# The Cycle of Family Function: A Conceptual Model for Family Medicine

Gabriel Smilkstein, MD
Seattle, Washington

Information gained from family studies requires integration in the educational matrix of family medicine. To facilitate this activity a model that synthesizes major theories and definitions is presented. This paper describes a conceptual model that includes components that have been identified as basic to the recognition and understanding of the family in trouble. It is proposed that knowledge of family function as represented in the model, the Cycle of Family Function, will, in turn, help the physician assess and manage problems presented by patients who are victims of stress related to family problems.

Assessment and management of family dysfunction is an area of study that has been ascendent during the past decade.[1-7] In family medicine the aim has been to use these studies to develop a body of knowledge that will allow physicians to approach the patient's family problems with the same competency they apply to biomedical problems.[8-16] To facilitate the utilization of knowledge from family studies, a model is needed that demonstrates the interrelationship of components that are critical to an understanding of the family in trouble.

The Cycle of Family Function is a conceptual framework that presents an empirical view of the responses that may result when a family experiences a stressful life event. It offers the student, resident physician, and family physician a common language with which to discuss family function, as well as a format that addresses the data base needed to assess and care for the family in trouble.

From the Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington. Requests for reprints should be addressed to Dr. Gabriel Smilkstein, Department of Family Medicine RF-30, School of Medicine, University of Washington, Seattle, WA 98195.

## Definition of Terms

An agreement on the meaning of family is essential for any discussion about this biopsychosocial unit. A review of the literature of various scientific disciplines reveals that each has interpreted the family to meet its own needs (Table 1).

The physician also requires a definition of family that is discipline specific, ie, a definition that clarifies structure and function of the family which is intimately associated with the patient whose problem is under study.

Biomedical problems, such as genetic abnormalities, are best understood by establishing a structural definition of the family (Table 2). In order to study psychosocial issues, however, the physician requires a definition of family that permits an understanding of family function as perceived by the patient (Table 3). The study of the biomedical and psychosocial problems of the patient within the context of the family requires, therefore, that both structural and functional components be included in the definition of family.

The definition of family that applies to the conceptual model described in this paper is as follows: the family is a basic societal unit in which members have a commitment to nurture each other emotionally and physically. The commitment is usually one to share resources such as time, space,

0094-3509/80/080223-10$02.50

**Table 1. Framework of Family Definitions Drawn from the Disciplines of Anthropology, Sociology, and Psychology**

| | |
|---|---|
| Institutional: | Focuses on the origin and evolution of the family institution with comparisons over space and time of its relationships to different societies and cultures [17] |
| Structural/ Functional: | Defines family by the relationships of its members to each other and existing social systems. Concentrates on how family systems are organized and operate [18] |
| Developmental: | Views of the family as a recognizable social institution consisting of interacting personalities, changing through time. It focuses attention on the longitudinal career of the family and its life-cycle [19] |

**Table 2. Structural Definitions of Family**

| | |
|---|---|
| Family of Orientation: | The nuclear family in which a person has had the status of child[20] |
| Family of Procreation: | The nuclear family in which a person has or had the status of parent[20] |
| Extended Family: | Any grouping whose members are related by descent, marriage, or adoption; broader than the nuclear family[20] |
| Joint Family: | Various groups of nuclear families, usually related biologically, who share property rights[20] |
| Polygamous Family: | Two or more nuclear families affiliated by plural marriage (eg, one man and two women and progeny)[21] |

and finances, and is made between two or more adults with or without children, and single adults with children. Family members usually function in a setting where there is a sense of home.

An understanding of the family in trouble requires that a definition be established for the family in health. A family in health is one whose members perceive it as cohesive and offering the nurturement and resources that are necessary for personal growth and sustenance in the face of life's challenges.

Terms used in the Cycle of Family Function are defined in Table 4. These definitions represent an empirical synthesis of concepts from the writings of medical and social scientists who have contributed to the study of the family. Students and practicing physicians must have an understanding of the vocabulary that is basic to the study of family function. A common language will encourage exchange that will enhance the growth and refinement of the family physician's ability to assess and manage the family in trouble.

**Table 3. Family Definitions Dependent upon Roles of Members**

| | |
|---|---|
| Family: | Any socially sanctioned relationship between nonsanguinely related, cohabitating adults of opposite sex, with or without children, which satisfies felt needs, mutual, symmetrical, or complimentary[22] |
| | Any cohabitating domestic relationship which is or has been sexually consequential, ie, resulting in gratification of partners or in reproduction[23] |
| Cohabitation: | A heterosexual couple without a legal contract who consistently share a living facility[24] |
| Commune: | A relationship of individuals who agree to make life commitments as members of one particular group rather than through many different groups[25] |
| Group Marriage: | A multilateral marriage in which each of three or more people considers himself or herself to have a primary relationship with at least two other individuals in the group[26] |

## Family Resources

The Cycle of Family Function (Figure 1) is a model that reflects the manner in which family member interaction ebbs and flows in response to the impact of life events. The impact of a stressful life event on a family in health will serve as a starting point in the study of the conceptual model of the Cycle of Family Function.

A nurturing family maintains equilibrium by utilizing its intrinsic resources on a day-to-day basis to meet the needs of its members. Stressful life events, however, induce a measure of disequilibrium that requires a special coping response on the part of family members. At these times family resources are put to the test. The major family resources are social, cultural, religious, economic, educational, environmental, and technological (eg, medical). These resources are considered effective in a family when the following conditions are met:

- Social interaction and communication are evident among family members. Family members also have well-balanced lines of communication to extrafamilial groups such as friends, sport groups, clubs, and other community organizations.
- Cultural pride or satisfaction can be identified, especially in distinct ethnic groups.
- Religion offers satisfying spiritual experiences as well as contacts with a likeminded extrafamilial support group.
- Economic stability is sufficient to provide both reasonable satisfaction with financial status and an ability to meet the economic demands of usual life events.
- Education of family members is adequate to allow members to solve or comprehend most of the problems that arise within the format of their lifestyle.
- Environmental conditions are such that the family is favored by clean air and water, and space to satisfy its needs for work, play, and home life.
- Technical resources, in this case medical care, are available through channels that are easily established and have previously been experienced satisfactorily.

### *Case Illustration 1*

Mrs. M., a 58-year-old married woman with four children, was informed she had breast cancer. Her husband of 30 years, who accompanied the patient to the physician's office for the biopsy report, was visibly upset by the news. He regained

**Table 4. Definition of Terms Used in the Cycle of Family Function**

| | |
|---|---|
| Equilibrium: | A state of family homeostasis in which member interaction results in emotional and physical nurturement, thus promoting growth of family members and the family unit[27-30] |
| Stressful Life Events: | A life experience that requires the family's use of resources for coping or adapting not usually required by the family members for the management of daily activities[31-36] |
| Crisis: | A state of family disequilibrium that results from failure to identify resources adequate to allow family members to cope with a stressful life event[37-42] |
| Disequilibrium: | A state of impaired functioning, nurturing, or role complimentarity in which a family, for the time being, can neither escape nor solve problems with their customary problem solving resources[30, 43-46] |
| Resources: | Those assets that serve the process of family nurturing and fall in the general categories of familial and extrafamilial social, cultural, religious, economic, educational, environmental, and medical support systems[4-5, 38, 47-50] |
| Adaptation: | The process by which family members utilize their resources to effect a resolution of a stressful life event and return to nurturing family function or equilibrium[51-53] |
| Maladaptation: | The process by which a family in crisis or disequilibrium chooses abnormal defense mechanisms to achieve some measure of equilibrium in family function[54-62] |
| Pathological Equilibrium: | A state of impaired interaction or nurturing within a family that follows the utilization of abnormal defense mechanisms to escape from anxiety of unresolved family crisis. Families in patholgical equilibrium may have members who are so isolated from their fellow members that they cannot receive help, or individuals who are so adhesive to their family members that independent function is paralyzed[3, 29, 38, 43, 44] |

his composure and listened with Mrs. M. to the physician's information on the course of action to be taken. The M.'s had a close family unit, and their long-term residence in the community was associated with a strong social support group of friends and neighbors. After her surgery Mrs. M. received some comfort from her friends and her husband; however, it was her children who

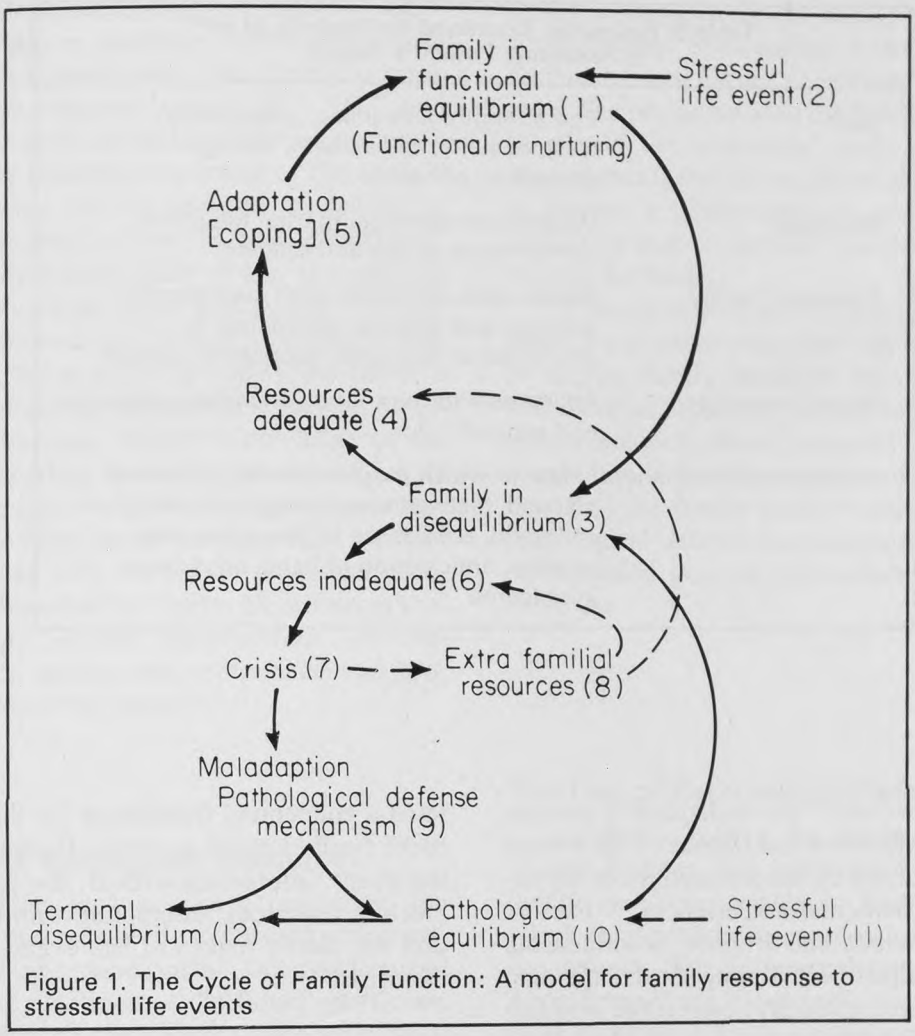


Figure 1. The Cycle of Family Function: A model for family response to stressful life events

seemed to understand her situation best. Mr. M. adjusted his work schedule so he was able to spend more time with his wife. Mrs. M. eventually became a volunteer in the American Cancer Society's home visiting program for breast cancer patients. Mrs. M. required only limited support from her physician in order to cope with the problem of cancer.

Those families whose resources are adequate and whose coping behavior is appropriate[63] are capable of adaptation, and return to functional equilibrium through the use of such coping behaviors as: sharing points of view, pooling resources, making appropriate role changes, adjusting the routine activities of work, study, and play, tolerating tension and discomfort when required, and appropriately postponing personal activities or desires for the benefit of family members under stress.

## Variation in Response to Stressful Life Events

There is evidence that stressful life events requiring social readjustments may lead to illness and that "the greater the magnitude of life change, the greater the risk of illness. . . ."[34-35] Masuda and Holmes,[36] chief architects of this theory, caution that when relating life changes to illness in individuals, significant variability may be expected. They state that, in general, there is concordance in cross-national and cross-cultural rank ordering of

**Table 5. Resources Examined by Nuckolls et al[49] in Assessing Patient's Assets**

| | |
|---|---|
| Self: | Ego strength, loneliness, adaptability, trust, hostility, self-esteem, crying, perception of health |
| Marriage: | Duration of marriage, marital happiness, concordance of age and religion |
| Extended Family: | Relationship of subject with own parents, siblings, and in-laws; confidence in emotional or economic support, if needed |
| Social Resources: | Adjustment to community, friendship patterns, and support |
| Definition of Pregnancy: | Extent to which pregnancy was desired or planned, feelings about pregnancy and childbirth, confidence in physician, fear of labor, anticipation of baby, confidence in outcome |

life events; however, "the individual's perceptions of the significance and impact of life events are clearly tempered by the uniqueness of his nature and environmental experiences." Factors identified by Masuda and Holmes as influencing the Social Readjustment Rating Scale are age, marital status, sex, ethnicity, education, and frequency of experiences.

The value of relating both psychosocial stresses and resources to outcome in health care was noted by Nuckolls et al[49] in a study of complications of pregnancy. The study revealed that taken alone, neither life stresses, as measured by Life Change Units score,[32,36] nor resources (Table 5) were significantly related to complications of pregnancy. However, when these variables were considered conjointly, women who had experienced major life stresses but had high resource scores had only a third of the complication rate of women with equal values for life stresses but low resource scores.

## Transition into Crisis

Hill,[38] a sociologist who has made seminal contributions to the study of family function, formulated a conceptual framework for the factors that make families prone to crisis. He stated that: "A, the event, interacting with B, the family's crisis-meeting resources, interacting with C, the definition the family makes of the event, produces X, the crisis."

### *Case Illustration 2*

Mrs. B., a 26-year-old married mother of one, called a physician at 2:00 AM to report that her child had a cold and that she did not know what to do. Mrs. B.'s own physician was not available, and the physician on call had had no previous contact with Mrs. B. or her family. The physician on call obtained a data base that revealed symptoms of a mild upper respiratory tract infection. The physician's initial reaction was to berate Mrs. B. for calling at 2:00 AM with a minor problem, but he recognized in Mrs. B.'s voice a heightened measure of anxiety. Based on this observation, he asked Mrs. B. why she had called for a problem that was apparently minor. After some hesitation Mrs. B. replied in tears that she had lost a baby two years before in a crib death, and the baby who

died went to sleep with symptoms of a mild cold.

It is important to recognize that the physician who wishes to understand the family's crisis clearly must investigate factors "A," "B," and "C." Analysis of the stressful life event alone will not adequately facilitate resolution of the crisis.[31] Information must also be obtained on family resources and function, as well as what Kluckholn[47] calls the family's orientation to the stressful life event that induced the crisis. Elucidation of a family's orientation to a crisis is important to the family physician, for it will help clarify the family's explanatory model or sociocultural view of an illness or psychosocial crisis.[53] Knowledge of the patient's explanatory model is valuable to family physicians for it establishes the congruence of the patient's view with that of the physician. Lack of congruence may lead the family physician to attempt to resolve a family crisis with resources that the patient may consider inappropriate. The consequences are usually non-compliance and prolongation of the crisis state.[60-66]

## Families with Inadequate Resources

When families lack adequate resources, the consequence of stressful life events may be crisis. Identification and assessment of psychosocial crisis are vital functions of the family physician, for a family physician is frequently the extrafamilial resource whom family members call upon to assist in resolving a crisis.[67]

### *Case Illustration 3*

Ms. S., a 15-year-old high school student, reported to her mother that she had been having unexplained nausea. A visit to the family physician established that Ms. S. was eight weeks pregnant. It was learned that the patient had been having unprotected intercourse for about six months with a high school boyfriend. The patient's mother's initial reaction was one of disbelief. She also feared her husband's response. The mother admitted that she and her daughter had never discussed sexual matters. In private consultation with Ms. S., the physician established that she was totally unprepared for the sexual experience or its consequences. She decided to have an abortion, a decision shared by her parents at a family conference. The physician used the family conference to: (1) clarify the immediate medical problems; (2) suggest measures that might be taken by the family to prevent a similar episode; and (3) facilitate a discussion that would mute the father's anger and reunite the family.

If a family is seen early in the development of a crisis, the physician may play the role of counselor in helping family members identify familial and extrafamilial resources needed for adaptation and crisis resolution. More frequently, the physician is sought late in the development of family dysfunction, and the family crisis is compounded by the pathological defense mechanisms that have been incorporated into the interaction between family members.

## The Use of Pathological Defenses

In order to relieve the stress and pain of the chaotic feelings that result from a family crisis, family members, unable to find resources with which to appropriately cope, adopt some form of ego defense. Some primary defenses described by Anna Freud[54] are listed in Table 6. Of these, the most common defense mechanisms the physician will identify in patients are somatization and projection.

### *Case Illustration 4*

Ronald, an eight-year-old with asthma, was brought to the family medical center by his mother who complained that her son's asthma was out of control. A review of Ronald's chart revealed that although he had had asthma for six years, his use of the clinic had escalated during the past year. He had missed three to four days of school per week and had appeared in the clinic almost biweekly. A review of his biomedical status failed to reveal any cause for the worsening of this asthma.

A consultation was sought with the clinic physician responsible for family studies. This was done because the resident physician felt that the

**Table 6. Psychological Defense Mechanisms Utilized by Family Members When Resources are Inadequate or Inappropriate for Managing a Family Crisis***

| | |
|---|---|
| Avoidance | Postponing |
| Conversion | Projection |
| Denial | Rationalization |
| Displacement | Repression |
| Identification | Somatization |
| Introjection | Transference |
| Masking | |

*These defense mechanisms may be used at times by highly functional families. In dysfunctional families the duration of use of these defense mechanisms is prolonged and the mechanisms chosen are usually more pathological (eg, denial)

mother was noncompliant. The resident physician reported that each time the mother brought in the child, she said she had stopped Ronald's medication because she thought he was improved. This pattern persisted in spite of the instructions given by the physician to continue base-line medications.

The consultant's psychosocial history revealed that about a year ago the family had moved from one part of the city to another. This necessitated leaving long-time neighbors and friends. About the same time, Ronald's father had started a job that involved many new stresses. Family history revealed that during the past year there had been an increase in minor disagreements which on occasion had erupted into major arguments. Family arguments tended to recede whenever Ronald's asthma worsened. Ronald's father apparently exerted a great deal of pressure on his spouse to be more effective in controlling Ronald's asthma. A review of the family's resources revealed that in their new home they felt quite isolated. They also reported that the family's energies had been depleted as a result of Ronald's chronic illness. (At a later interview it was discovered that Ronald's parents had also been experiencing progressive sexual dysfunction.)

Family counseling was initiated to help the family deal with their unresolved problems including their sexual dysfunction. It was evident that many of the family's problems were being projected onto Ronald as the identified patient. His mother was bringing him to the office, but she was saying, "Look at me."

In general, society approves the use of the physician for the management of somatic complaints. Thus, family members who seek relief from the anxieties of unresolved family crises frequently convert their anxieties into somatic complaints or project their anxieties on a member of the family who becomes the identified patient. Family members who bring their anxieties to a physician in the form of somatic problems are consciously or unconsciously hoping for recognition and resolution of their psychosocial problems.[60-62,67-69]

## Pathological Equilibrium and Terminal Disequilibrium

Pathological equilibrium exists in those families which have accumulated a series of unresolved crises and have incorporated into their family system pathological defense mechanisms that allow some measure of family nurturing to continue even though function is markedly impaired.

Families in pathological equilibrium will not only be marginal in their nurturing but they will usually be symptomatic. The physician may recognize members from families in pathological equilibrium since they will frequently report such symptoms as depression, fighting, scape-goating,

**Table 7. Behavioral Symptoms Seen in Families in "Pathological Equilibrium"***

| | | |
|---|---|---|
| Anger | Depression | Postponing |
| Arguing | Distorting | Running Away |
| Badgering | Evading | Refusing |
| Coercing | Holding Grudges | Scape-Goating |
| Complaining | Isolating | School Failure |
| Defiance | Lying | Silence |
| Demanding | Non-Participation | Withholding |
| Delinquency | Ordering | |

*These symptoms may be found at times in highly functional families. In families in pathological equilibrium, the duration and severity of the symptoms are markedly accentuated and prolonged

criticizing, or arguing (Table 7). Although treatment of symptoms may be appropriate to ease the pain that such behavior generates, it should be recognized that the symptoms reflect the family's pathological equilibrium, and therapy, if desired by the family or family member, should be directed at the cause. If therapy is desired, the physician should facilitate the identification of the stressful life events, resource deficiencies, and coping styles that triggered the dysfunctional process. The physician who has identified the etiology of a family's problems will be in the best position to assist the family in improving its level of function.

For some families, the Cycle of Family Function is ever downward. Failure to resolve crises, the discomfort of living with pathological defense mechanisms, and the poor nurturing environment of a family in pathological equilibrium, all serve to lead some families into terminal disequilibrium. In this state, nurturing functions are not discernible and family dissolution frequently occurs. Not all families can or should be saved, but it is hoped that a decision for termination is made after a meaningful assessment of the family's problems and potential for improved function.

## Summary

In this paper a conceptual model is presented that identifies the changes that may occur in family function as a consequence of stressful life events. The model demonstrates how, following a stressful life event, the outcomes of family function are influenced by family resources, coping behavior, extrafamilial resources, and defense mechanisms.

The integrated view that is featured in the Cycle of Family Function will serve to clarify the assessment and management of family function for the student, teacher, and practicing physician.

### References

1. Crawford CO: The family and health: A paradigm for analysis of interface dynamics. In Crawford CO (ed): Health and the Family. New York, Macmillan, 1971, pp 113-125

2. Bauman MH, Grace NT: Family process and family practice. J Fam Pract 1(2):24, 1974; also 4:1135, 1977

3. Minuchin S: Families and Family Therapy. Cambridge, Mass, Commonwealth Fund, Harvard University Press, 1974

4. Pratt L: Family Structure and Effective Health Behavior: The Energized Family. Boston, Houghton Mifflin, 1976

5. Smilkstein G: The family APGAR: A proposal for a family function test and its use by physicians. J Fam Pract 6:1231, 1978

6. Schmidt DD: The family as the unit of medical care. J Fam Pract 7:303, 1978

7. Good MJDV, Smilkstein G, Good BH, et al: The family APGAR index: A study of construct validity. J Fam Pract 8:577, 1979

8. Cowan DL, Sbarbaro JA: Family-centered health care: A viable reality? Med Care 10:164, 1972

9. McWhinney IR: An approach to the integration of behavioral science and clinical medicine. N Engl J Med 287:384, 1972

10. Carmichael LP: The family in medicine, process or entity? J Fam Pract 3:562, 1976

11. Curry HB: The family as our patient. J Fam Pract 4:757, 1977

12. Geyman JP: The family as the object of care in fam-