Communications

Obtaining Family Psychiatric History in Family Practice and Pediatric Practice

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A medical history usually includes a family history of disorders believed to be hereditary and a social history of circumstances that may affect patient care. Textbooks of medical interviewing suggest including mental disorders among those probably genetic disorders elicited in the family history. Genetic analysis of bipolar affective disorder (depressive illness) implies dominant transmission, whereas unipolar affective disorder (depression) seems to be pseudorecessive.[1] Schulsinger's study[2] of 10- to 20-year-old children of schizophrenic mothers indicates that their risk of schizophrenia is about eight times greater than that of matched control children. These children are also at increased risk for suicide or schizoid personality disorder. The prevalence of anxiety disorder is about 5 percent in the general population and 49 percent in the children of anxiety neurotics.[3] Twin studies have demonstrated a high concordance for obsessive-compulsive disorder.[4]

Not only are mental disorders important for genetic reasons, but the mental health of family members is also a significant part of the social environment, especially for the child or adolescent patient. Two thirds of children aged 5 to 15 years whose parents had an affective disorder (depression or mania) have been found to be depressed.[5] Children of depressed parents have also been found to have significant anxiety, conduct problems, and impulsivity or hyperactivity.[6] It has been documented that primary care physicians failed to diagnose about 50 percent of patients with depression or other mental disorder when evaluating them in a medical setting.[7] It is possible that a large number of physicians who care for children do not obtain family history data, which would provide an index of risk for either mental disorder in children or a compromised family environment.

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Methods

An anonymous survey was conducted regarding the evaluation of children in medical practice. The survey was sent to 180 randomly selected members of the Washington chapter of the American Academy of Family Physicians, all 41 family practice residents in 2 Seattle programs, 200 randomly selected American members of the North Pacific Pediatric Society, and all 51 University of Washington pediatric house officers. The focus of this report is the following question about taking family history: "When taking a family medical/social history, do you routinely inquire about mental disorders, including depression, anxiety, suicide, and alcoholism?" The 12 answers of "usually" or "most of the time" were included as "yes." The two answers of "in adult patients only" were counted as "no."

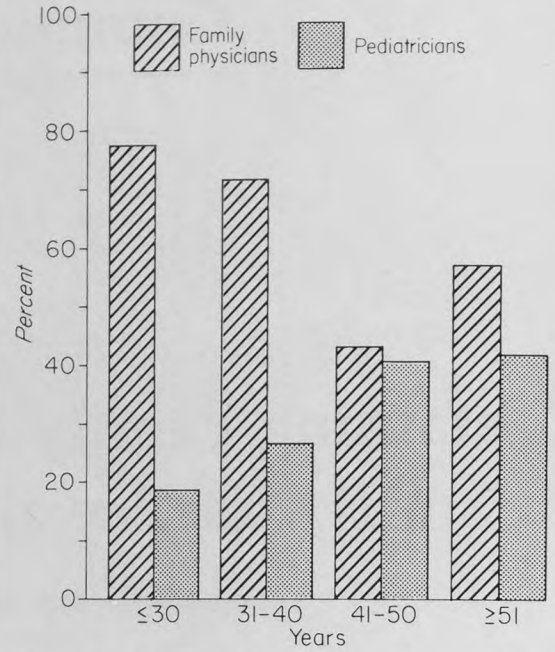

Figure 1. Percent of family physicians and pediatricians obtaining routine family psychiatric histories by age group of physicians

Results

Of the 472 questionnaires sent, 51.5 percent were returned. Family physicians constituted 41.7 percent of the respondents, and pediatricians, 58.3 percent of the respondents. Family history of mental disorder was reported to be obtained by 50.4 percent of the respondents and omitted by 49.6 percent of the respondents. Sex, population in practice location, and whether in residency or in practice yielded no significant differences. Family physicians obtained family histories significantly more often than pediatricians ($\chi^2_1 = 19.43$, $P < .001$). Whereas 67 percent of family physicians responded that they routinely inquire about mental disorders, 36 percent of pediatricians responded that they do so. When controlling for the specialty of the physician, age was a factor. The disparity between family physicians and pediatricians was greater for physicians aged 40 years or younger (Figure 1). There was no significant difference in the responses of family physicians and pediatricians aged 41 years and older. Responses did not differ by the number of years in practice. Physicians who provide office visits for psychosocial counseling were significantly more likely to inquire about family psychiatric history ($\chi^2_1 = 8.80$, $P < .005$). About 80 percent of both pediatricians and family physicians said that they provide some psychosocial counseling. There was no relationship between taking a family history and providing counseling about specific medical issues including compliance with medical recommendations.

Discussion

Questionnaires were completed anonymously to enhance the candor of responses. Also, embedding the family history question in a survey of other pediatric practices decreased the risk of significant response bias.

Nearly one half of the respondents reported that they fail to obtain a family history of common psychiatric disorders in routine medical examinations. Given the importance of family history, these results raised questions as to possible reasons for its omission from the interview. Nielsen and Williams[7] observed that details believed to be unimportant to medical evaluation are commonly excluded from the interview. Some respondents may

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have lacked role models in their formal education who inquired about family psychiatric history. It is possible that textbook recommendations are overlooked or forgotten if they are not validated through the performance of attending physicians or peers. One comment about embarrassment suggested that the cultural taboo surrounding mental illness might affect some physicians' ability to conduct a comprehensive medical interview. Just as certain issues of sexuality and death have been avoided by some physicians, inquiry about mental disorders, including alcoholism, may also trigger inhibitions and a sense of personal threat, especially if physicians have had a similar disorder in themselves or in a family member. Greater psychosocial interest of physicians who take family histories was indicated by the positive relationship between family history taking and provision of psychosocial counseling.

When compared with pediatricians, the greater tendency of family physicians to take histories is noteworthy. Training or selection factors may account for this difference. The difference in history taking between younger family physicians and pediatricians may have been accentuated by the increasing availability of family practice residencies in the 1970s. Physicians aged over 40 years who are categorized as family physicians most likely did not have a family practice residency. Family practice residencies have characteristically encouraged a focus on the whole family of the identified patient. Also, they frequently have included curriculum on the diagnosis and limited management of common mental disorders in their educational programs. These findings suggest that the recent emphasis in teaching about psychosocial concerns in family medicine is affecting physician performance.

Inquiry about family history of mental disorder provides more than information about risks and stresses facing patients; it also sets the stage for open discussion of issues about which the patient may be reticent. Furthermore, such an inquiry can provide comfort to affected families and individuals when their physicians demonstrate acceptance of mental disorders as warranting their routine consideration.

Findings from the study suggest a need to make a more concerted effort to teach the importance of

family history of mental disorders in comprehensive care.

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Gynecomastia Associated With Theophylline

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Gynecomastia is not rare; it is reported to occur in 60 to 70 percent of normal boys during puberty and 30 percent of asymptomatic adult men, with increasing frequency as men become older. Carlson's recent review[1] of the subject also lists many other pathological mechanisms that may cause gynecomastia (hypogonadism, neoplasms, refeeding after starvation, cirrhosis, hyperthyroidism, breast cancer). The condition may also be induced by various drugs.

When drug related, gynecomastia usually develops suddenly after the initiation of therapy and often abates when the drug is discontinued. This report will describe a patient who developed gynecomastia while taking a drug not previously known to cause this problem—theophylline.

Case Report

A 61-year-old man with asthma of many years' duration was given theophylline (Theo-Dur) for the first time in 200-mg time-release tablets, which were taken every 8 to 12 hours. Pharmacy records indicate that the prescription for 100 tablets was refilled about once a month for six months.

The patient developed unilateral gynecomastia one to two months after starting therapy. He was continued on the drug for four months, as the theophylline was not considered to cause the gyn-

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