How to Write a Family Case Report

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This manual details how to write a case report that uses the biopsychosocial approach in understanding and analyzing a patient's disease in the context of the family in crisis. It begins by describing the illness characteristics of the index patient - the onset, course, prognosis, and family illness trajectory. The family structure and dynamics are then identified using various family assessment tools such as genogram, APGAR, SCREEM-RES, lifeline, family map, etc. Lastly, the physician formulates a family diagnosis: the presence of alliances and coalitions, the family's strengths and coping mechanisms, how they adapt to the changes brought by the illness, etc. These data help the physician effectively engage the family as a source of support for the management of illness.

Key words: Family case, family meeting, family assessment

Introduction

A family case report documents how family physicians provide family-focused care. Aside from documenting an extensive history of illness, physical examination and ancillary tests, physicians gather data on the family structure and dynamics through various tools. These objective information (genogram, APGAR, SCREEM, lifeline, family map, ecomap, etc.), allow physicians to formulate a family diagnosis, conduct family interventions based on the family's needs, and help the family explore their strengths to overcome a family crisis specifically caused by a family member's illness. This manual will enumerate the various family assessment tools, provide examples of the analysis of family structure and dynamics and reporting of family diagnosis, and lastly, cite examples of family interventions which can help improve family relationships and, consequently, better patient health outcome. These are the contents of a Family Case report, which is intended to incorporate the family physician's unique approach to care - described as patient-centered (P), family-focused (F), and community-oriented (C), and based on the PFC matrix, which is a biopsychosocial approach to primary care.[1]

Patient-centered Care

A Family Case report starts with a summary of the patient's clinical data: chief complaint, history of present illness, family history, past medical history, environmental, social, and sexual history, pediatric history and adolescent history as deemed relevant, as well as objective data: physical examination, neurologic physical examination, etc. From these data arise the working impression, differential diagnosis, results of ancillary tests, and final diagnosis. This part must be brief versus an extensive discussion for a clinical case, and includes the patient's emotionally critical misperception (ECM) and psychosocial features.

A. Characteristics of the Illness

Families react differently according to the characteristics of illnesses (McDaniel, 1990) listed below.

1. Onset: Did the illness begin suddenly, or gradually?
   Families are caught off guard with illnesses with acute onset such as acute coronary syndrome and ruptured brain aneurysm. Family members need to adapt more quickly to a breadwinner suddenly losing his job as bus driver due to marked disability from a vehicular accident, versus a vendor with diagnosed COPD. Family members have more time to mobilize resources for illnesses with gradual onset.

2. Course: Is the illness progressive, constant, or relapsing?

3. Prognosis: What is the likelihood of recovery? Is there risk of sudden death?

4. Disability: What are the physical or mental limitations associated with the illness?
   A family will adapt differently to a mother who underwent mastectomy for breast cancer versus one who has depression and is not able to watch over her children.

These illness characteristics enable physicians to foresee the role changes, stresses, and demands in family members, and empathize with their confusion, fear, and anxiety.

B. Trajectory of Illness

After describing the illness, the physician determines at what stage of the trajectory of illness the family is in: Stage I: Onset of Illness, Stage II: Reaction to Diagnosis, Stage III: Major Therapeutic Efforts, Stage IV: Early Adjustment to Outcome, or Stage V: Adjustment to the Permanency of the Outcome.

Family-focused Care

Family Medicine physicians determine the family structure and study the family dynamics through family assessment tools. These data are gathered to produce a diagnosis and analysis of the family and subsequently to offer family therapy based on their needs.

A. Family Structure

1. What is the family structure (nuclear, extended, single parent, blended, communal) and how did it help or hinder the patient's management of disease? An example below from Hating Kapatid: A Family Case of Depression by Bascuña-Gaddi (2022) shows an analysis of how a family profile and structure affects the family member's reaction to the youngest sibling's diagnosis of depression.

> Family structure is the behavioral skeleton on which family life is built (Yu-Maglonzo, 2008). A patient's problem is the family's problem, and it is important for us to know the family psychodynamics to learn how will the patient's depression affect the family, what barriers exist from taking care of the patient, and how the family members can provide support for the patient. The G household had 6 members: GG's mother, 3 sisters, maternal aunt, and patient GG. His parents were separated and the father lived in another house, without a partner, children, nor a new family, in Silang, Cavite. The G family was neolocal, democratic, Roman Catholic, unilateral extended, and matriarchal. They were highly educated and belonged to the upper socioeconomic class. The G family's source of income was the father's company, and mother's profession. GG was the symptom carrier and his primary caregiver was his mother L.G. The decision makers in the family were mother LG and sister CG who was a Family Medicine resident. The maternal aunt was considered the nurturer.
>
> The G family prides itself in educational attainment and contributions to the community, and to succeed in one's profession is to give honor to the family and continue its legacy of excellence. When food, shelter, education, leisure activities are secured and provided for in abundance, it is difficult for the family members to believe and accept that the youngest son developed depression despite his privileges. On top of this, the Filipino culture grandstands resilience and positivity despite hardships, which are barriers to show empathy to people with mental health disorders. When family members are in denial of a patient's diagnosis, they are unable to support his needs, and it is difficult to recruit them as health allies.

Family Structure Analysis

2. What is the patient's birth order and how does this affect his behavior and relationships with family members?

3. Genogram

   A genogram has 3 or more generations and each generation is identified by Roman numerals. The first-born of each generation is farthest to the left, with siblings following to the right in order of birth. The family name is placed above each major family unit. Given names and ages are placed below each symbol. One member of the family is of greater medical significance because of an illness and he is known as the index patient and is identified with an arrow. Date is indicated when the chart was developed so that ages would be adjusted over time.

4. In which social class does the family belong to? How does this affect their management of illness?

5. Is the family democratic or authoritarian? Correlate this with your patient's case.

6. What is the family life cycle stage?

   What are the first and second order changes at this stage? Did they display any family strengths/weaknesses while going through the first and second order changes? Did the family encounter any issues relating to the critical tasks of the family life cycle stage? What is the responsibility of the physician at this stage? Show how you managed the family issues at this stage.

Family Life Cycle Stage Analysis and Correlation of 1st and 2nd Order Changes

> A family life cycle involves a sequence of stressful changes that requires compensating adjustments, which the family has done smoothly by undergoing the following 1st and 2nd order changes. The G family was on Life Cycle Stage V - launching family, as the first child, 32-year old AG has left home and lives with his new family. The children CG, IG, MG, and GG still lived at home with their mother. The first order changes at this stage were 32 year-old AG exiting the family home, and parents BG and LG living separately. The second order changes that occurred at this stage were a) the

second child, CG assumed the decision maker role left by AG, b) the parents renegotiated their marital system and decided to maintain marriage for the children but live in different houses in 2015. Their roles as breadwinners were continued, and c) an adult-adult relationship and intergenerational cooperation developed between parents and children. For these reasons, Family G continued to be functional despite their unconventional arrangement. It is important to note that patient GG's symptoms of depression did not start in 2015 during brother AG's exit from the family and his parent's separation.

B. Family Dynamics

After enumerating the salient features that prove that the family is in crisis, the physician uses the various tools for family assessment to probe the family relationships and family social and cultural systems, and in effect, to facilitate a new level of understanding of the patient's problem. The physician doesn't have to use all evaluation tools but rather, pick only what is applicable and relevant to the family case.

1. Family Lifeline

   Enumerate the family's significant events, and if applicable, show how this affected the patient's symptoms. Highlight the family's virtues and strengths used to overcome their previous challenges.

2. Family Map

   A family map depicts the diffuse/healthy/rigid boundaries, functional/dysfunctional relationships, escape, conflict, and coalition among family members. These guide questions, as recommended in by McDaniels (1990) in Family Oriented Primary Care, can help analyze a family system using a family map:

   i. What are the subgroups in the family (e.g., marital, sibling, grandparents, etc.) and are the boundaries between these subgroups healthy?
   ii. What are the important alliances in the family?
   iii. What coalitions exist in the family and who is siding against whom? Is there intergenerational coalition (e.g. a daughter and a grandmother against a mother).
   iv. Are there family members who are disengaged or isolated from each other?
   v. Is there triangulation, or when emotional issues arise between two members, do they focus on third person?

3. FAMILY APGAR

   This assessment tool is used to assess the family function. A screening instrument for family dysfunction, that will measure the individual's level of satisfaction about family relationships. (Leopando et. al., 1999)

4. SCREEM-RES

   What is the assessment of the family as to their capacity to participate in provision of health care or to cope with crises in terms of Social, Cultural, Religious, Economic, Educational and Medical factors affecting health (resources)? What are the pathology noted in each of the factors, if there are any, and correlate this with your family case.

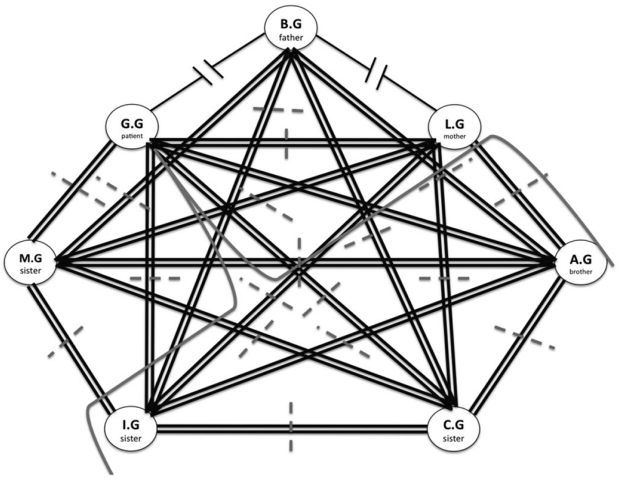

Figure 5. Sample Family Map of Index Family

A family map was used to document Family G's family system and dynamics in order to address their existing psychosocial issues, to understand how their relationships help nurture or hamper the patient G.G. 's mental health. Father BG and mother LG had a dysfunctional relationship. They had been separated since 2015 due to "we just fell out of love and decided we will be happier without each other," as stated by mother LG. They reported to remain civil and they communicate to schedule family gatherings for birthdays, Christmas, New Year, etc. and to compute the family finances. Patient GG had a dysfunctional relationship with his father BG. When BG left in2015, patient GG was only 15 years old. He recalled that he was confused at the time and didn't fully grasp what was happening, in contrast to his elder siblings who were mature enough to understand the separation. Patient GG said, "He gives me allowance and pays for my tuition fee but he stopped being my father." A coalition among siblings IG, CG, and AG against patient GG, as symbolized by the bracket, was depicted in the family map. They think that patient GG is spoiled and his epigastric pain and absenteeism were attributed to "just acting out." This coalition was a barrier for the siblings to empathize with the patient.

SCREEM-RES Analysis

SCREEM-RES helps the family members identify their resources to meet a crisis. The family had adequate religious, economic, educational, and medical resources, as reflected in their SCREEM-RES score 16, indicating they had adequate family resources to deal with a crisis. Mental health problems are stigmatized as "nasa isip mo lang yan," in our culture, which

emphasizes humor and resilience to overcome problems (Tanaka, 2018). This becomes a barrier for some members of the G family from extending empathy to people with mental health problems; hence, this becomes a problem despite the family's adequate religious, economic, educational, and medical resources. This was the most significant cultural pathology derived using SCREEM-RES. After learning about the family's adequate resources and identifying their cultural pathology, the physician can now extend empathy and employ interventions to G.G.'s siblings, who have difficulty accepting his diagnosis of depression, consequently hampering their ability to provide care to the patient.

5. Caregiver Strain Index

The family is the source of the patient's emotional, moral, and financial support. However, in a sudden or debilitating illness, they experience distress comparable to that of the patient. Ensuring the emotional and mental well-being of the caregiver will ensure that the patient is supported through family-focused care. There is a need to determine the presence of caregiver strain in the family. If present, use the genogram to identify another health ally.

C. Family Assessment

1. Level of Family Intervention

Identify what is the Family medicine physician's current level of family involvement and what interventions does the family need based on the diagnosis (See: Level I-VI of family interventions by Leopando).

2. Family Assessment

The following questions will help in formulating a family diagnosis:

- Who is the patient's health ally? Is he/she experiencing caregiver strain? Are there other potential health allies that may be tapped?
- What are the family issues uncovered using the family assessment tools, and how do they directly affect the patient's health?
- What family interventions can be proposed to address these family issues?
- McDaniels (1990) raised that family assessment tools often highlight the pathology of families and neglect strengths. It is important to also discuss strengths to empower the family members to overcome a family crisis by probing these points:
  - What are the family's strengths and sources of support?
  - What has helped the family cope with crises in the past?
  - How adaptable is the family to change?
  - Does the family accept outsiders, especially healthcare providers, into the family to help?

The Level of Family Involvement and Family Assessment enables the physician to plan, convene a family meeting and perform family intervention.

Community-oriented Care

Clinical science and public health are combined in community oriented primary care (COPC). In the analysis of individual and population-based care, it is a systematic approach that a primary care physician should employ (Leopando and Mercado, 2014). COPC is a health-care method based on epidemiology, primary care, preventive medicine, and health promotion ideas. COPC integrates the concepts of primary health care and community medicine in a systematic and coordinated manner. Community orientedness employs the social determinants of health (SDH) and World Health Organization (WHO) building blocks as a lens in the examination of the health system relevant to the given medical and psychosocial difficulties of the individual patient and family. A family physician should be able to examine the broad socio-cultural determinants, living and working situations, environment, and sanitation that may have an impact on the patient's condition.[1]

The data gathering in the community-oriented part of the family report must assess social determinants of health and building blocks of a health system within the patient's locality relevant to the presented medical and psychosocial issues of the case. This can be facilitated through the use of ECOMAP or SCREEM. The salient features of the assessments on the social determinants and building blocks of a health system that affect the patient's health are incorporated into the data analysis. The diagnosis or conclusion must contain summary statements or conclusions of the general effects of the social determinants of health and building blocks of the health system that could be enabling and a barrier to providing care for the patient. Management and interventions must be COPC-based solutions or tools to overcome barriers and facilitate the enabling effects of the identified social determinants and components of health system building blocks.

Summary table of the PFC matrix.

Components	Patient-centered	Family-focused	Community-oriented
Data	• Relevant clinical histories • Physical Findings • Context of psychosocial issues (individual) such as emotions attendant to the health condition including bioethical issues	• Assessment of family psychodynamics using family assessment tools, family systems assessment (STFRED)	• Assessment of social determinants of health and building blocks of a health system relevant to the presented medical and psychosocial issues of the case

Components	Patient-centered	Family-focused	Community-oriented
Analysis	• Salient clinical features and psychosocial, bioethical issues, etc	• Salient features of the family dynamics and/or family systems assessment	• Salient features of the assessments on the social determinants and building blocks of a health system
Diagnosis/ Conclusion/ Assumptions	• Medical diagnosis • Psychosocial diagnosis (using ICD V Codes)	• Summary statements of the issues identified in the assessments done (both enabling and barriers to care)	• Summary statements of the issues identified in the assessments done (both enabling and barriers to care)
Management/ Interventions	• Comprehensive medical interventions based on evidence and standards of care (encompassing all levels of care) • Individual psychosocial interventions such as psycho-educational approach (CEA), motivational and behavioral counseling etc appropriate to address the identified issues.	• Family interventions to address both medical and psychosocial issues identified	• Interventions (COPC based) to address the issues identified (existing and proposed)

Leopando Z, et al., 2000

Evaluation tool for case analysis using the PFC matrix.

CRITERIA	Done	Not Done
A. CONTENT		
Patient-centered Care		
Data Gathering • Provided an assessment that includes all of the following: History of Present Illness, ROS, Past Medical, Family Medical History, Pertinent Physical Examination • Provided a psychosocial assessment that includes at least most of the following: o patients' feelings on the medical condition, fears concern, doubt, predicament, bioethical issues		
Analysis of the Data • Provided an accurate analysis of the biomedical data (salient features) • Provided appropriate analysis of the psychosocial data to include most of the following: o Psychological issues using Illness trajectory, compliance issues, ethical issues		
Diagnosis/Conclusions/Assumption • Gave appropriate diagnosis based on logical clinical reasoning • Provided appropriate pyshosocial assessment (using ICD V code if appropriate) and bioethical issues if any		
Plan of Management (2 points) • Had appropriately managed the case using evidence-based treatment approaches including preventive, supportive and palliative strategies • Provided appropriate psychosocial care such as CEA, behavioral counseling, etc		

CRITERIA	Done	Not Done
Family-Focused Care		
Data Gathering • Assessed family dynamics using the appropriate family assessment tools to facilitate understanding on the enabling and barriers to care • Assessed family systems (ST FRED) as necessary to facilitate further understanding on the effect of the medical condition to the family		
Analysis of the Data • Provided salient features of the family dynamics on its enabling effects and/or barriers posed to the provision of care • Provided salient features on the effect of the medical problems on the family system.		
Diagnosis/Conclusions/Assumptions • Gave accurate diagnosis/conclusions on the enabling and barriers to care of the family dynamics of the the index patient • Provided appropriate diagnosis/conclusion on the effect of the medical condition to the family (that can be enabling or barrier to provision of care)		
Plan of Management • Provided appropriate family interventions to include most of the following: o Family counseling, health education, psychosocial support, wellness interventions o Appropriate referral, and/or multidisciplinary care		
Community-oriented Care		
Data Gathering Social Determinants of Health • Provided assessment of the general socio-cultural determinants (ECOMAP/SCREEM), living and working conditions, environment and sanitation that are attendant to the medical condition • Provided assessment of most important building blocks of health system within the locality of the patient affecting the existing medical condition o Service delivery, health workforce, health information system, access to essential medicines, financing and leadership/governance		
Analysis of Data • Provided salient features of the the social determinants and essential building blocks of health systems affecting the patient's health		
Diagnosis/Conclusions • Provided summary statements/conclusions of the general effects of the social determinants of health and building blocks of health system (both enabling and barrier to the provision of care)		
Plan of Management • Proposed SMART community-oriented solutions or tools to overcome the barriers and facilitate the enabling effects of the identified social deteminants and components of the building blocks of the health systems identified.		
B. PRESENTATION SKILLS		
The presentation was organized, systematic and used appropriate visual aids.		
C. GLOBAL ASSESSMENT		
Check the appropriate box below on the performance of the resident in the case analysis based on the expectations on the year level he or she is in.		
☐ Exceeds expectations ☐ Meets expectations ☐ Below expectations ☐Fails to meet expectations		

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