‘Multiple perspectives – collaboration or competition?’

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EWOPA 2015

Collaboration or competition?

or, other ideas for what might be happening

- Medical interventions

- Joe, a 10 year old white British boy is discussed repeatedly at weekly multi disciplinary ward rounds. There was a late diagnosis of ESRF which resulted in an emergency admission and lengthy in patient stay nine months ago. Reports at this time described a young person whose distress and related behaviour proved hard for his parents and ward staff to manage. The family live far away from the hospital and going home on PD there have been further reports of difficulties and numerous admissions related to this. The Consultant and CNS are worried about how thin he appears and have requested he have a gastrostomy.

- As the allocated member of the Psychosocial team, you are not so sure. Your initial assessment of the family situation suggests there are long standing parental difficulties with an acrimonious split and a background of parental mental health difficulties. You appreciate the worry about this boy's weight but fear a gastrostomy may compound matters i.e. adding a medical intervention to an already fraught situation and one in which his parents already appear to be struggling.

Collaboration or competition?

or, other ideas for what might be happening

- Timings:

- Esther, a 9 year Black British girl has had significant behavioural problems. The team speculate that this is driven by anxiety and stress; Esther's Consultant decides it would not be in Esther's interests for kidney transplant to take place until matters have resolved. However since starting haemodialysis, these more difficult behaviours appear to have settled down. The Consultant is now keen to press ahead with planning for transplant.

- You however are keen that further assessment and treatment take place. You notice that whilst more compliant with dialysis, Esther's continues to present in what seems an unusual way i.e. even allowing for haemodialysis and feeling unwell. She often doesn't speak, ignoring her mother and other staff, or alternatively, speaks like a child much younger than her years. The initial work begun with you suggests a child who is indeed anxious and feeling very isolated and strange. However you are now feeling under pressure.

Collaboration or competition?

or, other ideas for what might be happening

- How do histories and different paradigms inform what it is we do?
- Reviewing the implications of these - an overview and ideas about alternative approaches:

- - Multiple perspectives; wider systems - why does it matter?

- Bio Psychosocial model: an overarching view of illness and relationships

- - Understanding how professional differences are informed by:

- a. Discourses and illness as social construction
- b. How we might find ourselves 'positioned' in any exchange
- c. Where do we speak from? (What domain governs our exchanges)
- d. What are the opportunities and constraints of these?
- e. How might disruption and struggle be a good thing?
- - Case examples

- *Tension and discontinuity as an opportunity*

The importance of considering relationships and the wider system

- Second order cybernetics, observing systems
  - The observer is implicated

Multiple perspectives, the importance of the wider system

- **Safety** Differences in culture and values between professionals, plus strongly hierarchical relationships, were an important part of systemic problems that undermined safe, effective and respectful care to children with heart disease and their families. (Bristol Royal Infirmary Inquiry Report 2001)
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- **Social systems as a defence against anxiety** (Menzies 1959)

- ‘The problem of the referring person’. indicating that the referring professional was seen as part of the patients difficulties and could require intervention by the family therapist. (Selvini, Boscolo, Cecchin and Prata 1980) Related to this, the development of theory (Second Order Cybernetics) indicating how the observer is part of that being observed and implicated in constructing that which is being observed (Jones 1993)

Multiple perspectives, the importance of the wider system

- Patterns of behavior, beliefs and relationships in *both* family **and wider systems** may promote or hinder problem resolution and human development (Imber-Black 1988)

- It is important to consider a wider **picture of interaction between** the disease, individual, family, **healthcare providers and other bio psychosocial systems** (Engel 1977, McDaniel, Hepworth and Doherty 1992).

- Rolland's biopsychosocial systems model (of interaction between type and stage of illness, and the patient and family, their beliefs, life cycle stage and pre-existing relationships) also **very relevant for understanding the way healthcare professionals interact with patients and families**. (Rolland 1994)

The Biopsychosocial systems model

- Biosphere
- Society-nation
- Culture-subculture
- Community
- Family
- Two person
- **Person – experience and behavior**
- Nervous system
- Organs/organ systems
- Tissues
- Cells
- Molecules
- Atoms
- Subatomic particles

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

The Biopsychosocial systems model

- bio and psychosocial integrated and informing one another
- type of illness as a context
- time and phase of illness as a context e.g. diagnosis, crisis and chronic
- transition
- family and illness ‘systems’

However ...

- Biosphere
- Society-nation
- ***Culture-subculture***
- ***Organisation - professional discipline***
- ***Paediatric speciality - team***
- **Person – experience and behavior**
- Nervous system
- Organs/organ systems
- Tissues
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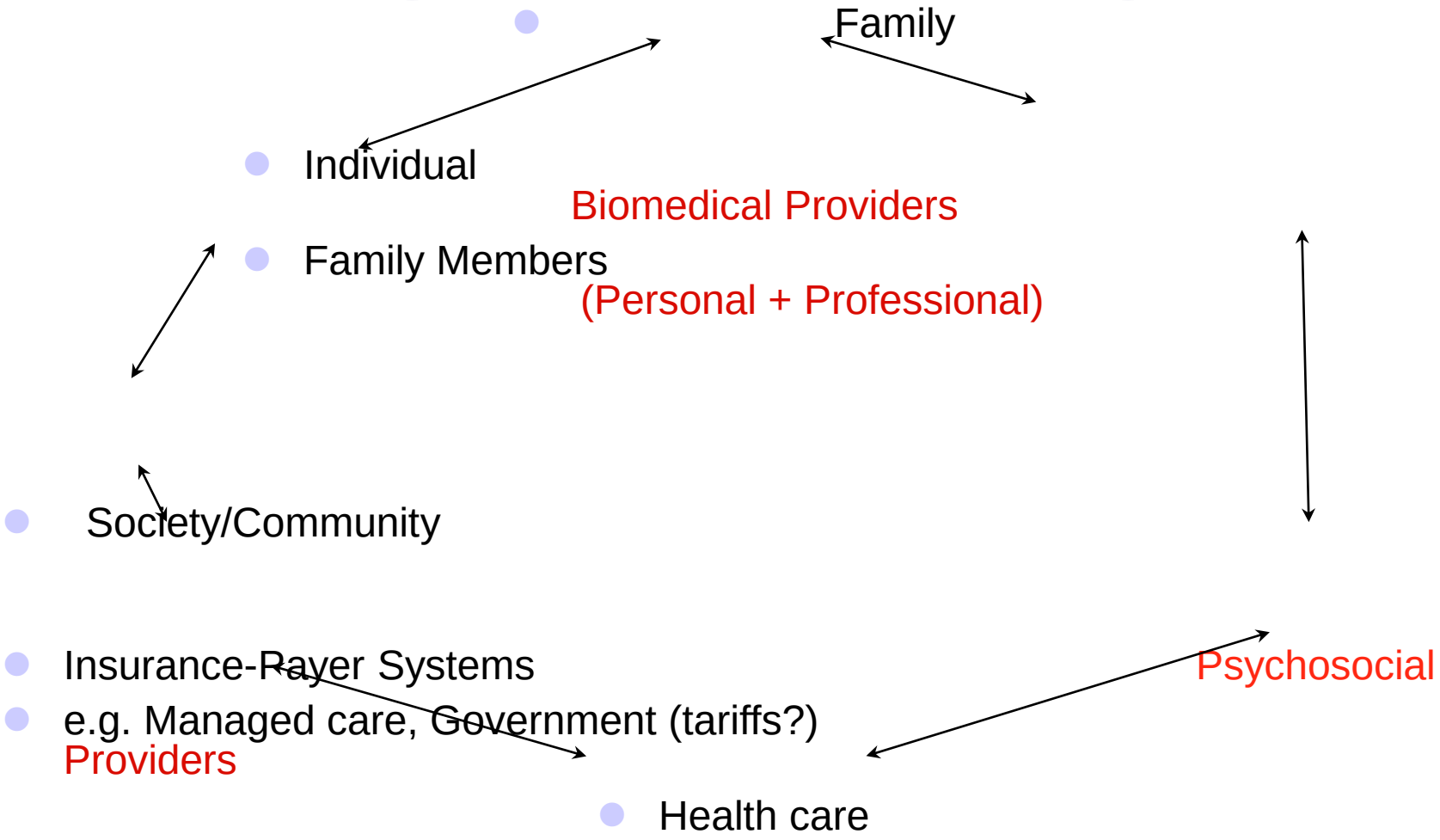
The Biopsychosocial systems model - fit of beliefs



From: Rolland, J.S. Families, Illness and Disability: An Integrative Treatment Model. New York: Basic Books, 1994

Differences in practice

Biomedical paradigm
Medical language

↕

Action oriented

Advice giving/Dr takes initiative

24 hour clock

Basic medical use of individual/family history

↕

Confidentiality

Professional distance?

Psychosocial paradigm

Psychosocial language

↕

Process oriented

Avoids advice.

Scheduled sessions

Extensive use of individual/family history

↕

Confidentiality

Emotional connection?

Discourse as a way of helping?

- Discourse as a system of representation
- Discourse is the production of knowledge through language
- Nothing has meaning outside discourse
- The concept of discourse is not about whether things exist but where meaning comes from
- Foregrounds the relationship between discourse, knowledge and power
- Discourse sustains a regime of truth
- - Foucault

what kind of discourses?

- illness is biological
- madness is to be feared
- mind and body split

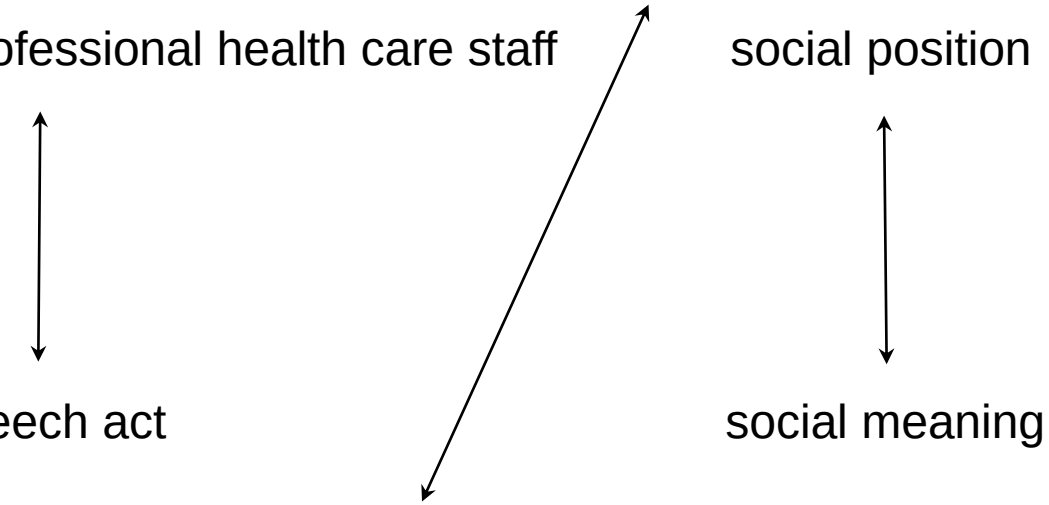
- Resulting in?
- more medical technologies
- tensions between diagnostic and relational frames
- subjugated discourses about relational experiences (often key in renal settings, see Down's work re understanding roles)
- less emphasis on other aspects of experience e.g. social context

socially constructed illness

- Chronic illness is not simply an individual subjective experience; it is **interpersonal and social**. The definition or meaning an individual gives to an illness is **profoundly influenced by and influences that person's social world**. The social culture and the social networks shape and are shaped by the individual's experiences. The **meaning of the illness is shared and negotiated in everyday interactions and it is deeply embedded in the social world**. As such it is inseparable from the structure and processes that constituted that social world (Atwood, 1996)

Positioned or being positioned

- Social forces or dominant discourses:

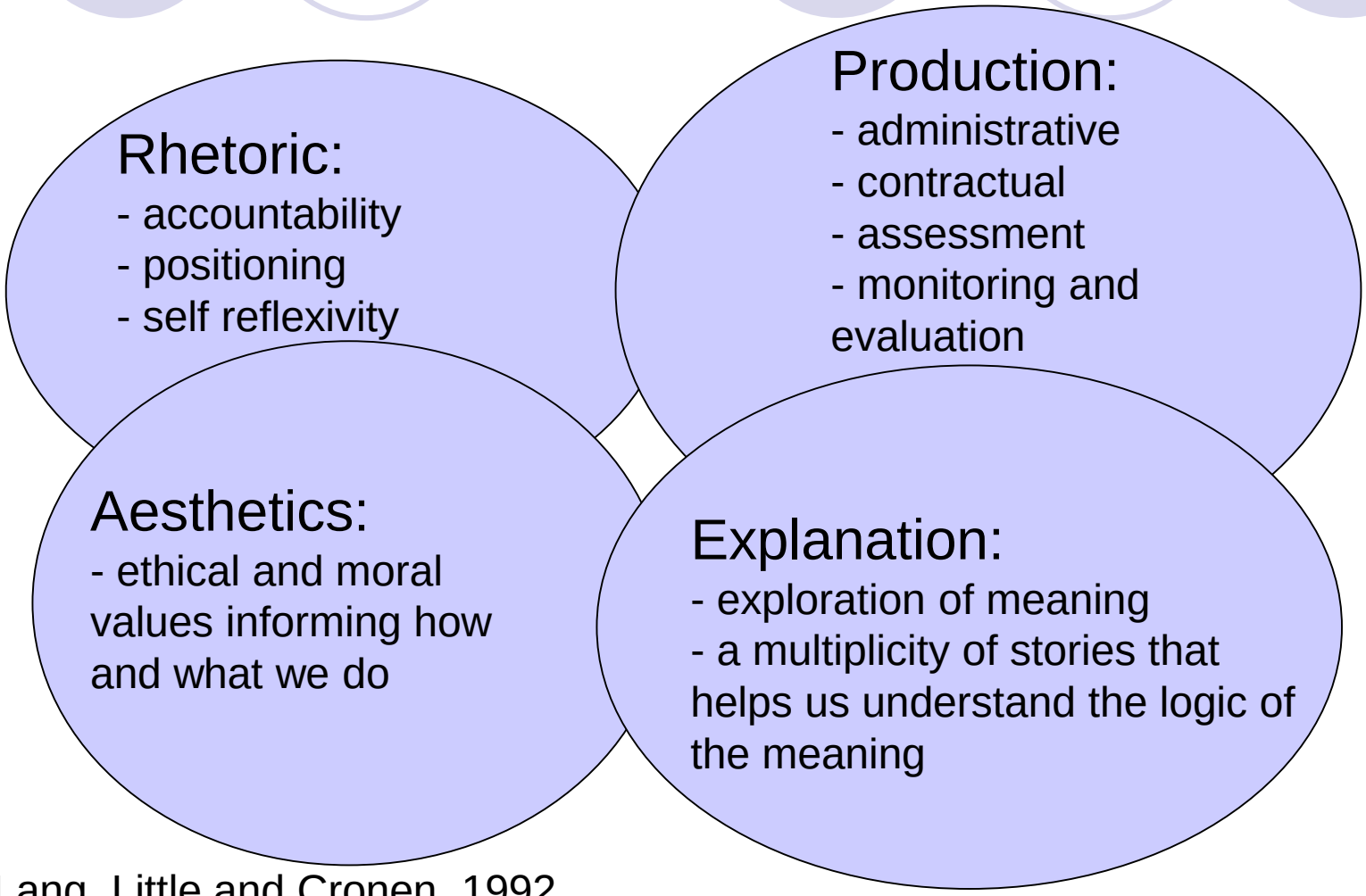


- Here the social meaning is derived from positioning of the professional health care staff, a product of the social force a conversation action is taken ‘to have’

Positioned or being positioned

- We’re in dynamic relationships
- All conversations have a social force
- Meaning unfolds with each turn of the conversation and is contingent on the positions people hold in relation to one another
- A position occupied by one conversational participant creates a storyline for others to be cast into / act into i.e. positioned by another e.g. invitations that may be taken up or not
- Positioning theory makes a strong link between the speech act and the social force
- Positioning theory invites us to give an account of our thinking and action
- - Harre

Domains theory



- Lang, Little and Cronen, 1992

Getting back to Jo and Esther..

- Ideas and experiences about illness are being performed and created as we speak and act
- *what is happening here in this exchange, what are we 'making'?*

- What choices am I and others making about how we are being positioned
- *what might be the opportunities and constraints of these for me and this family at this time?*

- There may be tensions between different domains and frames
- *where am I / others speaking from in this meeting e.g. which domain or frame?*

- If there are multiple positions, is there more scope for collaboration, a 'both/and' rather than 'either/or'?

- Move to relational networks and mutual influencing

Discontinuities and difficulties... disruption or opportunity?

- What is this difficulty telling me about any absent norms or received wisdom, orthodoxies and discourses?
- What the dominant discourses about how people using services are seen?
- What are beliefs of my organisation and this team about this topic?
- What are the stories not being told or listened to?
- To what extent are these beliefs either the same or different from my own?
- Orthodoxies about theory
- Overlooking history
- ***Where are the particular places of discontinuity for me / this team?***