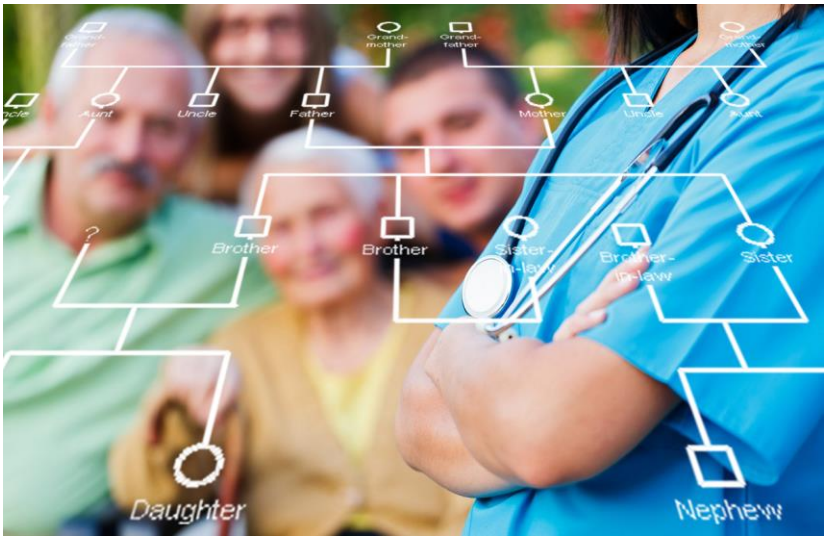
Family & Community Medicine
UNIVERSITY OF TORONTO

WORKING WITH FAMILIES INSTITUTE



Genograms:
Seeing Patients and Families Through Another Window

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In today's world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

Goals

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

How to Use the Modules

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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Bill Watson
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Toronto, 2014

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SUMMARY

The genogram is a practical, patient-centred tool that permits family physicians (FPs) to gather and record basic family information. The "skeletal" genogram identifies the patient's family members and their medical histories. It offers the physician a quick visual reference for understanding the patient's context, the family's influence, and the family's role in the patient's illness experience. Specifically, the genogram highlights genetic and family patterns of illness, indicates areas to consider for primary and secondary prevention, identifies the patient's risk for specific health problems and the need for screening, and assists in the development of a differential diagnosis and management plan. The "expanded" genogram builds on the basic genogram information by focusing on the identification of six specific categories: family structure, life-cycle stage, pattern repetition across generations, life events and family functioning, relational patterns and triangles, and family balance and imbalance. The expanded genogram provides the physician with a systemic assessment of the patient's and the family's biopsychosocial concerns and level of functioning. It can also be used as a therapeutic tool for both patients and families.

OBJECTIVES

After completing this module, you will be able to

1. determine when to consider using genograms.
2. construct skeletal and expanded genograms with patients.
3. recognize the therapeutic value of genograms.

Key Features

1. The basic genogram is a useful tool that allows physicians to gather and record basic family information, including genetic and family illness patterns.
2. The expanded genogram provides more detailed information on individual and family life-cycle stages, relationship patterns, and significant life events.

Core Competencies

The core competencies addressed are related to the FP's roles as a communicator, a family medicine expert, and a manager. They include the following:

1. Taking an appropriately thorough history in a timely manner
2. Obtaining a basic two-generation family genogram
3. Assessing family stability in terms of major life events (birth, disability, end-of-life care)
4. Intentionally exploring the patient's cultural and social context to better understand the impact of physical and psychosocial variables on their illness experience

INTRODUCTION

The genogram is a graphic representation of the family tree, providing medical and psychosocial information about a patient's family members and their relationships over at least three generations. Just as an electrocardiogram may provide evidence of cardiac damage, so the genogram may provide important additional information in the overall medical assessment and alert the physician to potential problems in family transitions and patterns. Used extensively by family therapists and counsellors to understand the family better, the construction of a genogram can be a systematic method of collecting, storing, and processing information about the patient and the family. This information can increase one's understanding of the patient's life context. It has been shown to be a useful tool that can be integrated with medical problem-solving to improve overall patient care.[1-6]

Genograms are useful in establishing a database on new patients, providing a more complete history, and building rapport in a nonthreatening manner. Genograms are especially helpful when one is dealing with patients who have vague, nonspecific complaints such as fatigue or insomnia, patients who have hypochondriasis or somatization, or patients with difficult psychosocial problems, including relationship and emotional problems. The genogram is especially useful for assessing patients with complex medical problems that are further complicated by comorbid conditions such as alcoholism and substance abuse, or for the exploration of biomedical, genetic, behavioural, and social issues.[4,7-9]

SKELETAL GENOGRAM

Many FPs use the appropriate symbols to create a routine skeletal genogram for all new patients joining their practices (see Figures 1 and 2). When the FP is developing a genogram, it is worthwhile explaining to the patient the purpose and use of the genogram. The FP can make a comment such as: "I would like to find out more about your family and keep this information in your medical record. This will be useful when we're developing prevention and treatment plans." Constructing the genogram with the patient is often helpful, because he or she can recognize patterns of thinking, feeling, and behaviour that have roots in the family. This process, in itself, can be therapeutic and reduce symptoms. While patients who are severely depressed may not be readily able to provide information for a genogram, most will be interested in participating. Even the most guarded person, quite unresponsive to open-ended questions, may be willing to discuss her or his family in a structured format.[6]

In the medical setting, skeletal genograms can be constructed in various ways. Patients can complete a form before the first visit, or someone else such as a nurse, a medical student, or a secretary may construct the genogram before the patient sees the physician for the first visit. Because of time limitations, usually only very basic information will emerge during the first visit; details can be added during future encounters. A skeletal genogram generally takes five to 10 minutes to construct; often information is limited to identification of family members and their medical histories. While a few extra minutes are required to complete a basic genogram, the quality and clinical usefulness of the information obtained makes this a worthwhile exercise.

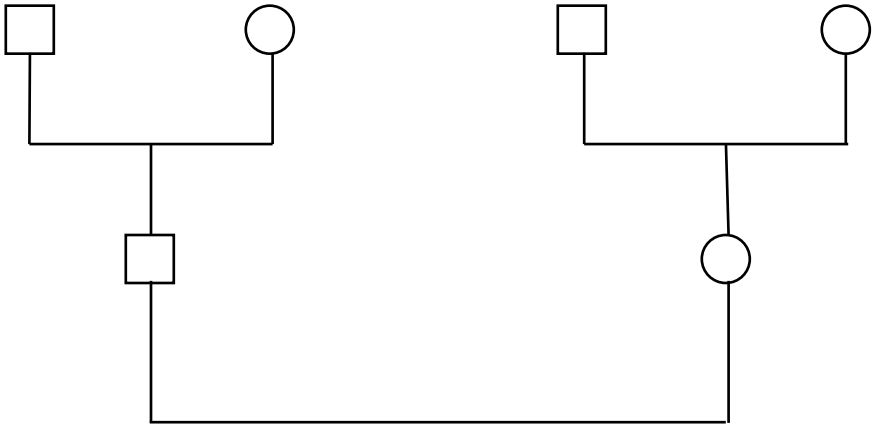
Evidence indicates genograms may be important in the management of medical problems.[7,10-15] Family physicians can use their knowledge of their patients' family relationships and patterns to develop diagnostic and therapeutic plans. Smilkstein[16] suggests that an assessment of family functioning is relevant to medical treatment because it

1. may permit the physician to anticipate illness behaviour, and, in some instances, initiate preventive measures.
2. can help the physician anticipate adherence concerns and evaluate available resources to assist the patient in complying with a management plan.
3. documents life events and may pinpoint stressors that can affect treatment.
4. can identify critical psychological problems that may call for active intervention and/or referral (e.g., somatization, high utilization, multiple complaints, and chronic pain).[16]

Figure 1 [2]
Skeletal genogram

Family name _____

Date completed _____

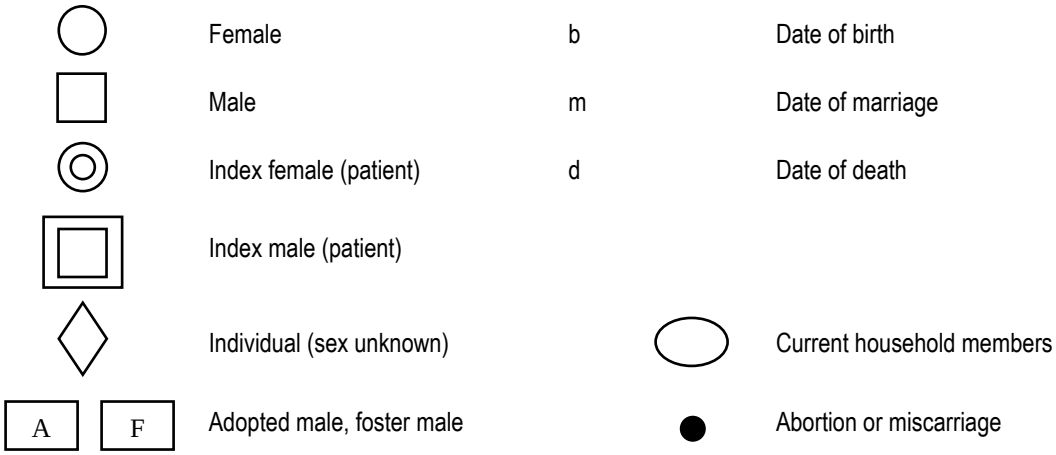


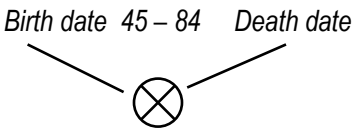
Cultural background _____

Major moves _____

Figure 2 [2]
Symbols used in the genogram

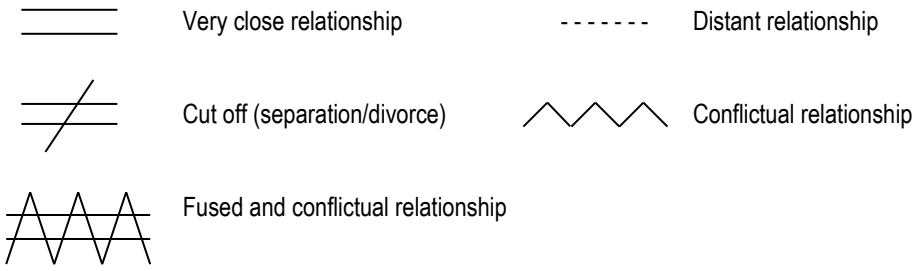
Basic





Relationship

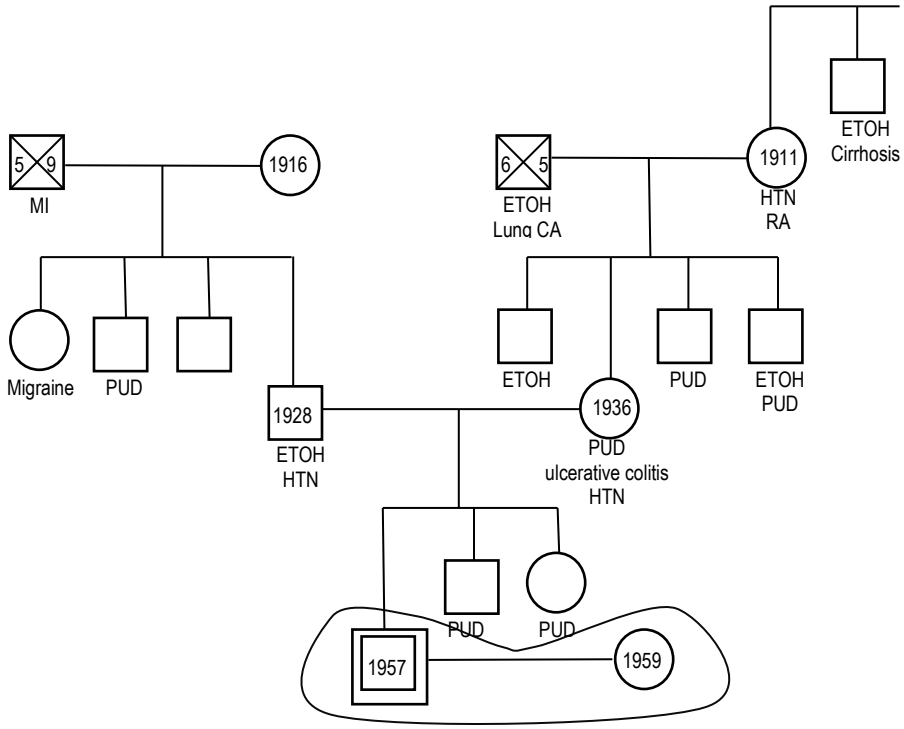
*These symbols are optional. They provide the least precise information on the genogram, but may be key indicators of family interaction patterns the physician may want to remember.



Task 1: Interpreting a Skeletal Genogram—The New Patient

Explain how the genogram in Figure 3 was obtained from a 56-year-old man who has joined your practice and is generally healthy. Explain how this tool will aid you in his medical care. What medical and psychosocial issues concern you?

Figure 3 [2]
Sample skeletal genogram



Discussion of the sample skeletal genogram

Determining the patient's alcohol consumption (both pattern and quantity) is important; consider screening with the CAGE questionnaire. With the history of cardiac disease and hypertension, his blood pressure must be checked regularly. The substantial history of alcoholism on both sides of the family means that discussing stress management techniques is important, as is warning against using alcohol as a relaxant. If the patient develops upper gastrointestinal symptoms, peptic ulcer disease (PUD) and gastritis from alcohol consumption would be differential diagnoses. If the patient presents with stress-related symptoms, areas to explore include his father's health and the common concerns of the adult child of an alcoholic.

EXPANDED GENOGRAM

Family physicians who provide counselling can integrate the expanded genogram into both their assessment and their clinical interventions with patients and families. The expanded genogram can yield high-quality information in six categories: family structure, life-cycle stage, pattern repetition across generations, life events and family functioning, relational patterns and triangles, and family balance and imbalance. [2,8]

The genogram interview can be a practical way of engaging both patients and families in a systemic approach to treatment. McGoldrick has suggested that this process shows the physician's interest in the family system, and thus improves rapport and reveals the ongoing connectedness of the family, in both the past and the future.[8] The "family genogram" is an expanded form of genogram that displays life events and relationship changes when they actually occur, and highlights temporal aspects of family history that the standard format sometimes obscures. It can be useful in complex family systems.[9]

Genograms can also be a useful tool in reframing behaviour, relationships, and connections among family members over time, and in "detoxifying" or normalizing the family's perception of itself. When family members present at the physician's office, they have usually adopted their own view of the problem and what needs to be changed. This is often a rigid view, based on the belief that only one person, the symptomatic one, needs to change. An example of this situation is the family with a child who has behaviour problems. The genogram can be helpful when one is working with such rigid systems. By using the genogram, the physician can organize questions around key family life experiences: birth, marriage, life transitions, illness, and death. Collecting information in this way can open a rigid family system and help the patient get in touch with paralyzing emotional and blocked personal issues. For instance, a simple question such as "How many siblings do you have?" may evoke intense reactions in a family in which the favourite son died in a drowning accident.

The genogram provides the physician with many opportunities to normalize family members' understanding of their situation. Using the information provided, the physician can actively reframe and interpret the meaning of behaviour within the family system, enabling family members to see themselves in a different way.[2]

Poon has suggested that after the physician constructs the genogram, he or she can ask questions to interpret the information obtained.[2] The questions fall into the six categories identified at the beginning of this section and examined in more detail in Table 1.

Table 1 [3]
Six Information Categories

Family structure

The physician can suggest normative expectations for behaviour and relationships: "It's not surprising that you are so responsible, as eldest children commonly are."

- Is the family's overall composition unique or average?
- If the family seems unique, what is so different about it?

Life-cycle stage

An understanding of life-cycle issues can help the physician normalize experiences: "The arrival of a baby in the family often causes stress as well as joy."

- Do life events fit normative expectations?
- When events do not fit normative life-cycle expectations, what are the family's possible difficulties in that phase of the life cycle?

Pattern repetition across generations

Pattern repetition reveals the larger context of problematic behaviour.

- Can you detect certain patterns and diseases that are repeated across the generations?
- Are any relationship patterns repeated across the generations?

Life events and family functioning

A coincidence of events may be evident, and this can be pointed out to the patient: "Maybe how you felt had something to do with all the stressful events that were occurring at the time."

- Are any coincidences evident between a certain life event and changes in the family?
- Are any problems occurring after certain life-transition points?
- Are any social, economic, or political situations having an impact on the family?

Relational patterns and triangles

These patterns and triangles help demonstrate the interdependence of family members.

- What are the various dyadic relationships in the family like?
    - Are closeness and/or separation evident? Are conflicts present? Is emotional cut-off observable?
- Do any triangular relationships exist in the family?
    - Do the triangles involve parents, children, in-laws, a third party, or a friend?
    - Do the triangles repeat across generations?
    - Could the third party in the triangle be an inanimate object or a hobby?

Family balance and imbalance

Family balance can shift, depending on circumstances: "Usually, when one person takes on more than his or her share of the responsibility, then the other person takes on less."

- How do individuals complement each other in a marriage?
- Is power distributed evenly or unevenly in the family?
- Who is included and excluded in the family?
- How are the various roles worked out in the family?
- Who takes on the role of caretaker, provider, or spokesperson? Who acts as an over- or under-functioning person?
- When imbalance occurs in a family, how do family members handle it?

Task 2: Constructing an Expanded Genogram

Most clinicians learn how to construct genograms with patients by first drawing their own family genogram and interpreting their own biopsychosocial issues. You can complete this exercise on your own, with a colleague, or in a small group setting. Use Figures 1 and 2, and the genogram in Task 1, as references and guides for constructing your genogram.

Step 1

Put the information about your current family in the genogram form. This includes you, your spouse, and all your children. The order of the children should be the oldest first on the left side of the paper, followed by the younger children in sequence. For each person, write the name, birthdate, and occupation. If any of the children are married, state the spouse's name and the names and ages of children with each spouse. Use standardized symbols to construct a three-generation genogram. Record all miscarriages, separations, divorces, birthdate and death date, causes of death, occupations, and education for each member. Finally, circle the members living with you.

Step 2

Repeat the process, noting all the information above for your family of origin. Make sure you provide information about your father's and mother's siblings.

Step 3

Repeat the process, noting all the information above for your maternal and paternal grandparents.

Step 4

At the bottom of the page, note your family's cultural background, major moves including the dates, and any other significant people who lived with or were important to the family.

Step 5

Beside the names of all the people in the genogram, note

- any significant medical history and illness.
- psychiatric, emotional, or behavioural problems.
- work-related stresses.
- problems with drugs, alcohol, or the law.

Step 6

For all the people in the genogram, indicate dyadic relationships of closeness, separation, conflict, and cut-off.

Task 3: Interpreting or Using the Genogram as a Therapeutic Tool

Using the genogram that you drew in Task 2, answer the following questions. Exploring these questions will highlight some of your own family-of-origin issues.

1. What are some patterns that strike you most?
2. As you look at your genogram, how do you feel about your own health?
3. Do you notice any specific health risks to which you may be exposed? What preventive measures do you think you need to take?
4. Try to interpret your own genogram. Are you surprised at some of your interpretations? If so, why?
5. Try to describe the relational dynamics of your family.
6. Which of these feel comfortable and which feel uncomfortable?
7. Do you recognize any unresolved issues in your past and present relationships with various family members?
8. In what way have these issues affected you as a person and as a family member?
9. How would you like to see this/these relationship(s) change?
10. How would you try to overcome the obstacles?

Task 4: Interpreting an Expanded Genogram—Recurrent Headaches

Figure 4 shows the genogram of a patient with chronic headaches. She came from a family with a history of divorce, in which a parent also had chronic headaches.[17] Because it is nonthreatening and indirect, this information may not emerge in any other way but through a genogram. A family history of these problems allows the physician to generate a hypothesis about a patient's presenting complaint quickly, and then ask questions that help in the development of a more accurate diagnosis and management plan.

CASE STUDY: JANE, AGED 24

Jane is recently married and presents at your office with recurrent headaches. Two months ago, these were diagnosed as "tension headaches." Her history and physical examination results, including those from neurological and funduscopic exams, are normal. The medication previously prescribed is not working and the headaches are worse.

Jane's headaches are characterized by pressure and aching in the back of the head and temples, and started when she was in high school. The current episode started with a two-week headache, followed by at least one headache weekly thereafter. The patient denies marital problems or other life stresses related to the headache.

You obtain additional information when you construct her genogram.

Currently, Jane is working full time as a receptionist, and is attending college part time. Her husband, Bob, who is also 24, is a full-time computer science/engineering student.

Jane is the eldest of three children. Her sisters are 21 and 18. They have no significant medical problems. Jane's father, who is 44, and her mother, who is 42, divorced when Jane was 14. Her father is healthy, but her mother has had headaches in the past.

Jane's paternal grandfather died of a myocardial infarction (MI) at age 69. Her paternal grandmother is 67 and well. Her father has two brothers, aged 40 and 46.

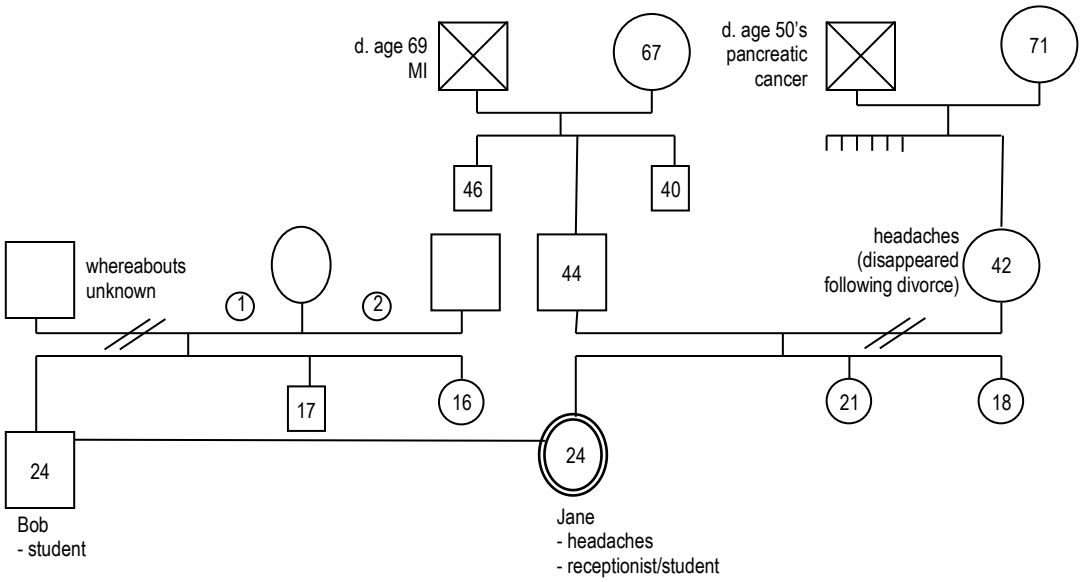
Jane's maternal grandfather died of pancreatic cancer in his 50s, and her 71-year-old maternal grandmother is well. Her mother is the youngest of seven siblings (five sisters and two brothers), none of whom has had significant illnesses.

Bob's parents also are divorced. His mother, who is 42, has since remarried. His father's whereabouts are unknown. Bob has a sister, aged 16, and a brother aged 17. On further questioning, Jane reveals that her mother's headaches disappeared following her divorce. Jane adds, "We kids never knew they had problems with their marriage." When asked further about her own marriage, Jane states that she and her husband were full-time students at the time of their wedding. Although she was carrying a heavier course load and was closer to graduation, they decided that she should be the one to combine work and part-time school attendance, while he continued full-time classes. The rationale for his light schedule was that this would allow him to obtain the best grades possible. Although Jane agreed to this arrangement, she seems unhappy about it. However, she still denies any marital problems and has expressed no discontent to her husband. (Adapted from Wilson and Becker.[18])

- ***What clues does the genogram provide about possible causes of Jane's tension headaches?***
- ***What is your hypothesis about the causes of Jane's headaches?***
- ***What suggestions do you make to Jane about managing her headaches?***

Note: Discussing the family life-cycle tasks of a couple at this stage would be helpful. See Poon and Bader's module "The Individual and Family Life Cycle: Predicting Important Transition Points" also posted on DFCMOpen.

Figure 4
Jane's genogram



CASE COMMENTARY

- ***What clues does the genogram provide about possible causes of Jane's tension headaches?***

Jane may be repeating her mother's pattern, in which marital unhappiness is not discussed and is accompanied by headaches. Jane and Bob may fear marital conflict because both are children of divorce. Both Jane and Bob are eldest children and may be "parentified" (i.e., involved in caring for their siblings); this may produce additional stress.

- ***What is your hypothesis about the causes of Jane's headaches?***

First you explore the meaning of the symptom. Then you explain the pathophysiology of tension-type headaches. You also explain how stress can be manifested physically in different ways with different people, and how the genogram allows the identification of several stressors in Jane's life. You ensure that the patient understands you recognize her pain is real. Then you ask her to list potential stressors. If she has difficulty with this task, you present your ideas and ask her to expand on them.

- ***What suggestions do you make to Jane about managing her headaches?***

First, you determine what treatment the patient expects will be useful; then you review strategies that have worked in the past. You explore stressors in greater detail. Determining whether headaches help Jane cope with or solve problems may be possible. Find out what happens when a headache occurs. For example, does Bob do extra household tasks, or does she take time off work or school? You ask the patient to keep a symptom diary, and suggest relaxation techniques, adequate sleep, rest, and diet, heat and massage, simple analgesics as needed, and regular follow-up care. You invite Bob to the next session to discuss management of the headaches.

CONCLUSION

The genogram is a schematic map of a family, and is the best tool yet devised for tracking the family's medical history and functioning. Genograms offer many benefits: systematic record-keeping with an easily read graphic format that can stay at the front of the chart, identification of illness patterns at a glance, rapport-building, and improved medical management through the identification of life events that could affect diagnosis and management.[8] The genogram expands the physician's and the patient's understanding of the presenting complaints, and the treatment options available. Initially, the genogram may take a few minutes to complete with patients, but it will save time in the long run and improve the quality of care.

NOTE TO TEACHERS

Learning to complete a genogram and incorporate it into your practice is relatively easy, as is teaching residents about genograms. We recommend that the use of genograms be taught relatively early in the residency. We believe that the more often residents see genograms in staff physicians' patient charts, and presented as part of case conferences or on ward rounds, the more likely they are to integrate genograms into their own practices.

As you prepare to teach this module, we recommend that you complete all the tasks, particularly the construction of your own genogram (Tasks 2 and 3). Christie-Seely notes that for patients in psychotherapy, awareness of "trauma, triangulation, addiction, conflict and alliances" is crucial, as repeated family patterns of illness and behaviour heighten recognition of their importance in families.[19] The physician's knowledge of these patterns leads to self-awareness of vulnerabilities and a humility that is essential in working democratically and therapeutically with families. One also must learn not to judge one's own family, a student's, a colleague's, or a patient's, and become familiar with an experience one asks of patients.

You may wish to construct and discuss your genogram in a session with some of your faculty peers. Our experience tells us that initially a person may feel uncomfortable sharing her or his genogram with others, particularly if unresolved issues are evident in the family of origin. However, this sharing can promote group cohesion, and increases the likelihood that a significant number of faculty members will use genograms when teaching residents.

The following are recommended strategies for teaching residents about genograms:

1. Pre-assign Task 1, so that the genogram is prepared before a group session.

2. At the group session, provide the following:
   - A definition of the genogram
   - An explanation of how to construct a skeletal genogram
   - An explanation of why, how, and when to use genograms in routine patient care
   - Copies of genograms from patient charts in your practice so thatresidents can describe how the information might facilitate patient care.

- A demonstration of genogram technique (i.e., construction of a genogram of a person at the session)
- Your own genogram

3. Assign Tasks 2 to 4. (The last task could be done at the session, with the residents breaking up into pairs.) These tasks can then be taken up at a subsequent session.

4. An additional strategy that can be illuminating and fun is presenting genograms of famous families such as the Kennedys and the Fondas. These are available in McGoldrick's *Genograms in Assessment and Intervention*.[8]

In a teaching session with residents, expect to spend a fair amount of time discussing how long completing a genogram takes. Discuss the difference between a skeletal genogram and an expanded genogram, and clarify that a genogram can be expanded over time, depending on the physician's need for information and the time available.

Many residents also are interested in knowing where to place the genogram in the chart. Family-oriented family medicine programs often have an area in the chart designated for genograms. Some programs also use a skeletal genogram form that includes reminder symbols at the bottom of the page, and that can be completed for each patient. You may wish to produce such a form for use in your setting, especially in the electronic medical record format.

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REFERENCES

1. Schilson E. Using genograms in family medicine: a family physician/family therapist collaboration. Fam Systems Med. 1993;11(2):201-8.
2. Poon V. Genogram: a diagnostic tool for family practice. Can J Diagnosis. 1993;10(1):135-47.
3. Waters I, Watson WJ, Wetzel W. Genograms: practical tools for the family physician. Can Fam Physician. 1994;40:282-6.
4. Crouch M, Davis T. Using the genogram (family tree) clinically. In: Crouch M, ed. The family in medical practice: a family systems primer. New York, NY: Springer-Verlag; 1987. p. 174-92.
5. Like RC, Rogers J, McGoldrick M. Reading and interpreting genograms: a systematic approach. J Fam Pract. 1988;28(4):407-12.
6. Campbell T. Family systems in family medicine. Clinics Fam Pract. 2001;3(1):1-17.
7. Rohrbaugh M. How do experts read family genograms? Fam Systems Med. 1992;10(1):78-89.
8. McGoldrick M. Genograms in assessment and intervention. 2nd ed. New York, NY: Norton & Co;1999. p. 169-75.
9. Friedman H, Rohrbaugh M, Krakauer S. The time-line genogram: highlighting temporal aspects of family relationships. Fam Process. 1988;27:293-303.
10. Gotler R. Focus on the family. Part I: what is your family focus style? Fam Pract Manag. 2001;8(3):49-50.
11. Greenwald J. The genogram scale as a predictor of high utilization in a family practice. Families Systems Health. 1998;16(4):375-91.
12. Rodie AR. Assessing quality. As pressure mounts for clinics to deliver quality, medical practice blueprints and genograms serve as useful tools. Marketing Health Services. 1999;19(2):16-24.
13. Rose P. Family history taking and genetic counseling in primary care. Fam Pract. 1999;16(1):78-83.
14. Mcllvain H. Using practice genograms to understand and describe practice configurations. Fam Med. 1998;30(7):490-6.
15. Gotler R. Focus on the family. Part II: does a family focus affect patient outcomes? Fam Pract Manag. 2001;8(4):45-6.
16. Smilkstein G. The physician and family function assessment. Fam Systems Med. 1984;2:263-78.
17. Like R. Reading and interpreting genograms: a systematic approach. J Fam Pract. 1988;26(4):407-12.
18. Wilson L, Becker L. The genogram. In: Working with families: a residents' workbook. Toronto, ON: Department of Family and Community Medicine, University of Toronto; 1992. p. 63-8.
19. Christie-Seely J. Counseling tips, techniques, and caveats. Can Fam Physician. 1995;41:817-25.

RESOURCES

Campbell T. Family systems in family medicine. Clinics Fam Pract. 2001;3(1):1-17.

Crouch M. Using the genogram (family tree) clinically. In: Crouch M, ed. The family in medical practice: a family systems primer. New York, NY: Springer-Verlag; 1987. p. 174-92.

McGoldrick M. Genograms in assessment and intervention. 2nd ed. New York, NY: Norton & Co; 1999. p. 169-75.