Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Family Emotional Health

To the Editor:

Studies of behavioral medicine and psychiatry are fraught with difficulties of definition and sampling. The paper by Goldstein, Snope, and McGreehan, "Family Emotional Health: A Survey of Family Practice Patients," in the January issue of *The Journal* (10:85, 1980), aptly demonstrates some of these problems. Family emotional health has been extensively and intensively studied in recent years and the authors' conclusions are mainly a repetition of the work of many sociologists and psychiatrists interested in this subject. I was surprised to see only four references quoted from the massive literature on the subject.

I have concerns about the study design. Did the sample of patients surveyed reflect the practice population served by the three family practice programs? If not, one cannot make general statements about the conclusions drawn by the authors. What was the time frame of the study? It is known that winter exacerbates psychiatric and psychosocial problems, and the seasonal timing of the study could therefore bias the results.

Although no patients refused the questionnaire and 82 percent completed it, were all the patients approached who attended and were in the waiting room of the centers? If not, this would again add bias to the results. It would be important to have this information in order to understand what kind of sample was being selected.

There is nothing in the paper that indicates the definitions used for "psychosocial problems." After all, the areas of concern which the authors use as headings in their tables cannot necessarily be equated with problems, or to put it another way, when is a problem really a problem? and to whom?

The authors also studied patient charts in order to identify psychological symptoms. Again, these are undefined in the paper but could include such symptoms as nervousness, headache, fatigue, trembling, and hyperventilation which could just as easily be organic symptoms. Another problem is that the results are displayed in absolute numbers. They do not indicate which patients and families had multiple areas of concern or multiple psychosocial problems or multiple psychological symptoms. If such multi-problem situations occurred, and I would venture that they did, then the percentages of the family practice center's population with emotional health problems would have to be adjusted.

It is self-evident and established in the literature that most families

Continued on page 378

Continued from page 375

are dysfunctional, at some time or other. Do these dysfunctions need to be uncovered at all times by the physician, and does the intervention (which is the logical sequence), in fact, alter the outcome, except in cases selected by their request for help?

I am not sure that we should be in the business of routinely picking over family dynamics; rather, using skillful interviewing and experience, one can identify the patients who may wish to be helped. My bias comes from a two-year experience (in private practice) of screening women in the 30- to 60-year age group for emotional and organic health problems using a questionnaire and outreach method. I was overwhelmed by the number of problems that came out of the woodwork and could have only continued by giving up a significant proportion of the "organic" element of my practice.

Peter Curtis, MD
Department of Family Medicine
University of North Carolina
Chapel Hill

The preceding letter was referred to Drs. Goldstein and Snope, and Ms. McGreehan who respond as follows:

There are several issues raised by Dr. Curtis' letter regarding our article (*Goldstein HS, Snope FC, McGreehan DM: Family Emotional Health: A Survey of Family Practice Patients. J Fam Pract 10:85, 1980).* First is the question of the results being self-evident and a duplication of already published data. We, of course, surveyed the extensive literature; data on family emotional health in family practices were not found. We would welcome specific citations if such studies have been done.

Secondly, the questions about survey design are valid. The data were collected in the fall and early winter and all patients were approached who were in the waiting rooms.

Thirdly, the question of what constitutes a problem is perhaps the most basic issue. The point being made is that a patient perceived problem is a symptom that requires evaluation. The patients by being surveyed were given the opportunity to say they had a symptom, just as symptom checklists do for organic symptoms. Of course in practice, if a physician communicates (by *not* asking) that emotional health is outside his/her specialty or expertise, then patients will only infrequently present such symptoms.

The core problem for family medicine as a specialty is made abundantly clear in the author's last paragraph. Is the family physician going to treat the whole family or is he/she going to ignore the family emotional health because to treat the whole family is "overwhelming." And why is it overwhelming? Is it lack of training that makes it so? Or are we too much imbued with technological medicine as an ideal? Family medicine (in spite of its stated goals and early investment in psychosocial training) has yet to declare conclusively that part of the defintion of a family physician is one who is expert in the area of family emotional health.

Harris S. Goldstein, MD
Frank C. Snope, MD
Deirdre M. McGreehan, MSW
Department of Family Medicine
College of Medicine and
Dentistry of New Jersey
Rutgers Medical School
Piscataway, New Jersey