intervene and follow those who somatize. This is because the family physician already has the trust of the patient, so engagement is not an issue. What is more, the doctor can quickly discern when there is a need to medically investigate symptoms. He or she can encourage the patient to talk, and by taking a family approach, can involve the spouse as the person to whom the patient discloses fears, worries and anxieties. The spouse will always need to see the family physician so that he or she can learn about somatization and how to help.

Otherwise the spouse will become alienated from the patient or become counter-therapeutic by trying to coerce the medical system to do more and more tests.

Thus in order to help people who somatize, it is **essential that there be a clear acceptance of the reality of norms, and of the difference between symptoms which signify underlying disease process and those which do not. This means the epistemology must be a form of realism.** The universe must also be one, not split into a dualism of matter and spirit, body and psyche.

Because of this, epistemologies which may be acceptable in some health professions, such as nursing, where diagnosis is not usually an issue, are **not** acceptable to the physician, who is ethically and legally bound to make the best possible diagnosis. Failure to be competent in this activity not only harms patients by failing to move them towards the good of their own health, it puts the clinician at jeopardy of legal and professional sanction. Thus **a purely subjective position cannot serve as an overriding epistemological framework for medical practitioners.**

In this case the patient was annoyed by the therapist, myself, and left disgruntled. However she returned to her family physician, who was present at the session, and apologised to her for her attitude and stated that she realised the therapist was right. She subsequently went back to work (which she had not done for over a year) and has been working

successfully since that time. While reality may be annoying (especially if one is attempting to flee from insight), the clinician, in my opinion, has an ethical obligation to inform the patient or client about truths regarding themselves which must be attended to. Reality is to be sought. Knowledge, truth, insight, and responsibility are not options. We are bound ethically to act in conformity with what we know.

This case raises the question of truth. Truth is being attuned to the real. Depth psychology helps people interpret themselves more truthfully. When we dissociate or repress, we will distort interpretations from that depth in both ourselves and others.[154]

Psychoanalysis, Gestalt, or Jungian therapies help us more truthfully interpret our depths. Gestalt goes less deeply than Freudian analysis, and Jungian analysis goes more deeply than Freudian analysis. Thus a full description of therapies and criteria for their appropriate use involves a differentiation of the psychological levels of consciousness. On the contrary, behaviourists, systems theorists, cybernetic-cists don't attend to the interior of the person.

In order to relate to another person, there needs to be common ground. This involves mutual understanding, common meaning and perhaps cultural fit between two people. Common meaning and common ground provide a basis for engagement as persons. We can share or inhabit each other's depths to some degree, but this requires that we are situated in truthful-

ness.[155] When we point to truth, we can reach mutual understanding as persons.

It is my belief that reality ultimately must be dealt with. It may be approached slowly with engagement, it may be facilitated through indirect techniques: metaphor, suggestion, questioning, reframing, paradox, and other strategies. Therapists may use a model which implies that all is relative, that there is no norm or truth, no good of order, but they must still move in their actions towards that undefined good of order, which is truth.

Philosophical Principles

Up to this point I have been discussing issues in epistemology which are relevant to my dissertation. While my discussion of method involves epistemology, I wish to focus more sharply on method itself. I will proceed by stating my assumptions, observations, understandings, and judgments about my own experiences.

The universe (being, the knowable) is one. When my thinking becomes dualistic, I have problems in both understanding clinical data and acting according to the data. This occurs in treating the problem of somatization, alcoholism, chronic pain, and chronic illness. Dualistic thinking leads to a reinforcement of illness by inferring that what the patient or client experiences is "in their heads" and therefore "something the patient is responsible for" or "at fault" about. This view is judgmental.

Unified thinking dissolves the split and leads to a movement toward health as discussed above in case about somatization (Case 4.5). Unity is a by-product of health, and health is a by-product of unity. By this I mean unity of mind and body, as well as unity in the subjective domain. Unity of mind, body and spirit is conducive to clarity of judgment and is the basis for freedom of choice, while choices are the basis of health maintenance.

Physicians who encourage and empower their patients to make healthy choices are fostering the development and maturity of their patients. Since the way for sound decision making is prepared by a clear-eyed apprehension of the data, insight, understanding and reasonable judgement, such a model of medical practice empowers the patient to be healthy at all levels of consciousness. This is also true in the unity of inter-subjectivity, which is friendship and community.[156] Apparent and real splits in this unity cause dysfunction.

Being, which is both inner and outer, is knowable, though there are multiple ways of coming to know the real. A complete restriction of knowing to any of the Four Quadrants of Wilber is a reduction which yields only limited data and therefore is subject to insufficient understanding and inaccurate judgment and thus incorrect conclusions. The success of any therapy demands that there has been contact with the real. If not, there is no distinction or criterion on which to distinguish success.

Success in action requires that there has been attention to the data, understanding of the data, appropriate hypothesis and sound judgment on the basis of the data. The actions and decisions of the client are then a reflection of their contact with the real, both subjectively and inter-subjectively. The therapist and the client or family must be attentive to the data, intelligent about the hypotheses, and reasonable in judgment about what fits the data. The outcome must be mutual understanding. In the subjective domain the outcome must yield truthfulness, sincerity, integrity, which leads to trustworthiness of the individual.[157]

Knowing - Awareness and Consciousness. When I woke up this morning I was dreaming. I saw a group of cars coming together at the edge of a road at which there was a precipice. One of the cars started to fall off the precipice. At this point I became aware that I was in my bed, that I was starting to see the light of morning coming through my window. I was waking up. Slowly I reflected on the dream, the images I saw, and on the possible meaning of the dream. I judged that the dream was different from my waking state of consciousness, based on my past experience of dreaming. This experience, which has happened countless times, establishes beyond a doubt that I am conscious and aware, and that I have other states of consciousness which include sleeping and dreaming. It further establishes beyond a doubt that, without any proof through reason, I exist. This judgment is made by reflecting upon my

experience of being conscious. It requires no underlying assumption other than my immediate experience of consciousness. It is a judgment based on the data of that experience. I experience myself as conscious every day. I seldom reflect on my existence as such.

What is it to know and to know that I know? Why is that knowing? I appeal to my experience as the data from which I can answer these questions. Firstly, as I noted above, I exist and am conscious. But how do I know the state of my own consciousness? Is it by looking inside my mind? When I do this, in meditation, I end up with a sort of emptiness or with various thoughts. This in itself does not inform me about the nature of my consciousness. When, however, I observe its actions which are externalized through words or writing and sometimes actions, I have the opportunity to examine my own consciousness. In other words, when I reflect on the process which has led me to knowledge, I come to knowledge of the process itself. I note that consciousness and language are not the same ontologically (relating to being or existence). As stated above, I have experienced consciousness but wordlessness during contemplation. I disagree, therefore, with postmodern thinkers who identify our interior world solely with language.

With these foundational premises, based on my experience, I will now reflect on the process which has led me to my knowledge. In each case of coming to know, I have begun with

a question about some data which I have experienced. As an example, going back to events mentioned in Chapter One when I was a family medicine resident, I experienced several patients who seemed to be well yet repeatedly presented themselves to doctors. This data led to a most important question. "Why are these people coming to see a doctor when they appear well?" This led me to reflect on how I think about and solve medical problems. Nowhere in my training, even in Family Medicine, (1975-77) had I been prepared for this problem. This led me to the conclusion that the medical model did not have within it the tools to understand my question. This suggested the hypothesis that there was some other model which I needed to complement my scientific thinking in order to understand the problem. This led to the next question: "How does the family and Family Therapy help me understand the problem and find a solution?" This question led me to training in Family Therapy in order to find out the answer, while continuing to be a medical clinician. This in turn led me to learn a model of Family Therapy, to experience the family as a system, and eventually to broaden my horizon to think systemically.

It was only years later that I had enough data to answer my initial question. I learned more about my initial patient by seeing more examples of somatization in my practice. These were people who went from doctor to doctor, from operation to operation, and still found no solution to their pain. The

synthesis of medical or empirical thinking with systemic thinking coalesced into the insight that the pain had symbolic meaning. It has symbolic meaning in the system in which these patients conducted their lives. I had to learn to distinguish between disease and illness, and discover how the body expresses stress through organic symptoms. This insight provided the mechanism for my systemic diagnosis. Stress occurs, but in some cases the person cannot deal with it through talking because of how they have been raised or the specific circumstances of their relationships and their mental health. The person is conscious of threat from some source, and the 'fight or flight' cascade of hormones are released.[158] [159] **The Transcendental Method** of Bernard Lonergan helps move past the reductionism of empirical science, beyond an entirely subjective interpretation of systemic thinking, to a rediscovery of the person and cognition. This rediscovery, with the addition of the subjective pole of cognition, solves the basic philosophical problem of what it is "to know" something. This paves the way for an integrated understanding of medicine, the behavioral sciences, perhaps even the arts.

The steps of coming to know the real, or the universe, or the data of our inner and outer experiences, involves four levels of consciousness. The first is attention to the data, the second is intelligent hypotheses about the data, the third is reasonable selection of the most appropriate hypothesis,

and the fourth is a decision for action which is based on a reasonable judgment of what is true and good. This in essence is the cornerstone of interdisciplinary thinking.[160]

An idea answers the question "what?" or "why?". An idea can be simply apprehended without judgment. This occurs in Narrative Therapy, as well as Gestalt Therapy, when, for instance, the therapist simply listens carefully without judging truthfulness, or without judging the meaning they themselves would place on the story of the client.

Understanding is simply the mind grasping an intelligible possibility. It is independent of reasoning, and occurs through insight into the data. Truth involves judgment.

Reasoning is to pass from known truth or truths to another truth which was not known previously. The client can reason that the current therapist does things very similarly to a therapist she saw in the past, who was very helpful. This reasoning will form the basis of judgment. Insight and understanding grasp only a possibility.

Judgment is a separate step in knowing in which the intellect affirms or denies the proposed idea, or confirms the existence of the idea to be a fact that the predicated idea pertains to the subject. Some questions for reasonableness (issuing in judgment) can be answered "yes" or "no." For instance, the client may judge that the therapist is good or not helpful, according to the data of what transpires between himself and the therapist.

Truth can be either logical or moral. Logical truth is the quality of the judgment, "it is true that it is so." It is the conformity of my affirmations and negations to what is and is not.[161] It is knowledge which has been derived through attentiveness to the data, intelligent formation of hypotheses which involve insight and understanding of the data, and judgment of which hypothesis most likely fits the data. Moral truth is when my external expression, such as in my words and deeds, represents my internal expression or judgment.[162]

All **knowing** is mediated by meaning of the knower. The knower is in a dynamic state of becoming. Truth is not only an aspect of being or the real, but it is historical and contextual in nature. This claim is well supported by a moderate or critical realism which is described in this thesis. It does not require an entirely subjective position to support it. Unlike Narrative Therapy, here we go beyond ourselves and our stories into the world of objective meaning through judgment about what is or is not.

Because of the nature of knowing and the nature of the real, there are three distinct notions of truth which pertain to family therapy. The first is the **truth of meaning for the clients.** This takes into account the horizon of the clients, their unconscious material, their selective inattention and flight from insight, their state of neurosis or health, and their biases. This notion of truth is dynamic and will be

influenced by therapy. The second notion is **truth of meaning for the therapist.** This takes into account all of the above but from the perspective of the therapist. The third is the **truth of society.** This is an intersubjective truth which represents the views of those with whom the client relates. Both the client and the therapist are refining their own meaning, understanding, and knowledge by contact with the real. This accounts for why there can be the impression (a false one) of the existence of multiverses and that there is no such thing as truth. If there were no possibility of truth, one might ask if the very project which is therapy has any meaning aside from perhaps making people feel better. This would limit the goal of therapy to the adjustment to some state of untruth, whether it be that of the client or the context of the client, that of the therapist, or that of society. Society may itself be in error as witnessed in Nazi Germany in the 1930's and 40's. It would be as if therapy were like a ship lost in the fog, with no maps, no knowledge of what lies beyond, and no idea of where it would be good to go. Implied in all the cases I have seen (and those discussed in this dissertation) is some notion of good or value, which can only be founded on some notion of the real.

Our thinking discloses that being can be understood in four distinct aspects of being, namely the subjective, the inter-subjective, the empirical/individual (objective), and the empirical inter-objective or reductionist system.[163]

This has been discussed above.

Wholeness is a sign of health, and it requires all four aspects of being, in both subjective and objective, as well as intersubjective and interobjective domains or modes. These modes are necessary for understanding, but do not divide being itself, which is unified or whole. Further, the unity of being is a spiritual unity. Lack of unity is oppressive to the human spirit. The simultaneous integration of all Four Quadrants is, in Wilber's thinking, the essence of spirituality.[164]

Epistemological and metaphysical restrictions, such as occur in empiricism and pure subjectivism, result in contradictions in my horizon analysis. Wholeness refers to thinking which is inclusive of all four domains or aspects of being, as well as integrating the conscious and unconscious, the physical and psychological, the material and spiritual. Breaking these into dualities fractures the person, the total reality of the human being, into an object. Medicine, therapy, religion, or culture which ignores personhood reduces persons into things. This is oppressive in itself.

Our current situation of pure subjectivity is a position which is in fact a reaction to a naive realism (what is real is what we perceive with our senses). This espoused pure subjectivity may seek to find the intellectual freedom to be and to become without absolute categories that limit persons to labels and without diagnoses which oppress by their use of

language. I propose that critical realism integrates the real or objective with subjectivity. It clearly preserves the subjective through intentionality, through a dynamic appreciation for the knowing subject as creating his or her own essence through experience and choice, and through the mediation of the world through the meaning of all knowers. Meaning is modified by the experience of the knower and is contributed to by the historical reality of the subject.

Objectivity is also saved through a notion of the real or being as that which is knowable. This avoids a relativism which would make everything depend on the knower's point of view. It avoids pure subjectivism which despairs of contact with being or the real. It escapes positivism which limits being to that which can be measured. It thus escapes all the limitations which would render a therapist unable to move through a range of horizons including that of the client, thus restricting the therapist from helping the client with the whole array of problems encountered.

Pure subjectivism is a useful perspective for obtaining new solutions and creative ideas. Its epistemology operates in a domain that is prior to judgment of fact. These stances exist in the realm of thinking (which includes fantasy) as opposed to the realm of fact or knowledge, although metaphors, myths, and stories which may or may not be true, still may have profound meaning.

> Less obvious is the way the iterative process works. It is not simply a matter of hearing the story over and over again, although that is important. It is rather that, as the individual proceeds along his or her transformational journey *hooks* are established in the individual's experience which allow for deeper understanding and comprehension. Thus the story may largely remain the same, but the perception of meaning will grow. Same old story, but richer and deeper.[165] [italics the author's]

In prescinding from judgment (ie., not making a judgment about the data which is understood), one avoids the negative implications of absolute truth, and thus oppressive language. There is no doubt that judgment can be oppressive, as can language.[166] However, claims that the real or factual cannot be known contradicts the very claim that therapy can help its clients. Further, if a theory claims there is no basis in fact, then there can be no basis to the theory which so claims. Thus it is to be dismissed out of hand. Bracketing reality by not moving understanding to judgment in the process of coming to know can be useful in therapy. Thus the positions of pure subjectivity cannot be dismissed. While authors may at times confuse judgment as described in this dissertation as one of the steps in coming to know with judgmentalism, which is pejorative, they are very useful clinically. The limits to their claims must, however, be recognized. The principle of contradiction that something cannot be so and not so at the same time and in the same sense precludes the claims of pure subjectivism as a principle of knowledge.

Good of order. The good of order not only refers to individual instances of order, but an underlying ordering of operations so that they are co-operations, ensuring that particular instances of that particular good will continue.[167] In Family Therapy this is indicated by a recognition that there is a good derived from being in a family and that there are inherent qualities in families which allow the family to cultivate this good. The good of order is seen in many of the cases discussed in this dissertation as a resolution to a more functional status. This good of order or the lack thereof allows us to assess a family as being either contributing to the stress and behaviour of a child (or any family member) or being a health support.

This good of order is such that marriage is seen to have a natural function in human affairs, that of the further nurturing and development of the marital partners and the meeting of their mutual needs, as well as their development into mature, loving, just individuals. Further, marriage is seen as a vehicle for bearing and raising children to be healthy persons in their own right. By extension, the therapist has a responsibility to recognize that clients come to be helped in their family or marital difficulties. There are of course marriages which are intrinsically abusive to one or the other party, and this is not a just situation worth preserving if there is no commitment to stop the abuse or no dedication to change. A system which sees no hierarchy of values, which

sees everything as relative, or which sees no possibility of truth, would be of little value to a couple seeking help for their marriage.

Pure Subjectivity as Creativity

In order to move beyond what appeared to be an either/or position, reality vs. pure subjectivity, I noted the fact that these new entirely subjective theories were **creative**, and they helped to pry people and families out of difficult situations in which they were mired. Bateson and his followers through the years have refined the concept of circular causality (discussed in Chapter Three) which involves denial of an initial cause. This liberates the system from the need to blame someone, from having to diagnose a person or a family or couple and ascribe cause and prognosis. It allows one to think without having to make judgments about what is real. This avoids judgmentalism and pathologizing. And this is a good way to get beyond a situation that seems to be at an impasse.

These systems thinkers may not have recognized that they had experienced another way of thinking, a systemic way, which is one of Three Ways of Thinking. I also experienced this awakening of systems thinking, but I could not throw away my linear thinking and continue to practice medicine. I thus needed to use both systems and reductionist thinking. Any claim that a systemic viewpoint is foundational fosters a competition between paradigms or between world views. The

answer is not either/or, it is both/and.

In Family Therapy conclusions are drawn in epistemology, metaphysics, ethics, cosmology, and rational psychology, all domains of philosophy. The basis for the conclusion is often not stated, and the implications of this conclusion are usually not fully explored. The critique of systems theory in Chapter Three shows the confusion which occurs when writers in a discipline allow bias to limit the data to which they will attend. It also shows the unfortunate results of incomplete understanding of the cognitive process, when relativism and pure subjectivism replace the acquisition of the facts.

Persons have the opportunity to evaluate their own deep and often hidden assumptions, and to reflect on the process they have gone through in coming to know. Persons have the data from which they can conclude that they have indeed acquired knowledge and the opportunity to evaluate the data of their own consciousness. We can reflect to see if we do indeed move through the steps in our coming to know. We all have the obligation to strive to free ourselves from bias and neurotic distortions. We all have the opportunity to affirm ourselves as knowers.

I must free clients to clarify and articulate their own assumptions, and guard against imposing my own values, and guard against projecting my values onto clients rather than having them truly reflect on what they really believe is worthwhile in their lives.

When we therapists take the opportunity to reflect on our assumptions and have the patient do likewise, we become empowered to reflect on the implications of the theoretical models which are available to us. We have the ability to critique any new model on the basis of how it compares with our own experience. We can reflect on whether the model allows us to treat the client with respect as a person, or as an object, which is not respectful of personhood. We can reflect on which goals the model sets out for us. We can insist that authors of new models, publishers of journals, and scholars, reflect and write about the assumptions of any new model. We can all learn the validity criteria which allows us to obtain facts and add new insights to our understanding.

The Need for Transformation of the Therapist.

Ian McWhinney[168] calls for a transformation of the medical method. The same can be said for a transformation of Family Therapy method. The therapists, the clinician, have an obligation to achieve as much consciousness as possible, at cognitive and psychological levels. This is not only because they must be aware of their own biases, but because they will deal with people and problems in all of these domains. One sees what one knows.

Just as couples project onto each other issues from their relationship with their own parents, so too can therapists project their own issues onto clients. If Family Therapy does not take this into account, this is liable to lead to lack of

self-awareness and self-consciousness. This runs the risk of incompetent and/or unethical practice due to projection and unconscious bias.

If a marital therapist were to have the **bias** that a marriage can be abandoned in circumstances which are not adequately justified or reasonable, I believe he or she would be unethical. For instance, the therapist may hold views which would suggest that an inequality in power of itself is an adequate basis for ending the marriage. An issue like physical and emotional abuse may indeed be adequate justification to seek dissolution of a marriage. However, therapists need to examine their own **biases** to be sure that they don't have an agenda based on their own unresolved issues. Thus **self-knowledge** is, in my opinion, an obligation for therapists. This includes knowledge of the unconscious. Analysis and Gestalt therapy can be very useful, as well as knowledge about the issues from their family of origin.[169] They should keep before them their own psychic work so that it does not interfere with their work as a therapist.

The contract. All therapy and clinical intervention presupposes a contract between the helper and the helped in which it is understood that the helper will help the patient or client to move closer to his own good. This good may be conceived in differing manners, such as the solution to a problem, the improvement of a relationship, the acquiring of more self-knowledge or self-acceptance, the ability to cope

with painful or difficult situations, the improvement of intimacy or communication, the better health of family members, either emotionally or physically, among others. In all these motives for seeking help, the patient or client relies on the fact that the clinician is capable of helping him and has some awareness of the good toward which the client must move. Otherwise, what is the contract? This contract implies the notion of good of order, and that the client wishes to move in that direction in some way. It is recognised that the desires or needs of the patient or client may conflict with those of other family members. It is essential that the therapist is able to distinguish mere desires and needs from the good, which is the intention of therapy. In order for this to happen, there must be an atmosphere of justness, mutual understanding, and rightness between the therapist and client.[170]

The Inadequacy of a Single Model

I remember seeing a couple during my initial training year in Family Therapy during which I focused on applying the McMaster Model of Family Function. This model did not contain within it psychoanalytic concepts (although some theories of family therapy are psychoanalytically based). I will quote this case from my book, Family Dynamics for Physicians.

> A couple were seen for a second time in protracted family therapy. Their 8-year-old son had a terrible self-image and was having emotional problems at school. In therapy both partners continually interpreted each other's messages as put-downs. Their style of relating at all times

> involved perceived criticism, defense, or attack. They continually interpreted reality pessimistically and were unable to make satisfactory adjustment because of their low self-images. They both needed nurturing parents so badly that they could not take turns nurturing each other.[171]

My experience of this couple, which lasted for at least a six-month period that ended in apparent lack of success, gave me the insight that I must include psychoanalytically-based theory as a part of my understanding of families. This is because analytic theory describes defenses, ego development, neurotic development and neurotic interaction. These concepts are essential in order to understand this situation. Even though I did not know that the field of Family Therapy had move away its analytic roots, I realized that concepts which are essential to working with people include transference, the unconscious, defense mechanisms, and stages of psychosocial development.

As a result of this experience, I integrated these theories and included individual psychodynamics as a part of my thinking about the context of the patient.[172] It was integrative because I found it necessary to use multiple models in order to understand the phenomena I was encountering clinically. This raises a question: **Can psychotherapy, especially Family Therapy be undertaken in the community with only one model?** I discovered that this was impossible even in my first year of training, likely due to my medical background in which thinking which is reductionist and individual in viewpoint is essential, and individuals, rather than families, are

seen.

I discovered the answer to this question from the data of my own experience. My question was answered when I realized I must expand my conceptual models of the family beyond a problem-solving approach in which systems ideas were implicit in the data of the family's experience rather than explicit in the model itself.[173] Yet there are many models,[174] and conflicting viewpoints arise between disciplines which have limited models and between therapists who hold different theories of family therapy.[175] This is because any specific model has its limitations.

Thus it is important to recognize that physicians and family therapists need to use multiple models. Family Medicine has developed its own model of patient-centered medicine. Specialists use models different from generalists. The same is true in psychotherapy.

The Need for an Inclusive Epistemology

By recognizing the importance of the personal, therapists and physicians can maintain a personal relationship as the healing factor. Is interdisciplinary thinking needed to facilitate interdisciplinary teaching? Are the ethics of respect for persons at risk in some health care or therapy models? Both therapy and medicine can become at times either patriarchal or impersonal. To avoid this we must maintain both empiricism and personhood, as well as contextual or systemic understanding. Further, we must avoid the potential

scepticism of therapy models which are based on incomplete or erroneous assumptions. These assumptions mistakenly consider what is creative thinking as an epistemology which cannot come to know external or objective data. It is resolved by making the next step, judgment, in which we decide whether the creative idea exists or not. Medicine and therapy often do not see the patient in the same way. This difference is resolved when we consider the personal way of thinking as foundational.[176]

Conclusion

The above principles lay the foundation for an interdisciplinary thinking. They provide an explanation of differing viewpoints on reality along with the maintenance of reality. They also point out that pure subjectivity is in truth the basis for creativity rather than an overall epistemological stance. With this in place, we can now move on to the building of an integrative vision.

CHAPTER FIVE

AN INCLUSIVE EPISTEMOLOGY FOR FAMILY THERAPY

Precis

This chapter describes an inclusive epistemology for Family Therapy. An inclusive epistemology includes ascending levels of consciousness attained from attending to the data, asking questions that arise from the data, creating hypotheses, and making judgments about which hypothesis best fits the data. Decisions are made on the basis of these judgments. Truth is possible and can be sought by the client and therapist. Knowing includes objectivity, which is attained through authentic subjectivity. Therapy is a relationship between the client and therapist which has specific goals which move the client toward the good of order. Meaning for the client is important and raises ethical issues. When the issues include illness, death and dying, the role of spirituality is helpful if the client is open to it. The assumptions of the therapist and client are important in guiding the therapist toward meeting the needs of the client.

Background

In reviewing the history of the western philosophy of science,[177] [178] and its current context,[179] as well as the experience documented in this dissertation, I formed a hypothesis as to what an inclusive epistemology for Family Therapy should contain.

Regardless of our discipline the following would be

included in interdisciplinary thinking. The steps listed need not be taken in order or in a single session. This interdisciplinary thinking can be used in whole or in part.

Raising of Consciousness

A starting point in interdisciplinary thinking is to recognize that both the therapist and client are raising their consciousness concerning the content of therapy. I refer to consciousness here in a different sense than the concept of conscious and unconscious as referred to by the analysts. I mean the level of awareness to which a person has come as described by Lonergan in his Transcendental Method. This is essential to all method.

The first level of consciousness is **awareness of the data**. It is essential that both therapist and client are attentive to this. Care must be taken to avoid excluding data, especially out of bias. From the data arise questions. For example, from watching a couple interact might spring the question, "How is the marriage?"

The second level of consciousness is the **formation of hypotheses** about the meaning of the data. These hypotheses will begin springing into the mind of the therapist at any time, sometimes when first meeting the family, sometimes when reviewing pre-session information or questionnaires. Insights into the data may occur at any time. Continued questioning and observation are often necessary to consider all the possibilities. Sometimes the correct hypothesis leaps out almost

immediately.

The third level of consciousness is **judgment concerning the correct hypothesis**. Up to this point any imaginings or creative ideas are considered as possibilities. This pre-judgment state may be maintained for a long time, but at some point, whether the therapist chooses or not, judgments will begin to occur. For instance, the following thoughts may occur: "This is a seriously disturbed family" or "This mother is over-protecting her child" or "This marriage is in serious trouble." These and other judgments are not a question of which model to use; they, like all the steps in consciousness are in fact how our cognitional structures work.

When the therapist fills out the diagnosis for the insurance company, a judgment is made. When the therapist asks for another session, a judgment has been made. When the therapist states that there is no more need for therapy, a judgment has been made. It is an illusion that our minds can remain judgment-free or that we can indefinitely "bracket" out any judgment of what is real and true. We come to know through our judgments. What therapist would claim, "I am value free; I conduct sessions which are client-centered; I never come to know anything in my sessions"?

Judgment is not only about what is and what is not, it is also about what is good and what is not. Again, it is not a matter of choosing to have such awareness; it is a part of the fabric of our cognitional structure. We recognize value. Our

emotions and those of our clients speak out our sometimes unconscious values. What decisions we make are not so automatic, however.

The fourth level is **decision-making.** We cannot decide not to decide, for not deciding is a decision not to decide. In other words, decisions as to what to do also follow from our judgments. This is true both for the therapist and the client. The therapist decides what line of questioning to take based on the answers he or she receives. The therapist decides when space must be created in a person's story so that new options might become apparent. The therapist decides when to redirect questioning. Sometimes the therapist decides that the marital relationship, or the parent-child relationship is abusive. The therapist then has certain obligations to the client and to society. Again, to draw on the slightly absurd, what therapist might say the following to a judge? "Your honour, I was aware that Sammy's father was sexually abusing him, but his father's story differed from that story, and he has as much right to his story as I have to mine or Sammy has to his. So I did nothing."

Decisions, both by the client and the therapist, must be based on judgment about the understanding of the data. To decide and act differently than according to our judgment about what is real and true in this case, is to act unethically. This puts responsibility squarely on the shoulders of the authentic subject. Subjectivity can be further distin-

guished as authentic or unauthentic. In the world mediated by meaning and motivated by value, objectivity is the consequence of authentic subjectivity, or genuine attention, genuine intelligence, genuine reasonableness, and genuine responsibility.

Both science and truthfulness in ordinary affairs obtain objectivity as the fruit of the attentiveness, intelligence, reasonableness and responsibility,[180] of therapist and client. By authentic I mean authentically subjective. A person who is authentically subjective is attentive to all the data available to him, is intelligent about the hypotheses or explanations he entertains, and is reasonable in his choice of the correct hypothesis. An authentic subject is also willing to look at where his biases and blind spots may be. He also seeks to develop himself beyond these biases and blind spots to the extent he is able. Authentic subjectivity is sometimes mistaken but always honourably so. It might genuinely and conscientiously misread the evidence, or fail to envisage a possibility. At least it heads towards truth and the elimination of mistakes.

By requiring therapists to be responsible for their own authenticity, I distance myself from any theory of family therapy which suggests that the therapist cannot know the truth. This is because we can only make sound decisions on the data as we know it. While a therapist may bracket or suspend judgment in order to listen to the patient's story

without obscuring it by the therapist's own biases, issues, and categories, the therapist at some point must take into consideration the real. This is because at least some clients are struggling to know themselves, or to understand their relationships, or to gain insight into their seemingly insurmountable problems. **To be responsible, therapy must ultimately be grounded in reality.** The therapist seeks to enhance the client's self-image and relieve their oppression, as long as this does not do violence to others. But this cannot be done as if there is not a context of reality and responsibility.

Goals for Therapy

Determine the goals of the therapist-client relationship. This is a part of setting the agenda. Is it to assess the patient's or client's need for therapy? Is it to discuss and help solve some troublesome problem? Is it to arrive at some diagnosis? Is it to assess the current development and facilitate growth in the relational or subjective domain? Is it to engage in long-term, introspective psychological work? Is it to heal a relationship in the family or family of origin? Is it to have a single session to advance the solution one notch or is it open ended? Are there a specific number of sessions which are to be limited in number? The client will need to clarify expectations; the therapist will need to confirm whether he or she is willing to try to meet them, or whether another agenda needs to be negotiated.

Regardless of the main reason why clients come to the therapist, there is a desired difference which the client seeks to obtain through therapy. This implies that there is a reason for approaching the therapist. This reason may be one of many. The reason has something to do with a state of consciousness, or a state in a relationship, or a state of family or marital function, or a state of individual function with which the client is not comfortable or which has been identified by some expert as requiring help.

Good of order: determining the desirable outcome. The cases we have discussed in this dissertation lead to the conclusion that **there is a good of order which can be grasped through intentionality, which can be sought through therapy, and which can be, at least to some extent, achieved through the process of engaging in therapy with integrity. How this good of order will be defined is partly determined by the needs, values, wants, and meaning ascribed to the problem by the client. Part will also be defined by the assumptions of the therapist.** Thus, both therapist and client co-create the solution. Implicit in all therapy is change toward a new direction which is the good of order. Change requires decision.

If the client's view of the good of order clashes with that of the therapist, there is of course a potential ethical dilemma. It is not good therapy for the therapist to force his or her notion of the good of order onto the client. At

the same time, ethical neutrality or value-neutral therapy is impossible. Implicit in any model of therapy is a set of values, a theory of cognition, and a notion of the good of order. It is important in such instances for the therapist, when it is appropriate, to lay his or her values and biases on the table in full view, so that the client is free to accept or reject the position of the therapist. The question is when should this occur? Timing is crucial.

Assessment of Meaning.

This is the patient's or client's understanding of the problem or situation which causes them to seek help. I disagree with the position of Lorraine Wright, and her nurse-family therapy colleagues that beliefs define meaning.[181] Meaning is not only constituted by beliefs, it is also constituted by contact with reality.[182] Solutions to problems can be limited by constraining beliefs or an overly narrow or restricted development of hypotheses.[183] Wright and her colleagues suggest that the fostering of facilitative beliefs increases solution options. Wright and her colleagues are interested in helping people with illnesses, and in this sense the hypothesis is assumed to be that positive thoughts are good thoughts because we feel better when we have them. Wright also appeals to a biological foundation for epistemology, as described by Maturana and Varela[184] in support of her position that the goal of therapy is to comfort patients or clients.

As a physician, I have a duty to be truthful to my own experience and knowledge, even if this does not at times enhance the comfort of my patient. For instance, if I were not truthful to my patient in diagnosing cancer, the patient would not have the benefit of important information from which to make crucial decisions, such as whether to undergo painful therapy. This truthfulness is an ethical obligation for me when I function as the patient's physician.

I agree that meaning and beliefs are essential components to healing. I further agree that maintaining a sense of hope has high therapeutic value. At the same time, denial is thought to be a stage of grieving which occurs prior to acceptance. It is my belief that persons who both accept their situation and find meaning within that reality use illness, death and dying as transformative experiences. The collusion of denial is not a solution to death. The recognition that illness, death, and dying are a part of living, not the failure of medicine or the defeat of life, is only one of the stages through which conscious beings pass. Suffering can be transformative. While it may be ethical for nurses to seek to alleviate constraining beliefs, some issues are not a matter of belief but of knowledge. I have never seen a patient with lung cancer survive the cancer, nor have I seen a unicorn. But it is less likely that I will see a unicorn than a survivor of lung cancer.

As a doctor, if I were to take the same approach as

Wright and her colleagues, I would rightfully lose the confidence of my patients and even more likely lose my license to practice medicine. Patients deserve the right to correct information as much as they deserve the right to maintain their denial should they choose. When a therapist also functions in another role, such as a physician, the two roles may blur, creating possible confusion for both the patient and the healer. Because of this, the physician may feel the obligation to refer the patient to another therapist whose goal is solely to comfort and support. As more physicians take up roles as therapists, the ethical implications of dual roles will need to be further clarified. A major issue for the therapist to clarify is the assumptions of the physician and patient as to the role of the physician-therapist. Some physicians, perhaps because of their beliefs, may be able to help the patient both maintain hope and deal with the reality of terminal illness. The spirituality of the physician and patient may transcend the situation.

A denial of reality is not what is called for, but contact with reality - not just the existential realities of decay and death, but also the transformative values found in one's spirituality. Part of reality is transcendence. In fact, being itself, the real, that which is the completion of all knowing in its totality, is transcendent.[185] As Thomas Matus puts it in conversation with Fritjof Capra and David Steindl-Rast:

> With regard to the assessment of Gregory Bateson that Christianity posits a dualistic framework, I would suggest that this is not really the genuine theological concept of divine transcendence. It's not that God is up there and the universe is down here. The image of horizon is excellent, because it suggests a context whose boundaries are continually receding. I would also suggest that God's transcendence is a transcendence inward. Saint Augustine invokes God by calling him *Deus intimor intimo meo*, "O God, closer to me than I am to myself, more intimate than my very innermost point." So it's a continually receding centre of creation that is hidden within creation, a centre that is everywhere but whose circumference is nowhere.[186] [quotes and italics, the author's]

Spirituality is especially important when we are in a situation in which we have no control and are faced with suffering. Illness, death, and dying are such situations, especially when spouses or family members are not supportive.

In spite of my differences with Wright and her colleagues in the domain of cognitive theory, we nonetheless agree that entering the world of meaning and beliefs of the client is essential. As nurses, Wright and her colleagues recognize the implications of denying reality, and they adopt the concept of objectivity-in-parenthesis in which

> ...entities are assumed to exist independent of the observer. Such entities are as numerous and broad as imagination might allow and may be explicitly or implicitly identified as truth, mind, knowledge, and so on. Within this avenue of explanation, we come to believe we have access to an objective reality.[187]

What these authors have done is contravene the principle of identity by adding a contradictory definition of being or reality. Being or reality becomes something which we cannot know, because the judgment "it is" or "it is not" is not made.

In effect, they have a theory which is incompatible with reality or objectivity but which rescues them from its inconsistencies by incorporating a contradiction. Wright has identified the need to create an environment in which judgment is suspended and imagination is given free rein. However, objective reality is not the domain of imagination, it is the domain of facts, which are to some degree objective.

Every therapist must function in a model and with the assumptions with which she feels comfortable. With time all therapists seem to find the models and approaches that work for them. This fit is important since it takes into consideration the meaning which the therapist brings to the therapeutic relationship.

Assumptions

If there are constraints which limit the therapist, such as time available for the client, theoretical orientation, differences in values from the client, these may need to be made explicit. If therapy is to be a brief, solution-focused context as opposed to an open-ended one, this will have to be negoiated. If the therapist has a specific orientation, this may have to be taken into account if this orientation is not suitable to the goals of the client.

Every therapist, like every client, has underlying assumptions, some of which are conscious and some are not. These assumptions are based on past experience, values, and training. These assumptions influence to a large extent what

the therapist discovers in the client, since the assumptions represent the "intentionality"[188] present in the mind of the therapist. By "intentionality" I mean that the therapist's thinking and judging are not simply psychological events; they refer to or mean objects distinct from him or herself.[189] Critical realism incorporates the concept of intentionality, again acknowledging the subjective aspect of knowing. Therapists need to try to suspend their own assumptions to the extent that they can listen to their clients and not become mired in their own agendas. In medicine, this is called a patient-centered approach.

The assumptions of the therapist are tied into the horizon of the therapist. This includes biases as well as experiential knowledge. Initially, therapists learn specific models and apply them. When the limitations of any one model become apparent, then another model is sought out and used. Every therapist implicitly or explicitly develops criteria for the approaches he takes. It is my hypothesis that if we were to study the actions of seasoned therapists, we would find that they use multiple models and select which one to use in a given circumstance according to characteristics of the client, the nature of the problem,[190] and their own comfort and skill level with different approaches. It will be important to document what master therapists actually do as opposed to what they say they do.

It will be for the therapist to choose the approach which

best fits with his own assumptions and the needs of the client. Some therapists see their job as identifying pathologizing interpersonal patterns and replacing them with healing interpersonal patterns. Others attempt to externalize oppressive messages or clinical diagnoses such as encopresis (soiling). Still others seek out deviations from the norms they have internalized through their training and experience and seek to normalize the situation; others focus on problems where people appear to be somehow stuck in their lives. Each of these approaches has underlying assumptions about people, problems, illness, oppression, and about what healing is.

The assumptions which the therapist has about the purpose of his art, about norms, about oppression and human nature, and about meaning are all a product of the therapist's experience. This is likely to change as new data becomes available. The client also has some notion of the good of order. The client brings to the therapist some need for change, and the client's world must be respected.

Every contract for therapy has an expressed or implied request by the client. This must always be addressed. If the request is inappropriate, this fact must be pointed out, and a new agenda collaboratively derived between client and therapist. The request may be the restoration of relationships, the solving of a problem, the establishment of capacity for relationship, the enhancing of self-esteem, coping, or relationship skills, among other things. The therapist has an

obligation to be aware of what the client is asking for, and to tell the client that the client's requests or needs cannot be fulfilled if this is the case.

Cases

Case 5.1. This case is that of a young woman, Sally, aged 14, who had a number of serious problems. Her two siblings had developmental problems, one being diagnosed with pan-developmental disorder. Sally developed an hysterical conversion disorder in which she had lost the use of one leg, and required prompt help to prevent the loss of a limb through disuse. Sally also developed severe depression. The parents were heavily involved in their church. When the father was confronted with a diagnosis of AIDS, he acknowledged that he had some homosexual encounters. He was sexually abused as a boy by his doctor.

A case like this, with abnormalities in each of the children and hysterical conversion of a limb, suggests a number of possibilities. One is a genetic problem that the children have inherited, accounting for the developmental problems in Sally and her siblings. Such a possibility underlines the importance of awareness on the part of health professionals (therapists, physicians) that such phenomena occur. Proper medical diagnosis is also crucial to the health of the patient and the family. A therapist who chooses to ignore these possibilities will fail to perform a competent intervention without help from another clinician who addresses those issues

not dealt with by the therapist. A broad perspective (and thus horizon) is required.

Also, the hysterical conversion reaction raises the possibility of unconscious factors affecting the physical status of the patient. The limb in question involved the foot and ankle which symbolize sexuality in Jungian analysis. The patient was just entering puberty. The potential issue of the father's sexual orientation was never discussed by family members, and only became known to the family physician when the father was diagnosed with a sexually transmitted disease.

Hysterical conversion brings out the intimate connection between mind and body, spirit and matter, body part and the symbolic nature of that body part, and the open expression of distress and its covert expression through body symptoms and depression. It cannot be understood as a sub-unit of the conscious mind which functions in an integrated manner and includes emotions in cognitive processes;[191] it resides rather in the more primitive parts of the brain which control the autonomic nervous systems and hormone production and excretion.

As a physician in this case, if I do not integrate data from the individual (subjective), the intersubjective (we), the objective individual (biology and science), and the objective systemic or the larger system, I will not intervene appropriately. The subjective domain cannot be disregarded if one is to help this girl and her family. This involves the

Interior in the sense described by Wilber's Upper Left Hand quadrant.[192] And as Wilber points out, this is the territory which Freud, Jung, and Piaget stressed in their systems of thought. Systems without the personal is Lower Right domain in Wilber's terms. This deals with objects which are interconnected. It deals with the outer, not the inner, and it reduces persons to a subsystem which is determined by the rules of the system.

Helping the patient required approaching her situation from all four of Wilber's quadrants, and all Three Ways of Thinking. It involved the help of physiotherapists, a consultant neurologist and an anaesthetist (for diagnosis of a possible disturbance in the autonomic nervous system). It required antidepressants.

Intervention also required a family assessment, which involves the systemic way of thinking. It involved individual therapy with a separate therapist which involves a relationship of persons and the personal way of thinking. Further, it implied dealing with the expectations of religion and the attitude of religion towards sexuality.

In reviewing an inclusive epistemology and applying it to this case, we note that data is required in both the biomedical, personal and systemic domains. The patient herself must come to the awareness that her foot does not have a disorder and that she can walk. This conclusion is sought by the family doctor, who used a neurologist and anesthetist to

determine if any physical abnormality was preventing the patient from walking. Consciousness in the clinician needs to be raised to the level of understanding as to why this adolescent required help to make her own needs conscious. Intervention into the family is required to determine why she needed to take on these symptoms to get help for her family.

The goals of the therapeutic relationship include the resumption of the patient's ability to walk, the treatment of her depression, and a sorting out of family issues. An assortment of models including the biomedical model were needed, and meaning here includes the symbolic meaning of the hysterical conversion disorder. The context of this patient includes the fact she is an adolescent with family problems. A communications approach is essential. The good of order includes her health and the health of her family. This case strongly supports the hypothesis that both reality and empirical data as well as subjective and intersubjective data are all required in working with families.

Case 2.3, continued. Debbie (Chapter 2), the somatizing patient with intense pain, regressed while I was on sabbatical for one year. She came to believe once again that she had a biological disease which was not yet diagnosed. When I returned and she recognized that I would not continue to search for some obscure medical diagnosis, she switched doctors. After several months of further investigation, and a review of Debbie's inpatient chart which revealed that she

did not come into hospital once while she was under my care, the new doctor told me that he informed Debbie that he was changing his approach to the one I had taken which was to acknowledge that her pain was real but not to continue to search for a physical cause.

In reviewing this case from the point of interdisciplinary thinking, we see that how the patient interpreted her illness determined how well she did. When she believed there was a biological illness, she continued to come to emergency departments and have repeated investigations. The patient's consciousness was expanded before the sabbatical time to the point where she has accepted that her illness was induced by stress and vulnerability due to her earlier sexual abuse. When she accepted that, she did not present to the emergency department and was out of hospital during that entire year. The goals of the intervention, to have her function in her job and marriage, were largely achieved. This reversed, however, when she was again treated as a patient whose disease had not yet been figured out. The physician who took over her care from me noted that my approach had worked. He also learned that she could be talked down from her pain and distress.

The assumptions of clinicians are very important. Debbie regressed when the physician assumed there was a pathological diagnosis, and he continued further investigations. The physician's investigation and use of medications and hospitalization reinforced her view that hers was a physical problem.

Once the assumption of somatization was entertained, another approach was undertaken. This situation required a patient-centered approach which is inclusive of the person and all Four Quadrants of Wilber. It also required an understanding that sexual abuse can lead to physical problems in the adult.

Case 3.2 (continued). In the case of Gail we again are confronted with the mind-body problem. Stress often finds a body part to express itself. In this case the goals of the therapist-client relationship are to help Gail deal with her stress and the underlying factors which are causing it. The **assessment of meaning** for Gail is revealed through her and her empty chair Gestalt work. In this case the results were dramatic in that she had immediate relief from headaches. This relief persisted throughout therapy. Her psychodramatic discussion with her mother (in fantasy) seemed to liberate her from her oppressive feelings. Gestalt Therapy is present-oriented by attempting to stay in contact with the client in the here and now. The therapist is highly present to the client without preconceived agendas, and in fact this presence is, in itself, therapeutic.[193] The ability to do this requires rigorous experiential training for the therapist, and this is done primarily by the therapist dealing with his or her own issues.

Family of origin issues were readily disclosed as problematic. Good of order required a recognition that issues needed to be dealt with. Consciousness was raised to the

level of understanding or insight, which occurred in the Gestalt experience.

Summary of an Inclusive Epistemology for Family Therapy

As the cases in this chapter indicate, an integral vision, which invites interdisciplinary thinking, requires a recognition by the clinician that data must be integrated from the individual interior (subjective, or "I"), the inter-subjective interior ("We"), the individual exterior ("It", biology) and the collective exterior (It, the system). Our starting point is personal. Healing and personal growth involves increasing levels of consciousness and awareness (in Lonergan's terms), moving from awareness of data, to understanding and judgment for both the therapist and the client.

Any model has a limited perspective and set of assumptions. Therapists must integrate into their horizons an adequate array of models to gain an adequately wide perspective in order to understand the wide variety of data which clients bring to them.

Differing disciplines, in working together, require a common set of goals and a recognition that there are norms (at least implied) and a good of order (at the very least implied in the request for change which the client makes). If there are multiple disciplines involved, then they must all have this good of order as a goal. The meaning which the patient attributes to his symptoms must be considered at the outset of

therapy. Clinicians from differing disciplines may at the same time hold differing assumptions about the causes and mechanisms of healing in any individual case.

CHAPTER SIX

IMPLICATIONS OF AN INTEGRATIVE VISION FOR MEDICAL EDUCATION AND FAMILY THERAPY

Precis

This chapter discusses the important implications of an inclusive epistemology to both medical education and Family Therapy. It allows an integrative vision which clarifies the models being used in the medical curriculum. With this in place the limits of the biomedical model, systems theory, the biopsychosocial model, and the patient-centered model are clarified. The theory is illustrated through the case histories of patients' illnesses. The place of spirituality and alternative medicine can also be described with the use of the integrative vision which supports problem-based learning in a dialogical manner. The place of Family Therapy is delineated so that it can be better integrated into the medical school curriculum and the health care system. Further implications of this dissertation in interdisciplinary education and ethics are described.

Introduction

The task of the postmodern era is to integrate that which has been divided during the Enlightenment.[194] The task for medical education in the twenty-first century is to integrate that which has been separated into specialized and sub-specialized areas of knowledge. A major application for this dissertation would be to contribute to this reintegration of

knowledge in the area of medical education and Family Therapy.

This dissertation has described the Four Quadrants of Wilber as a conceptualization of the whole from which medicine can be understood to derive its models. It also provides a structure by which these models can be taught. When I speak of the whole, I am referring to the Kosmos. Wilber explains the meaning of the word Kosmos as follows:

> We'll follow the course of evolution as it unfolds through the various domains, from matter to life to mind. You call these three major domains matter or cosmos, life or the biosphere, and mind or the noosphere. And all of these domains together you call the "Kosmos." [quotations the author's].[195]

This conceptualization lays the foundation for a new integrative vision of medical education which will have profound impact at all levels.

The integrative vision is derived with the application of critical realism to reflections on the Kosmos. On the highest level of integration we have Wilber's Four Quadrants of the universe. (See Diagram 6-1, p. 3.) They can be visioned as four equal quadrants which comprise a square representing the Kosmos. The Upper Right Hand, the exterior individual, includes atoms, cells, and the human body as it is known through empirical enquiry. The Lower Right Hand, the exterior collective, includes the external structures of systems, which in medicine includes members of the health care system when they are fulfilling their roles. Hospitals and other facilities are also in this quadrant, as are members of governments when fulfilling their roles in the management of the health

Interior **Left Hand Paths**		**Exterior** **Right Hand Paths**
Subjective		*Objective*
Individual attitudes about health and illness		Atoms, cells the human body as it can be known empirically Disease
INDIVIDUAL	I	it **INDIVIDUAL**
COLLECTIVE	we	it **COLLECTIVE**
Cultural attitudes about health and illness Explanatory models		Health Care System hospitals and clinics labs/technology Health care personnel
Intersubjective		*Interobjective*

Figure 6-1[196]

Wilber's Four Quadrants
Applied to the Health Care System

care system.

The Lower Left Hand, the interior collective, is the exclusively subjective systemic domain. It includes systems of meaning which exist in the culture of a family, the cultures of physicians and other health care workers, the culture of the health care system, and the governments which ultimately are responsible for that system at various levels. The Upper Left Hand, the interior individual, includes perceptions, emotions, symbols, or concepts as subjectively experienced by a patient, a health care worker, or an administrator of the system of health care delivery.

Critical realism is a theory of knowledge by which both the interior (subjective) and exterior (objective or empirical) can be known. The interdisciplinary vision, which includes the four quadrants, is a higher level of integration than the Three Ways of Thinking which includes the personal, empirical and systemic ways of thinking. Critical realism allows these models to be inclusive of those at lower levels of integration because it encompasses both subjective and objective knowledge.

Having described an integrative vision, we can see how models of healing can be described from the more simple (less inclusive) to the more complex. The biomedical model attends to the Upper Right Hand. The biopsychosocial model attends to the Upper Left, Upper Right and Lower Right Hands and views systems as its organizing framework rather than the personal

as foundational.

Family Medicine, which deals with any problem the patient brings to the doctor, requires an appropriately broad horizon. It incorporates a fully integrative model which recognizes the interior meanings of persons in a patient-centered model. It includes the Upper Right Hand (the empirical domain of medicine), the Lower Right Hand (the social systems which are the external context of the patient), the Lower Left Hand (the cultural explanatory models of illness and myths and about illness and healing), and the Upper Left Hand (the interior world of perceptions, emotions, fears, expectations, symbols and concepts). This model allows the conceptualization of the patient as a whole person in his or her context. I have named this in previous writing as whole-person medicine.[197]

The place of spirituality can now be more coherently conceptualized in medical teaching and practice. Spirituality is an integration of all four quadrants simultaneously and is truly wholistic thinking. As a number of cases in this dissertation have demonstrated, it is essential to include spirituality in our healing models, and it deserves its rightful place in medical education.

Medical Education

Undergraduate medical education. The following cases were used to teach the Three Ways of Thinking to first year medical students in the summer of 1997. These cases also illustrate the Four Quadrants. I should point out that my

initial presentation to the medical students in 1997 used the Three Ways of Thinking as an integrating principle. Although it is not as comprehensive as the Four Quadrants, it is very easily grasped and makes sense in the context of medical education at this level. My teaching colleague, Dr. David Swann, informed me that he thought the use of the Three Ways of Thinking is appropriate for the first year of medicine as it is easy to grasp and apply.[198] This year (August 1998) I have begun preparing these classes, and I find that the Four Quadrants is much more integrative of the theory I will be teaching. I intend to use it as my guiding principle and will explore its usefulness with my colleagues and the students.

Cases. Case 6.1. The first case I presented was that of Emil, a four-year-old boy I had seen in my office during the week preceding the class. He had a fever and other signs of what could have been either a bacterial or viral infection. My question, based on the data, was, which of the two was it? I ordered blood tests, and results were most consistent with a viral infection, and I sent the boy home with his mother with instructions on how to manage this condition. He improved, and his progress seemed to be fine. The night before the class in which I presented this case I got a call at about 10:30 in the evening. The fever had come back, and the mother was worried. I asked to meet her in the Emergency Department. There I again examined him and did blood tests. I used this story to illustrate the Empirical Way of Thinking,

which corresponds to the Upper Right Hand.

Case 6.2. I then presented a second case to the class of 75 medical students. This is the case of Sam, a 33-year-old patient of mine. I have taken care of his father, his wife, his daughter, and his grandmother. I have come to know him very well. As a medical student and during most of my career, I have been careful to try to separate my roles and keep them distinct. But over time I have come to realize that when you have a relationship in which the patient is known as a person, and when you know the family and see them through significant events, like heart surgery on their baby as in this case, the relationship becomes personal.

Several years ago, this young man developed an extremely rare and aggressive bone cancer called an Adamentinoma. The choice about whether or not to sever his leg above the cancer was made only after the patient learned everything there is to know about this condition from the perspective of both conventional and alternative medicine. He became more knowledgeable about his illness than all but a few physicians in the world. He made an informed decision not to have the leg amputated, so that he could continue to have as normal a life as possible, which for him included active participation in sports. He refused to be defeated by the cancer.

I continue to care medically for Sam and his family. I have always used a family approach and have met with Sam and his wife several times over the past five years. They appre-

ciate this and have asked that both of them be present at any meeting at which I would be discussing bad news. I saw them together to discuss the results of the bone scan which showed that the cancer had spread to his lower spine. He is often in intense pain, and I and the cancer specialists are treating it with high doses of morphine and other drugs. Radiation therapy and chemotherapy have been conducted to control the spread of the cancer.

This case illustrates the need for all four quadrants. The Upper Right Hand (the exterior individual or empirical) is required to make the empirical diagnosis of cancer. The Lower Right Hand (the exterior collective) is necessary to understand the external system of health care in which this man is now involved. This involves buildings (the cancer hospital and the offices and wards of hospitals), people who make up the system such as surgeons, internists, cancer specialists, and the family doctor, among others), and the patient's family unit. The case involves the Lower Left Hand, (the interior collective) in the community of meaning to which my patient belongs. This involves the spiritual belief system which supports him, and the values he holds as a very athletic Calgarian. This cultural system was paramount in Sam's decision not to have his leg removed. This case involves the Upper Left Hand (interior individual) in the inner world of meaning, the feelings and emotions which are precipitated in Sam and his wife as they each deal with this terrifying

disease. Using a patient-centered model, he is treated as a person by myself, the orthopedic surgeon, the cancer surgeon and the chest specialist when he developed metastases to the lung. Sam has participated in his care and has been the author of critical health care decisions. Indeed, in treating Sam as a person we recognize the spiritual dimension which emerges and increasingly becomes the most important factor as Sam continues to fight with his medical condition as it progresses towards its inevitable conclusion.

Sam uses shark fin oil and other alternative medicines to try to fight his cancer. The interdisciplinary thinking I have described in this dissertation provides the place where alternative medicine can now be more adequately defined. It does not fall under the Upper Right Hand alone as does biomedicine. It includes the Lower Left Hand (i.e., eastern and other cultures) and the Upper Left Hand (explanatory models of illness other than western medicine) as well. Health knowledge which is alternative to the biomedical model can be attained by the empirical method, through the use of studies to determine effectiveness. Since the physician is not usually involved, alternative medicine is often outside of the biomedical model. Also, the possibility of models other than the biomedical model can be integrated into the entire domain of medical knowledge and the medical curriculum. Eastern and Western systems of medicine may be integrated, since the whole of reality (the Kosmos) has been defined as the boundary for

our interdisciplinary thinking.

Case 6.1 - continued. The third example which I used to teach the medical students was in simply going back to the first case and describing what happened in the Emergency Department with Emil the night before the class. I informed the class that three years ago Emil's brother had died at six months of age of meningococcal meningitis, and that his mother was still grieving (Upper Left Hand). In fact, Emil's mother had been seeing me for a disabling back injury in which the pain was likely amplified because of reactivated grief. That night in the Emergency Department, I affirmed the impression that the rash which Emil had that night was the same kind of rash which occurred on his dying infant brother. I told the family that I went over all the empirical findings, and pointed out specifically how the empirical data was different from, or similar to that which Emil's brother had experienced (Upper Right Hand).

The mother's husband and sister were present, and I asked them all to talk it over and decide if they were willing to take Emil home, or if they would prefer that I admit him to hospital where his mother could stay with him overnight to help reassure her. In the end (it was 1:00 a.m.) the mother said that she was satisfied with the evidence I presented to her. She accepted my hypothesis and judgment that this was not meningococcal meningitis, and that she knew Emil would be more comfortable at home. The family left. I told the class

that I called the mother when I got home from the hospital, and asked her again if she was still comfortable having Emil at home. She said she was.

I presented to the class the data which showed that I could have confidence in sending Emil home with his family that night. They were caring; they were supportive; they communicated very well with me and with one another. My observations told me that they are a well functioning family (Lower Left and Lower Right Hands). I pointed out that I was now thinking in a systemic way. The class readily grasped that the context of this illness was a caring family, and that the concerns and meaning attributed to the signs and symptoms of this illness needed to be understood in a wholistic way, involving all three ways of thinking. The case also illustrates the need to understand issues in all four quadrants in order to give good and compassionate care. The case speaks for itself.

Case 6.3. A third case which I used with the medical students made a further point about the systemic way of thinking. I told them about a cute little four-year-old named Shameem whom I had seen several days previously. Her sister had died at an early age of a neurological disease. Shameem also had this rare genetic illness. I had delivered her and seen her as a baby when her father was in Canada working with an oil company. He had gone back to Saudi Arabia when Shameem was six months old because his job here ended. Prior to their

departure I sent Shameem to a pediatrician with documentation about her dead sister. The pediatrician found her to be healthy and told the parents he didn't think she had this condition. When they got back to Saudi Arabia, however, Shameem's development started to reverse itself, and she went from standing to being able only to sit. Her father, Ahmed, took her to London England where the diagnosis was made. He is now back in Canada as a landed immigrant so that he can get better health support for his daughter.

Her mother, Nadia, continued to bleed after the delivery, and I sent her to an obstetrician/gynecologist who performed a dilation and curettage (scraping out the womb). However, Shameem's father told me, as his wife spoke little English, that she had continued to bleed in Saudi Arabia. She conceived another child, but it was found that there was tissue still in the womb, and Nadia not only lost the fetus, but also had to have a hysterectomy. Children are central in the strong family units in Saudi Arabia. The parents in this family come from families each of which have eleven siblings. They all lived together on a large piece of land, and they had a family business. Ahmed and his wife and daughter are now alone in a strange country, with no extended family to support them. They need good support for their health.

This story illustrates the importance of an integrative vision or interdisciplinary thinking. The importance of the Lower Left Hand (interior collective or cultural) is espe-

cially illustrated in the importance of the culture of this family. The very high quality of the Canadian medical care system is also highlighted (Lower Right Hand). Again, all four quadrants are important.

A problem-based approach. When I was a medical student, the only course which was problem solving in nature was Medical Therapeutics. In this course students were given a medical problem, and we had to describe in writing how we would solve it. This was by far the most useful approach I experienced in my undergraduate medical education. The rest of my courses, aside from my work on the wards, were content-centered. My own experience confirms the validity of a problem-based education. Even to this day, I find that I learn best when I look for answers to the questions which the illnesses of my patients bring to my attention.

The interdisciplinary thinking and integrative vision described previously provides a cogent rationale and method for an undergraduate medical education based on problem solving.[199] Since the epistemology which I have described in this dissertation is based on the derivation of questions from the data, this dissertation clarifies the rationale for formulating problems which provide the questions to be solved and the general method for solving them.

Education which involves dialogue (i.e. a dialogical method) between educator and student about problems which are relevant to the student is appropriate in medical school.

This is radically different from the banking model of education in which knowledge is purportedly "deposited" into the mind of the student.

> Those truly committed to liberation must reject the banking concept in its entirety, adopting instead a concept of men and women as conscious beings, and consciousness as consciousness intent upon the world. They must abandon the educational goal of deposit-making and replace it with the posing of the problems of human beings in their relations with the world. "Problem-posing" education, responding to the essence of consciousness - *intentionality* - rejects communiques and embodies communication.[200] [quotes and italics the author's]

The dialogical method can be used in a medical curriculum which is problem based because it provides an integrating method for both students and teachers who are often subspecialists. This is important as we see a move toward problem-based education. A major challenge in this endeavour may be to educate the medical educator who is faced with the daunting task of helping medical trainees learn vast amounts of content which continually changes and evolves. The temptation in this situation is to add correspondingly larger amounts of content into an ever expanding yet finite curriculum.

This integrative vision allows students not only to learn to solve problems, but to learn how to learn through solving them. What is more, the distinction of the Universe into **I, We, and It** allows us to recognize the difference between an educational model which views the student as an **"It,"** as opposed to a model in which the educator and students are both subjects and persons, allowing for education which liber-

ates.[201] [202]

Postgraduate Medical Education. In addition to the above, the integrative vision described in this dissertation provides a foundation for postgraduate medical education which is appropriately dialogical, and for research which recognizes all four quadrants. Because of my integrative vision, the domain of the interpersonal may now be defined more accurately for the resident physician from a wholistic perspective. The artificial, dualist division of mind/body can be abandoned, and a unified view which sees the person as foundational can be developed. Curricula can be designed to address all four quadrants of reality.

In the discipline of Family Medicine, a patient-centered approach can now be fully rationalized, perhaps as a result of this dissertation, as being one which addresses all four quadrants, or all of reality. Achieving a higher viewpoint, as illustrated in the integrative vision of this dissertation, dissolves issues which dualism creates in such problems as somatization. A patient is viewed as a person. Pain is the pain of a unified person, and must be validated and understood in all four quadrants.

Family Therapy

In the fall of 1996 I attended a seminar in Toronto in which Lyman Wynne spoke about the history of Family Therapy up to the recent past. This was a truly welcome event for me because Wynne acknowledged that Family Therapy had erred in

not being collaborative with medicine. Some Family Therapy leaders have come to recognize that the discipline has become isolated. This has been described as an evolutionary misdirection. As Wynne states, this misdirection occurred by

> failing to be genuinely flexible and integrative in the selection of consultative and therapeutic approaches with specific families.[203]

I had felt this attitude when I attended Family Therapy meetings or discussed issues with Family Therapy colleagues. Family Therapy was not interested in the biological or biomedical view. Only now is there a realization that this has been a misdirection or a mistake. Wynne summarized the breadth of this mistake with the following comment. Family Therapy

> while continuing to develop a positive, distinctive professional identity, made a possible, potentially fatal misstep: to abandon the crucial, historic and continuing collaborative, multidisciplinary base of family therapy and hence be doomed to professional constriction and isolation, being left outside, like psychoanalysis, the mainstream of health care.[204]

In order to be included in the mainstream of health care, Family Therapy needs to recognize that the current models are too narrow to capture the concept of person, which is necessary in primary care. Systems theorists seem to oscillate between an entirely subjective (Lower Left Hand) and entirely objective (Lower Right Hand) position. What is more, by describing diagnosis or the labelling of families as pathologizing, Family Therapy has set itself up in opposition to biomedicine. This can cause conflict in a medical curricula

and further isolate Family Therapy.

Family Therapy education. The solution includes the adoption of critical realism and the acceptance of all four quadrants as necessary starting points for the derivation of our models. Family Therapy students can then be taught an interdisciplinary epistemology. The four quadrants would provide the framework to determine which models are most suited to which situation. If the emphasis is on teaching primarily the latest models, the valuable perspective of preceding models would certainly be lost. Models will change over time. The principles which all models have in common is that each views data from its own perspective. It might be helpful to teach students the interdisciplinary vision as a framework to help them critique and compare models, to identify their own assumptions, and to reflect on their own method of coming to know.

For instance, the Primary Care Family Assessment Model which I developed[205] includes the Lower Right Hand (family structure, or who is in the family), the Lower Left Hand (the connectedness of family members among themselves and with their context outside the family), and also the Upper Left Hand (emotions, love and commitment among other factors) and the Upper Right Hand (health from an empirical viewpoint). The model is inclusive because it is supported by critical realism and because it functions in primary care in which any problem can be brought to the clinician. It also integrates

the individual with the collective. This is unlike the systemic models discussed in Chapter Three which tend to be all either Lower Left (entirely subjective collective meaning) or Lower Right (entirely objective with individuals as functional elements in a larger system).

Interdisciplinary Education

The interdisciplinary thinking described and articulated in this dissertation provides a bridge between the thinking of physicians and that of therapists. It is my belief that medicine is in search of a way to integrate scientific knowledge with non-scientific knowledge. A most exciting educational application to me is the possibility of interdisciplinary education. The vision described in this dissertation provides a conceptual link between physicians, students and practitioners in the other disciplines involved in clinical care in a team setting, such as social work, nursing, and psychology, as has begun at the University of San Diego.[206] Having a picture of the whole allows different models to be taught without any model having to be representative of the entire medical perspective.

Once adequate research has been done to distinguish what assumptions different fields or disciplines have in common, curricula can be designed in which students from different faculties can be taught with courses that share common objectives. For instance, communication and interpersonal skills are common requirements for all the helping professions.

Being aware of the assumptions of each discipline and how they may be different from or similar to allied professions, will be useful in training our clinicians in interdisciplinary teamwork. Such teams will be vital as interdisciplinary clinical teams become more common in medical care. This direction is already being seriously considered and planned. The teams will also be vital as universities link faculties together in clusters, as is occurring at the University of Calgary. There could be core courses which would apply to all the disciplines concerned.

Ethical Implications

Relativity of criteria for truth. If there were no act of judgment about the appropriateness of our theories and how they fit with clinical experience, then all stories would bear equal credibility, as all would be relative. This would be to neglect the process of cognition in which data can be obtained upon which to base judgment. This is not an imposition, but a discerning of truth. If there is no way to attain truth, then the most articulate, or the strongest, or most manipulative person will dominate.

When a clinical model denies the existence of the real world, there are serious ethical problems. Our knowledge of reality forms the basis upon which our decisions are made, and our decisions are the basis of our moral behaviour. While distinctions can be made and contradictory theories rationalized by experts, others, students especially, may not have

the tools to make these distinctions. The ethical implications in systems theory have been well described earlier. All models have ethical implications because they are applied in real situations and guide clinicians in their judgments.

Lest it be assumed that these issues are not a present reality, let me mention a situation I discussed very recently. A therapist supervisor[207] was lamenting on how new Family Therapy graduates know only the most recent models. This supervisor was told by a student that it was unethical to provide information or make suggestions to a client. Presumably this was viewed as an imposition of one's own values on another. In a system of thinking where all stories are viewed equally, such a conclusion might seem possible. However, I think that we have the obligation to inform clients and patients when they need information.

Conclusion

This dissertation achieves its major objectives. It describes an integrating vision for medical education. It also provides interdisciplinary thinking to the fields of Family Therapy and Family Medicine. Through defining the whole (the Kosmos) the interdisciplinary vision is able to more clearly describe both the limits and boundaries of the different models which medicine and Family Therapy use to care for the sick.

Afterword

Whatever the value that this process of deriving an integrative vision will be determined to be, I myself have benefited from the experience. It has refined the way I teach and practice. It has provided some of the answers to the questions I have asked. What is more important, it has created a framework from which my future research will undoubtedly evolve. I hope the reader has shared with me in some of the excitement I feel about clarifying these important issues and in some way contributing to an expanded horizon for those who follow this area of interest in the next century.

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IMAGE EVALUATION
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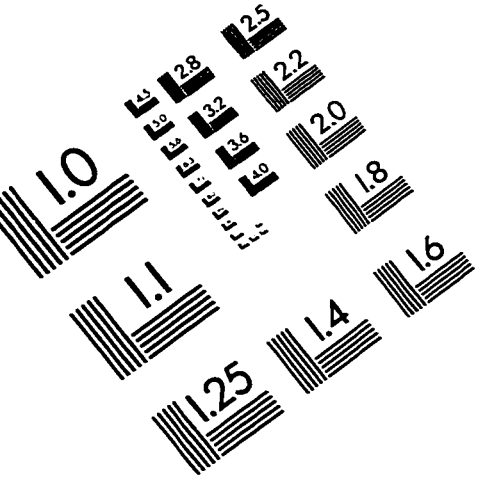

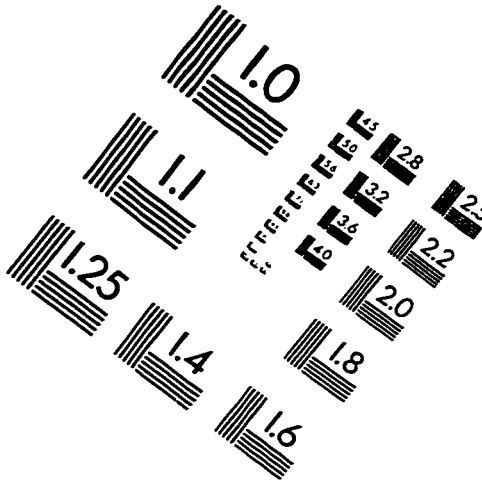

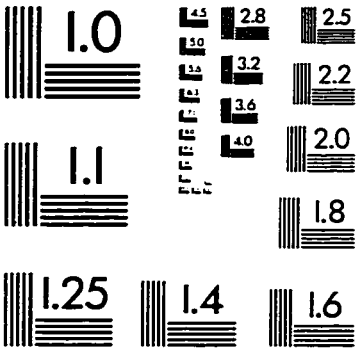

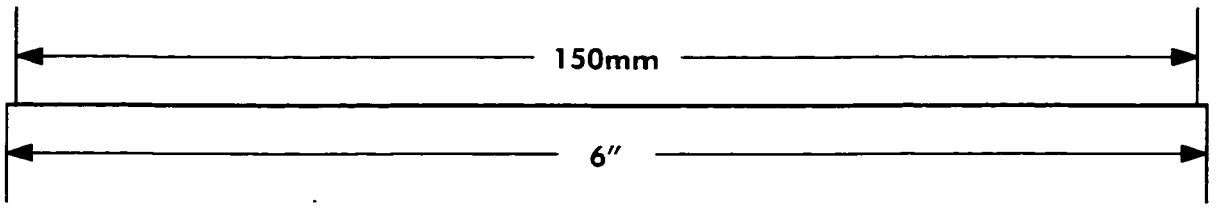

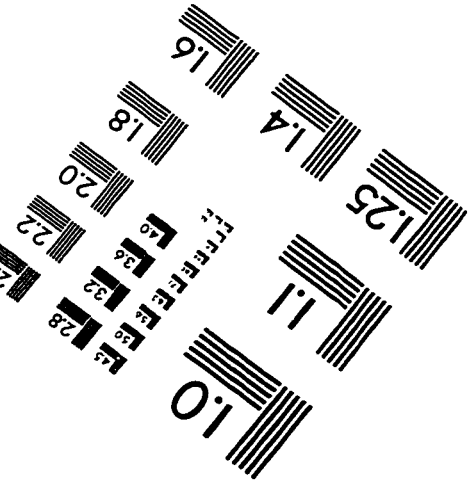

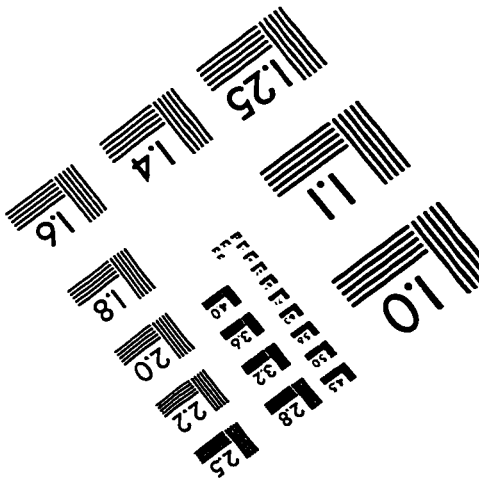

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