The Single-Session Family Interview

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Currently, attempts are being made to integrate family systems theory and technique into the practice of family physicians. Although the importance of the family has been demonstrated in a number of medical situations and although several authors have indicated situations in which it is useful for the physician to convene the family, to date no explicit guidelines have been developed for conducting a single-session family interview. This article presents a framework for conducting such an interview, structured in three stages (contracting, exploration, and closure) with clinical examples for each stage. The single-session family interview provides the family physician with realistic guidelines for helping families who face medical dilemmas and for improving the physician's practice. The guidelines have proven useful in teaching residents the skills involved in understanding family dynamics and conducting productive family meetings.

Many family practice residencies include the teaching of family systems theory and family therapy in their behavioral science curriculum. A review of the literature demonstrates that family medicine is attempting to incorporate a family systems perspective into its skills.[1–5]

The application of family systems concepts to family medicine has sometimes meant attempting to teach family therapy or family counseling to the physician. This approach often overestimates the capacity, motivation, or availability of the physician to conduct ongoing family counseling sessions. The availability of consultation and supervision is also problematic.

The authors of this paper perceived a need to design a framework for conducting a single-session family interview that is structured, goal directed, and of practical use to the family physician when dealing with illness management, family decision making, and adjustment reactions. The physician, while not a therapist to the family, is often in a position to help family members talk to each other about a painful topic, to help them acknowledge and accept angry feelings so that they can move toward more constructive behaviors, to reassure them that what they are doing is enough, or to help them plan for the future.

The importance of the family has been demonstrated in various medical situations: definitions of the nature and seriousness of symptoms,[6] family members' love and support as a risk-lowering factor,[7] family stress levels affecting health,[8] decisions on health care utilization,[9] family support as a predictor of the patient's level of cooperation with physician advice, and family as the social group most immediately affected by illness and medical treatment.[1] In addition, by respecting the role that family members play in patient problems, the physician can help to create an emotional climate in which patients are unlikely to perceive the physician as being negligent.[10]

The guidelines presented in this paper are useful to faculty who are teaching in residency programs and for physicians in community practice. The family interview outline integrates family systems concepts with the basic tools of medical interviewing. This interview format can be integrated into the behavioral science curriculum of family practice residencies as a learning objective for residents. In the family practice residency at Shadyside Hospital in Pittsburgh, the interview format is demonstrated at a monthly conference in which a case presented by a resident is followed by a family interview that the family therapy consultant and presenting resident conduct together. On an ongoing basis, residents are encouraged to schedule family interviews that employ this format and to obtain supervision and consultation from behavioral science faculty members when planning this intervention.

BACKGROUND

The family medicine literature has designated several situations that would benefit from family counseling by the

Submitted, revised, March 24, 1989.

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TABLE 1. STAGES OF THE FAMILY INTERVIEW

Stage 1—Contracting
- Physician statement of reasons and goals for meeting
- Family members' reasons for meeting
- Summary statement of mutual or different concerns

Stage 2—Exploration
- Impact of problem on family members
- Exploration of resources: external (ie, family, friends, financial, religious, and medical) and internal (ie, role flexibility, expression of emotion, and coping strategies)
- Observations of family dynamics: family life cycle, history, structure, members' roles, and perceptions of the illness

Stage 3—Closure
- Summary of situation: support of positive strengths and effort to normalize experience
- Responsibilities of family members: task assignments
- Follow-up requirements

physician.[11] Doherty and Baird[1] suggest family transition problems, other problems of recent origin, and illness-related problems as suitable for family counseling. Worby[12] suggests that family interviews can be useful at transitional points in the family life cycle; in health crises with acute onset and high probability of serious disability such as severe burns, heart attacks, and strokes; during slowly evolving health crises such as progressive renal failure and irreversible cardiac decompensation; in diagnostic problems complicated by depression, dementia, or severe pain; and in management problems in chronic illnesses such as diabetes and ulcerative colitis. It also has been suggested that family physicians schedule family conferences in cases of hopelessly ill patients to facilitate family discussion and help resolve family dilemmas regarding life-sustaining treatments.[13]

While indications for contact with the family and techniques for family counseling have been presented, there exists no framework for the single-session family interview in the family practice literature. Many physicians are skilled in interviewing the family because of experience. Others, particularly those in training, express the need to know what to do once the family is assembled.

The single-session interview format proposed here is one that physicians with varying levels of experience can adapt to their practice. Depending on the situation, the physician may conduct the interview in 30 to 45 minutes. The interview guidelines may be applied to a routine office visit, a hospital visit, or a family meeting specifically scheduled to address a certain issue. In the authors' experience, the single-session family interview has been utilized frequently in the following situations: discharge and disposition problems (particularly in cases of dementia, and chronic or terminal illness), child management issues, multiple somatic complaints, and family concern about a substance-abusing member.

Although the interview breaks down into three successive stages (Table 1), each with three components, it is not necessary to follow the sequence of tasks rigidly. Once comfortable with the three stages, the physician may adapt the guidelines to his or her own particular style.

THE INTERVIEW

Initially, before making the appointment with the family, the physician must specify (1) which family members should attend, (2) where the meeting will take place, (3) how long it will last, and (4) what the charge will be. The physician's expectations of the family are then clear.

Contracting

Contracting includes seeking mutual agreement between physician and family members about why they are meeting and what they hope to accomplish within a given time. To establish an effective contract, the physician must create a working relationship with the family.

The physician begins this process by greeting each family member, acknowledging his or her role in the family, and thanking those persons present for coming. The physician also informs them of how long the meeting will last and how much time at the end will be set aside for closure.

Clarifying the reason for the meeting sets the tone for constructive task-oriented dialogue. The physician takes responsibility for organizing the course and focus of the meeting and ensuring that everyone has an opportunity to speak. This stage of the interview is often the most uncomfortable, as the topic to be discussed may be one that family members have avoided; however, by approaching the topic directly, the physician demonstrates that difficult issues can be discussed in a safe and structured manner with positive results.

Physician Statement of Reasons and Goal for Meeting. After facilitating social introductions and outlining the time allotted for the meeting, the physician makes a clear statement about why the family is being convened. The physician must be honest and understandable and convey support.

> *Example:* "I have asked you to meet with me to plan John's discharge."
> *Example:* "I have requested a special meeting with both of you today [husband-stroke victim, wife-cancer patient] to discuss the stress you are experiencing," or "the impact of your illnesses on your teenage daughter," or "what plans you want to make for the future."
> *Example:* "I am meeting with you today at your request to discuss whether more should be done with your mother [Alzheimer's patient] and to answer your questions about her care."

Family Members' Reasons for Meeting. It is important to obtain from each family member a statement explaining

why that member is there. The physician as interview conductor must make sure each person has the opportunity to be heard before the family enters into a discussion. This step constructively influences content (everyone may have something different on his or her mind) as well as process (each family member needs recognition, validation, and permission to speak). When one family member enters into a discussion with the physician or another member before all present have had a chance to speak uninterruptedly, the physician notes the importance of the discussion but states that it would be preferable to hear from each participant first. In this way, the physician models good communication and a tolerance for difference.

Example: "I'd like to hear from each of you about what you would like to accomplish in this meeting."
Example: "Now that I've heard from your parents, I'm wondering, Melissa, why *you* think you are here."

Summary Statement of Mutual or Different Concerns. After hearing from all the family members, the physician must synthesize from their remarks a purpose for the meeting that everyone can endorse. The physician summarizes what has been said and distills from it a common goal. If there are differences of opinion that seem irreconcilable to a common purpose, the physician makes these differences the reason for the meeting. If there seem to be very different (or too many) agenda items, those that are realistic are chosen for discussion, and a second family interview is proposed to discuss others. Having accomplished a goal for the meeting, the physician and family members can move on to the second stage, one that involves more interaction.

Example: "It would seem that the task for today is to discuss your feelings about not being able to care for John at home, and your concern that John not feel rejected by you."
Example: "While it is a difficult issue to talk about, what seems to be on everyone's mind is what will happen to each family member, especially Melissa, if Mrs. C. becomes so sick she can no longer be the caretaker."
Example: "Since your mother's diagnosis of Alzheimer's disease, your concerns seem to be whether you are doing everything that you can for her and whether I am being helpful enough. Also, just not knowing what to do in this new situation seems to be causing you tremendous stress."

Exploration

Impact of Problem on Family Members. In this stage, the physician facilitates the discussion of how the problem has affected the entire family. Members are encouraged to speak with one another, and with the physician, about the impact the problem has had on their respective lives. In the process, the physician helps the family to (1) clarify issues, (2) verbalize previously unspoken concerns, and (3) acknowledge feelings.

During this stage the family demonstrates its style of interaction. Roles of each family member emerge, and dynamics that impede or enhance resolution of the problem can be observed. Often this meeting is the first time the family has sat down together to discuss openly a difficult problem. There may be instances when the family gets off the track, becomes negative, or tries to avoid crucial issues. The physician responds to these situations by supportively redirecting the discussion to the task established in the contracting stage.

Example: "Charles, can you tell your brother John how you feel about being unable to care for him at home? And John, can you tell Charles what you would like for yourself?"
Example: "Mrs. C., can you tell Melissa your plans for her future if you should get sicker and be unable to care for her. I know it is not something you like to think about, but it is important."
Example: "Mr. and Mrs. A., I would like you to share with each other your feelings about Mr. A.'s mother's Alzheimer's disease and not just your intellectual thoughts about it."

Exploring Resources. In this stage the family's resources and coping strategies are discussed. The physician asks what resources the family has used in the past to deal with difficult family problems and what resources they are using currently to cope. Normally, a family has internal resources such as role flexibility and rules that permit expression of emotion,[14] and external resources to which they reach out for various kinds of support—medical, psychological, social, financial, spiritual. Family strengths are emphasized, and areas where the family may need assistance are identified. The physician may suggest additional resources and explore family reactions to using these.

During the exploration stage the physician forms an impression of the family's coping style and its belief system about dealing with problems. These impressions are later used in the third stage (closure) for placing proposed solutions in a context that is acceptable to the family and in designing interventions that are realistic and sensitive to a family's particular style of coping. For example, does a family prefer to rely on itself and keep its problems private? Can the family make appropriate use of community agencies? Successful intervention must be congruent with a family's belief system about illness and health care.[15] More in-depth analyses of family coping styles can be found in the literature.[16]

Example: "It is clear that this family has always cared for its members on its own, but now that you are older, you may need to rely on outside help. This transition is difficult to make, yet there are ways you can still take care of each other."

Example: "Although the style of this family seems to be to keep feelings private, I think it is important to discuss the seriousness of your illnesses with each other so that you can plan what resources will be helpful to you. Mr. C., you mentioned a sister who is very supportive."
Example: "Mr. and Mrs. A., one reason you are so anxious may be that you have been handling your mother's Alzheimer's disease on your own. I think it would be very helpful to share some of your burden with your adult brothers and sisters and perhaps to attend group meetings here at the hospital for caretakers of Alzheimer's patients."

Observations of Family Dynamics. During exploration the physician will have the opportunity to observe how the family interrelates as a unit. In fact, the physician may be flooded with impressions about the family's roles, rules, method of communication, and boundaries. Although physicians have varying levels of expertise in assessing family dynamics, limited experience with families should not preclude this interview format. The more physicians work with families, the more familiar they will be with issues of the family life cycle, family structure, and family rules, and the better equipped they will be to make observations that are helpful to the family. Several authors have presented useful family assessment tools elsewhere in the literature.[17,18]

Certain feelings and behaviors expressed by family members can be reframed to the advantage of both the patient and family. When attempting to reframe behavior, it is important to stress family strengths. The physician can help family members understand that anger often results from hurt, or that overprotectiveness can be a manifestation of caring. By calling attention to the strengths, the physician reinforces the family's ability to cope with its problem, and at the same time offers a relationship to the family that is supportive and appreciative of its difficulties. A family with longstanding, highly dysfunctional interaction patterns will benefit from counseling for which referral can be made in the closure stage. Observation of family dynamics leads the family into this third state.

Example: "I believe this family's previous inability to discuss John's discharge is a result of tremendous caring for one another. Now that you're talking, I'm sure that you can come up with a plan that will work."
Example: "It is clear to me that Mr. and Mrs. C. have been avoiding planning for the future out of love for Melissa and because they wanted to protect her from harsh realities. Today you have begun to express some thoughts about the future, and to make plans that will bring all of you closer and structure some security into your lives."
Example: "This meeting has helped me see what a struggle it has been for you to deal with the unknown of Alzheimer's. Since one of the ways you cope with problems is to seek information, and since information does help people to feel in control, I think you would find the support group for families of Alzheimer's patients very useful."

CLOSURE

Summary of the Situation. In this final stage the physician attempts to tie together the information gained in the meeting with a summary that family members can accept. Family strengths are reiterated, and negatively construed behaviors are again relabeled in a way that helps the family move toward constructive solutions. In addition, the physician may legitimize the need for expression of differences and encourage both a tolerance for uncomfortable feelings and the acceptance of anger.

In this summary the problem the family experiences becomes normalized by helping the family combat feelings of failure and recognize that its members are not alone, that many families undergo such stress during times of transition or crisis. The physician's description of normal developmental tasks that occur during the family life cycle or of typical responses to loss can help the family put the changes they have experienced, as well as those they must yet undergo, into a positive perspective.

The physician may explain the impact of illness and loss on family life, or the importance of family support in making treatment regimens work, or the predictable difficulties families experience as their children grow. Families respond well to information that makes them feel less helpless and motivates them to try new coping behaviors.

Responsibilities of Family Members and the Assignment of Tasks. As part of closure, it is important to be clear about what family members should be expected to do. If someone is to contact a social service agency, that person should be so designated and the agency telephone number written down. If a referral to a support group is made, the physician should give the family the telephone number, and together the family members should decide who will call. One family member should be chosen to contact relatives or a clergyman, if necessary.

Homework may be assigned to reinforce the constructive gains begun in the meeting. The performance of homework translates into positive action that requires disciplined practice at home. If homework assignments are made, they should be as realistic and as concrete as possible. For example, if a married couple needs more time to talk, or if a father is to become more involved in caretaking and household tasks, when, where, and how should be specified to everyone's satisfaction. In this way, everyone affected knows what is expected, and misunderstandings are minimized. The family physician thus begins a process not only that the family will continue but also that reinforces the members' feelings of competency and unity.

Example: "I would like to ask your sister and brother to

visit two nursing homes that we recommend and then come back to the hospital and discuss them with John and Charles."

Example: "I would like you to choose two evenings this week to talk together about how you would feel and what you could do in case hospitalization or extended care may be necessary for your mother."

Example: "Which one of you would like to take responsibility for calling this number to talk to a member of the support group for families of Alzheimer's patients?"

Follow-up Requirements. Finally, the physician helps the family decide who will report back about the outcome of problem-solving strategies established at the interview and when this will happen. This action places constructive pressure on the family to implement treatment plans and reassures them that the physician will be available to talk with them or make appropriate counseling referrals if the plans do not work. In some families it is useful to appoint one member to communicate with the physician. Designating a single contact will cut down on extra telephone calls or attempts to engage the physician in alliances with various family members. In other families, the physician may find it more useful to schedule a follow-up session with all members.

CONCLUSIONS

An interview format has been described that structures and guides the physician in conducting a single-session family interview. Based on established principles of medical interviewing and family systems theory, this format is intended to be useful to both experienced physicians and those in training. In the authors' experience, this format has been helpful in the resolution of family difficulties and in the enhancement of the family physician's repertoire of skills. Those residents who have employed these interview techniques report satisfactory experiences, both in the management of family dilemmas and in the improvement of professional relationships with families and patients.

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