When Is It Helpful to Convene the Family?

David D. Schmidt, MD
Cleveland, Ohio

There are three factors supporting current efforts to bring the family into the mainstream of American medicine: (1) research capabilities of the discipline of epidemiology, (2) the intervention skills developed by family therapy, and (3) pressures to provide cost-effective care as economic resources diminish.

The fundamental question addressed in this paper is, when can it be helpful for the family physician to convene the family in the consultation room? Physicians in the field and residents in training are often reluctant to take this step because of time constraints, awkwardness in talking to two or more members of the family, and unfamiliarity with what to do with the information that is gathered. From currently available research data, a list of 14 medical conditions is presented in which it can be predicted that family functioning or nonfunctioning is contributing to the cause of disease, or that the family will experience a major reaction to the illness. These medical conditions offer an ideal opportunity to begin working with families. A specific case history illustrating this approach is presented to demonstrate that convening the family can be an important dimension of family medicine.

In a thoughtful recent review, Ransom[1] points out that the involvement of the medical profession with the family has been cyclical. In the past each renewal of interest has failed to generate sufficient momentum to launch family issues and concerns into the mainstream of medicine. The current high point of interest, stimulated in great part by the resurgence of family medicine, is the first since the beginning of World War II.

Will history record this as yet another abortive attempt? One can well predict not, because two major developments provide significant support for current efforts to promote family-centered care. This support was not available in past years. Over the last quarter century, epidemiology has blossomed as an effective discipline for quantitating the complex array of multiple factors that have an effect on the human organism. At the same time family therapy, as a branch of clinical behavioral science, has developed theoretical constructs and intervention strategies having great potential for enlarging the diagnostic and therapeutic capabilities of today's health care team that works with families. A third factor, which may be the most powerful catalyst for change, is the ever-increasing economic pressure to provide cost-effective care for the American people. Emerging data[2] confirm that centering health care on the family unit rather than the isolated individual patient reduces the inappropriate utilization of high-priced technology. Armed with some of the skills of epidemiology and family therapy, and encouraged by economic trends, family medicine has a

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good chance of bringing the family into the mainstream of American medicine.

The Fundamental Question

The fundamental question to be addressed in this paper is, when is it helpful for the physician to convene the family in the consultation room? The family physician is often "thinking family" while caring for the individual patient in the context of the family environment. When is it helpful to take the next step and gather the family together? The act of interviewing the patient along with appropriate members of the family is the first step toward any explicit family work. In certain instances this exercise is essential for diagnostic purposes, and in the family physician's universe it is frequently therapeutic as well.

In the Department of Family Medicine at Case Western Reserve University, the family has been convened on a regular basis for Grand Rounds. These teaching exercises tend to focus on the family's reaction to the illness of an index patient. It has been apparent that serious or chronic illness can overload a family's coping mechanism and produce dysfunctional transactional patterns. For example, a father's denial of his pancreatic cancer became evident through the 10-year-old son's aggressive acting out at school. When the family was convened, it was also discovered that the mother was depressed, and a 3-year-old sister was having nightmares and would not sleep alone.

Having such a family publicly interviewed each week at these Grand Rounds has done much to overcome the reluctance of faculty and residents to take that first step of calling the family together.

Physicians in the field and residents in training are often reluctant to convene the family for several reasons: (1) the family interview requires 40 to 60 minutes of time, (2) at first, some find it awkward to talk with two or more members of the family, (3) the physician must have at least minimal acquaintance with certain theoretical constructs to know what to be looking for in such a family interaction, and (4) one must be prepared to process the information obtained during such an interview to make effective recommendations for future management.

Family theory and family interviewing build on the knowledge and skills required to understand and care for individuals. The individual's history of psychosocial development is not ignored. In fact, parents' brief description of their families of origin and early experiences in the presence of each other and the children can provide therapeutic insights. In many families these stories have not been told before. In addition to having the opportunity to obtain historical information about the family, the act of convening the family takes the physician to a higher plane of data collection: the direct observation of interactions among individual family members.

If students, residents in training, and practicing physicians are going to accept the suggestion that they invest an additional hour in the care of certain patients, they must first be convinced that there is a need to do so.

Current Research on Family and Health

Table 1 summarizes the medical conditions for which there is a reasonable probability that there will be associated family problems. These are conditions in which psychosocial factors in general and family functioning in particular play an important role. This is not a theoretic listing. Each medical condition was selected because there are reasonable data to suggest one of two situations: (1) family functioning contributes to the cause of the disease, or (2) the family will probably have a major reaction to the illness. There are a number of other situations for which one might predict that a family interview could be helpful, though future research is needed to confirm these impressions.

There is already considerable research evidence confirming important family interactions in a number of medical problems. Women experiencing high stress with little support during pregnancy have a complication rate exceeding 90 percent.[3] Over 20 percent of expectant fathers will seek medical care for the couvade syndrome.[4] Men experiencing sympathetic symptoms during their wives' pregnancies seek more medical care than they did prior to their wives' pregnancies. In a study of children meeting the criteria for failure to thrive, the only factor that could distinguish this group from controls was the presence of family problems.[5] Recurrent childhood poisoning occurs

Table 1. Indications for Convening the Family

Medical Condition	Associated Family Situation Problem(s)	Supporting Data
Pregnancy	High stress, low support, complications; fathers have symptoms	Nuckolls,[3] Lipkin & Lamb[4]
Failure to thrive	General, unspecified	Mitchell et al[5]
Recurrent childhood poisoning	Stressful life events in context of emotional instability	Rogers[6]
Preschool behavior problems	Strained marital relationships	Richman[7]
School behavior problems	Marital disharmony	Whitehead[8]
Adolescent maladjustment	Effective parental coalition and clear intergenerational boundaries required for growth	Kleinman[9]
Major depression	Somatization, spouse and children become ill	Calling,[10] Widmer & Cadoret,[11] Crook & Raskin,[12] Aneshensil et al[13]
Chronic illness	Hidden patients within the family	Downes,[14] Klein[15]
Diabetes	Marital stress, nondiabetic child suffers, parents unnecessarily restrict activities and career aspirations	Downes,[16] Crain et al,[17] Katz,[18] Crain et al[19] Kronenfeld & Ory[20]
Arteriosclerotic heart disease, coronary bypass surgery	Family support improves medical and psychological outcomes	Medalie et al,[21] Zyzanski & Schmidt,[22] Segev & Schlesinger[23]
Poor adherence to medical regimen	Family's attitudes greatly influence patient adherence	Steiell,[24] Cooper & Lynch,[25] Heinzelmann & Bagley,[26] Oakes,[27] Litman,[28] Schulz[29]
High "inappropriate" use of health services	Family stress, health behavior is learned from the family, low support associated with high utilization	Mechanic,[30] Mechanic,[31] Blake et al[32]
Terminal illness	Spouse develops physical problems	Guillo,[33] Bertman[34]
Bereavement	Increased morbidity and mortality, little support from family when a neonate dies	Kraus & Lilienfield[35] Rees & Lutking,[36] Parkes & Brown,[37] Parkes et al,[38] Helmrath & Steinitz[39]

in the setting of stressful life events in the context of emotional instability.[6] Both preschool and school behavior problems are associated with marital disharmony.[7,8] Optimal adolescent adjustment requires an effective parental coalition and clear intergenerational boundaries.[9] A depressive reac-

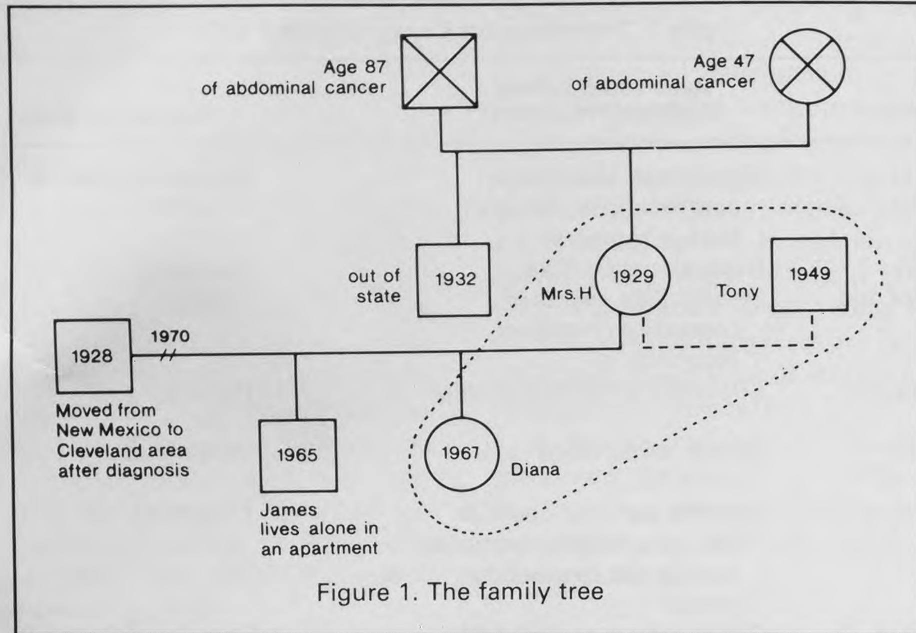

Figure 1. The family tree

tion may manifest itself as somatization in the index patient. The spouse and children in the family develop symptoms that result in a visit to a physician's office.[10-13] A chronic illness in one member of the family will produce symptoms in other members who do not have the illness.[14-16] Diabetes is associated with marital stress. A nondiabetic child suffers in the competition for parental nurturance.[17-20] Family support improves medical and psychological outcomes in arteriosclerotic heart disease.[21-23] The family's attitudes clearly influence patient adherence to treatment programs.[24-29] Patients with little support in their natural environment have a high rate of utilization of health services.[30-32] During the course of terminal illness, the spouse is at higher risk to develop physical problems.[33,34] There is increased morbidity and mortality during bereavement following the loss of a spouse.[35-39]

There are sparse data available to determine whether there is any benefit to be gained by convening the family around these medical problems. Research in the area offers a major challenge for the discipline of family medicine. The best information currently available comes from McMaster University. Family meetings were conducted dealing with emotional problems or masked psychosomatic complaints. This approach had a significant effect on the pattern of overall demands for health care made by the families. Forty-two families engaged in family sessions were matched with an equal number of families matched for problems and utilization during the previous year. The control group received traditional care. In the year following the first conjoint session, the study group showed a 49-percent decrease in their utilization of health services in contrast with a 10-percent increase in the control group of families.[40] Twenty-eight of the 42 families in the study group met only once or twice, which would suggest that convening the family saves time in the long run. The 60-minute investment can yield major dividends.

Case Illustration

To illustrate the value of convening the family, the following case history is presented of a patient and her family who recently came under the care of one of the family practice residents at University Hospitals of Cleveland. Figure 1 displays the family tree for this family.

Mrs. H. is a 53-year-old, previously healthy white woman who came to the Family Practice Center on December 1, 1981, complaining of rectal

bleeding of four months' duration. The bleeding had initially started as blood-streaked stools and progressed over time to dripping of blood and finally to occasional clots. The patient's stools remained soft and formed, but showed decreasing caliber. She had become aware of a nagging pain in her left lower abdomen and was bothered by a strong urge to defecate following meals. The patient had experienced no weight loss. Past medical history was remarkable only for an ectopic pregnancy and hemorrhoids. Both of the patient's parents had died of gastrointestinal cancers.

The physical examination was remarkable for tenderness to palpation in the left lower quadrant of the abdomen. A 3- to 4-cm ring-shaped growth with central ulceration was palpated in the distal dorsal rectum. The growth was friable and bled easily. A biopsy showed adenocarcinoma of the colon, poorly differentiated. Four days after diagnosis the patient was hospitalized. Barium enema showed no other lesions. Chest x-ray examination and all laboratory studies including chorionic embryonic antigen were within normal limits. Abdominal-perineal resection was performed on December 10, 1981. No gross intra-abdominal metastases were palpated. Pathology specimens showed the cancer to be extending through the muscular wall with metastases to 2 of 14 pericolic lymph nodes and 2 satellite nodules (Duke's C stage).

The patient's postoperative course was without complication, and she was discharged and has returned to full-time work as a medical illustrator.

The following is a transcript from a videotaped interview with the patient that was conducted three months after the surgery for one of the Grand Rounds.

MRS. H.: Dr. C. examined me and then, as you recall, you were called in and examined me. I was beginning to get the idea that this was a very serious matter—much more than hemorrhoids perhaps.

PHYSICIAN: What made you think that?

MRS. H.: Well, when you observed the site of the cancer and said, "It's friable," it was as though someone's house suddenly was on fire. It was very much an emergency situation. I know the meaning of friable. I just knew that this was a very serious matter. Your whole body told me that in a subtle way. I remember it as an announcement of imminent danger, if not death. It was a massive threat. I wished then to be alone for a time.

PHYSICIAN: I noticed that. I was trying to engage you to see if we could help you talk to your family or something. I think I said, "What could we do for you?" And you said, "Let me have my boots."

MRS. H.: Well, I wanted to run away, you know.

PHYSICIAN: I sensed that you wanted some space to yourself.

MRS. H.: Yes, I did.

PHYSICIAN: What did you do?

MRS. H.: I went to the bathroom again because I was still having to go to the bathroom a lot. I walked home. All the way I thought about everything. I was very upset. When I got home I announced to Tony the bad news, and we had a good cry.

PHYSICIAN: While you were waiting for the histology results (pathologic report) for those two days, what happened in your life? What did you do? What did you think about?

MRS. H.: Well, my brains were still boiling. I had read about people's acceptance of the inevitability of their own death. I guess about once an hour, every hour, I would go through all of the stages from nonacceptance, disbelief, anger, why is it happening to me, philosophical rationalization, and finally acceptance. I made a will. I called up the memorial society (that's a group in Cleveland that makes arrangement for your burial in a cheap coffin or a cremation so that you and your family will not have to bear the farcical expense of $3,000 to $4,000 to just put you in the ground). Then I decided there was one thing I must really do, if I was going to get sick right away, and that was to sort out some family photographs, so I started that project.

PHYSICIAN: How did your physician happen to get the whole family together to discuss the pathology results?

MRS. H.: Let me think. I think he just simply told me that he wanted us all to get together. Yes, he asked me to ask them all to come into the office at once.

PHYSICIAN: And they all were agreeable to that?

MRS. H.: They were, and I was very glad that they were there. I hung on to all of them. I was clutching them. It was great support.

PHYSICIAN: Did this take place in one of the examining rooms?

MRS. H.: No, it was in a pleasant sort of living room-like place with a couch or two. I was the most nervous one. Everybody else was being very brave. I dragged them all in there. I was hanging on to all of them at once. I had my arm around my son and I had Tony's hand. We all sat down. The chairs were arranged too far away so I made them all get the chairs around closer. Then Dr. C. came in, looking a bit nervous, but being brave. I don't remember how he introduced the subject, but he got through it and then asked us if we wanted to ask questions. My son asked something and Tony asked something. We talked there for about an hour. I remember things visually, but I don't remember what was said.

PHYSICIAN: But the message came out early that it was cancer?

MRS. H.: Yes, definitely. He was explaining that the whole family would all be involved in my illness. Before the operation, he said that this was often completely cured by surgery. There was no chemotherapy. After the operation, Dr. C. said that maybe I wouldn't have ten more years of life to look forward to—it was bad news—maybe six months to three years was all. But then he did very kindly say that there was "a lot we don't know."

PHYSICIAN: Did the rest of the family want this stark honesty?

MRS. H.: Well, that is the way I have raised my children. Yes, by far the truth is best for them. I've made a family policy ever since my children were small not to lie. I had parents who tried to conceal from me unpleasant things. The children won't have truth told them in the outer world, but I'll tell them the truth. So, that is what I had to do. Finally, I had to tell them a bad truth.

Comment

Much can be learned about the family from listening to patients and their families. This insightful and articulate woman teaches her physicians several important points:

1. It is extremely difficult for physicians to conceal their own reactions to a serious diagnosis. The patient can sense the situation from the physician's nonspoken behavior.

2. The period of waiting for laboratory results and definitive diagnosis and prognosis can be extremely stressful. Faced with uncertainty, patients frequently imagine the worst.

3. It is often very supportive to invite family members into the consultation room when serious conditions are to be discussed. Such conferences provide patients and families the opportunity to express major concerns that could never be identified without this opportunity.

4. It is usually best for the physician to take his cue from the patient concerning how explicit to be about the diagnosis and prognosis. This patient wanted to have as much information as possible. The physician provided the best estimates available without taking away all hope. Other patients may wish to rely more on denial as long as possible.

This is a good example of how convening the family can be an important dimension of family medicine.

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