

# **The Perinatal Genogram: A Systemic Assessment Tool**

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**Abstract:** The child-bearing years are a time of emotional and psychological vulnerability for most women. Prevalence rates for perinatal illness are as high as 25% depending on the method and timing of assessment. Current perinatal illness assessment tools tend to be symptom-focused, by-passing not only the systemic context within which symptoms present, but also the profound impact on the family system when the new mother is experiencing a mood or anxiety disorder. The following paper addresses the significance of the genogram in providing a broader psychosocial family assessment and de-stigmatizing treatment. A clinical example is provided.

**Keywords:** perinatal mood and anxiety disorders, postpartum depression, family systems theory, genogram

Pregnancy and childbirth is a time of emotional vulnerability for most women. Following birth, it is expected that as many as 80% of women will experience some change in their mental health (Gale & Harlow, 2003). Within the first year postpartum, one out of eight women will present with symptoms that indicate a mood and/or anxiety disorder of some significance (Beck, 2002). There are more psychiatric admissions around the child-bearing years than at any other time in the female life cycle (Cox, Murray, & Chapman, 1993; Stuart & O'Hara, 1995). Characteristically, a perinatal mood or anxiety disorder (PMAD) is accompanied by changes in sleep and appetite, confusion and disorientation, often described as foggiess, extreme anxiety, and for some women, a sense of emotional detachment from their infant (Blum, 2007). Women may feel so overwhelmed by the requirements of a new baby that they find themselves unable to cope, often wishing they could reverse the decision to become a mother. Other mothers may be haunted by repetitive images of harm coming to their baby and devise behavioral strategies to manage the fear that these intruding and destructive thoughts foretell what will happen in the future (Wood, Thomas, Droppleman & Meighan, 1997). For other women, birth is perceived as a traumatic event. Their experience of trauma may be the consequence of unplanned and/or frightening occurrences during labor and delivery (Beck & Barnes, 2006). Giving birth may also revive memories of earlier experiences in which they felt helpless or powerless. Although rare, postpartum psychosis is a potentially life-threatening bipolar episode (Blum, 2007; Chandra, Bhargavaraman, Raghunandan, & Shaligram, 2006) that constitutes a medical emergency in order to protect the safety of both mother and child. The incidence of suicide is 5% and infanticide, 4% for the one to two out of every thousand women who have postpartum psychosis (Parry, 1995).

Although it is the new mother who is generally identified as the patient, studies recognize that those mood and anxiety disorders that occur around pregnancy and birth impact the emotional well-being of the entire family (Chandra et al., 2006; Green, Broome & Mirabella, 2006; Halligan, Murray, Martins, & Cooper, 2006; Haslam, Pakenham, & Smith, 2006; Roberts, Bushnell, Collings, & Purdie, 2006; Shaw, Levitt, Wong, & Kaczorowski, 2006; Wisner, Chambers & Sit, 2006). Systems theory proposes that a change in one or more members of the system creates disequilibrium in other parts of the system (Nichols & Schwartz, 2010). The systemic perspective also acknowledges that the symptoms presented by the "identified patient" are essentially the emotional expression of a deeper systemic pain lurking beneath the seemingly ordinary details of a family's everyday functioning. With respect to women's reproductive mental health, there is a growing body of knowledge suggesting that other members of the family be included in treatment (Barnes, 2006; Blum, 2007; Dennis & Chung-Lee, 2006; Nysten, Moran, Franklin, & O'hara, 2006; Pearlstein et al., 2006). Because of the emotional and psychological contributions that each individual in the family system makes to the overall stability during the transition between pregnancy and the postpartum period, these authors propose that a thorough risk assessment during pregnancy as well as any diagnostic

evaluation postpartum should always address the presenting symptoms of a perinatal mood and anxiety disorder within the context of the family system.

While symptom presentation is critical to diagnosis and subsequent decisions about appropriate pharmacological treatment, it does not identify the systemic context within which these symptoms emerge. Traditional assessment tools used to screen for postpartum depression tend to be symptom-focused (Beck & Gable, 2001; Cox, Holden, & Sagovsky, 1987; Eberhard-Gran, Eskild, Samuelsen, & Tambs, 2006; Records, Rice & Beck, 2007). Generally, they are self-report questionnaires that inquire how a woman has been feeling during the previous one to two week period with the goal of identifying those symptoms that meet the criteria for a major depressive episode with postpartum onset. There is growing scientific recognition that the degree of psychosocial stress correlates with increased risk for the onset of perinatal illness (Beck, 2001; Chandra et. al., 2006; Bernazzani, Saucier, David, & Borgeat, 1997; Brugha et. al., 2000; Green et. al., 2006; Halligan et al., 2006; Haslam et al., 2006; Roberts et al., 2006; Shaw et al., 2006; Whiffen & Johnson, 1998); therefore it is important to include the context within which these symptoms develop or maintain in order to maximize the potential for successful assessment of PMAD and psychological treatment.

For this reason, an assessment tool that emphasizes the biopsychosocial aspects of a woman's life is needed for PMAD disorders. Genograms were developed based on the understanding that families are organized around history, as well as patterns of biological, emotional, legal, and relational structures. The genogram offers an opportunity for clinicians to probe further into areas that they may not have discovered through a self-assessment questionnaire or structured interviews like those typically used for PMADs. Genograms also make it possible for practitioners to assess a woman's life from genes to culture in order to adequately measure a woman's current story (Coupland & Serovich, 1999; Dunn & Levitt, 2000; McGoldrick, Gerson, & Petry, 2008; Thurtle, 1995). In this paper, the authors introduce the Genogram as an assessment tool for PMAD. A clinical example is provided and the perinatal Genogram is used exemplifying a systemic therapy perspective.

### **Family Systems Theory and Perinatal Mood and Anxiety Disorders**

Many researchers maintain that PMAD be assessed from a perspective that is all-inclusive and underscores the biological, psychological, social, and family aspects of a woman's life (Bentley, Melville, Berry, & Katon, 2007; Erskine et al., 2003; Ross, Sellers, Evans & Romach, 2004; Stanton, Lobel, Sears, & DeLuca, 2002). Approaching assessment from this focal point works well with a family systems perspective. Systems theory was originally developed as a way for classical science to better understand complex systems (Bertalanffy, 1963). Perinatal mood disorders are complex by the nature of their symptoms, the time of life in which this syndrome occurs and by the emotional challenges facing many of the family subsystems when the new mother is ill during pregnancy or in the postpartum period. Family systems theory emphasizes the interconnectivity between all aspects of one's life and ultimately the reciprocal impact of relationships on the mental health and well-being of individuals as well as dyads in the larger system. Thus, authors are now conceptualizing perinatal mood disorders from a family systems perspective (Beck, 2001; Shaw et al., 2006). Therefore, using a theory that focuses on complex systems not only becomes a logical model for conceptualizing perinatal illness, but also for assessing and treating these unique mood and anxiety disorders.

### **Genograms and Perinatal Mood Disorders**

The genogram evolved as a conceptual tool designed to understand family systems, utilizing both current and historical information (Butler, 2008; McGoldrick et. al., 2008). This is an important tool for PMADs because, in the medical model, perinatal depression is considered an illness of biological origins and hormonal changes. Therefore, in the medical model, PMAD is assessed based on medical history and biological markers (Beck, 2002). However, along with the biologically based factors, there are many psychosocial factors to consider for PMAD. This is why a number of authors suggest that a true understanding of PMAD can only come from a multidisciplinary perspective

(Beck, 2001). Along with incorporating systems theory as a guiding therapy for perinatal depression, some studies have also concluded that the assessment process should be a collaborative effort between the clinician and the family system themselves (Balaguer, Mary & Levitt, 2000). A few authors have acknowledged the need to not only understand both the woman's and her partner's experience during this time, but also to incorporate both of these perspectives into the assessment and treatment of perinatal illness (Barnes, 2006; Beck, 2001).

While a number of authors (Dunn & Levitt, 2000; Coupland & Serovich, 1999; McGoldrick et al., 2008) propose that including others in the creation of genograms and incorporating a systems perspective is important, the application is often much more difficult. Each individual is able to offer the wisdom of his/her historical perspective and experiences towards an understanding of the larger systemic perspective. Genograms provide a unique way to assess, build a collaborative relationship, work with clients during any stage of the reproductive years and enhance treatment. By the nature of their construction, genograms answer this call for the assessment and treatment of PMADs to be multidisciplinary and systemic.

## **Assessment**

The benefits of using a genogram as an assessment tool are plentiful (Butler, 2008; Coupland & Serovich, 1999; Hurley, 1982). The vast amount of information that can be discussed and noted is unique to the genogram. McGoldrick and colleagues (2008, p.62) refer to this as, "casting an information net." While most perinatal assessment tools are limited to gathering information about symptoms and risk factors, the simple diagrammatic of the genogram captures symptoms, risk factors, social supports, and the larger context of the family's life. Creating a genogram offers an alternative outlet to discussing a family's current situation (i.e. symptoms, dynamics, relationships, emotional state) by inviting the family into the process. Genograms also depict the wider family context including history, religion, culture, extended family, and even hypotheses or judgments about family patterns (McGoldrick et al., 2008). The genogram includes all the information that researchers suggest is necessary for perinatal assessment including information about biological, psychological, and social factors.

The perinatal genogram is designed for a thorough assessment of those factors that raise a women's vulnerability to an onset of a perinatal mood disorders. This tool displays a presenting problem text box which is designed to include the reason a woman or family is seeking treatment. The text box may have presenting problems listed, like separation, divorce, death in the family, but often the presenting problems are reflected in current symptoms (i.e. tearfulness, sleeplessness, irritability, anxiety, feeling overwhelmed, difficulty concentrating, confusion, lethargy, sense of doom, intruding destructive thoughts/images, suicidal thinking, feeling inadequate, withdrawal and isolation, helplessness, hopelessness, hearing voices, delusions or visual hallucinations.) This genogram type also displays a genogram legend that lists specific perinatal risk factors and the corresponding symbols. The legend includes the following risk factors; physical or sexual abuse, financial stress, fertility treatment, attempted suicide, complicated labor/delivery, ambivalence about motherhood, and pregnancy complications. The traditional genogram symbols as seen in McGoldrick et al. (2008) can also be used in the perinatal genogram to indicate gender, relationship history, immigration, conflict, fusion, births, deaths, illness, history of substance abuse, stressful life change, multiple births, pregnancy loss, etc.

The genogram offers a way to capture a full systemic and psychosocial picture of a family's life as it is recommended in the perinatal literature (Barnes, 2006; Dennis & Chung-Lee, 2006; Thurtle, 1995). The perinatal literature has also moved from only a deficit model of "at-risk" women based on their biological and psychological history, to highlighting a woman's resources, opportunities and personal strengths. (Blum, 2007; Dennis & Chung-Lee, 2006; Klier et al., 2007; Pearlstein et al., 2006; Thurtle, 1995) Likewise, studies have identified psychosocial protective factors (Dennis & Chung-Lee, 2006; Green et al., 2006; Haslam et al., 2006; Shaw et al., 2006), all of which the creation of a genogram can capture by mapping evident strengths in interpersonal relationships and discovering overlooked avenues of support within the family system.

## **Collaborative Nature**

Using a genogram as assessment for PMAD is completely different from the typical medical model interviews or self-assessments that are commonly used. One main reason is because the construction of a family's genogram can develop and enhance the therapist-client therapeutic alliance (Braverman, 1997; Kuehl, 1995) unlike other screening tools. Genograms are constructed collaboratively with the practitioners asking questions but letting the woman and family lead as they tell their story. It is also collaborative in that both the practitioner and family are learning from and seeing information unfold while they create the genogram. Typically, the biological nature of perinatal depression leads medical and mental health practitioners to screen, assess, and oftentimes treat from a medical model (Blum, 2007; Dennis & Chung-Lee, 2006; Forty et al., 2006), with little or no attention paid to the impact of psychological and psychosocial stress on the expression of symptoms (Dennis & Chung-Lee, 2006; Beck, 2007). A semi-structured interview is full of open-ended questions and discussion that is generated while completing the genogram. The medical model structured interview of focusing only on current symptoms sustains the doctor-patient role. When providers ask families about their traditions and their history (McGoldrick et al., 2008), they are communicating to family members that they are the experts on their own lives, eliminating the hierarchical relationship between a woman and her health care provider.

This hierarchy can be problematic during the antenatal period because women who are experiencing a mood disorder during this time may feel less empowered because they are already questioning their own capabilities and self-worth (Buist et al., 2006; Dennis & Chung-Lee, 2006; Whiffen & Johnson, 1998). It is important for women to assume an active role in their own treatment, which this type of collaborative approach encourages.

The process of therapists and families completing a genogram together opens the door to an exchange where women feel listened to and cared about (Dunn & Levitt, 2000). Creating a genogram also helps build rapport through the therapists' genuine interest and presence during this exploration of the family members' experiences. The providers' presence while helping families make meaning out of their history and current situation creates a different kind of clinical rapport that builds self-efficacy (Coupland & Serovich, 1999). Overall, the collaborative nature of this therapeutic model creates a safe and supportive environment in which healing can occur.

## **Timing**

In addition to the convenience of depicting the overview of a family's system on one page, the versatility of genograms is also noteworthy. Because current assessments generally focus on the last 7-to-14 days of a woman's experience, they generally exclude questions that may provide potentially significant psychosocial history. Due to the nature of this timeframe, they are only applicable at certain times of the antenatal period and, most commonly, during the first few months postpartum.

Genograms, however, can be completed as an assessment tool in a few minutes or clinicians and clients can work on genograms over many hours, months, or even years (McGoldrick, et al. 2008). The advantage of the genogram is that it can be used anytime during the reproductive years not only to identify risk, but to create a deeper understanding of a woman's sources of anxiety and depressive symptoms. For years, scholars have recognized and suggested that accurate assessment and early intervention may be preventative to the development of PMAD (Records et al., 2007). However, many of the current perinatal mood disorder assessments do not offer the versatility of timing that the genograms can offer. Because perinatal genograms specifically can be used at any stage of therapy, and more importantly, at any stage of the female life cycle, they can be extremely useful prior to pregnancy when women and their partners are thinking about having children or planning their long-term goals. Therefore, the genogram can be used as a preventative tool as well as an intervention for later on in the antenatal period.

## **Treatment**

Along with all the other benefits of using a genogram for PMAD, the perinatal genogram can also be used to create treatment plans and enact therapeutic interventions (Dunn & Levitt, 2000). Dunn & Levitt (2000) argue that using the genogram as only an assessment tool is limiting and disregards the potential treatment benefits. The systemic nature of a genogram can be an intervention in itself. The process of gathering the family information when constructing a genogram reduces stigma about mental health because it shows interest in a family's story, not just a woman's symptoms. This process indicates to the woman and the family that understanding the systemic context within which depressive symptoms emerge is important to a broader understanding of the presenting symptoms (McGoldrick et al., 2008). Offering this systemic understanding of perinatal mood and anxiety disorders also helps eradicate the notion that women have contributed to their illness by doing something wrong.

The genogram helps refocus families by showing interest in each individual's affective experience of the current situation and enlisting their suggestions about avenues of support that are beneficial to the system as a whole. Instead of pathologizing the mother and expecting her to change her mood to alleviate family distress, this approach inherently promotes family alliances, leading to potential changes in the system. In this compassionate manner, family members come to a better understanding of the context in which the mood disorder was created or maintained.

Genograms also give families a chance to redefine how they view themselves. This relabeling can be an important intervention for antenatal women. This is a natural time for women to redefine themselves; for many women entering motherhood is a crisis of identity as they struggle to integrate this new role of mother with their previous sense of self. Many women who struggle with PMAD label themselves as incompetent mothers (Dennis & Chung-Lee, 2006; Buist et al., 2006; Whiffen & Johnson, 1998) and develop a belief that their family would be better off with another mother. Redefining how a woman views herself is what McGoldrick and colleagues (2008) refer to as "detoxifying" the family perspective.

The depth of the information discussed while creating a genogram can have a positive influence on the pace of therapy and the ability to offer therapeutic interventions. McGoldrick and colleagues (2008) suggest that therapists can gather emotionally laden and complicated information about families almost instantly because of the nonthreatening and collaborative way of creating a pictorial representation of the family's life together. This allows therapists to move into intervention or treatment once the underlying issues are uncovered in the therapeutic process. Discussion about the family genogram can also be an opening for psycho-education. Helping the family to a better understanding of risk factors, sources of support, symptoms, and possible treatment options is one way to normalize a families' experience of perinatal illness while providing support for women during the perinatal period. Women with PMAD reported psychoeducational information as being helpful to them during this time (Blum, 2007; Dennis & Chung-Lee, 2006; Pearlstein et al., 2006).

## **The Perinatal Genogram**

### **Case Example**

Susan B is a 37-year-old Asian female and is referred by a local hospital for therapy. She has recently been diagnosed with postpartum psychosis. She has been married to Mitchell, age 34, for 6 years and has two daughters, ages 5 and 6 months. She had a miscarriage at 6 weeks in the year before her second daughter was born. Susan is the middle child in her family and has an older brother, Daniel, and a younger sister, Jessica, ages 40 and 25 respectively. She is currently on medical leave from her job as an administrative assistant with a law firm.

Mitchell, the youngest of the three sons, is of Russian descent and was born in England. The family came to the United States when he was 10. His older brother was 13 at the time and his younger brother was 12. Mitchell's mother died at age 50 of breast cancer and his father died of stomach cancer when he was 74. Just as was his wife's experience, he recalls his own family moving quite frequently during his childhood. He is currently a partner in a successful law firm, but has had to modify his schedule significantly to take over the care of their children during his wife's illness. In

addition, they have hired someone to live with them and help out while Susan is recovering. Both Mitchell and Susan are considerably overweight and acknowledge that food has always been a source of comfort.

When she was 6-years-old, Susan's father, with whom she was very close, died from a cocaine and alcohol overdose at the age of 26. Both her father and her mother, who is still living, abused drugs and sold cocaine and marijuana for a period of time when the children were young. When Susan was age seven, she and her siblings were removed from the home because of unstable living conditions and placed in foster care where they were emotionally and physically abused. At age 15, Susan and her sister went to visit their mother and ended up living with her again.

Her mother had multiple affairs while the children were growing up, many of whom made sexual advances towards Susan, all of which was ignored by her mother. At age 18, Susan was accepted on scholarship by a major university, and decided to live at home with her mother to defray living costs. Her mother, however, announced that she was moving across the country to live with her current boyfriend, which left Susan and her sister with her mother's rental agreement to fulfill and no financial resources. She secured a night job to pay the rent and, before long, had to suspend her educational goals in order to survive. At age 19, Susan was raped by a co-worker.

History taking reveals an extensive personal and family history of serious mood-related disorders on both sides of the family. The patient reports her father has having had several psychotic episodes and her sister as experiencing multiple depressive episodes, on occasion with psychotic features. Her brother uses marijuana on a regular basis. Her maternal aunt was also diagnosed with bipolar disorder. Susan had her first hospitalization around December of 1996, after losing her job, at which time she was diagnosed with bipolar disorder. Her second hospitalization occurred in 2000 as a result of the extreme stress incurred by balancing a full college load and a night shift in a clerical position. She attempted suicide and was hospitalized. Upon release, she tried again to commit suicide and was re-hospitalized.

The birth of her first daughter was traumatic for her, citing a premature induction of labor and a resulting unplanned Caesarean section as the cause. Several days postpartum, she began to manifest symptoms of mania and was admitted to the mental health unit of the hospital for 30 days. Upon her release, she stopped all medications, believing she could manage her illness without pharmacological intervention. Her second delivery, 5 years later, was a vaginal delivery. Although labor and delivery progressed more easily this time, within a few days of arriving home, she once again began to develop symptoms consistent with a manic episode. Her husband took her to the hospital where she was prescribed a medication protocol of Zyprexa, Lithium, Ativan, and Lexipro. Just prior to that hospitalization, her brother came to visit and called Child Protective Services as an intervention because he was concerned about her sister's mental well-being.

### **Genogram**

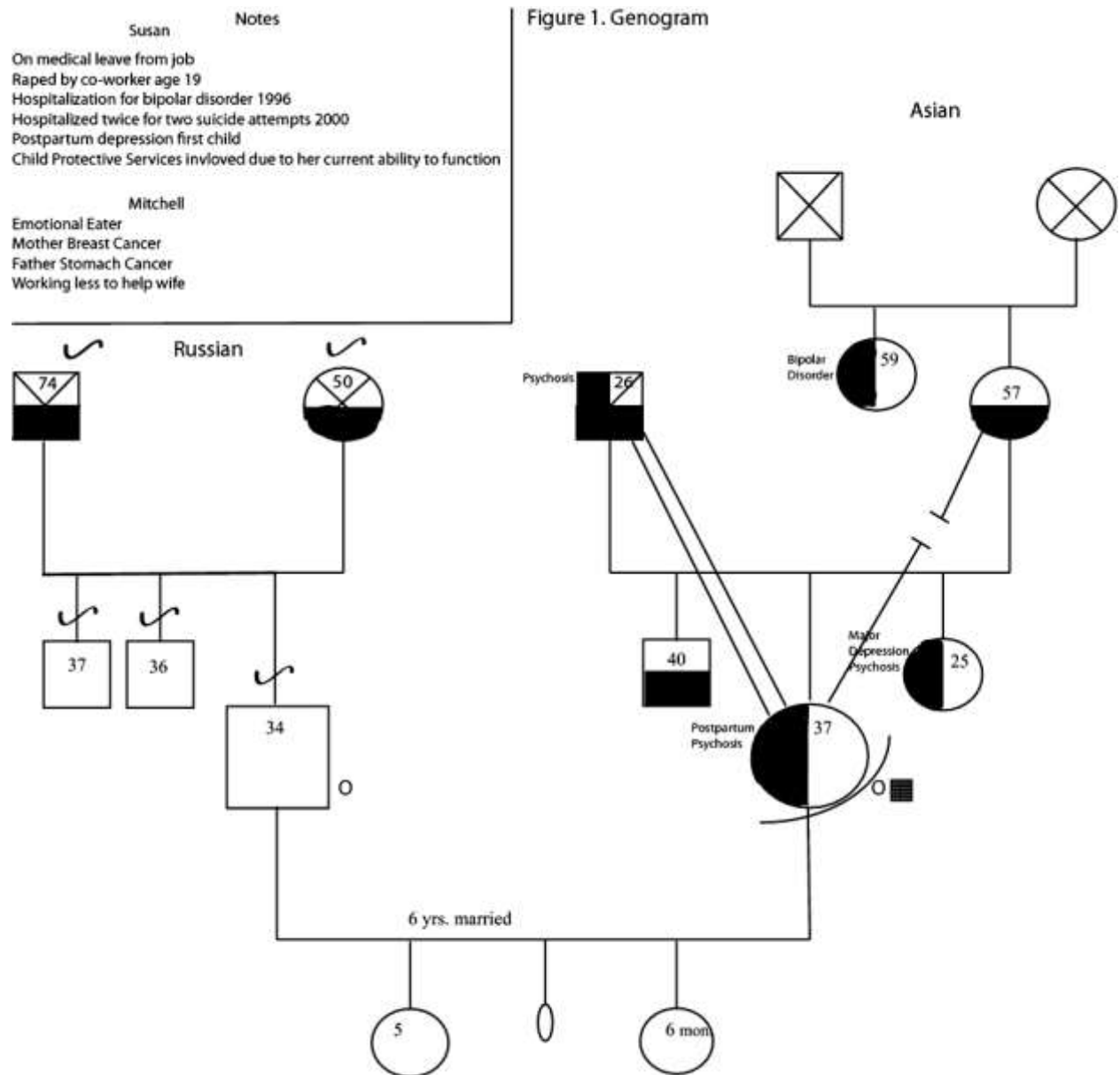
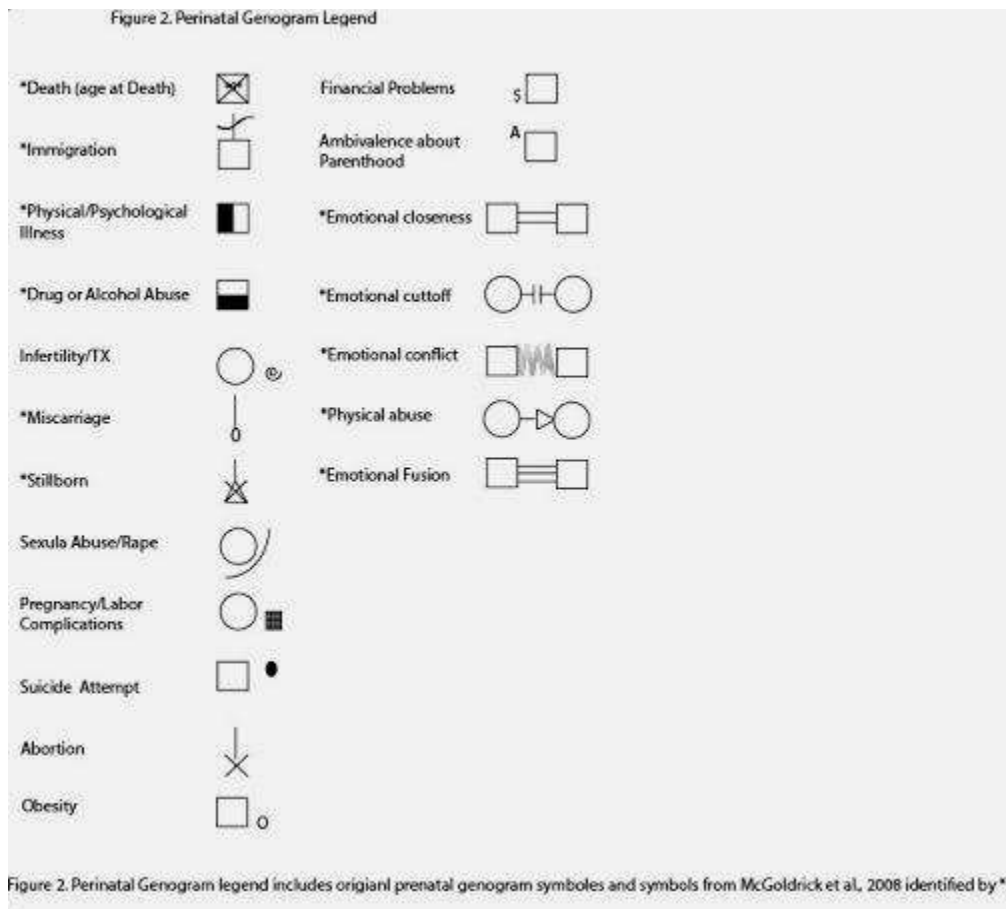


Figure 1. Perinatal Genogram for assessment and treatment of Susan's diagnosis of postpartum psychosis.

McGoldrick's early book on genograms (1985) created the foundation for the number of different symbols that are still standardly used to create a diagrammatic family history. Since then, McGoldrick and others have continued to revise and enhance the kinds of symbols that are incorporated because of an understanding that the genogram is an evolving tool for understanding and mapping out family systems. Because there are certain factors that increase vulnerability to perinatal mood and anxiety disorders, i.e. family history, other psychiatric history, trauma, and infertility, the authors of this paper have added some new symbols that give meaning to the unique experience of perinatal mood disorders. Figure one is the genogram created with Susan and Mitchell, when they entered therapy because of Susan's recent diagnosis of postpartum psychosis. Figure two is the genogram ledger specifying the symbols needed for the perinatal genogram.



## Conclusion

As many as one million women each year will suffer a perinatal mood or anxiety disorder (Beck, 2001). Assessment of risk during pregnancy becomes especially significant in terms of treatment postpartum and even prevention, as does an understanding of the context within which the actual symptoms of illness emerge.

Typically, the identified patient is the new mother, but from a systemic perspective we know that the identified patient's symptoms reflect a deeper and more pervasive family pain. Systems theory also recognizes that symptoms emerge within a biopsychosocial framework and that we cannot really address the symptoms of illness unless we also understand their origin. Observing personal and family patterns is one of the most powerful insights the creation of a genogram can offer. The visual image of a family system brings about opportunities for profound understanding and insight. It is a collaborative and relational process of inquiry between the therapist and the client that serves to acknowledge the richness and/or complexity of their family history at the same time providing the essential functions of normalizing and affirming individual experience. Most importantly, it offers an opportunity for individuals to discuss noticeable patterns of family experience, and in so doing, find different ways of managing family stress or even putting an end to specific generational cycles that have been harmful to overall mental health.

In the case of Susan, using the genogram to trace biopsychosocial patterns helped her understand how her family history had left her vulnerable to perinatal illness. The perinatal genogram created an opportunity for our deeper understanding of the origins of her mood disorder in a compassionate and de-stigmatizing way, gradually becoming an avenue for treatment in addition to its usefulness as a tool for assessment. She was able to identify an extensive family history of serious mood disorders, trauma, and loss that inevitably left her at risk for postpartum psychosis. As a result, she was able to understand that the onset of her perinatal illness was not her fault, that it



was a product of genetic and psychosocial factors that had created her vulnerability to illness. How we give voice to a mother's experience does offer opportunities to remove blame from the mother and focus on the whole process of family functioning.

Creating and exploring the genogram offers both process and content value. The process of creating a genogram lends itself to a deeper level of meaning, as families talk about their history, each other, their current situation and more. Research shows that couples therapy or family therapy may be one of the most appropriate modalities for treating perinatal mood disorders (Blum, 2007; Dennis & Chung-Lee, 2006; Pearlstein et al., 2006). Because genogram construction provides a wealth of information, family patterns are more easily identified. Clarifying a pattern through the process of completing a genogram then offers an opportunity to change that specific pattern.

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