Chapter 14

PRACTICE—A Family Assessment Tool for Family Medicine

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A family assessment form has been designed for use in assessing the function of the family as a unit. It is based on a systems approach and acts as a guide and a record for a family interview. The acronym PRACTICE denotes its use by family physicians and nurses, and is a reminder that repeated practice will develop and improve skill in family assessment.

The components of the PRACTICE schema are as follows:

Presenting problem or reason for interview (illness, hospitalization, behavioral or relationship problems).

Roles and structure. Included are hierarchical organization, boundaries and individuation, cohesion (from disengagement to enmeshment), and control (from chaos to rigidity).

Affect (emotional expression) family emotional tone (warmth, sadness, anger, humor).

Communication (verbal and nonverbal).

Time in the family life cycle. The dynamics of developmental stages are experienced differently by each family and may influence the occurrence and response to illness.

Illness in the family past and present. Usually the focus in family practice is on the illness, which may be the presenting problem masking dysfunction in the family unit. Past experience of illness, especially if frequent or serious, will modify response to illness in the present. The meaning of illness, health belief system, health practices, and lifestyle are also determined by the family.

Coping with stress (adaptability, family strengths and resources, coping in past and present).

Ecology and culture (interaction of the family with the environment). Social, cultural, religious, economic, educational and medical resources (SCREEM).[26]

(1)

An Educational Tool

The variables chosen have been derived from research on the healthy family[2,22] and from literature on family therapy based on systems theory.[10,20] It has been found useful to associate these assessment variables in an acronym to aid health professionals, particularly residents in family medicine and nurses in training, and to remind them of the various aspects of family function. Once skills in family assessment are fully developed, these forms like other such learning tools may be discarded. The insertion of forms in a patient's file does not necessarily imply good patient care; an informal approach may well be the best. However, it has been our experience that these forms provide a needed transition and structure for the learner and are a convenient means of recording and communicating family data.

The form should not be taken into the interview and filled out sequentially as a check list. The interviewer may or may not want to take notes during the family meeting, but the sections of the form should contain a one- or two-sentence impression of each aspect of family function. (For example, under the heading, Affect, the clinician might write the following: "Family very depressed, unable to respond to jokes or attempt to lighten atmosphere. Denied anger at anyone."; or under the heading, Roles: "Father very rigid, apparently makes all decisions. Mother lenient, undermining. Chaotic interview. Masked conflict between parents."

A list of family members present and absent from the interview should also be included. It should be remembered that it is often difficult for beginners to obtain a family's agreement for and cooperation during an interview. Some members may fail to show up; others may persistently give work or school as excuses for not coming, even when appointment times are flexible enough to accommodate late afternoon or evening hours. The more experienced professional has less difficulty with compliance, partly because his or her conviction that a family interview will be helpful may be greater than the beginner's, partly because he or she will not convey the discomfort of the beginner with such an interview to the family.

A family interview may be seen as very threatening or unusual; that it is a nonthreatening and routine part of care can be conveyed by phrases such as "I usually like to see the whole family if anyone is seriously ill or hospitalized to clear up any questions or worries anyone might have," or "I would like to see your husband too next visit as he may be able to give his perspective and help with your depression." If one or two family members are missing from the interview, despite originally agreeing that they would come, proceeding with the family assessment risks inaccurate data. A member who has not participated in the interview may cause difficulties later. Permitting members to miss the interview may allow the family to leave the problem at home. The missing member is often the most outspoken. In family therapy, the missing

member often represents the family's resistance to a family approach and may undermine the process if allowed to remain absent.

Much of the information needed to complete the form may be derived from the discussion of the presenting problem. For this discussion, if the interviewer is skillfull in having the family discuss the issue among themselves rather than answer his or her questions, communication patterns, the roles and structure of the family, and general emotional tone will become apparent. Some idea of the family's strengths and coping and its use of resources will also be conveyed.

Depending on the complexity of the presenting problem, and on the goals of the meeting, the interview and completion of the form can take anywhere from 15 minutes to an hour and a half; experience produces efficiency. An expert can recognize, in the first 5 minutes of the interview, behavior patterns indicative of family structure and themes that will be subsequently repeated. The way the family handles a current problem will tend to be typical of its ability to handle other problems. It has been shown that almost 75% of the information in an individual interview for a medical problem is obtained in the first 10 minutes;[3] similarly, most information about the family is available early on in a family interview if the interviewer is trained to perceive it.

Assessment, A Prerequisite for Action

Family intervention without assessment is like treatment without diagnosis. Assessment, diagnosis, and management are inextricably interwoven; to manage illness or maintain health in the family context means to understand the structure, function, development, and approach to health and illness of that particular family.

For a given problem, assessment of one or more of the items covered in the acronym PRACTICE is important for successful intervention. Rarely do all aspects need assessment. For example, in improving dietary compliance in diabetes the family's roles and structure ("R" in PRACTICE) and their experience with illness and their health belief system ("I" in PRACTICE) determine who does the shopping and cooking, who has the power to influence compliance (positively, or negatively if it produces rebellion), and whether the family believes diet will alter the course of the disease. Affect, communication, time in life cycle, coping, and the environment may be of little relevance to this particular problem.

P—PROBLEM

In identifying the problem of a family, an important step is the art of joining with the family system (see Chapter 12, Joining). The interviewer encourages family interaction, by asking about the presenting problem

and testing the family's communication and affect (emotional expression). Particular attention is paid to the mood of the family—whether the family is cheerful, angry, or unhappy. The family's mood is important when the clinician attempts to enlist its cooperation in solving the problem. Family organization and hierarchical structure as well as repetitive sequences of behavior will be noted. Previous attempts at problem resolution should be explored.[31] Thus, information on roles, affect, and communication and coping are often derived from discussion of the problem.

At the beginning of a family assessment the clinician elicits the family's description of the problem(s). The problem may be a physical illness that is causing family difficulties or is suggestive of a broader family problem contributing to the illness. Since the couple is the source of the family system's rules and functioning, they are assumed to be central; conflicts in other parts of the system are often displaced from an unrecognized or hidden problem in the couple. Conflict may be over *practical problems* ("instrumental"), such as money, roles, school and work difficulties, problems of *physiological control* (enuresis, encopresis); or problems of an admitted *emotional nature* ("affective"), such as marital conflict, sexual dysfunction, behavioral problems, and difficulty with the expression of negative or positive emotions. Instrumental and affective problems often co-exist; however, when only one area is a problem, its correction is less difficult.[10] During the stage of problem identification, attention is paid to the question of who identifies an issue as a problem. Is there consensus on the part of the other members or disagreement? Is there evidence of displacement? Is it an individual or a family problem? Has the time of onset been recent or has the problem been present for a long period? Is this the only problem? Often a child is labelled as *the* problem, but questioning about the existence of difficulties in other members may elicit a long list.

Similar to questions concerning physical symptoms, such as pain, the following questions may help make the diagnosis: Who is the identified patient in the family? (analogous to: Where is the pain?); Does the problem affect anyone else in the family directly or indirectly?; Are there any other problems? (Does the pain occur anywhere else in the body or radiate elsewhere?); When did the problem start *exactly*? (When and how did the pain start?); Under what circumstances? Has there been a new arrival in the family, death or illness elsewhere in the family?; What made the problem better or worse? For example, a son's conflict with a mother always became better when the father was away. What solutions have the family tried? (What medications have been tried with what results?) Family solutions (such as skin creams, or laxatives for appendicitis), often make the problem worse. Is the problem simply a normal aspect of living with others? Can the family understand it and solve it alone without exaggerating it into a real problem? (If the symptom is not serious, (eg., hyperventilation), does the patient understand it well enough

to prevent recurrence?). Will the family agree to look more closely at the problem through family therapy if the problem is serious and this is required, or is it asking only for symptomatic treatment? (If drastic measures like surgery or long-term medication are needed to stop the pain, will the patient comply?) Does the family understand the treatment and its side effects? Family therapy is successful in two out of three cases[11,31] but may be painful (like surgery) as well as productive of growth for individuals *and* family; Is the therapy available locally, or must the family go elsewhere? A family with an anorectic child may request and be able to afford a visit to Minuchin or a local expert on "psychosomatic families." A rural family may have no one but the district nurse or family physician to turn to. Such a clinician may have to attempt therapy despite inadequate training, or become better trained. Death from anorexia or alcoholism may occur where there are no facilities.

The patient's refusing treatment allows the disease to take its natural course: the patient may recover, become chronically ill, or die; families are often able to recover from even serious dysfunction, they may choose to live unhappily or with continuing secondary physical illness, or they may dissolve through divorce, estrangement of children, or death of a family member. Patients may effectively refuse treatment by doctor shopping. Similarly, for some families therapy is a way of life: each member may have his or her own therapist or several therapists. Like the dissatisfied individual patient who shops around, such families may be turning away from professionals who have failed to reach a correct diagnosis and are treating a symptom rather than the family distress that gives rise to it. Professionals may be failing to communicate or hold opposing opinions on treatment. The family physician may recommend family therapy while the school doctor or nurse has referred the child to psychiatry.

Sometimes more than one interview is required to clarify the issues. However, in using PRACTICE with the average family the clinician should be able to obtain a maximum of information in the first interview. After the interview, the clinician should be able to grasp the problem and decide with the family on the type of intervention (education, anticipatory guidance, support, facilitation, or referral). An important dimension of assessment is knowing when and where to refer a family for therapy; however, families who are in serious need of change and need family therapy by experts for the survival and sanity of their members are a relatively small percentage of the average practice.

If a family is able to use the information obtained from the family assessment to change itself, it is not in need of therapy. The benefit of the diagnostic impression given to the family by the health professional is that the family is given a broader perspective from outside the system and is able to relabel problems in a constructive way. For example, a twenty-year-old woman's noncompliance with asthma medication might be restated as a

mistaken way of telling her mother she needed more age-appropriate autonomy. The mother's overcontrol of her dating and higher education may be described as the natural maternal response to that last child leaving home, particularly when father is away all the time and yet does not want her to work. In the presence of the father, the suggestion that his workaholism might be related to the wife's refusal to do things alone with him, will make this restatement of the situation more effective. If the health professional correctly understands the role of the presenting problem in family dysfunction and is able to communicate his or her understanding to the family, the family may be able to initiate changes in the behavior leading to the symptom. The clinician must speak tactfully, indicating ideas as impressions rather than facts; diagnostic error is always possible. Error is less likely if the professional has successfully empathized and joined with all family members and is not covertly or unconsciously protecting a "victim." Such a stance would betray nonsystemic thinking and hence an incomplete family diagnosis.

R—ROLES

Accurate perception of the de facto roles, structure, and organization of a family is a difficult and challenging part of assessment, but the effort expended frequently provides a clue to the role of illness. If, for example, the husband is controlling and dominant and forbids the wife to work outside the home, the wife may express loneliness, boredom, and tension by developing an illness. This unconscious solution on the wife's part effectively corrects the lack of companionship and the balance of power since the sick, "weak" family member can control the attention and activities of family members through illness. The "sick role" is of obvious importance to the clinician (see Chapter 20).

Clear hierarchical organization is necessary for the healthy functioning of any system (see Chapters 1 and 2). The locus of power in a family is determined by who makes the important decisions, which is often a function of who controls the family's income. Power may be indicated by the greater talkativeness of one spouse, or by a spouse's ability to have the last word or to undermine the other spouse's decisions by nonverbal means. Democratic, flexible decision-making by both spouses who have an approximately equal say in major decisions, and who have clearly allocated responsibility for the minor ones, appears to work best in North American culture.

If the most powerful member of the family is not present during the interview, the assessment of the power structure will not only be incorrect, but management decisions made with the clinician may not be carried out or may be undermined: if the grandmother has the final say in family matters but was left out of the interview because she lives next door or in the apartment upstairs, a sick member's compliance with prescribed medication or diet may

be very poor. The grandmother may even persuade the family to use the herbalist across the street instead. It should, therefore, be ensured that all effective members of the family system are present if a family interview is indicated, even if this results in a rather crowded office.

Roles cause no problem if they are clear and accepted by all members of a family. If the family defines roles in such a way that conflicts exist with the surrounding social structure, as is the case in many immigrant families, problems result. Roles can be divided into two categories: instrumental and affective. Who does the breadwinning or the dishwashing are instrumental role assignments; whom the child runs to when hurt and whom the mother turns to for comfort when depressed indicate affective roles.

Role allocation and role accountability may be decided implicitly or explicitly by dictum or open discussion. Role satisfaction results when male and female role expectations match the actual roles, and correlates highly with marital outcome.[5] When role expectations change too quickly for adaptation to occur, as is happening in Western culture as a result of the women's liberation movement, or when an individual family moves from one culture to another with very different expectations, role strain and role conflict may result.

Effective behavioral control can only be expected when rules are clear, rewards and punishments are consistent, and parents are in basic agreement. Parents whose own parents were poor role models or who are in covert conflict with one another may exert no effective control; the result is chaos. Poor discipline that allows children to play with equipment in the doctor's office, to interrupt, or to leave the room are obvious clues. At the other extreme, one or both parents may be intolerant of normal childhood exuberance, and their rigid control will be revealed by the timidity or immobility of the family's children or by their covert or overt rebellion. Anorexia nervosa, enuresis, misbehavior or failure in school, or poor compliance with prescribed medication regimens may all be responses to such tight control. Such families may exhibit little tolerance when efforts towards individuation become manifest as the children reach adolescence.

The healthiest pattern, at least for North American families, is clear parental authority that allows increasing flexibility and age-appropriate autonomy as the children mature. Gordon[10] has labelled the three styles of parenting as authoritarian (parent wins), permissive (child wins), and negotiatory ("no win, no loss"). During a child's adolescence, the authoritarian style promotes rebellion, or timidity and repressed anger (the child may hate the parent), the permissive style produces obnoxious, "spoiled" children (the parent may end up hating the child), and the negotiatory style allows a slow, progressive increase in freedom *and* responsibility.

The degree of individual autonomy allowed in a family is a useful measure of health. Families at the two extremes of cohesion (enmeshment and

disengagement) are those most subject to pathology. A balance of autonomy and mutuality, deficient in enmeshed and disengaged families, respectively, is essential for individuation, the development of identity, self-esteem, maturity and health. Enmeshed families have blurred boundaries and are overinvolved with and overprotective of one another. Stress to one member reverberates through the system because every member is excessively responsive to every other. Roles tend to be confused; there is a lack of autonomy and independence:

> In one family with five children, the mother had bulimia, anorexia, and colitis. All family members took turns accompanying her to the bathroom because of diarrhea and vomiting. The 9-year-old girl with enuresis was advised and taunted by the other members of the family, who knew all the details of her doctor's visits and looked in her dresser to see her chart of dry and wet nights. The mother accompanied even older adolescents on their visits to the doctor, and all family members read each other's diaries and listened to telephone conversations.

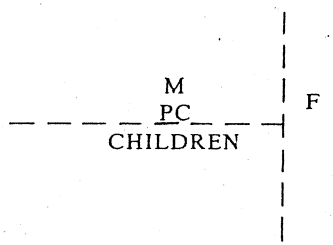
In such an enmeshed family, triangulation is a common occurrence and conflict is never resolved between two individuals without a third becoming involved. There is an emphasis on love and affection but true intimacy and honesty are absent since conflict tends to be avoided or detoured through another member. In contrast, disengaged families lack a sense of belonging and a capacity for interdependence. Boundaries are rigid and individual members have maximum autonomy but provide little support for each other when in difficulty. There is tolerance for a wide variation in behavior and stress has little effect on the family as a whole. There may be no response even when one is needed (as in the case of a delinquent child whose behavior was largely ignored by the parents until the police intervened). The children become adults with little ability to form satisfactory relationships.

Family structure can be illustrated graphically in one of two ways: by the family tree (genogram) particularly as developed by Bowen (see Chapter 11); or by family mapping.[20] Elaborate symbols can be used in the genogram to indicate triangulation, and close and conflictual relationships; or marginal notations regarding the character of individuals and the nature of their relationships can be made on the regular genogram. Boundary lines (around members of a household) and double or dotted lines (for close and conflictual or distant relationships respectively) can be added where important. The advantage of obtaining a detailed family tree has already been described (see Chapter 11).

Family roles can be diagrammed using Minuchin's method of "mapping" the family. This technique gives added information about the family hierarchy in the current family, but says nothing about the family of origin. It has the advantage of indicating the power structure and relationships by a special arrangement of symbols. In a map of the family,[20] the letters M, F, G, C, and PC

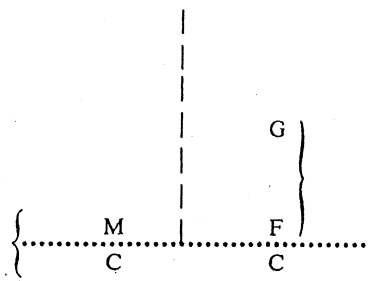
represent Mother, Father, Grandparent, Child, and Parentified Child, respectively. The symbol for the strongest member of the family is put at the top of the diagram.

For example, a family with a frequently absent father, a mother, and "parentified" child and two other children would be diagrammed as follows:



The same family, if reorganized into more satisfying relationships would be represented by:

A family with a dominant grandmother, a weak parental subsystem, a coalition between the father and his mother, and between the mother and her child would be represented by:



Symbols used include the following:

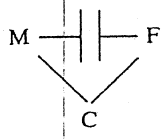
Boundaries: clear; diffuse; rigid, closed

Affiliation:

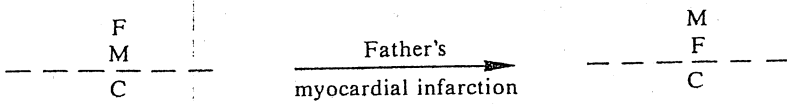
Overinvolvement:

Conflict: Coalition: Detouring:

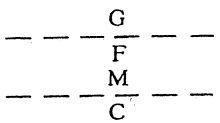
The "scapegoated" or "triangled" child with conflict avoidance in parents can be diagrammed as:



Diagrams can indicate change following illness, as in:



or



A—AFFECT (EMOTIONAL EXPRESSION)

Healthy families are capable of expressing a wide range of emotions, both positive and negative. If one emotion not only predominates but is used even when another would be more appropriate, the family may be in considerable difficulty. Individual members of a family may differ in their individual abilities to express both positive and negative emotions as appropriate. The presence of emotion in a family member, whether overt or covert, and also to whom it is directed should be noted. One member may be assigned the role of expressing anger or sadness for everyone, relieving the others of the need to express this emotion by giving a clue to how they may feel underneath. If one person is crying or very angry it is useful to enquire if others are feeling the same way. Children, particularly, frequently express the feelings of a parent, often the one of the same sex. An argument or fight between children often parallels a parental conflict.

Awareness of the characteristic emotional tone and observation of the family's ability to change this tone when challenged is important in family assessment. The family that can show a wide range of affect in one interview usually has a good prognosis for coping with stress.

Culture has a vast influence over the acceptability of different emotions or of their open expression; the tone of the interviewer, as well as his or her cultural or social class and language origin, influences the family. If the interviewer has difficulty recognizing or accepting emotions like anger, depression, or physical demonstrations of affection, the family will behave in a restrained manner for the sake of the professional.

Assessment should not imply value judgment. Family atmospheres vary widely in families who function well. Openness of expression may be overvalued by family professionals in North America. To impose the values of the family therapy movement or to be judgmental can be presumptuous, invasive of other persons' values, and unethical; however, to assess a family and predict coping ability is not to judge them. Empathy with the family precludes judgmental approaches; unconditioned regard for the family safeguards the principle that the clinician must not do any harm. A clinician's persistent dislike of one or more family members should suggest to him or her that transferring the family to another professional would be best. The systems approach facilitates empathy for all members of a family and decreases the likelihood of such dislike.

Empathy with the family can itself facilitate expression of emotion. Even a single interview can be helpful, especially at a time of crisis such as the terminal illness of a family member. Expression of repressed emotions, with the encouragement of a trusted professional, can result in a permanent change in the closeness and communication of that family. So often a clinician, afraid of releasing anger or sadness, ignores clues (tears in the eyes or a break in the voice) indicating stress that can be transformed by a brief comment into much needed emotional release.

C—COMMUNICATION

Communication is so important an aspect of functioning that many therapists[24] base assessment and treatment on this area almost exclusively. As in any system, health depends on both effective communication and effective hierarchical control (see Chapter 2).

Communication is the process by which people convey messages to each other. Expression of emotion and effective social communication are linked, but clarity of communication implies the transfer of information in a form that results in the correct message being received. Messages may be verbal or nonverbal and are usually a mixture of both in direct face to face contact. All families have their own patterns or methods of communicating. In family therapy, communication is described as being "direct" or "displaced" and "clear" or "masked." Four different ways in which a husband may communicate anger to his wife can be seen in the following examples:[12]

Clear and Direct:	"I am angry at you!" (said to the wife)
Masked and Direct:	"I don't like the way you comb your hair!" (said to the wife)
Clear and Displaced:	"I am angry at you!" (said to the daughter, when the husband is feeling angry at his wife)
Masked and Displaced:	"Women are so lazy!" (said to the daughter, when the husband is feeling angry at his wife)

A clinician can encourage direct communication *to* other members rather than *about* other members: ("Your father's here, why not say it to him, not me.") Mind-reading or speaking for another person can be discouraged. Family members can be encouraged to use "I-messages" instead of "you-messages";[11] for example, a woman might say to her husband, "when you come home late I feel lonely and depressed" instead of "you always come home late; you're so inconsiderate." The former states feelings and conveys an important message; the latter is accusatory and elicits similarly accusatory responses.

Families communicate in a variety of ways, and each family does so in a way that is very particular and identifiable as part of its personality. Knowing how a family communicates is an essential part of understanding how a family is organized. Even though words are the most obvious means of making a statement or expressing oneself, nonverbal messages (a sigh, a shrug, a sideways glance) can be just as effective and perhaps more convincing. Bateson[4] has written about "meta-messages," messages about the message and about the state of the relationship. In the healthy family these meta-communications, which are usually unconscious and nonverbal, do not contradict the verbal messages. Satir[25] has described nonverbal communication as a right brain function reflective of current emotional content and the actual status of the relationship; verbal communication, a left brain function, is considered to be a factual reference to the past or future.

Family communication is complex. "What did you do today?" can be an interested enquiry, a statement of affection, a routine meaningless greeting, or an accusation depending on which word is emphasized. The message will be altered by various nonverbal communications such as facial expression, tone of voice, distance of the questionner, and physical stance. Satir[25] has described the four most common positions in dysfunctional relationships (blaming, placating, super-reasonable, and irrelevant), which can be represented by physical positions such as the accusatory stance with a pointing finger.

Family rules control communication and meaning, particularly as to what constitutes "value messages" and "devalue messages." Strayhorn[29] describes how newlyweds must discover the meaning of each others' value messages. For example, help offered by a husband in cooking meals is, for him, a sign of caring and wanting to share in the household; the wife from a

very traditional family perceives the offer as the implication she is a poor cook. A wife interprets her husband's long work hours as a sign of lack of love and her own complaining as a sign of her love and need for him; the husband sees his hard work as a major sign of his commitment to his family's support and her nagging as lack of caring and appreciation. In one family, everyone is always late and no one worries about it; in contrast, the in-laws are always on time unless angry with one another. Such "non-correspondent rules" must be clarified.

Channels for value messages can be positive (helpfulness, physical contact, tidyness, time spent together, sexuality) or negative and painful. Negative channels include jealousy and possessive love, overfeeding and overeating to please each other, fighting for the sake of eventually making up, or the use of alcohol, which may increase closeness and physical contact.[28] Very destructive or "toxic" channels such as suicide threats to elicit messages of caring may be used if no other channels are open. Sickness may be a very often used channel in families who find it easy to care for the sick but otherwise cannot show affection. Getting fat may mean keeping oneself unattractive to others of the opposite sex (one study showed that marital problems followed intestinal bypass operations for obesity[18]). Cigarette smoking may be so tied up with an exchange of value messages that it is difficult to stop without helping patients become aware of the unconscious messages and linking them to a different behavior.[8,19,30] Development of positive channels must occur before one attempts to eliminate negative ones.[29]

The communication process is, without question, complex. One cannot hope to modify a family's response without first understanding its pattern of communication. Since physical symptoms have often been considered a mode of communication both to other family members and to the clinician,[1] their part in communication must be understood.

T—TIME IN LIFE CYCLE OF FAMILY

The particular time of the family life cycle may determine both occurrence of illness and the response to it. (Details of the stages of the life cycle and the family developmental tasks associated with each stage are discussed in Chapter 6.) Satisfactory completion of these tasks meets the needs of the family members and promotes the continued growth and development of the family unit.[8] No two families are alike, and "each experiences its own dynamics of formation, growth and dissolution."[7] At each developmental stage families go through normal transitions such as marriage, birth, adolescence, menopause, and retirement, but may also experience unexpected or tragic family life events.

Difficulty in coping with family transitions may lead to a visit to the family physician. For example, the birth of the first child in a family will require, at the very least, adjustment of roles and autonomy of the parents, learning child-care skills, and change from dyadic to tryadic interaction. Some families adapt with ease; others may lack the skills to cope with the change. A young mother under the stress of change may present with headache and fatigue or may focus on her child's symptoms of colic, constipation, or cold. Awareness of developmental stress in the family life cycle alerts the clinician to probe beyond this presenting symptom.

There are periods in the life cycle when visits to the doctor's office are frequent, partly because these are prescribed (immunization in infancy, premarital check-ups), partly because stress is generated by a family transition. Illness-prone families have a higher incidence of conflict and stress[15]; there are also illness-prone periods during the family life cycle. At the end of life we all become illness-prone, but the time at which this occurs is partly dependent on the stage in family life (widows and widowers are more illness-prone than married people of the same age) and on successful handling of previous challenges such as retirement and departure of children. The active octogenarian who leads a full life may do so despite arthritis or heart disease, or may remain free of illness because of an active, full life. The lonely pensioner with no interest in life is more likely to succumb to disease and disability.

Some authors[14] believe that the way families cope with each stage of the life cycle is the major factor in the development of illness. Illness reflects failure at a given developmental stage. It can also reflect stress or represent a solution to or an avoidance of a task: a mother overwhelmed with child-care responsibilities may lift her child in such a way as to slip a disc and force her reluctant husband into helping out with domestic tasks. Negotiation of tasks can be replaced by using sickness to change roles. A widow may threaten to have a heart attack if an adult daughter leaves home to get married, thus using illness to avoid the task of facing life alone and developing resources outside the family. Assessment of life cycle stage and apparent success with completion of previous stages is a key part of family assessment.

I—ILLNESS

To the health care provider the role that illness plays in the family is a crucial part of the family evaluation. The meaning of illness to a family will depend on many factors:

Family History of Illness. The history of illness in the family of origin and in the present nuclear family is a major determinant of family reactions. Frequent acute illness or chronic illness in the past will have an impact on the interpretation of new symptoms. It is possible that the expectation that illness will occur at a given time of life, in certain individuals in the family or in a

given organ system, will sometimes lead to such an illness. Such expectations and concern (for a particular part of the body) may play a role in the apparent genetic transmission of some diseases, or in a family organ vulnerability such as peptic ulcers or atherosclerotic heart disease. However, as Huygen[16] has pointed out, family patterns of disease often follow genetic tissue type (for example, families whose various secretory organs of dermal origin are predominantly affected). Interpretation of symptoms will be highly dependent on family experience. To a family with a strong family history of arthritis, an aching leg may be cause for great concern. Experience with health care providers in the past will color a family's expectations in the present. When suspicion or pessimism about the efficacy of drugs or doctors are passed through several generations, almost no effort on the part of the health care providers can reverse the belief. Indeed, such families' expectations and behavior usually lead to self-fulfilling prophecies by antagonizing medical staff. Discussion of the past and expression of empathy may help; hostility reinforces the family's beliefs.

Culture. The family diagnosis and the acceptance of illness or ill health are in part culturally determined: a patient from northern Europe, seeing illness as weakness may be highly stoical when compared to a patient from Greece. Denial may result and serious symptoms may be ignored. The Japanese individual is taught greater body awareness from early childhood and to the Western doctor may appear hypochondriacal.

Tertiary Gain (family need for a sick member).[6] The concept of secondary gain in the context of the family changes to a concept of maintenance of family homeostasis in which all family members are involved; this is called "tertiary gain." The mother who uses illness to induce guilt in children and to manipulate her husband is matched by a husband who accepts her dominance to excuse his alcoholism or absences from work. The child who focuses attention on himself or herself through frequent asthmatic attacks may also be protecting the parents from conflict. Madanes[17] has explored the role of illness in marriage when the sick role may maintain the balance of power. The question must be asked, Is it an advantage in this family to be sick? A question that is of enormous value in eliciting the role of recurrent sickness in a relationship or in a family is as follows: "If by some miracle you were to become completely better now, what would you do, or what would happen differently in the family that is not possible with your sickness?"

> In the M. family in which the wife had incapacitating back pain for 2 years, both spouses were asked this question in separate interviews. Mrs. M.'s answer was: "Oh, I guess I'd leave my husband." She had tried to leave him twice before but on each occasion he had threatened a heart attack. This helped Mrs. M. avoid facing her need for him and maintained the couple's belief that she was independent and could manage emotionally without him. The relationship was characterized by conflict; Mrs. M. was clearly boss of her ineffectual husband. When Mr. M. was asked the same question he said, "If she weren't sick she'd be back in control. This way I can keep the students out of the house, at least to some extent." The students of his wife, an artist, had clearly been having affairs with her in the past. The role of sickness in this family is dealt with in more detail in Chapter 20.

Sick-role assignment may occur in families with a vulnerable member: in one family, a child with a clubfoot became the family member who developed anorexia nervosa.[21] Family resemblances or even names may become the basis for expected behavior or illness, for example, a family in whom every member called Charles eventually became alcoholic. A family member may be inappropriately labelled as sick: Remen[23] gives an example of a woman in whom the whole family insisted on a diagnosis of angina. If the patient is cured another may take his place, indicating the need for sickness in such a family.

The Role of the Sick Member. Serious illness obviously has an impact on every family member. This may be because of the threatened loss of the sick member, or of his or her roles in the family; the loss of the important nurturing role of the mother has serious consequences. In most families more family disruption and subsequent illness or stress in other members occurs when the mother is seriously ill than when the father is ill. If there is complete financial dependence on the father, the only possible breadwinner, the converse may be true. An only child may produce overprotective concern for minor symptoms. A child born after the death of a sibling may have a special replacement role for his parents, and may be a "vulnerable child" as a result.

Recurrent Crises. Recent or remote family deaths, particularly if inadequately mourned, are a very major cause of subsequent pathology (see Chapter 21). Particularly if other crises occurred in the same period, a family may never regain its original functional level,[26] and the "ripple effect" of serious illness, mental breakdown, or other deaths in family members may follow.

C—COPING WITH STRESS

Adaptability is perhaps the most important characteristic of a family; with cohesion, it forms Olson's circumplex model of family function.[22] A focus on family strength and coping is both therapeutic and necessary to mobilize family resources to deal with a given problem. The family's history of coping with past stresses is a useful predictor of future coping. The history of illness, of stresses such as accidents, deaths, change of job or environment, and cultural change in both the nuclear family and families of origin should be elicited. General questions ("Has your family had a lot of stresses in the recent past?" "Have you had to deal with this sort of thing before?" "How did you

cope when that happened?") quickly give a picture of past stress and the response to it. If the family has been previously well and cannot recall a serious problem, then past coping cannot be assessed. However, such a family is likely to adapt well if it has maintained such a problem-free life style in the past. The occasional rigid or brittle, but previously lucky, family may succumb to the current stress as a result of the family system's poor adaptability. In contrast, illness-prone families may go from crisis to crisis and still hold together despite or because of the crises.

Information about past examples of a family's ability to cope may serve as a warning signal to the professional; as in the following examples: the son of a woman with cancer had developed ulcerative colitis after his father's death; although the son was less close to his mother, he was at risk for serious illness since her death would remind him of the earlier death of his father. In another family, injury to a daughter resulted in mutual recrimination between the parents. This couple reacted with anger at each other whenever a health crisis occurred, making the marriage vulnerable in case of serious illness, particularly of a child.

E—ECOLOGY OR ENVIRONMENT

Ecology, for the purpose of family assessment, is the study of the interaction of families with their environment and of the available environmental resources. The environment includes all the other systems that influence, or are influenced by the family system: the extended family, friends, school, employment, government agencies, religious and other community organizations, and the subculture and culture to which the family belongs.

The interaction of spouses with their families of origin has been observed to affect the incidence of problems and symptoms in the family. Emotional distance or closeness is deemed to be the important variable and is unrelated to a family's living in close proximity or far away.

Relationships outside the immediate family may compensate for inadequate family relationships and thus help the family to adapt in times of transition: if a pregnant woman is not having her increased psychological needs met by family members, it is important to find out if these needs are being met by the family of origin or by friends. A family with loose ties in which members tend to ignore family relationships may use community resources to carry out functions that could be done by the family system. This may be of immediate benefit but may also lead to overdependence on community resources.[13]

A closely knit family system may not allow members enough freedom to develop relationships in the community; in such a family, if the breadwinner is also the dominant member and becomes incapacitated, the other members of the family might be unable to reshuffle roles or obtain help from the environment. This can lead to breakdown of the system.

Smilkstein's acronym SCREEM[26] (see Chapter 13) is useful as a reminder of the important environmental resources of a family: Social, Cultural, Religious, Educational, Economic, and Medical.

PRACTICE

McGill Family Assessment Form

Family (or household) members present in interview. Names and ages.

Missing members. Names and ages.

Presenting problem(s) or reason for family interview. (Description, identified by whom? Onset, attempted solutions by family.)

Roles—structure, organization. (Who is dominant, nature of parental coalition, characteristics of boundaries, role flexibility. If possible, draw family map.)

Affect. (Predominant emotional tone, range of affect in this interview, difficulty in expressing emotion.)

Communication. (Clear, direct, masked, displaced, congruent. Who talks? Who listens to whom? Nonverbal communication.)

Time in life cycle of family. (Courtship, family in formation, child bearing, child rearing, child launching, contracting family, retirement, widow(er)-hood.)

Illness. (History or presence of serious illness, chronic or frequent acute illness. Sickness role—who tends to be sick in this family. Recent deaths.)

Coping. (Adaptability. Family strengths and resources. Coping in *past* and *present*.)

Ecology. (Relationship with families of origin. Financial status. Use of community, school, professional resources. Recreation.)

Overall rating

Does this family express the need for help?

□ YES □ NO □ DON'T KNOW

Do you believe this family is in need for help?

□ YES □ NO □ DON'T KNOW

In what specific areas?

Can you handle the problem?

□ on your own □ with supervision □ not at all

Should this family or any member be referred for:

□ family therapy □ couple therapy □ individual therapy

If individual, which one?

To whom?

Do you believe this family can change?

□ YES □ NO □ DON'T KNOW

Does this family believe it should change?

□ YES □ NO □ DON'T KNOW

Does this family believe it can change?

□ YES □ NO □ DON'T KNOW

What is your evidence for this opinion?

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