

**TOWARDS AN ECOSYSTEMIC UNDERSTANDING  
OF "ENDOMETRIOSIS"**

by

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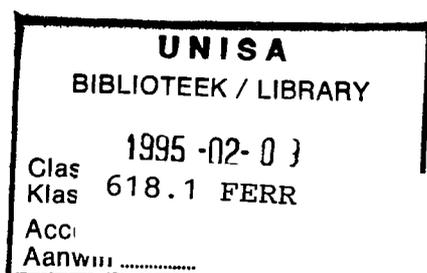
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## SUMMARY

Endometriosis or the "career woman's disease" is a puzzling disease affecting women in their reproductive years. Research on endometriosis has focussed on aspects such as the personality characteristics of sufferers and its correlation with infertility (Venter, 1980). As yet, the experiential world of endometriosis sufferers and the relationships which are influenced by their disease have received little attention (Weinstein, 1987).

Furthermore, endometriosis is construed as a physical disorder which is medically diagnosed and medically treated. As such, the epistemology surrounding the term "endometriosis" is an adherent to a largely non-contextual, non-systemic and intrinsically mechanistic biomedical model (Bogdan, 1984; Schwartz, 1982).

By using an ecosystemic epistemology, this dissertation will attempt to describe the unique experiential world of the afflicted woman in terms of her coping strategies in dealing with endometriosis and to formulate a description of the interactional patterns between herself and significant others directly influenced by her disease.

## CHAPTER 1

### INTRODUCTION

Auerswald (1985) states:

A whole new technology of prevention, diagnosis and treatment is taking shape. For example, labels, which describe syndrome, the etiology of which is multidetermined and may vary from case to case, need no longer be the focus of diagnosis, which will consist instead of identification in the total ecological field of the various etiological vectors in each case (p. 11).

This approach could prove most interesting in the study of "endometriosis".

#### Background to "Endometriosis"

Endometriosis is a puzzling disease affecting women in their reproductive years (Blumenthal, 1987; Hawkrigde, 1989). The name comes from the word "endometrium", which is the tissue that lines the inside of the uterus and builds up and sheds each month in the menstrual cycle. In endometriosis, tissue like the endometrium is found outside the uterus in other areas of the body (Hawkrigde, 1989). In these locations outside the uterus, the endometrial tissue develops into nodules, tumours, lesions, implants or growths (Cabe-Gill, 1991). Symptoms appear to worsen with time, though cycles of remission and recurrence are the pattern in some cases (Ballweg & Deutsch, 1988; Bernhard, 1982; Wild & Wilson, 1987).

More commonly known as the "career woman's disease" due to its association with delayed childbearing (Wallis, 1986), it has been termed an "equal-opportunity disease" since prevalence is high, and is of an insidious nature. Recent studies have shown that the disorder strikes women of all socio-economic groups, and even teenagers, although it is generally accepted that endometriosis is rare among Black women (Chatman, 1976; Kasule & Chimbira, 1987; Venter, 1980).

A major consequence of endometriosis appears to be the correlation that exists between infertility and endometriosis (Moghissi & Wallach, 1983; Venter, 1980). The incidence rate was noted as being 30-40% (Cramer, Dodek, & Israel, 1989; Venter, 1980; Wedell, Billings, & Fayez, 1985). Furthermore, in the event of "endometriosis", pregnancy often causes a temporary remission of symptoms. Consequently pregnancy is "prescribed" for women with "endometriosis" because it is believed that infertility is more likely the longer the disease is present. However due to the nature of "endometriosis", the prospect of pregnancy is halved (Venter, 1980; Wedell et al., 1985).

Fertility problems can have a major impact on the lives of endometriosis sufferers, especially since women have traditionally been raised to view motherhood as their primary adult role (Woods, Olshansky, & Draye, 1991). Studies have also shown that many infertile women regard their childless state as having a profoundly negative influence on the maintenance of friendships with fertile women (Woods et al., 1991). Furthermore, infertility tests and treatments are also highly stressful and treatments may be seen to be threatening, embarrassing and intrusive (Abbey, Halman, & Andrews, 1992).

The difficulties experienced by endometriosis sufferers are also exacerbated by the personality traits exhibited by these women, as well as the side effects of treatments. According to Venter (1980, p.895), women afflicted by endometriosis have been described as "over-anxious, intelligent and perfectionist". Characteristics such as perfectionism and anxiety may have an adverse effect on the ability of these women to cope with the disease, thereby also influencing the coping mechanisms of significant others in their lives.

The above mentioned difficulties may be further exacerbated by the negative side effects associated with hormonal treatment, for example, mood swings (Dizerga, Barber, & Hogden, 1980; Wallis, 1986). Lewis, Comite, Mallouh, Zadunaisky, Hutchinson-Williams, Cherksey and Yeager, (1987) conducted a preliminary study which suggested that endometriosis and bipolar disorder (a major psychiatric disorder in which both poles on an emotional dimension are manifested for example, both a manic and a depressive episode are present) may be closely related. In addition vasomotor disturbances (disturbances pertaining to the nerves that have control over muscular walls of the blood vessels....), weight gain and androgenic (secondary male

characteristics) effects have also been known to occur (Wallis, 1986; Weinstein, 1987). These all function as a further source of stress for the endometriosis sufferer (Daniluk, 1988; Mahlstedt, 1985; Wright, Duchesne, Sabourin, Bissonnette, Benoit, & Girard, 1991).

Adding to the stress and difficulties experienced by endometriosis sufferers is the mystery surrounding the aetiology of this disease. Although hereditary factors appear to play a role in that a higher incidence of significant endometriosis among blood-related women of certain families has been observed (Wallis, 1986), the aetiology is clouded by differing views. One theory ascribes it to "retrograde menstruation" (Wallis, 1986, p.50), while another suggests that the disease arises from misplaced embryonic cells that have lain around the abdominal cavity since birth (Muse, 1988; Wallis, 1986).

#### The Problem Premise

Although research on endometriosis has focussed on aspects such as the personality characteristics of sufferers and its correlation with infertility (Venter, 1980), as yet, the experiential world of women confronted by endometriosis and the relationships which are influenced by their disease have received little attention (Weinstein, 1987).

From the description of endometriosis, it follows that it is construed as a physical disorder which is medically diagnosed and medically treated. As such, the epistemology surrounding the term "endometriosis" is an adherent to the biomedical model which is largely non-contextual, non-systemic and intrinsically mechanistic (Bogdan, 1984; Schwartz, 1982).

In keeping with the Newtonian paradigm of Western civilization, endometriosis and its treatment therefore, is a concept which has largely been medicalized. The biomedical model in its most absolute form construes the body as separate from the mind, adhering to Cartesian dualism (Schwartz, 1982). The "erring womb" is divorced from a holistic view of the female patient and the patient from her social context. According to the mechanistic premise of analytical reductionism, any defect or disease is best understood when reduced to its elementary parts (Knobel, 1984; Ranney, 1980; Redwine, 1987).

When endometriosis is dualistically diagnosed as either organic or psychogenic, a division is created between medical and mental health treatment. Endometriosis sufferers seldom consult mental health workers due to their overriding physical symptomatology (Petersen & Hasselbring, 1987).

Furthermore, referrals are only made on an ad hoc basis when the physician suspects some psychiatric condition due to the elusive nature of the disease or when the patient becomes bothersome. The possibility of a biopsychosocial course of endometriosis, where occurrence, impact and adjustment are integrally interrelated, does not fall within the realm of the biomedical model's construction of defective health (Petersen & Hasselbring, 1987).

In addition, with the onset of increased specialization in all fields of medicine and the race to find newer and more effective methods of treatment, further fragmentation of the health care process ensues as well as a concurrent sense of decreased responsibility by all persons concerned, including that of the patient (Bloch, 1983). "Endometriosis" by definition is predominantly limited to the female population although rare cases of this disease have been identified in men (Ballwegg & Deutsch, 1988). This therefore facilitates the major focus of attention to be on gynaecological problems exclusive to the female endometriosis sufferer and reduced to "elimination by nature of gender". The male partner's needs in most cases are largely disregarded as his presence has no particular relevance and generally makes no contribution to the nature, or treatment of the disease (Bloch, 1983).

### Purpose of the Study

This dissertation is an attempt to describe the unique experiential world of the afflicted woman in terms of her coping strategies in dealing with endometriosis and to formulate a description of the interactional patterns between herself and significant others who are directly influenced by her disease. In short therefore, belief systems regarding the family's perception of endometriosis will be explored. In so doing, a construction of the phenomenon of endometriosis as a holistic, biopsychosocial entity will be made whereby the Newtonian epistemologies and fragmentary nature of over-specialization are integrated into the participant-observer relationship and which therefore moves

towards patterns which connect and interrelate as characterised by the ecosystemic approach (Keeney, 1983a).

The ecosystemic perspective as an alternative approach to that of the medical model has been chosen as it is "... the broadest view for looking at all possible systems, levels of systems and interrelations among systems" (Keeney, 1983b, p. 34), whereby patterns of relationships, ecology, whole systems, interrelationships and contexts are observed (Keeney, 1979).

In chapter 2, interpersonal systems from the ecosystemic perspective will be discussed. This chapter will also include an elucidation of ecosystems, and co-evolutionary processes fundamental to this paradigm. Furthermore, the ecosystemic paradigm will be elaborated upon to include its particular reference to "endometriosis" sufferers and their family members.

Whilst including an overview of research with regard to endometriosis in the family to date, chapter 3 will elaborate on the predominant factors and effects of endometriosis. Furthermore, treatment measures which may be taken in the management of endometriosis will also be discussed briefly. True to the ecosystemic epistemology of "man in context", the doctor-patient relationship as part of the endometriosis sufferer's interdependent system, will be emphasised.

Chapter 4 will describe the research design to be used in the study. In particular, the focus will be on positivistic and ecosystemic research principles, and will also include the research hypothesis. The description of the genogram as a research instrument which facilitates a linking process between the endometriosis sufferer, her family and the participant-observer will be elaborated upon. This will be done in order to facilitate an elucidation of the exploration of intergenerational transmission of the families' belief systems and behaviours which have developed about significant family events in the past and the present. In particular, the focus will be on how relationships are organised around the women suffering from endometriosis and their families.

A presentation of the detailed process analyses of the case illustrations of the three women and their families is forwarded in chapter 5 by means of a description of the genograms that will be co-created in each of the three cases.

Chapter 6 addresses the conclusions and implications of the findings of the research design. The ecosystemic approach as an alternative perspective is juxtaposed with the implications of the diagnosis of "endometriosis" for the women and their families. Included in this chapter is a critique of the research design and suggestions regarding future recommendations are forwarded.

## CHAPTER 2

### THE ECOSYSTEMIC PERSPECTIVE - A PARADIGM FOR SECOND-ORDER CYBERNETIC EPISTEMOLOGY

#### Introduction

In this chapter the ecosystemic paradigm as an alternative means of viewing reality will be forwarded with particular reference to the use of such a perspective when examining "endometriosis". In particular, a central feature of the evolutionary paradigm, namely that of cybernetics will be elaborated upon. Furthermore, processes which co-evolve and which are integral to the ecosystemic paradigm will be explained. Limitations inherent in a Newtonian paradigm will be discussed. To conclude this chapter, alternative and complementary approaches to the concept of "endometriosis" will also be presented.

#### An Ecosystemic Perspective of "Endometriosis"

Ecology is the study of the complex interrelatedness of all living organisms in nature, including humans (Keeney, 1984). The ecosystemic paradigm evolved from the study of a section of this interrelated living universe, specifically from the study of human interactional systems in the wider socio-cultural context (Auerswald, 1987).

The notion of interrelation furthermore stresses the importance of interdependence between the component parts of a system. As all elements in a system are related, a change in one affects every other element (Lines, 1987). Consequently a shift beyond the Newtonian model necessitated an alternative means of viewing reality. Whereas Newtonian epistemology posits atomistic, reductionistic and anti-contextual principles, ecosystemic epistemology emphasises ecology, interrelationships and context and, as such, offers an entirely new and more complex way of viewing and understanding the world (Keeney, 1979). Therefore, the concept "endometriosis" seen in holistic terms, requires an understanding of its occurrence as part of an encompassing network of relationship patterns. An evolutionary paradigm provides an alternative view of reality. The concept of cybernetics and the inherent differences between first-order and second-order cybernetics will be elucidated.

## Cybernetics

The primary idea underlying the term "cybernetics", identified by the mathematician Norbert Wiener in 1948, is that "...pattern organises physical and mental processes" (Keeney, 1983a, p. 64). Consequently both the parts and wholes of phenomena are examined in terms of their patterns of organisation (Keeney, 1982). The new science of information, pattern and organisation therefore provides an alternative way of viewing reality.

As Keeney (1983a, p. 64) states: "An encounter with cybernetics is somewhat analogous to a Japanese landscape, where pattern, rather than objects is primary. The objects fade into the background while pattern is brought into focus".

Cybernetics is based on the complementary relationship between stability and change. Complementarity as a co-evolutionary process will be discussed during the course of this chapter in order to elucidate this term.

In cybernetics, stability and change are seen as inseparable: "Cybernetics proposes that change cannot be found without a roof of stability over its head. Similarly, stability will always be rooted to underlying processes of change" (Keeney, 1983a, p. 48). Furthermore, living systems continually adjust to internal and external changes in order to conserve their essential structure. This is achieved through a recursive process called the feedback loop which is used as the basis of explanation in cybernetics (Keeney, 1983a). Feedback is a method of controlling a system by reinserting into it the results of its past performance (Keeney, 1983a). If these results are merely used as numerical data for the criticism of the system and its regulation, we have the simple feedback of the control engineers. If, however, the information which proceeds backward from the performance is able to change the general method and pattern of performance, we have a process which may be called learning (Keeney, 1983a).

### The Shift from First-Order to Second-Order Cybernetics

The shift from first-order to second-order cybernetics occurred with the

growth of the constructivist philosophy within the field of psychotherapy. The constructivist philosophy maintains that all knowledge is a construction of mind in the social domain and that there is consequently no objective reality (Hoffman, 1981). The corollary postulate is that man can never merely observe or see, because his attempts to do so will necessarily involve creation and invention (Hoffman, 1981). Given this philosophy, the shift from first-order cybernetics or in other words, the cybernetics of the observed system, to second-order cybernetics, that is the cybernetics of the observing system, became inevitable.

During the first-order cybernetic movement, it was believed that the therapist had a "duty" to alter pathological family homeostasis (Hoffman, 1981). Moreover, the therapist would be able to adopt a "metaposition" or external position to the system (Hoffman, 1990). However, according to second-order cybernetic thinking, if reality can be constructed, it can never be examined from an outside position. The emphasis is therefore placed on perspectives of the participating system.

With the shift to second-order cybernetic thinking, a view was adopted which included second-order cybernetic concepts such as can be found in Varela's basic tenet that systems are autopoietic (Hoffman, 1981). Autopoietic systems are self-creating and autonomous. This is in contrast to the first-order cybernetic idea of the family as allopoietic, that is, capable of being controlled and programmed externally to the system (Hoffman, 1981).

Second-order cybernetics also avoids the implication of a system such as the family, created by a problem. The focus is rather on dialogue around a particular problem as opposed to treatment of the problem. Second-order cybernetics is also based on the assumption that the therapist remains non-judgemental and sides with everybody in order to find the meaning behind events and actions of the system. Issues of control and power are de-emphasised and the benefits of the social and natural ecology are taken into consideration, for example, in the case where only a few members of a family arrive for an appointment this event is not treated as a maneuver to be "counteracted" (Hoffman, 1990) but the meaning behind the ecology is examined.

In addition, the therapist's position in second-order cybernetic thinking is a

lateral as opposed to a hierarchical one. The family are invited to participate in the therapist's discussion surrounding their problem. In addition, this epistemology is a way of adopting an instructive stance in therapy. It is primarily pluralistic in nature, holding multi-perspective views as opposed to a monistic perspective (Hoffman, 1990).

Embodied in the shift to second-order cybernetics was a shift from the world of pathological structure to the world of meaning (Anderson & Goolishian, 1988). Traditionally family models focussed on altering objectively perceivable facets of behaviour, such as dysfunctional family structures and interactional patterns. These models remain within the observed system's framework. However, if a constructivist framework is adopted, perceivable facets are exchanged for premises, ideas and meanings held by the entire observing system comprised of the members of the family and the therapist (Hoffman, 1981).

Second-order cybernetic therapy as stressed by Anderson and Goolishian (1988, p. 391), is a linguistic event in which new meanings are continuously evolving towards the "dis-solving" of problems. The metagoal of the second-order cybernetic therapist is therefore the co-evolution of new meaning through dialogue.

At this point it is relevant to briefly elaborate upon the co-evolution of new meaning through dialogue as a second-order cybernetic intervention. This is in contrast to the first-order cybernetic notion that a family system can be manipulated. Specific reference to "endometriosis" as a "problem" within a system will be made.

### The Co-evolution of New Meanings

As will be seen during the course of this dissertation, an attempt is made to explore how a family system with a linearly defined problem such as "endometriosis" may be examined from an ecosystemic paradigm. Traditional Newtonian or linear epistemology (THE ECOSYSTEMIC PERSPECTIVE - A PARADIGM FOR SECOND-ORDER CYBERNETIC EPISTEMOLOGY, p. 7) favours structure, matter and stability as opposed to the emphasis on process, pattern and relationships of an ecosystemic epistemology. Consequently a diagnosis

of "endometriosis" according to the medical model places the female member in the sick role. The meaning attributed to her "condition" therefore, as held by her significant others and the wider system of which she is a member, is one of "victim" and identified patient. Her "illness" is medically managed and treated from a behavioural perspective. The focus is placed on internal changes within her body as opposed to changes in interactional patterns which may result from her "illness".

This linear perspective creates labels for "illnesses" in order to structure phenomena. Labelling as an adherent to a Newtonian paradigm is discussed in detail during the course of this chapter as is the concept of illness. By creating labels, barriers to understanding people on their own terms are formed and the ability to empathise with others is lost (Bogdan, 1984). However, if an approach such as the ecosystemic approach is adopted, intervention techniques inherent to a second-order cybernetic epistemology for example, genograms (Genot, 1989) as used in this study, emphasise process, pattern and relationships. Consequently both the inner and outer system of the "endometriosis" member are explored in order to facilitate a co-evolution of new meanings between an observing system rather than adhering to a linear meaning attributed to an observed system.

In addition, by attributing new meanings to events and phenomena, labels are abandoned and attention is shifted from the deficiencies of the person to those of the society and service systems (Bogdan, 1984). Thus, instead of asking what is wrong with the person, the kinds of environments and services which can be created to accommodate all persons in the society are examined whereby they may be treated with the necessary respect and dignity. Most importantly, when labels are abandoned, those perspectives which have been ignored have to be taken into account (Bogdan, 1984).

### Summary

Cybernetic epistemology prescribes a way of recognising and knowing patterns that organise events. It is a process of knowing, constructing and maintaining a world of experience rather than consisting of a map, model or theory. As such, cybernetics directs one to find patterns which connect parts such as members of a family and a therapist. In this way, the basic postulates of cybernetic epistemology allows one to talk of patterns and not lose sight of

the recursive connection between phenomena.

The traditional Newtonian concept of "endometriosis" mentioned in (Labelling and "Endometriosis" - Adherence to a Newtonian Paradigm, p. 21) is an exclusive focus which disregards all other integral components of the wider ecosystem of which the woman labelled as an "endometriosis" sufferer is a part.

This conceptualisation of "endometriosis" can be criticised on epistemological grounds. A discussion on atomism and additional ecosystemic concepts such as double description, coherence, complementarity and equifinality will elucidate the problems inherent in using the classification "endometriosis" according to the traditional medical model.

### Atomism and the Diagnosis of "Endometriosis"

Atomism refers to the theoretical position that it is possible to reduce reality to basic units or least particulars (Schwartzman, 1984). An atom is a system composed of energy relations and subsystems (Bowler, 1981). This approach (which is embodied by the medical model) posits that entities are separate from the wider system to which they belong and that these entities possess exclusive qualities that are distinct from the other elements in the context. Traditional research on "endometriosis" clearly indicates an atomistic stance, since the "endometriosis" sufferer is consistently perceived to be an entity separate from the family system to which she belongs, thereby overlooking the interactional processes within the family.

In keeping with the fundamental premise of Newtonian epistemology which assumes that reality is unlevelled and can be reduced to least particulars or rudimentary units, (Keeney, 1982) atomism however also incorporates a basic contradiction. Whereas Newtonian epistemology posits a "disconnectedness" or "separateness" from the wider context (Auerswald, 1987), atomistic rudimentary units are inextricably connected to the context in which they are found. They therefore, cannot be perceived as having a "disconnectedness" or "separateness" from their context (Schwartzman, 1984).

Bateson (1980, pp. 15-16) states that when a linear epistemology is used, "...we abstract from relationship and from the experiences of interaction to create objects and to endow them with characteristics". Furthermore, as

Watzlawick, Weakland and Fisch (1974, p. 22) warn, a monadic view of man (i.e. adoption of a linear model) leads to a "reification of what reveal themselves more and more as complex patterns of relationship and interaction". In order to elucidate the importance of viewing patterns of relationship and interaction as part of an ecosystemic epistemology when viewing "endometriosis", the concept of double description will be elaborated upon.

### Double Description

Bateson's (1971, p. 243) fundamental principle of systems theory states: "double description is required in order to move from one level to another. Views from every side of the relationship must be juxtaposed in order to achieve a general sense of the relationship as a whole". This approach is also supported by Penn (1982, p. 271) and Keeney (1983, p. 52). As Keeney, (1979, p. 120) explains, "if you want to understand some phenomenon or appearance you must consider that phenomenon within the context of all completed circuits which are relevant to it". Double description refers to the emergence of two or more interpretations of the same phenomenon or event, from different perspectives. Information gathered from two or more perspectives implies "news of difference" (Bateson, 1972, p. 132) which is the only type of information living systems can register. When considering the concept "endometriosis" therefore, interpretation in slightly different ways by two members of the therapeutic system, will occur.

During interaction with a family in which the female member has "endometriosis", a double description will occur once the traditional definition of "endometriosis" is juxtaposed with the family's view of "endometriosis". The co-creation of the genogram will facilitate this principle. "News of difference" may result in a perturbation in the family's conceptualisation of "endometriosis", which could give rise to a more useful, adaptive definition, in line with their individual ecology of ideas as it has evolved across generations. This more useful definition would be opposed to a definition of "endometriosis" externally provided by professionals in the medical field.

Families constitute elements of a living structure which functions according to the organising principles which underlie all forms of life (Campbell & de Carteret, 1984). One such organisation principle is the concept of complementarity (Keeney, 1979).

"Endometriosis" therefore, cannot be understood as separate from the inextricable connectedness to the family seen in holistic terms since complementarity is present between the individual woman and her family.

### Complementarity and the Diagnosis "Endometriosis"

Complementarity implies that actions and transactions of each individual in the family are not independent entities but part of a necessary movement. As such complementarity plays a reciprocal and mutual role in maintaining and rectifying imbalance of a system. As Falzer (1986, p. 353) notes: "When the father is a father and the son is a son,...when the husband is really a husband and the wife a wife, then there is order."

When considering individuals in the family as discrete entities in a given system, the self is seen as both a "particle and a wave" (Falzer, 1986, p. 353). In the individual's experience, the focus is on the individual as a whole. When the complementary aspects of the self become parts of a whole, the other parts of that whole which also are discrete entities, are seen as affecting the behaviour and experience of all parts. Beyond the parts appears a multibodied, purposeful organism whose parts are regarded by the rules of the greater whole (Minunchin, 1974).

Keeney and Ross (1985, p. 46) in their discussion of complementarity, state that experience is structured in terms of pairs, dualities, or distinctions and that "any pattern, value, ideal, or behavioural tendency is always present at any time, along with its polar opposite. Only the relative emphasis given each pole and the ways of arranging their simultaneous expression tend to change".

Furthermore, they suggest that an observer of a family system may perceive distinctions as either "a duality of excluding opposites or a recursive complementarity of self-referential sides" (Keeney & Ross, 1985, p. 49). According to them "Recursive complementarity" refers to the higher-order view of a distinction where the interaction between its different sides is underscored. Here the two sides must maintain a difference to interact, while their interaction connects them as a whole system. Recursive complementarity thus points to how the different sides of a relationship participate as a complementary

connection and yet remain distinct from one another.

In direct contrast therefore to the dualistic Newtonian concept of the traditional medical epistemology, complementarity suggests that apparently opposite phenomena regarded previously as discrete and separate are regarded as complementary parts of a whole that are manifested on different levels of a system. Traditionally regarded as contradictory, concepts such as "health or illness"; "adequate or inadequate"; "rigid or flexible" can therefore not be understood in dualistic terms but as parts of a systemic whole (Keeney, 1979).

Traditional research has disregarded the integral complementarities that exist throughout the entire system of which the "endometriosis sufferer" forms a part. This presents major disadvantages to the concept of "endometriosis".

These complementary responses to the "endometriosis" member vary from family to family since each family comprises a unique system (Boscolo, Cecchin, Hoffman, & Penn, 1987). Furthermore, the complementary responses to "endometriosis" co-evolve differently with each family and is influenced by the nature of the family's interaction with professionals involved with the "endometriosis" member and by the responses from members of the community.

To illustrate, a family member may respond to the "endometriosis" member in a superior manner which co-evolves complementary to another family member's and or, professional's responses which may be optimistic and supportive. A specific pattern of interaction is subsequently co-evolved whereby the interaction of these interlocking responses evoke and maintain one another. A definition of "endometriosis" must therefore include individuals' responses to the labelled "illness". As family systems are unique and consequently co-evolved responses are also unique, this definition will differ from family to family. No single definition is possible since any definition of "endometriosis" includes responses to such a label.

Based on the notion of complementarity the particular family and significant others in the woman's life should all constitute part of the definition of "endometriosis". Each possible response to the "endometriosis" sufferer is part of the complex whole of which "endometriosis" is a single part. The complementary counterpart of "endometriosis" could be "endometriosis free" or "symptom free". Therefore, seen in terms of a relational whole, "endometriosis" and "endometriosis free" mutually define one another; the one cannot be

understood without the other as they both constitute the definition "endometriosis".

Complementary relationships which form coherence are interlocking, evoke and maintain one another, thus triggering a specific interactional pattern.

As Keeney and Ross (1985, p. 167) state, "...there is a tendency for living things to join up, establish linkages, live inside each other, return to earlier arrangements, get along whenever possible. This is the way of the world".

Dallos and Aldridge (1986, p. 69) in describing complementary dyadic relationships, suggest that each person behaves in a manner which presupposes the behaviour of the other whilst concurrently providing "the reason for the behaviour of the other" . It follows therefore that each person's definition of the relationship is a bid towards the maintenance of an apparently homeostatic balance with the particular system. Therefore behaviours between the relationships of the members would have to be complementary in order to maintain periodic homeostasis or stability. The specific interactional arrangement between two partners in a relationship may involve the following processes:

- If one partner is unaffectionate in a relationship this may evoke aloofness in the other partner. This aloofness may then encourage and provide the rationale for an increased amount of affection, which in turn will demand further aloofness. This progressive complementary pattern suggests that both partners' behavioural styles and definition of the relationship maintain each other.

The concept of coherence as proposed by Dell (1982a; 1982b), is closely linked to the concept of complementarity and will be elaborated upon with specific reference to "endometriosis".

### Coherence

The ecosystemic concept of coherence refers to the way in which pieces of a system fit in a balance "internal to itself and external to its environment" (Hoffman, 1981). In this manner the family system has to fit in within its environment, and the family members have to fit in within the family system. It is therefore a complementary process of congruent and interdependent functioning which occurs between the various members of a family system. Behaviour of the family members is consequently mutually maintained and evoked. The following illustration describes the principle of coherence:

- Each family has a set of rules which develops over time and which reflects the ways in which the family perceives, understands and reacts to life-events and the world external to their system. They therefore develop an "ecology of ideas" which is unique to their system and to the way in which they perceive their world, during a process of co-evolution. When considering family therapy, a mutual exchange and recursive feedback of ideas between the family and a therapist occurs in relation to the problem which the family presents at therapy, for example, inadequate coping mechanism of the "endometriosis" sufferer. This recurring feedback process will facilitate the co-evolution of a new behaviour pattern which forms a coherence between the family and the therapist as the newest member in the therapeutic system (Dell, 1982b).
- If the concept of coherence is applied to the term "endometriosis", this emphasises the need for a more inclusive and comprehensive term. If it is assumed that complementarity between all family members exists, the need for a definition of "endometriosis" that would recognise this complementarity is implied.

"Endometriosis" therefore, cannot be understood as separate from the inextricable connectedness to the family as seen holistically, since complementarity is present between the individual woman and her family. Consequently, from an ecosystemic perspective it is proposed that an approach to families of "endometriosis" members which caters for the uniqueness of each family system be utilized. At present, as indicated by the review of research trends in "endometriosis", there is an increasing need for research to broaden its

parameters to include the "family system" when finding appropriate interventions for families of "endometriosis" members. One method in which this approach may be represented is by means of the genogram.

The genogram is a co-created diagrammatic representation by the therapist and family of a family's evolutionary processes, including patterns in relationships and the evolution of their belief systems extending over two or three generations (Lieberman, 1979b; 1979c). The family may therefore be assisted in perceiving their "endometriosis" member and their unique reaction to having an "endometriosis" member in the wider context of understanding their own ideational development. Through exploration of their family of origin (previous generations) this understanding is facilitated. In ecosystemic terms therefore, the family is regarded as a system which co-evolves in unique ways across generations. The concepts of open systems and equifinality will be discussed in order to illustrate this process.

### Open Systems and Equifinality

The premise that families co-evolve in unique ways across generations is interwoven with the concepts of open systems and equifinality (Hoffman, 1990). Important to note is that the openness or closedness of a system should be conceptualised as relative openness/closedness since disintegration of the system would result if it were completely permeable or non-permeable. Inherent processes to open systems are characterised by the ongoing, mutual, reciprocal interactions between a system and its environment.

The internal plasticity and flexibility of living systems, whose functioning is determined by dynamic relations rather than rigid mechanical structures, give rise to a number of characteristic properties that can be seen as different aspects of self-organisation. Open systems need to maintain a continuous exchange of energy and information with their environments in order to stay alive. This exchange involves taking in ordered structures and using some of their components to maintain or increase the order of the system. Thus, open systems use feedback mechanisms, defined as "...methods of controlling a system by re-inserting into it the result of its past performance" (Wachtel 1982, p. 341) and as such continually operate far from equilibrium.

Having stated the above, it is also important to note that open systems operate under a degree of stability. The stable and steady state implied in this description, has a dynamic property in that the system organises and calibrates its interactive processes uniquely in order to reach stability and therefore maintain itself.

In the dynamics of self-maintenance, fluctuations play a central role. Prigogine (1978) argues that a system can be described in terms of interdependent variables, each of which can vary over a wide range between an upper and lower limit. These limits are referred to as the system's parameters. Even when there is no disturbance, all variables oscillate between these limits/parameters so that the system is in a state of continuous fluctuation.

Fluctuations as defined by Dell and Goolishian (1981, p. 176), are "spontaneous deviations away from equilibrium or from a steady state, which occur in any physiochemical system". When there is a disturbance, the system tends to return to its original state by dampening the fluctuation.

Furthermore, Prigogine (1977) suggests that many systems mutate toward new regimes of dynamic interaction whenever they become stifled by "...the debris of past entropy production" (Dell & Goolishian, 1981, p. 176). "Order through fluctuation" (Dell & Goolishian, 1981, p. 180) is considered to provide the dynamic conditions for such evolving, non-equilibrium systems. This particular way of functioning has a range of stability within which fluctuations are dampened and the system remains more or less unchanged (Dell & Goolishian, 1981). In order for the system to maintain a state of steadiness or stability, it must continuously regulate and adjust itself by means of positive and negative feedback loops. Internal and external conditions on a structural level facilitate such regulations and adjustments of the system (Efran & Lukens, 1985). Two important principles are relevant to the present discussion. These are namely morphogenesis and morphostasis (Hoffman, 1981).

Morphogenesis refers to the family's potential to change its basic structure or pattern of interaction whereas morphostasis implies that the potential of the family's pattern of interaction is to remain stable (Penn, 1982). This continuous interplay of patterns of reorganisation (morphogenesis) and the maintenance of new patterns (morphostasis) is dependent on the ideational paradigm of the family system.

A third principle is influential in the continuous adjustment of the system to its environment, namely equifinality (Watzlawick et al., 1967). Equifinality according to Durkin (1981, p. 341) is "the openboundaried adaptive process whereby living structures achieve morphogenesis. The outcome of equifinal processes cannot be predicted from initial conditions, nor its specific path of progress. Rather it depends on the moment-to-moment opportunities available in the immediate environment."

The following quotation from Bateson (1972) illustrates the mutual interaction of man and his environment or context:

...consider a man felling a tree with an axe. Each stroke of the axe is modified or corrected, according to the shape and the cut face of the tree left by the previous stroke. This self-corrective process is brought about by a total system, tree-eyes-brain-muscles-axe-stroke-tree; and it is this total system that has the characteristics of ....mind. (p. 73)

When applying this dialectic process to families, implications are profound. Bowen (1978) points out that family members interact in such a way that a change in the behaviour of one member inevitably affects all others, and their reactions to this change are in turn reacted to by all members. Furthermore, observation of this interaction over time reveals that it is patterned out of the totality of possible behaviours of which only a few are resorted to, especially under stress. These behaviours have a negative feedback quality and thereby ensure the stability of the family system as a whole.

In the framework of this wider model, intervention is directed at the interaction (both within the family and between the family and other systems), which is synonymous with process (Andolfi, Angelo, Menghi, & Nicolo-Corigliano, 1983). This is in contrast to an approach which focuses on the elucidation of the meaning (content) of the behaviour of any one of the individual members (Bateson, 1971).

Guerin (1976), echoes this approach:

...we try to sort and then to block the behaviour feedback loops that lead

the family to a dead-end. We let the families test, through trial and error, other interactional loops while we remain open to the appearing and the proliferation of unusual material external to our field. (p. 68)

The participant-observer therefore is open to the singularities and inherent problem-solving capabilities of the system, in this way.

Furthermore, the participant-observer in providing opinions about existing familial patterns of interaction and relationships, becomes a perturbator of that family system. As such, the co-evolutionary processes integral to human systems and equifinality as found in families, representing relatively open systems, may be receptive to change when the parameters of their stable patterns (systemically organised interactions) are challenged or perturbed (Penn, 1982). By introducing a new perspective into the family's belief system, the participant-observer as perturbator may facilitate changes in the meaning which the family members attach to events, symptoms, or conditions such as "endometriosis". The pooling and interplay of the two ideational paradigms of the family and the participant-observer, may give rise to a new belief system. This co-creation and co-evolution of ideas is in keeping with ecosystemic epistemology which therefore provides an alternative way of viewing reality.

#### Labelling and "Endometriosis" - Adherence to a Newtonian Paradigm

Traditionally, medical diagnosis has been tied to the process of ascribing a label to an individual in order to signify the particular pathology and class of symptoms exhibited (Keeney, 1979). This perspective therefore holds the assumption that an individual is the receptor of lineal, causal effects and therefore the site of pathology. Furthermore, this non-systemic perspective may hinder the process of inducing change in any relationship system (Keeney, 1979; Schwartz, 1982). Labelling, therefore is the need of a specific sphere in society to embark on an often unknown course of action in order to allay uncertainties regarding an unknown factor be it behaviour, or illness (Breitkopf & Bakoulis, 1988a).

The concept of illness as related to "endometriosis" will be elaborated upon in order to emphasise the inherent limitations of a linear epistemology.

## The Concept of Illness and "Endometriosis"

Wynne (1983) suggests that all human beings specific to Occidental cultures, seek explanations for developmental events and experiences such as serious illnesses. "Causes", responsibility and blame are inevitably invoked in these circumstances in their efforts to reduce the stress of ambiguity and provide a clearer basis for coping.

Patients, family members and most health care professionals organise the experience of illness in a lineal, "causal" sequence. "Cause" as such is inextricably linked to responsibility and blame. This perspective is in keeping with the reductionistic and Newtonian view which perceives illness categories as fixed niches that fit awkwardly into the "...fluid, subjective shaped processes of systemic change," (Wynne, Shields, & Sirkin, 1992, p. 4).

Wynne et al. (1992) contend that a focus on illness has been viewed as a clinical error because the coping and adaptive skills, the assets and resources of individuals and family are overlooked. Furthermore they suggest that the acceptance of illness has implied a faulty causal model. According to them the status of being a patient and having an illness has been perceived as inherently stigmatizing; likely to lead to scapegoating and thus as adding to the difficulties of obtaining support and achieving change.

In examining the controversies surrounding the concept of illness in the field of family therapy, Wynne et al. (1992) contend that it is more appropriate to conceptualise and work with illness as a narrative placed in a biopsychosocial context, rather than a biotechnical, reductionistic reframing of illness as disease.

Following from this perspective the researchers pay attention to illness which has previously been viewed as pathologising and disempowering, thereby neglecting the possible health, strengths and solutions. In discussing the concept of illness, Paxton (1981) prototypically defines illness as "a construct used to explain certain non-volitional, maladaptive patterns of distress and or behaviour that impairs an individual's capacity to function". Wynne et al. (1992) criticize this definition on the grounds that it barely starts to convey the complexity of meanings and perceptions associated with this phenomenon that can but need not be viewed reductionistically. They propose that illness is

firstly both a subjective experience and observable appearance and behaviour. Secondly in keeping with Wynne's (1984) perspective of illness, they contend that it is crucial to realize that both the experience of illness and the observation of "ill functioning" individuals, quickly become part of a transactional, related narrative. In this sense, illness is far removed from being merely a category of intra-individual impairment (Wynne et al., 1992).

In making the distinction between illness and non-illness, major variations in cultural context and differences in alternative perspectives arise. In particular, differences in perceptions between patients and physicians have become manifest in the terminological distinction between "illness" & "disease" (Hammond & Haney, 1978; Wynne, 1984). As Hammond and Haney (1978, p. 11) crisply put it: "Patients suffer illness, physicians diagnose and treat 'diseases'". Because illness and disease involve differing perspectives, illness can be experienced (by patients) without disease and disease can be diagnosed (by physicians) without the experience of illness (Hammond & Haney, 1978). This combination of perspectives (beliefs, beliefs about others' beliefs etc.) is what Bogdan (1984) refers to when he uses the term "ecology of ideas".

De Shazer (1982) has most convincingly described the clinical value of externalising problems or illnesses. He recommends that two questions mainly be asked in order to bring this perception of a problem into focus. One question should elucidate the impact of the illness upon the lives and relationships of the family members and the second, should examine the impact and influence of the family members upon the "life" or course of the problem. Giving attention to the latter question paves the way for active coping. Furthermore, White (1986) emphasises how a network of mutually reinforcing beliefs channels and restrains the on-going evolution of redundant patterns of behaviour between the participants involved. Externalising the problem of illness as suggested by De Shazer (1982), means not a loss of responsibility but rather a heightened recognition of the possibilities of taking effective responsibility.

Despite the diversity of explanations for illness from a broad historical and cross-cultural perspective, they are all efforts at interpreting and subsequently coping with an inherently distressful and often mystifying experience (Broome & Wallace, 1984). In order to illustrate the diversity of perspectives regarding "endometriosis" as an illness, alternative and complementary approaches to

"endometriosis" will be discussed briefly with particular reference to research trends in the medical field. Furthermore, the importance of implementing a broader paradigm such as an ecosystemic epistemology, will be mentioned.

### Alternative and Complementary Approaches to "Endometriosis"

Alternative and complementary approaches to "endometriosis" have largely focussed on research with reference to further medical treatment, for example vitamin therapy, herbal medication, homeopathic and macrobiotic diets. Although still of medical origin, such alternative approaches to research on "endometriosis", have recognised the need for examination of the "endometriosis" sufferer and her wider system to include a more comprehensive approach to research in the field of "endometriosis". In addition, a need for research from an ecosystemic epistemology as implied by Efran and Lukens (1985) and Held and Pols (1985), stresses the interrelationship and ecology of the wider system as well as the complexities involved in social interaction. Keeney (1979, p. 120), in keeping with this epistemology states that "mutual, reciprocal, simultaneous interactions define, identify and constitute whole systems".

Commentary by Shiloh, Larom and Ben-Rafael (1991) and Taylor (1978), on the increased frequency of "endometriosis" and its controversial nature together with a limited understanding of the nature of disease, suggest that the major challenges facing medical personnel is not only their increased understanding of the disease by means of research but also their understanding of the way "endometriosis" can affect the relationships of family and friends. Shiloh et al. (1991) therefore suggest the incorporation of a less linear biomedical model into the management of the "endometriosis" sufferer.

Minimal research on "endometriosis" offers suggestions for treating the female sufferer and her family as a connected whole, nor are there suggestions regarding how the family may understand their own unique perspective regarding "endometriosis" in order to enrich their contact with labelled "endometriosis" sufferers and to facilitate effective ways of focusing on assets and strengths in their intermanagement of the disease.

Commenting on the isolation and lack of knowledge available to women

who suffer from "endometriosis", Candiani, Vercellini, Fedele, Colombo and Candiani, (1991) suggest that further research is needed to determine why a gap exists between what women want to know regarding "endometriosis" and what they are told by medical personnel.

The research overview of "endometriosis" which will be discussed in chapter 3, will illustrate how emphasis is placed on the traditional paradigm, and will indicate how the focus has been placed on only one level of the system which comprises "endometriosis", thereby revealing atomistic inferences. Emphasis on the physiology involved in "endometriosis" for example disregards the other integral components comprising "endometriosis" as a whole, such as the emotional aspects experienced by the "endometriosis" sufferer. A further example is that of research which focuses exclusively on treatment options for the "endometriosis" sufferer. Here again, the focus is on only one component of the system comprising "endometriosis". Relationships which may possibly be affected are disregarded despite their constituting integral parts in the conceptualisation of "endometriosis" in holistic terms. The recognition of a complementary relationship therefore between all the components in the "endometriosis" sufferer's ecosystem including that of her family and the community are of paramount importance if "endometriosis" is to be understood from the ecosystemic paradigm.

"Endometriosis" by definition elicits different responses which co-evolve with the label "endometriosis". What is required therefore is a reconceptualisation of "endometriosis" from an ecosystemic perspective recognising elements of inter-connectedness and context specifically with reference to the psychosocial levels of human systems and their reciprocal interconnectedness with the biological levels. These elements include all the complementary responses of the "endometriosis" sufferer's family and community that co-evolve with the "endometriosis" sufferer's behaviour. One way that "endometriosis" may be conceptualised is as a unique system of co-evolutionary complementary responses as contained within the ecosystemic paradigm.

### Conclusion

Whilst rigid persistence with a Newtonian epistemology is prevalent, the increasing need for an alternative approach was stressed. Furthermore, an

ecosystemic approach to "endometriosis" was presented. In particular, the unique nature of each family's ideational world and the inherent complementarity found in the interactions between an "endometriosis" member and her family can be included in this approach.

Relational patterns and ecological parts of the family system could moreover be linked from this perspective. Therefore, an unique definition of "endometriosis" could co-evolve between the participant-observer and the family.

In co-evolving a process whereby family members are provided with an opportunity to participate in the formulation of a unique systemic definition, the desirability of employing this procedure above the more traditional Newtonian dichotomy is debated.

In chapter 3, research trends concerning endometriosis sufferers as well as families of endometriosis sufferers, are reviewed.

## CHAPTER 3

### "ENDOMETRIOSIS" IN THE FAMILY - A RESEARCH OVERVIEW

Wynne (1984) states that:

Illness is not simply a personal experience, it is transactional communication, .... deeply embedded in the social world and consequently it is inseparable from the structure and processes that constitute that world. An inquiry into the meaning of illness is a journey into relationships. (p. 299)

#### Introduction

The research on "endometriosis" has to date been conceptualised within the traditional Newtonian framework. An overview of this research and the main trends in the literature will be provided in this chapter in order to facilitate a general orientation to the way "endometriosis" has been conceptualised within this framework. Following this, a critique will be proposed concerning the premises on which the traditional research method is based. Suggestions for conducting research in this field will also be included.

Before commencing the research review, the concept "endometriosis" requires some attention as various approaches to diagnosing the illness have been forwarded. Cherry (1991, p. 24) proposes a profile of the "typical endometriosis patient" as indicated in Table 3.1 (see page 28).

The American Fertility Society (1979) alternatively proposes a medical model of diagnostic criteria for assessing "endometriosis". This method consists of a point system based on number, size and location of "endometriosis" implants which designate mild, moderate, severe or extensive disease.

The American Fertility Society's four stages reflecting the degree of occurrence of "endometriosis" (Wilson, 1987) are classified as illustrated in table 3.2 (see page 29).

This specific classification system is regarded as the latest and most

**Table 3.1**

Suggested Profile of a Typical  
"Endometriosis" Patient

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Criteria

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98% female  
Onset during menstruation years  
30-40 age group with no children  
High stress career  
Presence of hereditary factors  
Chronic abdominal pain  
High infertility occurrence  
Dyspareunia

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Cherry, S.H. (1991)  
Coping with endometriosis.

**Table 3.2**Degree of Occurrence of "Endometriosis"

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Classification	Score
Stage	
1 Mild	1- 5
2 Moderate	6-15
3 Severe	16-30
4 Extensive	31-54

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Note: Classification form designed by the  
American Fertility Society, 1979.

appropriate, being considered particularly helpful in explaining locality and extent of "endometriosis" and in comparing pre- and post- treatment status. The importance of this classification system will be discussed during the course of this chapter.

### General Research Overview

The major areas of research on "endometriosis" include the following:-

- infertility;
- chronic pain;
- therapy or treatment;
- secondary side effects;

To a lesser degree research on "endometriosis" has included:

- the influence of "endometriosis" on spouse and family systems;
- future planning.

Various aspects of "endometriosis" have been examined, yet as the research overview will suggest, certain areas have been touched on superficially or in some instances, overlooked. The main aspects of "endometriosis" which have been examined are namely, the physical effects of "endometriosis" and the implications which these effects hold for intimacy in particular. In addition to the physical effects of the illness, the emotional effects as well as possible infertility and treatment of the patient's illness have been reviewed. Furthermore, the doctor-patient relationship as one of the most important facets of the "endometriosis" sufferer's system has been examined. These aspects will be discussed briefly.

### Physical Effects of "Endometriosis"

Research on "endometriosis" has focussed mainly on physical aspects resulting from the disease (Cohen, 1982). Medical symptoms in particular, are attended to due to the linear, fragmented approach of the medical model. More often than not, sufficient guidance, emotional support or resources which enable women to cope with the psychological aspects of "endometriosis" are

overlooked (Berg & Wilson, 1991; Weinstein, 1988). Relentlessness of symptoms, the most significant being pain, infertility and sexual incompetence cause great distress and life disruption (Dmowski, 1991; Weinstein, 1988). Furthermore, as "endometriosis" is regarded as being exclusive to females, "significant others" who constitute the nuclear and extended family are excluded. In particular, the sexual relationships of the "endometriosis" sufferer may be affected (Huffman, 1971).

### Sexual relationships and "endometriosis"

The sexual relationship between women with "endometriosis" and their partners has been examined due to the symptomatology of the disease. Huffman (1971) found that a change in sexual behaviour occurred due to acquired dyspareunia (coital pain), a common symptom of "endometriosis". All coital activity may be rejected as a result leading to stressful marital relationships (Cranshaw, 1985).

### Pain

Konickx, Sole, Van Den Brouke and Brosens (1980) suggest that the perception of pain is a complex combination of the individual's ability to consciously and unconsciously inhibit pain, but also is strongly influenced by the behaviour of others. In women with "endometriosis", chronic pelvic pain is a marked symptom. However, among this population are women who may have dysfunctional pain behaviour and the researchers caution that the patient with a long history of chronic pelvic pain and numerous operation procedures must be studied carefully before further surgery intervention is undertaken. This is particularly important as infertility as a result of preventative surgical intervention may occur.

### Infertility and "Endometriosis"

Ballwegg and Deutsch (1988) in reviewing adjustment and personal concerns regarding "endometriosis", found that emotions varied from feeling good about themselves as individuals and life, to devastation and disgust due to acquired infertility (Olive, Franklin, & Gratkins, 1982). Infertility has been shown to be the single largest fear regarding "endometriosis", followed by surgery and treatment (Hayman, 1991).

Infertility in particular has been a major consequence of "endometriosis" (Spangler, Jones, & Jones, 1971; Walker, 1988). Because of the "disease" connotation with "endometriosis", a woman has her feelings of "abnormality" reinforced. Guilt over being the partner "at fault" can lead to depression and to a breakdown in marital communication (Garner & Webster, 1985). Furthermore, the monthly hopes and failures of the infertile woman lead to a "roller coaster" effect that can be particularly destructive to her daily functioning (Jones, 1988).

In a study conducted by Menning (1980) themes of stress and grief were identified in her interviews with infertile women. She found that in general women expressed surprise at their infertility and subsequently expressed denial, anger, unworthiness or guilt and depression.

Sandelowski and Pollock (Menning 1980) found that infertility was a multifaceted experience rather than merely failure to get pregnant. Common to women's experiences were themes of ambiguity, temporality and otherness (Garcia & Davod, 1977; Insler & Lunenfeld, 1986). According to Drake and Grunert (1980) the impact of infertility affects five significant relationships which are amongst others: the relationship with a life partner, with family and friends, involvement in and commitment to work and their relationship with the health-care system. Given the extent of the effect of "endometriosis" on relationships, significant others as well as the "endometriosis" sufferer, the emotional well-being of the "endometriosis" sufferer is important.

#### Emotional Effects of "Endometriosis"

In her study on the emotional impact of "endometriosis" on women, Weinstein (1988) found that emotional repercussions of "endometriosis" varied according to the individual with reference to the severity of the disease, the frequency and virulence with which it recurs, the degree to which it disrupts a woman's life and the amount and quality of support received from her doctor, family and friends.

However, all women whose symptoms were severe enough to interfere with daily activities or threaten major life goals (careers, relationship,

parenthood) will typically perceive the diagnosis of "endometriosis" as a crisis and experience several stages of adaptation. These included the stressful impact of the diagnosis; denial; fear; recurrence and frustration. Wesson (1984) found that the stressful impact of the diagnosis in particular, affected the "endometriosis" patient's adaptation to daily activities.

Weinstein (1988) also reports that the most pressing need for women struggling with the emotional aspects of "endometriosis" is that of support. Due to the differences in diagnosis, information on the subject and the loneliness associated with "endometriosis", women afflicted by the disease have taken it upon themselves to form support groups or join "endometriosis" associations in order to reduce their feelings of isolation. In an extensive study conducted by Weber and Ballweg (Ballweg & Deutsch, 1988) "endometriosis" sufferers reported that they would turn for support to anyone "who would listen". This included a combination of partners, family and friends, their own medical practitioners and infertility support groups. Support groups and professional counsellors have been found to provide a safe and non-judgmental environment which assist the "endometriosis" sufferer and her family in coping with her disease (Weinstein, 1988). The manner in which "endometriosis" is treated and managed is of paramount importance to the affected woman and her wider system.

#### Treatment of "Endometriosis"

The second most common fear of "endometriosis" as mentioned previously is that of treatment of the disease. Studies concerning the management of "endometriosis" have been extensive. A common finding is that treatment may vary according to the patient's preference and childbearing status. In one such study, Cramer et al. (1989) confirmed earlier studies that oral contraceptives or alternative hormonal drugs were suited to women who did not desire pregnancy but wished to preserve reproductive capacity. Furthermore laproscopic surgery may be successful in treating mild to moderate cases of "endometriosis" in the event of infertility. Women unconcerned with fertility may consider a partial or total hysterectomy. As treatment is therefore largely of a medical nature, the relationship which the "endometriosis" sufferer has with her doctor is significant.

### The Doctor-Patient Relationship

Significant relationships of "endometriosis" sufferers have received some attention. In particular, the doctor-patient relationship and the sexual relationships of the "endometriosis" sufferer have been examined.

Wheeler and Malinak (1983) conducted a study which focussed on the level of dissatisfaction that women with "endometriosis" felt about their medical care. Results obtained from the study showed that women needed to become more assertive in order to get the kind of medical care they needed. Pepperell and McBain (1985) conducted a study which highlighted the need for a feminist perspective in dealing with "endometriosis". In particular it was felt that a useful strategy which could serve as a basis for counselling women with "endometriosis" was one which was based on feminist elements such as a decrease in sex stereotyping as well as one based on concepts of dependence and passivity. These two concepts played an important role in determining what level of well-being the "endometriosis" sufferer would be able to achieve.

Medical and psychological literature has many references to the psychosocial problems in chronic diseases including problems in the physician-patient relationship. The psychosocial aspects of "endometriosis" therefore, when considering its reported exclusive effect on the reproductive organs of women, render an understanding of such aspects particularly important in the physician-patient relationship (Jones, 1988).

#### Types of doctor-patient relationships

Three types of physician-patient relationships have been described, namely: active/passive; guidance/co-operation; and mutual participation (Jones, 1988). In the long-term relationship established between the patient with "endometriosis" and her physician, all three types of interactions may be appropriate.

For most clinical interactions, the active/passive model is dysfunctional for the patient and her physician. Similarly the patient who engages in the guidance/ co-operation style of interaction is often faced with unexpected consequences following a therapeutic decision. The most satisfactory

physician-patient relationship is that of mutual participation whereby the patient is encouraged to explore her medical and psychological needs and which provides the diagnosis and therapeutic options appropriate to the particular stage of "endometriosis" and level of personal development (Jones, 1988).

### Conclusion

From the research review on "endometriosis", it was indicated that the majority of research studies conducted has been conceptualised from an atomistic Newtonian paradigm (Keeney, 1982). Furthermore, little attention has been paid to the "gap" which exists between the identified patient (in true linear style) and the increasing need to connect interventions with the "endometriosis" member to her wider ecosystem.

In keeping with the reductionistic perspective, subsequent interventions are focussed solely on the individual and suggest that the labelled "endometriosis" member is atomistically conceptualised as an entity separate from her family and community.

Limitations inherent in the traditional diagnostic process emphasise the need for less linear models and a shift in focus to the "endometriosis" member in a wider systemic context.

Chapter 4 will take the form of a description and elaboration of the proposed ecosystemic research design to be used with "endometriosis" sufferers and their families.

## CHAPTER 4

### RESEARCH DESIGN

#### Introduction

In this chapter the proposed research design to be used with "endometriosis" sufferers and their families will be explained. The research hypothesis is presented after discussion involving the requirements for ecosystemic research. Finally an explanation of how the genogram will be used with "endometriosis" sufferers and their families will be presented. Included in this section will be the proposed research procedures to be used with the affected women and their families.

#### Positivistic and Ecosystemic Research Principles.

Wassenaar (1987) states that in the family therapy field at present an epistemological and methodological impasse exists between linear positivistic science and the ecosystemic principles on which family therapy is based.

Newtonian positivistic science requires a research of a "scientific" nature: a concern with objectivity; quantifiable measurement, and outcome. According to the ecosystemic paradigm however, emphasis is placed on the ecology, relationships and whole systems. In contrast to positivistic epistemology, it focuses on interrelation, context and complexity (Keeney, 1979).

When one considers positivistic research, a distinction may be drawn between the psychological researcher concerned with separating outcome from process and the system's clinician who attempts to incorporate outcome into the therapeutic process (Wassenaar, 1987). This and other problematic issues in the epistemological impasse have led Campbell and De Carteret (1983) to suggest that "each clinician or group of clinicians should become his own researcher, and develop his own interventions which are useful with his specific families" (p. 146).

Schwartz (1982) in commenting on the paradigmatic shift in psychology from a linear, positivistic model to a circular ecosystemic model contends that a subsequent shift in methods for assessing these processes has not occurred.

In addition Schwartzmann (1984) advances the argument that an adherence to the linear research model may be compared to a social ritual, which like all rituals, prescribes the limit of what is regarded as research and therefore prevents change from occurring within the field of psychology.

Wassenaar (1987) however proposed that neither an exclusive positivistic or exclusive ecosystemic methodology may be considered to be more effective in determining the nature of "truth" or "reality". As Keeney (1983, p. 92) suggests:

...perhaps researchers in both schools have lost sight of the fact that form and process, structure and function, part and pattern, observer and observation, reductionism and holism, are 'cybernetic complementarities'. Although founded on fundamentally different principles, both the linear positivistic and circular ecosystemic research approaches should be conceptualised as having equivalent validity, in their explanations of the nature of 'truth'.

The usefulness of these two approaches should not be discounted. On the one hand, positivistic research has value in describing phenomena at an atomistic level and on the other, ecosystemic research has value in facilitating the identification and understanding of patterns which comprise and are comprised by these "atoms" (Wassenaar, 1987). Keeney (1983) suggests that both approaches should be considered in the search for understanding the process of change.

However, for the purposes of this study, atomism as described in chapter 2: THE ECOSYSTEMIC PERSPECTIVE - A PARADIGM FOR SECOND-ORDER CYBERNETIC EPISTEMOLOGY (page 12) maintains the Newtonian perspective of linear causality. This approach is not conducive to explaining how the wider system of the "endometriosis" sufferer may be implicated, which is what this study will investigate. Furthermore, ecosystemic research is more suitable to the investigation of process, patterns and context which exist within a wider structure. The Newtonian perspective considers matter, structure and is not contextual, therefore questioning the validity of an investigation into the implication of "endometriosis" on the wider system of the "endometriosis" sufferer.

Bearing atomism in mind, as Keeney (1983) suggests, in order to understand the process of change if any, mere adherence to this model would limit the possibility of investigating the relationships between significant others and the "endometriosis" member. Consequently a process of "more of the same" as opposed to "news of difference" between the "endometriosis" sufferer and her significant others, would be escalated.

In order to explain the relevance of ecosystemic research in more detail, this epistemology will now receive attention.

### Ecosystemic Research

Inherent to ecosystemic research is the way in which this form of epistemology discerns and derives knowledge from patterns (processes) that organise events within a family system (Keeney, 1982). An example of such a pattern or sequence of events may be illustrated as follows:

The obnoxious behaviour of a child is facilitated and maintained by her parents' repeated and violent arguments around child rearing. Her behaviour towards her father elicits an aggressive response from him and a protective response from her mother. This serves as a trigger for their conflict. The mother's protective response will therefore elicit and maintain such behaviour from the child. Similarly the father's aggressive response to the mother, will elicit and maintain the obnoxious behaviour of the child. This pattern may persist even though the various family members alter their position within the family system - daughter may direct her behaviour towards her mother which would provoke her father to become angry at the mother with regard to child-rearing practices yet again.

When employing an ecosystemic epistemology, the therapist or researcher must perceive and conceptualise family systems in an ecosystemic way (Keeney, 1979).

Bateson (1972, p. 243) suggests that ecosystemic epistemology defines the term "system" as "any unit containing feedback structure and therefore competent to process information". Therapeutic situations may also be seen as systems. In this instance the therapist or researcher joins a cybernetic

network which consists of a complex, intertwined process of human interaction in which relevant information processed during the course of the therapeutic encounter, includes symptomatic and therapeutic communications (Keeney, 1979).

Furthermore, once the network of interaction has been identified, the researcher or therapist can attempt, by means of therapeutic communication such as interventions, to restructure the network. This position of the researcher or therapist assumes that he or she has subsequently become an integral part of the system. Therefore, due to properties of all living systems, a simultaneous and mutual process of interaction occurs. Penn (1982) suggests in this regard that these simultaneous, mutual interactions which occur between a family and a therapist or researcher co-evolve a context which may have the potential of changing its structure.

The family-therapist-or-researcher system will therefore facilitate a change in the behaviour of family members as well as in the behaviour of the "newest member" in the system namely the researcher or therapist (Keeney, 1982). Change or morphogenesis in a therapeutic system requires concurrent change in the relationship structure of that system. Perturbations of this nature influence the stability of a system which as a result is required to "compensate" or "not compensate" in order to accommodate the therapist or researcher (Keeney, 1979).

The mutually interdependent relationship of the researcher/therapist is described by Wynne (1985) in his commentary on the work of the Milan group Palazzoli, Boscolo, Cecchin and Prata. Their methods of conducting family therapy sessions are widely used. These involve direct observation of a therapy session by a team of therapists, the formulation and introduction of testable hypotheses into the therapy session and the assessment of the validity of the hypotheses in future sessions.

The working hypothesis on which the Milan Group based their experimental research is that "the family is a self-regulating system which controls itself according to rules formed over a period of time through a process of trial and error" (Palazzoli et al., 1978, p. 3). A family with a psychotic child may be used as an example. In this instance, assessment of the family's

patterns of interaction by the therapist and the observing team of therapists would lead to the formulation of a systemic hypothesis. Intricate patterns of interaction between extended family members, serve to divert attention away from the central problem of the nuclear family namely the relationship between the husband and wife. A working hypothesis is then formed from this systemic hypothesis which enables the therapist to introduce perturbations or interventions into the therapeutic system. With the introduction of this hypothesis, the "accuracy" of the hypothesis is tested. The working hypothesis could be that the child's psychotic behaviour serves to facilitate and maintain disconfirmation of the marital relationship by involving the mother and "pushing" the father away to work, thus establishing and reinforcing their separation from one another. In further sessions, the tracking-and-exploring of family processes is guided by the identified central theme of hypothesis. Campbell and de Carteret (1984) regard this process as an attempt to gather information which can affirm or disqualify the hypothesis. Subsequently, therapy and research may be regarded as mutually interdependent in a common, systemic process, according to ecosystemic principles which underlie this process.

For the purposes of this study, this dissertation will attempt to describe the unique experiential world of the "endometriosis" sufferer and her impact on significant others. This will be done by formulating hypotheses with regard to process and patterns as characterised by the ecosystemic approach, relying therefore on mutual interdependence between the participant-observer and the system under investigation. In so doing, an investigation and examination of belief systems regarding the family's perception of "endometriosis" is facilitated. Furthermore, a construction of the phenomenon of "endometriosis" as a holistic, biopsychosocial entity is subsequently possible within the framework of an ecosystemic paradigm as opposed to the fragmentary nature of over-specialization of the Newtonian approach.

The research hypothesis to be formulated for the purposes of this study will be described briefly.

### Research Hypothesis

The family possess a specific structure with regard to patterns of interaction and the conceptualisation of a particular world view of ideational framework. Consequently, the belief system of the family, which has been

organised and incorporated into the existing framework of reference has to be perturbed in order to extend the limits of their existing organisational structure.

The therapist, by making use of the genogram provides a form of perturbation whereby the belief system of the family is subtly confronted and challenged in order to bring about a level of difference in the family structure. Care is taken however, to preserve coherence with the family's current structure or the possibility of facilitating morphogenesis will be minimal.

Based on the above assumption, the following research hypothesis may be formulated:

- Conceptualisation of the "endometriosis" sufferer in the family may be perceived meaningfully as a result of the reciprocal influence of belief systems held by the family and the therapist which may potentially co-evolve into a structurally new belief system.

In order to achieve a significantly different level of conceptualisation, this revised framework will maintain coherence with the previous organisational structure yet introject sufficient perturbation into the family systems resulting in the generation of new perspectives with regard to "endometriosis".

## Research Method

### Introduction

Due to the ecosystemic nature of the research done in this study, it was considered appropriate to use a method which would facilitate revision of the family's current perspectives of "endometriosis". Consequently, the method decided upon was the genogram.

### Method

The genogram represents a diagrammatic presentation of family relationships and the patterns which connect them, spanning at least three generations. In order to elucidate this aspect of the research design, it will be

described and elaborated upon. Explanation of symbols used in the genogram is diagrammatically represented in Table 4.1 (p. 43).

### The Genogram as Therapeutic Instrument

A genogram is defined as a "diagram of extended family relationships including at least three generations" (Genot, 1989; Hartman, 1978; Heintz, 1987).

The genogram developed by Bowen (Gewirtzman, 1987) and elaborated on by Guerin and Pendagast (1976) as well as Wachtel (1982) supplies an "aerial view of the larger system (Hof & Berger, 1986). It enables the therapist to embark on a family journey to examine the impact of family loyalties, traditions and "scripts" on a family's functioning.

An important advantage of this technique over a standard clinical interview is that a wider net is cast whereby everyone involved is significant. In this manner, the possibility of revealing alliances, family secrets and emotional cut-offs is increased. During the process of drawing the genogram a sense of distance and organisation is attributed to the material, thus facilitating rationality and objectivity. In addition, the possibility of increasing or decreasing effect as the journey progresses is offered (Hof & Berger, 1986). Family contacts which are usually initiated as a way of gathering history, may contribute to basic shifts in family dynamics.

The genogram allows the therapist a quick and thorough entry into a family's processes such as their cultural development, traditions (Duhl, 1981) and belief systems (Lieberman, 1989). This method of joining with a family enables the therapist to interact in a way which conveys acceptance and understanding of the unique way in which the family is organised while simultaneously experiencing their patterns of interaction (Minuchin, 1974).

### Technique Applied in Tracking Family Maps

Genot (1989) describes the construction of the genogram as a network of mutually influencing processes between the belief systems of the family and researcher/participant observer which co-creates a specific reality regarding the way the family has developed over generations. This reality is however,

Table 4.1

Symbols Used to Represent the Genogram

---

Symbols	
	male member
	female member
M'	marriage
/d	divorce
	member deceased
X	miscarriage

---

NOTE: Adapted from Lieberman (1979 Fig. 4.1, p. 69)  
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subjective reality, due to the uniqueness of each family's belief system. Similarly, the belief system of various therapists is unique to each therapist. One may therefore expect that the different therapists may possibly uncover different realities within the family's history.

Of importance in this regard, is the ability of the participant observer to be sufficiently "tuned in" to the clues the family system brings, when suggesting alterations in current belief systems. For instance if a family's conceptual framework does not leave scope for inter-marriage between cultures, as between a Christian and a Jew, a therapist would receive a negative response if he or she suggested closeness with family members who had married cross-culturally. This interpretation would not be acceptable within the parameters of the family's framework as it is in direct opposition to their existing belief system. Furthermore, if the therapist accepted and acknowledged the family's isolation of "erring" family members, no shift would occur in perception because the introduction of "more of the same" would lay the foundation for a "stalemate" position in conceptualisation. Families will not register input which is at odds with their own belief system. Alternatively if a belief system were co-created which involved preserving the conceptualisation of intermarriage as "taboo", yet introducing a sufficiently different way in which the family perceive cross-cultural marriages, the family may be able to shift in their existing belief system.

Use of the genogram to bring about change in family functioning can occur in the following way:

By systematic inquiry into family patterns, the family provide the therapist with a map of multigenerational influences which are stored, transformed and manifested in the present (Wachtel, 1982). The therapist's comments on this map will introduce a degree of complexity into the family's framework of reference and belief system. During this co-evolutionary process, the therapist may suggest alternative perspectives and in so doing, enable the family to amend their existing conceptualisation of their world. This process may elicit new responses for family members. Genot (1989) proposes that the family can respond selectively to those new ideas which are consistent with the conceptual/perceptual links imposed by their unique conceptual organisation. When co-creating a genogram therefore, a recursive, mutually influential

process of constructing a new reality is provided for the family enabling them to move away from their current position of "stuckness".

During the co-construction of a new reality by means of the genogram Duhl (1981), Heintz (1979) and Lieberman (1979a) stress the advantages of facilitating an awareness between family members of one another's perspectives for example in dealing with sensitive issues such as the presence of "endometriosis" in the family. This may elicit a change in the quality of communication around delicate issues in the family (Guerin & Pendagast, 1976).

A growing awareness of differences in perspectives between family members paves the way for a larger measure of accommodation of opinions and world views of the various individuals within the family system.

A further important potential use of the genogram is as a way of assisting family members to become more in touch with their emotions and elucidate delicate issues or "secrets" (Wachtel, 1982). In particular, the genogram enables the therapist to connect and ally with various family members on neutral territory rather than around explicit discussion of the presenting family conflict or secrets. Information gathered from the co-construction of the genogram therefore elucidates certain family processes within a family system.

Genograms as a therapeutic intervention provide clues to what is making optimal family functioning difficult and also serve as an empathic bridge between generations (Wachtel, 1982).

During the co-creation of the genogram, the therapist tracks the family's map. Information such as family members' names, ages, dates of birth, marriage(s) or divorce(s) is obtained. Furthermore, children's birth(s) and death(s) of members are noted. In addition, patterns within family relationships are explored. For example this process information consists of identifying emotionally peripheral members, close-distant relationships, the family's frequency of interaction with one another and geographical location of family members.

In tracking the family map, the therapist creates a context in which a different perspective regarding "endometriosis" may emerge, as a result of the co-evolutionary process between the family and therapist.

### Participants

For the purpose of the study three women and their families were selected. The main criterium for selection was that each woman had to be an "endometriosis" sufferer. Age was not considered to be a significant variable. Marriage was also considered to be an important criterium due to the fact that the marital relationship would be examined in terms of physical and emotional effects of "endometriosis" as discussed in chapter three. The presence or absence of children as a result of "endometriosis" was considered to be relevant to the study.

### Procedure

Initially the research procedure involved eliciting participation of three women diagnosed with "endometriosis". These women represented three families of origin and in some instances, had their own family.

The request for participation was formulated as follows:

Each woman was asked whether she would be interested in participation in an assignment which was aimed at exploring her and her family's current perception of "endometriosis". Furthermore, each woman was told that the information she provided during the assignment would be a valuable contribution to the present field of knowledge regarding "endometriosis" sufferers and their families. Participation in the assignment would involve three separate one hour interviews. The interviews would be spread over a period of six weeks thereby offering the women and their families two week intervals, in order to fully integrate information which may have emerged from the foregoing sessions.

### Format of Interviews

The sessions involved the following:

Session One: Interviews with the "endometriosis" member of the family to ascertain her existing conceptualisation and perception of her diagnosis and the

ways in which family members shared her belief system or differed in their own conceptualisation of "endometriosis". Themes evolving during this session were explored as well as patterns of interconnectedness between family members. An endeavour was made to introduce morphogenetic re-formulations regarding "endometriosis" to the woman and her family in this session and subsequent sessions and explore the extent to which these re-formulations had influenced the family's framework of reference.

Session Two: The co-construction of a detailed genogram with the "endometriosis" member and her family, focussing in particular on the belief systems and conceptualisations which the family members hold regarding "endometriosis" in general and regarding their "endometriosis" member. Relationship patterns in the nuclear and extended families as they evolved transgenerationally were explored and tracked. Re-formulations introduced in the first session were also explored in order to establish whether an alteration of the family's original conceptualisation of "endometriosis" had taken place. As in session one, morphogenetic reformulations regarding "endometriosis" were once again introduced.

Session Three: Feedback from the families regarding "news of difference" if any, relevant to the introduction of morphogenetic re-formulations in the previous session. The new meanings concerning "endometriosis" were explored with the family to clarify how they differed from their initial conceptualisation.

### Summary

Chapter 4 provided a discussion of positivistic and ecosystemic principles. Ecosystemic research was subsequently elaborated upon in order to elucidate its usefulness as a research design. The research hypothesis and research method were forwarded, providing a basis for the description of the research. In chapter 5, case illustrations of the three participating families will be forwarded.

## CHAPTER 5

### CASE ILLUSTRATIONS

#### Introduction

The current chapter will describe content and process analyses derived from interviews conducted with three women, each of whom has "endometriosis", and their respective families. Each session will integrate three different levels of analyses:

- The verbal content of the communication.
- The non-verbal aspect of the communication.
- The interactive patterns during the sessions.

Of particular significance in the various levels of analyses, is the description of the recursive feedback loops between the family members' belief system regarding their "endometriosis" member and the belief system of the interviewer concerning "endometriosis" members and their families.

As discussed in chapter 4, the research format will consist of three one hour sessions with the "endometriosis" member and her family spaced across a six week interval. Given this format, co-evolution of the various belief systems over three sessions may be facilitated and explored and then integrated to include the three different levels of analyses mentioned.

The three case illustrations are individually divided into the following sections:

- the background and belief system of each member and her spouse's family of origin;
- the presentation and exploration of the family's genogram;
- an analysis of the first interview in which the "endometriosis" sufferer and her

family's belief system is presented as well as the interviewer's interpretations of the meanings she and her family have attached to her "illness";

- an analysis of the second interview will include an assessment of the development in the ideas of the family and interviewer regarding the meaning of having an "endometriosis" family member;
- an analysis of the third and final interview with the "endometriosis" member and her family and an assessment of the co-evolutionary processes that were involved in establishing a reformulation in the family, regarding their "endometriosis" member.

The three generations that are described in each genogram are specified as follows:

- the "first generation" is regarded as the family of origin;
- the "endometriosis" member and her siblings are regarded as the "second generation";
- children born out of marriages between the "endometriosis" members and their spouses as the "third generation".

### Case Illustration: Family A

#### Session One

Present at this session: Elsabe

Ernst was away on a business trip

Johan was asleep

#### Background to the Session

The interviewer opened the session by requesting that Elsabe discuss any negative perceptions she may have regarding her participation in the interview

process. This was done to put her at ease due to the delicate and possibly threatening nature of the information which would be elicited during the course of the interview. Once she had confirmed her comfort with the process, she proceeded to describe her current perceptions and experiences of being a "labelled endometriosis" sufferer.

Elsabe does not consider herself to be the typical "endometriosis" patient. At present she has a healthy three year old son and although "diagnosed" at a very early age (21 years old), she states that she believes her "endometriosis" to be either in remission or very mild. However, she is currently trying to conceive her second child and is experiencing difficulty in this regard. Her first baby was conceived after eight months of her second marriage and she was hoping that the second time would be as easy. Furthermore, physical symptoms associated with "endometriosis" have reappeared and increased in severity. In addition to this Elsabe suffers from severe pre-menstrual tension which she terms a major stressor in her life and marriage.

Although a highly qualified nursing sister by profession, she procrastinates in going for a medical examination in case "a problem" is discovered. She describes herself as possibly being in a "denial phase" with regard to "endometriosis", a state which is further reinforced by the lack of debilitating physical symptoms, supplying her therefore with no overriding reason to seek medical assistance at present. She also considers medical procedures associated with "endometriosis" uncomfortable and would consequently avoid them where possible.

### Themes Explored in the Course of the Session

The theme of "fertility" was explored as it is particularly relevant to "endometriosis" and was repeatedly mentioned by Elsabe during the interview. She stated that although she does not consider herself to have a very strong maternal instinct, she is an "excellent mother" to her child. The aspect of fertility did not concern her previously because she had not had the "uphill and often unsuccessful" battle that many of the other "endometriosis" sufferers encounter. Furthermore, she put it at the back of her mind and it "disappeared", and this is what she intends doing again. At present the thought of possible infertility gives her a "twinge" as she would very much like to have a "playmate" for her son, but it would not devastate her world if a

hysterectomy were required.

Although verbally disconfirming the impact of possible infertility, the interviewer noted that Elsabe was decidedly uncomfortable when discussing this issue. In addition, these responses were interpreted by the interviewer as indicative of Elsabe's attempt to maintain control of her life by remaining ambivalent with regard to "endometriosis" and subsequent infertility.

Ernst is also satisfied with only one child, therefore taking pressure off Elsabe with regard to falling pregnant again. He too is described as not having a very strong paternal instinct although he is an enthusiastic and caring father. The interviewer attempted to convey the belief that acknowledging the mutual influence between the spouse subsystem in particular, could be valuable to them and had the potential to promote growth for the whole family. In addition, the interviewer confirmed Elsabe's perception of herself as a "good mother" and, although she did not downplay her ambivalence regarding a second child, she suggested that Elsabe's and Ernst's belief system regarding children may be currently influential in their decision to extend their nuclear family.

The interviewer complimented Elsabe on her efficient coping mechanisms which she used to conceptualise "endometriosis". As opposed to Elsabe's perceived "denial" phase and Ernst's apparent indifference, this re-formulation was introduced into the system in order to facilitate new ideas regarding "endometriosis". Further exploration revealed that from Ernst's perspective, Elsabe's "endometriosis" is not considered to be a problem. She states that she gives him literature to read and answers any questions he may have regarding her "illness". Furthermore, the belief system within the spouse subsystem regarding "endometriosis" is that of it being "a fairly new discovery and just a theory". In this conceptualisation of "endometriosis", both Ernst and Elsabe are able to distance themselves from negative implications which may be associated with the "illness". Furthermore, due to the birth of Johan, they have shown themselves to be "reproductively competent" as well as guarded against the "threat" of infertility in Elsabe's case. By the occurrence of these recursive feedback loops into the spouse subsystem, the perception of "endometriosis" is removed to an even greater degree.

Throughout the interview, Elsabe dismissed "endometriosis" and focussed

on pre-menstrual tension. During the past ten years she had received repeated and numerous medications to manage her discomfort. This response was perceived by the interviewer as an attempt on Elsabe's part at externalising "endometriosis", as physically, it was a body "failure". Due to the emphasis on competence, Elsabe's persistence with discussing pre-menstrual tension which was an acceptable and common phenomenon rather than a "failure" was perceived as being a metaphor for preserving her personal boundary and maintaining her role of "competence".

As the interview progressed, further themes of depression, external and internal stressors which Elsabe and Ernst had encountered, confirmed their adequate coping skills. When asked what effect her competence has on Ernst, Elsabe replied, "he's comfortable with it. He is also a very competent person in his own right and considers us a good team. When I become too dominating, he puts his foot down." Elsabe stressed that although she is regarded as a very "bossy" person by her family, she is also particularly independent and prefers to use her own internal resources in order to face challenges. The interviewer, through circular questioning, then explored the theme of failure and learned that it would be more threatening for Elsabe to fail than for Ernst, therefore it was important for her to maintain a "competent disposition" at all times. Both her parents are competent persons and the belief system of her family of origin, regarding success and achievement is thus well integrated into her present family system. The interviewer re-formulated Elsabe's current perception of "competence" as a well-developed sense of responsibility towards herself and her family.

Existing marital stressors as a result of "endometriosis" were then explored. Elsabe considers herself "pain-free" at present. She and Ernst enjoy a satisfactory relationship apart from physical complaints and mood swings which she considers to be related to pre-menstrual tension. Ernst is stated as being particularly understanding and sympathetic during this time although sometimes his patience "wears thin". The interviewer expressed appreciation for Elsabe's openness in this connection. With this comment the interviewer attempted to convey to Elsabe that it was both commendable and acceptable to express vulnerability. Other than her difficulty in conceiving a second child, Elsabe's daily functioning is not affected by "endometriosis".

A discussion concerning the profile of a typical "endometriosis" sufferer

ensued. Elsabe describes herself as anxious, as a result of situational or environmental factors but not to an excessive degree. The theme of anxiety is reported to be central in both her parents' cases, but she considers her coping skills to be sufficiently adequate when handling external and internal stressors.

#### Co-evolved Themes from this Session

Despite Elsabe's discomfort surrounding the issue of fertility, she and the interviewer were able to explore this theme during the course of the session. The interviewer's conceptualisation of Elsabe's belief system regarding "endometriosis" as a "failure" prompted the idea of a connection between a fear of failing and her marked degree of competence. Consequently, a more positive attitude towards 'taking "endometriosis" out of the closet' had begun to co-evolve in the system. It was apparent that "endometriosis" was beginning to be perceived as less of a "failure" and lack of control, if acknowledged. Further co-evolution of the acceptability of sharing and acknowledging vulnerable feelings had also begun to take place.

#### Session Two and Background to Genogram (see page 54)

Present at this session: Elsabe and Ernst

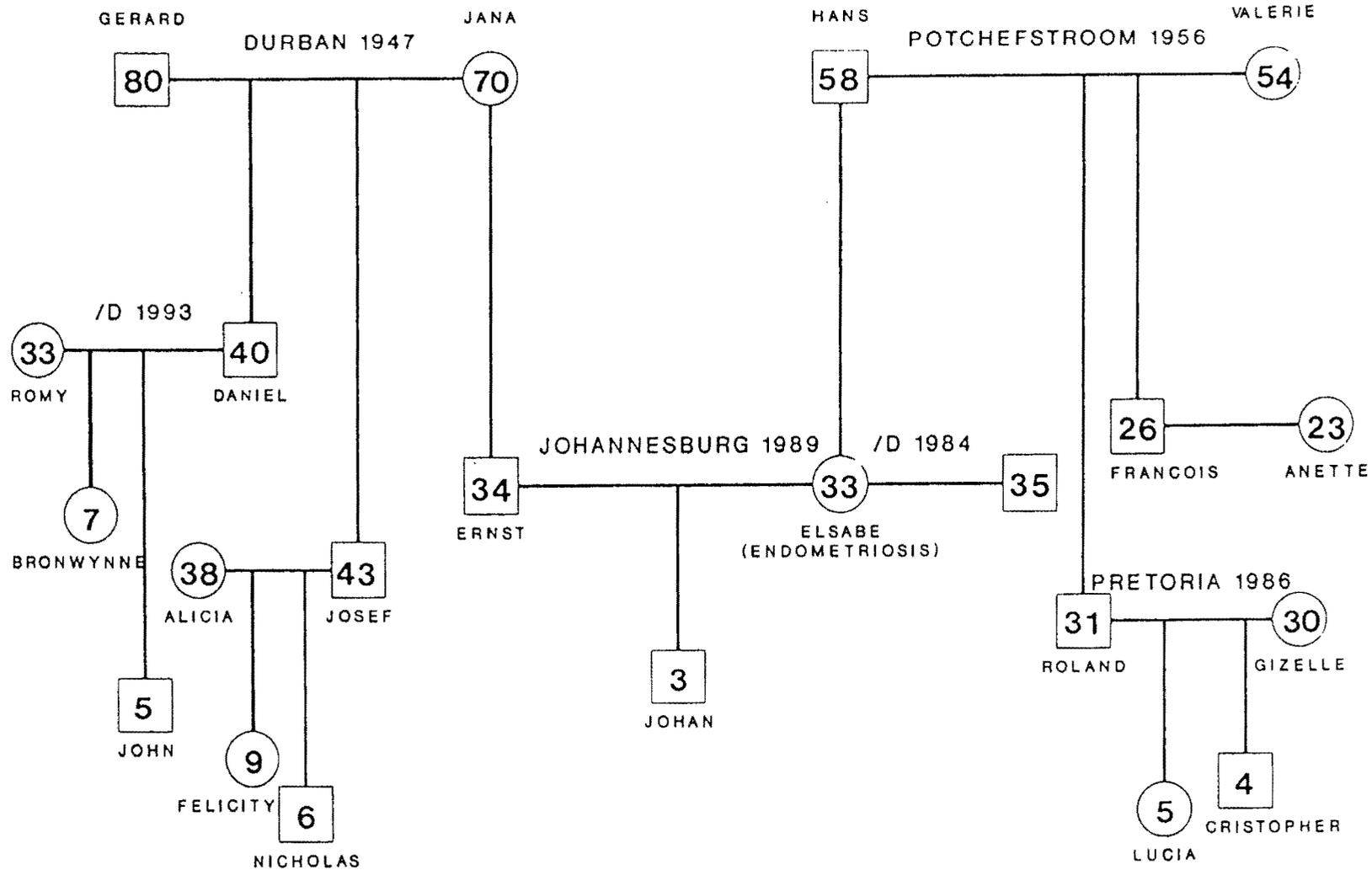
#### First generation: (husband's family)

Ernst's parents were married in Durban in 1947. His 80 year old father, Gerard, was a school principal at a private school. Currently he is retired. His 70 year old mother, Jana, is a retired drama teacher. They still reside in Durban.

#### First generation: (wife's family)

Elsabe's parents were married in Potchefstroom in 1956. Her 58 year old father Hans, is a school inspector. Her 54 year old mother Valerie, who previously was a school teacher, is currently a homemaker. They reside in Potchefstroom.

Genogram : Family A



Second generation: (husband's family)

Ernst, aged 34 years, is a financial consultant. He has two brothers. The eldest brother Josef, 43 years old, is married to Alicia who is 38 years old. Daniel, his second eldest brother, is 40 years old and recently divorced from Romy, who is 33 years old.

Second generation: (wife's family)

Elsabe, aged 33 years, is a nursing sister and has "endometriosis". She has two younger brothers. Roland, 31 years old, is married to Gizelle who is 30 years old. Her youngest brother Francois, 26 years old, is married to 23 year old Anette.

Third generation: (husband's family)

Ernst and Elsabe have one son, Johan aged 3 years. Josef and Alicia have one daughter, Felicity, nine years old and a son, Nicholas, six years old. Daniel and Romy have a daughter, Bronwynne, seven years old and a son, John, five years old.

Third generation: (wife's family)

Elsabe's eldest brother Roland and his wife Gizelle, have one daughter, Lucia aged 5 years and a son, Christopher, aged 4 years. Francois and Anette are newly married and have no children.

Background and Belief System of the Family of Origin

With the view to initiating the process of co-constructing Ernst's belief system, he told the interviewer in a relaxed and factual manner that his father's position regarding men was that they should be authoritative, heads of their family and strong in character. He added however, that his parents were more intent on impressing this notion on his elder brothers as he was conceived much later than his brothers in the hope that he would be a girl. His upbringing lacked the strictness which his brothers had endured in the family household. Furthermore, marriage partners were to be subservient and obedient. Respect

for the head of the family was of paramount importance and women had to "know their place and be good mothers to their children". "Sensitive" issues were always kept very private and not discussed. In particular, divorce was frowned upon and stigmatized.

After inquiring about his mother, Ernst explained that she, in particular, was more lenient towards him and although not encouraging femininity, had a certain gentleness in her approach which she had not shown towards his brothers. She had assumed the traditional role of housewife under protest once her children were born. She is described as an eccentric and creative person, perfectly suited to drama. She had married Ernst's father late in her adult life and found it difficult to adjust to her new role. Her maternal instinct is not particularly strong yet she is considered to be a warm and caring mother. When asked what his parents shared concerning their attitude to life, Ernst explained that they believed in family loyalty and cohesion.

The interviewer then explored how Ernst's parents' framework had influenced his choice of a marriage partner. Firstly, Elsabe was a young divorcee and secondly had told him that she may never be able to have children. Initially Ernst's parents had kept Elsabe peripheral to their family circle. Although they never discussed her status as a divorcee, her experience of their attitude towards her had made her very uncomfortable. Ernst's position however, as the youngest and favoured child gained her a place in their family circle. Their grandson, Johan, confirmed her position. At this point Ernst added that his parents were never informed of Elsabe's "endometriosis" as such issues were not open to discussion between family members. Elsabe has currently informed them of her difficulty in falling pregnant, but although sympathetic, Ernst's mother avoids elaborating upon her concern.

Elsabe's parents were described as very prominent people in the community. Strongly autocratic and ambitious, Elsabe's father fulfilled the role of the breadwinner and her mother the dutiful housewife. Not particularly maternal, children were seen as a duty rather than a necessity and Elsabe describes her relationship with her mother as "politely distant and unemotional." She added that her family of origin was particularly "together", adding that competence was significantly important to all members. The interviewer suggested to Elsabe that her family were obviously highly skilled in their use of

coping mechanisms. Furthermore, due to their strong religious orientation, her divorce was a traumatic event for all family members and had a particularly negative effect on her. She regards it as the most stressful event which she has ever had to cope with, including her experience of "endometriosis".

The interviewer then asked Elsabe how her parents' attitudes influenced her perception of "endometriosis". She said that her father has sympathy with her not falling pregnant, but never discusses the issue with her and her mother repeatedly questions her wanting another child. There is consequently less pressure on her to remain "competent" in this area. Her eldest brother, although ignorant with regard to the conceptualisation of "endometriosis", is considered to be supportive and sympathetic. Her youngest brother is emotionally distant.

It became apparent during the course of the interview, that the theme of control by remaining competent, was of significance in both Ernst and Elsabe's families of origin. Furthermore, in particular, the desperate longing for children evaded both mothers in their families of origin. Both themes had become an integral part of the spouse's belief system. Elsabe's verbally vague, yet competent management of "endometriosis" and Ernst's apparent indifference to the conceptualisation of the "disease" evoked complementary responses within the spouse subsystem. These responses co-evolved to create a coherence around Elsabe's and Ernst's competence in managing a perceived "failure". The ambivalence with regard to having children in both partners' families of origin was closely linked to the detached way in which they reacted to "endometriosis".

#### Background and Responses to the Diagnosis of Elsabe as having "Endometriosis"

Ernst suggested that the interviewer talk to Elsabe regarding "endometriosis" as "she's the nurse" thereby clearly indicating his perception of the "illness" as adherence to a medical model. She was spontaneous and open regarding her experience of the "illness". She appeared to consider it her responsibility and as she had adequately coped for the past 12 years, she did not see any reason for her not to continue doing so, unless plagued by chronic pain or infertility. Furthermore, she stated that at the time of diagnosing the disease, she was on the verge of a specifically traumatic divorce and had "more

important things to worry about" than her new "illness".

The interviewer then asked Ernst how he initially came to understand the fact that Elsabe had "endometriosis" and his thoughts surrounding her "illness". His response was given in a very factual tone, in which he conveyed his acceptance of her diagnosis, as he was not particularly pre-occupied with having children at the time of meeting Elsabe. Furthermore, the symptoms of "endometriosis" have never come between them, causing him little, if any, marital stress. His perception of "endometriosis" is also that of it being a theory rather than an "illness". This conceptualisation is mainly due to information shared by Elsabe on the subject.

Elsabe left at this point to attend to Johan who was crying in the bedroom. On her return, the themes touched upon in the first session were explored. As Ernst was away on business, the interviewer, with Elsabe's help orientated him to the interpretations made during the previous session. In particular, the perceptions of competence versus failure were focussed upon and linked to the belief systems of their families of origin and the way in which these perceptions had formed an integral part of their own belief system. In addition to this, Elsabe's reluctance in acknowledging her disease, confirmed the strength of her belief system and the belief system of her family of origin that to expose weakness to the world was unacceptable. Their ambivalence concerning their second child diverted the attention away from them having to acknowledge possible infertility due to "endometriosis", thereby conserving their competent front. Their responses to the concept "endometriosis" in the family were indicative of the way the unchangeable nature of the diagnosis had elicited morphostasis in their family system.

The interviewer conceptualised their responses to Elsabe's "endometriosis" as indicative of their successful adjustment in having to additionally manage this disease and positively connoted their current ambivalence concerning a second child as their strong sense of responsibility regarding their future. Ernst and Elsabe both looked pleased with this response and appeared to be willing to co-operate in discussing further themes which had co-evolved during the first session.

In order to introduce difference into their belief system regarding

"endometriosis", the interviewer asked if there had been any beneficial outcomes of having "endometriosis".

Both family members immediately looked surprised and laughed. The interviewer interpreted this as the introduction of a new idea or conceptualisation of "illnesses being beneficial" as opposed to detrimental. Elsabe instantly replied that as "endometriosis" was also known as the "silent disease" she would say that in her case, she was "unaware" of its occurrence in her body, due to the lack of "unmanageable symptoms". By not experiencing the physical symptoms to such a large degree, she would therefore say it was beneficial. Ernst added by saying that it was beneficial to both of them because by experiencing difficulty with having a second child, it has made him more appreciative of his son and more aware of the aspect of infertility. This response evoked a process of mutual interaction between the members regarding the theme of infertility and a "playmate" for Johan. This process continued whereby Elsabe and Ernst discussed the benefits Johan would have if he were an only child. Previously Ernst stated that he had taken it for granted that if "one wanted a baby, one would have a baby". He also stressed that if he did not have Johan, he is sure that it would have had a greater impact on his paternal instinct, although it would not become an overriding factor in his life. The "endometriosis" per se however, had not brought family members any closer than previously due to their belief system that "delicate issues" and "failures" were seldom acknowledged or discussed between them. Therefore, Elsabe was considered positively in most instances as she had produced Johan. Due to Elsabe's competent management of "endometriosis", however, she had created morphostasis between her nuclear- and her and Ernst's families of origin.

In an attempt to explore the aspect of "morphostasis by competence" further, the interviewer discovered by means of circular questioning that only Ernst, Daniel and Elsabe's sister-in-law Gizelle would give her room to be incompetent. Elsabe appeared slightly relieved by this discovery. However, it was not an option she would consider because it would affect her perception of herself. She would feel that she was letting her family down although she believes that this conviction is not as strong as previously. When asked what had brought about a slight transition, she replied with a smile, "the divorce. At the time I wanted to become part of a witness protection programme, where no-one would recognise me or find me. I was so ashamed and my parents did

not tell anyone." Elsabe's "failure" in this regard was therefore acceptable within her nuclear family and also provided a link between her and Ernst's nuclear family, to the nuclear families of Daniel and Romy and Roland and Gizelle.

Both Elsabe and Ernst had expressed ambivalence regarding her "endometriosis" and how it would affect their fertility. They both stressed however, their lack of overriding maternal and paternal instincts and their acceptance of Johan as their only child if it were to be the case. Here conflicting ideas were presented by the couple. Elsabe stressed the importance of learning to share with peers from an early age whilst Ernst disconfirmed this necessity taking place within their nuclear family. Being much younger than both his brothers, he explained that he had often felt like an only child and that he had not "turned out so badly". He suggested that Johan could learn to share by attending playschool when he was a little older. The interviewer connoted their disagreement about Johan growing up as an only child, by suggesting to them that their dedication to their son's well-being was evidenced by the intense way they discussed him with each other.

### The Belief System of Family A

Ernst's acceptance of Elsabe's competent management of "endometriosis" and his ambivalence with regard to having only one child were all responses that formed a coherence with the belief system in his family of origin. It appeared that for Ernst, Elsabe was "competently fertile" because they had Johan. Furthermore, he did not consider her to be a threat to the good image of the family by "failing" in a previous marital relationship or "failing" to fall pregnant. In addition to this he did not harbour negative or anxious feelings towards her possible infertility as a result of "endometriosis".

Elsabe's current perception of herself is positive and was directly related to her family of origin's emphasis on women having to be caring and competent mothers towards their children. However, due to the lack of a very strong maternal instinct in particularly her mother's case, Elsabe's role-model, and the belief system of her family system form a coherence with the belief system in her nuclear family. In addition to this, Elsabe links the belief system of her nuclear family to the belief system of her family by taking pressure off herself in terms of

remaining ambivalent as opposed to "failing", with regard to conceiving a second child. She continues to divert covert pressure from family members by portraying "competence" in remaining ambivalent.

The reciprocal influence between Ernst and Elsabe's responses to one another's belief systems had co-evolved a subtle shift in their belief system of their nuclear family. Included in this shift was an understanding of their complementary coherence regarding Johan. Ernst's resignation with having only one child was maintained by Elsabe's ambivalence with regard to falling pregnant for the second time. In both their families of origin, the emphasis on remaining competent manifested itself in Elsabe's competent management of "endometriosis".

#### Co-evolved Themes from this Session

The interviewer's conceptualisations of Ernst and Elsabe's belief system as related to their perception of "endometriosis", influenced her responses to the couple.

The belief system of the interviewer concerning "endometriosis" sufferers and their families included:

- the belief that family cohesion, loyalty, mutual support, respect and understanding as opposed to rejection of "failing members" is important between family members. Furthermore, family development and growth should be an ongoing process. The emphasis on extension of the nuclear family should not be of overriding importance and members should be allowed to display autonomy in this decision. A firm belief that the diagnostic label of "endometriosis" should be re-conceptualised, acknowledging the sufferer's physical limitations, yet emphasising and encouraging her competence in other spheres.

#### Session Three

Present at the session: Elsabe and Ernst

Johan was asleep

Elsabe and Ernst appeared very relaxed and stated that they had finalised arrangements for an overseas holiday that day. The interviewer facilitated a brief discussion around this subject as it was considered to be conducive to the creation of a congenial atmosphere in this final session.

When asked how they had perceived the previous sessions in retrospect, Elsabe immediately answered by saying that although she had been very guarded in her sharing of information in the first session, she had found it comfortable to engage in dialogue around "endometriosis". Although Ernst was not present at the first session she had informed him of the content and involved him in questions which had been discussed during the interview. Furthermore, discussing her struggle to fall pregnant with a "neutral party" had made her pensive regarding her "indifferent and matter of fact" attitude towards the importance of having a second child. She has subsequently been faced with making several career choices but has in the interim come to the realisation that a second child is vitally important to her. Although initially stating that she would not be subjecting herself to the treatment procedures necessary to increase the possibility of fertility, Elsabe has subsequently decided to undergo treatment despite the discomfort associated with these procedures.

The interviewer commented on this "shift" in Elsabe's perception of having a second child and complimented her on her strong commitment she had made to the preparation for another pregnancy. Ernst at this stage commented that although he knew that they may be facing an uphill battle, he was overjoyed when Elsabe had shared her decision with him. They had also decided that if after a year, Elsabe had not conceived a child, they would apply for adoption as they realised the importance of having a playmate for Johan. Furthermore, their decision, although a cautious one, had brought about a sense of peace and relief in their relationship. Other than remaining ambivalent about a second child, insight gained after the initial interview had led them to focus on a particular "strategy". The disappointment which Elsabe had secretly felt discovering that she was battling to have a second child had now been channelled into a constructive plan of action, namely to assume fertility treatment. If that proved to be unsuccessful, they would adopt a second child. Ernst also added that although he had not been present at the first session, listening to Elsabe's conceptualisation of the interview had awakened in him an increased awareness of Johan and how much he meant to him.

The discussion was then directed towards the couple's perception of the second session and new ideas which may have co-evolved from that interview. Patterns and themes which had been discussed had elicited much discussion between the couple as they attempted to link previous difficulties to the belief systems of their families of origin. Furthermore, their own ideas surrounding Elsabe's "competence versus failure" as co-evolved during the session had been re-examined and, although still an integral part of the belief system, had been de-emphasised. Elsabe felt that she had reached a stage of acceptance where "endometriosis" would be perceived as contributing to her self-confidence rather than questioning it and her other many competencies. Conceptualisations surrounding familial relationships had also been examined and both parties had discovered that their perceived unique experiences of family members overlapped in numerous instances. The interviewer encouraged the couple to maintain their enthusiasm surrounding evolution of new ideas concerning their own family and their families of origin.

At this point it must be emphasised that the belief system of the interviewer is not assumed to be the "blueprint" for families to adhere to. The uniqueness of each belief system is acknowledged with reference to its coherence with the individual autonomous systems.

By interacting with the nuclear family, the reciprocal influence of their and the interviewer's perceptions regarding "endometriosis" paved the way for the co-evolution of alternative ideas in this connection. The introduction of an alternative approach towards "endometriosis" by exploring its benefits within the spouse and child-subsystems had co-evolved. In addition, the re-conceptualisation concerning the acceptance of "failure" had begun to take place.

#### Case Illustration: Family B

##### Session One

Present at this session: Werner and Marisel

### Background to the Session

The interviewer opened the session by requesting Marisel and Werner to discuss any negative perceptions they may have regarding their participation in the interview process. This was done to put them at ease due to the delicate and possibly threatening nature of the information which would be elicited during the course of the interview. Once they had confirmed their comfort with the process, Marisel proceeded to describe her current perceptions and experiences of being a "labelled endometriosis" sufferer.

Marisel considers herself to be the typical "endometriosis" patient. At present she has suffered two miscarriages within short succession of each other and she and Werner had undergone six "in vitro" procedures throughout the past seven years, to no avail. They have decided to stop going for fertility treatment as Marisel's health is being affected by the continual medical examinations and procedures. At this point the interviewer commented on the couple's perseverance in their attempts to have a child and stated that their optimism evident in their numerous treatment procedures was remarkable.

Although "diagnosed" at a very early age (22 years old), Marisel states that her "endometriosis" is severe. Whilst being exposed to chronic pain throughout most of the month, she states that she and Werner also experience sexual difficulties within their marital relationship due to her "illness". This in addition to her negative perception of herself as a woman and her "nagging" with regard to Werner's reluctance to adopt a child, are additional stressors in their relationship. Marisel is physically unable to conceive a child as her uterus is inoperably displaced. Moreover, the "endometriosis" has caused her pelvic organs to be affected beyond repair. She has had to sacrifice most of her second Fallopian tube after numerous laparotomies and has two large grape-like cysts on her uterus which are frequently treated due to her predisposition to hereditary cancer. Medical professionals and Werner have suggested that she undergo a hysterectomy in order to improve her quality of life but she continues to procrastinate while clinging to the hope that a miracle may take place and she may still fall pregnant. She does however realise that her chances are minimal but "it's all we have at the moment". Although stating that she is relieved that their medical treatment for infertility has terminated, Marisel has entered an early menopause stage which is an additional source of tension and

disappointment. Doctors have informed the couple that they have reached the "end of the road", but Marisel is unable to reconcile herself with her infertility and the fact that she is always "ill". Werner on the other hand believes that he would be able to accept their childlessness as Marisel is most important to him.

The interviewer commented on the couple's mutual support and understanding of one another. Non-verbally and verbally it was evident that Marisel's "illness" had not affected the couple's commitment towards one another.

### Themes Explored in the Course of this Session

The theme of "commitment" was explored as it is considered to be significant in their role and perception of "endometriosis" and was repeatedly indicated by Marisel and Werner during the interview. Marisel and Werner stated that they have conflicting reasons for their need for a child. Marisel on the one hand has a particularly strong maternal instinct, which she desperately wishes to express, whereas Werner, an only child, feels it is his "duty" to produce an heir in order to prevent extinction of his family name.

The interviewer commented on their mutual commitment and perseverance in their attempts to produce a child, despite having to expose themselves to lengthy and uncomfortable medical procedures.

At present the realisation of infertility presents a particularly dark future for Marisel who considers herself inadequate in her attempts to fulfil the traditional role of "mother". Marisel's perception of herself as "inadequate" was subtly challenged by the interviewer as this formed a coherence with her perseverance and exposure to medical procedures as well as her marked optimism against "all odds".

The interviewer then asked her in what other areas Marisel perceived herself as being "inadequate" and she replied, "it sounds arrogant but I'm capable of doing most things" and laughed. Werner indicated his support of Marisel by confirming this statement.

### Co-evolved Themes from this Session

The interviewer positively connoted Marisel's perception of her "inadequacy" which elicited the beginning of a new conceptualisation regarding her abilities as opposed to her inabilities. In addition to this, the interviewer commented on the supportive environment in which Marisel was allowed to be "inadequate", namely her marriage to Werner, as evident in his unconditional support of her. Initially this comment evoked surprise in both Marisel and Werner as it had not previously been considered in that perspective. Their response indicated that a shift had occurred in their perception of "endometriosis" as being potentially debilitating to their marital relationship.

### Session Two and Background to Genogram (see page 67)

Present at this session: Werner and Marisel  
Marisel's sister Lizanne and Adrian her husband

#### First generation: (husband's family)

Werner's parents were married in Johannesburg in 1945. His 73 year old father, Karl, was a school teacher at a private school. Currently he is retired and lives with Marisel and Werner in a flatlet adjoining their home. His mother, Heidi, died in 1991 after a long battle with cancer.

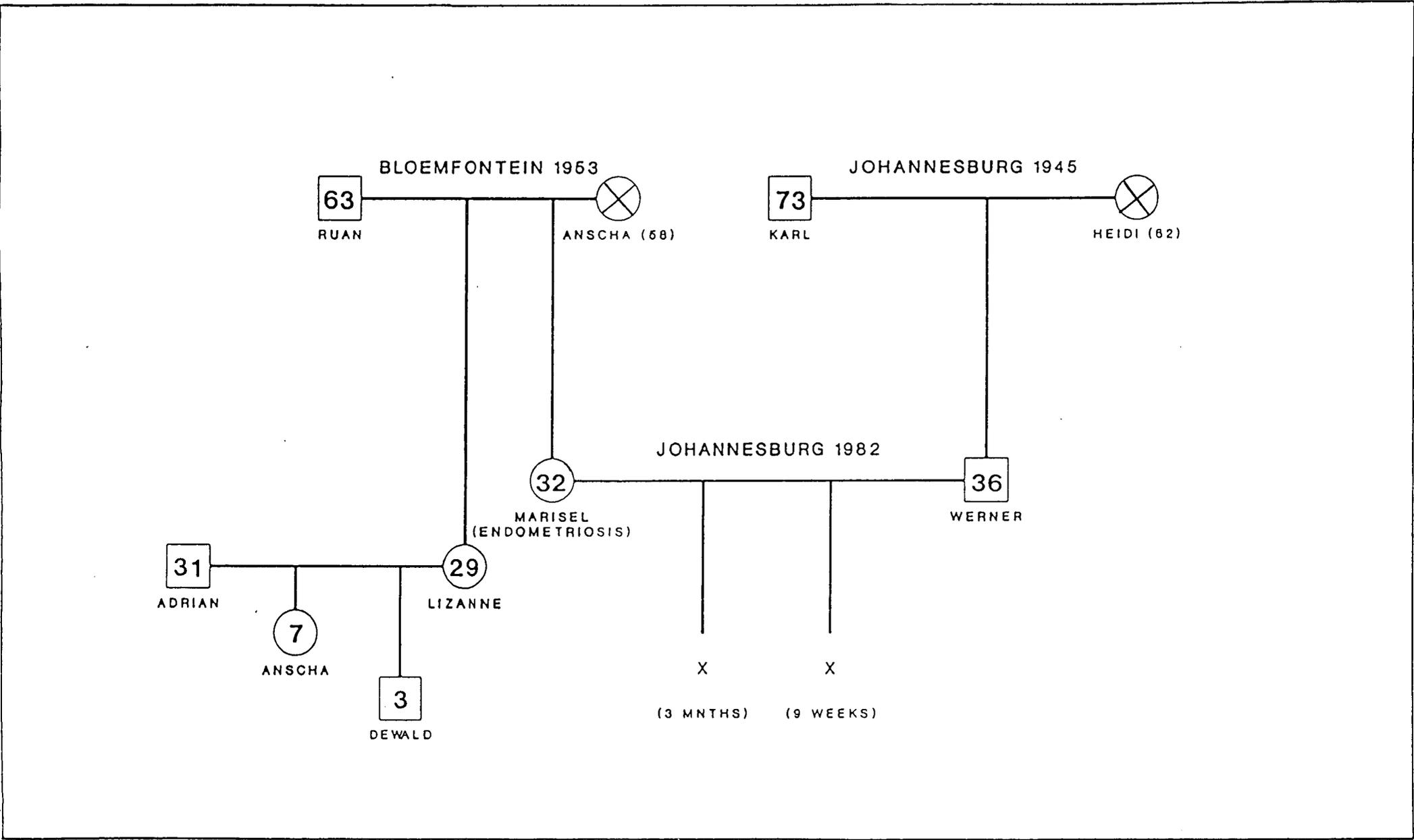
#### First generation: (wife's family)

Marisel's parents were married in Bloemfontein in 1953. Her 63 year old father Ruan is a police colonel. Her mother Anscha died in 1991 from lymph cancer. Ruan chose to continue living in the family home in Blackheath, Johannesburg.

#### Second generation: (husband's family)

Werner, aged 36 years, is an electrical engineer. He has no brothers or sisters.

Genogram : Family B



Second generation: (wife's family)

Marisel, aged 32 years, is a nursing sister and has "endometriosis". She has a younger sister Lizanne, 29 years old.

Third generation: (husband's family)

Werner and Marisel have no children. After Marisel's two unsuccessful pregnancies, the couple were told that children of their own had become a future impossibility.

Third generation: (wife's family)

Marisel's younger sister Lizanne and her husband Adrian have one daughter, Anscha, aged 7 years and a son, Dewald aged 4 years.

Background and Belief System of the Family of Origin

Marisel elaborated on the fact that her father was a very caring and supportive person as evidenced in his protectiveness towards his wife and his two daughters. Being in the South African Police reinforced his disposition in this regard as he was a firm believer that women were to be protected seeing that they formed the nucleus around which a family was centered. Although family in general were of particular importance to Ruan, the nuclear family was considered to be most important. Children especially, were regarded as being essential members of a family unit. Linked to this perception, family ties were considered to be religiously upheld and he believed in the physical- and emotional security of the family unit. Furthermore, Ruan stressed the importance of support for family members by the family unit.

Marisel shared this information with pride and spontaneity and was noticeably content when speaking about her father's protectiveness towards his family.

The marital relationship with Marisel's mother was a very close one and Marisel explained that her mother's death had been a severe blow to him. His dependent nature and Anscha's strong need to express caring had provided the couple with a consensual complementarity in their relationship until her death in 1991.

Anscha had been an orphan until her marriage to Ruan. Although a strong-willed, independent person, her maternal instinct was particularly strong. Marisel suggested that it was due to her mother's lack of biological maternal care that she had developed such a strong need to nurture and belong to a family unit of her own. She needed the security which Ruan freely supplied in an egalitarian manner.

The interviewer commented that it was apparent that the family unit as a measure of security was predominant. Of further importance were strong family ties and cohesiveness among family members.

When discussing Werner's family of origin it became evident that family ties were also of paramount importance to his parents. In keeping with Ruan and Anscha's emphasis on the family unit as a security measure, Karl and Heidi had firmly upheld cohesiveness and support of family members by the family unit.

Marisel and Werner explained that having been brought up in such familial environments, they had to date not been able to fulfil the need to create a family unit in which the elements of cohesiveness and support of new members could be manifested. For both partners this unfulfilled need held negative connotations.

The interviewer confirmed their commitment to family ties and bonds as had been laid down in their families of origin.

#### Responses to Marisel's Diagnosis of "Endometriosis"

Marisel explained that few family members were aware of her diagnosis of "endometriosis" as she had difficulty sharing the symptoms with them. She had found previously that explanations had become too painful and were often misunderstood even after lengthy discussions, leaving her miserable and very "depressed".

The interviewer commented that Marisel's perception of herself as a

"patient" could possibly contribute to her hesitancy in sharing symptoms with the significant others in her family. This hesitancy may also be reinforced by the fact that Marisel, being a nursing sister, had a linear, medical frame of reference in her interaction with people in terms of their being either "well" or "ill". Marisel confirmed this statement without hesitation.

In particular Marisel received much sympathy rather than empathy which had confirmed her perception of herself as "inadequate". Whilst sharing a very close relationship with her father, his concern about her physical symptoms and inability to have children had put considerable strain on their relationship. She felt that she had disappointed him to a large degree due to her inability to produce her own family which would have continued the thread of supportiveness and cohesion which he and her mother had initially woven and integrated into their own family unit. The interviewer stated that Marisel's integration of the belief system of her family of origin appeared to be very strong.

Marisel's relationship with her mother had produced significant pressure on her to have a child. This shift had come about with the onset of her mother's terminal illness. Although she had already become a grandmother of two, her wish was to see Marisel and Werner's child before she died. In addition to this, Marisel and Werner had pressurised themselves into repeated "in vitro" procedures which were continually unsuccessful. Marisel's mother felt powerless to help them and had repeatedly expressed her compassion, while being very supportive, although not understanding the full implication of Marisel's diagnosis. Once again, after her mother's death, Marisel felt guilty of disappointing her and letting the family down. Her only alternative in which to fulfil her mother's wish was time, and this too had become a closed door as her mother and herself had run out of time.

The interviewer commented that the powerlessness experienced by Marisel's mother in altering her daughter's childless state was mirrored in Marisel's powerlessness with regard to her control of time. Both members were consequently in a position of little control over events in their respective lives.

Lizanne and Adrian, whilst being very supportive when necessary, were hesitant to discuss Marisel's infertility or illness with her as they had correctly assumed that it would produce much pain. Furthermore, their "adequacy"

versus their sister-in-law's "inadequacy" made them very uncomfortable and guilty at times. Instead they chose to treat her with kid gloves and slowly introduced their own children into Werner and Marisel's home as compensation for their childlessness. Once again Marisel explained that their pity was difficult for her to accept and she therefore preferred not to discuss her mood swings or related symptoms with them.

The interviewer commented on the theme of emotional pain which is particularly evident in this relationship as it is in the relationship between Marisel and her father. Lizanne is also considered to be very close to Marisel but her heartache at Marisel's infertility is a source of embarrassment for her as Marisel is unable to "mend the tear". When questioned about his perception of Marisel's illness, Adrian explained that when she had miscarried her babies, he had been able to provide theological support for her and Werner as he was a qualified minister of religion. Subsequently however, that role had fallen away as Marisel and Werner no longer initiated discussion around Marisel's infertility or their longing for children of their own. However as she has a strong religious orientation, Marisel considers Adrian's practical advice and support most comforting.

When the interviewer questioned Werner about his parents' reaction to Marisel's diagnosis, he explained that it had been a continual and very trying time for all members concerned due to the additional pressure of him being an only child and therefore having to produce an heir whether it be a boy or a girl. Marisel explained that her relationship with Werner's mother in particular had changed as she herself had difficulty in conceiving Werner and had miscarried prior to her pregnancy with him. Her understanding of Marisel's infertility was therefore considered to be very good before she had become terminally ill. Once she had become bedridden, she had exercised an intolerable amount of pressure on the couple to have a child. In addition to this Marisel was experiencing the same scenario from her own mother and from her numerous unsuccessful attempts at "in vitro" treatment. Disappointment in her inability to conceive a child once again manifested itself in Marisel's interaction with the rest of her family members. This perception of herself letting the family down was confirmed due to both parents being perfectionistic and rigid in their frames of reference.

Werner's perception of Marisel's illness initially was one of sympathy as he felt that he had been "freed from the responsibility of having to produce a child" and the pressure had now been displaced onto Marisel entirely. Their relationship, described by Werner as a symmetrical one, was considered to be particularly intense. Due to Marisel's diagnosis however, the interviewer commented that the symmetry had apparently undergone considerable fluctuations due to the continual complementary feedback into their marital system of "disappointment-optimism" when going for the numerous medical examinations and treatments. Marisel puts much pressure on Werner to adopt a child and felt sympathetic towards him in his obvious reluctance in this regard. The interviewer commented that by being sympathetic towards him, Marisel was making an attempt to maintain their symmetrical relationship.

At present Werner's perception of their childless state has shifted to one of irritation and frustration at times. Due to the symptoms related to the diagnosis, Marisel is unable to engage in much sexual activity which is increasingly worsened. This places considerable strain on their relationship. However Werner tries to be supportive and understanding. Furthermore, Werner's perception of Marisel's illness is confirmed by her mood swings as a result of continuous hormonal treatment. Once again, pressure is placed on their relationship as he becomes angry with her and often withdraws when she is feeling "down". In addition, the continual emotional outbursts with regard to their childlessness is a source of frustration for him. Marisel at this point interjected and confirmed that Werner is subjected to some "terrible" days at home although he remains supportive and tries to compensate by taking her on luxurious holidays and making her life at home as pleasant as possible. Furthermore she added that they preferred to contain their emotional pain within their relationship as opposed to sharing it with members outside their family unit.

The interviewer commented that although they had been through difficult stages in their relationship, their close emotional support of one another during these experiences was apparent.

### The Belief System of Family B

A very apparent belief system that had co-evolved during the course of this session may be described as the commitment to the importance of family

support and cohesiveness. Although necessitating the assistance of medical personnel for the couple's childlessness, their own emotional pain was discussed and contained by the couple themselves. To a large degree, the reactions of other family members to their childlessness had brought about this coping mechanism. In particular, Marisel and Werner disliked being pitied which was a general reaction from family members. Optimism was of particular importance to the couple as was their attitude of living "one day at a time". They believed in the exclusive intimacy and companionship offered within a marital relationship. Furthermore tolerance and patience as important factors had been thoroughly tested and had subsequently featured very strongly in their interactional patterns with one another. Friendships were important to the couple but were an increasing source of emotional pain. Their friends were either in the position where they were raising children or voluntarily childless. Marisel's frustration with her own childlessness had negative effects on both groups of friends. In particular, she found it difficult to accept voluntary childlessness because she felt these friends were not fulfilling the role which she was so willing to fulfil but could not. The belief that she was an unfulfilled woman was particularly strong at such times. As a result friendships, although important, remain a source of emotional pain. At such times the couple have to offer mutual support to one another by becoming optimistic and positive with regard to their childless future.

### Session Three

Present at the session: Marisel and Werner

The interviewer asked Marisel and Werner what they perceived had changed if anything, in their marital relationship after the first session until the present session. Marisel replied that she had done much retrospection without Werner's help at times and had come to realise that she had fallen into the trap of interacting with family members and friends in a manner which elicited sympathy from them. She was particularly opposed to their sympathy and strongly resisted it but realised that by talking about her childless state continuously, there was very little other way in which she allowed people to interact with her.

The interviewer commented on her honesty and added that even in her

own experience of Marisel's interactional pattern, she had frequently felt the "pull" to be sympathetic towards her. Marisel added that instead of persisting with this interactional pattern of egocentricity, she had had a shift in focus and had been attempting to make herself increasingly aware of other persons' difficulties as opposed to her own. Furthermore, her thoughts surrounding children and her own condition had consumed her and she had made a concerted effort to distribute the amount of mental and physical energy she had spent on such thought processes to include hobbies and, of paramount importance, her marriage.

Werner interrupted at this point by stating that there had been a very marked change in Marisel and he wanted to compliment her on her efforts while he knew how difficult it was for her to focus on anything else but her need for a child. He mentioned that in particular they were able to discuss children and adoption at times without Marisel becoming emotional and withdrawing from the conversation. Furthermore, she no longer nagged him to adopt a child which took a lot of pressure off him and which increased his desire to be a supportive husband to her. Their marital relationship had undergone a positive change in that Marisel had become increasingly attentive as opposed to her previous "lukewarm" attitude.

When the interviewer expressed interest at Marisel's shift in focus, she replied that it was very important to retain her marriage to Werner and she had realised that children would come second to their own happiness. Furthermore, she had also come to realise that their reasons for wanting children were fundamentally different and she considered it unfair to try and force Werner to adopt a child because her need was greater than his. She stated that she would want both of them to feel equally ready and happy about making a decision to adopt if ever such an opportunity arose.

A further idea which had co-evolved over the past six weeks had been the perception of a "time out" strategy. To Marisel this meant that she would be focussing on giving herself time and space away from her pre-occupation with children. She felt that she had been hard on herself and Werner over the past few months with regard to their childlessness and wanted to "take a break" from this mode of thought. Marisel's "time-out" strategy had significant advantages for Werner as he had already started experiencing. He added that Marisel had become less selective with regard to extending invitations to friends who had

children and those who did not. Previously Marisel had begun to withdraw from friends with children and those who were voluntarily childless as it had become too painful for her to be in their company. In addition, her mood swings as a result of her hormonal treatment had contributed to making her abrupt and unapproachable at times. Both factors were not conducive to forming and maintaining friendships. As a result, Werner had also had to adjust to a quieter social life at home. This discouraged him as the alternative was a childless Marisel who would constantly be trying to draw him into emotional conversations surrounding adoption. Since Marisel had implemented her "time-out" strategy, they had started seeing friends more frequently and Marisel's new interactional pattern could therefore be tested, reinforced or amended.

The interviewer complimented Marisel on her insight and optimism as well as her initiative in empowering herself as opposed to continuing a "more of the same" interactional pattern. Werner too was complimented on his flexibility with regard to Marisel's concerted efforts to improve the quality of their marital relationship.

### Case Illustration: Family C

#### Session One

Present at this session: Ashley and Lloyd

Lance and Steven were asleep

In this initial interview, Ashley in particular appeared very nervous. The interviewer attempted to put her at her ease by facilitating discussion around her and Lloyd's expectations of the interview and their perceptions of the purpose of the study. Misconceptions regarding the interviewer's role in the study were clarified and reformulated. Ashley had perceived the interview as consisting of a list of questions which had to be completed and which the interviewer as "psychiatrist" would then interpret. The interviewer's role as researcher and participant observer was explained and discussed.

Belief systems regarding sharing of "delicate and sensitive" information initiated discussion around Ashley's slight hesitancy to participate fully in the session. When asked by the interviewer what had made her decide to respond to the initial advertisement, Ashley replied that she wanted to assist other women who were suffering from "endometriosis" by telling "her story". She had however grown-up in a home where subjects such as menstruation and sex were never discussed especially not with men present. Furthermore, she felt vulnerable and embarrassed about having "endometriosis" and never discussed her illness with anybody other than Lloyd.

The interviewer expressed empathy with Ashley's disposition and stressed that although certain questions may be of a "delicate and sensitive" nature, a safe environment would be created during the course of the session, which would allow her to discuss "endometriosis" as she wished. She was also given the reassurance that if she perceived certain questions to be too invasive, they would be reframed so as to put her at her ease. She was also reassured of the confidential nature of the information received. Furthermore, the interviewer emphasised that as she was a female participant observer, her understanding of the information shared would be enhanced as opposed to that of a male counterpart. Ashley emphatically responded that if the interviewer had been a male, she would not have participated in the study. A clear indication was therefore given of the strength of Ashley's belief system regarding privacy of "delicate and sensitive" subjects.

Current perceptions regarding Ashley's endometriosis were then discussed. She began by saying that although she was physically much improved since her total hysterectomy three years previously, her hormonal treatment gave rise to an increased weight gain and acne. This led her to feelings of inferiority and unattractiveness. In addition, her mood swings were frequently characterised by depression and hypersensitivity which made interaction with her family members strained and conflictual at times. Lloyd smilingly nodded his head and the couple laughed. Ashley explained that Lloyd was often scapegoated for her mood swings which made their relationship very tense at times. Although he understood her difficulty he knew how she had suffered previously and did not want to see her go through the discomfort again. Furthermore, as Ashley had been declared "endometriosis-free" at her recent examination, they had been able to resume normal marital relations

seeing that Ashley currently experienced no pain during sexual intercourse. Both parties were relieved because Ashley, in addition to coping with the pain of endometriosis, felt guilty about rejecting Lloyd if he initiated intercourse as she would not be able to stand the pain. She and Lloyd also experienced frustration with not being able to continue a normal marital relationship as they had prior to Ashley's diagnosis.

The interviewer briefly responded empathetically and went on to comment that both Ashley and Lloyd appeared to be at ease discussing "sensitive" issues at present. They responded that they were much more comfortable and were enjoying the session.

Lloyd mentioned that he was also very proud to be the father of two beautiful and healthy sons. The couple had battled to have both their children and would have liked to have a third child, in the hope that it would be a girl. The need for Ashley to have a hysterectomy however had dashed that hope. Initially she in particular had been very depressed. She had felt cheated and pressurised into terminating her "womanhood" and she often felt like an object rather than a woman due to her hysterectomy. Furthermore, her extended family, although sympathetic, were distant as they did not fully understand the concept "endometriosis" due to Ashley sharing information selectively. She was angry at being pitied. She wanted their support but was unable to express this need as she was too embarrassed and knew they would not fully understand. She therefore confined her support system to Lloyd and to the rest of her family she put up a front of "coping very well" and never really wanting a little girl as "boys were much easier to raise". She also believed that she was being punished because she had not felt ready to have Lance but had been advised by her physician to fall pregnant in order to control the "endometriosis". During her months of pregnancy with him she had been constantly ill and often wished the baby away. With Lloyd's help however, she was able to pull herself out of her "rut" and attend to her family.

### Co-evolved Themes from this Session

Despite her initial hesitancy to explore "delicate and sensitive" issues relating to "endometriosis", Ashley progressively shared more of her struggles and side effects of her illness during the course of the session. Lloyd's

perseverance and support of Ashley was highlighted as a predominant theme particularly after the birth of Lance. Furthermore, Ashley's determination to regain her strength and her commitment to family life was a recurring pattern which had been reinforced after Lance's birth. The complementarity of Ashley's dependence and Lloyd's independence as a new father and home-maker during that stage had shifted to its current state of symmetrical parenting, once Ashley had regained her fighting spirit. A further theme had begun to co-evolve namely the idea that in a safe environment it was acceptable to acknowledge and share vulnerable feelings.

### Genogram

TABLE : 5.3 Genogram of Family C (see page 79)

#### Session Two and Background to Genogram

Present at this session: Lloyd and Ashley

#### First generation: (husband's family)

Lloyd's parents were married in Pretoria in 1956. His 62 year old father Graeme, is a mechanical engineer. His mother Louise, aged 57 years, is a housewife and member of many extra-mural organisations.

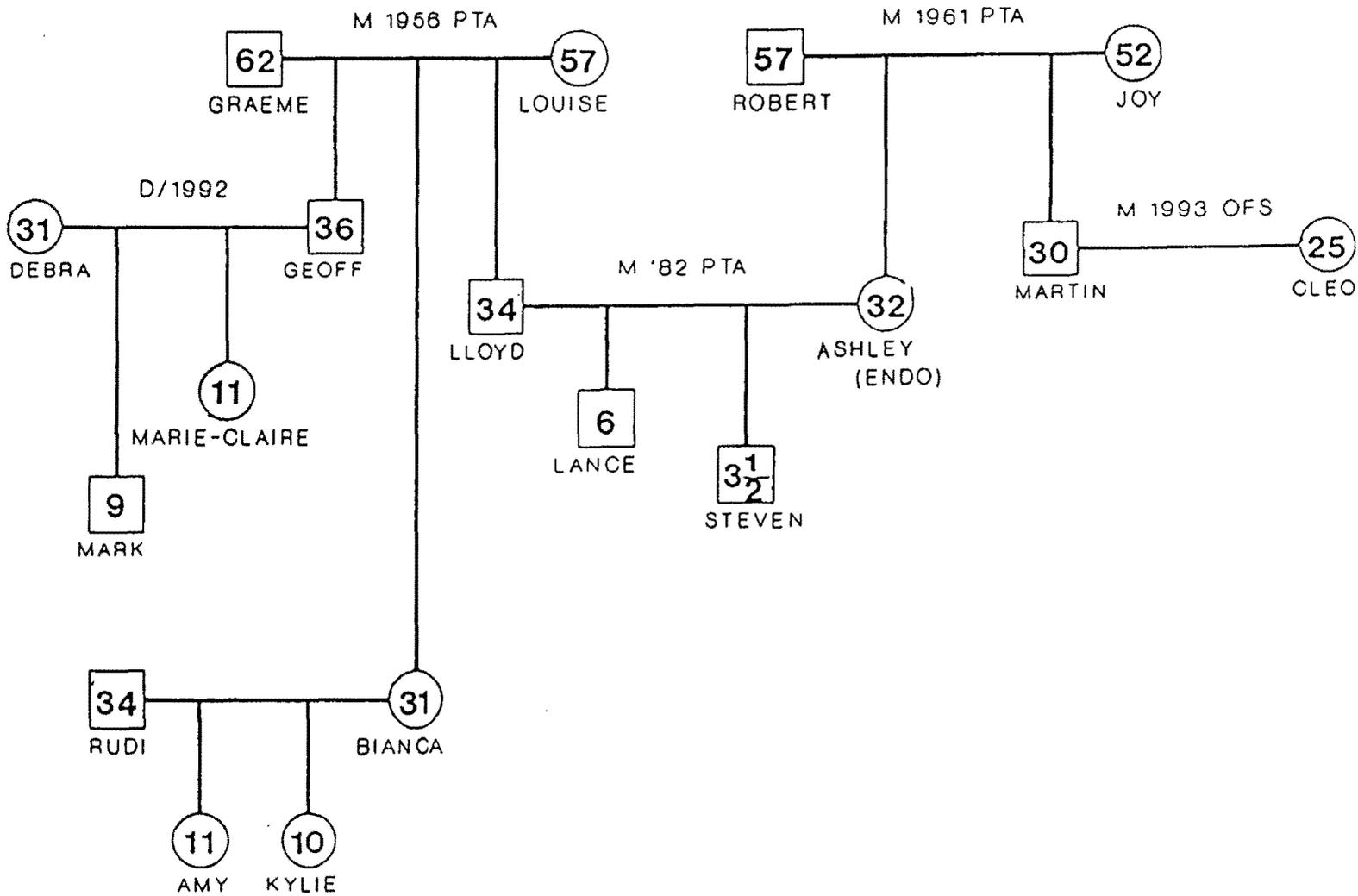
#### First generation: (wife's family)

Ashley's parents were married in Pretoria in 1961. Her 57 year old father Robert, is the owner of a steel company. Her 52 year old mother Joy, runs a nursery school from home. They currently live next door to Ashley and Lloyd.

#### Second generation: (husband's family)

Lloyd, aged 34 years, is an aircraft engineer. He has one brother and a sister. His brother Geoff, aged 36 years, is an architect and is divorced from Debra, aged 31 years. His sister Bianca, aged 31 years, is a secretary for a financial institution. She is married to Rudi, aged 34 years.

Genogram : Family C



Second generation: (wife's family)

Ashley, 32 years old, is a systems analyst and has "endometriosis". She has a younger brother Martin, aged 30 years, who is married to Cleo, aged 25 years.

Third generation: (husband's family)

Ashley and Lloyd have two sons, Lance aged 6 years and Steven aged 3 and a half years. Lloyd's brother Geoff and his wife Debra have one daughter Marie-Claire, aged 11 years and a son Mark, aged 9 years. Phillip's sister Bianca and her husband Rudi have two daughters. Amy is 11 and Kylie 10 years old.

Third generation: (wife's family)

Ashley's younger brother Martin and his wife Cleo were recently married. They have no children.

Background and Belief System of the Family of Origin

During the co-creation of the genogram, the children showed marked interest in the tape recorder and asked whether they could speak into the microphone. Lance and Steven were both very amused to hear their own voices but soon got bored. They both stood very close to their mother while Lloyd made everybody present a cup of coffee. When however, they started becoming disruptive, Ashley told them to go and play in their bedroom. Lloyd left the room to read the boys a bedtime story.

The interviewer commented on the apparent smooth running of the household and Ashley replied that she and Lloyd share the same ideas about child-rearing which made having children "a pleasure". The mutual dependence in their relationship was closely linked to the amount of support the couple afforded one another. This theme frequently emerged during the sessions.

When Ashley discussed her family of origin with the interviewer, she did so with apparent sadness. She explained how she had enjoyed a close relationship with both her parents up until her marriage. Once Lloyd had entered their lives, her father had withdrawn although they had often attempted to include him in their nuclear family. He was described as being a perfectionist and a workaholic. While being the traditional head of the home and provider, he was also very dependent on his family for warmth and affection. Family ties were strong and of paramount importance was each member's happiness. Ashley mentioned that she was always treated as an individual with an opinion which allowed her a large degree of autonomy and self-confidence. Her mother, while sharing her husband's perspective with regard to establishing autonomy in their children, was described as being less dependent and more domineering. She was particularly ambitious and wanted her children to do better than she had done academically. Also a very warm and caring person, she adored her grandchildren and they were very close to her. She too, however had withdrawn once Ashley had married as she believed a husband had first priority in a relationship. Ashley mentioned that both she and her brother had received very little physical punishment from either of her parents.

When asked by the interviewer how she thought her childhood experiences had influenced the way she perceived her present life, Ashley immediately responded that she wanted her own sons to have the type of childhood she had been given especially in these troubled times. She explained that she wanted her children to grow up in their stride and not be pushed into directions they would not be happy in. Materialistic values, although important, should be placed second to happiness and the sense of belonging in the family unit. Furthermore, both she and Lloyd try, where possible, to avoid physical punishment of their sons. This had been a theme in her own childhood.

After the interviewer commented on the strong sense of belonging and commitment to the happiness of each family member, she moved to concentrate on Lloyd's side of the genogram. Lloyd explained that his father was a particularly domineering and chauvinistic man who was emotionally controlled and who reserved physical contact with his family. He was particularly rigid and critical in his manner and spent a great deal of time at work rather than at

home. Emphasis was placed on independence of family members and the development of a sense of responsibility in each of the children. As a result Lloyd had found it difficult to approach his father for help with various problems as he was expected to solve his own problems. His mother and himself did not share a close relationship. He described himself as the "odd one out" in their family as she particularly favoured Bianca and Geoff. However, she was fiercely protective towards her family and believed that confrontation was especially necessary when resolving implicit or explicit conflict between family members. Lloyd described her as being more affectionate than his father but also very reserved with regard to physical contact. This reservedness also occurred in her interaction with Lloyd and Ashley's sons. As a result they were rarely visited, rather contacted telephonically.

#### Background and Responses to Ashley's Diagnosis of "Endometriosis"

Ashley described the circumstances surrounding her diagnosis matter-of-factly and honestly. Although she has had to undergo a total hysterectomy as a result of her illness, she is content and pain-free at present. She receives hormonal treatment at six monthly intervals. The treatment has effected a weight gain of ten kilograms and has left her feeling self-conscious and depressed at times. She had also had much difficulty in finding a label for her pain and on numerous occasions was referred to a psychologist. Although she never attended psychotherapy, she very often had doubts as to her mental stability. These doubts increased when she started behaving uncharacteristically intolerant of Lloyd's playfulness in their interaction with one another. After a six year struggle, she was eventually diagnosed as having "severe endometriosis". This put pressure on the couple to have children sooner than what they were prepared for, but valuing the importance of family life, both she and Lloyd decided to start a family. Lance was born during that time. Ashley had difficulty in conceiving Steven as the endometriosis had become very extensive. Although wanting to have a daughter, Ashley's severe discomfort and emotionally erratic disposition coerced her into having a hysterectomy. She explained that at first she experienced great difficulty in accepting her hysterectomy but with Lloyd's reassurance and support and an improved marital relationship, she has "never looked back". She also stated that the fact that having had two children had also made the world of difference and that she was very appreciative and grateful that they had not waited before starting a family or else she and Lloyd may have been childless at this stage.

During the time Ashley was describing the background to her diagnosis, Lloyd had been silent, nodding intermittently and smiling at certain stages of the discussion.

The interviewer commented on his ability to contain the contents of the conversation and he replied, "we are all in this together and I have two beautiful sons". Ashley confirmed his statement and once again emphasised Lloyd's very supportive and caring nature which had been severely tested during her struggle for a diagnosis.

The interviewer referred to the genogram and asked Ashley who in the family, other than Lloyd, had supported her during her struggle for reassurance that she was physically as opposed to mentally ill. She replied that, coming from a conservative background, she found it particularly difficult to discuss "sensitive issues" with her family members, including her mother. Although they would not reject her if she felt the need to do so, the nature of their relationships had never previously included discussion about "private matters". Consequently she had only discussed her fears within her marital relationship and with Debra, her former sister-in-law. This unique relationship had come about during Ashley's struggle to fall pregnant with Lance. Debra had allowed her to vent her feelings and discuss intimate aspects of her illness from a female perspective. She considered her to be a very genuine friend and felt strong support from her. This relationship has remained firm even though she and Lloyd's brother Geoff are now divorced.

Ashley went on to say that her parents were curious at one stage as to her childless state and superficially hinted that both she and Lloyd should seek medical advice. They did not persist in their concerned interest however and subtly joked about their "naivety" in conceiving a baby. Ashley had preferred to maintain her silence surrounding her struggle.

Louise, Ashley's mother-in-law, is mentioned as being the least supportive of all. Given Louise's indifference to family connectedness, Ashley felt the least inclined to discuss her illness with her. Furthermore, since Lance and Steven's birth she has shown little interest in her grandsons. Strong conflictual relationships are very evident between Ashley and her in-laws. In particular the complementarity between Louise's withdrawal from her daughter-in-law and her

sons and Ashley and Lloyd's protectiveness over their family, is noticeable. Due to Debra and Geoff's recent divorce, Ashley has focussed most of her energy and loyalty on Debra's side. This has caused severe conflict in the family as she is seen as having a divided sense of loyalty. Throughout the conflict however, Lloyd has chosen to support Ashley. Consequently he dutifully makes telephone calls to maintain contact with his parents, or visits them on his own. He does not place pressure on Ashley or his sons to accompany him. Ashley stated that she is willing to try and diffuse the present volatile situation, but she will not initiate negotiation around a solution for the problem.

The interviewer interpreted Ashley's strong stance in this connection as a reflection of her belief in family connectedness and sense of belonging, evident in her family of origin.

As there is little contact between the rest of her in-laws and herself, Ashley believes that the less they know about her illness, the better for all concerned.

The interviewer commented on the territorial nature of Ashley's decisions with regard to sharing of information and asked her whether she perceived herself as very territorial in her manner. She readily agreed and proceeded to explain the rationale behind this as an instinctive "protectiveness" which she believes was transmitted from her family of origin. Furthermore, she went on to add that she does not feel safe in discussing anything of a lighthearted nature with her in-laws let alone of a serious nature. For a shift to occur, the environment would have to become caring, protective and one in which she and her family would feel safe. Until that stage, she would not allow herself to become vulnerable to them.

### The Belief System of Family C

A very prominent belief system in Ashley's family of origin was the importance of family connectedness and warmth and affection. In addition to this the development of autonomy and independence was encouraged. A belief in "old fashioned values" was also evident. On Lloyd's side of the family "old fashioned values" featured strongly. Furthermore, a strong sense of responsibility and independence had also been transmitted to him from his family of origin.

Ashley's protectiveness of the boundary around her nuclear family, influenced the way she interacted with her indifferent in-laws and maintained her belief system regarding the discussion of "private matters" outside her home. In this way she was able to assert herself independently and autonomously in her interactional patterns with them particularly with regard to her illness.

Lloyd's responses to Ashley were characteristic of his need to belong, which he had never experienced in his own family home. In this way his response formed a complementarity to his family's response to Ashley. Their indifference maintained his strong involvement with her. Ashley and Lloyd's belief system involved the perspective that "old fashioned values" were wholesome and should be respected. Furthermore, family connectedness and a strong sense of belonging were important in leading each member towards independence and autonomy. The necessity of warmth and affection was encouraged as was physical contact between members of the family.

#### Co-evolved Themes from this Session

The reservedness in the discussion of "private matters" was maintained by the belief system, co-evolving a coherent set of responses towards Ashley. For Lloyd, Ashley represented a safe haven, where he could "fit in" as opposed to feeling "out" in his own family. Furthermore the exclusivity of their marital relationship afforded him the privilege of sharing intimate details of her struggle for a diagnosis and illness with Ashley. In this way she affirmed his sense of belonging in the family as he had become her confidante. In addition the belief system of autonomy provided him with a sense of responsibility to his family as their head. Ashley, although also autonomous did not threaten his position. Her sense of independence and protectiveness towards her family boundaries as well as her strong sense of loyalty enabled her to hold a unique and favourable position as wife to Lloyd and mother to their sons.

Lloyd's divided loyalties with regard to his nuclear family and family of origin did not threaten his relationship with his family in any way. Ashley allowed him the freedom to be a son, which he complemented by being a very interested and involved father. He too freed Ashley from involvement with his family as he had become their representative in his relationship with her. By

her committed involvement with her nuclear family and her protectiveness of their boundaries a complementarity had developed between them which had become mutually exclusive.

### Session Three

Present at this session: Ashley and Lloyd

Lance and Steven stayed briefly to meet the interviewer

The interviewer opened the discussion by asking Ashley and Lloyd what their impressions of the previous sessions had been. Ashley started by saying that she felt that although initially struggling with sharing "delicate and sensitive" information in the first interview, once the interviewer had left she and Lloyd had continued discussing the themes which had been co-evolved during the time before the second interview. Lloyd interjected that it had been as if a sluice gate had been opened and he in particular felt grateful that Ashley had been given the opportunity to talk to a "neutral" party. Ashley commented that she had felt a sense of relief that she could talk to a person who "understands". She also experienced a sense of freedom and had thought about discussing certain aspects of her "illness" with her mother if the subject was approached. She had thought that a good method to facilitate discussion would be to elaborate on the side-effects (skin problems, weight gain) and she would then be able to test the climate, and if she felt safe, would be able to elicit further conversation. This idea had co-evolved as Ashley had been told she was now "endometriosis-free" and she therefore felt less embarrassed and more confident in discussing an illness that she had conquered as opposed to discussing an illness that she was currently experiencing.

When discussing session two, Ashley and Lloyd explained how they had enjoyed co-creating the genogram as patterns and themes had been expressed which had stimulated their interest in their family and the way in which they had perceived them previously. Ashley commented that she was slightly embarrassed however, at the revelation of the conflictual relationships between herself and her in-laws and this would generally be regarded as a family "secret".

The interviewer commented that Ashley appeared to be much more confident about herself in relation to her illness at present than previously. She replied by saying that she felt inspired with regard to starting new ventures and persevering till they were established. This new found confidence she put down to having made major decisions which would involve many risks and challenges but which would help her achieve goals which she had had to put on hold due to "endometriosis". One such goal had led Ashley to decide that she would be stopping full-time work and starting a child-care centre at home in the very near future. This would give her more time to be with her sons and take pressure off her of having to perform at a pace which may adversely affect her progressive convalescence from "endometriosis". She had also considered including her mother in this venture as she lived adjacent to her and would be an asset to have in the business. Her mother was a financial wizard and would consequently have more contact with her grandchildren whom she treasured. In this way, Ashley was becoming less territorial with regard to her own family and initiating contact with her extended family. Lloyd voiced his approval for Ashley's new project and had also planned in becoming involved by building an additional room onto their home which could be used as a playroom for the children.

The interviewer complimented Ashley and Lloyd on the enthusiasm they had both shown for developing new ideas about their lives subsequent to Ashley's recent release from "endometriosis" and for their willingness to risk involvement in challenging projects. Furthermore the interviewer complimented Ashley on her decision to extend her nuclear family boundaries to include members of her family of origin and thereby initiate improved familial relationships.

## CHAPTER 6

### CONCLUSION

#### Introduction

This chapter will discuss the unique belief systems and new perspectives that co-evolved between the interviewer and each family. This will be done by examining whether the ecosystemic principles of morphogenesis or morphostasis occurred. A discussion of the research hypothesis is forwarded based on the research findings. Furthermore, a critique of the research design employed with the "endometriosis" sufferers and their families will also be presented. Finally, the research conclusions are discussed and the implications of those conclusions are presented. Future recommendations will conclude the chapter.

Before commencing an elaboration of the research findings it is relevant at this point to refer back to the statement of the research problem and the research hypothesis.

The research problem as described in chapter 1 focussed on the lack of attention which women afflicted by "endometriosis" have received in terms of their relationships with significant others. Due to the nature of the disease, and the medical interpretations thus far given to "endometriosis", the female member has had to contend with a label describing her illness and her mode of treatment on an individual level. As such, treatment and management of "endometriosis" have largely excluded the wider system to which the "endometriosis" member belongs. Consequently, the emotional aspects of a physically debilitating disease on a system has been disregarded.

Seen from this perspective therefore, adherence to a Newtonian, linear epistemology to date is evident, and a holistic view of the female "endometriosis" sufferer is subsequently lost.

In order to examine whether the wider system of the "endometriosis" member is significant in maintaining a Newtonian perspective or whether the

formation of new belief systems regarding "endometriosis" may occur between the "endometriosis" member, her significant others and the interviewer, a broader perspective has to be introduced which would allow for such an investigation. It should be emphasised that the interviewer has a role as perturbator of the family system rather than as an agent of change. If morphogenesis is seen to occur in the study the interviewer has achieved the goal of perturbing the system significantly enough for the facilitation of a shift to a different conceptual level. As mentioned, the use of an alternative perspective, would facilitate such a shift. One such perspective which may be used is the ecosystemic paradigm with its emphasis on process, patterns and context. By means of this approach, a holistic view rather than a reductionistic view is employed when considering the research problem and the research hypothesis.

As stated in chapter 4, the research hypothesis which was formulated for the purposes of this study was as follows:

- Conceptualisation of the "endometriosis" sufferer in the family may be perceived meaningfully as a result of the reciprocal influence of belief systems held by the family and the interviewer which may potentially co-evolve into a structurally new belief system.

In order to achieve a significantly different level of conceptualisation (second-order change), this revised framework will maintain coherence with the previous organisational structure yet introject sufficient perturbation into the family system resulting in the generation of new perspectives with regard to "endometriosis".

This hypothesis in essence therefore stated that reciprocal influence between the interviewer and the family may lead to a more meaningful conceptualisation of the "endometriosis" sufferer. This may occur due to the potential derived from such reciprocal influence which facilitates the co-evolution of a structurally alternative belief system regarding the "endometriosis" member in the family. Furthermore, as discussed in chapter four, both the research hypothesis and the research design were formulated according to the ecosystemic perspective. By using this approach, conclusive

generalisations across families are avoided in the research assumption. Illustrations of the three case studies will serve to confirm the inherent uniqueness evident in each family's responses to their "endometriosis" member.

In addition to the autonomous and unique nature of each family, the research showed that the development and maintenance of each family's ecology of ideas was organised in a distinctive and unique way. This was seen when introducing the genogram to the various families thereby facilitating the co-evolution of alternative perspectives regarding the concept "endometriosis".

Bearing the above in mind, the research findings will be discussed with regard to the occurrence of morphogenesis or morphostasis and with regard to the co-evolution of new perspectives within the system. The co-evolution of new perspectives in particular will emphasise the need for the use of an ecosystemic paradigm as opposed to the implementation of a Newtonian epistemology.

## Research Findings

### Morphogenesis or Morphostasis

The genogram as research instrument triggered morphogenesis in each family. This process occurred due to the recursive feedback between the participant/observer and each family regarding transgenerational information. The researcher's use of circular questioning about each member's perception of the "endometriosis" sufferer and relationships concerning the "endometriosis" member provided perturbations for the way in which they currently conceptualised and interacted with the "endometriosis" member. Furthermore, as participant observer, the researcher introduced differences to existing belief systems with comments regarding interactive patterns in the families of "endometriosis" sufferers. This was accomplished by means of double descriptions and as such mirrored the researcher's perspective of the interactive patterns between members. Double descriptions and circular questions provided perturbations which triggered a morphogenetic phase in each family. The genogram also served to clarify information about the family's belief systems regarding the "endometriosis" members.

In Family A, Ernst and Elsabe were asked circular questions about their belief systems regarding success and the importance of remaining competent under challenging circumstances. Furthermore, their ambivalence with regard to having only one child and their reasons for such ambivalence were elucidated during the course of the interview. The circular questions also focussed on the complementarity between Ernst's acceptance of Elsabe's current infertility and her non-acceptance of incompetence in falling pregnant.

The interviewer's perspective of and comments about the acceptability of sharing and acknowledging vulnerability with reference to Elsabe's fears about incompetence formed a double description to the way they viewed "endometriosis". In addition, questions concerning the re-conceptualisation of failure had triggered a morphogenetic phase.

In Family B, the process of mutual reciprocal influence between the interviewer's belief system and the family's system concerning "endometriosis", co-evolved over the sessions to create subtle changes in their belief system, thereby facilitating and generating a different perspective of the diagnosis "endometriosis".

It became apparent during the course of the interviews that Marisel was provided with a context in which she could express her perceived inadequacy in a holding environment. Furthermore, the interviewer deduced that by giving Marisel a larger degree of permission to be inadequate, she was reassured of the unconditional support by her family system as well as her adequacy and competency in other spheres of her life.

The genogram of family B also facilitated a three-fold process:

Firstly, it enabled the interviewer to ask circular questions regarding main issues in the members' belief systems. Secondly, it allowed the interviewer to comment on such issues and thirdly express perspectives on issues such as complementarity and coherence between Marisel's voluntary need for fulfilment of her maternal instinct and Werner's duty to provide an heir in order to prevent extinction of his family name. In addition, issues around competence versus inadequacy with regard to Marisel's "endometriosis" and the couple's optimism and commitment to family cohesion as evident by their commitment to

continued treatment indicated a shift in their previous conceptualisation of "endometriosis". Marisel's growing acceptance of a childless future was a further indication of the reconceptualisation which had formed during the sessions. These double descriptions and circular questions introduced a morphogenetic phase in this family and challenge the existing conceptualisations regarding "endometriosis".

The information obtained about family C enabled the participant/observer to facilitate a discussion around the complementarities between autonomy versus submissiveness and involvement versus indifference by means of circular questioning. A further aspect of the couple's interaction which could be considered in this manner was the complementarity between Lloyd's independent "fatherhood" status. His disposition allowed Ashley the opportunity to take time out and become dependent until she regained her strength and could once more resume a position of symmetry in relation to Lloyd.

Furthermore, a morphogenetic phase was triggered due to circular questions, comments and interactions between the interviewer and the family. In particular the re-conceptualisation of sharing and acknowledging of vulnerability in the family's belief system, contributed to the morphogenetic phase.

Similarly the recursive interaction between the interviewer and each family evoked equifinal processes supported by the co-construction of the genogram. This therefore led to a morphogenetic phase in each family. During this phase, "news of difference" was introduced into existing belief systems and re-conceptualisations surrounding "endometriosis" co-evolved. The organisation and structure of each family determine the extent to which a new belief system would be established. Furthermore, the new belief system was a product of the co-creation between the belief systems of both families of the couple, the couple and the participant/observer regarding their "endometriosis" member. The main finding of this study was that the newly co-evolved belief system was symmetrical to the family's existing belief system but was sufficiently different to introduce receptiveness to conceptualisation changes regarding the diagnosed "endometriosis" member.

### Co-evolution of New Perspectives

In Family A, during the phase of morphogenesis, the idea that illness was playing a beneficial and acknowledged role, as opposed to being denied was forwarded.

This new knowledge could therefore become part of the well developed sense of responsibility and dedication to their family unit which Elsabe and Ernst had already integrated and valued. In addition, by acknowledging vulnerability, the ambivalence which was felt surrounding a second child had facilitated a commitment to increasingly successful adjustment surrounding infertility. In this way, Elsabe had extended her personal parameters to include the possibility of falling pregnant again. By planning and taking the necessary steps, which emphasized her commitment to difference rather than her safety in ambivalence, Elsabe would allow herself to find alternatives to the label of "endometriosis".

Elsabe and Ernst's conceptualisation of the diagnosis "endometriosis" co-evolved from Elsabe's bleak perception of herself to a more positive and flexible one. Ernst had seldom expressed his concern regarding "endometriosis" as Elsabe remained "competent" in producing Johan. Therefore, new perspectives that co-evolved between the interviewer and this family were coherent with their existing belief system, but provided sufficient "news of difference". This "news of difference" was therefore unique to the family and facilitated a change in their previous conceptualisation of "endometriosis".

In Family B, the reciprocal influence and recursiveness of perspectives between Marisel, Werner and the interviewer, co-evolved a new belief system regarding Marisel. By offering the family a broader conceptualisation of their "struggle" as indicated by their perseverance and unlimited optimism rather than failure, an increased positive attitude and feeling of adequacy was established. This served to integrate Marisel's diagnosis of "endometriosis". In addition, a shift occurred in perspectives regarding Marisel in the "patient" role. Family members now regarded her with greater empathy and insight as a result of "endometriosis". By becoming increasingly empathic, Marisel's family, including Werner, avoided the stimulus pull of sympathy and pity which Marisel

had previously elicited from family members.

The interviewer's circular questions and process comments gave Marisel insight into her interactional patterns with members of her family in her maintenance of her "sick" role. Furthermore, her perceptions of the diagnosis of "endometriosis" were further enhanced as she gained insight into the limitations which she placed on herself and family members by her interactional style. By use of positive connotations and the family's responses to Marisel's diagnosis, an alternative perspective thus co-evolved, de-emphasizing Marisel's passive sick role and childless state and including the concept of renewing her marital commitment to her husband and extending her personal boundaries to include rather than distance friends who have children. A shift in focus had occurred. Instead of being egocentric with regard to "endometriosis" and the limitations it had placed on her fertility, the co-evolution of an alternative perspective would allow Marisel to look beyond her limitations and move towards increased fulfilment and personal growth.

The mutual exchange of perspectives between the interviewer and Family C co-created a shift in their belief system regarding Ashley's position in her own and extended families. It appeared that although still maintaining a strong sense of family connectedness, Lloyd and in particular Ashley's conceptualisation of the establishment of boundaries between her family and her extended family had changed. Ashley had indicated a willingness to become more open to discussing "endometriosis" with her mother now that she had been declared symptom-free as well as allowing herself to become open to other family members. Her territorial boundaries were not as rigid as previously therefore by feeling more integrated and confident about herself, Ashley had displayed a need to extend her connectedness to include other members of her and Lloyd's families.

Ashley's increased positive disposition was also perceived by Lloyd as having the potential to evoke a more positive relationship between herself and extended members of their families.

The idea of a future with Ashley's "endometriosis" had co-evolved from initial anxiety and resistance to a more optimistic and confident perspective that Ashley's acceptance rather than defensiveness regarding "endometriosis" could lead to increased family closeness.

Furthermore, plans for starting a creche which would include her mother as part of the management team indicated Ashley's re-conceptualisation of herself as being less defensive and increasingly flexible with regard to her integration of "endometriosis". Ashley's flexibility as opposed to her previous firm rigidity had allowed her to take more risks in her own life and expose herself to new experiences. In so doing, members of her family had begun to conceptualise the diagnosis of "endometriosis" as having more positive connotations and implications for the family systems.

### A Critique of the Research Design

By using the genogram, an effective context was created in which explanations of each family's responses to their "endometriosis" member were facilitated. This was achieved through linking such responses to the belief systems in their families of origin.

However one limitation of the study was that families were interviewed in their own homes as opposed to in geographically proximate surroundings. Therefore, while providing a familiar and safe context for the families the home environment may have created a context in which the family members' receptiveness to conceptual changes and alternative perspectives may have been lessened. Alternatively, receptiveness to conceptual changes and different perspectives may have improved, given the familiar surroundings in which the interviews took place. Location therefore, may have reduced or increased the impact of mutual recursiveness between the interviewer and family members.

A further limitation of the research design was that all the family members were not always present at each session as had been arranged prior to commencement of the study. Consequently, changes of a conceptual nature may have been more impactful for members of the families if participation had been consistent for all the sessions.

In addition, receptiveness to conceptual changes and new perspectives during the course of the interviews may have been greater if all family members had allowed themselves to participate more fully in the co-evolution of new

ideas. Although changes did occur, the impact of the co-evolution of these changes may have been greater if participation had been more spontaneous in the co-evolution of new ideas.

Finally, the research design could also be criticised from a Newtonian perspective. The primary focus of traditional linear epistemology is on the atomistic examination of entities in space and the progression of events in linear clocktime. This is in opposition to the ecosystemic paradigm which has as its primary focus patterns which connect objects and the relationships between them. Consequently, this study would have no place within a linear epistemology.

### Conclusion and Recommendations

The positivistic and ecosystemic approaches to the classification of human behaviour are mutually exclusive as discussed in chapter 2. When examining the positivistic use of the classification, "endometriosis" is a static entity distinct from the pattern of communication between the diagnosed female member and her family. Furthermore, the description of the condition is reified implying a permanent condition. As the case illustrations demonstrated in chapter 5, the atomistic description of "endometriosis" was of limited value to the female sufferer and her family. In addition the description of "endometriosis" in itself did not assist the families with regard to coping with and or understanding the mutual interaction between themselves and their "endometriosis" member.

"Endometriosis" by definition has negative connotations for the female sufferer. It obscures positive characteristics which the woman in question may have for example determination, sensitivity, optimism, trust, hope, vitality, femininity and sexuality. Such behaviours are inextricably linked to the "endometriosis" sufferer's entire family and consequently, as elucidated by the case illustrations, have unique ramifications for each family.

The diagnosis of "endometriosis" sufferer in each family, as illustrated in chapter 5, is an integral part of the complementary coherences in the families. Consequently, there is a need for a more inclusive definition of traditionally diagnosed "endometriosis" sufferers. By using an ecosystemic approach with families of "endometriosis" sufferers the potential to co-create such a definition

is established.

Based on the information generated by the research with the three families, suggestions for interventions with the diagnosed "endometriosis" sufferers and their families include the implementation of an ecosystem by mental health professionals using the genogram in a co-constructed process. In this way, a unique diagnosis may co-evolve which is not confined to the "endometriosis" member but which includes the complementary response of the family members to the "endometriosis" sufferer. Furthermore, the co-evolved diagnosis will be consistent with their belief system.

Additionally, closer links between medical doctors and mental health professionals or family therapists should be formed with regard to women who are diagnosed as having "endometriosis". Due to the significant effect such a diagnosis has on the relationships within the family, in particular the marital relationships, intervention by family therapists could facilitate a more comprehensive treatment plan which would include linking the traditional diagnosis to the ecology of ideas in these families.

Therefore, the consulting physician, when informing the afflicted female of the family of an "endometriosis" diagnosis, should whenever possible, be joined by a family therapist at the consultation as well as the woman's partner. In this way the family are afforded the opportunity of having a family therapist assist them with conceptualising the "endometriosis" sufferer in ways that are coherent with their unique belief system and their responses to their "endometriosis" member. Following this interview, an ongoing family support service should be available to these women and their families, in order to enable them to understand and cope with their own responses and the interactions of family members to their diagnosis. In addition, ongoing long term research is required with these families to assess the benefits of the ecosystemic approach with families of "endometriosis" sufferers.

When using the ecological approach with "endometriosis" sufferers, the need for close communication, co-operation and co-ordination between various private, public and volunteer organisations which offer social, health and other services to such women and their families is implied. The focus of assistance therefore should be on the needs of the "endometriosis" sufferer and her family

and how the different support system may best co-operate and interface to provide the most appropriate services for "endometriosis" sufferers and their families. The ecological approach will require comprehensive and co-ordinated community planning so that all those who are involved with the "endometriosis" sufferer and her family are included. In the ecosystemic framework, "endometriosis" may be conceptualised as an integral and important part of the family system and as part of the dynamics necessary for the growth and development of the family as a whole.

The term "endometriosis" does not signal a beginning or an end but connects as an integrated and coherent part of a co-created evolving system.

Weinstein (1988), comments on the progress made in identifying "endometriosis" at an earlier stage and particularly emphasises the restriction of the quality of life. According to Weinstein it is now more commonly understood that "endometriosis" affects not only the woman who has it, but also her friends, her family and her employer. This knowledge is considered to be helpful from an emotional point of view. Furthermore, Weinstein suggests that from an interactional perspective, it is much easier to co-evolve new alternatives from a context in which everybody has "endometriosis" and how it may affect the female sufferer on a daily basis.

Although an understanding of the nature and causes of "endometriosis" remains a great challenge in the medical field, "endometriosis" may also be viewed as a coherent and integral part of a co-evolved system. By approaching "endometriosis" from an ecosystemic perspective one would be approaching it as one would approach a Rubik's cube. Each new movement necessitates additional changes and alters previous positions whilst solving the puzzle. The cube has to be turned around constantly, juxtaposed and examined from every possible angle in order to attempt a problem solution. In like manner, a shift in "endometriosis" being examined solely from a diagnostic perspective may occur, to include alternative methods such as an ecosystemic approach. Consequently, approaches to solving the "endometriosis" Rubik's cube become multifaceted, giving rise to a broader spectrum of available solutions when faced with a challenging and mystifying reality.

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