

# The Genogram

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The genogram is presented as a technique to record both genetic and interpersonal family-household data. Working with model patients, and using standard instructions and symbols, family medicine residents elicited and recorded an average of 83 percent of available information items during interviews that lasted an average of 16 minutes. Interpretation of data derived from genograms written by other physicians was achieved with a high degree of accuracy (91 to 96 percent correct answers to 25 questions on each of three family-households). The genogram appears to be a practical instrument to record and retrieve family-household data, but its wide application will require standardization of both the technique of recording and the symbols employed.

The family physician optimally sees all members of the same family or household. Regardless of the number of members in a family attending the physician's practice, the physician has an interest in gathering both genetic and interpersonal data in addition to the usual medical information. This enhances his/her understanding of the health status of the family members and of the environment in which they live. For physicians who include family member's charts in one folder, data regarding related members of the family or household are usually obtained initially from one family member. Additional family information is obtained at the time of visits from other family members.

A display of genetic as well as family history and interactional information, along with significant events, on a single diagram or "genogram"<sup>1</sup>

is an attractive concept because retrieval of data may be facilitated by this technique. The technique lends itself to rapid scanning by both the physician and other health care providers, if the genograms are uniformly coded. It reduces the need for copious progress notes with copies in each of the several family members' charts. Incidental illnesses of individuals need not be noted on the genogram unless they constitute a crisis in the life of that family; these notes more properly belong on the individual's medical record chart.

Medalie<sup>2</sup> suggests separate use of the traditional family tree and a "psychofigure." The family tree depicts several generations with sex, birth and death dates, and genetic diseases. The psychofigure describes interactions between the several members of the household, including relationships which are hostile, distant, discordant, and over-involved.

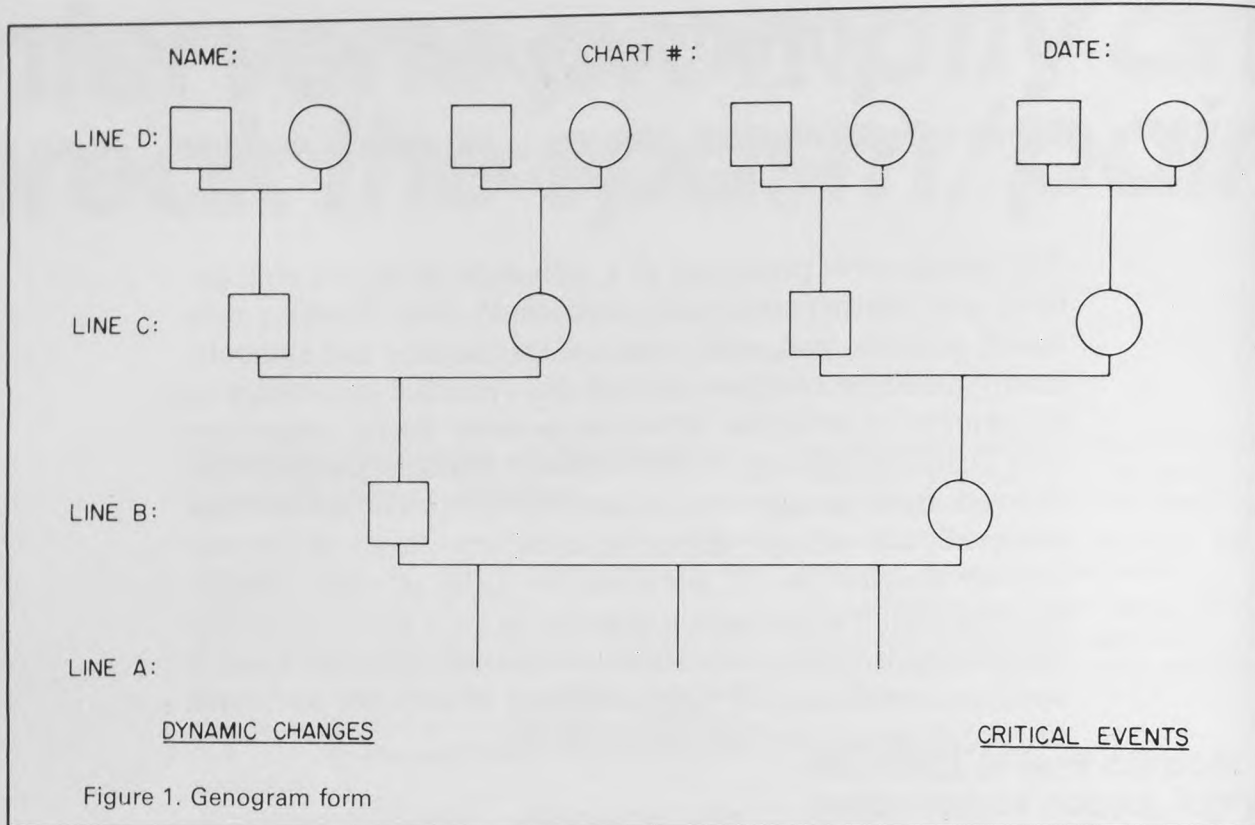
Gordon<sup>3</sup> advises that a "pedigree chart" be kept simple and short. Since this diagram is used primarily by geneticists, relatives by marriage are omitted because they are not genetically relevant to the analysis. Obviously, such omission is in-

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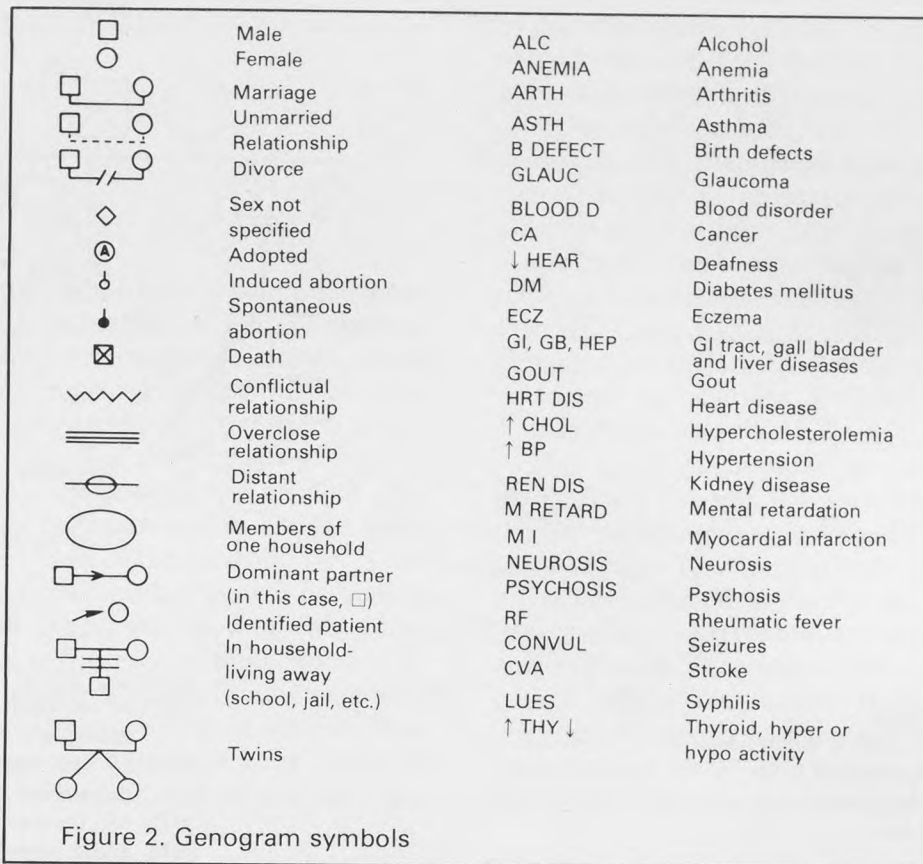
appropriate for family physicians' records because the presence of an illness or chronic condition within a family or household network may alter the balance of the relationships within that system.

Hartman<sup>4</sup> describes the use of a genogram which permits family therapists to record and read social and interactional data about three or four generations of the family in order to illustrate the family's system of functioning. The use of family portraits is advocated by Cormack.<sup>5</sup> He points out that information about members of a family household is difficult to remember, especially regarding those members who are not personally known to the physician. Genetic and interactional information about such absent members needs to be noted and kept as available and current as the data regarding the patient who makes regular or frequent visits to the physician.

Despite numerous discussions in the literature, the actual utility and practicality of these various types of recordings have not been studied, nor has a standard method of recording been developed. This communication reports on the ability of a health care provider, in this case the family practice resident, to collect these data from programmed patients and measures the ability of other health care providers to interpret the data that have been so recorded.

### Methods

In this pilot investigation, an attempt was first made to determine whether or not the genogram

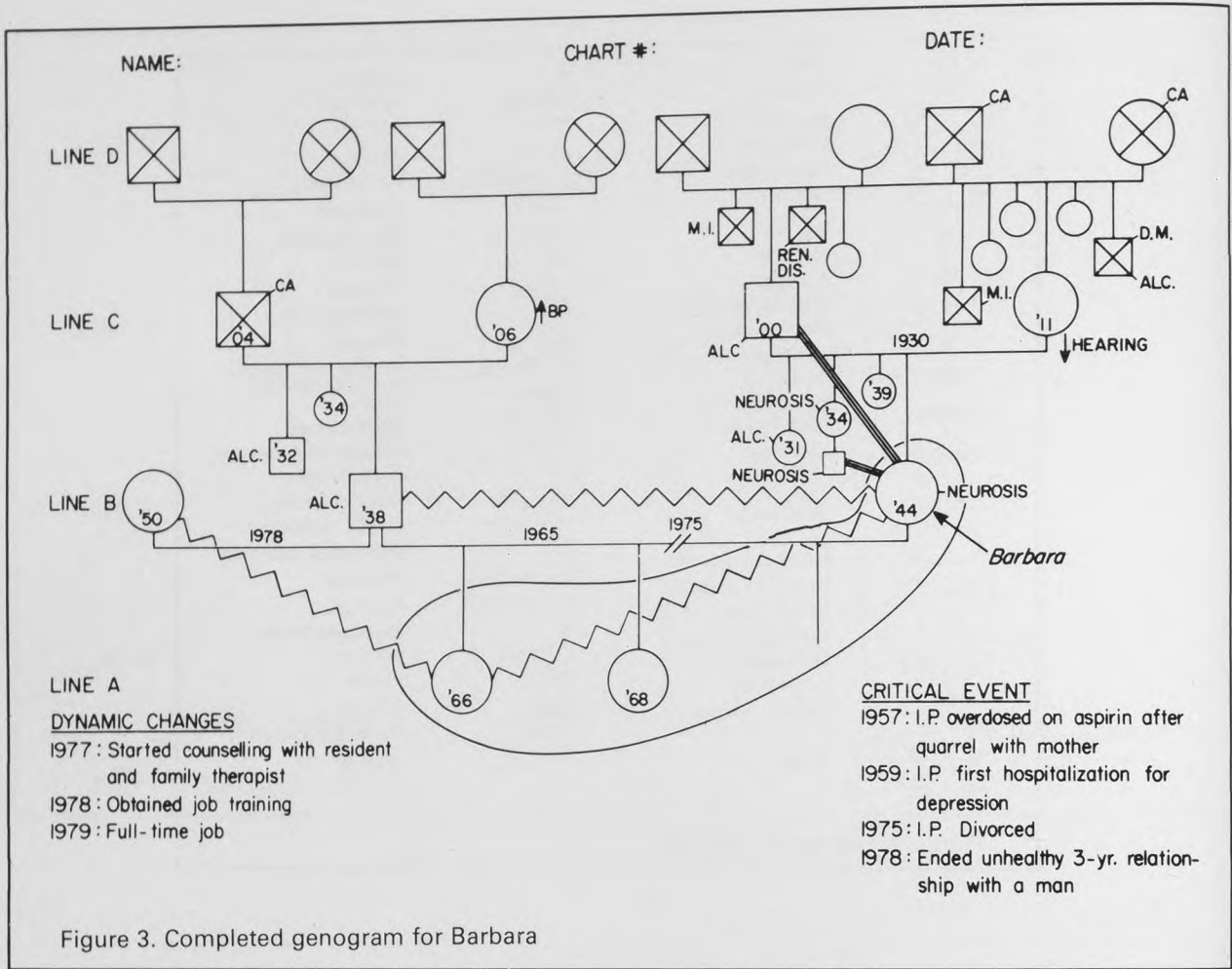


can be used to codify a useful amount of information about a patient's family in a reasonable period of time.

Six family practice residents were given a blank genogram (Figure 1) and legend (Figure 2) and brief but specific instructions on the method of recording a genogram (available on request from the authors). Three patients were recruited and instructed to respond only to the questions asked by the physician. Each patient was interviewed by the six physicians who collected demographic, genetic, and interpersonal information. Other medical data such as chief complaint, present illness, and review of systems were not obtained. The times of the start and completion of the interview

were recorded by the physician.

The genogram and legend used in this study consist of the classical family tree and a specific, brief coded classification of diseases, health problems, social events, and family interactions. A completed genogram is illustrated in Figure 3. The family described in this genogram shows the identified patient (IP) named Barbara, who presented to the Family Health Center with aches, pains, and nonspecific symptoms. Figure 3 is a genogram depicting the information obtained from Barbara by the physicians in the study. Her family history shows the presence of cancer (CA) and diabetes mellitus (DM) on her mother's side, myocardial infarction (MI) on both sides, and alcoholism



(ALC) in a sister and parent. Another sister, along with that sister's son, had received a diagnosis of neurosis. Barbara is not thought to have an affective disorder although a manic-depressive illness had earlier been considered among diagnostic possibilities. The present household (shown by an unbroken circle) consists of Barbara and her two daughters. After ten years of a conflictual relationship (~~~~) with an alcoholic husband, Barbara obtained a divorce (—/—/—) in 1975. Barbara's husband re-

cently remarried and his new wife now appears to be in conflict with the older daughter, who also has conflict with her real mother, Barbara. Barbara has an extremely close relationship with both her father and her nephew (//).

Critical events in the life of the patient and also dynamic changes which have taken place since the patient joined the family practice are noted.

For the second part of the investigation, six different physicians were asked to read three

genograms completed by the investigators, and to answer 25 questions about each of the families.

## Results

The average time required to record a genogram was 16 minutes with a range of 9 to 30 minutes. The percent of information items elicited by each of the physicians ranged from 66 to 93 percent, with an average score of 83 percent. These scores were derived by dividing the number of discrete information items obtained by the resident over the total number of separate items obtained by all six physicians for each of the patients.

The six physicians who interpreted completed and standardized genograms showed little variation in their scores. For each of three patients, 25 questions were asked, each requiring a true/false answer, and the correct numbers of answers were converted to a percentage score. The range of scores was 91 to 96 percent, with an average score of 94.5 percent.

## Discussion

Data from this preliminary investigation indicate that the information required to complete a genogram may be elicited and recorded in about a quarter of an hour. It is anticipated that the length of time may be reduced as health care providers become more familiar with the technique. On the other hand, experience with "unschooled" patients may demonstrate that a greater period of time will be required to complete the form. The continuity dimension of family medicine, however, permits small increments of time to be taken at each of several visits to complete the form.

Although the model patients were instructed to furnish information as freely as possible in areas that are often sensitive, there was considerable variation in recording of the data. Even greater variation may be expected from actual patients, and will depend upon several variables which include patient comfort, sensitivity of the informa-

tion, physician interviewing skills, and the nature of the relationship between the physician and the patient. Nevertheless, findings from this preliminary study indicate that physicians can correctly interpret data recorded with the schema that is proposed. If this technique is to have wide application, it will be necessary to derive standard symbols to record the data. Agreement on such a classification can best be achieved through an interested organization, such as the North American Primary Care Research Group or the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA).

The value of introducing this technique in patient care has not yet been demonstrated, although its informal usage at one residency program appears to improve both patient care and physician satisfaction. In the final analysis, the impact of any intervention in a health care setting must be measured by improved health status of the patient and/or the family; studies designed to measure changes in outcome related to the use of the genogram are difficult but necessary if this new technique is to gain wide acceptance.

## References

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