Teaching the Family System Concept in Family Medicine

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Teaching the family system concept to physicians is difficult, as it entails a new way of thinking, at odds with the familiar linear medical model that focuses on the individual patient. This conceptual difference and the confusion between working with families in family medicine and family therapy explain the slow or superficial acceptance of the family as the unit of care.

Five principles have been found to be useful in teaching: (1) specific teaching techniques should take into account previous training and current time constraints; (2) evidence for the relevance of system theory to diagnosis, treatment, and prevention should be evaluated early in the teaching program; (3) clarity of expectations is crucial; (4) emphasis should be on the natural role of the family physician as first-line family advisor and the use of interviewing and observational skills already well developed; and (5) synthesis of the psychosocial and physical aspects of illness will occur naturally if the family physician is the teacher of family system concepts and the role model for their application in practice.

In many family medicine practices and programs, "family" is a misnomer. Most programs rightly stress the importance of whole person medicine, but few have gone beyond the traditional focus on the individual as the patient. The family as a system is not yet of primary concern; for example, the family system was emphasized in fewer than 10 percent of residency programs assessed by the Society of Teachers of Family Medicine.[1]

Considering the family as patient can improve medical care.[2-5] Diagnoses become more accurate, therapy becomes more appropriate, and compliance is increased. Yet despite attention to the family system concept in the literature of family medicine,[2-9] it remains poorly understood and only superficially accepted and applied. As a result, in some family medicine residency programs and practices, physicians may never see a whole family together, family charts are not the rule, and even family registration may not be encouraged. One family medicine resident described his entire training in the area of the family as two seminars

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given by a medical sociologist, too abstract and full of jargon to be useful.[10] Not surprisingly, practicing physicians have little knowledge of important background facts on the family,[11,12] let alone a knowledge of family relationships.

Two studies illustrate the lack of acceptance and application of the concept of the family as a system. One showed that all family members were followed by the same physician in only 28 percent of families in a San Diego suburb practice.[13] A questionnaire given to family practice patients in New Jersey confirmed the under-reporting of social problems of other studies.[14] Sixty-four percent of patients perceived problems or concerns in the emotional life of their family. Only 26.5 percent of the charts had notes on psychological symptoms on the present or past visits of these patients, while only 3.5 percent recorded any psychosocial diagnosis.

There appear to be two principal reasons for the reluctance to develop a family focus. The first is the conceptually difficult transition from the *linear* deterministic medical model (cause A leads to illness B), where the focus is the individual patient, to the *cybernetic* model of the family as a *system,* in which the pattern of interrelationships is seen to have impact on health and disease. There is a vast difference between looking at the individual patient and looking at the illness as one piece of a jigsaw puzzle, where the whole picture is the system (family or community) in which that piece is embedded. Geyman has spoken of a "profound conceptual shift" as being necessary before the family can become the focus,[15] and teachers who have not made this conceptual shift[16] may be irritated by what they see as too great an emphasis on the family.

The second problem is confusion between the skills of a family physician working with families and those of family therapy, a separate discipline. Just as a family physician may in some environments and with extra training do surgery or anesthesia, so may a family physician with the inclination, ability, and further training do family therapy. Most will not. To be able to interview and assess a family, to understand individual illness as a part of the family system, and to have the "family as patient" is not family therapy.

The individual and the system approaches are illustrated by the following example:

One family physician was treating nine-year-old Martin A. for abdominal pain for which no organic cause could be found. His mother was seen separately for a recent exacerbation of asthma. Mr. A. was monitored by a cardiologist. After several months with no improvement of the boy's symptom or the mother's asthma, a family interview by a second family physician revealed the following: a lonely child whose older siblings had recently left home had developed abdominal pains soon after losing the dog to which his mother was allergic. This had developed after Mr. A. had had coronary bypass surgery, a topic that was never discussed by the family. Mrs. A. did not want the dog, as she was now anxious to change from her role of housewife tied to the home. Her husband's operation had increased his insecurity and hence his authoritarianism, upsetting the original precarious balance in the family. Treating abdominal pain, asthma, and cardiac disease separately had missed the opportunity to improve the family's adjustment to a life threatening illness. This was achieved by four sessions with the second family physician. The boy's isolation from his parents decreased in parallel with their verbalization of fears for Mr. A.'s health. A change in family structure, necessitated by the older siblings' departure, as well as by Mr. A.'s illness, occurred when Mrs. A. was able to find a job, relieving some of the wage earning pressure on her husband. Pains and asthma disappeared. A new equilibrium with better communication had been reached.*

An ability to observe relationships and an understanding of the family life cycle and response to illness enabled the physician to convert a potential crisis situation with frequent visits to the office into improved adaptation and less use of physician time.

Teaching Principles

For the conceptual shift to occur so that family physicians can understand and evaluate the relevance and validity of family concepts for their practice, several steps are required. The learner must first understand that this is quite a new way

*All clinical examples are from the author's practice.

of thinking about what seems to be a familiar topic, the family. He must then be convinced by the research evidence that to learn this new perspective will improve his efficiency and efficacy as a physician. Finally, he must develop the habit of "thinking systems" and the skills of working with families.

In this paper five principles are discussed that are useful in developing a family orientation in residency programs. These principles also apply to postgraduate training of the practicing physician. In contrast to the resident the physician with several years' experience of families will already have a concept of the family as a unit important to health. Some physicians will intuitively have developed a system approach.

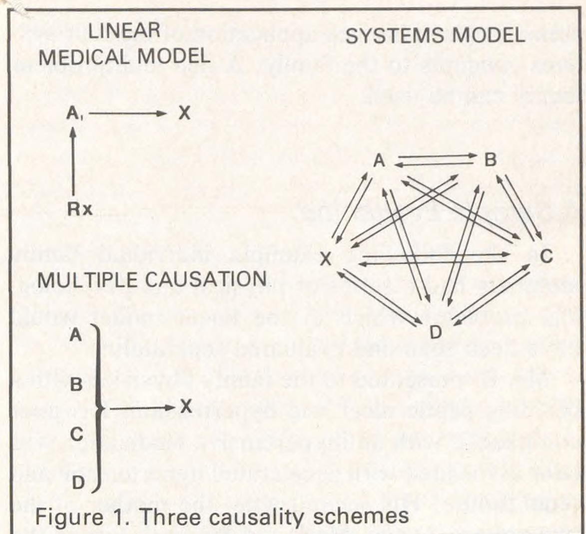

Figure 1. Three causality schemes

A Familiar Model Should Be Used to Teach a New Concept

The physician has been trained in another context to think in system terms—the body's organ systems. Using the familiar endocrine system as analogy clarifies the difference between a system and an individual approach. In physiology cybernetic rather than linear thinking is familiar and the focus is on the system, not on the individual part. The system view suggests that it is better to treat the adrenals as part of the endocrine system or a liver with reference to its alcoholic owner. As is a focus on the organ at times in order, so is a focus on the individual. But the inability to bring the family into focus produces the same distortions of reality as would broad generalizations about the ill patient from the pathologist's slide.

It is not easy to accept a system concept.[17] It is part of Western culture to see the "natural" unit as the individual. (Similarly it is the mind-body dichotomy of Descartes that underlies the artificial polarity of the functional and organic concepts of Western medicine.) Moreover, language, being linear, forces one to look at causality in sequential terms: A leads to B and B leads to C. The question, Why? is stressed, which assumes unidirectional causation from the past. Neglected are asking How? or What is happening? questions that focus on patterns of interaction in the present.[18] From the linear causal chain or even multiple causality to the system view is a quantum leap (Figure 1). Illness B is no longer isolated and caused by A; A is not the causal factor but part of a larger pattern or feedback system.

As a model, the endocrine system illustrates four concepts of general systems theory that are applicable to the family as a system:

1. The whole system must be understood in order to understand the diseased organ; the whole is greater than the sum of its parts.
2. Homeostasis is essential to well-being and operates in sickness as well as in health; it is maintained by complex positive and negative feedback mechanisms.
3. The emphasis is not only on the organs themselves but also on the hormones or interrelationships, which are the means to assess the system's function.
4. Changes may occur in many areas remote from the original pathological focus; all organs may be affected by a change in one organ.

It is useful to demonstrate the close analogy of a family to the hierarchical endocrine system whose hormonal stimulants lie in the cerebral cortex. To facilitate transfer of knowledge from the familiar systems thinking of physiology, visual learning has been particularly useful. Using a diagram of the endocrine system with family figures appropriately superimposed (ancestors in the cortex, grandparents in the hypothalamus, parents in the pituitary, and children in adrenals, thyroid, pan-

creas, etc) emphasizes application of the four systems concepts to the family. A real multiproblem family can be used.

A Sample Evaluation

In the following example individual family members had a series of physical and psychological problems which in the linear model would have been seen and evaluated separately:

Mr. B. presented to the family physician with a bleeding peptic ulcer and hypertension. His poor compliance with antihypertensive medication was later associated with accelerated hypertension and renal failure. His second wife, the mother of the two youngest sons, Mark and Michael, visited the physician with frequent headaches. Two older sons, Peter and George, in their twenties, had unstable relationships with their girlfriends and intermittently returned home. First Mark, then Michael, developed abdominal pains. The one daughter, Ann, had several episodes of delinquency and suicide attempts. Both parents and two sons had thalassemia minor. Two family members had giardiasis.

The family orientation requires that each family member and their symptoms be understood as part of a whole (concept 1). Further information came from family members once the physician had become a trusted family confidant:

The father's first wife died at the birth of Ann, the third child, and the father clearly had unresolved guilt over her death. That she had hemorrhaged at home after the birth was a family secret, and the father was ostracized by her family, who held him responsible. He in turn ostracized his son, George, when he eventually married a girlfriend of whom the parents disapproved. The second wife had difficulty relating to the three older children. The family had a pattern of denial and avoidance of difficult topics, which resulted in physical illness or severed relationships. (Of George, the father said, "He is dead as far as I'm concerned.")

Homeostasis (concept 2) was disturbed by Ann's developing sexuality and resemblance to her dead mother, which increased the insecurity of her stepmother and her father's guilt. The father's renal failure, which was never discussed, and the older boys' leaving home further disturbed the equilibrium. Feedback mechanisms maintained the avoidance of conflict areas. Rather than openly face the father's illness and its implications, the family prompted the sons to come home periodically, ostensibly because of problems with their girlfriends, but in fact to take over the fathering and breadwinning roles. Ann similarly maintained the family denial by drawing the attention of the family and the medical profession away from her father's illness to herself through delinquent and suicidal behavior. Ann's feelings about her mother's death and her father's illness could not be dealt with directly without altering the family system.

To treat this, it was essential to understand family relationships (concept 3). These could not be assessed without observation of family members' interaction together, since, individually, conflict was denied. In a family assessment interview the second wife's power became apparent. Normally reticent when seen alone, here she was in complete charge. She answered all questions directed to her husband and increased his sick role through overprotective concern. She demonstrated obvious but unspoken jealousy of the dead wife and resentment of her stepdaughter; in fact, she was unable to tolerate Ann's presence in the same room (when asked previously about her relationships, she said she got along very well with her stepdaughter).

Diagnosis, treatment, and compliance were all improved by understanding how individual symptoms or illnesses supported the disturbed family functioning. The father's initial poor compliance related to his feelings of guilt and his resistance to the increasing power of his wife. The younger sons' abdominal pains were found to have no organic basis and disappeared when the similarity to the father's ulcer symptoms was discussed. Diagnosis and hence rational treatment of the daughter's odd behavior (first thought to be manic-depressive psychosis or fugue on initial individual evaluation by a psychiatrist) were only possible in the context of the family system. Similarly, helping the older sons with relationships with their girlfriends involved helping them and their parents with their difficulty in leaving home.

Thus unresolved conflict over the death of the first wife and the subsequent communication block led to far-reaching effects on every family member (concept 4).

Evidence Should Be Presented Demonstrating the Relevance of the Family System to Medical Care

Medical students are trained to be skeptical of theories and treatment regimens for which scientific evidence for efficacy are not available. It is therefore incumbent on the teacher to be familiar with the evidence that links disease and the family system. Studies are presented that show the impact of illness on the family as well as the family system's impact on the illness of a family member. In addition, mention is made of the treatment considerations and compliance expectations that pertain to management of the family as a system. It has been found that presentation of these studies at the beginning of a course on the family allows the students to evaluate for themselves whether understanding the family will be important in their future practice.

Improved or More Complete Diagnoses

Several authors have recently reviewed research demonstrating the impact of the family system on the physical as well as the psychological health of the individual members.[2-5] Diagnoses may be missed, incorrect, or incomplete if the family is ignored. Duff and Hollingshead found a misdiagnosis rate of 26 percent in an eastern American teaching hospital.[12] Ninety-eight percent of the physicians in this study stated they did not need to know more about their patients but were unaware of family issues such as identification with illness of a dead relative, which would have clarified diagnosis.

Treating the presenting physical illness may be equivalent to treating a symptom and ignoring the underlying diagnosis. Meyer and Haggerty studied streptococcal infections in 16 families (100 people) over a one-year period.[19] They demonstrated the effects of acute and of chronic family stress on the occurrence of the infection, the carrier state, and the immunological response. Infection was four times more likely to occur in the two weeks following acute stress, such as divorce or death of a relative, than in the two weeks preceding it. In families with chronic stress (rated independently by two observers using Bell and Vogel's 16-point rating scale[20]), the rates of elevated antistreptolysin zero titer per infection were higher (49 percent of patients compared to 21 percent in low-stress families; $P<0.01$) as were infection and carrier rates. Apart from being "tickets of admission," the minor illnesses often seen in the family physician's office may point to family dysfunction as sources of lowered resistance.

Chambers and Reiser found that an emotional crisis was the predominant precipitating cause in 19 of 25 consecutive hospital admissions for congestive heart failure.[21] The incidences of myocardial infarction, tuberculosis, diabetes, cardiovascular accidents, and cancer are higher in the widowed than married of the same age.[22,23] Since the mortality rates also are higher,[23,24] increased incidence is unlikely to be attributed to earlier detection (which might result from greater contact with health care facilities). Holmes and Rahe have clearly linked stressful life events, of which the first seven are disruptions in the family, with the development of illness.[25]

Most physicians are well aware that physical symptoms often mask problems of living, since North American culture is more accepting of physical complaints than it is of psychological complaints. The limitations of traditional diagnostic labels have been recognized by Engel[26] and McWhinney[27]; they developed diagnostic schemata to allow for multiple causality but did not look beyond the individual patient to the family system. That stress affects the individual was recognized, but that the individual's illness may relieve the family stress was not.

The system perspective takes diagnosis one step further. Dealing with the psychological problem behind the symptom or illness may constitute symptomatic treatment if the individual alone is considered; only treatment of the underlying disturbance in the family can effectively eliminate the cause of distress. Just as the presenting symptom of an individual patient may change from headache to abdominal pain if the underlying depression is not treated, so the identified problem in a family may change. For example, in one family an asthmatic child improved, but a sibling developed recurrent boils. Then a second sibling developed eczema. Once the fighting between their divorced parents was resolved through therapy, the frequent visits for physical illness stopped dramatically.

Treatment

Both compliance and results of treatment are influenced by family factors. Several studies recently reviewed by Schmidt have demonstrated that compliance is strongly influenced by the family attitude to the illness and treatment regimen and is related to the general level of family functioning.[28] Hoebel showed that persistent high risk behavior in men with heart disease could be altered by five sessions with their wives, in contrast to discussion with the men themselves, which was ineffective.[29]

Therapy for part of a family system can be dangerous. For example, individual psychotherapy of one spouse has been shown to lead frequently to illness in the partner or marital breakdown.[30] Obese patients undergoing intestinal bypass operations manifested marital problems in the postoperative period when the family was ignored.[31] These facts clearly emphasize the role of the family system; at the same time, however, they do not negate the need to treat the individual's medical problem. Assessing the family may increase accuracy of diagnosis; therefore, treatment will be more appropriate.

Studies of diabetic children by Minuchin et al have demonstrated both the relationship between home environment and ketoacidosis and the effects of family therapy on acidosis.[32] Of 13 diabetic children who were hospitalized an average of 12 times per year for severe ketoacidosis, after family therapy 3 had only one admission per year, while 10 children had no admissions. The children, prior to family therapy, had been easy to control while in hospital but were extremely resistant to insulin while at home (500 units in 19 hours at home compared to a daily hospital requirement of 30 units).[33] Similar studies of severe steroid dependent childhood asthma and of anorexia nervosa demonstrated that families who denied conflict, particularly between the parents, could trigger a psychosomatic crisis in the child.[32]

Prevention

Awareness of the family life cycle[4,34] and the family tasks and specific risks associated with each stage make anticipatory guidance possible. For instance, the need to measure blood pressure of a father in the context of couple monitoring during pregnancy will only be recognized by the physician who knows that expectant fathers are at increased risk.[35]

Prevention of myocardial infarction involves diet, exercise, and cigarette control. The Framingham study,[36] in which these risk factors were evaluated, did not examine family function. In a prospective study of angina in 10,000 men, however, Medalie et al showed that family dysfunction was a greater risk factor than cigarette smoking and was as important as hypertension and cholesterol.[37] There was a threefold increase in the incidence of angina in families with severe dysfunction compared to those with no dysfunction (16/219 at risk, or 88/1000, and 50/1636 at risk, or 31/1000, respectively). Lynch cites further evidence of the link between family dysfunction and heart disease, as well as other diseases in his classic book *The Broken Heart, The Medical Consequences of Loneliness*.[23] Nesser assessed the degree of family fragmentation in blacks in counties of North Carolina and found a high correlation with stroke morbidity for these counties.[38] For example, in counties with most social disruption (divorce, single-parent families, illegitimacy, and imprisonment) males aged 35 to 44 years had an annual mortality rate from strokes that was three times higher than in counties with the least disruption. A prospective study of pregnancy[39] showed a complication rate of 90 percent in women from high-stress families with low support. Another study of pregnancy[40] showed a relationship between premature delivery and stressful life events.

There is some evidence that these effects of family distress can be prevented with appropriate crisis intervention, ventilation of anxiety, and involvement of family members in medical decisions, all of which can at least reduce the stress.

Prevention in the family physician's office implies providing additional support at times of stress and counseling the family. That a disturbed family system can produce or aggravate disease has implications for prophylaxis; family therapy may reduce the need for sickness. Conversely, illness in an individual has an obvious impact on the family,[41-43] and use of community, church, and extended family may lighten the burden. Morbidity after death or disease of a relative may be prevented if the emotional impact is expressed with

the support of a family physician[44] rather than channeled into physical illness. Indirect evidence for prevention comes from decreased use of medical services when family emotional problems are dealt with.[45,46]

Outcomes of Family Therapy

If family assessment indicates the need and acceptance of family therapy (less than five percent in the author's practice) rather than one or two counseling sessions, referral will usually be necessary. Outcome studies of family therapy have been recently reviewed.[30] Each of 200 studies reviewed showed that family therapy was equal to or superior to individual therapy; therapy for the family or marital system was the treatment of choice for marital problems, sexual dysfunction, and psychosomatic and behavior problems of childhood, including juvenile delinquency. Overall improvement rates were two out of three families in well-designed studies. Watzlawick et al found positive outcomes after an average of seven hours of family therapy in 71 of 97 families (73 percent).[47] Success was defined as achievement of the goal agreed on by the family and therapist at the onset of therapy as well as maintenance of that goal, an absence of new problems, and no other need for therapy at a one-year follow-up session.

Expectations for a Family Physician Should Be Clear: The System Orientation Does Not Imply Radical Changes in Practice or Family Therapy by the Family Physician. Skills Should Be in Family Assessment

The conceptual shift and ability to work with families implies improved family assessment and support for the family system. A family physician with a system orientation will still see individuals in his office 95 percent of the time. He or she may be more aware of "the family in the patient," will know all members of most families in the practice, and will respond to clues indicating the need for a family interview.

Except for the occasional family physician with sufficient particular interest to motivate him to obtain further training, family physicians should not be family therapists. However, in order to avoid errors in diagnosis and treatment and poor compliance in patients, and in order to know when and to whom to refer, family physicians should be proficient in *family assessment.* Various schemata for assessing the family are available. Smilkstein's Family APGAR[7] and Pless and Satterwhite's Family Function Index[48] are useful screening techniques, but since they are given to individuals, they do not fully assess the family system and only tap admitted dissatisfaction. The Family Assessment Schema by Arbogast et al[9] and the Family Categories Schema by Epstein et al,[49] in contrast, are based on an interview of the whole family. They are designed to assess family interaction, the emotional climate of the family, problem defining and solving, role expectations and behavior, and cultural supports. Unless a physician can evaluate verbal and nonverbal family interactions, his position will be analogous to that of the endocrinologist who is unable to measure the concentration of hormones, and he will therefore sometimes fail to make the correct diagnosis. Physicians who prefer an initial interview with the whole family when they join the practice both avoid this danger and emphasize to their patients their family perspective. They also facilitate future requests to see more than one family member. Assessing the family emotional climate is aided by the presence of the children, who do not use the denial and intellectualizations of adults. This is best demonstrated to a resident by the experience of including children in family interviews. Broder gives a good outline of the family assessment interview.[50] Barnhill's article on healthy family systems[51] is an excellent review of the theoretical framework for assessment.

When is a family interview appropriate? The following list of clinical situations that suggest a solution may be found by identifying a disturbance in the family system has been useful:

1. Diseases that are causally related to lifestyles and environmental factors
2. Difficulty in the management of chronic illness; poor compliance
3. Frequent visits for symptoms with poor response to treatment (eg, fatigue, headache, abdominal pains, backache)
4. Frequent visits to the office by different family members
5. Emotional, behavioral, or relationship prob-

lems (eg, sexual counseling requires assessment of the marital system)

6. Family crisis and loss of family composition through death, divorce, hospitalization; loss of a job or a move

7. Anticipatory guidance for family developmental stages (eg, prenatal couple counseling, preretirement counseling)

8. Health promotion (eg, change in lifestyle, nutrition, immunization, genetic counseling)

The family assessment interview with a family physician is not the same as that with a family therapist. The family physician already has a well-developed relationship with at least most individuals of the family. The focus of the assessment may be on health promotion or illness, since they may be the reason for the interview. Prevention is a prime goal, one that is not appropriate for a family therapist, who usually sees a family at a much later stage of problem formation. However, evaluation of the family structure and the stage in the life cycle, of coping mechanisms, and of family strengths can lead to a family "diagnosis." The diagnostic impression can be conveyed to the family much as a physical diagnosis would be explained. Relabeling of issues and support may lead to new insight or improved coping, without any attempt by the clinician at system change. In a small proportion of families, destructive and rigid behavior patterns may indicate the need for system change and family therapy. To clarify the difference between the family content of family medicine and family therapy, contrasts are listed in Table 1.

The question of time must always be addressed: how can more time be found for teaching about families or for seeing whole families? Even with a heavy practice load, there is time, as most family physicians will attest. One or two hours per week set aside for family assessment is sufficient in the average practice. To be effective, however, interventions do not always need time: Remen has described a two-minute corridor consultation with a surgeon that was more effective than a consultation of several hours with an internist.[52] There is evidence that a single one-hour session with a family can produce change through relabeling problems or suggesting new solutions.[53] With a dying patient, parents-to-be in the delivery room, or a family seen during a house call, the appropriate intervention may be quite brief. What is needed is a warm empathic personality plus a real understanding of each family system. Accurate evaluation of a problem and more effective intervention will eventually save time[45]; inappropriate interventions may unknowingly contribute to family pathology or dysfunction. For example, hospitalization of a patient with a psychosomatic illness or "mental breakdown" may encourage a permanent sick role for that member and avoidance by the family of the underlying communication problem or conflict.[33]

Emphasis on Skills and Roles as Family Advisor Already Familiar to the Physician Will Increase Acceptance of a Family Orientation by Residents, Faculty, and Practicing Physicians

It is important to emphasize that the physician already has skills and knowledge about families. If family system theory has not been taught in medical school, a resident is faced with learning yet another set of concepts and skills when he or she is anxious to put in practice his new role as physician. If family system theory is introduced as an entirely new field of study, particularly since it also holds the threat of increasing awareness of family issues in the physician's own family, the resident may retreat to safer and more familiar medical ground. Similarly, faculty members with no training in this area may avoid family issues unless enlisted to help teach it. A physician in practice for several years, however, will be more likely to welcome theory that confirms his intuitive observations of families.

Interviewing and observational skills are already part of the family physician's repertoire, and his role as first-line family confidant is inevitable. Unless a physician indicates lack of interest or inability to listen or to empathize, he is usually the first professional to hear of family problems and the first to see dysfunction and disease. He will inevitably give advice and support; as in other areas, his counsel should be based on knowledge. He has already "joined" the family, a process it may take a family therapist months to achieve. Many families will not agree to go elsewhere, even if referral is recommended—the stigma of talking to your physician is nil.

Table 1. Contrast between Working with Families in Family Medicine and Family Therapy

Family Medicine	Family Therapy
Focus on prevention and on normal developmental tasks of family rather than dysfunction	Focus on treatment of family dysfunction
If change occurs, initiative comes from within the system. No contract for change	Change dependent on intervention from outside system
Longer contact (in years) with family over time	Therapy for 3 to 12 months is usual
Briefer (half-hour) and fewer (1 to 3 average) sessions with whole family perhaps several weeks apart	Longer (one hour) and more (weekly) sessions with whole family (7 to 10 minimum)
Individual contacts can add to overall picture of family in less threatening manner (focus may be on physical symptom)	Whole family or subsystems usually seen. Resistance may be high; many families refuse family therapy
Broader focus available through familiarity with the extended family over time, and with the community	Only immediate family members known to the therapist and focus is on limited problem areas
Clinician has often joined with members separately prior to whole family interview	"Joining" may take several months
Relationship facilitated by dependence on clinician's medical expertise	Credibility as someone with expertise on family may be higher
Lack of expertise in managing difficult family problems and exceeding limits of training may result in problems if family refuses to see family therapist	Much greater expertise and experience with difficult families makes crises into occasions for change

In contrast to the older physician's comfort with families, some residents find that learning to interview the family is difficult.[54] Developing this skill should be facilitated by the physician's prior contact with individual members of the family. Interviewing couples may be an easier first step in learning to stimulate and observe interactions. Promoting interaction is difficult for beginners, who tend to conduct a series of simultaneous interviews with family members as individuals, with every member communicating with the physician instead of with each other. Assessments in the home give more information and may be less threatening for both physician and family, especially when part of a regular house call.

In order for residents to experience for themselves the power of a family system to mold behavior, the technique of family simulations has been found a useful teaching method. Each resident becomes a family member of his choosing, and the family system is allowed to develop naturally around a presenting problem. This technique has been well described by Sigal and Levin.[55] The use of family simulations can also desensitize residents to the interviewer role. Role playing of difficult family situations can be used to teach interviewing and intervention techniques. The resident has been well trained to observe physical signs of illness of his patients; learning to observe the nonverbal interactions between patients is a similar skill. It requires practice. Videotapes of resident interviews are invaluable both in review of patient interaction and in self-observation of the resident's own nonverbal behavior. Self-awareness

and the ability to use one's emotional reaction to a family are an important part of family assessment. The resident should also learn to become aware of being taken into the family system and the possible consequences of this. Family "sculpting" has been found useful in conveying, through physical analogy, the interdependence of parts of the system as well as the unique character of each family. Its use in "well families" is described by Papp et al in a well-written article[56] that is very useful for teaching system principles.

Good outcomes from any form of therapy are linked with well-known characteristics in the therapist, such as unconditional acceptance or liking of the patient, nonpossessive warmth, congruence of genuineness, and accurate empathy.[57] Training of family physicians and, indeed, selection of residents should take these characteristics into account.

Physical and Emotional Problems Are Interrelated. Their Separation Is Discouraged if a Family Physician Teaches Family System Concepts

The family system is intimately involved in both physical and emotional disease. The educational structure should not separate the psychological from the physical.

In introducing family concepts, it is crucial that the teacher should be perceived as understanding family practice and the importance of life-and-death issues. It is therefore preferable that the teacher be a competent family physician who has the ability to focus on the organ, the individual, the family, or the community as the patient situation demands. Psychologists, social workers, and psychiatrists are invaluable sources of expertise, but, unless they are supported by physicians with a systems view, they may be seen as outsiders trying to impose their concepts, often expressed in an unfamiliar language, on those whose job is to preserve life and eradicate disease. If a student's role models do not emphasize the family, all such teaching will be ineffective.

A critical mass of faculty who fully understand system theory is necessary for the family to become the focus of attention. In contrast, untrained family physicians may retard the introduction of the family system view. Such physicians, on the basis of years in practice, may believe that they have all the knowledge they need to teach important family concepts. Instead, however, they may impede the transmission of knowledge based on recent advances in family theory; in particular, they may not be aware of the conceptual changes implied by the system view and will continue to teach an individual focus.

Small-group learning is particularly applicable to teaching family dynamics; the group process itself can illustrate system principles.[58] Learning to think interactionally[59] can be facilitated or contradicted by the learning environment. Administrative support is the sine qua non for a family oriented program. The program director should be convinced of the value of this approach and preferably be a role model in its implementation.

Conclusion

Understanding the role of the family in illness requires a transition from linear to system thinking. The family, rather than the individual, then becomes the patient, whose symptoms can only be understood in relation to the whole. The physician's knowledge of biologic systems, his justified skepticism and his need for research evidence, his time and his skills with the individual patient—all need to be used efficiently in learning this new approach. The transition to a system approach may not occur, despite the availability of appropriate texts and use of family interviews, if medical teachers who have learned to think in system terms are not available. For family medicine residents, the need for knowledge in the psychological areas is much less apparent than for the older practicing physician. Introduction of family system concepts can induce resistance that is common when new concepts are introduced, particularly those with implications of assessment of one's self and family. But once a physician becomes comfortable and skilled in family assessment, his position in the community as the family confidant makes him invaluable in detecting and preventing problems arising from family dysfunction. In such a role he brings a rare dimension to primary care.

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