

---

# Family Practice Forum

---

## Family Illness Rituals

Michael L. Glenn, MD  
Everett, Massachusetts

Rituals are repeated patterns of behavior, often containing deeply compacted meanings. At subtler levels they are shrouded in metaphor and psychological significance.

The student of family process quickly learns that families have rituals for dealing with many aspects of life. Among these are rituals for dealing with illness. Just as an individual's daily habits reflect his or her inner conflicts, so a family's rituals can condense and express its beliefs, images, style, and role assignments. Further, they provide models for dealing with sickness that are passed down from generation to generation; this influence extends into the physician's office. Sensitivity to such patterns can attune the physician to the basic family dynamics.

At the heart of family illness rituals is the issue of caretaking. Who cares for the sick? Who takes

care of the caretaker? Do both members of a couple care for one another in times of illness, or is the relationship fixed in one direction only? What happens to a family when a previously healthy member falls ill? How long does the family take to recognize an illness? Who recognizes it? What does it take to qualify as sick, and what must happen to warrant going to a physician? What weight does the physician's pronouncement carry in the family? Often, the way a couple first handles illness in one of its members sets a pattern that may endure for years.

Illness rituals are richly imbued with the symbolism of bodily functions. In this, they approximate religious rites. Consider, for example, the rituals surrounding the cleansing of the sick: bathing those who cannot wash themselves, wiping off accumulated excreta, dressing wounds, changing catheters, and so on. Which family member is assigned to bathe the sick? Does one particular child care for an ill parent and thus become drawn ever more intricately into his or her life, or is such a duty shared? Is the caretaker position esteemed or looked down on? Is it a source of argument? Does it lead to a shift in power relationships or living

---

From the Department of Sociomedical Sciences, Boston University School of Medicine, Boston, Massachusetts. Requests for reprints should be addressed to Dr. Michael L. Glenn, Everett Family Practice, 137 Ferry Street, Everett, MA 02149.

Continued on page 952

0094-3509/82/050950-03\$00.75  
© 1982 Appleton-Century-Crofts



Continued from page 950

**Coly-Mycin® S Otic****with Neomycin and Hydrocortisone**

(colistin sulfate—neomycin sulfate—thonzonium bromide—hydrocortisone acetate otic suspension)

**INDICATIONS AND USAGE**

For the treatment of superficial bacterial infections of the external auditory canal, caused by organisms susceptible to the action of the antibiotics; and for the treatment of infections of mastoidectomy and fenestration cavities, caused by organisms susceptible to the antibiotics.

**CONTRAINDICATIONS**

This product is contraindicated in those individuals who have shown hypersensitivity to any of its components, and in herpes simplex, vaccinia and varicella.

**WARNINGS**

As with other antibiotic preparations, prolonged treatment may result in overgrowth of nonsusceptible organisms and fungi.

If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed.

Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

**PRECAUTIONS****General**

If sensitization or irritation occurs, medication should be discontinued promptly.

This drug should be used with care in cases of perforated ear drum and in longstanding cases of chronic otitis media because of the possibility of ototoxicity caused by neomycin.

Treatment should not be continued for longer than ten days.

Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

**ADVERSE REACTIONS**

Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

**DOSAGE AND ADMINISTRATION**

The external auditory canal should be thoroughly cleansed and dried with a sterile cotton applicator.

For adults, 4 drops of the suspension should be instilled into the affected ear 3 or 4 times daily. For infants and children, 3 drops are suggested because of the smaller capacity of the ear canal.

The patient should lie with the affected ear upward and then the drops should be instilled. This position should be maintained for 5 minutes to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear.

If preferred, a cotton wick may be inserted into the canal and then the cotton may be saturated with the solution. This wick should be kept moist by adding further solution every 4 hours. The wick should be replaced at least once every 24 hours.

**HOW SUPPLIED**

Coly-Mycin S Otic is supplied as:  
N 0071-3141-08—5 ml bottle  
N 0071-3141-10—10 ml bottle

Each ml contains: Colistin sulfate equivalent to 3 mg of colistin base, Neomycin sulfate equivalent to 3.3 mg neomycin base, Hydrocortisone acetate 10 mg (1%), thonzonium bromide 0.5 mg (0.05%), and Polysorbate 80 in an aqueous vehicle buffered with acetic acid and sodium acetate. Thimerosal (mercury derivative) 0.002% added as a preservative.

**Shake well before using.**

Store at controlled room temperature 59°-86°F (15°-30°C). Stable for 18 months at room temperature; prolonged exposure to higher temperatures should be avoided.

3141C031

arrangements? Further, when a child is disabled, which parent or other sibling takes up the burden of care?

Illness rituals can be approached in several ways. One simple schema divides them into rituals relating to acute or chronic illness of minor or major severity, with a final category being rituals related to death and dying.

Minor repeated illnesses often arouse memories in us. What happened when, as a child, we were "sick?" Were we swathed in comforters, propped up on pillows, and permitted to lie in bed and listen to the radio or watch television, freed from all responsibilities? Did we have special things to read and special foods to eat and drink?

People are often indulged when they are sick and are given special soups or juices, alcoholic beverages, colas, tonics, teas, and the like. Children with chest colds receive mustard plasters, unguents and poultices, rubs, and vaporizers. Others must fight to prove they are sick. Some children are sent to school unless they have a fever. Others are sent to school even if they have a fever. At times, one parent may adopt a pampering attitude toward the sick child while the other may be more stern.

Families that must cope with chronic illnesses can be transformed by the task. They start accepting the accoutrements of illness as family objects and develop rituals of handling them. Such is the case of an invalid's wheelchair, for instance. Where is it kept? Whose job is it to care for it? Does the same family member always wheel the invalid about, or do several take turns? Does the invalid insist on being "independent," or is the illness an occasion for greater claim for assistance? How does the wheelchair restrict where the patient can go: to people's homes, to the bathroom, to the physician's office?

One couple with a fairly equal relationship loved going out to eat. When the husband was injured in an automobile accident, he became confined to a wheelchair. As a result, it was necessary for the wife to be the more aggressive member of the couple. If they wanted to go out to eat, she had to scout out a restaurant that could accommodate wheelchairs, get the wheelchair into a car, and so

Continued on page 954



# KLOTRIX®

(POTASSIUM CHLORIDE) SLOW-RELEASE TABLETS, 10 mEq

**DESCRIPTION** KLOTRIX is a film-coated (not enteric-coated) tablet containing 750 mg potassium chloride (equivalent to 10 mEq) in a wax matrix. This formulation is intended to provide a controlled release of potassium from the matrix to minimize the likelihood of producing high localized concentrations of potassium within the gastrointestinal tract.

**INDICATIONS—BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.**

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy, and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and, if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

**CONTRAINDICATIONS** In patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (eg, spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the G.I. tract. In these instances, potassium supplementation should be with a liquid preparation.

**WARNINGS Hyperkalemia:** In patients with impaired mechanisms for excreting potassium, administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium intravenously but may also occur when given orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. Use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

**Interaction with potassium-sparing diuretics:** Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (eg, spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

**Gastrointestinal lesions:** Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. KLOTRIX is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains less than one per 100,000 patient-years. KLOTRIX should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

**Metabolic acidosis:** Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

**PRECAUTIONS** Potassium depletion is ordinarily diagnosed by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. Treatment of potassium depletion particularly in presence of cardiac disease, renal disease, or acidosis, requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, electrocardiogram and clinical status of patient.

**ADVERSE REACTIONS** Most common to oral potassium salts: nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by diluting the preparation further, taking the dose with meals, or reducing the dose. One of the most severe adverse effects is hyperkalemia (see Contraindications and Warnings). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration and perforation (see Contraindications and Warnings); other factors known to be associated with such conditions were present in many of these patients. Skin rash has been reported rarely.

**DOSAGE AND ADMINISTRATION** The usual dietary intake of potassium by the average adult is 40 to 80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq per day or more for the treatment of potassium depletion.

**Note:** KLOTRIX® slow-release tablets must be swallowed whole and never crushed or chewed.

Following release of the potassium chloride, the expended wax matrix, which is not absorbed, may be observed in the stool.

**HOW SUPPLIED** Bottles of 100, 1000, and Unit Dose cartons of 100.

**Mead Johnson**

PHARMACEUTICAL DIVISION

Mead Johnson & Company • Evansville, Indiana 47721 USA

02

M.J.L. 2-4698

## FAMILY ILLNESS RITUALS

Continued from page 952

on. Eating out was no longer something the couple could do spontaneously. The conflict around this change in a valued ritual symbolized the tasks they faced in redefining their relationship.

Rituals connected with severe illness also include such things as the visit to the hospital, patterned family interaction with the physician, and, in cases where death attends, the "vigil." A crisis encountered in an acute illness usually requires the family to reorganize itself, to bury minor discontent for a time, and to present a unified front to the physician. Many families know who is to take charge during an episode of illness. Some families restructure themselves in the face of illness, an arrangement that may last after the illness resolves, and still other families may be unable to come together as a result of old conflicts that may actually deepen.

Bound up in all this is the question of affective tie and duty. Does the family regard the sick member as entitled to ample support, as in the case of the matriarch who grows old amidst guilt and responsibility, or does the family shy away from such a burden, feeling overwhelmed by the cost in time and money and unable to broach the alienation that has driven the generations apart.

Family attitudes toward the body and bodily functions become evident during illness. Intimate personal matters, such as vomiting, diarrhea, incontinence, and so on, must be handled. Which member does the cleaning up? Are family members sick by themselves, or does someone (who?) hold their heads?

While seemingly trivial, such gentle patterns that we can touchingly recall—brushing the hair of an invalid parent, giving a sponge bath to a sick child—are keys that fit into our family's particular mold. They describe the importance our family gave to being sick. They predict how strong or helpless we may be when we fall ill. They foreshadow our notions of appropriate care and clarify family squabbles over the same.

For the family physician, illness rituals provide rich information about the context in which illness arises, about the impact of illness on the family unit, and about the depth of family resources that may be available to help treat or cure the illness and to make the patient more comfortable at a time of severe stress.