

The Family Life Cycle and Its Implications for Family Practice

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The content of family medicine is based not only on information from many basic and clinical sciences, but also on its own specific body of knowledge and skills, which is the hallmark of every academic discipline. This specific body of knowledge is developing rapidly and includes many new medical concepts which we need to examine in depth in order to apply them to our clinical work. This article will address itself to one of these concepts—the family life cycle—and its implications for family practice.

The family life cycle perspective as a tool in family diagnosis began with Paul Glick, Duvall, and Hill.^{1,2} The essential emphasis is on the changing experience of families over time. For practical purposes, it assumes that families have a beginning and an end and between these two points the family goes through a life span development in which a number of distinct sequential stages or phases may be recognized. In each of these phases a number of specific developmental tasks may be delineated.^{1,3} As families pass through each phase and from one stage to the next, they will go through a number of normal and expected transitions, as well as occasionally an unexpected crisis. These changes during the life cycle provide a perspective that there is a transmission of certain biologic components as well as behavioral and social processes throughout the cycle and from one generation to the next within the family⁴ (Table 1).

The pulse of family life over time is marked by irregular fluctuations on an annual or monthly or even a daily basis. Some families have small fluctuations in their pattern while others vary greatly in a manner which, if it were plotted, might remind us of the irregularity of atrial fibrillation. This fluctuation occurring against a larger background of

periodicity makes up a family developmental pattern which flows from the growing stage of family formation, through the expanding stages of child bearing, child rearing, and child launching, to the contracting periods of the empty nest, widowhood, and termination (Figure 1). This process of family development is highly interrelated with the individual life development of each individual member. Table 2 is an attempt to correlate the individual and family life cycles to age. This sequence of development is based on the nuclear family with all its variations. The nuclear family is an appropriate model because despite changes in life-style, the vast majority (± 80 percent) of the American population still live in intact, nuclear families (Tables 3 and 4). I believe that the principles of the developmental family life cycle approach can, with slight modifications, be applied to almost every type of family structure except perhaps a few "way-out" ones. Despite this universal concept of family life cycle development, each individual family lives out its life cycle in its own unique fashion within the overall pattern.

Many years ago, Shakespeare, in his perceptive and brilliant manner, divided the individual into seven ages of man.⁷ Similarly, the family life cycle has been divided into stages with various authors using different markers and thus numbers of divisions to outline the stages. Sorokin and Kirkpatrick used a 4-stage cycle, Bigelow 7, Duval 8, and Rodgers went to the other extreme of 22. These stages are only a convenient division for study of a process which in real life flows on in a continuous, albeit irregular, fashion.

When I started teaching in a medical school I used a four-stage cycle, but as our knowledge of its application increased and our teaching became more accepted, we subdivided a little more, and presently I favor the scheme shown in Table 5. I have, however, no argument with those who prefer a shorter or longer stage cycle.

In the majority of families, their life cycle

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Table 1. Key Points of Family Life Cycle Concept
1. Changes over time
2. A beginning and an end
3. Family development with sequential stages/phases
4. Phase-specific developmental tasks
5. Normal transitions and unexpected crises
6. Transmission of biologic, behavioral, and social processes

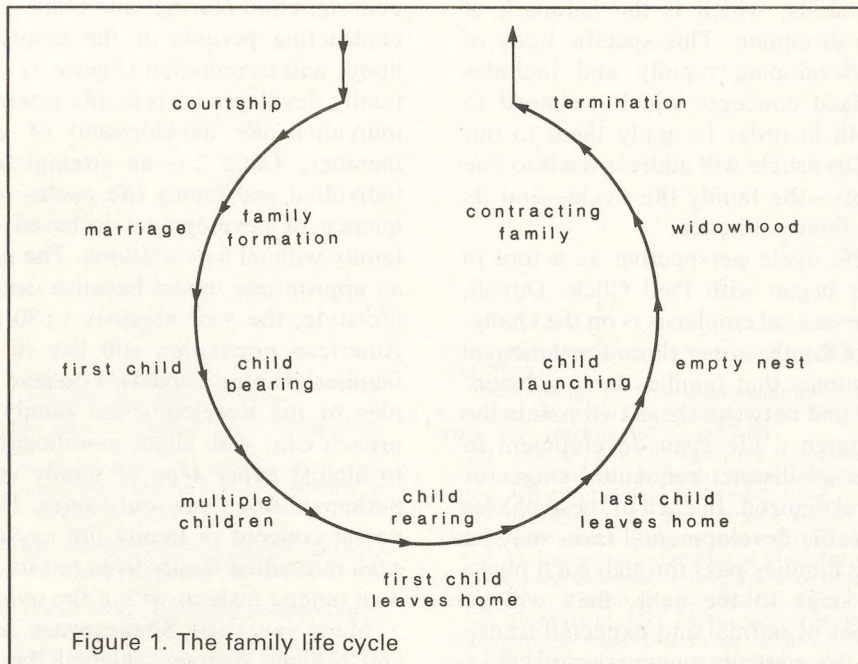


Figure 1. The family life cycle

passes through each stage in succession, but there are many families which do not. For example, an elderly couple (both in their 60s) who marry will be in both the pre and postmarital, as well as middle-age stages, simultaneously. They will then move to late adulthood without the intervening Stages II to IV (Table 5). Another example is divorced people with children who remarry and repeat Stage I while also being in Stage III or IV, and later they go into Stage II (expectant couple). For these examples I would like to give the name of *reconstituted family life cycles*. In other words, the *usual*

family life cycle applies to the majority of families that pass successively through the cycle, whereas the *reconstituted family life cycle* applies to the modifications as mentioned.

A further principle of this developmental family life cycle approach is that during each stage, as well as during the transition from one stage to another, there will be certain events which can be predicted and which the majority of families will experience. These include: marriage, pregnancy, birth, parenthood, beginning school, adolescence, school graduation, leaving for college, starting

Table 2. Relationship of Individual and Family Life Cycle to Age*

Age**	Individual Life Cycle	Tasks	Family Life Cycle
0-1	Infancy Oral	Basic trust vs mistrust	
	Childhood		
2-3	Early: anal	Autonomy vs doubt and shame	
4-5	Middle: preschool	Initiative vs guilt	
6-11	Late: latency	Industry vs inferiority	
	Adolescence		
12-17	Early	Identity vs role confusion	Courting
	Middle		Going steady
18-21	Late: pulling up roots		Marriage: associated couple Pregnancy
	Adulthood		
22-27	Early: leaving family transition	Intimacy vs isolation	
28-39	: the "30" transition : "settling down"		First child Multiple children
		Generativity vs stagnation	First child leaves home First grandchild
40-59	Middle: midlife : the "50" transition	Ego integrity vs despair	
			Last child leaves home Multiple grandchildren
60-69	Late		Couple again: empty nest Widowhood
	Old Age		
70+	Adjustment to death		Termination

*A composite picture based on Freud, Erikson, Levinson, Lidz, Duvall, Gould, Glick, Hill, and others.
**Age groups are approximate as the life cycle stages show a great deal of variation and overlap.

work, empty nest, menopause, retirement, widowhood. These *developmental* events, which can be predicted, may be called *normative (expected) transitions*, which may or may not lead to a crisis situation. On the other hand, there are many unexpected transitions such as sudden severe illness, severe accidents, birth of a baby with a severe congenital abnormality, unexpected failures, rape, murder, and loss of a family member. These are always crises and are variously named *situational or unexpected or accidental crises*.⁸ I prefer the term *unexpected*, with its well-known reaction stages—shock, realization, defensive retreat, acknowledgement, and finally, adaptation or maladaptation.

The last general principle I would like to discuss is that of the *developmental task concept*.¹ This implies the recognition that within each stage or phase of family life cycle development, there are specific developmental tasks which need to be accomplished before the transition to the next cycle. The adequate or inadequate accomplishment of these tasks will determine the nature of the family functioning.

"A *developmental task* is a task which arises at or about a certain period in the life of an individual, successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks."⁹ In

Table 3. Estimated Distribution of Type of Family Structure in the United States⁵

Family Type	% Distribution
Nuclear family	79
With children (44)	
Dyad without children (15)	
Remarried nuclear (15)	
Others (5)	
Single parent	13
"Experimental" types	8
Total	100

addition, we may add that developmental tasks differ from culture to culture, from region to region, and from socioeconomic class to class. Finally, the developmental task also implies the assumption of responsibility for accomplishment on the part of the person.

This developmental task concept gives rise to certain principles which may be listed as follows:

1. At each stage of the life cycle everybody faces responsibilities and adjustments of maturation.

2. The developmental tasks of any given period must be accomplished before going on to the next level of maturation. (If the tasks are not accomplished, the person/family is at a disadvantage at all subsequent levels.)

3. Very few developmental tasks can be mastered in isolation, but are always influenced by the family, the subculture, and society.

4. No one else can accomplish these tasks for the individual.

5. A parent, physician, or other "provider" who assists an individual/family in these tasks is promoting individual and family development.

Each stage in the family life cycle has its developmental phases, tasks, transitions, and crises, ie, its own physiology, pathology, and behavioral characteristics.

Let me now try to highlight a few of these characteristics which have clinical implications for two stages of the life cycle. For this purpose let us examine the *expectant couple* period and *middle-age* period.

The Expectant Couple (Stage II of Family Life Cycle)

This important stage is marked by developmental crises which are involved in intimacy patterns between the couple and those inherent in bearing children, which Erikson¹⁰ calls "generativity."^{*} The mutual adjustment of the couple is a continuation of the processes started in the previous stage. Over and above the understanding of these adjustment processes, we need to have the knowledge of the physiologic and pathologic changes that occur in the woman during pregnancy. These changes in her body systems, nutrition, libido, emotions, as well as common complaints, disorders, and life threatening conditions, are well known to family physicians.

I would, however, like to emphasize *the husband* and *the expectant couple*. Some years ago while practicing in a rural area, some husbands of pregnant women under my care asked me to meet with them and explain "pregnancy changes." Instead of a small group, over 50 assorted males came to the evening meeting, and the nature of their questions (some curious, some anxious) influenced me to change my practice routine. Subsequently, I urged every pregnant woman to try to bring her husband with her when she came for her periodic check-ups. These joint sessions became one of the most satisfying aspects of my busy practice. In addition, I urged the husbands to come in for a complete check-up during the time that their wives were pregnant. This allowed us time for discussion as well as examination, and the points I shall mention were the result of these contacts.

The physiologic changes and health status of males during their wives' pregnancies have not, to my knowledge, been studied scientifically; but my clinical experience has convinced me that this is an important element in the successful outcome of this stage of the family life cycle.

The husband's reactions and health status are influenced by a number of factors: his past life experience; his motivation for marriage; adaptation to his new roles; knowledge and understanding of his wife's changes and reactions; the sup-

^{*}Note: In some places in the United States, one in four or five females who get married is already pregnant or has had one or more babies. In this family life cycle concept, the time of the legal marriage, however, does not alter the life cycle concept, even though it may affect the couple's relationship.

	Families No. in thousands	%	White	Black
Total	55,712	100.0	100%	100%
Husband-wife families	46,971	84.3	86.9	60.9
Families with male head	1,499	2.7	2.6	3.8
Families with female head	7,242	13.0	10.5	35.3

port he receives from his wife; his family of orientation and peers. An additional important point is, whether he wanted the pregnancy at that time. We have all experienced couples in which he wanted the pregnancy and she did not; where she wanted it and he did not; as well as those where both rejected, or in the majority of cases, both desired the pregnancy. The ease of management was, of course, clearly related to this last point.

Some of the variations in the husband's metabolism that I have noticed are related to: sleep patterns, appetite, blood pressure, libido, bowel habits, and emotional variability. Thus, some of the common problems encountered were: congestion of the testes (easy cure); tension headaches; early morning waking; epigastric pain; tiredness; anxiety; elation; rise in blood pressure (which, except in one instance, reverted to acceptable levels after the birth), and changes in frequency of sexual demands. In addition, other conditions recurred, or were aggravated and occasionally helped during this stage, eg, asthma, psoriasis, alcoholism, and emotional instability. Occasionally the changes in the husband (eg, rise in blood pressure) occurred at the same time as his wife's, but sometimes they differed in their timing.

The management of the couple was thus very much related to both the wife's and husband's state of health as well as their complementary or conflicting relationships. This management was complicated further if an unexpected crisis occurred, whether it was the discovery in the woman of diabetes or hemorrhage, or the misfortune of the husband, eg, accident, loss of job; or, of both, when there was a death of a close friend or relative.

One further point is important. When we encourage our pregnant patients to reduce or

I. Pre and postmarital
II. The expectant couple
III. The first child
IV. Multiple children and early adulthood
A. Without adolescents present
B. With adolescents
V. Middle age (adulthood)
VI. Late adulthood
Old age
VII. Widowhood
Termination (death and dying)

cease smoking,^{11,12} account must be taken of the husband's smoking habits. If she ceases and he does not, studies indicate that she probably inhales a great deal as a "passive smoker/inhaler" with similar deleterious effects on the fetus.

This approach by the physician to the expectant couple is often an important added factor in their "support system"¹³ which improves pregnancy outcome figures.¹⁴

The Middle-Age Period: The Contracting Family (Stage V)

Grow Old along with me!

The best is yet to be,

The last of life, for which the first was made. . .

Robert Browning

This is the period when child launching is com-

Age No. Examinations	40-44 (3,307)	50-54 (2,176)	60+ (961)
Variables			
Weight/height ²	2.59	2.60	2.55
Hand-strength	43	40	35 (kg)
Vital capacity	93.8	92.6	90.1%
Systolic blood pressure	129	137	149 mmHg
Diastolic blood pressure	81	85	87 mmHg
Total serum cholesterol	294	213	215 mg/100 ml
Casual glucose	86	90	95 mg/100 ml
Total calories	2,907	2,666	2,435 per day
Total fat	97	88	77 gm/day
Total carbohydrates	396	362	331 gm/day
Total proteins	110	103	98 gm/day

pleted, ie, the last child leaves home and the nuclear family is contracting in the sense that the parents are left alone. This stage is often called the "empty-nest" period, but the connotation that it is an empty or negative period is not always true.¹⁵ On the contrary, many couples feel that it is a "second honeymoon" and others that it is the "age of fulfillment" as suggested in the above quotation from Browning. This stage spans about 20 years and lasts until approximately the age of retirement of one or both partners. It is during this stage that the important transitions of the menopause and the "midlife (50) crisis" occur.^{16,17}

It is important to note that in extended families and some other extended kin networks, there is never really an "empty-nest" because the parent or parents are not left alone even if their own children leave.¹⁸ It is interesting to speculate if the menopause and midlife crises are easier to adjust to in these extended families.

Lidz¹⁵ believes that middle age is a stage of the mind when "there is an awareness that the peak years of life are passing." The body is slowing down and it is time for stock taking and evaluation. What one wished to become (expectations, hopes, and wishes) is weighed against what one has become (reality), and one wonders if the imbalance will ever be rectified.

The *developmental tasks* of this stage may be summarized:

1. Adjusting to the body's physical and physiological changes
2. Adjusting to the reality of the work situation
3. Helping children leave home and become responsible adults
4. Maintaining contact with children and grandchildren
5. Reorganizing own living arrangements
6. Readjusting to being a couple again
7. Assuring own economic security for old age
8. Maintaining and even increasing participation in community life
9. Assuring adequate and satisfactory medical supervision for old age
10. Making adequate living arrangements for own parents (some couples, even at this age, have this responsibility).

It is extremely important for family physicians to understand the physiologic changes that occur during this period of life, in order to clear up misunderstandings and help middle-aged people adjust to the reality of the changes. During our long-term study of 10,000 men, we were able to record the changes that occurred in some biologic and behavioral characteristics¹⁹ and these are depicted in Tables 6 and 7. Based on the literature^{20,21} and our clinical experience, the sexual changes that occur are presented in Table 8.

Emotional and social changes play an important role in middle-age, and it is said that although per-

Table 7. Changes During Middle Age

Decrease in:
 Sleep
 Sexual activity
 Physical activity
 Smoking
 Visual acuity
 Hearing acuity

Increase in:
 Sensitivity to drugs

Table 8. Middle-Age Sexual Changes

Diminution in size of organs
 Increase in fibrotic tissue
 Decrease in secretion of sex hormones

Male
 Erection takes longer
 Orgasm slower in coming
 Ejaculation less forceful
 Libido—great variation

Female
 Most inhibitions overcome
 Orgasm—? less forceful
 more regular
 Libido—great variation

Intercourse
 Routine/unexciting
 or
 More satisfying
 than before

sonality is continuous over time, at this stage of the life cycle, central characteristics become more clearly delineated and perhaps inflexible, while cherished values become even more salient.²² To account for these personality changes, Cumming and Henry²³ proposed the “*disengagement theory*” (Table 9). Briefly stated, the circle of friends becomes more and more constricted and limited. Most workers in the field agree with the process of disengagement, but few believe it is either inevitable or desirable. Figure 2 shows a spectrum or scale of Erikson’s middle-age development with generativity at one end and self-absorption or disengagement at the other.¹⁰ An interesting clinical feature which is not rarely seen is the difference between the partners in a middle-aged couple. Very often the females have become more self-confident, more expansive, and more talkative than previously; while the males have tended to move toward the other end of the scale and have become quieter and perhaps more self-absorbed.

As a number of studies have shown,²⁴ there is a high correlation between the quality of their relationship, from complementarity to conflict, and their satisfaction with their lives (Table 10).

Table 11 shows the realities of the occupational sphere for the middle-aged male and, more and more these days, the female also.

All the previously mentioned points are potential areas for stress, conflict, maladjustment, and crisis. An important factor in the maintaining of the homeostasis and health of the couple is the quality of their relationship and therefore the mutual “support” they receive from each other. If the intrafamilial support is inadequate or totally

Table 9. The Disengagement Theory

1. Alteration in perception of *time*
 - is running out
 - definite end point
2. Constriction of *ego boundaries*
 - outer→inner orientation
 - decrease of social contacts

lacking, a substitute support system might be other relatives, friends, religious ministers, or the personal physician/health care team. The absence of a meaningful support system has been shown to affect the individual and the couple’s health status. One example of this is the effect of husbands’ perception of their wives’ support or lack of it, as related to the subsequent development in the next five years, of angina pectoris in the male (Table 12). With support, the high-risk group had a considerably reduced incidence of angina pectoris. This support, it must be emphasized, was per-

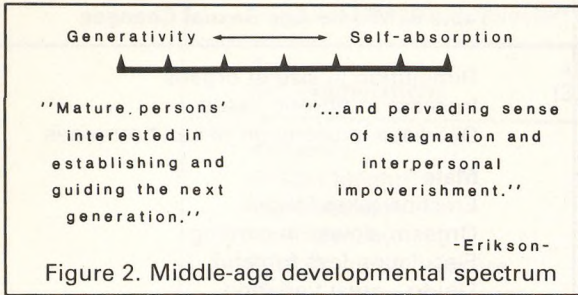


Table 10. Correlation in Middle-Aged Couples Between Type of Relationship and Satisfaction with Their Family Lives²²

Relationship	Satisfaction
Complementary	High (<15%)
Parallel	Medium (55-65)
Conflict	Low (30)
a. stay together b. separate or divorce	

ceived when the males were free of symptoms and the angina developed in the five years following their declaration of "wife support."²⁵ It is also well known that with support, a crisis can often be weathered and the couple emerge from it with a strengthened relationship.

A feature of the common morbidity and mortality lists of this stage²² of the life cycle is the rise in incidence of chronic diseases (Table 13). In regard to chronic diseases, there is one clinical point and a number of epidemiologic principles that are worth emphasizing. The clinical point is that in the management of patients with chronic diseases, we must never forget to support the "caretaker" (usually the spouse) who often develops covert diseases while caring for the primary patient. In this situation, the caretaker often becomes what I call the "hidden patient"²⁶ who shocks us occasionally by hemorrhaging from an ulcer, developing hypertension, or (as did one patient of mine many years ago) committing suicide.

Implications for Family Practice

The obvious clinical implications of the foregoing can be summarized briefly.

1. A data system based on families is needed, in which the family information must include at least a family tree, household census, and family problem list.
2. Analysis is useful of morbidity, mortality, and hospitalization figures on the basis of stage of family life cycle as well as age, sex, and race.

There have been questions of whether the family life cycle approach is better than the age approach.³ While I feel that both the age and family life cycle approaches should be integrated, the fol-

Table 11. Middle-Age Occupational Spectrum

Reached(ing) the top
Working, but will never reach top or expectations
Adjusting to new occupation
No work, no hope, welfare

lowing is an example where I think the family life cycle and age is superior to the "age only" approach.

Example: In our departmental practices, we have had three female teenagers, aged 17-19 years, who developed insulin dependent diabetes mellitus.

- The first one lives at home and is the middle of three children (multiple children stage)
- The second lives alone in an apartment in Cleveland and works and studies half-time. Her family lives in Boston (early adulthood, trying to become independent)
- The third lives with a man (associated couple) and is pregnant (family formation stage)

The adequate management of these similarly aged diabetic patients will be very different in each case.

3. The family life concept is also relevant to acute care of patients, including crisis situations (see previous example); to patients with chronic diseases or conditions; and in preventive and promotive aspects of our work.

The use of the developmental family life cycle

Table 12. The Effect of the Wife's Support on Adult Males at High Risk for Developing Angina Pectoris in the Subsequent Five Years²⁵

Level of Wife's Love and Support	Number of Subjects at Risk	Angina Pectoris Incidence Rate/1,000
None	183	93
Slight	150	73
Moderate	242	45
High	637	52

.01 < P < .05

approach is perhaps best illustrated in the "well" or "health" examinations. In a recent seminar with our new residents on the subject of *periodic health examinations*, it was felt that the *objectives* should be:

1. To establish *mutual understanding, trust and rapport* with the patient and his/her family.

2. To collect *data base information* on each *individual and the whole family*. This should allow us to:

- A. do specific prevention, eg, immunizations,
- B. detect abnormalities, disease, major problems and high-risk patients, in order to:
 - prevent complications and disability
 - treat specific findings
 - attempt to alter habits and life-styles which contribute to high risk of diseases, eg, smoking, overeating, lack of exercise
 - attempt to reduce or prevent transmission of deleterious processes and diseases within the family, or to reinforce those processes that are positive
 - discuss and try to help them find solutions for their major problems.

3. To provide *anticipatory guidance* based on present and future stages of the *individual and family life cycle development*, with their predictable stresses and potential crises. This is probably one of the most important applications of the family life cycle concept, and will become one of the major factors which will differentiate health examinations performed by family physicians from those by other types of physicians.

4. To detect and define *health attributes and strengths* in the family, and their *coping patterns and support systems*.²⁷

Table 13. Common Conditions During Middle-Age Period

Morbidity
Respiratory infections
Well-health examinations
Chronic diseases
Primary emotional and familial disorders
Miscellaneous: eg, undifferentiated musculoskeletal social adjustment
Mortality
Cardiovascular, including hypertension
Carcinoma
Cerebrovascular
Accidents and trauma
Chronic obstructive lung disease (COLD)

5. To accomplish all of the above objectives in order to make a *family diagnosis, problem list, and management plan*.

(Note that screening procedures for specific diseases play an important but not dominant part in the above scheme.)

The methodology by which this is carried out *over time* includes: individual examinations, an interview and discussion with the parents and/or other key members of the family, probably a home visit, and, after a team meeting, a final summing up with the key members of the family.

The foregoing discussion has *educational implications* for the preparation of family physicians in

that their basic knowledge should include: clinical knowledge and skills; behavioral sciences; growth and development of individual and family; epidemiology of common conditions of life cycle stages; and management skills such as therapeutics, counseling "catalyst," and anticipatory guidance. In addition, it also means that we must extend our expertise of interviewing and counseling individuals to include dyads (eg, husband and wife, mother and child), triads (eg, parents and adolescent), whole families, and other small groups.

These concepts also have *research implications*.

Some hypotheses that come to mind which could be tested are:

- Health and disease conditions can be shown to be significantly different when using the family life cycle as an independent variable.²⁸
- The family life cycle used together with age and sex will prove a better discriminant of abnormal conditions than age and sex alone.
- The support systems of three generational families are better than two generational ones.
- This kind of health examination improves rapport and increases compliance.
- That males and females of the same age group will have less hypertension if they are in the "multiple children" stage than if they are in the "empty-nest" period.

There are also other kinds of research projects. For example, there is the possibility of taking two groups of families matched by size, age, origin, race, and health status and, on one group, carry out health examinations based on the anticipatory guidance of the family life cycle developmental concept, and on the other, carry out health examinations based on screening for pathology only. Then evaluate, over time, the effect of their health status and if many or any of the predicted crises or diseases were prevented or diminished in their deleterious effect.

The above discussion just begins to scratch the surface of the possibilities for applying the family life cycle concepts to clinical work in family practice, especially in the preventive field, but in research as well. It presents family medicine with an interesting and stimulating challenge, and our skills in using the family life cycle concept in preventive work will differentiate family physicians from others.

References

1. Duvall EM: Marriage and Family Development, ed 5. Philadelphia, JB Lippincott, 1977
2. Hill R, Mattessich P: Reconstruction of family development theories: A progress report. Presented at the Annual Meeting of the National Council on Family Relations, Theory Development and Methodology Workshop, San Diego, October 1977
3. Worby CM: The family life cycle: An orienting concept for the family practice specialist. *J Med Educ* 46:198, 1971
4. Medalie JH: Family Medicine: Principles and Applications. Baltimore, Williams and Wilkins, 1978, pp 67-108
5. Cogswell BE, Sussman MB: Changing family and marriage forms: Complications for human service systems. *Fam Coordinator* 21:505, 1972
6. Household and family characteristics. In Bureau of Census (Suitland, Md): Population Reports, No. 291. Government Printing Office, 1976
7. Shakespeare W: As You Like It, Act 2, scene 7
8. Gartner RB, Fulmer RH, Weinschel M, et al: The family life cycle: Developmental crisis and their structural impact on families in a community mental health center. *Fam Process* 17:47, 1978
9. Havighurst RJ: Human Development and Education. New York, Longmans, Green, 1953
10. Erikson EH: Childhood and Society. New York, WW Norton, 1963, pp 219-234
11. Rush D, Kass EH: Maternal smoking: A reassessment of the association with perinatal mortality. *Am J Epidemiol* 96:183, 1972
12. Butler NR, Goldstein H: Smoking in pregnancy and subsequent child development. *Br Med J* 4:573, 1973
13. Caplan G: Emotional implications of pregnancy and influence on family relationships. In Stuart HC, Prugh DG (eds): *The Healthy Child*. Cambridge, Mass, Harvard University Press, 1960, pp 72-81
14. Nuckolls KB, Cassel J, Kaplan BH: Psychosocial asset, life crisis and the prognosis of pregnancy. *Am J Epidemiol* 95:431, 1972
15. Lidz T: *The Person*, ed 4. New York, Basic Books, 1968, p 457
16. Gould R: The phases of adult life: A study in developmental psychology. *Am J Psychiatry* 129:5, 1972
17. Levinson DJ, Darrow CN, Klein EB, et al: *The Seasons of a Man's Life*. New York, Alfred A Knopf, 1978, p 191
18. Stack CB: *All Our Kin: Strategies for Survival in a Black Community*. New York, Harper and Row, 1974, pp 90-95
19. Medalie JH, Kahn HA, Neufeld HN, et al: *Physicians Fact Book*. Jerusalem, Israel Ischemic Heart Disease Project, 1968
20. Masters WH, Johnson VE: *Human Sexual Response*. Boston, Little, Brown, 1966
21. McCary JL: Sexual advantages of middle-aged men. *Med Aspects Hum Sexual* 7:138, 1973
22. Medalie JH: Family Medicine: Principles and Applications. Baltimore, Williams and Wilkins, 1978, pp 171-201
23. Cumming E, Henry WE: *Growing Old*. New York, Basic Books, 1961
24. Neugarten BL, Guttman DL: Age-sex roles and personality in middle-age: A thematic apperception study. *Psychol Mono* 72: 17, 1958
25. Medalie JH, Goldbourt U: Angina pectoris among 10,000 men: Part 2: Psychosocial and other risk factors as evidenced by a multivariate analysis of a five year incidence study. *Am J Med* 60:910, 1976
26. Medalie JH: The hidden patient. Presented at Quail Hollow Conference, Case Western Reserve University School of Medicine, Cleveland, November 1975
27. Kaplan BH, Cassel JC, Gore S: Social support and health. *Med Care* 15 (suppl 5): 47, 1977
28. Lansing JB, Kish L: Family life cycle as an independent variable. *Am Sociol Rev* 22:512, 1957