The Family as the Object of Care in Family Practice

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Family practice as a specialty is based upon the continuing and comprehensive care of families. Much emphasis has been placed upon care of the "whole person" and the family, but actual practice still reflects a predominant focus on the individual, rather than the family, as the object of care. There is an important conceptual and practical difference between caring for the individual in the context of the family and caring for the family itself as the patient. Both approaches are required for family medicine to realize its potential in the ongoing care of families. This paper outlines some useful concepts and principles which can help to increase the capability of family physicians to deal with the common problems of individuals and their families.

It is axiomatic that the specialty of family practice is involved in the comprehensive, ongoing care of individual patients and their families, and that the knowledge and skills required by the family physician include a broad range of clinical competencies. It is likewise axiomatic that the family is the basic unit of care in family practice, but involved herein is a profound conceptual shift extending well beyond the care of the "whole patient" to the care of the *family*, not just the individual, as the patient. Although this point is part of the everyday language of the developing discipline of family medicine, a gap usually exists between this conceptual goal and actual practice, including teaching practices with intended commitment to this goal.

Family practice residency programs throughout the country have placed varying degrees of emphasis on behavioral science as a curricular approach to this general area. The development of a strong teaching effort in behavioral science, however, does not assure that the family as a unit becomes the object of care. In response to this problem, various writers have wondered where the family is in family practice.[1-4] As Carmichael says: "To care for the patient in the context of the family is one thing; to turn the family into the object of care is another."[4]

The purpose of this paper is to address this subject as a generic problem, outline some basic concepts relating to the family as the object of care, and suggest some useful principles for family physicians attempting to reorient their practice toward the family as the patient.

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Introductory Views of the Family

The family is usually described as a dynamic entity with its own life structure and homeostatic mechanisms. It is not just a group of related people living together, but a system greater than the sum of its parts within which, it is hoped, the emotional and physical needs of its members are provided.

Olsen has made the following observations of family organizations:[5]

> The family organization is obviously influenced by the parents' previous family experience and the culture in which the family exists, but within the family the members occupy and function in roles in relationship to one another (father-husband, daughter-sister, etc). They seem to function in these roles according to the expectations of the whole family, and the action of any member affects all, producing reaction, counterreaction, and shifts in family equilibrium.

And further,

> Families are highly organized and have developed homeostatic mechanisms for the maintenance of a tolerable stability, while at the same time satisfaction of the emotional and physical needs of the members is provided.

The family can be defined most broadly as the intimate enduring social relations in which a person is incorporated and "brought up." The family is a genetic unit in both biological and psychological terms. It is the matrix of personality development and is the most intense emotional unit in society. Each family is unique and different, and there is an increasing rate of change and variation among families in this country.

Various definitions are commonly used to describe major types of families. Ransom and Vandervoort have defined the family as "a significant group of intimates, with a history and a future."[3] Smilkstein has defined the family 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."[6] Although others have suggested variations of these definitions, we can pursue the basic issues without full agreement on a single definition.

Stage	"Normal" Crises	Clinical Problems
Birth of family	Early sexual adjustment	Sexual problems
Expansion of family		
Early (Preschool)	Birth of child	Postpartum depression
Middle (School)	Separation anxiety	Hyperactive child
Late (Adolescence)	"Empty nest" syndrome Teenage identity crisis	Last fling Juvenile delinquency
Dispersion	Career stagnation	Depression
Independence	Menopause Marital readjustment Death of parents	Depression Alcoholism
Replacement	Physical disability Retirement Death of mate Loneliness	Organic brain syndrome Depression Suicide

Table 1. Examples of Major Crises

The fact that we live in a complex and changing culture characterized by rapid technological, social, and cultural changes challenges homeostatic interrelationships within the family. Continuous shifts are being seen in religious, cultural, and sexual values. An individual in a changing society will encounter a larger number of identity crises in his/her lifetime than in previous generations. At the same time a wider variety of family types are in evidence than in previous years as a result of increasing interest in alternative life-styles. An important example is the increasing number of single-parent families.

Curry takes this one step further to a view of the family as a basic unit of humanity:[1]

An illness has far greater ramifications than just the perception of discomfort by the person who is dis-eased. There are those to whom he has a responsibility – he fears that he may fail them. There are those who look to him for support – they feel fear and insecurity and they are dis-eased along with him. Further plans which involve others are clouded over with doubt. This man or whole person is now a human being because of all the relationships he has about him, all the feelings that exist between others and himself, especially with members of the nuclear family, the simple family, the extended family, and even the community. It is, in the last analysis, our relationships with others which make our lives happy and meaningful, which give us our humanity.

Some Basic Concepts

In exploring the role of the family as a basic unit of health care, it is useful to consider some basic concepts.

The Family as a Viable and Continuing Unit in Society

Though American society and family structures are admittedly undergoing many changes, there is strong evidence that the family is here to stay. There are proportionately more married people in the United States now than at any time in the history of reliable census data.[7] When divorce occurs, there is a tendency toward remarriage. Moreover, as reflected by such statistics as suicide rates, it has been amply demonstrated that family life is more conducive to satisfactory living adjustments than is the unmarried state.

Further, in Curry's words,

The family is the oldest recorded institution of man; it preceded even the church and state. Every recorded civilization had a nuclear family as its foundation.[2] . . . Through the ages the family has served the purpose of procreation, continuation of the species, and socialization of the young. As children grew up they were oriented to the world through their family relationships. They first experienced love, care, and had their needs met, realized sex differences, learned to work, learned to relate to members of an extended family, the community, and a wider circle of people through the family. After they were so oriented they matured, found a mate, and started the cycle all over again, all to be repeated thousands of times in the history of mankind.[1]

The Family as an Evolving Unit

Toffler has stressed the problem of the impact of an increasing rate of change within this society and its impact upon individuals and families.[8] People in this country live in a nonrepetitive context (ie, parents or occupational predecessors can no longer serve as valid models from which to learn how to cope with the particular stresses in the future).

All families change over time. Most families are subject to greater or lesser degrees of disorganization during their histories, and in this culture, families tend to have a beginning and an end. Worby proposes the concept of a family life cycle, during which a number of distinct sequential phases occur. Within each of these phases a number of phase-specific tasks can be

delineated; "These tasks arouse considerable stress within the family system and require of all family members a continuous mutual and reciprocal set of readjustments."[9]

Family Life Cycles with Predictable Crises

There are five basic developmental phases for every elementary family.

1. *Birth of family.* Elementary family originates with marriage of couple.
2. *Phase of expansion.* Begins with birth of first child and continues until the youngest child reaches adulthood. This phase includes the period of fertility, the period of physical and social maturation of children.
3. *Phase of dispersion.* Begins when the first child achieves adult status and continues until all children have grown and left home.
4. *Phase of independence.* Begins when all children have reached adulthood and left home so that the parents again live alone.
5. *Phase of replacement.* Begins when the parents retire from their major life roles and ends with their death. Usually includes a dependency stage of variable length.

The life cycle of the family is one of constant change as its individuals grow and develop and as their roles and interrelationships within the family change. Each major event for an individual may create a "crisis" for the family, which is constantly reorganizing in response to multiple crises during each phase of family development. Examples of such crises include childbirth, adolescence, occupational change, major illness, disability, and death.

The basic structure shown in Table 1 serves as a useful framework to facilitate understanding of behavioral problems within families, and can further serve as an aid in predicting possible future behavioral problems at later stages of the family's life cycle.

Such a conceptual framework can be useful to the family physician in everyday practice by increasing his/her awareness of potential future crises in the individual patient and his/her family. It is well known that individuals with certain stress problems have a greater likelihood of developing other problems as a result of future crises. Thus, the physician caring for an obstetric patient with postpartum depression would observe her more closely five years later for signs of separation anxiety. This framework also illustrates that two or more individual "crises" may be concurrent at any given time in a family's development; for example, depression and an "empty nest syndrome" in a 45-year-old wife and mother may coexist with a teenage identity crisis in her 18-year-old son and youngest child.

As a result of his work with a *social readjustment rating scale,* Holmes has concluded that generalizations can be made about the relative stress on family life caused by various life crises. For example, "normative" crises, such as marriage, pregnancy, and retirement, are especially stressful, while divorce, separation, and death are the most stressful among "non-normative" crises.[10]

Reorganization of the Family Around Critical Events

It is now well recognized that a critical event, such as major illness in an individual family member, often precipitates crisis within the family with resultant disequilibrium and need for reorganization. Previous roles and rules of intrafamily relationships frequently fail to maintain satisfactory family organization when a family member is in the hospital, in danger of dying, disabled, or making new demands on the family.

A family's reaction to crisis has been divided by Hill into three basic phases: (1) initial period of stunned denial; (2) period of confusion, anxiety, and frequently resentment toward the sick family member; and (3) period of recovery and reorganization.[11] The phase of reorganization is perhaps the most unpredictable and potentially disruptive of all. While the reorganized family may function as well as or better than before the crisis, the result can often be serious emotional pain or functional disability in one or more family members other than the one who is ill. New relationships between family members will have evolved which the physician should understand. In addition to the possible need for treatment of other members of the family, he/she may find that the recovery or rehabilitation of his/her patient may be unfavorably affected by family reorganization. This underscores the importance of considering the entire family when treating an individual patient with a serious disease or disability.

Family Dynamics as Cause of Illness Behavior

The social interactions of a person who is sick or who thinks he/she is sick can be described as "illness behavior." Such behavior may be appropriate or inappropriate according to the circumstances. Examples of inappropriate illness behavior could take the form of an individual with severe and apparent organic disease refusing to assume the sick role, as well as the other side of the issue whereby an individual without organic disease may acquire a sick role.

Bursten describes this example of the role of family dynamics in affecting illness behavior which involves inappropriate hospitalization of a patient.[12]

> We have studied the family of a patient who had a long-standing, mild, chronic bronchitis due to smoking. He had been a mild-mannered husband until his brother had shown a high degree of self-assertiveness in changing his job. Encouraged by his brother's success, the patient became more self-assertive in his own family. This assertiveness threatened his wife who "put him in his place" by worrying about his chronic cough. The wife suggested that he go to the hospital for an intensive examination. Feeling defeated by his wife's refusal to allow him his self-assertion, the patient complied. Thus, a family conflict was resolved by the shift in the patient's role from an assertive husband to a sick and compliant patient.

Peachey has studied the incidence of illness in 25 families of a rural family practice. She has demonstrated four basic patterns of illness – constant illness, regular periodicity, clustering, and simultaneity, and suggests that such patterns may hold predictive value.[13] It is therefore important to remember that the sick role may be adopted in an attempt to resolve an actual or potential family crisis, and that the family may at times demand that a family member assume this role.

Frequent Association of Organic and Functional Problems

Numerous studies have demonstrated the widespread occurrence of functional disorders in the practices of all physicians regardless of their specialty. For example, in one study of 141 randomly selected family physicians in Washington State, 71 percent of the physicians reported between 20 and 30 percent of their patients had "significant mental, psychological, or emotional impairment of some sort."[14] Over one half of these patients presented with a "physical" complaint, but were found to have associated emotional or "psychiatric" problems. All too often, the physician manages organic problems more effectively than the functional elements, which frequently jeopardizes the patient's rehabilitation from the disease state.

Some Useful Principles

It is now pertinent to outline several principles especially useful to family physicians. A useful perspective on emotional illness has been put forth by Ganz:[15]

> In my practice, I see very little imagined illness. But I see lots of physical illness the cause of which lies in the environment, the personality, or the emotional makeup of the patient. To my way of thinking, "stress illness" communicates a more acceptable and certainly more proper image to patients. It also indicates to the doctor a truer etiology.

Features Can Be Identified Which Are Found in Healthy Families Adapting Well to Stress and Change

Olsen has suggested these features:[5]

1. There is a clear separation of the generations so that the parents are satisfying each other's emotional needs or, in case of conflict, are able to fight straight.
2. There is a flexibility within and between roles so that shifting can be tolerated with relative comfort.
3. There is a tolerance for individuation. The family can accept and enjoy differences and can tolerate the anxiety of disequilibrium in the system as the members grow and change.
4. Communications among the family members are direct and consistent and tend to confirm the self-esteem of each.

A Request for Medical Help May Reflect an Attempt to Resolve a Family Crisis, Not an Individual Patient's Problem

It is well recognized that the person presenting with an illness frequently represents the symptom-carrier for the whole family, thereby acting as a signal that the entire family relationship is in distress.[2,16,17] All practicing physicians, particularly those involved in primary care, can recall many patients who presented with a chief complaint which was not the real reason for seeking care but a kind of "ticket" which was felt by the patient to be "legitimate" in medical terms. It takes a perceptive physician to uncover the real problem in these situations, and in many instances it is related to causative or associated family conflicts. In addition, even when the patient's complaints are valid and undisguised, there may be forces within the family which favor the patient's continued sick role and failure to respond to medical management. The physician must therefore involve other members of the family in the care of such individual patients, and it holds a considerable advantage if he/she takes care of the family as a unit.

Critical Events or Crises in Families are Nodal Points Where Further Reorganization of the Family can be Constructively Altered

Studies on crisis intervention have demonstrated that the family in crisis is less resistant to change than it is under ordinary circumstances.[18] Family therapy usually seeks to shift the equilibrium of the troubled family to a more favorable milieu. Therefore, the physician taking care of the family in crisis has a unique opportunity to deal constructively with the family as a unit as well as with the individual family member. In order to do so, he/she must have a basic understanding of the family's dynamics, remain objective and nonjudgmental, avoid siding with one family member against others, and facilitate a process of improved communication and understanding within the family.

The Physician Must Learn to Think in Terms of the Family as His/Her Patient if He/She is to be Effective in Managing Illness in Individual Patients

This is simple to say but remarkably difficult to practice. All physicians have been conditioned by traditional medical education to focus predominantly on the sick patient, and the first priority is always the diagnosis and therapy of the individual's clinical problems. The pressures and time constraints of a busy practice may present further barriers to taking the broader view. But, in many

instances, it is this next step – seeing the family as a unit as the patient – which is required for intervention to be effective. Indeed, the wholeness of the individual patient cannot be fully appreciated by the physician without some understanding of his/her family.

In Major Illness of Individual Patients, the Family Also Has the Illness

Just as disorders in the family unit can precipitate illness in individual family members, so can major illness in the individual lead to illness of the family itself. The family is thrown into disequilibrium, acute illness or exacerbations of chronic illness may be precipitated in other family members, and the family will attempt to shift toward a new homeostasis which will be more tolerable. Serious emotional problems or impairment of functional ability may occur in other family members which will call for further intervention beyond the care of the individual patient with the initial illness.

Continuing Efforts are Required to Integrate Behavioral Science with Clinical Medicine

McWhinney suggests that the common failure by physicians to integrate behavioral science with clinical medicine is due to a lack of a schema for classifying patient behavior. He has proposed taxonomies for patient behavior and social factors in illness which can facilitate the physician's attempts to deal with behavioral issues concurrently with organic medical problems.[19]

A common example of a clinical problem requiring a comprehensive approach is the patient presenting with fatigue. Rockwell and Burr have described an excellent integrative approach to the diagnosis and care of the tired patient which addresses both organic and functional causes.[20]

The Resources of the Family can Often be Effectively Mobilized to Assist in the Care of the Sick Individual

The potential resources of the family are frequently not appreciated or used by the physician in caring for the sick family member. Based upon the preceding interrelationships which have been described within families, it appears clear that the perceptive and skilled physician can often utilize the efforts of other family members in facilitating the recovery of sick individuals.

Comment

The state of the art is constantly improving concerning the potential of the practicing family physician to apply the concepts and principles which have been outlined. Smilkstein has described a family problem-oriented medical record which can facilitate the assessment of levels of family function and dysfunction in terms of five parameters: commitment, adaptation, mutuality, differentiation, and intimacy.[6] Grace, Neal, Wellock, and Pile have described a family-oriented medical record which has been useful in everyday practice.[21] Liebman, Silbergleit, and Farber have reported on the value of the family conference in the care of the patient with cancer.[22] Hoebel has found that brief family-interactional therapy is effective in the management of cardiac-related high-risk behaviors.[23]

The family physician's close relationship to a large number of families in his/her practice over a period of many years provides him/her an excellent opportunity to reduce the effects of stress illness among families. In order to provide appropriate care to individuals and their families, the family physician should have a broad understanding of the family life cycle, its attendant crises and stresses, and its behavioral problems. Such an understanding will improve his/her ability to view the family as an evolving unit, to anticipate (and possibly prevent) future problems among members of the family, and to better recognize and manage both organic and behavioral problems as they occur. Essential to this goal, however, is the physician's everyday perception of the family, not just the individual, as the patient and object of care.

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