(2th ed) Text Book of Family practice

12

Assessment of Family Function

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Generations of physicians have recorded family histories in their office and hospital charts. Yet, when these charts are examined, their data are, in general, biomedical and descriptive of the structure of the family—that is, a listing of members of the patient's nuclear and extended family, and the diseases they have had that may give genetic or environmental information that pertains to the patient's health. Few family histories describe the functional relationship between family members and the patient.

Before the family physician embarks on assessment of family function, the question must be asked: Is the quality of interactional relationships between and among family members a factor in the patient's health status? Based on studies that date from 1945 when Richardson published his classic book, *Patients Have Families,* the answer is yes.[1] Richardson's longitudinal studies of families revealed close correlation between medical problems and family member conflicts. Dunbar, who coined the term psychosomatic, gave clarification to the disease states that may result from emotionally traumatic experiences, including those traumatic experiences that result from interactional conflict between family members.[2]

Other examples of studies that highlight the relationship between family function and the health of family members include those of Meyer and Haggerty,[3] Medalie and Goldbourt,[4] and Pratt.[5] The frequency and significance of family dysfunction in the presence of streptococcal infections was shown by Meyer and Haggerty. Studies by Medalie and Goldbourt demonstrated the influence of family member interaction on coronary artery disease morbidity and mortality. In a book entitled, *Family Structure and Effective Health Behavior,* Pratt showed that "energized" families, or those in a functionally effective state, are capable of a greater measure of self-care, and thus a decreased use of health care facilities compared to dysfunctional families.

That family dysfunction can be assessed in a physician's office has been shown in recent studies with the Family APGAR[6,7] (p. 78). This questionnaire for the assessment of family function has been given at the University of Washington to a series of subjects in a psychiatric outpatient clinic, a family medical center, and within the college community. An example of results from these studies shows that patients at the family medicine clinic who have a record of high clinic utilization (>9 visits per year) have significantly lower (more dysfunctional) Family APGAR scores than those who use the clinic less.

The physician who is capable of detecting and assessing family influences on the patient is in a position to initiate more meaningful management plans.[8] Such plans are directed toward appropriate therapy for the patient's somatic problem and utilization of resources available within the family. In some instances, however, the patient's family may be responsible for the patient's condition. In order to determine whether the family is a resource for the patient or a source of the patient's illness, the family physician requires an understanding of family function that includes a utilitarian format for data gathering, assessment, and planning. If the family is to be a meaningful part of the role played by the family physician, there is a need for a pragmatic schema that permits rapid assessment of family function, and intervention techniques that are within the purview of the busy practitioner.

Understanding Family Function and Assessment

A definition of the family—and of the family in health—is essential to a discussion of the assessment of family function. In many cases, a patient's family, or primary social support system, varies in design from the basic nuclear family. Table 12.1 demonstrates the variety of family lifestyles that are present in the United States today. For this reason, an all-inclusive definition of family is needed to reflect both the structure and the function of the myriad family life-styles that the physician may encounter.

Early definitions of family emphasized such functions as (1) reproduction, (2) sexual role definition, (3) economic cooperation, and (4) socialization of offspring.[9] Such definitions do not have universal application in our more complex industrialized Western society. A definition that focuses on a few universal function traits of families and allows for family structure that may be homosexual, commune, or single-parent is as follows:

> Family is a sociocultural system consisting of an adult and one or more persons, adults or children, in which there is a commitment to nurture members emotionally and physically and to share resources such as time, space, and finances.
>
> The family in health is one whose members perceive it as cohesive and offering the resources and guidance that are necessary for a member's growth and sustenance in the face of life's challenges.

The foregoing definitions should suggest to the family physician that a commitment by family members to cooperate in the process of nurturing is critical to the success of a family. Furthermore, the resources available in a family influence its ability to function effectively. Thus commitment, nurturing activities, and resources are the key items to be assessed by family physicians who wish to understand the interactional relationship in families.

Table 12.1 Composition of US Households in the 1970s (%)

Type of Household	1970	1978
Married couple with no children under 18	30.3	29.9
Married couple with children under 18	40.3	32.4
One parent with child under 18	5.3	7.3
Other (e.g., extended)	5.6	5.3
Alone or shared quarters with nonrelative	18.8	25.1

Adapted from Macklin ED: J Marr Fam 42(4), 1980.

Assessing Family Function in the Face of Stressful Life Events

Before progressing to a pragmatic format for family study that will be applicable in a family physician's practice, a model is needed to present an empiric view of the responses that may result when family members experience a stressful life event. The model, *Cycle of Family Function*[10] (Fig. 12.1), is designed to reflect the pathways that must be explored in assessing these responses. Clarification of the terms used in this model is found in Table 12.2. The model is best studied by following the effect of a stressful life event on a family. A nurturing family maintains equilibrium by utilizing its intrinsic resources on a day-to-day basis to meet the needs of its members (Table 12.3). Stressful life events, however, induce a measure of disequilibrium that requires special coping responses on the

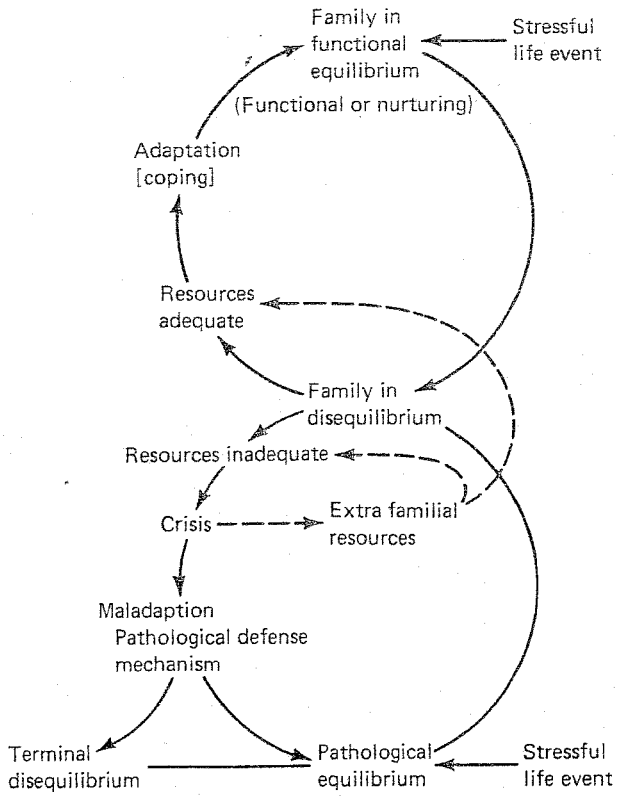

Fig. 12.1. The cycle of family function: a model for family response to stressful life events. From Smilkstein.[10]

Table 12.2 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
Stressful life event:	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 routine activities
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
Disequilibrium:	A state of impaired functioning, nurturing, or role complementarity in which a family, for the time being, can neither escape nor solve problems with their customary problem solving resources
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
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
Maladaptation:	The process by which a family in crisis or disequilibrium chooses abnormal defense mechanisms to achieve some measure of equilibrium in family function
Pathologic 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 pathologic 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

From Smilkstein.[10]

Table 12.3 Adaptive or Coping Behavior in Functional/ Nurturing Families with Adequate Resources

1. Resources pooled
2. Points of view shared
3. Individual growth and change accepted
4. Affection shared
5. Time, space and money shared
6. Listening skills employed
7. Individual family member activities adjusted, postponed, or modified to meet total family needs
8. Role changes accepted (orchestrated)
   Adaptation or coping techniques utilized by family take into account needs of individuals and the family unit
9. Nurturing family rituals experiences are utilized as a supportive and cohesive force
10. Humor is used appropriately as a tension relieving instrument

part of family members. At these times, resources are put to the test.

There are seven basic categories of resources that may be considered essential to family function. These resources are social, cultural, religious, economic, educational, environmental, and medical (or technologic). Family 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, neighbors, and 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 like-minded 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 life-style.

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.

Medical care resources, like other technologic resources, are effective when they are available through channels that are easily established and have previously been experienced satisfactorily.

When experiencing a given stressful life event, the family in health will cope by drawing upon the necessary resources to bring the family into equilibrium again. Hill, a sociologist who has made seminal contributions to the study of family function, formulated a conceptual framework for the factors that participate in this interaction.[11] He stated that: "A (stressful life) 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." It should be recognized that the interaction of A + B + C may also produce resolution of the disequilibrium associated with the stressful life event if the family's resources and coping style are appropriate. Family crisis is a consequence of failure to cope. A failure to cope usually occurs when the magnitude of the stressful life event exceeds the family resources. At these times of crisis, the physician may be consulted as the extrafamilial resource.

It is important to recognize that the physician who wishes to understand the family's crisis must investigate factors "A," "B," and "C." Analysis of the stressful life event alone will not adequately facilitate resolution of the crisis. Information must also be obtained on family resources, as well as what Kluckholn calls the family's orientation to the stressful life event that induced the crisis.[12] 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.[13] 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 noncompliance and prolongation of the crisis state.[14-20]

If a family is seen early in the development of a crisis, the physician may play the role of counselor in helping family members to identify 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 pathologic defense mechanisms that have been incorporated into the interaction between family members.

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 are listed in Table 12.4.[21] Of these, the most common defense mechanisms the physician will identify in patients are somatization and projection.

Pathologic Equilibrium and Terminal Disequilibrium

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

Families in pathologic equilibrium are not only marginal in their nurturing, but usually also symptomatic. The physician may recognize members from families in pathologic equilibrium, since they will frequently report such symptoms as depression, fighting, scapegoating, criticizing, or arguing (Table 12.5). Al-

Table 12.4 Psychologic 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 pathologic (e.g., denial).

From Smilkstein.[10]

Table 12.5 Behavioral Symptoms Seen in Families in "Pathologic Equilibrium"*

Anger	Depression	Postponing
Arguing	Distorting	Running away
Badgering	Evading	Refusing
Coercing	Holding grudges	Scape-goating
Complaining	Isolating	School failure
Defiance	Lying	Silence
Demanding	Nonparticipation	Withholding
Delinquency	Ordering	

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

From Smilkstein.[10]

though 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 pathologic 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 is in the best position to assist the family in improving its level of function by encouraging negotiation of conflicting points of view and facilitating the identification of appropriate resources.

For some families, the Cycle of Family Function is ever downward. Failure to resolve crises, the discomfort of living with pathologic defense mechanisms, and the poor nurturing environment of a family in pathologic 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.

Assessing Family Function in Clinical Practice

The theoretic basis for assessment of family function in clinical practice has been studied and reported in depth.[22-27] General acceptance of the worth of family assessment exists in academic family medicine.[28-30] The transport of the academically accepted principle of family health care to the clinical practitioner necessitates a vehicle that is utilitarian and responsive to

Clinical practice requires a focused or problem-oriented approach to health care. The problem-oriented medical record (POMR) has served to systematize the physician's development of a data base assessment and plan for biomedically oriented problems.[31] The same format may be applied to the psychosocial problems that are associated with family function investigations. Approaching biomedical and psychosocial problems with the same format gives credence to the biopsychosocial approach to health care championed by Engel.[32]

When to Study Family Function

There are three situations in the doctor-patient encounter in which knowledge of family function may facilitate health problem assessment and management: (1) when a new patient enters into a practice, (2) when family members are called upon to assist in patient care, and (3) when a patient's history overtly or covertly suggests family dysfunction as the etiology of a health problem.

New Patient

The physician who obtains knowledge of a new patient's family's structure and function will be in a position to anticipate illness behavior, and in some instances initiate preventative measures. An example is parenting education to enhance family nurturing. To facilitate data gathering, Bauman and Grace recommended a home visit for new patients,[33] but few physicians have incorporated this routine into their practice.

The intake history, self-completed by new patients in an office or clinic, will contain background information on family studies. The Society of Teachers of Family Medicine, at its fall 1981 workshop on *Family in Graduate Family Practice Training,* strongly recommended the inclusion of instruments such as the family tree (genogram, Chap. 31) and the Family APGAR in the initial work-up.

The Family APGAR is a five-item family function screening questionnaire that measures the patient's perception of five components of family function (Figs. 12.2 and 12.3). Part I of the Family APGAR presents the basic questions. The patient checks one of three choices that are scored as "almost always (2 points), some of the time (1 point), or hardly ever (0 points)." Scores for all five questions are then added. The instrument is valuable not only because the score indicates the status of family function, but also because each item in the Family APGAR question

Family APGAR questionnaire

Part I

The following questions have been designed to help us better understand you and your family. You should feel free to ask questions about any item in the questionnaire.

The space for comments should be used when you wish to give additional information or if you wish to discuss the way the question is applied to your family. Please try to answer all questions.

Family is defined as the individual(s) with whom you usually live. If you live alone, your "family" consists of persons with whom you now have the strongest emotional ties.

For each question, check only one box

	Almost always	Some of the time	Hardly ever
I am satisfied that I can turn to my family for help when something is troubling me.	☐	☐	☐
Comments: _____			
I am satisfied with the way my family talks over things with me and shares problems with me.	☐	☐	☐
Comments: _____			
I am satisfied that my family accepts and supports my wishes to take on new activities or directions.	☐	☐	☐
Comments: _____			
I am satisfied with the way my family expresses affection and responds to my emotions, such as anger, sorrow, and love.	☐	☐	☐
Comments: _____			
I am satisfied with the way my family and I share time together.	☐	☐	☐
Comments: _____			

Adapted from Smilkstein G. *J Fam Pract* 6(6) 1231-1239, 1978

Fig. 12.2. Family APGAR questionnaire, Part I.

physician's knowledge about a given area of family function. For example, if a patient scores low (0 or 1) in the statement "I am satisfied with the way my family and I share time together," the physician could offer an open ended probe such as: "I see that you have a problem with the way you and your family spend time together. Tell me about it."

The Family APGAR-I helps to define the degree of a patient's satisfaction with family function, whereas the answers to Part II help to delineate the patient's relationship with individual family members or other persons who have supportive roles in his or her life. The supportive relationships that the patient lists in Part II may help the physician identify persons who can be called on to provide assistance, if needed. Furthermore, the answers to Part II may well indicate a conflict between the patient and a family member that is not revealed in Part I of the Family APGAR.

Family APGAR questionnaire

Part II

Who lives in your home*? List the persons according to their relationship to you (for example, spouse, significant other†, child, or friend).

Relationship	Age	Sex

Check the column that best describes how you now get along with each member of the family listed

Well	Fairly	Poorly

If you don't live with your own family, list the persons to whom you turn for help most frequently. List according to relationship (for example, family member, friend, associate at work, or neighbor)

Relationship	Age	Sex

Check the column that best describes how you now get along with each person listed

Well	Fairly	Poorly

*If you have established your own family, consider your "home" as the place where you live with your spouse, children, or "significant other" (see next footnote for definition), otherwise, consider home as your place of origin, for example, the place where your parents or those who raised you live

†Significant other is the partner you live with in a physically and emotionally nurturing relationship but to whom you are not married

Fig. 12.3. Family APGAR questionnaire, Part II.

Family Member Assisting in Patient Care

When family members are called upon to assist in patient care, the physician's knowledge of patient–family member interaction can be beneficial in anticipating compliance. Studies have shown that family member motivation to care for the sick is influenced by family function.[34-37] Also, physicians should recognize that a possible response to the stress of caring for a family member who is ill will be an increase in the appearance of health problems in those who are doing the caring.[38-44]

Physician and Family Dysfunction

The need for the physician to intervene actively in the problem of family dysfunction usually occurs, however, when the patient overtly or covertly declares family dysfunction to be the critical problem. Table 12.6 offers examples of overt manifestations of family dysfunction that few physicians have trouble identifying. The common trap for most physicians is that they tend to deal with the symptom, school truancy for example, as the primary problem. Under these circumstances a child and the school problem are

Table 12.6 Examples of Overt Symptoms of Family Dysfunction

Reports of:	1. Impending divorce or separation
	2. Excessive arguing, fighting, baiting
	3. Noncommunication
	4. Incest, child abuse, juvenile delinquency, runaway, school behavior problem, school failure

treated as the arena for therapeutic intervention. If, as hypothesized, truancy is a reflection of family problems, then studies should be triangular—that is, encompassing the child, school, and family.

Studies suggest that most family dysfunction problems that are brought to the physician are hidden under a facade of physical symptoms. Under these circumstances, family dysfunction problems are covertly represented through psychosomatic illness, vague symptoms of organic disease, long lists of physical problems, and visits to multiple physicians[45] (Table 12.7).

POMR Approach to the Assessment and Management of the Dysfunctional Family

The physician who has identified family dysfunction as a priority problem will want a format that offers a rational systematic approach to problem clarification and resolution. Use of the POMR headings of data base, assessment, and plan makes such an approach feasible.

Data Base

When a patient overtly presents a family problem, the psychosocial data base may be addressed directly. However, when the physician suspects a somatic problem as the covert representation of family dysfunction, the somatic problem must be studied first with care and concern. In most instances, patients will permit entry into the psychosocial realm only after the physician has shown interest and concern about the patient's chief somatic complaint. Unfortunately, some patients are so locked into the socially accepted somatic representation of all illness that they find it almost impossible to discuss the psychosocial etiology of health problems. Under these circumstances, even though rapport has been established and caring shown, the patient will insist on the somatic orientation to health care. In such cases, the physician must direct his efforts toward maintaining the patient in a functional state and keeping open avenues of communication, so that psychosocial conflict may eventually surface. However, reinforcement of the somatic problem must be avoided, lest the patient develop a permanent disability with its comforting secondary gains.

Table 12.8 covers the data base to be obtained by the physician who is permitted to explore the psychosocial realm. The data on which the physician focuses are: (1) stressful life events that correlate with the onset of the patient's/family's symptoms of dysfunction, (2) the significance of the stressful life events identified, and (3) the resources available to the family (Table 12.9).

Assessment

Family problem assessment is represented in Table 12.10 as being categorically assigned to four areas:

Table 12.7 Examples of Covert Symptoms of Family Dysfunction

Reports of:	1. Somatization—physical symptoms generated by anxiety of psychosocial conflict
	2. Excessive utilization of health care facilities
	3. Doctor shopping
	4. Patient-completed check list of system review reveals a long "laundry list" of symptoms

Table 12.8 POMR Format for Family Study

Data base:
What information to obtain:
1. Stressful life events
2. Significance of stressful life events
3. Resources—social, cultural, religious, educational, economic and medical (technologic)

Table 12.9 POMR Format for Family Study

Data Base:
How to identify resources:
1. Satisfaction with self-esteem
2. Satisfaction with family
   How does family function?
   (1) History of family member interaction
   (2) Questionnaire—Family APGAR
3. Satisfaction with extrafamilial support persons or groups (friends, neighbors, and fellow workers)

Table 12.10 POMR Format for Family Study

Assessment (problem identification):
A. Dysfunctional family status
B. Unresolved stressful life events
C. Poverty of resources, such as social, cultural, religious, economic, educational, and/or medical
D. Pathologic coping or adaptation techniques with comments on family's dysfunctional symptoms

(1) family dysfunction characterized as mild, moderate, or severe, (2) unresolved stressful life events that are weighted according to the impact on family members (minor or major), (3) resources that are unavailable or depleted are noted in this category, and (4) pathologic coping or adaptation techniques are noted in this final category along with family symptoms.

Plan

This chapter's focus is family assessment, but a brief comment on intervention is appropriate, since the POMR format concludes with plan. Table 12.11 indicates the four levels of intervention that are available to a family physician. The level of intervention will depend on the physician's interest and training as well as those forces that always impinge on practice performance—time and financial constraints, office personnel support, and patient acceptance.

Case History in Family Assessment

A case history will be used to illustrate the features of family assessment that have been highlighted in this chapter. P.B. is a 36-year-old white married mother of two girls (ages 9 and 11). Her husband is a salesman whose hours are irregular. The family recently moved to this city to accommodate her husband's shift to a new sales territory. There are no extended family members near their new home.

Table 12.11 POMR Format for Family Study

Plan
A. Supportive therapy to permit ongoing function
B. Counseling to facilitate problem and resource identification
C. Counseling to enhance crisis resolution-negotiation
D. Referral for family therapy

Problem: Recurrent Headaches

The patient reported a history of 6 months of recurrent headaches that were highly variable in duration and time of appearance. They tended to occur two or three times a week, almost always on weekends, and lasted from a few hours to all day. The headaches rarely awakened the patient during the night, but they frequently kept her from falling asleep. The patient claimed that she obtained relief from medications such as diazepam, acetaminophen, and codeine, but that the relief was temporary. Her request was for diazepam to "tide her over" until she could get settled in the new community.

The patient's past history was not significant, and her family history revealed a vague recollection of her mother having headaches when she was younger. Physical examination was not contributory; vital signs and pertinent evaluations were essentially normal. Assessment was tension headache, etiology unknown.

Plan

Analgesics were prescribed to last one week and the patient was requested to return for further discussion of her symptoms.

Second Visit

A review of the patient's history from her first visit revealed a number of items that were highly suggestive of a psychosocial etiology, possibly family dysfunction:

1. Diagnosis of tension headache, a common form of somatization
2. A recent move with loss of social support persons
3. A history of doctor shopping
4. A "laundry list" of physical symptoms
5. A suggestion that her husband was not available, "irregular hours"
6. The appearance of tension headaches on weekends when her husband was home
7. A Family APGAR score of 3, suggestive of severely dysfunctional family. (The Family APGAR is a part of the routine intake history completed by patients on entry into the practice.)

The patient revealed that the analgesics had done little good, and she wanted something more effective. To relate her physical problem to her home situation, the patient was asked how her headaches interfered with her function at home with her children and husband. This request for information led to a ventilation of symptoms of family distress, such as her over-reacting to the children with anger and sometimes physical abuse, and arguments with her husband that led to

hours and sometimes days of noncommunication. At times, when her headache got too severe, her husband would assume household tasks. The patient affirmed that she had not established any friends with whom she could discuss personal matters. The patient was asked what were some of the major life experiences she had had during the last year that had an impact on her life. She hesitated for awhile, and then spoke mainly of the move that had resulted in separation from family, long-standing friends, and professional help with which she was familiar.

Assessment

1. Family dysfunction
2. Stressful life event, move to new city
3. Poverty of sociocultural resources
4. Symptoms (family and patient): tension headaches, arguing, possible physical abuse of child

Plan

Owing to the patient's hesitancy to discuss family issues, the physician negotiated for the use of a small number of diazepam to be taken during the week until her next visit.

Third Visit

At the outset of the third visit the patient was willing to initiate a discussion of her home situation. This was facilitated by the physician asking the patient, "How are things at home?" (a conscious effort made not to ask about the patient's symptoms, the headache). At this third meeting the physician guided the patient to a discussion of her relationship with her husband. By the end of the 20-minute interview it was learned that the major stressful life event of 6 months ago was the patient's discovery that her husband had been involved in an extramarital affair. Communication and sexual dysfunction followed this discovery.

Assessment

Same as for second visit with the addition of the stressful life event extramarital affair and the symptoms of sexual dysfunction.

Plan

With an adequate data base established, a joint meeting of husband and wife was recommended and accepted. The purpose of this meeting was to:

1. Initiate support for both partners so that they would survive their acute crisis.
2. Indicate that marital and sexual therapy were available.
3. Establish that the purpose of further professional assistance would be to assist the couple in understanding each other's needs.
4. Explain that once needs are identified family members can negotiate solutions that permit continuation of nurturing family function.

Addendum

This couple accepted a marriage-sexual counseling center referrral, and a 6-month follow-up revealed a major improvement in family function. During the period of marital and sexual counseling, the patient was offered and accepted a maintenance visit with the physician once a month so that her physical problems could be addressed. The patient voluntarily cancelled these visits after the third month.

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