

Cultural Genogram: A Tool for Teaching and Practice

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Cultural issues affect patients', families', and providers' perspectives on health, illness, and disease, thus a provider's sensitivity and awareness to cultural issues can influence the quality and outcome of the patient and family encounter. As the population of the United States becomes more culturally diverse, health care professionals render care to patients whose cultural beliefs, values, attitudes, and health practices differ from their own. The cultural genogram is used as an educational tool to teach health care professionals a structured way to address patients' and families' cultural beliefs and practices. This article describes instructional activities for undergraduates, graduates, and faculty; presents a case ex-

ample and personal reflections of a resident in family medicine; describes practical issues for the clinician; and proposes implications for evaluation and research.

Keywords: genogram, cultural genogram, cultural diversity, medical education, primary health care

Cultural issues affect patients', families', and health providers' perspectives on health, illness, and disease; thus a provider's sensitivity and awareness to cultural issues can influence the quality and outcome of the patient and family encounter. As the population of the United States becomes more culturally diverse, health care professionals will render care to patients whose cultural beliefs, values, attitudes, and health practices differ from their own. It is challenging for a provider to learn the myriad diverse cultural beliefs and practices he or she may encounter. Changing demographics of both patients and health care providers have prompted the introduction of curriculum interventions related to cultural diversity in medical education. Concerns expressed by trainees have included the recognition that they lack specific knowledge about different cultures but feel ill at ease asking questions

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about culturally sensitive information. These concerns indicate the need for a structured or standardized approach to facilitate gathering cultural information relevant to the provision of health care.

The purpose of this article is to delineate differences between the traditional genogram and the cultural genogram and to describe activities used to teach undergraduates, medical students, residents, and faculty using the cultural genogram. Practical issues related to clinical practice are addressed, as are implications for evaluation of cultural genogram training and research examining the tool's clinical utility.

DIFFERENCES BETWEEN THE TRADITIONAL GENOGRAM AND THE CULTURAL GENOGRAM

In primary care, health care providers use the genogram as a tool to record important information about a patient's family. Some health care offices, institutions, and agencies consider the genogram to be one of the vital signs and include it in the patient's medical record (E. Durante, personal communication, August 10, 2002). In many health care training programs, the genogram is used to focus trainees' attention on the family and biopsychosocial context of the patient's health and wellness issues (Blossom, 1992; Harbin, 1980; McGuinness, Noonan, & Dyer, 2005; Shellenberger, Shurden, & Treadwell, 1988; Zamudio & Hill, 2004). Much like a family tree, the genogram graphically presents demographic information about the family and highlights the index patient providing the reported genogram information. Other types of information that can be reported include individuals' medical and psychiatric histories, their health behaviors, and their genetic information (McGoldrick, Gerson, & Shellenberger, 1999). In keeping with its theoretical origins (Kerr & Bowen, 1988), the genogram graphic illustrates the nature of the relationships in the patient's family according to the index patient's perceptions.

The theoretical basis for training health care professionals using the cultural genogram derives from training programs in medicine, nursing, and family therapy. Training programs in health care address culture and ethnicity as determinants of health and focus on preparing medical and nursing students and primary care residents for a clinician-patient relationship that is informed by identification of one's own cultural heritage and health beliefs (Boufford & Shonubi, 1986; Campinha-Bacote, 2006; Culhane-Pera, Like, Lebensohn-Chialvo, & Loewe, 2000). Genograms have been used to train health care professionals in undergraduate medicine, family medicine and psychiatry residencies, and nursing, as well as family and general physicians in practice (Davies, Davies, & Rutledge, 1995; Howkins & Allison, 1997; Shellenberger, Shurden, & Treadwell, 1988; Shore, Wilkie, & Croughan-Minihane, 1994; Tisher & Jackson, 2003). Family therapy training programs were the first to promote the use of the cultural genogram to prepare culturally competent therapists (Hardy & Laszloffy, 1995; Keiley et al., 2002). Trainees explore their own ethnic and cultural heritages and draw personal genograms depicting these origins. At Mercer University in Macon, Georgia, professors modified the questions from training seminars conducted by Boufford and Shonubi (1986) and used the genogram as the tool for guiding the interview and recording information. Mercer University's outline for the cultural genogram interview is found in Table 1.

As seen in Table 1, traditional questions asked and drawn in a genogram interview include information on who lives in the household; where other family members live; recent health-related and other changes within the family; key family members; ethnic, cultural, or gender variables; and family relationships and roles (McGoldrick et al., 1999). For example, a female adult patient who has a conflictual relationship with her spouse and a close relationship

Table 1
Cultural Genogram Interview

Part I. Traditional genogram

- A. *Nuclear family: Begin the genogram by asking for information about who lives in the household and draw the information you collect
 - 1. Who lives in the household (name, age, gender, occupation, and education)?
 - 2. Where do other members live?
 - 3. What health-related changes or problems have the family faced most recently?
 - a. Pregnancies, illnesses, hospitalization, deaths, and so forth
 - b. Psychiatric problems (depression, anxieties, and phobias)
 - c. Addictions (alcohol or drugs)
 - d. Divorces, marriages, or natural disasters
 - 4. What other changes or problems have the family faced most recently?
 - a. Work (job changes, unemployment, and level of satisfaction)
 - b. School (achievements or problems)
 - c. Legal problems (arrests, lost professional license, and current status of litigation)
- B. *Parents' birth families: Draw information on parents' birth families
 - 1. Number of siblings, occupation, level of education, and illnesses
 - 2. Place in birth order
 - 3. Parents' marriage (and separations, divorces, or remarriages)
 - 4. Cause of any deaths in the family
 - 5. Who acted as the primary caretakers if not the parents?
- C. Additional generations (optional). Inquire about other generations
 - 1. Parent's parents (names, dates of birth and death, causes of death, occupation, and health)
 - 2. Their siblings (names, dates of birth and death, occupation, and health)
 - 3. Who are the family health experts?

Part II. Ethnic and cultural information

- A. Probe ethnic and cultural variables
 - 1. *Country of origin of people listed on genogram
 - 2. *Ethnic identification (how would individuals describe their ethnic origin, and what does this mean to them?)
 - 3. *Religion and level of commitment to their religion
 - 4. Degree of assimilation of people listed on genogram
 - 5. Inquire about dominance and submission patterns
 - 6. When confronted with a health crisis or decision, do you approach the decision according to how parents or grandparents dealt with the decision or from how those around you approach the decision?
- B. Health beliefs and behavior
 - 1. What is the family's definition of health (e.g. ability to work, feel good, lack of symptoms, spiritual grace, being well fed, germ-related, mental outlook, etc.)? How concerned were they about health when you were growing up?
 - 2. *Explanatory model of disease: What did your parents believe caused illness (e.g., neglect, punishment from God, natural causes, exposure to drafts, germ theory, dressing poorly in cold weather, getting wet, disturbances in the body systems, eating poorly, body size)?
 - 3. Were the views of your parents similar to the views of your grandparents or other significant family members?
 - 4. *How did they (your parents) view and treat common illnesses (colds, stomachaches, etc.), including the following?
 - a. Common home remedies
 - b. Attitude toward doctors and prescription medication
 - c. Use of alternative health practices, herbs, supplements, and so forth
 - d. Consultation with traditional or alternative healers (lay practitioners, ministers, healers, herbalists, spiritists, root workers, etc.) and their practices

(Continued)

Table 1 (Continued)

5. How was emotional illness viewed?
6. Did religion play a role in curing illness?
7. Rituals for maintaining health (prayers, herbs)?
8. Rituals for handling death (attitude toward dying, body disposal, commemorative ceremonies)?
9. Beliefs about what happens after death?
10. Stigma or trauma associated with any death or loss?
11. Gender issues
a. Impact of gender roles on household situation, on handling major life events, on individual functioning, and so forth
b. What are the gender roles within the family or culture regarding expressions of grief, funeral arrangements, or commemorative rituals?
C. Health maintenance and disease prevention practices
1. What were some of the family practices to prevent illness (e.g., laxatives, herbs, spiritualist consultations, regular visits to physicians, prayers, vitamins, fresh air, exercise, nutrition, use of certain foods, self-medications, etc.)?
2. What types of illnesses were most often treated at home? How were these illnesses treated?
3. What is the impact of gender roles on decisions made about health and illness (e.g., grandparent, mother, or father)?
4. Who took charge of the sick person (e.g., mother or father)? How are/were elderly relatives cared for, and by whom?

Note. An asterisk represents essential information that should be collected during the initial interview; other items in the outline may be addressed later in a stepwise fashion if time is limited during the initial interview.

with their child is represented by conflict and closeness lines drawn to the respective family members on her genogram (Figure 1). This genogram example is discussed more fully below.

The cultural genogram used in the health care setting adds questions such as countries of origin of key family members, identification of family members who are considered to be health experts, health beliefs and behaviors of current family and parent generations, gender roles within the household and culture, and health re-

sources used outside the family and outside the mainstream medical system. The information gathered is recorded pictorially on the genogram graphic and with notes to accompany it. Figure 2 provides an example of a patient's cultural genogram drawn by his physician, a second-year resident in family medicine. In the genogram, symbols represent various aspects of family life such as relationships, substance use, and lifestyle choices such as homosexuality. It is hoped that professionals in the fields in which genograms are used will come to

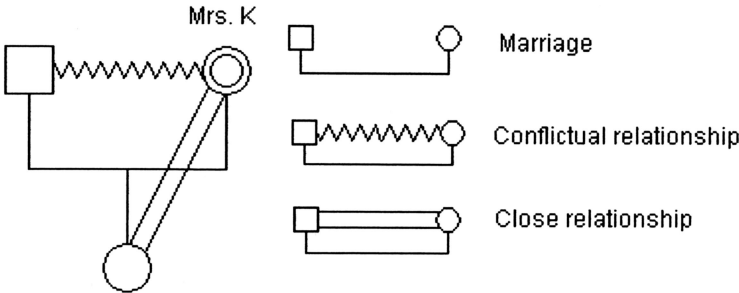


Figure 1. Mrs. K's Traditional Genogram.

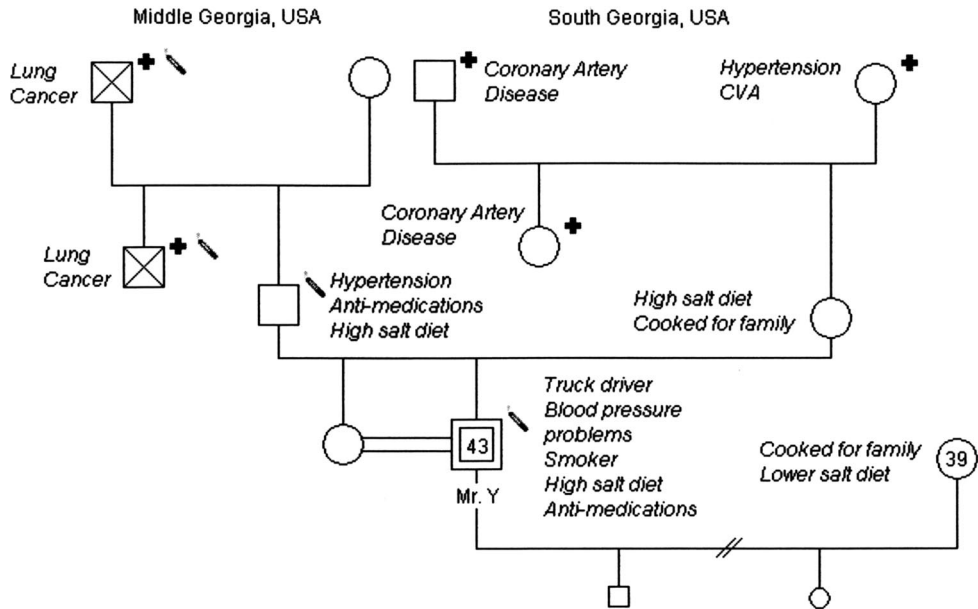


Figure 2. Mr. Y's Cultural Genogram.

consensus regarding additional symbols to represent various aspects of culture. The difficulties that professionals must address include selecting which aspects of culture are deemed important; choosing symbols to represent those aspects; and managing the increased complexity of the genogram that would result from adding more symbols. We encourage these discussions. Meanwhile, notes can be made adjacent to the figures to delineate important information about the individuals depicted.

THE CULTURAL GENOGRAM IN MEDICAL EDUCATION

Accrediting bodies, including the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), have recognized the value of cultural competence education in altering racial and ethnic disparities in health care (Smedley, 2003). These bodies include required training in cultural competency as part of the core requirements for all undergraduate and graduate medical education programs, regardless of specialty (ACGME, 2006;

LCME, 2005). Cultural competency is stipulated in the competency requirement for interpersonal and communication skills (ACGME Competency 4; LCME Standards ED-21 and ED-22) and for professionalism (ACGME Competency 5; LCME Standard ED-23). In addition to accreditation and legislative mandates, culturally competent health care providers can respond to demographic changes in the United States, assist in eliminating health disparities, and improve quality of care and health outcomes (Goode & Dunne, 2003). Furthermore, researchers have identified that cultural competence training improves the knowledge, skills, and attitudes of health professionals and that this training has a beneficial effect on patient satisfaction (Beach et al., 2005) and the potential to reduce the likelihood of liability and malpractice claims (Goode & Dunne, 2003).

Cultural competence training must go beyond simple knowledge of cultural details. As Zweifler and Gonzales (1998, p. 1056) pointed out, "Physicians must be trained to be sensitive to cultural differences and patterns but on the other hand,

cannot be expected to know the many cultures of their patients in depth.” Indeed, although residents cite a lack of knowledge about specific cultures as a major cause of communication difficulties, their preceptors often note that something more basic is lacking (Lingard, Tallett, & Rosenfield, 2002). A first step toward cultural competency is demonstrating interest and respect during history taking, seeking understanding of the patient in a nonjudgmental format, and demonstrating insight regarding prejudice and conflict (Cook, Kosokolasaki, & O’Brien, 2005; Juarez et al., 2006; Lingard et al., 2002; Purden, 2005; Sarkisian et al., 2005). Tools like the cultural genogram equip clinicians in training to gather cultural information and use it to practice in a way that is culturally sensitive yet not overly time consuming in a busy clinic.

The mandate to conduct training in cultural competency may seem overwhelming to training programs. Reports by faculty in residency programs cite several factors impeding curricular development in multicultural issues, including time, money, faculty expertise, and the perception of a lack of cultural diversity in the community (Culhane-Pera et al., 2000).

Most family medicine programs train residents to use the genogram as a tool for the biopsychosocial understanding of the patient. Expansion of training to include the concept of cultural sensitivity, with queries specific to cultural beliefs and preferences, takes little additional training time. Rather than use specialized rotations to teach cultural competency, residency programs can teach the cultural genogram during orientation of interns and reinforce its use in regular patient presentations in clinic and during behavioral science case reviews. Including the cultural genogram in the assessment of a new patient occurs naturally as part of the intake history and adds little time to the overall history.

The cultural genogram does not have to be completed in one visit; it is a tool that

can grow and develop with additional patient contact. In Table 1, we identified with an asterisk the aspects of the cultural genogram interview that we recommend collecting on the first visit, with other aspects of the interview to be addressed at subsequent visits. In this manner, the clinician conducting the cultural genogram interview makes effective use of office time, presents medical information in a culturally appropriate fashion for the patient and family, and increases the likelihood of collaboration with the patient and patient’s family regarding treatment options.

By routinely using the cultural genogram in clinical practice, trainees begin to look for nuances that may be significant although not readily apparent (Culhane-Pera et al., 2000). In the process of attending to what happens as they ask genogram questions—for example, a tearful response as the patient reveals an episode of torture—trainees build rapport and develop a more comprehensive understanding of the patient. This deeper grasp of the patient’s past and present experiences and responses may contribute to designing more effective treatment strategies. For example, by using reflective listening with the statement “It looks to me like these memories are still troubling to you” or open questions such as “Tell me more about your experience if you feel comfortable to do so,” trainees contribute to the healing process of the patient traumatized by torture. At the same time, trainees will have a clearer picture of when referral to a mental health specialist is warranted.

Another concern regarding cultural competency is that of introducing international medical graduates to U.S. culture (Kales et al., 2005). In a study that examined physicians’ ability to identify depression in White versus African American patients, no difference was noted in the appropriate diagnosis on the basis of the patient’s ethnicity. However, international medical graduates were more likely to show an inability to perceive depression regardless of

patient ethnicity (Kales et al., 2005). This difference was attributed to a lack of understanding of cultural norms different from their own—a database deficiency, in a sense. For example, in our program, a female international medical graduate (with an Indian and East African background) considered abortion to be a socially and religiously acceptable form of birth control in settings in which alternate means were not available or had failed. She had great difficulty understanding and supporting a teenage patient's decision not to even consider this choice when faced with an unplanned pregnancy. The resident remained focused on "correcting the situation" and allowing the girl to stay in school and finish her education—a highly valued commodity in her culture. However, the girl and her family were devout Christian fundamentalists. Their tradition was accepting of early marriage and child rearing. Higher education was not a tradition in the family, and little value was placed on educating women beyond high school. By using the cultural genogram and asking the patient to identify the import of cultural phenomena, residents such as this one will find guidance in overcoming this barrier to care.

THE CULTURAL GENOGRAM IN UNDERGRADUATE EDUCATION

The focus of our medical school on primary care and the biopsychosocial model has resulted in a curriculum for first-year students that includes basic instruction and practice in using genograms and an introduction to family functioning and cultural competence. Their introduction to the genogram and the theoretical base of information about family functioning in health and illness occurs as part of a 6-hr curricular sequence titled "Understanding and Assessing Families in Primary Care Medicine" (also known as "Family Systems"). This sequence is taught in small groups of seven or eight students with a faculty tutor. Tools used to evaluate family systems and to glean information helpful for genogram construction are taught during this

sequence. These tools include the Family APGAR (adaptation, partnership, growth, affection, resolve) and SCREEM (social, cultural, religious, educational, economic, and medical; Smilkstein, 1983), family life cycle (Gerson, 1995), and chronic illness typology and illness time line (Roland, 1984). Students practice what they have learned by assessing two families during a 2-week rotation with a community-based preceptor. They complete two genogram interviews, draw genograms, compile reports describing their families, and receive feedback from medical school faculty on their reports. Students follow these two families from the preceptor's practice longitudinally when they return to the community-based practice for 4 weeks during both the 2nd and 4th years of medical school. During this time, they update the genograms and other family assessment tools. Students are introduced to information about cultural competence during a 2-hr session that includes readings and small-group discussions.

As a method of integrating students' knowledge about cultural competence and about genogram interviewing, students participate in a small-group cultural genogram exercise following the Year 1 community visit. The cultural genogram provides an opportunity to extend the family systems work after the students have been introduced to the traditional genogram and its application in a primary care setting. Each small group of seven or eight students and a faculty facilitator work with an individual designated as a "cultural educator." Cultural educators from a wide variety of cultural backgrounds are recruited from the community, the medical school faculty, and the university's various graduate programs. These educators volunteer to share information about their culture and cultural practices with the students. We instruct the cultural educators that they are free not to respond to a particular question or to respond in a way representative of others in their culture. The cultural educators receive a copy of the cul-

tural genogram questions before the session and also receive a small honorarium or gift for their participation.

On the day of the session, the cultural educators arrive early so that they have an opportunity to meet with the group facilitator. Often the educator is paired with the group facilitator who recruited him or her or an individual who speaks the same language if this might be an obstacle to communicating with the group. Because of Georgia's growing Hispanic population, at least half of the cultural educators recruited have been Hispanic. Students are encouraged to practice their language skills, usually Spanish, if their cultural educator is willing.

The curricular experience begins with a large-group session conducted with the students, facilitators, and cultural educators. A clinician, preferably one with medical practice experience caring for a diverse cultural group, introduces the topic and discusses cultural practices that have influenced care. Other faculty members review the format of the upcoming small-group session, provide a quick review of the genogram, and present the cultural adaptation to the genogram.

The small groups of students interact with a cultural educator and group facilitator for approximately 65 min, asking questions about the culture, drawing a genogram, and becoming more comfortable with culturally related information. As part of the debriefing after the small-group session, students identify and discuss three pieces of cultural information that would be important for a physician to know when caring for this patient, identify what worked well with the exercise and what was uncomfortable about the experience, and describe how a clinician could use the cultural genogram in practice.

Students have evaluated this experience very positively. Our students, who are predominantly Caucasian and Georgia residents, specifically rated the opportunity to interview and interact with someone of an-

other culture as highly valuable, particularly in the small-group setting. They also rated very positively their use of the cultural genogram as a structured guide to elicit cultural information. We have also conducted this exercise so that students interacted with two cultural educators, each for a 45-min session. Student feedback was that they were too rushed and wanted longer interaction time with the cultural educator. The next year, when the session was lengthened to encourage a more in-depth experience with only one cultural educator, the students requested interaction with more than one cultural educator.

Students exhibit curiosity and interest in other cultures. The focus of this experience is not to educate the students about as many cultures as possible but to focus on a structured approach to identify cultural information for use in the clinical setting. This sometimes creates a tension with those students who want detailed information about many cultures.

THE CULTURAL GENOGRAM IN GRADUATE MEDICAL EDUCATION

Introducing the cultural genogram to residents in various stages of training can be challenging. Some of the concerns are how to make the tool clinically valuable, how to obtain the information in a timely manner, how to document the information in the medical record, and how to maintain the confidentiality of the information that is gathered. To address these concerns and teach this concept, we first introduce the cultural genogram in a nonclinical setting, demonstrating how this tool can be used in a multicultural practice and with homogeneous groups. Several faculty members volunteer to share their cultural genogram during this session. This is helpful in showing residents how the tool can be used to gather important information about a person's culture as it relates to health care in what they might consider "an average White male." The residents also practice using

the tool on each other to become familiar with the process of exploring information that can be obtained from the cultural genogram. The residents are taught how to draw the cultural genogram and store this information in the chart. The residents also have access to computer software to aid in generating a genogram that can be used in the chart (*Genogram-Maker Millennium*, 2007). Finally, faculty members encourage the use of the genogram as a dynamic tool so that residents do not feel compelled to obtain all of the history in one visit and can tailor the information for each encounter. These concepts and activities occur over several hours of longitudinal didactic teaching and experiential use in the residency clinic and during retreats with all of the family medicine residents in one group.

We also use the teachable moment to remind residents of the usefulness of the cultural genogram. For instance, when a resident is having difficulty managing a patient's chronic disease in the clinic, the faculty preceptor might ask the resident to consider how the cultural genogram might be useful in this situation.

One resident became particularly interested in the use of the cultural genogram and chose to focus her required behavioral science presentation on this topic. She chose to explore the family genogram of a patient who had some cultural similarities to her own family, although she and the patient came from very different parts of the world. She described the case and her personal reflections on the case at the teaching conference.

Case Study Described by a Second-Year Resident in Family Medicine

The patient was a 43-year-old White male truck driver sent to the office because his blood pressure was very high. The patient stated that he had been diagnosed with hypertension 2 years earlier but was never prescribed medication to control it. The patient, who looked slightly angry, added that he felt well and considered him-

self to be a healthy man. I initiated a genogram interview (see Figure 2). The patient described a strong family history of hypertension in many family members and coronary artery disease in his maternal grandfather and aunt. In addition, two other family members, an uncle and his paternal grandfather, had died of lung cancer. Surprisingly, the patient stated that until he saw his genogram, he had never realized that he had such a strong family history of lung cancer. The patient revealed that he had smoked a half pack per day for 22 years and asked whether there were screening tests for lung cancer.

Later, when asked about food preference and preparation, the patient replied that he mostly ate canned food or frozen foods, and he preferred heavily seasoned food and fried meat. Furthermore, a salt shaker was "always" on his table. He also drank 4–5 cups of coffee daily to help him stay awake. When asked who was responsible for fixing his food, the patient became tense and asked why these questions were being asked and how they related to his condition. He was told that salt could increase his blood pressure and that canned food and frozen food contained a lot of salt. The patient replied that he was divorced, "can't cook really good, and don't have time for it." He admitted that his sister had mentioned the importance of salt restriction, but that he did not believe that food could affect his blood pressure.

During a follow-up visit 3 weeks later, the patient's blood pressure was still high. When asked whether he had taken his medicine every day, the patient said, "Only when I remember to do it. You know, I am doing fine. I don't have headaches, pain, or anything like that." During this visit, the patient was more open and talkative and revealed additional information about his family.

During a discussion about the importance of following through with recommended treatment, I asked about the patient's definition of health and his view of medical

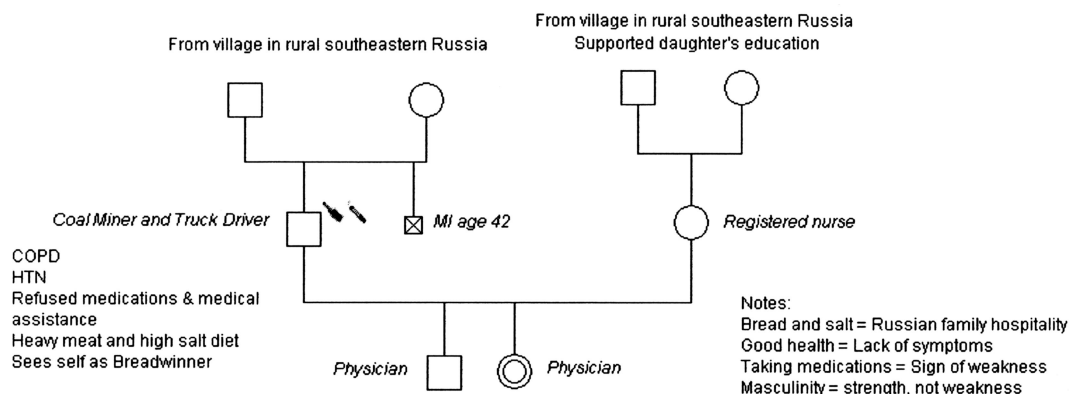


Figure 3. Dr. W's Cultural Genogram. COPD = chronic obstructive pulmonary disease; MI = myocardial infarction; HTN = hypertension.

intervention. The patient stated that to him, being healthy meant feeling good, being able to work, and not being in pain. On the other hand, being ill to him meant being weak and unmasculine. The patient's father, also hypertensive, never took his medication on a regular basis and believed that medication could cause more harm than good to the body. This multigenerational belief about medicines seemed to contribute significantly to the patient's lack of interest in treatment recommendations.

Again, the patient mentioned his sister, who called him regularly and worried about his problem with blood pressure. His divorce had brought a lot of tension between him and his parents. His older sister was the only person who was close to him in whom he could confide about his disease.

From the genogram interview, it was clear that this patient preferred not to take a lot of medicine and preferred to focus on feeling well. I chose treatment options to address these preferences, including selecting a medication to be given just once a day, and spent additional time in patient education focusing on maintaining a healthful diet and lifestyle.

Resident's Personal Reflections

When I met the patient described above, I was struggling with my own frustration about my father, who has chronic obstructive

pulmonary disease and hypertension, and who refused for years to take prescribed medications. The faculty encouraged me to draw my own cultural genogram (see Figure 3) and to consider how my family history, beliefs, and customs compared with those of my patient. This process provided valuable insights into the effects of culture on the health of both my father and my patient, enhanced my understanding of patient care, enabled me to plan acceptable treatment options, and provided insight that facilitated my discussions with the patient regarding changes in behavior.

My father and mother are both from small villages in rural southeastern Russia, where male chauvinism is common. The lifestyle that is encouraged in these rural small towns includes heavy chain smoking, drinking vodka, and eating bread and heavy meats saturated with salt at every meal. Men see themselves as the breadwinners, and women see themselves as housewives. My mother broke the mold early in her life by finishing high school and becoming a registered nurse. Her family supported her in this effort. Her family eventually moved from Russia to the Ukraine, where she married my father. My father was in the Russian mode of male domination; for him, his work as a coal miner and truck driver verified his "male

dominance attitude," which says that "men are strong and not weak." As a result of his hard work and chain smoking, he developed chronic obstructive pulmonary disease and later hypertension. However, as his dominant male attitude prevailed, he refused to seek medical assistance or take medication on a regular basis. In his mind, to medicate himself would have been a sign of weakness. My mother, a nurse, and my younger brother and I, both physicians, continually encouraged him to stop smoking and to start taking medications. Only the tragic death of my father's younger brother from a myocardial infarction at the age of 42 made my father resolve to stop smoking. Salt intake is another health issue that has never been resolved. In Russia, salt is an essential part of each meal and should always be on the table. Everyone in my family ate heavily salted foods. This habit, which comes from times when "bread and salt" represented Russian family hospitality, was almost impossible to break. My father's attitude helps me to understand why some patients refuse to heed physicians' cautions and to take prescribed medications.

Exploring my own cultural genogram and the patient's cultural genogram enhanced my understanding of our differences and led to better medical care. For example, becoming aware of my personal family experiences compelled me to realize that my family members, like my patient, consider good health to be a lack of symptoms. At the same time, taking medication is a sign of weakness, a quality disdained by my patient and my family members. These beliefs led to my father's and my patient's strong resolve not to change their eating patterns. Information from the patient's cultural genogram taught me the value of identifying the patient's readiness to learn about his disease and to investigate health issues that he might not bring up. The cultural genogram assisted in my planning interventions and treatment options that would be acceptable to this par-

ticular patient. I was surprised that even though the patient and my father are from very different cultural backgrounds, they hold similar beliefs and react in similar ways to health concerns and suggestions for change.

Subtle differences in their cultures, however, led to ideas about ways to motivate my patient. In my culture, the emphasis is on tradition and remaining faithful to old ways of addressing health issues. In my patient's family, there was much pride in the educational accomplishments of younger family members, and in fact, one family member was in medical school. We discussed the contributions that education and research could make for his problem of hypertension and included this family member who is in training in one of our medical visits.

Evaluation of Resident's Teaching Session

Residents (8), students (5), and faculty (1) in attendance at the conference evaluated the teaching session as excellent and of great value to them. When invited to list the best features of the teaching session, participants said the cultural genogram was a very important way of obtaining information from the patient, the application of the cultural genogram was practical in nature, and the case illustration with personal experiences was a positive feature. The aspect named as least helpful by 1 participant was that more examples of actual genograms were not included. When invited to list topics for future sessions, another participant wanted to hear specific ways to deal with other cultures, for example, patients from African American backgrounds.

FACULTY DEVELOPMENT USING THE CULTURAL GENOGRAM

Over the past 5 years, the cultural genogram has been successfully presented in 2-hr faculty development workshops at regional and national seminars to illus-

trate how it can be used to educate culturally competent physicians. The target audience has been medical school and family medicine residency faculty, who can then serve as multipliers to take this effective strategy for teaching cultural competence back to their medical schools for use with medical students, residents, and faculty. Four faculty presenters who have participated as presenters or facilitators in cultural genogram teaching sessions form the teaching team. The sessions begin with a didactic presentation highlighting the need for cultural competency teaching as the U.S. population becomes more diverse, describing difficulties experienced in the cross-cultural clinical encounter, reviewing ways in which the traditional genogram is constructed and used in individual patient encounters, and describing how the genogram is adapted to add information on family members' countries of origin, health beliefs, traditional health practices, and management of common illnesses such as colds and stomachaches. Two presenters of differing cultural backgrounds then demonstrate construction of the cultural genogram in a simulated patient encounter. Subsequently, all audience members participate in a small-group role-play exercise in which they graphically depict the family of one of the group members, using a handout with specific questions (see Table 1) to help guide the acquisition of cultural information. Each group of 6–8 participants is provided with a flip chart for recording information, and faculty facilitators rotate from group to group to provide assistance as needed. After constructing their cultural genograms, each group presents their drawing to the entire participant group, reflecting on insights gained and the strengths and weaknesses of the approach. The workshop concludes with a discussion of possible applications of this method at individuals' home institutions. This model of teaching primary care faculty can also be used to teach faculty of other health care disciplines, including nurses, nurse practitioners, and physician assistants. The work-

shop was awarded the "Promising Medical Education Scholar" award of the Southern Group on Educational Affairs in 2004. In formal evaluations, participants have commented on the richness of the information elicited with this method, the focus on the patient, the structured approach to the interview, the illustration that we all have culture, and the longitudinal picture of the patient presented. Although the participants were positive about the use of the cultural genogram in an academic setting, they expressed concerns regarding the amount of time required to gather the information in the clinic setting and the potential for losing sight of the patient's feelings and wondered whether nonphysician providers could be used to complete the genogram.

PRACTICAL ISSUES RELATED TO CLINICAL USE

In seminars with faculty, residents, and medical students, questions surface about how to use the cultural genogram tool in a way that will enhance the clinical encounter. Questions include how to conduct the interview in an efficient way, how to notate specific cultural information on the genogram, how to record the information so it is readable, how to store information in the medical record so it is protected, and how to bill for time spent with the patient to gather cultural information. Each of these questions is addressed.

Conducting the Interview in an Efficient Way

Many clinicians prefer to construct the genogram in a stepwise fashion at successive visits. The cultural genogram can be constructed over several patient encounters, by drawing the graphic as information is revealed, by collecting biomedical information at a first visit and cultural information at a second visit, or by adding successive generations to the genogram longitudinally. We suggest that these basic elements noted by an asterisk in Table 1 be collected during the construction of the

original genogram. Other items listed in the cultural section of the genogram may be collected in later visits or as particular illnesses or problems are encountered with the patient or the patient's family.

Notating Specific Cultural Information on the Genogram

For recording cultural information—such as who makes the medical decisions, who prepares the meals, and the family definition of health—notes are made next to the people identified as key persons in the patient's family (see Figure 3). Key themes are included at the top or side of the genogram, indicating the family's religion and the role it plays, the definition of health, and other themes of note. Because the genogram is a dynamic tool, at subsequent visits when the use of the genogram is needed, key themes and points of the previous genograms are reviewed to see what, if anything, has changed. This information is kept together on the chart in a chronological fashion.

Recording Information So It Is Readable

Electronic records of genograms are much more readable than hand-drawn versions. Software for creating genograms is available from GenoWare, Inc., and WonderWare (*Genogram-Maker Millennium*, 2007; Relativity, 2003). Health care professionals using electronic health records are hopeful that in the future, fully integrated software will allow users to create and save genograms while in the health record system. At present, users have to alternate between the electronic health record system and the genogram program by copying and pasting or scanning into the record genograms that were drawn in the genogram software programs, which makes the task cumbersome.

Recording cultural information on the genogram without the computer software poses several challenges. When paper, not software, is used to create the genogram, particular care must be taken to make

the drawing legible. The sheet is dated, patient identifiers are noted, and figures are drawn with standardized symbols and terminology.

Storing Information in the Medical Record So It Is Protected

Special legal requirements for increased confidentiality apply if the patient has HIV infection or a psychiatric or substance abuse disorder. Some medical practices create a special section of the medical chart where information relevant to such issues is stored. Release of this information to any third party requires a separate informed consent. Creation of such a section in the medical record establishes a safe place for storing genograms with sensitive information such as adoption, family violence, or HIV infection.

Billing for Time Spent Gathering Cultural Information

Gathering extensive family and cultural information frequently requires extra provider time beyond that of a routine office visit. Physicians can be reimbursed if the time extends beyond certain limits if they appropriately document the level of service.

Use of the Cultural Genogram in Health Care Groups

The cultural genogram could be a particularly helpful tool to use in health care groups for teaching about chronic diseases such as diabetes and hypertension. In our area, for example, diabetes education groups are frequently conducted with White and African American patients, whose understanding of diabetes may be dramatically different. Allowing patients of differing cultural backgrounds to provide information for cultural genograms could provide all participants with insights about beliefs that affect their disease management. In addition, diabetes educators could learn of potentially healthful or harmful

traditional practices that could be addressed in their teaching.

IMPLICATIONS FOR EVALUATION AND RESEARCH

Evaluation of cultural genogram training is warranted. Trainees in medicine and residency are becoming increasingly diverse, and many arrive with traditional health beliefs and practices different from those in the region where they train. Assessment of students and residents before and after cultural genogram training—for example, using the Cultural Competence Self-Assessment Questionnaire (Godkin & Savageau, 2001)—would ascertain changes in trainees' understanding of cultural differences and how these differences affect health care.

Studies are needed to ascertain the costs of incorporating cultural genogram education and interviewing in training programs compared with the benefits gained by the physician, the patient, the office system, and the patient's family system. Studies could track improvements in patient health outcomes; improvements in the patient's willingness to collaborate with the physician; improvements in patient, physician, and family satisfaction; and increases in efficiency of office visits. Additional studies could determine the most efficient ways to collect genogram information, for example, comparing the completion of the interview in one versus several office visits, having another office staff member complete part of the interview, or having the patient complete part of the information independently.

CONCLUSION

When patient and provider do not share a common culture, communication can be challenging. Misunderstanding a patient's culture and family can lead to the patient's feeling disrespected or uncomfortable or receiving care that is inconsistent with important cultural practices. The increasing cultural diversity of the U.S. population,

combined with the increasing cultural diversity of medical students and primary care residents, has created a critical need for approaches to cultural sensitivity training that are not tied to any single culture. The cultural genogram is a creative, practical tool that assists clinicians in understanding the patient's family and cultural context. By building on this understanding, providers can then develop management plans that are more consistent with the patient's worldview and more likely to be followed. We believe that many clinicians will find the cultural genogram to be an important tool for increasing their understanding of their patients' health care needs and improving the quality of service they provide.

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