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WHY GENOGRAMS?

A genogram is a format for drawing a family tree that records information about family members and their relationships over at least three generations. Genograms display family information graphically in a way that provides a quick gestalt of complex family patterns and a rich source of hypotheses about how a clinical problem may be connected to the family context and the evolution of both problem and context over time.

In the following chapters, we outline our basic approach to genogram construction, present an outline for collecting genogram information in a family assessment, offer principles of genogram interpretation based on family systems theory, describe genogram applications in clinical practice, and finally, discuss the future potential of computerized genograms for family research. Along the way we use the genograms of various well-known families to enliven the subject.

Despite the widespread use of genograms by family therapists and physicians, there is no generally agreed-upon "right way" to do a genogram. Even among clinicians with similar theoretical orientations, there is only a loose consensus about what specific information to seek, how to record it, and what it all means. This book presents a standardized genogram format and describes the interpretive principles upon which genograms are based. Guidelines developed over the past ten or twelve years in collaboration with many colleagues are presented here as work in progress. They represent one way to do a genogram – a useful way, we believe – one which has been revised many times and will no doubt be revised again in the future.

Genograms are appealing to clinicians because they are tangible and graphic representations of a family. They allow the clinician to

map the family structure clearly and to note and update the family "picture" as it emerges. For a clinical record, the genogram provides an efficient clinical summary, allowing a therapist unfamiliar with a case to grasp quickly a large amount of information about a family and to have a view of potential problems. While notes written in a chart or questionnaire answers may become lost in a clinical record, genogram information is immediately recognizable and can be added to and corrected at each clinical visit as more is learned about the family.

Genograms make it easier for a clinician to keep in mind family members, patterns and events that may have recurring significance in a family's ongoing care. Just as language potentiates and organizes our thought processes, family diagrams which map relationships and patterns of functioning may help clinicians think systemically about how events and relationships in their clients' lives are related to patterns of health and illness.

The information on a genogram is best understood from a systemic perspective. The genogram interview should be seen as one part of a comprehensive, systemic, clinical assessment. There is no quantitative measurement scale by which the clinician can use a genogram in a cookbook fashion to make clinical predictions. Rather, the genogram is a subjective interpretive tool with which the clinician can generate tentative hypotheses for further systemic evaluation.

Typically, the genogram is constructed in the first session and revised as new information becomes available. Thus, the initial assessment forms the basis for treatment. It is important to emphasize, however, that family therapists typically do not compartmentalize assessment and treatment. Each interaction of the therapist with the family informs the assessment and thus influences the next intervention.

Genograms can help family members see themselves in a new way and are thus an important way of "joining" with families in therapy. They enable an interviewer to reframe, detoxify, and normalize emotion-laden issues, creating a systemic perspective which helps to track family issues through space and time. Also, the genogram interview provides a ready vehicle for systemic questioning, which, in addition to providing information for the clinician, begins to orient the family to a systemic perspective. The genogram helps both the clinician and the family to see the "larger picture," both currently

and historically; that is, the structural, relational, and functional information about a family on a genogram can be viewed both horizontally across the family context and vertically through the generations.

Scanning the breadth of the current family context allows the clinician to assess the connectedness of the immediate players in the family drama to each other, as well as to the broader system, and to evaluate the family's strengths and vulnerabilities in relation to the overall situation. Consequently, we include on the genogram the entire cast of characters – nuclear and extended family members as well as significant non-family members who have ever lived with or played a major role in the family's life – and a summary of the present family situation, including relevant events and problems. Current behavior and problems of family members can then be traced on the genogram from multiple perspectives. The index person (the person with the problem or symptom) may be viewed in the context of various subsystems, such as siblings, triangles, complementary and symmetrically reciprocal relationships, or in relation to the broader meta systems such as community, social institutions (schools, courts, etc.), and the broader sociocultural context.

By scanning the family system historically and assessing previous life cycle transitions, one can place present issues in the context of the family's evolutionary patterns. Thus, the genogram usually includes at least three generations of family members, as well as nodal and critical events in the family's history, particularly as related to the life cycle. When family members are questioned about the present situation in relation to the themes, myths, rules, and emotionally charged issues of previous generations, repetitive patterns become clear. Genograms "let the calendar speak" by suggesting possible connections between family events. Patterns of previous illness and earlier shifts in family relationships brought about through changes in family structure and other critical life changes can easily be noted on the genogram, providing a rich source of hypotheses about what leads to change in a particular family. (In conjunction with genograms, we usually include a family chronology, which depicts the family history in chronological order – see explanation on pp. 19–20.)

Genograms are most often associated with Bowen's family systems theory (Bowen, 1978; Carter & McGoldrick Orfanidis, 1976; Guerin & Pendagast, 1976; McGoldrick, 1977; Pendagast & Sherman, 1977; Bradt, 1980), but they are used by clinicians of other orientations as well (Hartman, 1978; Lieberman, 1979; Paul & Paul,

1974; Smoyak, 1982; Wachtel, 1982). In family therapy, genogram applications range from multigenerational mapping of the family emotional system using a Bowen framework, to systemic hypothesizing for Milan-style paradoxical interventions, to developing "projective" hypotheses about the workings of the unconscious from genogram interviews, to simply depicting the cast of characters in the family. Some family therapists have stressed the usefulness of genograms for keeping track of complex relational configurations seen in remarried families (McGoldrick & Carter, 1980; Sager et al., 1983), and for engaging and keeping track of information with families of certain ethnic backgrounds (Garcia Preto, 1982; Moitoza, 1982) and at certain points in the life cycle, such as later life.

Although structural and strategic family therapy theorists (Haley, 1976; Madanes, 1981; Minuchin, 1974) have not used genograms in their approaches, preferring to focus on the emotional relationships in the immediate family rather than on the biological and/or legal structure, they are nevertheless concerned about hierarchical structures, particularly coalitions where generational boundaries are crossed. The genogram can highlight both current and historical family patterns to illustrate these and other dysfunctional family structures.

Family physicians have used genograms to record family medical history efficiently and reliably (Jolly, Froom, & Rosen, 1980; Medalie, 1978; Mullins, & Christie-Seely, 1984; Rakel, 1977). They have, in fact, attempted to standardize genogram symbols (Jolly et al., 1980; McGoldrick, Froom & Snope, in preparation) and to develop efficient procedures for using genograms in medical practice (Rogers & Durkin, 1984).

Given the widespread use of the genogram by different family professionals, there is surprisingly little detailed information about its use, interpretation, and application. This book attempts to fill this gap. We begin by reviewing the systemic assumptions that guide us in using genograms in our work.

A FAMILY SYSTEMS PERSPECTIVE

The concept of system is used to refer to a group of people who interact as a functional whole. Neither people nor their problems exist in a vacuum. Both are inextricably interwoven with broader interactional systems, the most fundamental of which is the family.

The family is the primary and, except in rare instances, the most powerful system to which a person ever belongs. In this framework, "family" consists of the entire kinship network of at least three generations, both as it currently exists and as it has evolved through time (Carter & McGoldrick, 1980). The physical, social and emotional functioning of family members is profoundly interdependent, with changes in one part of the system reverberating in other parts of the system. In addition, family interactions and relationships tend to be highly reciprocal, patterned and repetitive. It is this redundancy of pattern that allows us to make tentative predictions from the genogram.

A basic assumption made here is that problems and symptoms reflect a system's adaptation to its total context at a given moment in time. The adaptive efforts of members of the system reverberate throughout many levels of a system – from the biological to the intrapsychic to the interpersonal, i.e., nuclear and extended family, community, culture and beyond (Bowen, 1978; Engel, 1980; Scheflen, 1981). Also, family behaviors, including problems and symptoms, derive further emotional and normative meaning in relation to both the sociocultural (Elder, 1977; McGoldrick, Pearce, & Giordano, 1982) and historical (McGoldrick & Walsh, 1983) context of the family. Thus, a systemic perspective involves understanding the problem on as many levels as possible.

Since the genogram has developed primarily out of the family systems theory of Murray Bowen (1978), the conceptual framework for analyzing genogram patterns has been based on his ideas. The following is for the most part derived from Bowen's work.

People are organized within family systems according to generation, age, and sex, to name a few of the most common factors. Where you fit in the family structure can influence your functioning, relational patterns, and the type of family you form for the next generation. Walter Toman (1976) has emphasized the importance of sex and birth order in shaping sibling relationships and characteristics. Given different family structural configurations mapped on the genogram, the clinician can tentatively predict likely personality characteristics and relational compatibility problems.

Families repeat themselves. What happens in one generation will often repeat itself in the next, i.e., the same issues tend to be played out from generation to generation, though the actual behavior may take a variety of forms. Bowen terms this the multigenerational

transmission of family patterns. The hypothesis is that relationship patterns in previous generations could provide implicit models for family functioning in the next generation. On the genogram, we look for patterns of functioning, relationships and structure continuing or alternating from one generation to the next.

Clearly, this systems approach involves an understanding of both the current and historical context of the family. We agree with Carter (1978) that the "flow of anxiety" in a family system occurs along both vertical and horizontal dimensions. The "vertical" flow derives from patterns of relating and functioning that are transmitted historically down the generations, primarily through the process of emotional triangling. The "horizontal" flow of anxiety emanates from current stresses on the family as it moves forward through time, coping with the inevitable changes, misfortunes and transitions in the family life cycle. With enough stress on this horizontal axis, any family will experience dysfunction. Furthermore, stressors on the vertical axis may create added problems, so that even a small horizontal stress can have serious repercussions on the system. For example, if a young mother has many unresolved issues with her mother and/or father (vertical anxiety), she may have a particularly difficult time dealing with the normal vicissitudes of parenthood (horizontal anxiety). The genogram helps the clinician to trace the flow of anxiety down through the generations and across the current family context.

Given our historical perspective, we take a systemic view of the "coincidences" of events. Concurrent events in different parts of the family are not viewed as simply random happenings; rather, they are seen as often interconnected in a systemic way. In addition, critical events are more likely to occur at some times than at others, especially the nodal points of life cycle transition in a family's history. Symptoms tend to cluster around such transitions in the family life cycle, when family members face the task of reorganizing their relations with one another in order to go on to the next phase. The symptomatic family becomes stuck in time, unable to resolve its impasse by reorganizing and moving on. The history and relationship patterns revealed in a genogram assessment provide important clues about the nature of this impasse—how a symptom may have arisen to preserve or to prevent some relationship pattern or to protect some legacy of previous generations.

There are many types of relationship patterns in families. Of particular interest are patterns of relational distance. People may be very close or very distant or somewhere in between. At one extreme are family members who are very distant from or in conflict with each other. The family may actually be in danger of breaking up. At the other extreme is what is called emotional "fusion" or "stuck-togetherness" of individuals in the family system. Family members in fused or poorly differentiated relationships are vulnerable to dysfunction, which is assumed to occur when the level of stress or anxiety exceeds the system's capacity to deal with it. The more closed the boundaries of a system become, the more immune it is to input from the environment, and consequently, the more rigid family patterns become. In other words, family members in a closed, fused system react automatically to one another, practically impervious to events outside the system that require adaptation to changing conditions. Fusion may involve either positive or negative relationships; i.e., family members may feel very good about each other or experience almost nothing but hostility and conflict. In either case, there is an overdependent bond that ties the family together. With genograms clinicians can map family boundaries and indicate which family subsystems are fused and thus likely to be closed to new input about changing conditions.

As Bowen has pointed out, two-person relationships tend to be unstable. Under stress two people tend to draw in a third, stabilizing the system by forming a coalition, the two joining in relation to the third. The basic unit of an emotional system thus tends to be the triangle. As we shall see, genograms can help the clinician identify key triangles in a family system, see how triangular patterns repeat from one generation to the next, and design strategies for changing them.

Finally, as noted in our definition of system, the members of a system fit together as a functional whole. That is, the behaviors of different family members are complementary or reciprocal. This leads us to expect a certain interdependent fit or balance in families, involving give and take, action and reaction. Thus, a lack (e.g., irresponsibility) in one part of the family may be complemented by a surplus (overresponsibility) in another part of the family. The genogram helps the clinician pinpoint the contrasts and idiosyncrasies in families that indicate the type of complementarity or reciprocal balance.

A CAVEAT

Throughout this book, we make assertions about families based on their genograms. Let us remind you that our observations about these genograms are given only as tentative hypotheses. This is true for genogram interpretations in general. At best, they offer provocative suggestions for further exploration. Predictions based on the genogram are not fact. The principles for interpreting genograms should be seen as rules of thumb—nothing more.

In many of the genograms shown in this book, we provide more information than our discussion attempts to cover. We encourage readers to use these illustrative genograms as a departure point for further developing their own skills in using and interpreting genograms.

Clearly, a genogram is limited in how much information it can display. Clinicians gather a great deal more important information on people's lives than can ever appear on genograms. Therefore, genograms should never be used clinically out of context, as we do here for didactic purposes. The genogram is just one part of an ongoing clinical investigation and must be integrated into the total family assessment.

2

CONSTRUCTING GENOGRAMS

Genograms are part of the more general process of family assessment. In this chapter we will describe how to both construct a genogram and elicit relevant genogram information from a family during assessment.

CREATING A GENOGRAM

Creating a genogram involves three levels: 1) mapping the family structure, 2) recording family information, and 3) delineating family relationships.

Mapping the Family Structure

The backbone of a genogram is a graphic depiction of how different family members are biologically and legally related to one another from one generation to the next. This map is a construction of figures representing people and lines delineating their relationships. As with any map, the representation will have meaning only if the symbols are defined for those who are trying to read the genogram. Not surprisingly, there is a great deal of diversity in the way clinicians draw genograms. Different groups have their own favorite symbols and ways of dealing with complicated family constellations, which often leads to confusion in reading other clinicians' genograms. Recently a group of family physicians and family therapists (a Task Force of the North American Primary Care Research Group), chaired by McGoldrick, has collaborated to standardize the symbols and pro-

Differences in resources can also become problematic when one sibling becomes more successful than the others. For example, if one sibling in a family becomes a physician and all others do poorly, there is often an imbalance; the successful one cannot meet the needs of the siblings and they in turn resent both her or his success and the lack of support. When resources (emotional as well as financial) are lacking, one frequently sees siblings cutting off, particularly around the caretaking of a parent or an ill sibling. There may be endless debates about who did more for the person in need. In other families, where most siblings are doing well and only one sibling or one parent is in need, it may be easier to develop a satisfactory balance of resources without unduly taxing any one member.

In sum, reading the genogram for patterns of contrast and balance in family structure, roles, functioning, and resources allows the clinician to derive hypotheses about how the family is adapting to imbalances that may be stressing the system.

4

CLINICAL USES OF THE GENOGRAM

We have only begun to tap the rich clinical potential of the genogram. Here we will focus on its use in family therapy and family practice.

THE GENOGRAM IN FAMILY THERAPY

The genogram arose out of the practice of family therapy; therefore, not surprisingly, most of its applications have been pioneered in this field. Genograms have been used in many different ways by different therapists. We will focus on four specific uses: 1) to engage the whole family; 2) to unblock the system; 3) to clarify family patterns; and 4) to reframe and detoxify family issues. A comprehensive discussion of the clinical application of genograms is beyond the scope of this book, and the following should be seen only as suggestive.

Engaging the Family

In order to be of help, the family therapist must first engage the family in the therapeutic process. Preferably, as many relevant family members as possible will be involved so that the clinician will better see the problem in its familial context. The genogram interview usually provides a practical way of engaging the whole family in a systemic approach to treatment.

Genogram interviewing shows interest in the whole family system. The process of mapping family information on the genogram implies

that a larger picture of the situation is needed to understand the problem and conveys a major systemic assumption: All family members are involved in whatever happens to any member. It also suggests the ongoing connectedness of the family, both with the past and with the future.

Equally important, the genogram interview often allows the therapist to build rapport with family members around issues of specific concern to the family. Genogram questioning goes to the heart of family experiences: birth, illness, death, and intense relationships. Its structure provides an orienting framework for discussion of the full range of family experiences and for tracking and bringing into focus difficult issues such as family illnesses, losses, and conflicts.

Genograms often provide almost instant access to complex, emotionally loaded family material. However, the structure of the genogram interview seems to elicit such information in a relatively nonthreatening way. Neutral, matter-of-fact gathering of information to complete a family diagram often leads to matter-of-fact giving of information. Even the most guarded person, quite unresponsive to open-ended questions, may be willing to discuss his or her family in such a structured format (McGoldrick, 1977; Wachtel, 1982).

There is something impressive about not just gathering information but also displaying it to the family in an organized, graphic way. Some clinicians will display the genogram to the family either on the blackboard (Carter, 1982) or on large note pads (Bradt, 1980). Genograms seem to possess a certain mystique and thus may be an important "hook" for some families. Wachtel (1982) has argued that their power may be something like psychological tests, which add weight and credibility to inferences a clinician may make about family patterns.

Sometimes, while a genogram is taken, one spouse may appear bored or the children become restless (Wachtel, 1982). The key to gaining receptivity with such families is to build connections carefully outward from the presenting problem in a way that demonstrates the relevance of the larger family context to the family's immediate concerns. In our experience there have been occasional, but infrequent, situations in which family members have been so resistant to discussions of genogram information that we have had to leave the subject until we found another way of engaging them. In those situations when we have eventually succeeded in building a relationship with the family, we have found that the resistance came from

painful memories of family experiences, for example, the stigma of a parent who committed suicide or was in a mental hospital.

Unblocking the System

When a family comes in with a problem, it has often adopted its own view of the problem and what needs to be changed. This is often a rigid, nonsystemic view based on the belief that only one person, the symptomatic one, needs to change. Any effort to move directly into other problematic areas of the family will often be blocked by vehement denial of other family difficulties.

The genogram can be useful in working with such rigid systems. The genogram interview organizes questioning around key family life experiences: birth, marriage, life transitions, illness and death. Collecting information on these events can open up a rigid family system and help clients get in touch with paralyzing blocked emotional and interpersonal issues. Sometimes, seemingly innocuous questions may provoke an intense reaction, as when a client burst into tears after being asked how many siblings he had. The question had stirred up memories of his favorite brother, who had died in a drowning accident. Ostensibly simple questions may also unearth family secrets, such as when the question, "How long have you been married?" leads to embarrassment or concealment for a couple who conceived their first child before marriage. Even questions of geography, such as, "Where does your son live?" may be a sensitive issue to a parent whose son is in jail or in a psychiatric hospital or totally out of contact with the parent. The family's initial concealment of information may often be overcome by careful, sensitive exploration of the situation.

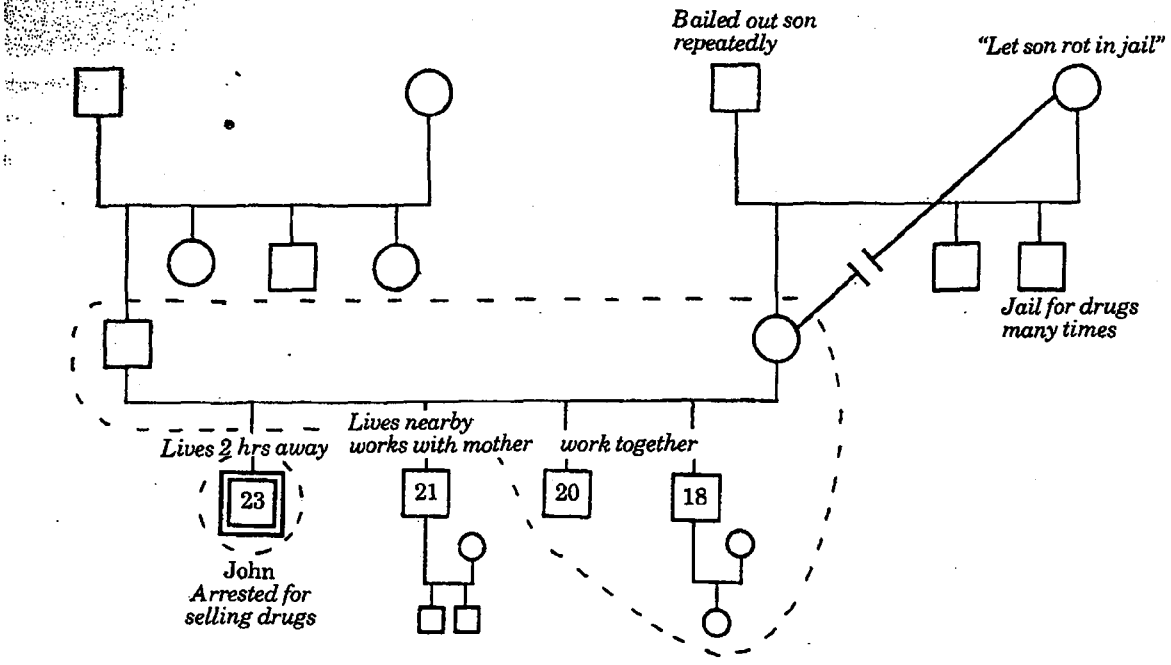


Diagram 4.1 The G. family

For example, the G.'s, an Italian/WASP family, were referred for consultation by their lawyer, who hoped the referral would influence the court case of the oldest of their three sons, John, who had been arrested for selling drugs. The genogram is shown in Diagram 4.1.

Initially the family presented a united front: They were a close, loving family whose son had come under the influence of "bad friends." They denied the seriousness of the son's crime, offered little factual information, minimized any relationship problems, but said they were willing to do anything to help. Few connections were apparent in gathering the basic genogram information until we got to the question of the whereabouts of the maternal uncle. Mrs. G. said that she did not know where her brother was, but then admitted that he was in jail and had had many previous arrests. This led to questioning about the maternal grandmother's reaction to John's problem, at which point the family's united front began to break down. The parents reluctantly admitted that they had stopped talking to the maternal grandmother since John's arrest because of her "insensitive" response: "Let him rot in jail." (Mr. and Mrs. G. had taken a second mortgage on their house to pay their son's bail and legal fees.) Mrs. G. said she had always been very close to her mother

and could not understand what had happened, but said she viewed her mother as "disloyal." Further detailed questioning led to the information that Mrs. G.'s brother had first been arrested at age 23 (John's present age). The maternal grandfather had repeatedly bailed his son out of trouble, spending all the family savings on this, against the grandmother's wishes, and she was now very bitter that her son had brought almost total ruin on her family. It was only through discussing the details of the uncle's criminal behavior (a family secret that John and his brothers did not know), that the family's "cool" about their present situation was broken. Mrs. G. talked about her pain in watching her own mother's agony over the years, as well as her own fury at her brother for the shame he had brought on the family. She was desperately afraid of reliving her parents' experience, but since even discussing the matter with her mother made her more fearful that the family was "doomed" to repeat the past, she had stopped talking to her mother. As we talked, John's brothers opened up for the first time in the interview, expressing their resentment of their brother for putting the family in the terrible position of having to decide whether to put their life savings on the line or let John go to jail. The father, who had been the most adamant in denying any family difficulties, talked about his sense of betrayal and failure that his son had so cut him off. It was only through the leverage of the previous family experiences that the family's present conflicts became evident.

The genogram interview is especially useful for engaging obsessive, unresponsive or uninvolved clients. The obsessive client who otherwise dwells on the endless details of family minutiae often comes quickly to emotionally loaded and significant material during a genogram interview. Unresponsive clients often find themselves caught up in reciting and responding to the family drama.

In their attempt to avoid dealing with painful past experiences and unresolved emotional issues, families often rigidify their relationships and view of the themselves. Calm, nonthreatening, "research" questions can often open up these matters, so that family members can begin to relate to one another in a different way around such issues.

One common issue around which families become blocked is that of loss and death. Norman and Betty Paul (1974) use genograms to unblock the family system by focusing on losses in the multigenerational family. They do not treat symptoms directly, but rather in-

volve the clients in a search for deaths or life-threatening experiences in either the immediate or extended family. In the Pauls' view, the "forgetting" and distortion in family members' perceptions that occur around loss are among the most important factors influencing symptom development. The Pauls routinely send genogram forms to prospective clients to be completed before the first session; they find that this gives them important information about how the clients orient themselves to their original family. In the first session they carefully track the dates of birth and death and the causes of death of family members for the past three generations. In their experience, clients usually indicate some degree of mystification about doing their genograms. They report an interesting example of a response to the genogram in *A Marital Puzzle* (1974). A husband was asked to bring genogram information to the first therapy session. He left off the chart the fact that both of his parents had died, although he had been specifically asked for it; when questioned, he said he did not remember exactly when they had died. The Pauls' therapeutic model involves rediscovery of such dissociated family experiences.

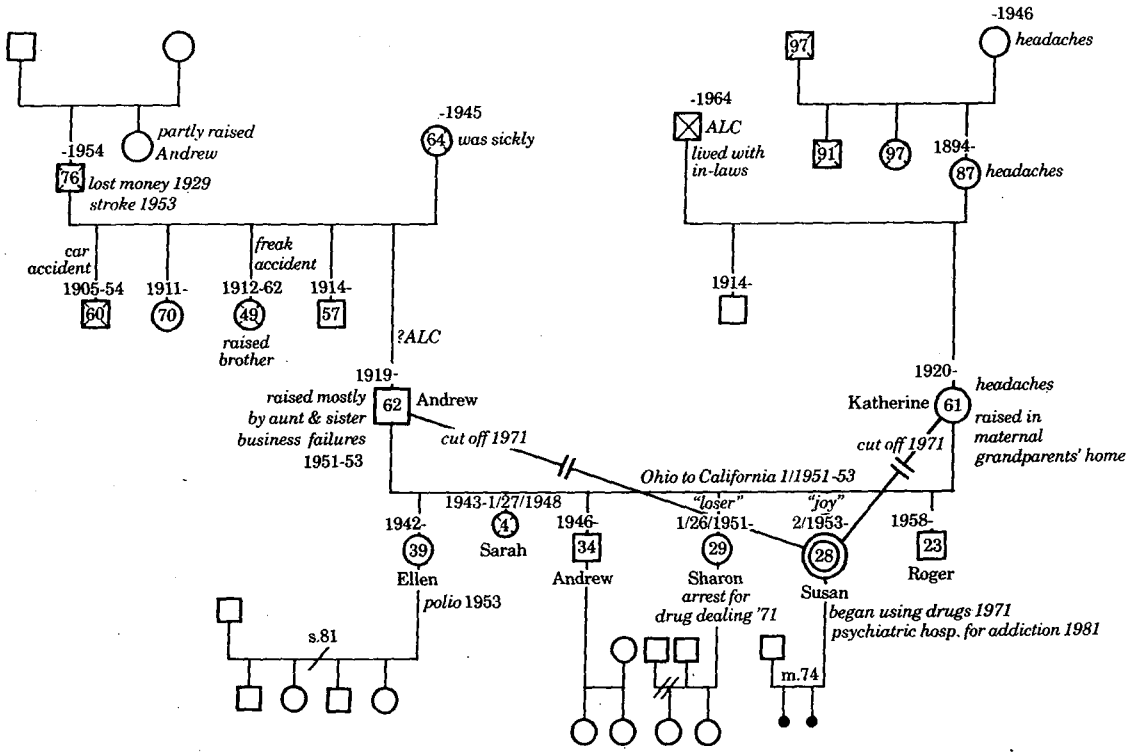
Clarifying Family Patterns

Clarifying family patterns is at the heart of genogram usage. As we collect information to complete the genogram, we are constantly constructing and revising hypotheses based on our ongoing understanding of the family. Then, in conjunction with other clinical data, we often present our observations to the family. We usually offer our observations as tentative hypotheses which the family may confirm or disprove.

The G. family discussed above illustrates how the genogram can become a guide for both family and therapist to patterns, clarifying the present dilemma in ways which open up possibilities for alternative behavior in the future. From the genogram, we could see a pattern of repetition of criminal behavior. Then, as the connection was made between the son's and the uncle's criminal behavior and the possibility of the family history being repeated was pointed out, the family began to look at the son's behavior within the family context and to explore the legacy and conflicts that were perpetuating the behavior.

Clarifying family patterns serves an educational function for the

family, allowing family members to see their behavior as connected and within the family context. Cognitive understanding of symptomatic behavior as it relates to emotionally charged relationships can increase the family's sense of mastery over the family plight. In addition, it is often difficult to maintain dysfunctional behavior once the family patterns that underlie it are clarified.



KEY EVENTS

1/27/48	Sarah dies, age 4	1953	Father's business failed and family returned to Ohio	1971	Sharon arrested for drug dealing—Father bailed her out
1/26/51	Sharon born	1953	Susan born	1971	Susan began living with boyfriend-parents disowned her
2/51	Family moved 2,000 miles for new business	1953	Ellen got polio		
1953	PGF had stroke				

November 1981

Diagram 4.2 The B. family

In the B. family a number of patterns needing clarification became apparent in the process of interpreting the genogram. Susan B. first sought help for headaches in 1971, when her parents disowned her for moving in with her boyfriend while in college. She began a long history of addiction to Valium and other prescription drugs, culminating in a hospitalization for drug abuse in 1981. The genogram (Diagram 4.2) was constructed in the first interview.

Applying the interpretive principles to the genogram reveals a number of significant clinical patterns. In terms of pattern repetition across generations (Category 3), Susan was the fourth generation of women suffering from chronic headaches. In addition, Susan's pattern of anesthetizing herself with drugs fits with her mother's pill-taking for headaches and her father's and maternal grandfather's alcohol abuse.

By tracking the coincidence and impact of significant events (Category 4), we find that Susan was born in February, a special time of the year for her family: An older sister had died five years earlier, on January 27, 1948, and another sister, Sharon, had been born on January 26, 1951, the very month the family moved 2000 miles away from their home so that the father could go into business with his brother-in-law. In addition, Susan, born in 1953, came into the family at a time following multiple crises: The father's business had failed, his brother-in-law moved in with the family, and his father had a stroke while visiting and had to move in and be nursed until his death a year later. The oldest daughter contracted polio (the sister who had died had had spinal meningitis) and had to be put in a iron lung for several months, and following the business failure, the family moved back to the Midwest to start over. A year later, father's older brother died in a car accident. Both parents are the youngest in their sibling constellation (mother's mother was also a youngest). Given the youngest's propensity to expect to be cared for by others (Category 1: family structure), one might speculate about how well they could support and care for one another during this difficult period.

Noticing all the difficulties of this period, the therapist inquired further as to its impact on the family. Mother reported that Susan was her one "joy" in the midst of everything else that was going wrong. The two surviving daughters came to play complementary roles: Susan was the "good" child while Sharon became the "loser." Interestingly, two months before Susan's cut-off from her parents, Sharon had been bailed out by her parents after having been arrested with her drug dealer husband. Seeing the patterns on the genogram, the therapist was able to explore and clarify with the family the cross-generational repetition of coping methods, the impact of critical family events, and the interconnectedness of the two sisters' behavior.

Reframing and Detoxifying Family Issues

Families develop their own particular ways of viewing themselves. In problematic families, the family's perspective is often rigid and resistant to change or to alternative views of the situation. Genograms are an important tool for reframing behavior, relationships, and time connections in the family, and for "detoxifying" and normalizing the family's perception of itself. Suggesting alternative interpretations of the family's experience points the way to new possibilities in the future.

The genogram interview allows the clinician many opportunities to normalize the family members' understanding of their situation. Simply bringing up an issue or putting it in a more normative perspective can often "detoxify" it. Using information gathered on the genogram, the clinician can also actively reframe the meaning of behavior in the family system, enabling the family members to see themselves in a different way. The interpretive guidelines indicate some of the possible ways for doing this. The family structure (Category 1) suggests normative expectations for behavior and relationships (e.g., "It's not surprising you're so responsible since oldest children commonly are." Or, "Usually two youngest who marry tend to be waiting for each other to take care of them. How did it go with you?"). Similarly, an understanding of life cycle fit (Category 2) can provide a normalizing experience (e.g., "People who marry as late as you did are usually pretty set in their ways"). Pattern repetition (Category 3) and the coincidence of events (Category 4) show the larger context of problematic behavior (e.g., "Maybe how you were feeling had something to do with all the stressful events that were occurring at the time"). And relational patterns (Category 5) and family balance (Category 6) help demonstrate the interdependency of family members (e.g., "Most people react that way as the odd person out." Or, "Usually, when one person takes on more than her share of responsibility, then the other person takes on less").

Bowen is a master at detoxifying reactive responses with genogram questioning. For example, below is an excerpt of an interview by Bowen of a man who felt intimidated by his "domineering, possessive mother":

> *Bowen:* What are the problems of being the only child of an only child mother?

Client: My mother was a very domineering woman who never wanted to let go of anything she possessed, including me.

Bowen: Well, if you're the only one, wouldn't that be sort of predictable? Often in a relationship like that people can with some accuracy know what the other thinks . . . in other words, you're describing a sort of an intense relationship, and not too unusual with a mother and an only son, especially a mother who doesn't have a husband, and your mother was an only. How would you characterize your mother's relationship with her mother?

Here Bowen is using what we would call family structure (Category 1) to normalize a mother's behavior and the special mother-child bond of an only child. Bowen's therapy is characterized throughout by such tracking, detoxifying and reframing of multigenerational family patterns.

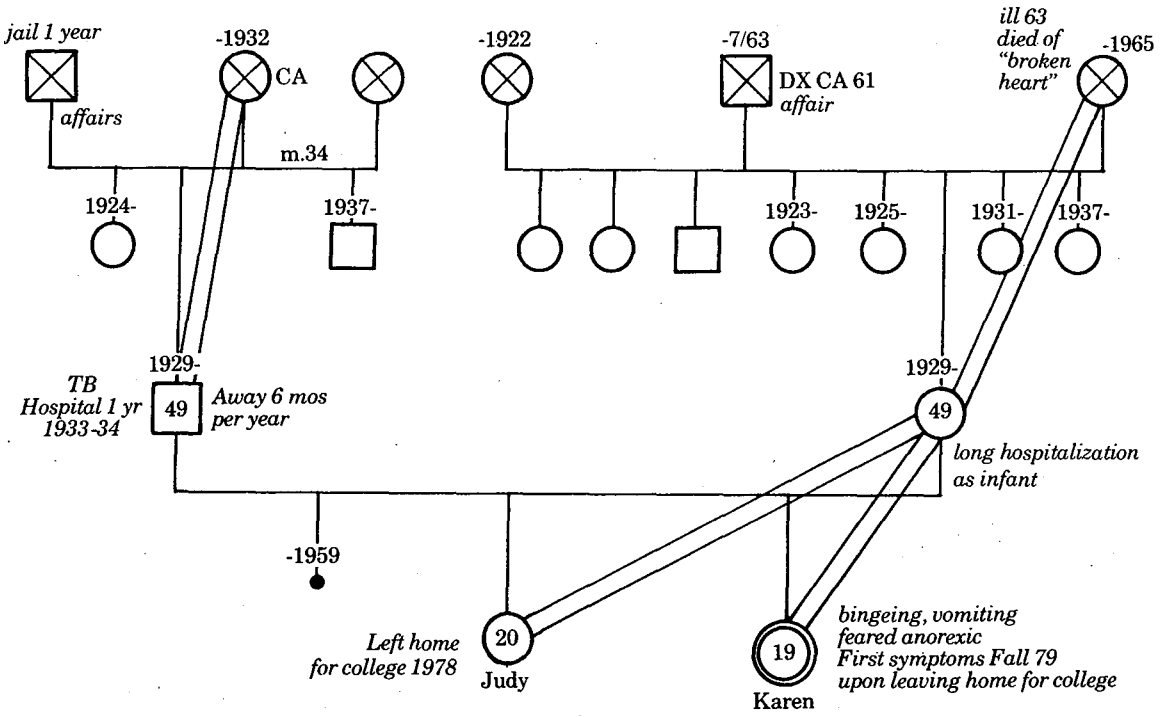
Other Uses of the Genogram in Family Therapy

Family therapists with a Bowen systemic approach have been using genograms for many years as the primary tool for assessment and for designing therapeutic interventions. More recently, therapists with different approaches have come to use the genogram for recordkeeping, family assessment, and designing strategic interventions.

Wachtel has suggested using the genogram as a "quasi-projective technique" in family therapy, revealing unarticulated fears, wishes and values of the individuals in the family. She takes about four one-hour sessions to complete a genogram on a marital couple. After getting the basic "factual data," she asks each spouse for a list of adjectives to describe each family member, and then for stories to illustrate the adjectives used. She keeps track of the conceptions the spouses have about various family members and how these conceptions are passed down from one generation to another. She then investigates the spouses' conception of the relationships between people, commenting throughout "on emerging family issues, patterns, and assumptions and their possible relevance to the current situation" (1982, p. 342). Differences of opinion become grist for the mill of therapy, and spouses are urged to seek missing genogram information between sessions.

More recently, therapists using a strategic approach have come to use the genogram not only for recordkeeping and family assessment, but as a map for designing strategic interventions. The following example, taken from a case in which a modification of the Milan model was used, illustrates the strategic use of genogram patterns and events.

The S. family applied for help because the younger of their two daughters, Karen, age 19, had begun to binge and vomit after leaving home for college and had been losing weight. Judy, her older sister, was one year ahead of Karen at a local college. All members described their family as closer than other families, loving and open. Karen's problem was a mystery to everyone, herself included. The genogram (Diagram 4.3) was taken on the family.



September 1980

Diagram 4.3 The S. family

The therapist used the information gathered from the genogram to "positively connote" and normalize the family's behavior and experience. The current family situation was related to the repetition of family patterns (Category 3), the impact of critical events in the family's history (Category 4), and the complementary balance of family functioning (Category 6). For example, Karen's difficulties

leaving home were related to her special position in the family due to deaths of maternal grandparents shortly after her birth. The special closeness of the family was explained by the parents' early childhood experiences with loss and isolation: the mother having had a long hospitalization when 18 months old and the father losing his mother and being hospitalized at age three. The parents' fears of closeness with each other and Karen's need to protect them were also explained and justified by the early losses. And the observation of a female sisterhood both among the daughters and among the mother's siblings was used to cast a sympathetic light on the father's isolation in the family. Thus, the genogram was used to depict a positive, understanding view of the family while at the same time implying that change was possible when the family was ready for it. An excerpt from the first session will give the flavor of how the genogram information is used to reframe the family's pattern of adaptation in a positive way:

> *Therapist:* We have been very impressed with the closeness and mutual sacrifice you all show for your family. Even from the little we have heard about your background, we can understand some of the issues: For example, Mrs. S.'s father's diagnosis of cancer coincided with her pregnancy with Karen, and shortly after her birth he died and then his wife died of a "broken heart" shortly afterwards, making Karen's position in the family a very special one. Mr. S., who had very little warmth in his own family because of his mother's early death, has been forced to be away from his family half the year for work; yet the family makes great efforts to include you when you are available. Somehow, it seems to us that Karen's not eating is symbolic of the family's sacrifice for each other to maintain closeness in the face of the difficulties and losses they have experienced.

Pointing out why a family is the way it is and cannot change sometimes leads to change. Genogram patterns are used in this therapeutic model first to convey a positive understanding of the present dysfunctional situation and thus paradoxically challenge the rigidity of the present stabilization. As change does occur, genogram information is again used to reinforce emerging patterns and to underline the normative evolution of the family.

For example, as the S. family's therapy continued, various family triangles were dealt with in clinical interventions. One triangle in-

volved the mother and daughters together with the father in the outside position. (There can be more than three people involved in a triangle. They occupy three positions: two in and one out.) During the course of therapy both Judy and Karen developed relationships with boyfriends. We then raised questions about whether these relationships would threaten the sisterhood since the daughters were demonstrating loyalty to persons outside the basic nuclear family triangle where the women, daughters and mother, were close and the father was in the outside position. This point was reinforced by pointing out that a similar triangle had existed in Mrs. S.'s family of origin, where the father was kept "on a pedestal" and always an outsider to the mother-daughter closeness. Pointing out the triangles and validating the loyalty issues seemed to add enough flexibility to the system for the daughters to maintain relationships outside the home.

GENOGRAM APPLICATIONS IN FAMILY PRACTICE

Families can be a source of both stress and support in times of medical illness. The genogram, as a primary tool for describing families and their functioning, is a crucial instrument in family health care. In the following brief discussion, we will focus on three areas: 1) systemic medical recordkeeping, 2) rapport-building, and 3) medical management and preventive medicine.

Systemic Medical Recordkeeping

Family physicians and other health care personnel with a commitment to continuing comprehensive care assume the responsibility of treating individuals not alone but in the context of their families (Litman, 1974; Richardson, 1945). There is, moreover, growing research evidence of the relationship between the level of family functioning and the physical and emotional well-being of each family member (Lewis et al., 1976; Schmidt, 1978). The illness of an individual family member will disrupt the family's functioning; on the other hand, family dynamics may have a role in the development of illness in family members (Doherty & Baird, 1983). For example, family stresses have been related to the occurrence of a variety of illnesses (Haggerty & Albert, 1967) and to the severity and duration of respiratory illnesses in children (Boyce et al., 1977). In addition, the importance of family supports in counteracting such stresses

(Caplan, 1976; Cobb, 1976; Massad, 1980) and the role of family functioning in adherence and clinical response to treatment regimens (Steidl et al., 1980) have been demonstrated. In other words, the relationship between the family and the patient is a major factor in the development and outcome of an illness.

Thus, it makes sense for health care providers to gather family information relevant to understanding medical problems in their systemic family context. Unfortunately, however, most physicians do not pay systematic attention to family patterns, because they have no way to keep track of them and they have not been taught how to make use of family information in the limited time they have available.

The genogram is perhaps the most clinically useful tool so far developed for assessing these connections between the family and illness. It is both efficient and economical since it enables the physician to gather quickly specifically relevant information on the family and to record the information in a clear, easily readable format.

The major advantage of the genogram is its graphic format. When there is a genogram in the medical record, the clinician can glance at it and get an immediate picture of the family and medical situation without wading through a stack of notes. Critical medical information can be flagged on the genogram and the current medical problem can be seen immediately in its larger familial and historical context. Thus, the genogram in itself enhances a systemic perspective of illness.

Genograms can be gathered in a medical setting in a number of ways. Patients can complete a form before their first visit (see Appendix, Part 3). Or a technician, nurse, secretary or medical student can take a genogram before the patient sees the physician for the first visit. Such genograms can be collected in 15–20 minutes even by a relatively unskilled interviewer. Or the physician can take the genogram, either at the first interview or as part of the patient's comprehensive medical history interview. Practically, however, due to time limitations, the physician may be able to gather only very basic information in the first interview; details can be added to the genogram as a relationship develops with the patient.

Rapport-building

The process of gathering family information with the genogram

may contribute to the establishment of rapport between the clinician and the patient. Interestingly, Rogers and Durkin (1984) found that most patients, after being given a 20-minute genogram interview, felt that such an interview could improve their medical care and their communication with their physicians. In an increasingly complex, technological, fast-paced medical world, patients sometimes complain of impersonal medical technologists who show interest only in their disorders, rather than in them as people. Genogram interviewing shows an interest in the well-being of each family member. This can be particularly important since medical compliance is so often related to the family's confidence and trust in the physician and other medical personnel.

Medical Management and Preventive Medicine

Finally, there is the application of the genogram in the management of medical treatment. Family physicians can and sometimes do use their knowledge of patients' family relationships and patterns to develop diagnostic and therapeutic plans for their patients (Anstett & Collins, 1982; Christie-Seely, 1981; Fossom et al., 1982; Rosen et al., 1982). The information on the genogram may be used directly in treatment planning or as a basis for referral.

Smilkstein (1984) has recently argued that an assessment of family functioning is relevant to medical treatment in that: 1) the physician may be able to "anticipate illness behavior, and in some instances to initiate preventive measures"; 2) such an assessment "can be beneficial in anticipating compliance" and evaluating available resources for aiding in compliance; 3) documenting life events may pinpoint stressors that may affect treatment; and 4) critical psychosocial problems may call for active intervention and/or outside referral. He suggests that it is particularly in "patient problem areas such as somatization, high utilization, multiple complaints, and chronic pain that assessment of family functioning and social support in general will be most rewarding" (pp. 266–7).

The genogram as an assessment instrument may serve all of the above functions. Indications on the genogram of previous illnesses or symptom patterns may lead to early detection of a problem and preventive treatment of family members at risk. The relational patterns on a genogram may suggest the likelihood of a family's complying with a given treatment recommendation and indicate what social supports will be available for managing an illness. The genogram

shows the critical life events that may be stressing a patient, both currently and historically. Such events suggest a reorganization of the family to adapt to the change, particularly when life cycle transitions or role changes are involved. And finally, the genogram is an important record of the psychosocial functioning of the family that may indicate when intervention is necessary.

Following are two examples of how a genogram may be used in medical treatment.

The first example illustrates the importance of gathering information in the initial interview. A 28-year-old chemical engineer sought help at a local family practice center for stomach pains in August 1984. Because it was customary for the nurse to take a genogram on new patients prior to the doctor-patient encounter, Diagram 4.4 was drawn.

Working from the genogram, the doctor began by trying to put the patient's stomach pain in context. She noted that this was a particularly difficult time for Mr. A. and hypothesized that recent critical family events might have had a stressful impact on him and his family (Category 4, life events and family functioning). The patient and his wife of one and a half years were in the midst of several major transitions. They had moved six months earlier and they were expecting their first child in five months. In addition, the patient's sister and her husband had recently separated, an event whose impact might be reverberating throughout the family system.

Looking carefully at the genogram we notice a number of temporal connections, anniversary reactions, and repetitive patterns that might be exacerbating the stressful nature of the upcoming events for Mr. A. His first wife had died of cancer in August 1981, which might well make this time of year particularly painful for him (Category 4, anniversary reaction). There is a repetitive pattern of early female death: His mother, his maternal grandmother, and his first wife all died in their twenties, which might make him acutely sensitive to physical vulnerability of women in his family (Category 3, multigenerational patterns). It thus seemed likely to the physician that Mr. A. would be particularly worried about his wife's upcoming childbirth, especially since his maternal grandmother had died in childbirth and his sister had had two miscarriages before her recent separation.

Since Mr. A. and his mother occupied similar sibling positions on the genogram (both were youngests), the physician speculated that

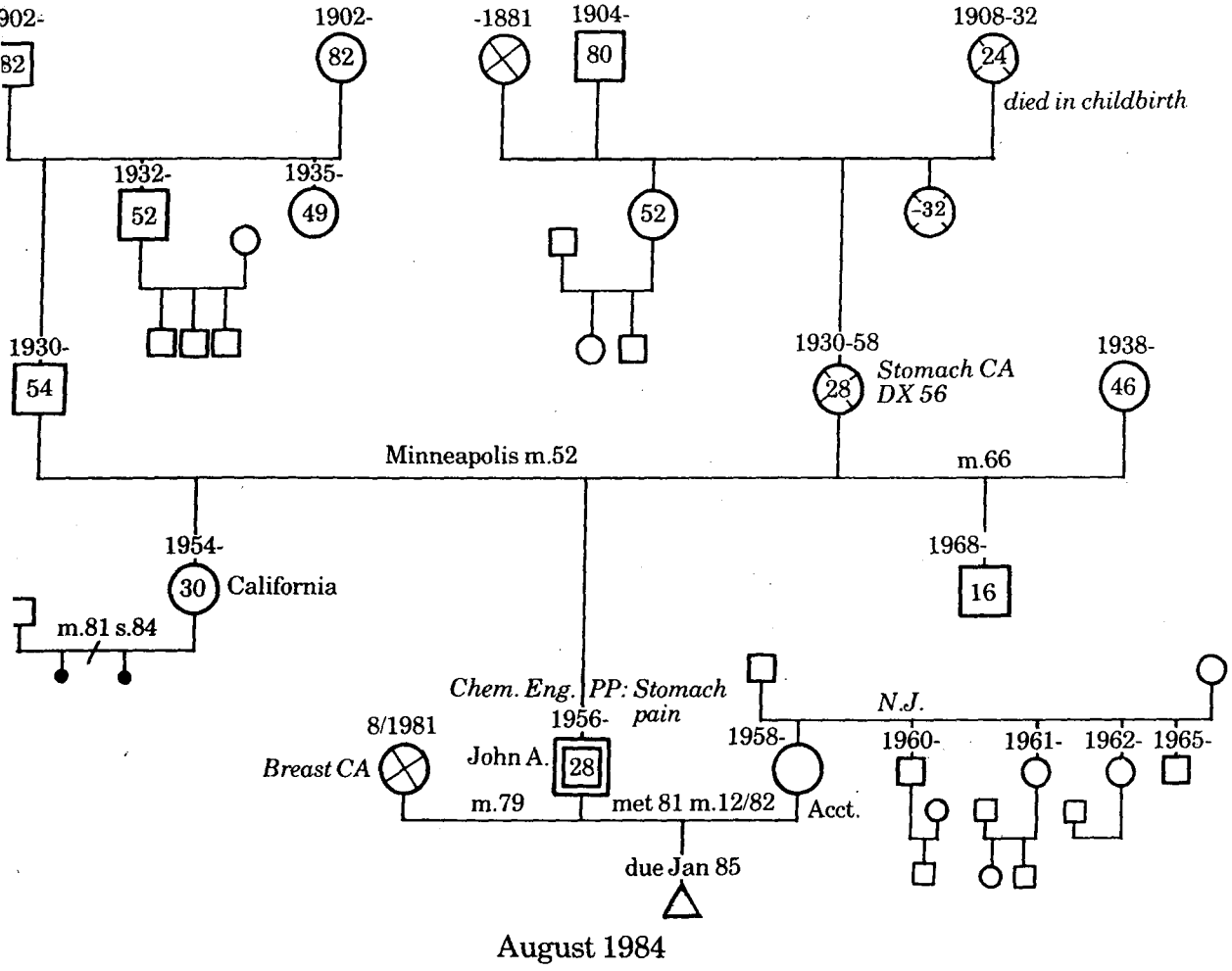


Diagram 4.4 The A. family

Mr. A. might have identified with his mother (Category 3, repeated structural patterns) and might now fear dying himself, since he was the same age as his mother when she died (Category 4, coincidence of life events).

The physician also noted the timing of the couple's marriage (Category 2, life cycle fit). Mr. A. met his current wife a week after his first wife's funeral and they were married within a year. Given the short transition period, the physician wondered whether Mr. A. had resolved his relationship with his first wife and hypothesized a hidden triangle in which the present wife was in some ways the

outsider to the unresolved relationship with his first wife (Category 5, triangles in remarried families).

And finally, looking at the level of support in the family, it was evident that Mr. A. had no family in the area, while his wife's parents and all her siblings were nearby, which, perhaps, left the couple with an imbalance in emotional resources (Category 6).

During a brief discussion of these family factors, Mr. A. was able to admit his fears about the pregnancy, as well as continuing thoughts of his first wife, about which he felt guilty. He accepted a referral for consultation with a family therapist. Physical examination did indicate that Mr. A. was suffering from gastroesophageal reflux, probably exacerbated by his emotional state. Medication was prescribed. The patient was requested to bring his wife along to his follow-up visit two weeks later. At that time he had gone for the consultation with the family therapist and his symptoms had disappeared. He and his wife were apparently doing a good deal of talking about his past experiences and he was feeling much better psychologically as well as physically.

The genogram interview had identified the psychosocial stressors that needed to be dealt with and the referral had begun the process, easing the pressure for Mr. A. and his family. The genogram allowed the physician the opportunity to practice preventive medicine.

The next example illustrates a more complex case, in which the response to genogram information was less immediate. Dan R. went to see his physician complaining of heart palpitations. The doctor learned that his father had died of a heart attack and his mother of multiple heart attacks and strokes, but could find no evidence of an organic problem. He decided that he needed to find out more about Mr. R.'s family history and obtained the genogram shown in Diagram 4.5.

The doctor noted from the genogram a number of family events that might be affecting Mr. R. (Category 4, life events and family functioning). His son, John, who had had many behavioral and drug problems before joining the service, was due to return home shortly, and perhaps Mr. R. was worried about the problems starting again. His ex-wife's mother had recently died, which might lead to his ex-wife's putting more pressure on him because of her own grief and anxiety. Mr. R. had a sister who was continuing to deteriorate from multiple sclerosis. As the oldest in the family, and with his parents

no longer alive, he was likely feeling responsible for his sister's care (Category 1, sibling constellation), particularly as his brother had died of the same disease. He might also fear his own genetic vulnerability to the disease.

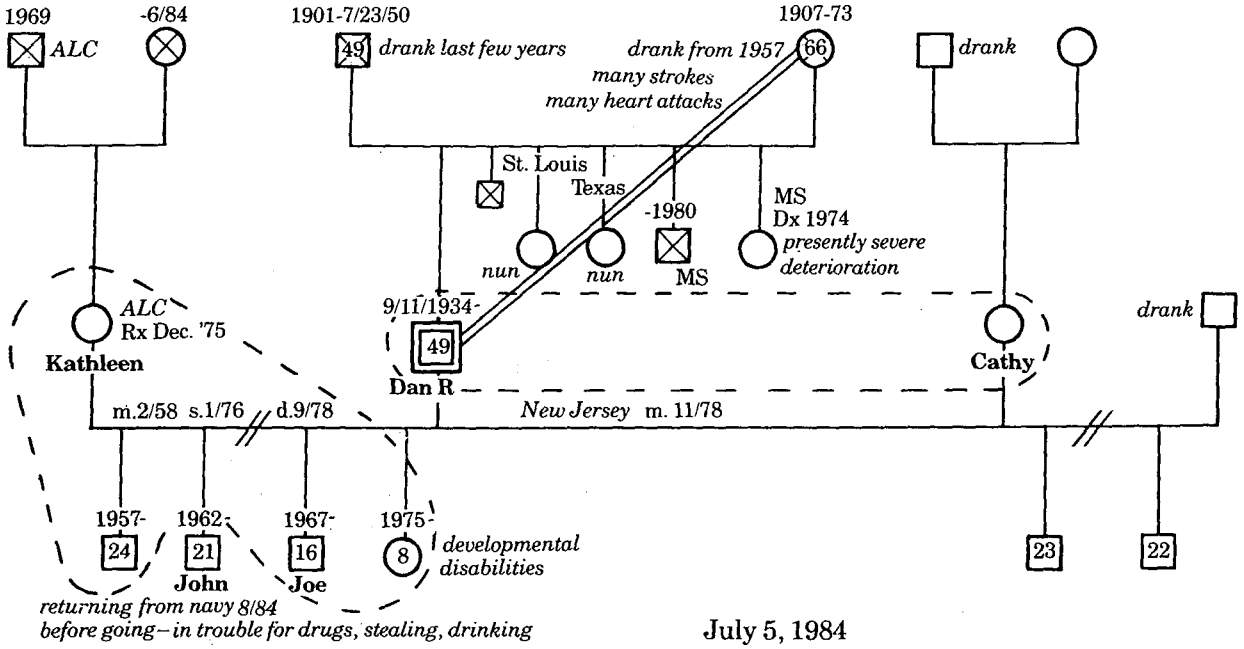


Diagram 4.5 The R. family

Also of interest to the family physician was the potential repetition of a structural pattern (Category 3) and the patient's possible anniversary reaction (Category 4). Mr. R. was now the same age as his father when he had died of a heart attack, and Mr. R.'s youngest son, Joe, was 16, the age he had been at the time his father died. Perhaps Mr. R. feared that history would repeat itself and the heart palpitations were an expression of this anxiety.

Finally, there was the pattern repetition (Category 3) of drinking in the family. Both of his parents had had drinking problems, as did his son, his first wife, and the families of both of his wives. Based on this history, it was possible that Mr. R. had a drinking problem or that his family thought he did.

Based on the genogram information, the physician was able to ask Mr. R. about each of these areas of concern: his son coming home, his ex-wife, his debilitated sister, his being the same age as his father when he died, and the drinking. While Mr. R. admitted to some general concern in each of these areas except drinking, he

was sure they had no bearing on his physical state, saying he never let things like that get to him. As for the drinking, he said his wife thought he drank too much, but that was just because her father and her first husband were alcoholics and she was too sensitive. This answer, of course, raised more questions about the extent and nature of his drinking and about his relationship with his wife. Although physical findings were negative, the physician decided, on the basis of the information gathered here and the patient's response, to request a follow-up visit with both Mr. and Mrs. R. two weeks later, "just to see how the heart was doing."

At the follow-up meeting the family stresses were reviewed and Mrs. R. confirmed her worries about her husband's anxiety and drinking. The doctor mentioned the possibility of their going to AA or Al-Anon or to therapy, but the idea was immediately rejected by both spouses. However, a month later Mrs. R. called back, saying that she felt the tension had not diminished and she would now like the name of a therapist they could consult. The doctor again suggested that she could attend Al-Anon, but she refused, although she did take the name of a local therapist. At medical follow-up six months later, Mr. R. proudly announced that he had celebrated his 50th birthday and felt very relieved and healthy. He said he had been trying to deal with his ex-wife about their son John, who seemed not to be getting on his feet after leaving the navy and was drinking too much.

Although neither Mr. R. nor his wife responded immediately to the doctor's observations about the family situation, the genogram did help him to assess the family stress and relationship factors and gradually to become an important resource for the spouses at the point when they could respond. They will undoubtedly need to turn to him again in the future, and having the genogram in the chart will make it easier for him to keep track of ongoing changes as the children develop, as Mr. R.'s sister's condition gets worse, as his conflicts with his ex-wife abate or continue, and if tension with his present wife over alcohol resurfaces.

There are indications that when one member of a family is in distress, others will react as well (Huygen, 1982; Widmer et al., 1980). In this case, by recognizing the multiple stresses Mr. R. was experiencing, the physician became aware of the need to bring in Mrs. R. as well, to evaluate her response and ability to support her husband, and to at least plant the seed that other help was available

for them if they should want to use it. This probably made it easier for Mrs. R. to seek the referral when she did, since her doctor was already familiar with the situation and had himself suggested a source of help for them.

In sum, genograms used in medical practice can suggest what family patterns are repeating themselves, so that preventive measures can be taken; what resources the patient has to help with an illness; what problems there may be in medical compliance; what family stresses may be intensifying the difficulty; and what type of further psychosocial intervention is needed, such as including others in follow-up medical visits or making outside referrals.