

## A Diagnostic Problem and Family Assessment

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**D**R. JANET CHRISTIE-SEELY (*Associate Professor, Department of Family Medicine*): The value of family assessment in particularly difficult diagnostic problems is illustrated by this case presentation. Family assessment in general practice does not mean a major time commitment; it does mean seeing the family together in the office, by the bedside, or on a home visit, doing a family genogram, and observing the family's interactions. From this assessment information can be obtained quickly that may throw a completely different light on the physical complaints of the patient, eventual diagnosis, and most important, how to deal with the problem. Working with the family in practice is not family therapy, but does use family systems theory. Illness can be a symptom of triangulation in the family system, a solution to disturbed homeostasis, or a manifestation of repeat family patterns or of sick-role modeling. Often several of these factors are combined, as this case demonstrates.

Family assessment can be therapeutic as well as diagnostic. A nonjudgmental stance and positive relabeling of the problem can often enable the family to change its response to stress and the need for illness. A single session in which the diagnostic impression is relayed and family communication facilitated can result in change, particularly if the problem is of recent origin. This lady's illness had been present for four years, and it took four sessions with the couple, spread a month apart, to resolve her symptoms. Dr. John Seely will present the case.

**D**R. JOHN SEELY (*Professor and Chairman, Department of Medicine*): Mrs. M. was referred to me a year ago because of diarrhea, which she had had for three years. Previously she had been well and had no tendency to somatize. The diarrhea was primarily nocturnal and intermittent, but was severe. She had been investigated the previous year, but because of her past medical health, I felt it unlikely that this diarrhea was functional and decided to reinvestigate. On barium

enema a colonic polyp was found; she was admitted and had a partial bowel resection. There was no sign of carcinoma, but following the resection she developed a bowel obstruction and then an abscess. She had a rather stormy three months' period in the hospital and then recovered. On recovery she was weak, however, and tended to lose her balance easily. Findings on neurologic examination were normal, and there were no biochemical or other reasons for the weakness that we could find. She also had recurrent vaginitis following the bowel surgery, which was bothersome and hard to treat. The diarrhea also continued. It was at this point I referred this patient to Dr. Christie-Seely, as I was wondering whether there might after all be a functional basis to her problem.

**D**R. CHRISTIE-SEELY: As a family physician, I usually know the families of my patients and see illness as part of their family context. I find the family genogram is a particularly useful tool to get to know a new family and their illness history. Using a systems orientation I assess interrelationships and stresses and their connection, if any, with the symptoms or illness. Briefly, systems thinking is similar to thinking in physiology,<sup>1</sup> in which a given organ is seen as part of inter-related organs linked through positive and negative feedback loops maintaining a state of homeostasis or health. If a part is isolated and the rest not considered in diagnosis or treatment, there will be a poor medical outcome, as for instance, in treating an enlarged thyroid gland without measuring thyroid and pituitary hormones or considering the rest of the endocrine system. Similarly, dealing with an unhealthy part of a family system at best has limited results and at times can further escalate family dysfunction. A chronic symptom may become part of family homeostasis and be maintained by the family. The normal stresses of the family life cycle often trigger illness as a means of coping when family functioning and communication is poor.

On hearing the history, therefore, I saw the recent onset of symptoms from that perspective. Onset of symptoms at the age of 60 years in a married woman raises the possibility of an "empty-nest" syndrome. We often see the onset of symptoms in an older patient at the time of departure of the last child, if not just

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before, particularly in a woman with a career of motherhood, as was true of this patient. The symptoms may serve to keep the children near the home or bring them back. At the back of an empty-nest problem is difficulty in the couple system, particularly likely if children arrived soon after marriage so that the couple relationship has always revolved around parenting. That diarrhea was nocturnal suggested no organic clue, as would nocturnal urinary symptoms, and I wondered about a sexual problem or possibly nightmares from a deeper psychological issue. The bowel obstruction and abscess suggested lowered resistance possibly related to stress. That the patient had also had recurrent vaginitis again suggested to me the possibility of a sexual problem.

**FIRST-YEAR RESIDENT IN FAMILY MEDICINE:** But surely bowel obstruction, abscess, and vaginitis are all organic conditions?

**DR. CHRISTIE-SEELY:** The longer I'm in practice, the more the traditional division into organic and functional makes no sense. I believe the difference is a matter of degree and duration; organic disease becomes demonstrable when functional conditions have been present for long enough, as when hyperacidity produces a peptic ulcer, or when the environmental or internal stress is sufficiently severe to produce irreversible changes at the organ or cellular level.

Over the past 30 years an increasing body of research has linked stress with organic illness.<sup>2-7</sup> Recent studies are elucidating the mechanisms by which stress predisposes to illness, particularly studies of neurohumeral mechanisms and immunology. For example, a study of T-lymphocyte function<sup>8</sup> in bereaved individuals showed a drop in maximal function six weeks after the death of a spouse, illustrating one mechanism for the increased mortality rate in bereaved individuals from cancer, infections such as tuberculosis, renal and heart disease, and diabetes.<sup>9</sup> The 17 hydroxy-ketosteroids<sup>10</sup> levels of parents of leukemic children increase after the death of the child, and there is an associated increase in morbidity from all illnesses.

The family is a frequent stressor, and is also responsible for the environment where sickness behavior is learned and sick-role models are often available. Lifetime behaviors such as smoking, drinking, and type A behaviors are learned or fostered in the family, as is the attitude toward physicians and other health professionals. "Illness-prone families"<sup>11</sup> who have high incidence of disease, disability, and early death also have dysfunction, divorce, and delinquency—all the "D's"! The family can also be a major support; loneliness increases the rate of illness.<sup>3,7</sup>

**DR. SEELY:** In this family, I believe the patient's husband had back problems. But they seemed a very close couple. He usually came with her and was extremely supportive. There was a recent family stress

Continued on page 332

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*Continued from page 330*

- Family (or household) members present in interview, names and ages:
- Missing members—names and ages:
- P—Presenting problem(s) or reason for family interview (Description, identified by whom? Onset, attempted solutions by family)
- R—Roles—structure, organization (Who is dominant, nature of parental coalition, triangles and alliances, characteristics of boundaries, role flexibility)
- A—Affect (Predominant emotional tone, range of affect in this interview, difficulty in expressing emotion)
- C—Communication (Clear, direct, masked, displaced, congruent. Who talks? Who listens to whom? Nonverbal communication. Communication through illness)
- T—Time (Courtship, family in formation, childbearing, childrearing, child launching, contracting family, retirement, widow(er)hood)
- I—Illness (History or presence of serious illness, chronic, or frequent acute illness. Sickness role—who tends to be sick in this family? Recent deaths. Family experience with health care system)
- C—Coping or adaptability (Family strengths and resources. Coping in past and present)
- E—Ecology or environment (Relationship with families of origin. Financial status. Culture and religion. Use of community, school, professional resources. Recreation)

**Figure 1. PRACTICE—McGill Family Assessment Form. From Christie-Seeley<sup>15</sup>**

that I knew of, however: Mrs. M.'s mother made two suicide attempts and was getting increasingly senile and difficult, and she had to be put in a nursing home. This occurred about three years ago.

DR. CHRISTIE-SEELY: Yes, Mrs. M.'s mother moved in with them shortly before their youngest child left home. Quite often the middle-aged parents who are about to be freed of the responsibilities of their children find themselves having to look after one of their elderly parents who has been widowed. Sometimes this situation reflects the need of the couple to have a third person in the home so that the couple doesn't have to deal with being alone together. I think such was the case in this family. A concept of family systems theory useful in family practice is that of triangulation. When two people in a close relationship get into conflict, they often drag in a third person. Parents tend to bring children into their interactions, either scapegoating a child (one parent tends to pick on the child while the other parent rescues the child, thus detouring their conflict through the child), or by trying to get the child to take sides. Similarly, children will try to drag a parent into their conflict to be the arbitrator or rescuer. Bowen<sup>12</sup> has proposed that illness in a spouse, illness in a child, or behavioral problems in one parent or a child may be the symptom of marital conflict. When such conflict is overt, there is less need to detour the problem through a third party or through symptomatic behavior.

Minuchin and colleagues<sup>13,14</sup> have studied children with labile diabetes, severe steroid-dependent asthma, and anorexia nervosa and found a common set of characteristics in the families of these children. They were enmeshed (overly close) families in which conflict was denied: they typically said they were happy, loving families with only one problem, the one sick child. The

child who had a physiologic predisposition to the illness would have an exacerbation of symptoms when family tension increased. Family therapy in all cases got asthmatic children off steroids, restored diabetic control, decreased hospital admissions in the labile diabetics, and restored weight and menses in the anorectics.

Mr. and Mrs. M. were similar to these psychosomatic families in that they denied conflict and appeared to be a very close couple. I suspect this characteristic of conflict avoidance is typical of many of the families we see in practice where underground tension manifests as physical complaints or often as real illness—both more culturally acceptable than marital problems.

Mrs. M.'s mother's suicide attempts prior to leaving the home would suggest some family dysfunction, probably compounding or compounded by the increasing disability of an aging parent.

When doing a family interview, observing what goes on between people is important. Mr. and Mrs. M. appeared very affectionate, but changed the subject rapidly if I approached any areas of conflict. Communication is one of the main variables in family assessment—is it open and direct, indirect and placating, or blaming? The other important areas described in the family therapy literature are affect (emotional expression) and family roles or structure (Who is in charge? Who does what?). We have developed an assessment form<sup>15</sup> using these variables and adding variables important in family medicine (Figure 1). The history of illness in the family may indicate an illness-prone family, sick-role modeling, or a previous caretaker role, as was the case for Mr. M. The genogram often reveals the human tendency to repeat history—childhood traumas are repeated in adulthood; similar patterns of illness repeat through genetic



mechanisms, symptom mimicry, or expectation. The time in the family life cycle often indicates important stressors relating to illness. Family strengths and coping styles give clues to reactions to illness in the past. For example, the development of ulcerative colitis after his father's death in a man dealing with his mother's terminal illness should suggest the need for help in ventilating his grief. The ecology or environment comprises all the cultural, social, religious, educational, and economic resources and sources of stress surrounding a family. The acronym PRACTICE begins with a "P" for presenting problem, which is usually the focus of the interview.

DR. SEELY: When I attended your first interview with the couple, I was struck with how rapidly you obtained a lot of significant information by doing a family genogram. It made the time sequence of events and stresses and the onset of symptoms very clear. I was also surprised at how such a reticent couple could become very comfortable with the process and not threatened by it. In fact, they seemed to enjoy it and very quickly stopped being defensive.

DR. CHRISTIE-SEELY: It depends how you do it. I do the genogram on a large flip chart, so it does not seem like private information on the chart that only I can see. The family always gets caught up in the process if questions are asked in a nonjudgmental, but interested, manner, and they learn a lot about their own family. In many families in family practice a single session doing the genogram will give the family enough information about their stresses and coping strategies that they will problem solve the rest themselves. For instance, in one family, 11-year-old twins who were present pointed out on the genogram that the father's chest pain and symptom of shaking occurred when he was 43 years old, which was the age at which his sister had died of a pulmonary embolus and hyperthyroidism. One twin also commented that since the onset of the father's chest pain, quarreling between his parents had been reduced by 50 percent. If possible, I always have the children present, particularly if they're still at home, as discussion of the illness invariably relieves rather than increases their anxiety, and they are often marvelous sources of information! In the M. family there were three adult children, but all married and living in another city.

FIRST-YEAR RESIDENT: When you want the whole family to come in, how do you get them to come?

DR. CHRISTIE-SEELY: That's a good question. The quick answer is that if you're convinced it's important, you will probably be able to persuade the family to think so too, and they'll usually come in. If all family members are in your practice and know you already, it's usually easy. When a family joins my practice, I generally get their health history in a family interview. This saves time, allows me to assess the family, often gets more accurate information, and

makes it easy to reconvene them later.

SECOND-YEAR FAMILY PRACTICE RESIDENT: Doing a genogram takes a long time. How often do you do them?

DR. CHRISTIE-SEELY: A brief genogram can be done in five minutes and put in the chart to be added to later. But, you're right—the genogram I did on this family took about three quarters of an hour. We forget, however, how much time we spend on patients who come back time after time for the same symptoms and nothing much changes. If you can get to the bottom of an issue, and I find the genogram a great help in doing that, you save time in the end. It is also an aid to crisis intervention.<sup>16</sup> There is some evidence that dealing with the psychological issues decreases utilization for medical care subsequently.<sup>17-19</sup>

You need to try doing genograms for yourself to see whether you find them worthwhile. In the M. family the genogram identified the following recent family stresses (Figure 2):

1. Mr. and Mrs. M. had three married children; Mrs. M. had been very close to her children just as Mr. M. had been "married" to his work in the mine. The last child left home two years after Mrs. M.'s widowed mother came to live with her. There was no open conflict between son-in-law and her mother, who was blind and had ankylosing spondylitis, but Mrs. M. admitted she felt very torn between them (a description implying triangulation and buried conflict). Her mother's suicide attempts were a message to her daughter that she was not paying enough attention to her. Mrs. M. became tearful when mentioning having to institutionalize her mother. The day prior to her most recent visit to her mother in the nursing home, the couple had an argument, and the visit was only 20 minutes because "my husband doesn't like it if I stay very long; he gets bored." That day she had an exacerbation of diarrhea. The reason Mr. M. disliked visiting the institution then became apparent.

2. Mr. M.'s father died of "epilepsy" when Mr. M. was one year old; his stepfather died when Mr. M. was ten years old. In 1942, soon after all six sons had left her for the army, his mother became psychotic and made a suicide attempt. Mr. M., at the age of 23 years, was the one who had to take the responsibility for committing her. Subsequent annual visits to the hospital were extremely painful because of her bizarre behavior. His oldest brother, a father substitute, died in 1977. Then his mother died in 1980, just before the onset of his wife's diarrhea. Guilt over not caring better for her seemed to be assuaged by being caretaker for his wife.

3. In 1981, exactly a year after his mother's death, Mr. M. was admitted for a back operation. He had been a miner all his life and had had a long history of back pain. In 1982 the couple and Mrs. M.'s mother moved into a mobile home where the tensions in the triangle

*Continued on page 337*



- P—Presenting problem(s) or reason for family interview (Description, identified by whom? Onset, attempted solutions by family)  
 Diarrhea (nocturnal) × 4 years, vaginitis. Weakness and dizziness—needs support in walking. (Possible early alcoholism in husband.)
- R—Roles—structure, organization (Who is dominant, nature of parental coalition, triangles and alliances, characteristics of boundaries, role flexibility)  
 Couple alone for two years for first time. Underground power struggle over roles. No open negotiation.
- A—Affect (Predominant emotional tone, range of affect in this interview, difficulty in expressing emotion)  
 Warm and loving—anger and sadness buried below surface. Fear of conflict and negativity. Tears provoked guilt as being self-indulgent; needed permission to cry (Scottish stoicism). Husband—guilt over his mother.
- C—Communication (Clear, direct, masked, displaced, congruent. Who talks? Who listens to whom? Nonverbal communication. Communication through illness)  
 Via physical symptoms (back pain in husband, diarrhea and vaginitis—excuses to avoid sex; household tasks avoided through symptoms) Communication of positive feelings—very good; none of negative feelings.
- T—Time (Courtship, family in formation, childbearing, childrearing, child launching, contracting family, retirement, widow(er)hood)  
 Onset of symptoms associated with life cycle task of institutionalizing patient's mother, who had moved in prior to last child's departure; empty nest in family with no couple-negotiation time before first child.
- I—Illness (History or presence of serious illness, chronic, or frequent acute illness. Sickness role—who tends to be sick in this family? Recent deaths. Family experience with health care system)  
 Both had mothers who they had to institutionalize following suicide attempts. Visits to Mrs. M.'s mother, therefore, an ongoing trauma for both. Mr. M.'s guilt assuaged by caretaking role with wife. Fear of aging in both.
- C—Coping or adaptability (Family strengths and resources. Coping in past and present)  
 A lot of caring and openly shown affection. Strong couple bond, able to cope with reality of minor conflicts if put in perspective.
- E—Ecology or Environment (Relationship with families of origin. Financial status. Culture and religion. Use of community, school, professional resources. Recreation)  
 Extended family: Three very supportive children, six grandchildren. Network of friends. Culture—Scottish: "stiff upper lip;" "be good."

**Figure 2. Summary of case using acronym "PRACTICE"**

were compounded by lack of space. Mr. M.'s back made him irritable and unable to move furniture, and the house move was a near disaster. A clear result of Mrs. M.'s symptoms was that her husband was now doing a great deal of housework. Relationships deteriorated and stress increased, and in November 1983 Mrs. M.'s mother made the two suicide attempts. There were intimations of a subtle power struggle over "who does what" as well as over the mother-in-law problem.

Use of the genogram allowed the couple to see for the first time that the stresses might be related to the diarrhea. The diarrhea and unsteadiness in turn had enabled Mrs. M. to control the situation at home.

DR. SEELY: Yes, Mrs. M. did seem rather manipulative. In fact, she was rather frustrating to treat, although she was always a very pleasant woman.

DR. CHRISTIE-SEELY: I think most of us find manipulating patients most exasperating. I find systems theory helps me stay nonjudgmental, as it helps me understand how a family system determines behavior. Understanding the difficult patient as a victim of his or her family of origin or present household helps one empathize with the manipulative, seductive,

aggressive, or helpless patient. Neither Mr. or Mrs. M. were aware that they used back pain, weakness, diarrhea, or a lack of balance as a means of avoiding the onerous task of looking after Mrs. M.'s blind and arthritic mother, and of attempting to control the behavior of their partner. Papp et al<sup>20</sup> describe a family system as "an emotional unit with no villains, heroes, good people, healthy or unhealthy members," a rather difficult concept for physicians who are used to labeling people. A typical chain reaction, or "family dance," which involves every member and can be set off by any one member, is a repetitive event even in healthy families. Often illness becomes a part of such a family dance. Illness can be a means of saying no to excessive demands and an excuse for expressing caring and attention and prompting change in the partner. One issue that Mrs. M. had difficulty raising was her husband's drinking pattern. Hesitantly she began to complain that every two weeks or so he would drink excessively. This behavior had improved since the onset of her symptoms, which were a message to him about how much she needed his stability.

It was also observed during the interview that be-



cause Mrs. M.'s balance was precarious, her husband had to take her arm or otherwise support her, and tended always to go with her to medical appointments. Thus, there was frequent physical contact between the couple, giving the impression of a close, loving relationship. However, they admitted to having had a sexual problem since Mr. M.'s back operation. Back pain had made intercourse difficult, and when he began to recover, his wife was getting sick. Not only did she tend to have diarrhea at night, but she developed a severe vaginitis, originally from an antibiotic-induced yeast infection, that lasted for months. The couple became very defensive at any suggestion of any problems between them, but were able to discuss his fear of impotence and aging, which was the core of the problem.

A second session revealed the reasons for fear of conflict. Between the sessions Mrs. M. had had a brief hospital admission because of bronchitis, but had had no fever and no apparent bronchospasm. On her way to the hospital, Mr. M. said "she almost passed out," as she had apparently in the past. I suddenly recognized the significance of her weakness and dizziness, which had been the subject of neurologic investigation. I described hyperventilation in physiologic terms to the couple, and then suggested that we try it in the office as an experiment. I explained, too, that I commonly did this with patients who had had difficulty breathing, which Mrs. M. admitted to prior to the hospitalization, not only to see whether the symptoms fitted the explanation, but also to get at the emotions that sometimes trigger these symptoms.<sup>21</sup>

Hyperventilation, after an initial period of resisting it, produced a profound crying spell in which Mrs. M. described her guilt at rescuing her mother from the suicide attempt, as her mother was so negative about life. She angrily recounted how her mother accused her father of drinking too much, and of reinterpreting the past in an entirely negative fashion. Mrs. M. was torn between guilt and anger and fear of the helplessness that her mother was experiencing with aging. Her own fear of helplessness was being expressed by the weakness and inability to stand on her own feet ("My legs keep feeling they're going to give way.").

Through ventilation of her grief, Mrs. M.'s diarrhea gradually decreased, then stopped. She was also able to negotiate about family tasks and other minor problems between the couple after I emphasized their obvious love and mutual appreciation. She had been loathe to bring up any negative issues with her husband for fear of being negative and unappreciative like her mother. Mr. M.'s drinking, once she raised the issue, decreased drastically between the first and second sessions and was no longer a problem.

On the fourth and final session with the couple, we reviewed life stresses on the genogram. Mrs. M. had been well previously except for an episode of rheumatic fever and Boeck's sarcoid, which occurred together

six weeks after the birth of her first child. At that time her parents had come over from England to be with her a week before the birth, but they caused more stress than they relieved. They left to go back to England only after Mrs. M. got sick and had to be hospitalized, leaving her husband alone in charge of the baby. Clearly Mrs. M.'s illness prompted their departure. At this point in the session Mrs. M. suddenly impulsively said: "I had to get sick to get rid of mother" and began to cry. Her mother had been bossing constantly, which was particularly difficult for Mr. M. Clearly, that was the beginning of the triangle between her mother and Mrs. M. and her husband. Mrs. M. realized she still felt guilty about her mother and the fact that she "again had to get ill to get rid of her" by developing diarrhea. This was the prime reason for her illness. The illness, however, was also useful for Mr. M. in dealing with his guilt about his own mother, and for the couple as a unit as a means of avoiding conflict. The question, "What would be different for you and your family if you were miraculously cured tomorrow?" can be very useful to elicit the role of illness.<sup>15</sup> Dansak<sup>22</sup> has coined the term *tertiary gain* for the gain that the family system as a unit derives from the illness. I then paradoxically suggested it might be very difficult for her if she got rid of all her symptoms and that she should hang on to either a little diarrhea or some unsteadiness of gait to reassure herself she had an excuse to not look after her mother. She admitted her mother is happier where she is, but also that if she were perfectly well, she would probably feel more guilty. She then said she wouldn't be able to have her mother anyway because of Mr. M.'s back, as lifting a blind and arthritic old lady was not possible for either of them now. I agreed and said that it was probably important for Mr. M. to still have back symptoms.

DR. SEELY: A follow-up visit showed that that strategy worked. Mrs. M.'s diarrhea is gone and her gait is now normal.

DR. CHRISTIE-SEELY: To summarize then, this case is typical of many families in my practice in which a family interview and genogram were done because of physical symptoms. I have learned to go beyond the individual when the medical model is no longer productive, specifically in diagnostic problems, problems of compliance, frequent acute illness, and any chronic illness or terminal illness. I have found it an efficient means of obtaining relevant information and in the long run a saving in time.

If approached in a nonjudgmental and empathic fashion, the patient and family can learn as much from the same data as the physician; in many cases they can see themselves and the symptom in a new light and make their own changes in the direction of greater health. Obtaining family data often leads to a breakthrough in the individual patient. I also believe that a family systems orientation will be the new paradigm in family medicine<sup>23,24</sup> that is needed to explain undiffer-



entiated symptoms and other areas that fit poorly with the traditional medical view. Family physicians who have the privilege of treating the whole family and observing its interaction with illness may lead to a breakthrough in medicine as a whole.

**References**

1. Christie-Seely JE: Teaching the family system concept in family medicine. *J Fam Pract* 1981; 13:391-401
2. Rahe RH, Mahan J, Arthur R: Prediction of near-future health changes from subjects' preceding life changes. *J Psychosom Res* 1970; 14:401-405
3. Lynch JL: *The Broken Heart: The Medical Consequences of Loneliness*. New York, Basic Books, 1977
4. Medalie JH, Goldbourt U: Angina pectoris among 10,000 men, Part 2: Psychosocial and other risk factors as evidenced by a multivariate analysis of a five-year incidence study. *Am J Med* 1976; 60:910-921
5. Ruberman W, Weinblatt E, Goldberg JD, Chaudhary BS: Psychosocial influences on mortality after myocardial infarction. *N Engl J Med* 1984; 311:552-559
6. Schmale AH, Iker H: Hopelessness as a predictor of cervical cancer. *Soc Sci Med* 1971; 5:95-100
7. Christie-Seely JE: Life stress and illness: A symptoms approach. *Can Fam Physician* 1983; 29:533-540
8. Bartrop RW, Lazarus L, Luckhurst E, et al: Depressed lymphocyte function after bereavement. *Lancet* 1977; 1:834-836
9. Kraus AS, Lillienfeld AM: Some epidemiological aspects of the high mortality rate in the young widowed group. *J Chronic Dis* 1959; 10:207-217
10. Hofer MA, Wolff CT, Friedman SB, et al: A psychoendocrine study of bereavement: Part 1. 17-Hydroxycorticosteroid excretion rates of parents following death of their children from leukemia. *Psychosom Med* 1972; 34:481-491
11. Hinkle LE Jr, Plummer N: Life stress and industrial absenteeism: The concentration of illness and absenteeism in one segment of a working population. *Ind Med Surg* 1952; 21:363-375
12. Bowen M: *Family Therapy in Clinical Practice*. New York, Jason Aronson, 1978
13. Minuchin S, Baker L, Rosman BL, et al: A conceptual model of psychosomatic illness in children. Family organization and family therapy. *Arch Gen Psychiatry* 1975; 32:1031-1038
14. Minuchin S, Rosman BL, Baker L: *Psychosomatic Families, Anorexia Nervosa in Context*. Cambridge, Harvard University Press, 1978
15. Christie-Seely JE (ed): *Working With the Family in Primary Care: A Systems Approach to Health and Illness*. New York, Praeger Publishers, 1984
16. Sproul MS, Gallagher RM: The genogram as an aid to crisis intervention. *J Fam Pract* 1982; 14:959-960
17. Huygen FJA: *Family Medicine: The Medical Life History of Families*. Nijmegen, Netherlands, Dekker and Van de Vegt, 1978
18. Goldberg ID, Krantz G, Locke BZ: Effects of a short-term outpatient psychiatric therapy benefit on the utilization of medical services in a prepaid group practice medical program. *Med Care* 1970; 8:419-428
19. Follette W, Cummings NA: Psychiatric services and medical utilization in a prepaid health plan setting. *Med Care* 1967; 5:25-35
20. Papp P, Silverstein O, Carter E: Family sculpting in preventive work with well families. *Fam Process* 1973; 12:197-212
21. Sulzbacher S, Wong BR, McKeen J, et al: Long-term therapeutic effects of a three-month intensive growth group. *J Clin Psychiatry* 1981; 42:148-153
22. Dansak DA: On the tertiary gain of illness. *Compr Psychiatry* 1973; 14:523-534
23. Kuhn S: *The Structure of Scientific Revolutions*, ed 2, enlarged. Chicago, University of Chicago Press, 1980
24. McWhinney I: Time Change and the Physician. Presented at the Plenary Session, 16th Annual Spring Conference of the Society of Teachers of Family Medicine, Boston, Mass, May 10, 1983