

# Using the Genogram (Family Tree) Clinically

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## What Is a Genogram?

The genogram (family tree) is an extraordinarily versatile clinical tool that can help inexperienced clinicians obtain family and social history information from patients more easily. The more experienced the clinician becomes, the more effective and time efficient the genogram is for helping the clinician elicit family information and use it to take good care of patients.

The genogram can be thought of as an X-ray of the family—an "x ray without the roent." It gives the physician and the patient a graphic display of the family, including the family's patterns of illness and psychosocial problems. When patients see the constellations of family disease and problems highlighted on the family tree, they appear to take them more seriously, as if realizing their implications for the first time. The sedentary, overweight, hypertensive, diabetic, cigarette-smoking man whose genogram is shown in Figure 8.1 began to acknowledge the likely consequences of his life-style and poor compliance with his medical regimen after seeing his genogram drawn out. The dramatic pattern of early coronary heart disease is more vivid in graphic form.

The genogram often reveals family skeletons (e.g., an illegitimate child), dislocated families (e.g., with a disowned or runaway child), osteoporotic families vulnerable to stress fracture (e.g., a distant marital relationship nearing the empty nest phase of the life cycle), and families with compound fractures (multiple divorces and remarriages). The physician does not have to do anything with this information except record it and keep it in mind when he/she sees family members in the future. It may or may not ever be directly relevant to patient care, but if it is not known, its relevance cannot be judged. Depending on the patient, the physician, and the circumstances of the visit (including how busy the physician is), some family information will suggest preventive or therapeutic intervention by the physician and/or referral to other community resources. For example, eliciting a family history of spouse abuse may open the door for a female

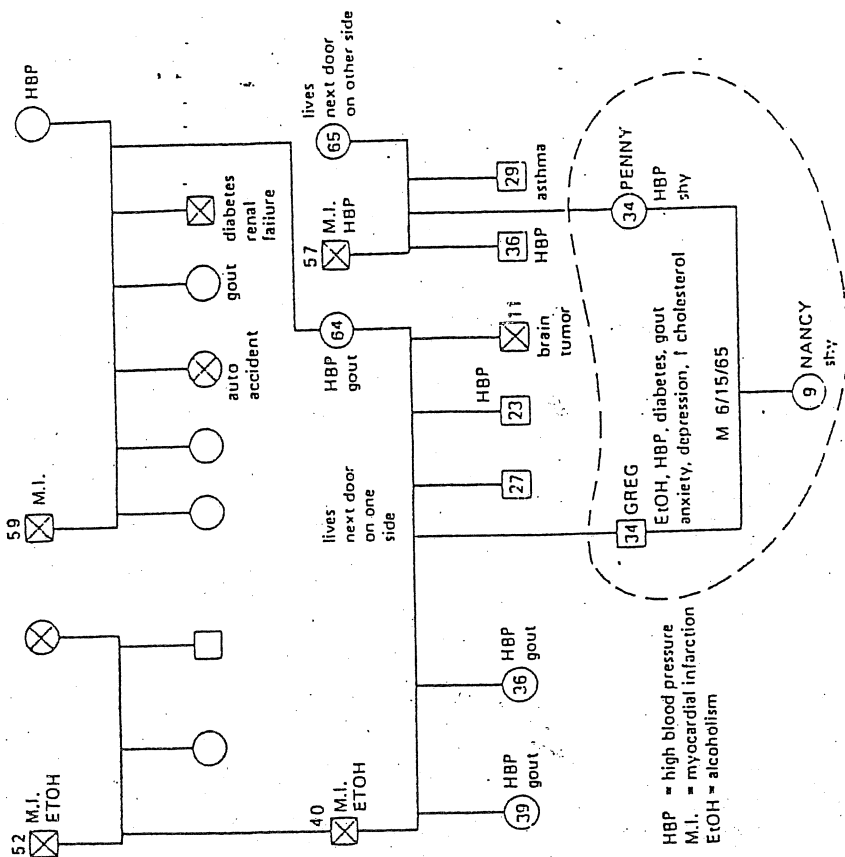


FIGURE 8.1. Family illness patterns as revealed in a genogram.

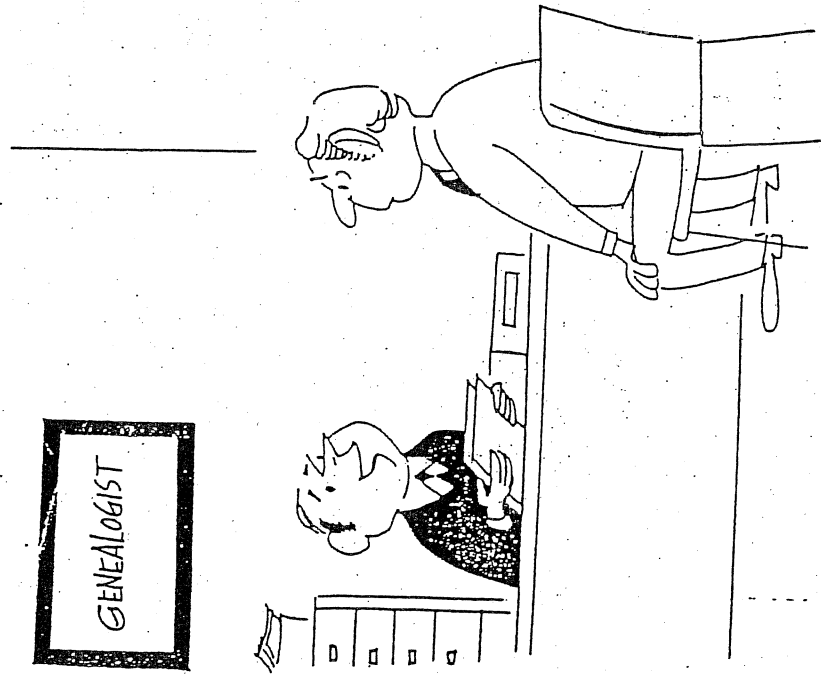
patient to tell the physician that her husband has been beating her for several months. The physician can then do brief supportive counseling and put the woman in touch with the nearest shelter for battered women.

The process of the physician and the patient drawing the family tree together facilitates the doctor-patient-family relationship in several ways. Asking about family information in a structured, matter-of-fact way helps the interviewer remain objective and reduces physician discomfort when inquiring about sensitive issues like divorce. When the physician is comfortable with his/her questioning, the genogram seems to foster honesty by lowering the patient's resistance to talking about embarrassing or painful matters, such as alcoholism and sexual abuse. Sharing family information with the physician often builds rapport and trust more quickly than usual. For anxious patients who come in to the doctor in some degree of crisis, doing a genogram has a nonspecific calming effect. Asking patients factual

communications are scattered and irrational, when patients' thoughts and families usually helps them concentrate on reality better, allowing them to begin to deal with their problems in a constructive way.

## Historical Perspective

The genogram is a modification of the genealogical family tree and the genetic pedigree. The abbreviated version, the "skeletal" genogram, was first described in 1975 (1). Since then several variations in the basic technique have been proposed for doing genograms and using them in patient care (2-9). The first author began doing genograms early in his family



"Shall I continue searching your family tree? I just found one of your relatives hanging from one."

always gets a genogram as part of his initial evaluation of a new patient. The second author, an experienced psychotherapist, began doing genograms relatively recently. She has been particularly impressed with how much family information can be gotten in a very short time with the genogram, and how quickly she was able to incorporate the genogram into her assessment routine.

This chapter will introduce the genogram technique and discuss how it can be used. Major emphasis will be placed on using the genogram routinely with new patients, and on using it to evaluate and manage puzzling, complicated, or difficult patients. After reading this chapter and doing the learning exercises, you should be able to:

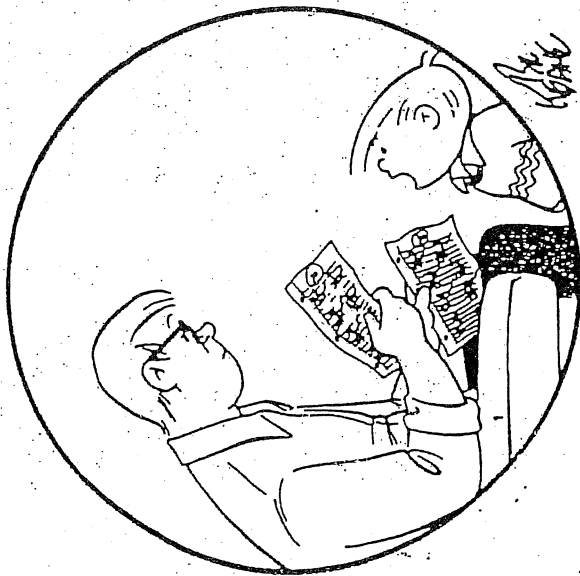
1. Conduct a brief genogram interview, eliciting and recording on a skeletal genogram the basic information about important events and serious illnesses in three generations of a patient's family.
2. Discuss associated patterns of emotional intensity and illness seen in genograms of patient families.

## Why Not Do Genograms?

Despite being promoted for the past 5 years, the genogram is not yet widely used in medical settings. Doing a "skeletal" genogram takes 5 to 20 minutes (4,5), time that the busy and stressed clinician may be reluctant to commit to an unfamiliar approach for getting and storing clinical information. A sense of time urgency pushes the clinician to take care of business in a straightforward, no-frills manner much of the time. The authors believe that doing genograms, while taking a little more time in the short run, will actually save time in the long run.

Reviewing the information on the family tree can obviate the need to repeatedly inquire about family history that is forgotten after each visit unless it is recorded somewhere in the chart in retrievable form (10). Often the genogram yields important clues that allow the physician to hone right in on the problem, rather than spending a lot of time going through laundry lists of symptoms. This is particularly true for familial problems that often present in vague ways, such as depression and anxiety disorders (11,12). Anytime the patient is admitted to the hospital, the family history can be extracted easily from the genogram, and kept in mind during diagnostic work-ups and illness management.

For the physician in training, learning to do genograms requires more knowledge and skills to be mastered, on top of the overwhelming amount already expected of the competent physician. Unless the physician trainee decides that the payoff may be worth the effort, dealing with family history and other family matters tends to get squashed under the weight of other higher priorities. More important than saving time, doing a genogram can improve the quality of care given to the patient.



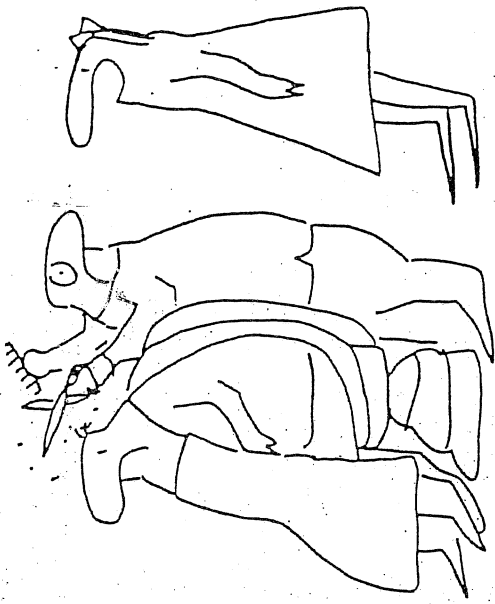
"Miss Johnson thinks she knows my trouble. What does 'hereditary' mean?"

Many physicians question how appropriate it is for them to venture into the family area, invited or not. Family physicians especially risk biting off more than they can chew and digest. Psychosocial areas seem to be easier for many physicians to resist tackling, perhaps because they are seen as somehow being outside the legitimate purview of the physician, even if they do strongly affect health and illness (13).

Another reason genograms are avoided is that it is sometimes difficult to decide how to use family tree information to help patients and their families. It is easy to feel overwhelmed by the volume and nature of the data and confused about what to do with it, especially when seeing families like the one in Figure 8.1 with tangled patterns of, for example, heart disease, cancer, alcoholism, diabetes, and depression. When a family is this complicated, the patient is usually confused about his/her problems also. Getting the facts of the family can help the patient and physician pick a place to start to work on a manageable part of a complicated situation.

### How to Do a Skeletal Genogram

When a physician sees a new patient, the chief complaint, history of present illness, past medical history, and review of systems take precedence in the interview. After that information is obtained, the clinician traditionally elicits family history and social history and records the information



"It may not be my place to say this, Dr. Winkle, but I feel a general practitioner should establish where his boundaries are..."

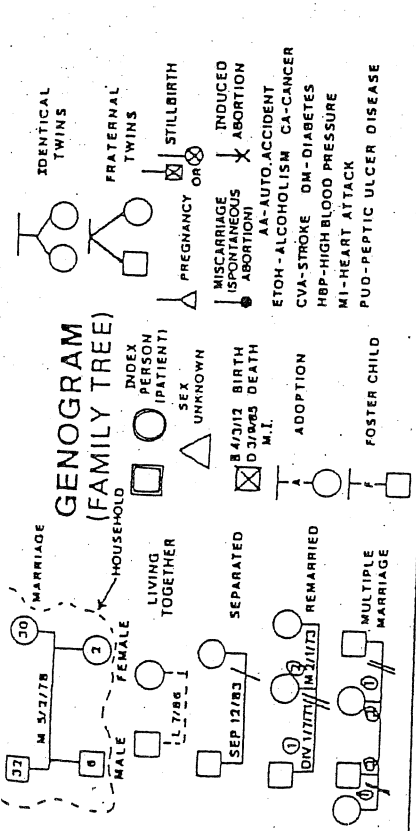
in prose form. The genogram is a useful tool for eliciting family and social history and recording it in an alternative graphic format that highlights patterns of illness and dysfunction in families.

The symbols shown in Figure 8.2 are the ones the authors use for the genogram. Others use somewhat different notations. Most of these symbols agree with McGoldrick and Gerson's recently proposed standard set of genogram symbols (9). For the skeletal genogram, the basic information includes:

- The sex and approximate age of each family member. For an adult patient, this information is obtained for current and past marital partners, children, parents, and grandparents. Information about deceased members is often especially useful (e.g., age at death and cause of death).
- Serious physical and mental health problems for each family member. Specific inquiry is desirable for heart disease, high blood pressure, diabetes, stroke, cancer, nerve problems, depression, alcoholism, and suicide.

When doing a genogram, the information is easy to decipher later if you:

- Indicate the identified patient with a doubly outlined circle or square.
- Place the "clinical nuclear family" roughly in the middle of the diagram, with previous marriages off to the right and left.



NAME	DATE
GREAT GRANDPARENTS	
GRANDPARENTS	
AUNTS & UNCLAS	
COUSINS	
PARENTS	
SIBLINGS	
NIECES & NEPHEWS	
PATIENT & SPOUSE/PARTNER(S)	
CHILDREN	
GRANDCHILDREN	

FIGURE 8.2. Genogram form and symbol key.

- Place siblings in chronological order, unless they are from multiple marriages.
- Offset index patient, spouse(s), and ancestors a little below their siblings.
- Indicate exact age (if known) inside the person's symbol, with date of birth alongside, or indicate approximate ages relative to the patient as +4, -3, etc. inside or alongside the circle or square that symbolizes the person.
- Indicate death by crossing through the person's symbol; add date died beside, and age at death inside or alongside the person's symbol.

- Indicate separation with single slash, divorce with two slashes across marriage line.
- Number marriages for spouses, with dates of marriage, separation, and divorce.
- Indicate remarriage to same person with multiple marriage lines.
- Enclose current household members with an interrupted line (dashes).
- Try to keep members of the same generation on the same horizontal level for each branch of the family.

### How to Use Genograms in Routine Patient Care

One way to use the genogram is to routinely fill one out on most new patients. A "bare bones" genogram for a family with few members can be drawn in less than 5 minutes on a sheet of paper, or a special form such as the one in Figure 8.2. To fit a genogram on a page this size, make each person's circle or square about 6 to 8 millimeters in diameter and print small. The genogram can be conveniently used if placed at or near the front of the chart—opposite or just under the problem list, for example. One genogram can be done for the first member of each family to be seen, and copies made for the chart of each other family member receiving care in that setting.

#### Learning Exercise #1: Pregnant and Anxious

The genogram in Figure 8.3 is that of a young woman the first author saw initially for pregnancy care. Before reading the following section, take a minute or two to scan the genogram. Ask yourself, How could the information on this genogram help the physician take good care of the patient? Jane's only biologic sibling died soon after birth from a neural tube defect 2 years before Jane was born. This raises two important considerations for her care. First, she will probably be much more anxious than the average first-time mother about the normalcy of her baby, and may need more reassurance than usual on this point. Second, because her baby is at increased risk for having a neural tube defect, a screening amniocentesis is indicated.

Social support is another area for concern with this patient. She is now pregnant by either her ex-husband, whom she had been dating until right around the probable time of conception, or by her boyfriend, whom she began seeing around that time also. She was raised by her strict Baptist grandparents. Her grandmother has fortunately been supportive despite the awkward circumstances. Without a resident father figure, parenting will be more stressful for Jane, particularly when stress increases (e.g., when the baby gets sick).

#### Learning Exercise #2: An Intense Family Practice Resident

A family practice resident's genogram is shown in Figure 8.4. Before reading the material below, scan the genogram briefly. What health prob-

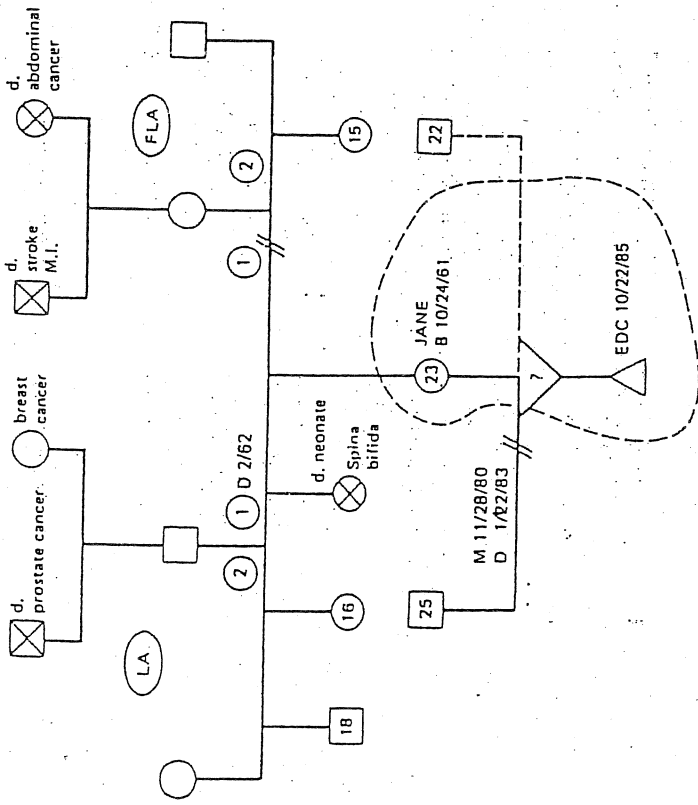


FIGURE 8.3. Jane's bare bones genogram (Learning Exercise #1).

lems would this physician be vulnerable to under conditions of increased stress?

The most striking patterns in Dr. X's family are those of heart disease, peptic ulcer disease, and alcoholism. While he was chief resident during the third year of his residency, Dr. X experienced multiple episodes of gastric distress, relieved by antacids. He exhibits many of the features of coronary-prone (Type A) behavior. Through family-oriented counseling he realized that, despite sound dietary and exercise habits, he would probably be at increased risk for coronary heart disease in his middle-age years, unless he modified how he handled stress (14). He also identified strong family emotional patterns that appeared to be connected to the illness patterns, and he made substantial progress with changing how he responded to stressful situations. His gastrointestinal symptoms ceased, and his general functioning improved markedly, both personally and professionally.

### Learning Exercise #3: Somatization and Loss

The genogram in Figure 8.5 is that of a 7-year-old girl who was referred by a family practice resident to the second author for help with persistent

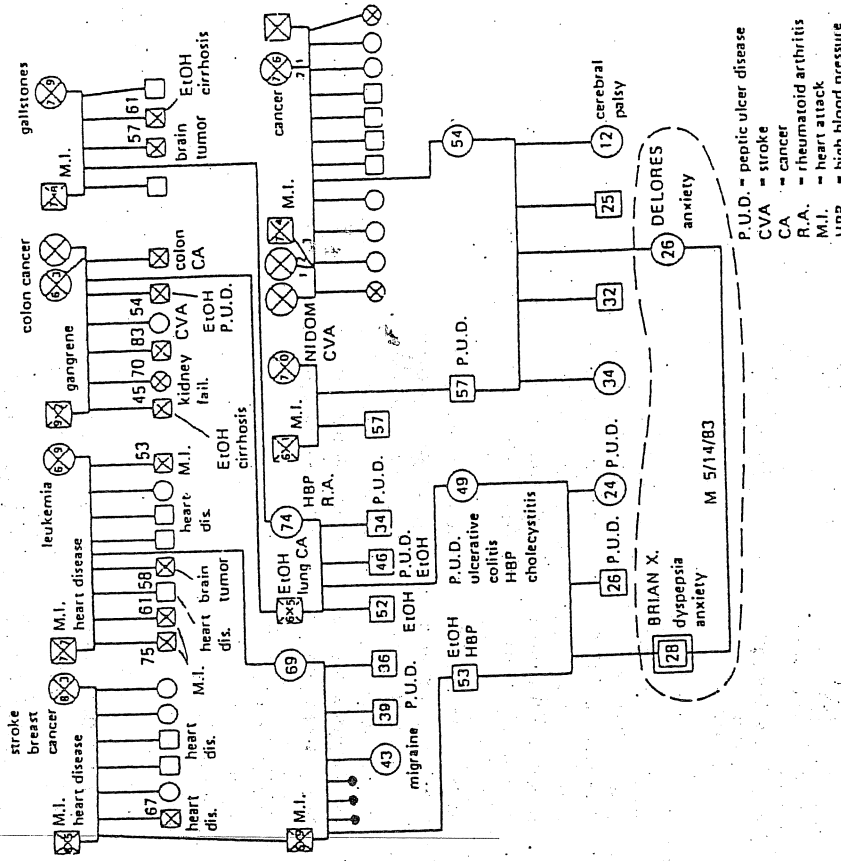


FIGURE 8.4. Brian X. an intense physician (Learning Exercise #2).

constipation. Before reading the following section, scan the genogram, asking yourself how it could be useful to you as the physician. Then look at it again and think about how it could be useful to a behavioral consultant.

Anna was born with a congenital heart problem (atrial septal defect), which concerned her parents and physicians greatly. She was referred to the behavioral scientist because she was having frequent abdominal pain and had not had an unassisted bowel movement in 6 weeks. She had missed a lot of school. The parents and physicians had tried everything they could think of short of hospitalization. The focus had been mostly on her gastrointestinal system, and some residents were suggesting that she undergo an extensive diagnostic work-up.

The consultant's objective in doing Anna's genogram was to understand Anna and her symptoms better by seeing what had been happening in the family. She interviewed Anna first, then talked with her mother with Anna in the room to fill in dates and other details. The genogram helped her get important details quickly

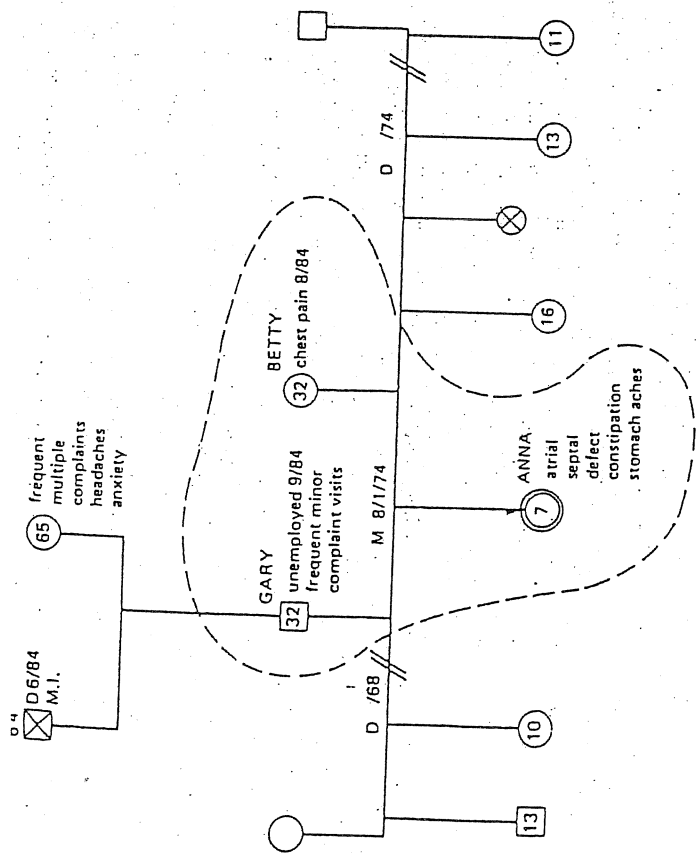


FIGURE 8.5. Somatization and loss in Anna and her family (Learning Exercise #3).

and organize them in a useful manner. The broad questions to be investigated were:

- What's going on with Anna and with her family?
- What bigger picture do her symptoms fit into?

The resident had gotten little family history, and the information he had elicited had not been organized so that it helped him understand the situation.

Anna's stomach aches began in August around the time school started. The genogram shows that Anna's paternal grandfather died of a heart attack 2 months earlier, in June. Anna and her mother had found him dead in the bathroom. Anna was very attached to her grandfather and felt great sadness after his death. Betty, Anna's mother, began having chest pain in August and was taken to the hospital, afraid she was having a heart attack too. The genogram indicates that somatization is a family pattern of responding to stress, with Anna's father, mother, and paternal grandmother all visiting physicians frequently with vague somatic complaints in times of stress. In the interview, the mother stated that Anna was a very special child, the only child of the second marriage for her middle-age parents.

The consultant talked to Anna about her feelings of sadness and anger, and she told Anna that her stomach was pretty smart, that it was saying "I feel something unpleasant. A lot has been going on here." The genogram helped the consultant see the dynamics behind the school avoidance in this child whose medical problems

amplified everyone's anxiety. Upon questioning Betty reported that Anna had not been going to school much of the time, and that she got called to pick Anna up on the days she did go. The school, as well as the parents, overresponded to Anna's symptoms. By talking and playing with Anna, the consultant discovered that she was afraid of her mother's potential for having a heart attack, and was scared about her own heart condition.

Treatment focused on dealing with Anna's fear directly instead of her stomach. Together with the resident, Anna's heart condition and Betty's health were discussed with Anna and Betty in great detail. The resident drew Anna's heart and explained the problem she had and answered all her questions. He explained her mother's high blood pressure and stress briefly in age-appropriate terms. Betty was prompted to tell Anna how she was taking better care of her health. In a private session with Anna, the consultant told her that she thought Anna's stomach aches were her sign of distress and fear, and that it might be easier on her stomach if she expressed her feelings more openly. Because she liked to draw, she was encouraged to draw when she felt bad, and to tell her mother about her scary feelings. In a joint session with Anna and her mother, a plan was formulated for leaving her at school unless she was clearly ill in a different way than before. Strategies were developed for Anna's dealing with her fear at school (get a hug from a teacher, for example). The mother was also encouraged to listen to Anna's scary feelings.

Clinicians are aided by the specific details and by the big picture of the family and social situation that the genogram portrays graphically. In this case the genogram helped the behavioral scientist, the resident physician, Anna, and her mother to arrive at a shared understanding of the problem and to solve Anna's problem with constipation and stomach aches. She has done well for over a year since her last session with the behavioral scientist.

### Uses of the Genogram

If the clinician scans the genogram for 30 seconds before seeing the patient/client, the information on it can be used to:

- Allow the regular care provider to quickly review the family situation (e.g., second marriage, two of three children born into previous marriages).
- Allow a nonregular care provider to quickly get a sense of the family, improving continuity and comprehensiveness of care (e.g., strong history of anxiety disorders and somatization).
- Build rapport by using the family members' first names.
- Identify significant illness risk factors (e.g., family history of diabetes in an overweight patient).
- Raise the diagnostic index of suspicion. May indicate screening for an individual at high risk (e.g., mammogram with family history of breast cancer).

- Pave the way for sustained patient education about life-style, motivating the patient to make changes (e.g., encouraging smoking cessation with family history of emphysema or lung cancer).
- Demonstrate the clinician's belief that family matters are an important part of an individual's overall health picture (e.g., marital satisfaction).
- Legitimize future discussion of family matters (e.g., problem with a child).
- Allow the patient's family concerns to emerge more quickly than they would otherwise tend to (e.g., erectile dysfunction, soon after it first occurs, rather than after it becomes more resistant to treatment).
- Locate the family in the life cycle, and highlight critical events (15).
- Normalize anxiety related to difficult stages and transitions of the life cycle so that the patient understands his/her distress to be a normal response to a universal stressor (e.g., middle-age adults considering putting their elderly mother in a nursing home).
- Anticipate trouble with future life cycle transitions (e.g., discuss adolescent sexuality and contraception with preadolescents in a family with a tradition of teenage pregnancy).

#### Learning Exercise #4: Pregnant and Seropositive for Syphilis

The only way to learn whether the genogram could be useful to you as a clinician is to do them with a number of patients and see what you think. To get you started, here is a written summary of the facts about the family of an actual patient the first author saw recently (names changed for anonymity).

Dawn R., an 18-year-old white female, pregnant for the first time, came to the Family Practice Center for prenatal care in December 1985, at about 10 weeks gestation. She was asymptomatic. (Her past medical history will be discussed later.) Her physical examination revealed a uterine size compatible with her menstrual dates, and was otherwise unremarkable.

On a sheet of typing or notebook paper draw the patient's skeletal genogram, using the following information and the symbol key in Figure 8.2.

Dawn was born February 28, 1967, the second of four children. She married her husband John in August, 1985. It was the first marriage for Dawn and the second marriage for John, who is 23 years old. John was previously married to Brenda S., from whom he separated on January 8, 1983, and divorced in January, 1984, because of her infidelity. He and Brenda had a son, Randall, born August 2, 1983 (after they had separated), who has been healthy. Brenda has since remarried and has no contact with John.

Dawn has brothers ages 20 (Billy) and 14 (Danny), and a 13-year-old sister (Crystal), all without any serious health problems. Her mother, Mary, age 38, had a duodenal ulcer at age 17; she has high blood pressure, as do two maternal uncles, ages 35 and 30, and the 60-year-old maternal grandmother, Pearl. Dawn's maternal grandfather, Robert, died in 1966 from an oil field injury. Her 43-year-old father,

Dean, spent about 6 months in a hospital with a nervous breakdown, beginning immediately after Dawn's birth. Dean's parents were divorced when he was 2 years old, and he was raised by his maternal grandmother from that point on. Dean has one older brother, age 48, and a half brother age 27 and a half sister age 24, by his mother's second marriage. Dawn's paternal grandfather, Jim, died in 1975 of unknown cause, when Dawn was 8 years old. Her paternal grandmother, Ruth, had a heart attack in 1981.

Look over the genogram you have drawn, and answer these questions:

- What susceptibilities to illness does Dawn's genogram show?
- What psychosocial or emotional patterns are red flags signaling potential problems for Dawn in the future?

The author drew Dawn's genogram as it is shown in Figure 8.6. It isn't important that your drawing be exactly the same, but that it legibly portray

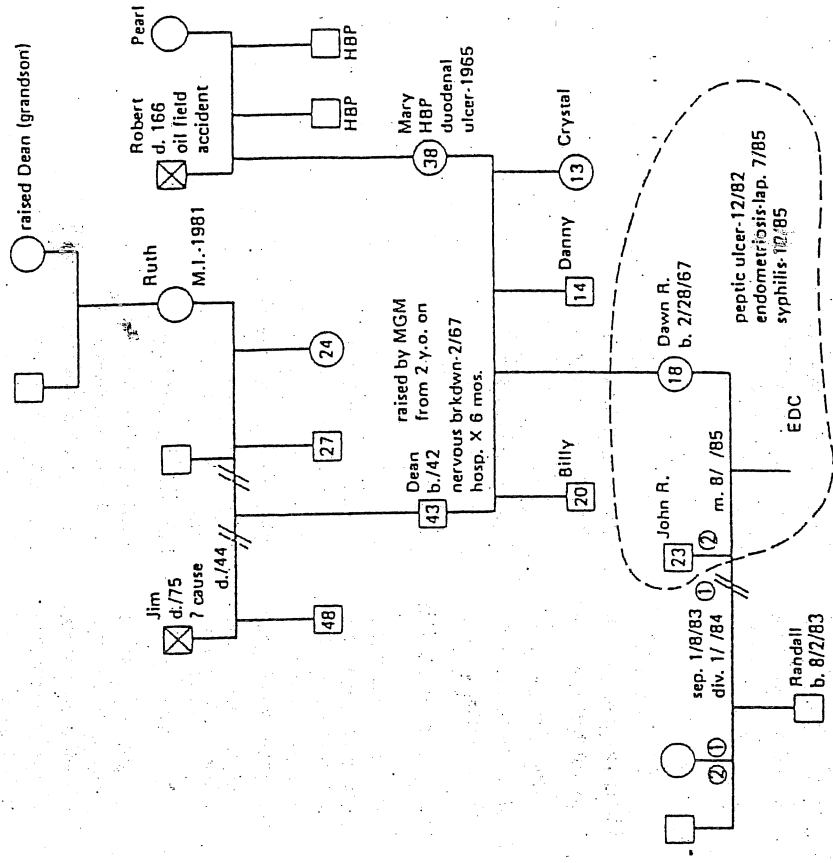


FIGURE 8.6. Sample genogram for Dawn R (Learning Exercise #4).

the people, relationships, and other information accurately. Based on known familial illness patterns and Dawn's family history, she is at increased risk for high blood pressure, peptic ulcer disease, and mental illness (11, 12, 16, 17). She and her family members would be expected to be relatively vulnerable to dysfunction under increased stress.

Dawn's medical history was notable for peptic ulcer disease diagnosed in December, 1982, and endometriosis diagnosed by laparoscopy in July, 1985. She denied any history of venereal disease. She related to the physician comfortably, with good eye contact, and responded articulately to questions. She wore very heavy facial makeup, which often indicates marginal emotional stability.

When her prenatal lab work returned, the serum test for syphilis (RPR) and a confirmatory fluorescent treponemal antibody absorption test (FTA-ABS) were both positive, but a third test, the microhemagglutinin antibody to *Treponema pallidum* (MHATP), was negative. Dawn and John both continued to deny any sexual contact with anyone else, except for John's remote contact with his ex-wife almost 3 years previously. Each of two injections of benzathine penicillin 2 weeks apart was followed by a high fever (Jarisch-Herxheimer reaction versus drug reaction). When John's syphilis serology came back negative, and Dawn continued to steadfastly deny any extramarital intercourse, the diagnostic assessment remained muddled. While the initial test results may have been invalid, a repeat RPR was positive to eight dilutions, indicating a high likelihood of syphilis.

The author will follow Dawn more closely than usual during and after her pregnancy to monitor her emotional coping and watch for other problems. She may be particularly vulnerable to preclampsia and postpartum depression. Her weight gain so far has been suboptimal despite reported adequate food intake. The confounding syphilis situation continues to stir up anxiety in the couple and the extended families.

### Elaborating the Skeletal Genogram

The genogram technique is paradoxical, in that it is both highly structured and very flexible. Since the genogram is not based on any particular theory or approach, it may be used by care providers with various theoretical and clinical approaches. In terms of the personality dimensions characterized by Meyers (18), the genogram can be used comfortably by either the person who gathers and processes data intuitively, or the person who has a more concrete "sensing" approach to data gathering. Both factual cognitive data and subjective emotional information can be easily obtained by probing in areas relevant to the patient's problems. Information from the family tree can be expanded and clues followed up on with straightforward interviewing, or by using supplementary techniques such as the Family Circle (19).

One theoretical-clinical "school" uses the genogram as the main way

of gathering information and subsequently working with individuals and families. Multigenerational (Bowen) family systems theory asserts that present patterns of illness and coping with illness stem from patterns in the past (3). Specifically, genetic predispositions interact with life experiences to produce illness in individuals and emotional patterns in families. Illness experiences influence, and are influenced by, the emotional patterns in families.

Family members cope with illness in ways related to how previous generations adapted to members' being ill. Ways of coping with illness include denying its seriousness or existence, being strong, avoiding the ill person, becoming physically ill, and turning to religion or other support systems. Family roles that may shift in response to illness include functional ones such as breadwinner, head of household, and caretaker, as well as less functional ones like family scapegoat and the sick role. Changes in roles following serious illness (e.g., a heart attack) are accompanied by intense feelings of frustration, resentment, and fear of death and dying. As with other emotional patterns, there is a strong tendency for past patterns of coping with illness to recur in succeeding generations. The genogram is well-suited for detecting and clarifying such patterns.

In trying to make sense out of chaotic information the genogram can be used to focus sharply on certain patterns for particular purposes. Chronic illness can be managed better, for example, by getting additional family information to flesh out the skeletal genogram. Elaboration of the skeletal genogram is useful with puzzling, complicated, or difficult patients when:

- Management of a disease or illness is unsatisfactory, and where the reasons are poorly understood or suspected to be related to family matters.
- The patient is disabled or dysfunctional out of proportion to the apparent severity of the disease.
- Serious emotional, behavioral, or physical problems begin or worsen in any family member. The family may present in crisis with such problems.

Gathering expanded genogram information can:

- Give a broader picture of the patient's problems (e.g., daily use of marijuana in a young married woman whose father was alcoholic).
- Estimate a patient's prognosis (e.g., somatization and depression in a 42-year-old woman, two of whose siblings committed suicide).
- Allow a more realistic appraisal of physician and patient goals (establishing a realistic therapeutic plan with the patient in Learning Exercise #4). Decreases doctor and patient frustration by establishing clear boundaries, realistic expectations, and a verbal or written contract spelling out therapeutic goals and responsibilities of the patient and physician.



- Suggest alternate management strategies (e.g., referral to Alcoholics Anonymous, Al-Anon, Al-a-Teen, or Adult Children of Alcoholics). Lessen the patients' anxiety by getting them to think about the facts of their families, and by encouraging patients to shift somewhat away from being preoccupied with negative feelings.

To expand the skeletal genogram with chronic illness or disability in mind, some important details to pursue are:

- The dates of onset and diagnosis of serious chronic illnesses.
- The overall course of the illnesses and timing of exacerbations.
- The personal relationships and overall life course of the ill person.
- Who did most of the caretaking for the ill member, for how long, how well, with what attitude about it, with what degree of personal sacrifice, and with what effects on his/her other personal relationships and general functioning.

When more detailed genogram information is being recorded, a larger size paper is needed. A pad of blank paper about 24 by 36 inches works very well for drawing the genograms of occasional families with whom the clinician decides to work more intensively to try to get better results. If the family is seen more than once or twice, the first draft usually becomes very messy, with multiple changes and additions as the family finds out more about its distant members. A redraft that clearly presents the updated facts is easier to work with if the clinician plans to continue seeing the family.

The facts about chronic illness or disability in the family may be used to better understand how the family is handling the situation now, and how it will probably cope in the future, unless something changes. An example of a difficult long-term situation is the "keeper syndrome" (20). As parents age or get sick, someone is elected to the caretaker role. Caretakers usually adopt the role with mixed feelings, which generate conflict (open or submerged) that contributes to health problems, such as headache and depression. The clinician who is aware of the high risk nature of this role can sometimes prevent some of its negative effects by exploring the caretaker's thoughts and feelings and helping him/her negotiate an equitable cooperative arrangement with other relatives.

Often a family that is having difficulty adjusting to chronic illness is repeating a maladaptive pattern from previous generations. If this can be discovered, and clarified with the family, they may then choose between continuing this pattern and pursuing alternatives that promote outcomes that the family prefers. When illness is life-threatening, maladaptive patterns are more rigid and difficult to change. Family members who are acting based on survival urges can seldom calmly analyze and modify their actions without help from a more objective outside party. If the physician is prepared and willing to do so, he/she can help people change

maladaptive patterns, like a coach helps athletes get rid of habits that impair performance.

### Learning Exercise #5: Your Own Family

The family that you know the most about is your own. The value of using the genogram to learn about families is probably best appreciated by doing your own genogram. If you have not already done so, draw your genogram before reading the next chapter, using the key in Figure 8.2 as necessary. After you have finished it, examine it with these questions in mind:

- What patterns of "physical" illness and disease appear in the various branches of my family?
- What emotional patterns and "mental" illnesses appear?
- Where do I fit into the family patterns in the past? Now? In the future?
- What family patterns am I involved in that have negative implications for my long-term health and functioning and for my family?

Save your genogram and reexamine it after reading the following chapter, in which the first author presents his own family and discusses the benefits to be gained by working on one's own family issues.

### Summary

In this chapter, the authors presented the genogram (family tree) as a practical technique for promoting family-oriented care in both training and community practice settings. It can help the clinician take good care of people by:

- Integrating data on the physical and mental aspects of health and illness. (This information is dichotomized in written histories and notes.)
- Graphically displaying multigenerational patterns of illness and dysfunction, for the clinician to use as time, interest, and skills permit.

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# Working with One's Own Family Issues: A Path for Professional Development

Michael A. Crouch

The complex interactions in patients' family systems, and in the therapeutic system that includes the family and the clinician, have been extensively described and analyzed in the literature (1-9). Less attention has been devoted to how issues related to the clinician's nuclear family (10,11) and family of origin (12-14) influence health care and medical education. As the sketch on page 194 shows, every clinical interaction involves the family backgrounds of the clinician and the patient, even though both parties are seldom aware of these dynamics.

Shortly after becoming a faculty member in a family practice residency program, I began a part-time 2-year training program in family therapy, hoping to learn approaches and techniques that could be adapted for use by a busy family physician. The conceptual framework taught in the program was Bowen Family Systems Theory, and I quickly discovered this meant that the training would compel me to examine my relationship with my family to a greater extent than I ever had before.

Learning about myself and my family in this way has been the most valuable educational experience of my life. In this chapter I will discuss the family systems theory that I have found to be most applicable for me as a physician. I will also discuss some of the work I have done on my own family issues, and explain how I have benefited from understanding my family better.

After examining your own genogram (see Learning Exercise #5 in Chapter 8) and reading this chapter, you should be able to:

1. Identify any patterns of illness in your family. What are the implications of these patterns for your health, your health habits, and your life-style?
2. Describe the major emotional patterns, the general level of differentiation, and the level of chronic anxiety in your family.
3. Describe how your family patterns could affect your effectiveness as a physician. What kinds of patients would you be most likely to have difficulty with?

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