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PRINCIPLES OF FAMILY HEALTH

This section outlines the basic principles of **family** health and illustrates their use through the case of the Goldner **family**. These principles are relevant for all types of primary care and for a variety of problems, ranging from simple self-limiting health conditions to complex biopsychosocial issues.

Use Biopsychosocial Approach

Since a family-oriented approach is based on the biopsychosocial model, the primary care physician must avoid a split between biomedical and psychosocial issues or problems in patient care. Using a completely integrated, biopsychosocial approach is difficult in clinical practice. Western culture and medical training place great emphasis on diagnosing problems as either physical or emotional and often focus exclusively on one aspect of the problem. The challenge for the physician is to evaluate simultaneously the biomedical and psychosocial aspects of the problem and to decide at which or levels of the biopsychosocial model to intervene. The family-oriented physician assumes that the **family** context will be relevant to most clinical problems, as illustrated in Jim Goldner's case.

*Dr. C had known the Goldner **family** for almost 20 years. He saw Betsy regularly for her Pap smears and to monitor her hypothyroidism. He had seen Jim twice almost 10 years earlier. He had initially seen Jim for tendinitis in his hand and had convinced him to return for a complete physical examination. At that time, Dr. C talked to Jim about his coronary risk factors, stressing the importance of stopping smoking. Jim never returned for his fasting lipid profile or follow-up. Dr. C was aware of Betsy's concerns about her husband's health and her son's problems.*

*In his initial history, Dr. C learned about the **family** conflict that had precipitated Jim's symptoms. He realized that these **family** issues would have to be dealt with after Jim's condition had stabilized and he was out of the intensive care unit (ICU). Dr. C met with the Goldner **family**—Betsy, the children, and Jim's sister—at the hospital the following morning. He explained the event medically, Jim's current condition, and the treatment plans. He answered their questions and encouraged them to share their fears about Jim dying. Dr. C reassured them that Jim was stable, that thrombolysis had been started promptly enough to prevent serious damage, and that they would be contacted immediately about any change. Dr. C wanted to meet with them again to discuss Jim's ongoing care after he was out of the ICU.*

Assess Family Context of Presenting Symptoms

Since most health problems are influenced by, and also influence, the **family**, the physician should have some understanding of the **family** context of every patient. This may be as simple as knowing who is in the household, what treatments other **family** members have recommended, or who is the patient's primary caregiver.

Patients may have physical symptoms that are related to **family** stress or **family** problems. These physical symptoms may represent a stress-related illness, an exacerbation of an underlying chronic illness, or some type of somatization for which no physiologic abnormalities can be found. Experienced primary care physicians are aware of "red flags" that indicate the need for more complete exploration of the problem. These red flags may include stress-related symptoms (e.g., chronic headaches), unexplained or inconsistent physical symptoms, the patient's mood, or who accompanies the patient to the visit. In these situations the physician might ask the patient, "Have you had to deal with any recent changes or stresses at home?"

A few other simple questions can be used to assess the **family** context quickly. "How has this problem

affected you and your **family**?" allows the physician to assess the impact of the illness on the patient and **family**. **Family** health beliefs can be explored by asking, "What does your **family** think may have caused or could treat this problem?" "How could your **family** be helpful to you in dealing with this problem?" or "What suggestions have **family** members made to you about this problem?" can begin the discussion of how to use **family** members as a resource. By being alert to red flags and addressing routine **family** assessment issues, the physician can begin to assess the situation effectively and efficiently.

Use Genogram for Family Assessment

The genogram, or **family** tree, is the most basic and useful tool in family-oriented primary care. It is a simple method for obtaining and recording basic **family** information that provides a visual record of the **family** ^[16] (Fig. 6-2). Although similar to the **family** pedigree, used to obtain **family** histories of genetic diseases, the genogram also provides information about **family** structure, relationship patterns, developmental issues, life cycle stages, and stressful life events. Fig. 6-3 shows the genogram of the Goldner **family**. Glancing at a patient's genogram gives the physician a "snapshot" of the patient's context and the **family** issues that may be relevant to that visit.

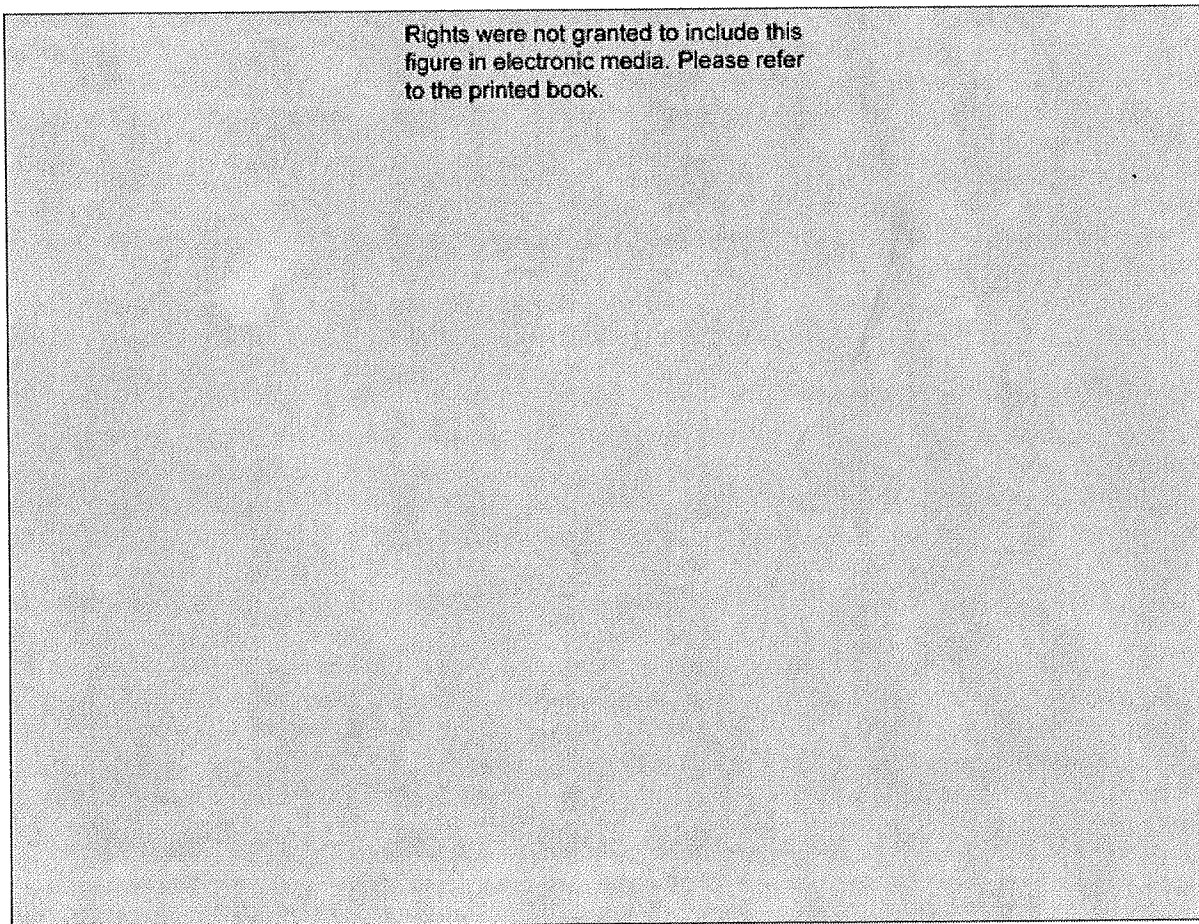


Figure 6-2 Genogram format. (Redrawn from McGoldrick MSW, Gerson R: *Genograms in family assessment*, New York, 1986, Norton.)

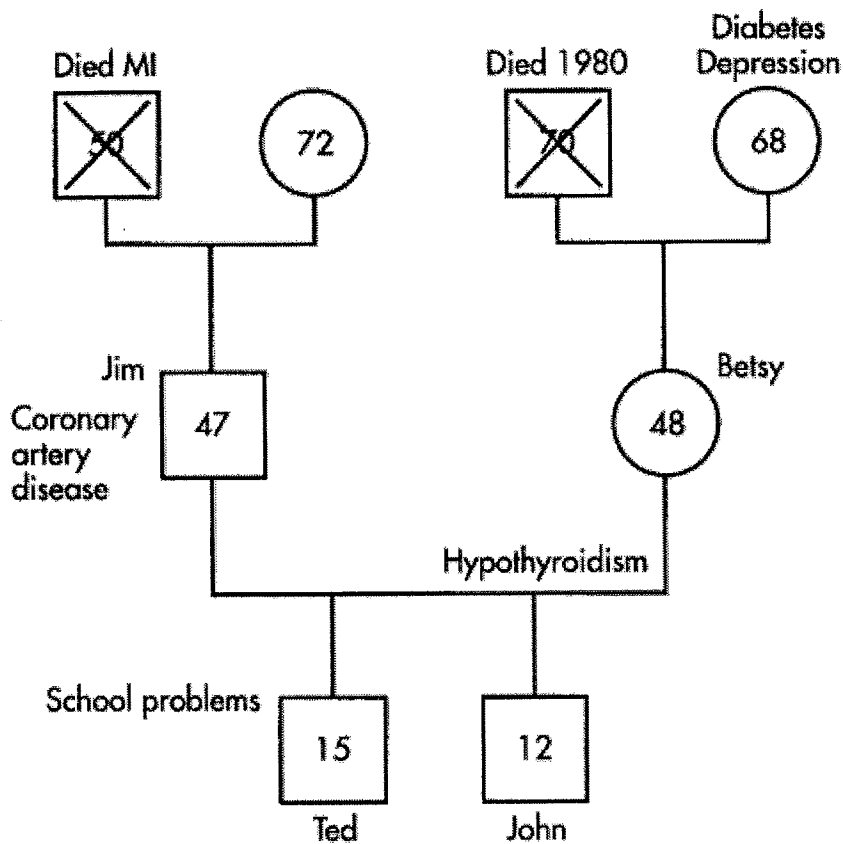


Figure 6-3 Goldner family genogram.

Many family-oriented physicians do a brief, skeletal genogram as part of the **family** and social history during the initial visit or physical examination. With practice, such a genogram can be obtained in less than 5 minutes and added to on subsequent visits. Patients are usually comfortable with providing **family** information and helpful in constructing the **family** tree. The genogram shows the patient that the physician is interested in all aspects of the patient's life. It also helps the physician to identify risk factors for inherited diseases and other problems. When the genogram is obtained as a part of routine practice, patients are more likely to reveal sensitive and important **family** issues, such as substance abuse or domestic violence.

The genogram is also helpful in caring for difficult and frustrating patients with complex medical problems. Little may be known about these patients' **family** and context. Using one appointment or 15 minutes to obtain a more detailed genogram can provide useful data about these patients and their problems. The genogram can help the patient and physician begin the gradual shift from a narrow focus on physical symptoms to a broader view of the patient's life circumstances.

*Jim's condition stabilized in the ICU, and he underwent cardiac catheterization, which showed distal narrowing in a branch of his left anterior descending coronary artery. During visits to the ICU, Dr. C began to talk with Jim about the events that precipitated his MI and about his cardiac risk factors. Dr. C obtained a more complete genogram related to heart disease in Jim's **family**. In the process, Jim talked about his conflict with his father and how Jim's father had dealt with his heart disease. Jim agreed to meet as a **family** with Dr. C to discuss his illness and how his **family** could help.*

Explore Family's Developmental Challenges and Stresses

With the genogram and the ages of **family** members, the primary care physician can obtain a good sense of what developmental issues the **family** is likely to confront and whether these normative stresses are affecting

the health of **family** members. The **family life cycle** is a useful conceptual framework for understanding **family** development. [5] Similar to the individual life cycle, the **family life cycle** assumes that **families** go through different stages for which specific developmental tasks must be accomplished. **Families** who do not accomplish these developmental tasks at one stage may develop difficulties with subsequent **family** development. For example, some **families** have difficulties allowing young adult members to establish personal autonomy and independence. Young women sometimes become pregnant as a way to separate from their parents and start their own **families**. These women experience enormous stress as they try to live on their own, form an intimate relationship with a partner, and raise a child, all at the same time. They are at high risk for developing physical or emotional health problems.

Many normative **family** life transitions can be very stressful and can precipitate or exacerbate health problems. Many women and some men in their 40s are faced with the demands of caring for elderly and disabled parents while raising young children. The genogram allows the physician to identify quickly and explore these types of developmental stressors.

Dr. C was aware of many developmental stresses faced by the Goldner family. The most immediate was their fear of Jim's premature death or disability. His wife was particularly concerned about whether he could return to his work as an automobile sales manager, which was very stressful. Ted's struggles to develop a sense of autonomy within his family and peer group was an obvious source of ongoing stress. Betsy's father had died 5 years previously, and her mother was declining physically and emotionally. Jim and Betsy had been contemplating whether to have her mother move in with them or find a supervised apartment for her. Betsy had recently gone through menopause and was concerned whether Jim still found her physically and sexually attractive.

Meet with Family Members

For many health problems, it may be helpful to meet and consult with a **family** member during a regularly scheduled office visit. Research has shown that **family** members often accompany the patient to the medical office, either remaining in the waiting room or joining the patient in the examination room. In the Direct Observation of Primary Care study, Medalie et al [17] evaluated the content of more than 4000 office visits to 138 **family** physicians. They found that another **family** member was present during 32% of visits, most often when the patient was a child under 13 (97%) or elderly (25%) but also 12% of the time with adult patients. Overall, another **family** member's health problem was discussed at 18% of these visits. Botelho et al [2] found that 39% of patients came to a **family** medicine center with a **family** member or friend and that two thirds of these accompanied the patient into the examination room. In a study of **family** practices in Ontario, one third of patients were accompanied by a **family** member or friend, who was usually described as an advocate for the patient. [3] This research documents that **family** members frequently accompany patients into the examination room or are present in the waiting room.

Meeting and consulting with **family** members during a routine visit can be helpful whenever the health problem is likely to have a significant impact on other **family** members or when **family** members can be a resource in the treatment plan. The most relevant **family** member for adult patients is usually the spouse. Inviting the partner or spouse to accompany the patient should be considered with (1) diagnosis of a serious condition during a chronic illness, (2) noncompliance with treatment recommendations, (3) somatization or unexplained medical symptoms, and (4) health problems that have a significant interpersonal component (e.g., marital problems, sexual dysfunction).

Involving **family** members in a routine medical visit rarely takes extra time. Visits may even be more efficient when a **family** member can provide important information about the health problem. The examination or consultation room must have an extra chair for the **family** member.

When a patient has a complaint related to an interpersonal problem, the physician tends to support and empathize with the patient, inadvertently taking sides in the conflict. The challenge for the primary care physician working with **families** is to maintain a positive relationship or alliance with each **family** member and avoid taking sides in any conflict or problem, except when the patient's safety is at risk. The physician must avoid blaming other **family** members or siding with the patient against another **family** member. To listen

repeatedly to a patient complain about another **family** member is similar to only prescribing pain medication for a peptic ulcer; the patient feels better acutely while the underlying problem worsens. Meeting with the patient and other **family** members can help the physician avoid taking sides in a **family** conflict and maintain positive relationships with everyone involved.

Meet with Extended Family

Although the primary care physician can use a family-oriented approach while seeing an individual patient or meeting with **family** members during a routine office visit, at times it is helpful to convene the entire **family** for a more extended **family** conference. The decision to convene a **family** conference usually depends on the seriousness of the health problem and its impact on the **family**. During a hospitalization the physician should meet with the **family** at least twice, on admission and shortly before discharge. **Family** members can often provide valuable information about the events leading up to the admission, and they want information about the patient's medical condition. Before discharge the physician can review the course of the hospitalization and the plans for outpatient care and can elicit any **family** concerns about the patient returning home. This latter visit recognizes that the **family** usually must assume care of the patient after discharge.

It is particularly important to meet with the **family** when the diagnosis of a terminal illness is made or when a patient dies. **Family** members are often in a state of shock and need information and support. Because of the strong emotions surrounding death in a **family**, often a high degree of denial can interfere with effective communication and the sharing of feelings. Death is often viewed as a failure by the physician and is often accompanied by feelings of guilt. This guilt may result in the physician avoiding the **family** when it is most important for both parties to meet. Physicians should routinely see **family** members for follow-up during the first 6 months after a loss.

*Dr. C met with the entire Goldner **family** before Jim left the hospital. He reviewed the events at the hospital and the treatment plans. At Dr. C's request, Betsy participated in the hospital cardiac rehabilitation program with her husband and agreed to continue as an outpatient. She went to the informational lectures and even used the treadmill to experience the exertion her husband could safely tolerate. The couple met with the hospital nutritionist to review Jim's diet, and they agreed to work together to help Jim stop smoking. Dr. C met with the couple alone to discuss how to resume their sexual activity. He made an appointment for outpatient follow-up for 1 month.*

*At the follow-up visit, Jim was doing well. He was actively participating in the cardiac rehabilitation program and had not smoked any cigarettes. Betsy was concerned, however, that Jim was doing too much physical activity too soon. He had returned to work full time and had put up the storm windows on their house the previous weekend. Jim complained that Betsy was always nagging him to "take it easy" and telling what he should and should not do. Dr. C helped the couple to negotiate a compromise. Jim agreed to cut back on some of his activities that were excessive and frightening his wife, and Betsy agreed not to monitor Jim's behavior. They agreed to return as a **family** in 1 month.*

Assess Levels of Working with Families

When working with **families** in primary care, physicians should determine their level of involvement. As in other primary care areas, physicians must decide what level of skills and knowledge they have or want to have in a particular area. For example, when treating cardiac patients, physicians must decide whether they have the skills and interests to treat complicated post-MI patients in the ICU or whether they want to limit treatment to outpatient care of uncomplicated cardiac problems and refer other patients to a cardiologist.

Doherty and Baird^[9] have outlined five levels of physicians' involvement with **families** and the knowledge, personal development, and skills needed for each ([Box 6-1](#)). This classification was developed to recognize that all physicians work with **families** at some level and that some problems require the expertise of a trained **family** therapist. Most primary care physicians usually work at level two, providing ongoing medical information and advice to **families**, and level three, eliciting feelings and providing support to **families**. Level four, performing systematic assessment and planned intervention, usually requires additional training in

family systems theory and its application. At this level, physicians can provide brief and focused primary care **family** counseling for uncomplicated **family** problems. More complex and chronic **family** problems demand **family** therapy, a specialty service that requires 3 to 5 years of training and supervision and that is beyond the interest and training of most primary care physicians.

Box 6-1

Levels of Physician Involvement with Families *

Level One: Minimal Emphasis on Family

The baseline level of involvement consists of dealing with **families** only as necessary for practical and medicolegal reasons, but not viewing communication with **families** as integral to the physician's role or as involving skills for the physician to develop. This level presumably characterizes most medical school training, in which biomedical issues are the sole conscious focus of patient care.

Level Two: Ongoing Medical Information and Advice

Knowledge base

Primarily medical, plus awareness of the triangular dimension of the physician-patient relationship

Personal development

Openness to engage patients and **families** in a collaborative way

Skills

1. Regularly and clearly communicating medical findings and treatment options to **family** members
2. Asking **family** members questions that elicit relevant diagnostic and treatment information
3. Attentively listening to **family** members' questions and concerns
4. Advising **families** about how to handle the patient's medical and rehabilitation needs
5. For large or demanding **families**, knowing how to channel communication through one or two key members
6. Identifying gross **family** dysfunction that interferes with medical treatment, and referring the **family** to a therapist

Level Three: Feelings and Support

Knowledge base

Normal **family** development and reactions to stress

Personal development

Awareness of one's own feelings in relationship to the patient and **family**

Skills

1. Asking questions that elicit **family** members' expressions of concerns and feelings related to the patient's condition and its effect on the **family**
2. Empathically listening to **family** members' concerns and feelings, and

normalizing them where appropriate

3. Forming a preliminary assessment of the family's level of functioning as it relates to the patient's problem
4. Encouraging **family** members in their efforts to cope as a **family** with their situation
5. Tailoring medical advice to the family's unique needs, concerns, and feelings
6. Identifying **family** dysfunction, and fitting a referral recommendation to the family's unique situation

Level Four: Systematic Assessment and Planned Intervention

Knowledge base

Family systems

Personal development

Awareness of one's own participation in systems, including the therapeutic triangle, medical system, one's own **family** system, and larger community systems

Skills

1. Engaging **family** members, including reluctant ones, in a planned **family** conference or a series of conferences
2. Structuring a conference with even a poorly communicating **family** in such a way that all members have a chance to express themselves
3. Systematically assessing the family's level of functioning
4. Supporting individual members while avoiding coalitions
5. Reframing the family's definition of their problem in a way that makes problem solving more achievable
6. Helping the **family** members view their difficulty as one that requires new forms of collaborative efforts
7. Helping **family** members generate alternative, mutually acceptable ways to cope with their difficulty
8. Helping the **family** balance their coping efforts by calibrating their various roles in a way that allows support without sacrificing anyone's autonomy
9. Identifying **family** dysfunction that lies beyond primary care treatment, and orchestrating a referral by educating the **family** and the therapist about what to expect from one another

Level Five: Family Therapy

Knowledge base

Family systems and patterns whereby dysfunctional **families** interact with professionals and other health care systems

Personal development

Ability to handle intense emotions in **families** and self and to maintain neutrality in the face of strong pressure from **family** members or other professionals

Skills

The following is not an exhaustive list of **family** therapy skills but rather several key skills that distinguish level five involvement from primary care involvement with **families**.

1. Interviewing **families** or **family** members who are difficult to engage
2. Efficiently generating and testing hypotheses about the family's difficulties and interaction patterns
3. Escalating conflict in the **family** to break a **family** impasse
4. Temporarily siding with one **family** member against another
5. Constructively dealing with a family's strong resistance to change

6

Negotiating collaborative relationships with other professionals and other systems who are working with the **family**, even when these groups are at odds with one another

* From Doherty WJ, Baird MA, editors: *Family-centered medical care: a clinical casebook*, New York, 1987, Guilford.

Deciding whether to treat a **family** or marital problem with primary care counseling depends on the physician's interests, expertise, and availability. The physician who does not have the interest, time, or additional training in **family** counseling should refer these problems to a skilled therapist. Many **family** physicians, however, find these problems interesting, challenging, and enriching to their practice and want to counsel **families**. [15] [Box 6-2](#) shows the types of problems that typically can be managed in primary care counseling and those that usually require consultation and often referral to a mental health professional.

*Dr. C met with the Goldner **family** again 3 months after Jim's heart attack. For the first few weeks after Jim's return from the hospital, Ted had been on his best behavior, not wanting to upset his father. As Jim resumed his usual activities and returned to work, however, Ted resumed his previous behaviors, and the arguments flared up again. Dr. C explored the problem with the Goldners, asking each about the issues. He recognized that the **family** problems were serious and longstanding. It was clear that Ted was abusing alcohol and perhaps drugs and would need further evaluation. Dr. C also suspected that Ted's behavior had kept his parents' focus on him and that they were not dealing with serious underlying marital problems.*

*Dr. C recommended that the Goldners see Dr. M, a psychologist and **family** therapist with whom Dr. C often collaborated. Dr. C explained that he thought their issues were serious,*

could affect Jim's health, and deserved treatment by an expert in **family** relations. Because Dr. C had established their trust during Jim's hospitalization, they agreed to see the **family** therapist. An appointment was made with Dr. M while they were in the office, and a follow-up appointment was made with Dr. C for several weeks after that.

Box 6-2

Problems Addressed in Primary Care and Referred to Specialists

Problems Typically Seen in Primary Care Counseling

- Adjustment to diagnosis of new illness
- Other adjustment or situational disorders
- Crises of limited severity or duration
- Behavioral problems
- Mild depressive reactions
- Mild anxiety reactions
- Uncomplicated grief reactions

Problems Usually Referred to Mental Health Specialist

- Suicidal or homicidal ideation, intent, or behavior
- Psychotic behavior
- Sexual or physical abuse
- Substance abuse
- Somatic fixation
- Moderate to severe marital and sexual problems
- Multiproblem **family** situations
- Problems resistant to change in primary care counseling

Many **family** and marital problems are too chronic, complex, or time consuming for the **family** physician to counsel. These problems necessitate referral to a marriage and **family** therapist. [14] [18] This specialty requires several years of supervised training after residency. Unlike the medical specialists whom **family** physicians meet and work with in the hospital, skilled therapists are not as easily found in the community. The most frequently used method for finding a good therapist is to ask respected colleagues whom they use and why. The American Association of Marriage and **Family** Therapy, the accrediting organization for **family** therapists, issues a directory of certified **family** therapists by city. Perhaps the most useful way to find a good and trusted therapist in the community is to arrange face-to-face meetings with several recommended therapists to learn about their interactive approaches, their theoretic orientations, and their interests and experience in interfacing with the medical system.

Counseling for referral is an important skill for primary care physicians to learn. It involves identifying key problems faced by the patient and **family**, including as many **family** members as reasonable in clarifying a desire for change, and contacting the appropriate family-oriented mental health professional. Patients are more likely to follow through on such referrals if the physician knows the professional by name. The physician should clarify the collaborative relationship with the therapist and that they will work as a team to provide care for the patient and **family**.

When referring a patient, couple, or **family** to a therapist, it is helpful to consult the therapist early in the process to share ideas and strategies and clarify the consultation or referral question. If the referral is the physician's idea rather than the patient's, it is often necessary to maximize the patient's motivation to see the therapist. Using the patient's language and understanding of the problem can help pitch the referral. Referring for an "evaluation" or "consultation" is

usually more acceptable than for "**family** therapy." Some patients hear a referral for **family** therapy as meaning that their **family** is bad or in some way responsible for the current problem. Having the patient make the appointment with the therapist while still in the physician's office can also help facilitate the referral. With reluctant, difficult, or somatizing patients, a joint session with the therapist may be extremely helpful in facilitating a referral.

The timing of a referral to a therapist is important. With some patients and **families**, it may take months or years to reach an agreement about a therapy referral. After the couple or **family** members have gone for consultation or ongoing therapy, the referring physician must communicate regularly with the therapist and inform the patient and **family** that the physician will continue to see the patient and collaborate with the therapist. Regular communication between the physician and psychotherapist helps avoid confusion or triangulation and facilitates clear treatment planning and division of labor.

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