The Family in Trouble —How to Tell

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The family in trouble is infrequently treated as a unit. The health care system is structured to meet the needs of individuals. If the family is to be "the center of medical care delivery," the physician will require a format for inquiry that will enhance the identification of family problems. The Family Problem-Oriented Record is suggested as a vehicle to meet this need in family medicine.

The physician is frequently presented with problems whose effective solution requires an understanding of the patient's family. Yet, faced with a shortage of time and the absence of a standardized technique for studying the family, the physician usually enters the problem-solving process without an adequate family data base, problem list, or plan.

Social scientists have long emphasized the need for family diagnosis for clarification of the critical relationships between individuals and their families.[1-3] As Gomberg[4] said, "An understanding of the individual as an individual is incomplete unless we can have a comprehensive understanding of the family of which he is a part."

Family medicine, as "the discipline affecting all practice by putting the family into the center of medical-care delivery,"[5] is uniquely suited for introducing a systematic approach to family study and diagnosis.[6] Although there is a growing body of literature on family therapy,[7-24] little has been contributed toward the development of a concept of family evaluation that has specific application to the family physician's practice.

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The purpose of this paper is to draw upon the contributions made by the behavioral, medical, and social sciences and to propose a schema for family study and diagnosis that will have pragmatic application for the physician.

Definition of Family

Since the physician may encounter family relationships of the widest variety, much care must be taken in establishing a definition of "family." In this paper, "family" will be defined as adult partners, with or without children, and single parents with children. These people function in a setting where there is a sense of home and they have an agreement to establish nurturing relationships. This definition does not include the items classically assigned to the family, "procreation, orientation, division of labor between the sexes, and status-giving"[25] because emotional dysfunction is more related to failures in the nurturing aspect of family life than to the particular life style of an individual family.

The Family Problem-Oriented Record

The problem-oriented record has been chosen by an increasing number of physicians as a most effective method of recording a patient's health status.[26-28] In order to utilize the advantages of this concept for family study and diagnosis, the author has modified the problem-oriented record for the individual so that the format (data base, numbered problem list, titled plan and follow-up) may be applied to the family. The goal of the Family Problem-Oriented Record (Family POR) is to provide a vehicle that will systematize the study of the family and enhance the exchange of information between health science students and teachers and among professionals.

1. Data Base

The data base of the Family POR includes analysis of three target areas. These are the *crisis episode* (the present illness or problem), the *resources of the family* (past history), and the *functional status of the family* (system review).

Crises may be defined as emotionally or physically significant episodes that produce change in the lives of family members. The Family POR designates crises as normative or nonnormative: a crisis is normative if it is part of the planned, expected, or normal processes of a family (eg, birth, marriage, menopause, or a move to a new area); or nonnormative if it is due to an unexpected or tragic family life experience (eg, injury, illness, loss of job, or death).

Hill's[29] taxonomy of crises has contributed much to the understanding of the generic features of family stress. Table 1 lists crises that involve sudden gain or loss of status or goods, threat of or actual departure of a family member, addition of a member to the family, and demoralization or negative change in the moral position of a family member.

In the Family POR, life crises should be identified and documented. The information obtained may not only reveal previous patterns of adaptation, but may also be valuable in predicting family dysfunction or illness.

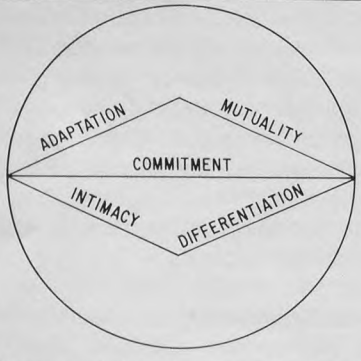
The acronym SCEEM has been applied by the author to the social, cultural, economic, educational and medical resources of a family. SCEEM items that could reflect strength of family resources include evidence of balanced social interaction, cultural pride, economic stability, educational adequacy, absence of disease, and established lines for health care. Examples of family deficiencies in the

Table 1. Generic Classification of Family Crisis

Crises involving status shift	Sudden impoverishment Prolonged unemployment Sudden wealth or fame Political declassing
Crises of abandonment	Death of child or spouse Hospitalization of child or spouse Runaway Divorce
Crises of addition	Unwanted pregnancy Adoption Gain of stepfather, stepmother or stepsiblings Extended family or friends become household members
Crises of demoralization	Adultery Alcoholism Drug abuse Delinquency

Modified from Hill[29]

various SCEEM categories are social isolation or overcommitment, cultural conflicts, economic depression or abnormal concern with money matters, educational handicap or inappropriate training, and medical deprivation or major medical-surgical problems.



Commitment is the pledge to be responsible to and for other members of the family.

Adaptation is the capability for behavior modification in times of crisis or stress.

Mutuality is the sharing of nurturing needs by family members.

Differentiation is the measure of individual maturation and development that is allowed within the family structure.

Intimacy is the caring or loving relationship that exists among family members.

Figure 1. The Family in Health

Once the physician has defined the crisis episode and family resources, an estimate may be made of the family's functional status. A model has been designed for the Family POR which is called the "family in health." The family in health is defined as a nurturing unit that demonstrates functional integrity of five components: commitment, adaptability, mutuality, differentiation and intimacy. These items are defined in Figure 1. Dysfunction or loss of a family's capacity to nurture is manifested by a disturbance in one or more of the components.

During the initial portion of an interview with a family member, while the crisis episode is being revealed, information is usually available that reflects the condition of the five components of family function. Amplification or clarification of data may be desired. Specific questions may be useful.

Commitment is evaluated by questions that deal with the quantitative contributions of time and money that each member makes to the family. Qualitative estimates of family function are ascertained through study of the remaining four components of the family in health. Examples of questions that contribute to the physician's understanding of family commitment are: Does your spouse or partner spend adequate time at home? Does your spouse or partner spend adequate time with the children? Is the income of adult family members shared?

To measure *adaptation,* inquiry should be made to determine if the family has a past history of a major crisis. If so, how did various family members respond to the experience? To whom did family members turn in times of stress or crisis? If aid was sought from spouse, parent, or children, rather than from a friend, lawyer, or physician, then the adaptation component is probably functional and indicative of successful family nurturing.

While commitment may be measured by the amount of time spent in family activities, *mutuality* is more appropriately measured by the quality of shared time. Family communication is a vital indicator of the functional status of the mutuality component. Conversation of the family in health is likely to be supportive, considerate, warm, and empathetic. In dysfunctional families, conversation is usually described as aggressive, quarrelsome, cold, and rejecting. Questions that may clarify the measure of mutuality in a family are the following: Are you satisfied with the way your spouse or partner shares his or her time with you? Do you feel that your spouse or partner understands your goals in life? Are you able to have a frank discussion with your spouse or partner on any subject of mutual concern?

The fourth component to be considered is *differentiation.* A family tends to function within a set of guidelines which establish its life style. Differentiation may be defined as the degree of flexibility, change, growth, or maturation that is permitted within these family guidelines. The spectrum of permissible differentiation is as wide as that of family life-styles and ranges from authoritarian to anarchistic. The family in health allows members reasonable freedom of choice in self-definition and goal-determination.

Questions that offer insight into the family's position on differentiation delve into its tolerance for change. Is there flexibility in family members' attitudes about religion, neighbors, smoking, or drinking? Are teenagers allowed freedom to choose their hair styles, dress, study habits, jobs or dates? What are the family members'

attitudes about school and church attendance? Are members comfortable with the present life style of their family?

Intimacy as a component of family health can best be observed by the physician when family members appear for consultation. Much information can be gained by observing the physical contact between family members and their exchange of words and looks. Sexual relations are only a part of family intimacy, but a sexual history may reveal critical areas of unresolved conflict.

Physicians should recognize that their attitudes are formulated primarily from observation of their own cultural, social, economic, and educational group.[11] For example, in a white American middle-class family, intimacy would probably be expressed by hand, eye, and lip contact, but in an Asian culture the same behavior could have negative connotations. Physician sensitivity to cultural variations in the family under study is essential if an appropriate comparison is to be made to the family in health.

2. Problem List

From the data base a problem list is prepared that indicates the family's crisis episodes, resource deficiencies, and dysfunctional status.

Active and inactive crises should be listed. The acute episode that brought the family to the physician will head the numbered problem list, followed by unresolved or active crises that appear to contribute to family dysfunction. Inactive crises that have apparently been resolved, but which may have contributed to family dysfunction should also appear on the problem list.

Resource deficiencies may be ascertained from the SCEEM analysis.

Disturbances in function of the components of the "family in health" are the final items in the problem list. Commitment, adaptability, mutuality, differentiation and intimacy should be rated qualitatively as mildly, moderately, or severely dysfunctional.

3. Plan

The approach the physician takes to aid the family will depend upon the severity and complexity of the problem list. A problem list that adds up to mild family dysfunction reflects a family whose life style may be adversely affected but which remains functionally intact (that is, in general there is a continuation of nurturing activities). In these instances, the plan requires that available resources be called upon to help resolve the crisis episode. Supportive measures should also be instituted to assist the family members most critically affected by the crisis.

A problem list that suggests severe family dysfunction, whereby all or most members of the family no longer fulfill nurturing activities, requires that therapy be initiated for the entire family. It is essential that the physician recognize the gravity of such situations and not offer placebos or unrealistic interim solutions for conditions that require cultural and psychological resuscitation (CPR). Priorities must be established to protect family members until a therapeutic environment can be established that will permit rational decisions for or against the continuation of the family as a functioning unit.

4. Follow-up

If the physician is not directly involved in family therapy, a consultant should be requested to maintain communications. Follow-up records are best recorded in the standard SOAP form of the problem-oriented record: subjective and objective information, assessment and plan. The physician who maintains an updated family data base is in a position to coordinate the therapeutic needs of family members.

Case Study — Debby and Paul

1. Data Base

September 15, 1974 — Chief complaint: Debby, 28, and Paul, 29, came today for counseling because they felt that their five-year marriage was in jeopardy. In fact, this morning Paul had threatened to leave home.

a. Crisis Episodes

Acute crises: Debby and Paul explained that for the past few months they had been having arguments with increasing frequency. On the morning of the office visit a minor disagreement of apparently little substance had flared into a major argument. Paul had terminated the argument with the threat that he was leaving home.

A review of their past year indicated that the marriage relationship was deteriorating. A summer vacation that was planned to bring about improvement had never materialized because of a series of minor illnesses experienced by Debby and their 21-month-old adopted son, Tommy. They finally spent a five-day vacation at the end of the summer at Paul's parents' home.

Past crises: Shortly after marriage Debby, who had a Master's degree, got a job as an elementary school teacher. Paul entered ministerial school where he eventually obtained his Master's degree. At the time of the office visit Paul was a Ph.D. candidate in education, teaching part time.

The first two years of Paul's and Debby's life after their marriage had been fairly uneventful and nurturing. Then Debby, a juvenile diabetic, experienced the first of a series of illnesses and surgeries that lasted for three years. These included:

3/30/70	Left salpingo-oophorectomy
11/24/70	Abdominal abscess drainage
10/17/71	Hysterectomy
5/14/72	Appendectomy
11/15/73	Left breast biopsy (benign)

The first hint of failure of family function came in the fall of 1973 when they requested consultation regarding their decrease in sexual compatability. They reported some improvement after counseling.

Following the hysterectomy the couple decided to adopt a child. They felt very fortunate when they heard that a boy was available for adoption. Debby resigned from her teaching job so she could be a full-time mother. They were completely absorbed with their new roles as parents.

Most recent arguments had to do with minor household activities. The couple said that demands of their respective parents that they visit had also caused much conflict. They visited Paul's parents three to four times per year, and Debby's 12 to 16 times per year.

The couple had moved three times in the last five years and once during the past year.

b. Family Resources

Debby and Paul had similar back-

grounds socially, culturally, educationally and economically. Both were active in religious groups at church. They exchanged social engagements with friends approximately weekly. Education was important to both of them and they felt they had been appropriately educated. They had no major economic concerns. Medical problems were almost exlusively Debby's. Although she had not been hospitalized for her diabetes, she had great difficulty with insulin regulation and was considered a "brittle" diabetic.

c. Functional Status

Commitment – With the exception of the acute crisis that brought Debby and Paul to the physician, there had been no threat of a break in the commitment. The couple spend much time together, sharing in social activities and Tommy's care. They share their income and make efforts to do long-range economic planning.

Adaptability – Following each of the crises associated with Debby's illnesses and surgeries, Paul seemed to have shown increasing signs of restlessness and instability. Subsequent to the initial excitement of the adoption, the nurturing qualities of the marriage reached a new low.

Mutuality – Communication between Debby and Paul had steadily deteriorated. Paul claimed that every time he attempted to discuss their problems Debby started crying. There had been much shouting and arguing. Debby said that Paul frequently used harsh words, and she felt that he had been cold toward her.

Differentiation – Debby and Paul both wished to continue their education. They felt their mutual goals were appropriate. Now that Debby had given up teaching she was taking music and dance classes. She wanted to continue studying both music and art, and Paul agreed with her desire to do so.

Intimacy – Although the couple claimed that sexual relations had been, with some reservations, satisfactory, the warmth of daily communication through touch, look, and word seemed to be gone. Debby said, "How would you feel if when your husband came home he didn't even look at you, just went right to the baby, gave him a hug and kiss, and then left the room?"

2. Problem List

Prob. No.	Date of Start	Problem	Date Inactive
		Crises:	
1	9/15/74	Paul left home	9/15/74
2	Age 5	Debby's diabetes	
3		Debby's surgeries	
		a. Salpingo-oophorectomy, left	3/30/70
		b. Abscess, abdominal, drainage	11/24/70
		c. Hysterectomy	10/17/71
		d. Appendectomy	5/14/72
		e. Breast biopsy, left	11/15/73
4		Paul's change of status	
		Master's degree	June '73
	Sept. '73	Ph.D. candidate	
5	Dec. '72	Adoption	
6	Dec. '72	Debby's change of status Teacher to homemaker	
7	Summer '74	Vacations	Fall '74
8	Summer '74	Visit with in-laws (Paul's) Frequent visits to in-laws (Debby's)	Summer '74
9		Moves – 3 times in 5 years	

Resource Deficiencies:

Review suggests no serious deficiencies in SCEEM items except as caused by Debby's acute illnesses and diabetes (see above).

Functional Status: ("Family in Health" items)

Commitment –
Although threatened by Paul's departure, willingness of this couple to seek counseling suggests that this component is functional.

Adaptability –
Paul, who appears to have a somewhat weak and uneven ego development, was heavily reliant on Debby for nurturing support. She was unable to fulfill this role during her illnesses and following the adoption. Paul was unable to cope or adapt to the loss of a supportive wife, so he, in turn, denied Debby the nurturing support that she needed. Adaptability is moderately dysfunctional.

2. Problem List

Prob. No.	Date of Start	Problem	Date Inactive
		Mutuality – The couple recognizes their failure in communication. Their voice messages are frequently loud, harsh, and aggressive. They are aware that they are hurting each other, but are unable to do anything about it. This component is severely dysfunctional.	
		Differentiation – The couple apparently has positive feelings about the roles of both partners. Self-development and educational advancement is acceptable in this family. This component appears to be functional.	
		Intimacy – Some small measure of a caring relationship remains, but there has been a marked decrease in warmth of interaction as measured by touch, look and voice. Intimacy is moderately dysfunctional.	

3. Plan

Problems No. 1–9: September 15, 1974. The priority item on the problem list is the threat of Paul's leaving. The initial counseling session dealt with the anger that had developed because of the failure of the couple to nurture each other. As Debby and Paul reviewed the crises in their lives for the preceding three years, they saw how Debby's illness, Paul's educational program and the adoption had challenged their ability to meet each other's needs. They left the office with a resolve to work at correcting this problem.

4. Follow-up

Problem No. 1: October 5, 1974. Debby and Paul feel committed to pursue counseling and remain together while they work through their problems.

Problems No. 2, 3, 4 and 6: They again discussed previous life crises and were able to gain additional insight into how circumstances had drained them of resources to meet each other's needs.

Problem No. 5: The major impact on their lives, they discovered, was the adoption. In their anxiety to meet the demands of the adoption agency social worker, their parents, their friends, and the child's physician, they had, to a great extent, ignored each other. At the termination of the final visit, they made a resolve to balance out their activities so that they could better nurture each other and their adopted son.

Problem No. 8: There was much discussion about future visits to in-laws and the need to balance extended-family needs with their own.

Discussion

The significance of a crisis to a family is largely dependent upon the family's own definition of the event.[29] Kluckholn[2] calls this the family's "value orientation." For example, in one family a pregnant, unwed teenager may be forced to leave home, while in another, with a different set of cultural and societal standards, the pregnancy may be celebrated.

A single crisis episode may have a high enough value orientation to bring a family member to the physician for help. More frequently, the cumulative stress of a series of crises causes the dysfunction that requires professional assistance. A study by Holmes[30] indicated that generalizations can be made about the relative stress on family life caused by various life crises. Among normative crises, marriage, retirement, and pregnancy are particularly stressful, while the nonnormative crises causing the most family upheaval are death, divorce, and separation. Holmes also suggested that illness or dysfunction is a predictable consequence of stress when multiple crises reach a critical level.

From studies in a pediatric practice, there is evidence that when children face major changes in their environment, they must attempt to adjust their internal milieu; failure to make sufficient psychological and physiological adjustments may result in either physical or mental disease.[31,32] The same seems to be true for adults.[33,34]

Figure 2 offers a schematic representation of the effect of crises in a family. The concept is designed to show that a crisis has an initial dysfunctional influence on a family. The depth of dysfunction depends on two factors: the level at which the family functioned at the onset of the crisis and the family's value orientation toward the crisis episode. The time interval required for recovery from the crisis is to a great extent dependent on the ability of the family members to communicate. The level of reorganization achieved by the family, which may be below, equal to, or above the previous level of function, is largely dependent on the resources available to the family.

When the physician must reach a decision on the management of a family crisis, accurate identification of relevant problems is necessary if an effective solution is to be found. Completion of the Family POR should facilitate problem identification of the family in trouble.

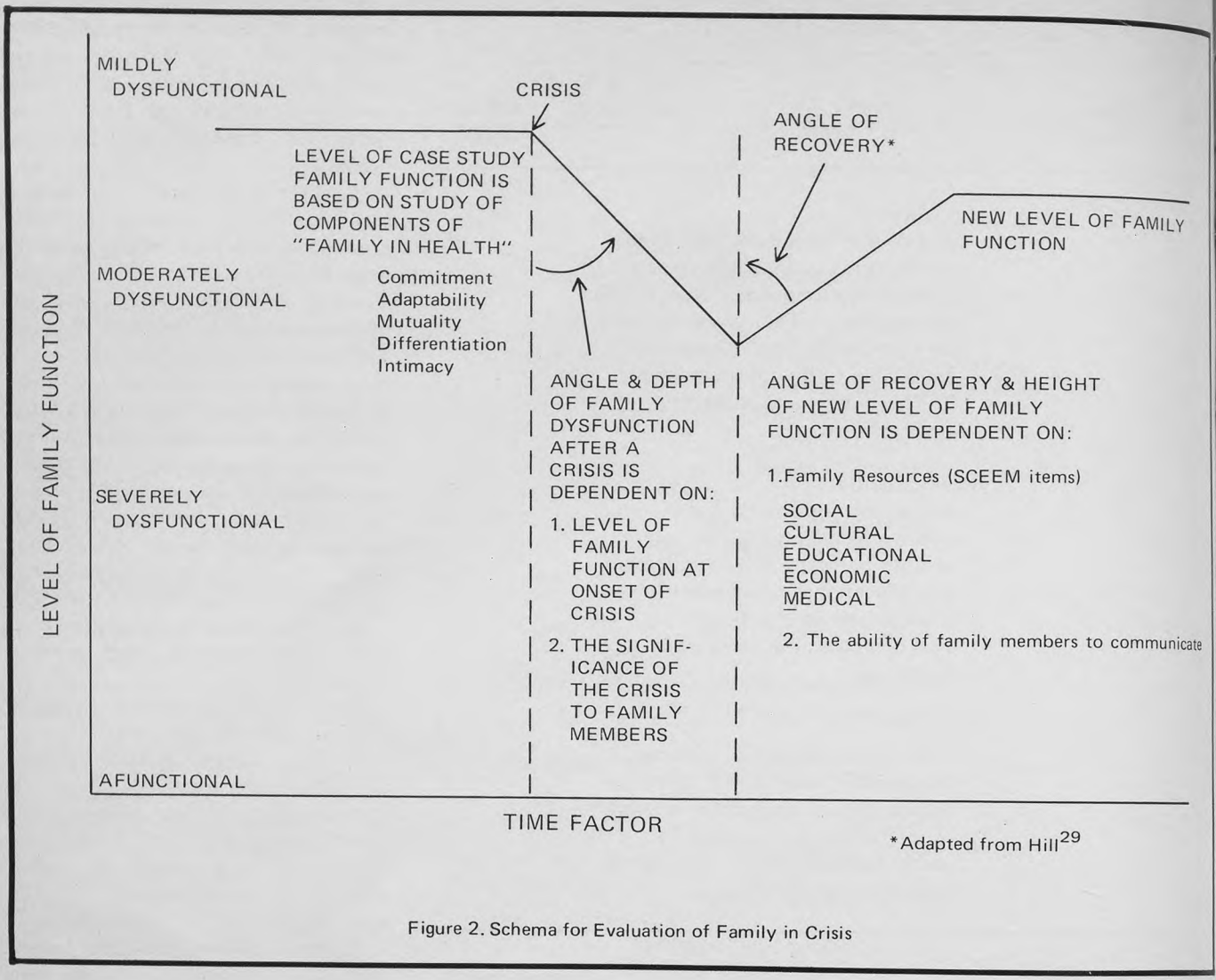


Figure 2. Schema for Evaluation of Family in Crisis

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