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ORIGINAL ARTICLE

Medical-family clinical history: description of composition, functionality, typology, life cycle and patterns of 100 families

Historia clínica médico-familiar: descripción de composición, funcionalidad, tipología, ciclo vital y patrones familiares de 100 familias

Yeyetsy G. Ordóñez-Azuara[1]*, Raúl F. Gutiérrez-Herrera[1], Raymundo Herrera-Hernandez[1], Maricruz J. Montelongo-Rodríguez[1], Hector M. Riquelme-Heras[1], and Heber A. Rodriguez-Ondarza[2]

[1]Departamento de Medicina Familiar; [2]Facultad de Medicina. Universidad Autónoma de Nuevo León, Monterrey, Nuevo León, Mexico

ABSTRACT: Background: Family medicine aims to restore family health, but there remains a paucity of clinical practice in daily family assessment. **Objective:** Describe the composition, functionality, typology, life cycle and family patterns of 100 Mexican families. **Material and methods:** Observational, cross-sectional, descriptive study with non-probability convenience sampling of 100 families consulted at DMFHUUANL in Monterrey, Nuevo León, Mexico (2022-2023). **Results:** The majority were women (65%), 20-29 years old (26%), single (40%), housewifes(34%), and catholics (60%), consulting for pain and gastrointestinal symptoms (26%) The predominant family composition was 4+1 (25%), and 81% functional. Family typology: simple nuclear (37%), nuclear integrated by PPH (49% according to the 2005 Consensus and 36% by DMFUANL), 61% traditional, 88% services, 100% urban. According to Family Life Cycle (FLC): 25% retirement and death (Geyman), 26% placement platform (Duvall), 33% contraction (WHO). 98% presented family repetition patterns. This determination facilitated the identification of families in need of work with families (35%). **Conclusions:** Family compositions of 4+1 and 5+1 sizes were more functional; the simple nuclear typology, an integrated nucleus that subsists through services persists in this urban area; the contraction phase of the FVC according to WHO predominated. Frequent family patterns were bachelor's degree, housewife, alcoholism, and diabetes mellitus.

Keywords: Family. Family composition. Family relations. Family health. Medical history taking.

RESUMEN: Antecedentes: La medicina familiar procura restaurar la salud familiar, pero persiste poca práctica clínica de evaluación cotidiana de la familia. **Objetivo**: Describir composición, funcionalidad, tipología, ciclo vital y patrones familiares de 100 familias. **Material y métodos:** Estudio observacional, transversal, descriptivo, muestreo no probabilístico a conveniencia, de 100 familias consultadas en DMFHUUANL en Monterrey, Nuevo León, México (2022-2023). **Resultados**: La mayoría: mujeres (65%), 20-29 años (26%), solteros (40%), amas de casa (34%), católicos (60%), consultando por dolor y síntomas gastrointestinales (26%). La composición familiar predominante fue 4+1 (25%) y 81% de funcionalidad. Tipología familiar: nuclear simple (37%), núcleo integrado por PFH (49% por Consenso 2005 y 36% por DMFUANL), 61% tradicional, 88% servicios, 100% urbana, por Ciclo Vital Familiar (CVF) 25% retiro y muerte (Geyman), 26% plataforma de colocación (Duvall), 33% contracción (OMS). El 98% presentaron patrones de repetición familiar, esta determinación facilitó identificar familias que necesitan trabajo con familias (35%). **Conclusiones:** Hubo más funcionalidad en la composición familiar de tamaño 4+1 y 5+1, la tipología nuclear simple, núcleo integrado que subsiste por servicios persiste en esta zona urbana; predominó la fase contracción del CVF por OMS. Los patrones familiares frecuentes fueron la licenciatura, ama de casa, alcoholismo y diabetes *mellitus*.

Palabras clave: Familia. Composición familiar. Relaciones familiares. Salud familiar. Historia médico-familiar.

***Correspondencia:**
Yeyetsy G. Ordóñez-Azuara
E-mail: yeyetsy_10@hotmail.com

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INTRODUCTION

The goal of family medicine is to address problems that affect family health, understood as complete biopsychosocial well-being –the balance and interaction among its components and the family's capacity to adapt as a group– considering the family as an integrated system and part of society. This vision is achieved through education, assistance, and patient-centered research contextualized to the family[1-3].

Family physicians resolve more than 80% of health needs; however, despite clinical guidelines, maintaining homeostasis and restoring family health remains a challenge. Although these professionals possess biomedical clinical skills, family assessment is not a routine part of daily practice due to limited undergraduate training, insufficient clinical aptitude in the family approach, a mechanistic medical model within the health system, and time constraints during consultations, all of which result in low empathy when working with families[3-5].

Working with families is a planned family medicine intervention aimed at improving or restoring family health through a systematic, collaborative medical methodology. This approach requires a family medicine assessment that, from a systemic perspective, allows identification of key structural and sociodynamic aspects of the family from the outset. Therefore, the initial assessment should include at minimum the evaluation of basic elements such as family typology, composition, functionality, life cycle, and patterns of familial repetition. These components are essential for effective family assessment and intervention, facilitating the restoration of family health[6-9].

The objective of this study was to describe family composition, functionality, typology, life cycle, and patterns of familial repetition in 100 families of patients attending specialty consultations in a Department of Family Medicine in Mexico, with the aim of guiding the initial approach to family-centered care[9,10].

MATERIALS AND METHODS

We conducted an observational, descriptive, exploratory, cross-sectional study in patients attending the Family Medicine Department (DMFHU) of *Universidad Autónoma de Nuevo León* (UANL) (Nuevo León, Mexico). The DMFHUUANL has conducted "Family Work" for more than 13 years and was the only consolidated program within the National Register of Quality Graduate Programs in Mexico. Since 2021, it has been accredited by the *Consejo Nacional de Ciencia y Tecnología* (CONACYT, now SECIHTI) as the only internationally competitive postgraduate program in Family Medicine. It is located in northeastern Mexico and provides care to the general population[10].

Authorization was obtained from *Hospital Universitario "Dr. José Eleuterio González"* Research Ethics Committee (registry No. MF21-00008; CONBIOÉTICA-19-CEI-001-20160404).

Consultations, surveys, and interviews were conducted with 100 index patients (duration, 45-60 minutes each) to determine family characteristics using a family medical history. A nonprobabilistic convenience sampling method was applied for this exploratory descriptive study with a sample of 100 families. Eligible participants were new patients aged ≥18 years who provided informed consent. Patients with reported cognitive impairment were excluded. Five families were excluded due to incomplete survey data. The index patient was defined as the family member seeking family medical attention (the primary source of family information) at the DMFHUUANL between May 2022 and June 2023.

VARIABLES AND MEASUREMENT INSTRUMENTS

Sociodemographic characteristics, family composition and functionality, typology, life cycle, and patterns of familial repetition were determined using semistructured interviews,

Table 1. List of instruments used in the family medical history and their respective determinations

Instruments	Determination
Questionnaire of sociodemographic characteristics	Sex, age, marital status, occupation, religion, place of residence, and reason for consultation
Family composition	Perception of family size
Family APGAR	Perception of family functionality
Genogram	Typology, life cycle, and pattern of familial repetition

the general clinical record of the DMFHUUANL, and the family medical record.

Family assessment was structured for a systemic approach to identify aspects of family structure according to McGoldrick and Gerson's categories 1-3: (1) family structure; (2) family life cycle; (3) generational repetition patterns; (4) family life events and functioning; (5) relational patterns and triangles; and (6) family balance and imbalance. Based on expert recommendations from the DMFHUUANL, the basic elements selected for initial family assessment included: (a) sociodemographic characteristics and reason for consultation; (b) family composition table; (c) family functionality according to composition; and (d) family genogram[2,6,9,11].

Family composition was determined using the family composition table (Ordóñez et al., 2022, modified version), which identifies each member's role, name, age, sex, education, occupation, religion, and illnesses as reported by the index patient, as well as overall family size[6,12].

Family functionality was assessed using the Family APGAR, a brief screening tool with reliability comparable to FACES or FF-SIL. Developed by Smilkstein in 1978, the Family APGAR evaluates 5 dimensions of perceived family functioning: (1) Adaptation – the ability to use intra- and extrafamilial resources to resolve problems during stress or critical events; (2) Partnership – the involvement of family members in decision-making and problem-solving; (3) Growth – the family's support for physical, emotional, and personal development; (4) Affection – expression and satisfaction with emotional interactions; and (5) Resolve – the perception of family commitment to sharing time, space, and resources. The instrument has demonstrated reliability (Cronbach $\alpha = 0.71$-0.83) and can be administered via interview or self-report (except in individuals who are illiterate). Each item is rated on a 3-point Likert scale (almost never = 0, sometimes = 1, almost always = 2), yielding total scores of 0-10. Scores > 6 indicate functional families, whereas scores < 6 indicate dysfunction (0-2 severe; 3-6 mild)[13-15].

Family typology, life cycle, and patterns of repetition were assessed using the genogram, a tool derived from the systemic approach of psychiatrist Murray Bowen (1978) and later standardized by McGoldrick and Gerson. Descriptions by Rakel, Seely, Rogers, and Revilla contributed to its use in family medicine by incorporating biomedical and psychosocial information and establishing symbolic conventions, though no international standardization exists. In this study, the symbols proposed by the *Consejo Mexicano de Medicina Familiar para el Estudio de Salud Familiar* were used[9,11,16-18].

The DMFHUUANL medical record was used, and Table 1 lists the instruments employed in the family medical record and their respective measures.

Family types were classified according to the criteria proposed by the 2005 *Consejo Mexicano de Medicina Familiar para el Estudio de Salud Familiar*, and the 2022 DMFHUUANL classification (Table 2)[12,16,19-21].

Familial repetition patterns were identified when 2 or more generations shared the

Table 2. Classification of family typology

Family type	Classification	%	Definition
It is the classification proposed by various authors and organizations for the study of the family. In this study, the typology was based on the *2005 Mexican Consensus on Family Medicine*, the Consejo Mexicano de Medicina Familiar para el Estudio de Salud Familiar for the Study of the Family, the INEGI, and the Department of Family Medicine at UANL, to classify according to: – Kinship – Physical presence in the household (PFH) or cohabitation – Demography, and – Development	**By kinship (Mexican Consensus 2005):**		
	With kinship:		
	Nuclear		Man and woman without children
	Nuclear simple		Father and mother with 1 to 3 children
	Nuclear large		Father and mother with 4 or more children
	Reconstituted (binuclear)		Father and mother in which one or both are divorced or widowed and have children from a prior union
	Single-parent		Father or mother with children
	Extended single-parent		Father or mother with children, plus other relatives
	Composite extended single-parent		Father or mother with children, plus other persons with and without kinship
	Extended		Father and mother with children, plus other relatives
	Composite extended		Father and mother with children, plus other persons with and without kinship
	Nonparental		Relatives with kinship ties who perform family roles without the presence of parents (eg, uncles and nephews/nieces, grandparents and grandchildren, cousins or siblings, etc)
	Without kinship:		
	Extended single-parent without kinship		Father or mother with children, plus other nonrelatives
	Groups similar to families		Persons without kinship ties who perform family roles (eg, groups of friends, students, religious groups, persons living in hospices or nursing homes, etc)
	By physical presence in the household (Mexican Consensus 2005):		
	Integrated nucleus		Presence of both parents in the household
	Nonintegrated nucleus		Physical absence of one of the parents from the household
	Ascending extended		Married children or those in a consensual union living in a parent's home
	Descending extended		Parents living in the home of one of their children
	By physical presence in the household (Census Household, INEGI Mexico):		
	Family household		Household in which at least one member has kinship with the head of household
	Nuclear		Couples without children; parents and children; or only the mother or father with children
	Expanded		Nuclear plus relatives: aunts, cousins, siblings, etc
	Composite		Nuclear or expanded plus at least one nonrelative
	Non-family household		None of the members are related
	One-person		A single person
	Coresidents		Two or more persons without kinship with the head of household

(Continued)

Table 2. Classification of family typology *(continuation)*

Family type	Classification	%	Definition
It is the classification proposed by various authors and organizations for the study of the family. In this study, the typology was based on the *2005 Mexican Consensus on Family Medicine*, the Consejo Mexicano de Medicina Familiar para el Estudio de Salud Familiar for the Study of the Family, the INEGI, and the Department of Family Medicine at UANL, to classify according to: – Kinship – Physical presence in the household (PFH) or cohabitation – Demography, and – Development	**By physical presence in the household (DMFHUUANL): Home**		Household: a unit composed of one or more persons, related or not by kinship ties, who usually reside in the same private dwelling
	One-person		Person living alone
	Couple		Intimate couple living alone (no children)
	Integrated nucleus (IN)		Presence in the household of members of the nucleus (from which the index patient is part or descends) who have children and may or may not live with them
	Nonintegrated nucleus (NNI)		Absence from the household of one or more members of the nucleus (from which the index patient is part or descends); they have children but may or may not live with them
	Fraternal		Only siblings live together
	P, IN, NNI, or fraternal – Composite		Add the word "composite" when, in addition to the integrated or nonintegrated nucleus or fraternal household, other persons and/or non-kin members live in the home
	Expanded (A)		Any couple or nuclear type plus other kin living in the same household
	A – *Composite		Add the word "composite" when, in addition to the expanded household, other persons and/or non-kin members live in the home
	Coresidents		Group of persons who share the same household without kinship and without performing roles/functions similar to a family (eg, nursing homes or orphanages)
	Demography		
	Rural		Place of residence in a population < 2,500 inhabitants
	Urbana		Place of residence in a population ≥ 2,500 inhabitants
	Development		
	Traditional		The father or father figure works and is the household provider
	Modern		The mother or mother figure works

same characteristics regarding education, occupation, substance use, or past medical history.[6,11,17,20] The family life cycle was determined using the classifications by Geyman, Duvall, the World Health Organization (WHO), and McGoldrick and Carter[1-24].

Data were entered into a Microsoft Excel 2022 database and analyzed descriptively using frequency and percentage distributions. Results were described narratively and presented in tables where appropriate.

RESULTS

A total of 100 index patients were included; most were women aged 20-29 years, single, homemakers, Catholic, and residing in Monterrey. Table 3 illustrates the

Table 3. Description of sociodemographic characteristics of 100 index patients

Sex	Age	Marital status	Occupation	Religion	Place of residence
65% women	26%	40% single	34% homemaker	68% Catholic	52% Monterrey
35% men	22% ≥ 60 years	33% married	20% students	13% none	39% Metropolitan area
	16% 40-49 years	12% consensual union	18% employed	9% Christian	4% Other localities in Nuevo León
	14% 30-39 years	9% widowed	9% unemployed	3% Jehovah's Witness	3% San Luis Potosí
	14% 50-59 years	4% separated	9% merchants	2% Agnostic	1% Coahuila
	8% 10-19 years	4% divorced	4% construction workers	1% Baptist	1% Tamaulipas
			3% retired	Pentecostal	
			2% laborers	Adventist	
			1% day laborer (farmer)	Believer	
100%	100%	100%	100%	100%	100%

n = 100.

Table 4. Description of family composition and functionality

Family composition		Functional (81%)	Dysfunctional (19%)
Classification	%		
4 + 1	25%	20	5
5 + 1	23%	21	2
3 + 1	19%	15	4
6 + 1	12%	9	3
2 + 1	9%	5	4
8 + 1	7%	7	0
7 + 1	3%	3	0
1 + 1	2%	1	1
Total	100%	81	19

n = 100.

sociodemographic characteristics of the index patients included in the study.

REASONS FOR CONSULTATION

The most frequent reason for consultation (23%) was abdominal pain and/or GI symptoms, followed by pain or lesions of the upper or lower limbs (7%), metabolic control (7%), low back pain (6%), joint pain or stiffness (5%), groin or genital pain/lesion (5%), general check-up (5%), test interpretation (5%), referral (5%), chest pain (4%), rhinopharyngeal symptoms (3%), urinary symptoms (3%), headache (3%), anxiety (3%), rectal or perianal lesion (3%), skin, hair, or nail disease (2%), stress (2%), nausea (2%), dizziness (1%), syncope (1%), gynecologic symptoms (1%), tremor (1%), jaundice (1%), substance dependence (1%), and work-leave request (1%).

FAMILY COMPOSITION AND PERCEIVED FUNCTIONALITY

The most frequent family composition was 25% with 4 + 1 members. Family functionality, as perceived by the index patient, was rated functional in 81% of families and dysfunctional in the remainder, who were scheduled for follow-up to initiate family work interventions. Table 4 illustrates family composition and corresponding functionality.

FAMILY TYPOLOGY

Family typology was classified as follows:

- By kinship (Mexican Consensus, 2005): nuclear simple (37%), single-parent (15%), nuclear large (14%), reconstituted (12%), extended (11%), extended single-parent (5%), nonparental (2%), nuclear (2%), composite extended (1%), and extended composite single-parent (1%).
- By means of subsistence: services (88%), commerce (11%), and agriculture (1%).
- By physical presence in the household (PFH): integrated nucleus (49%), nonintegrated nucleus (28%), ascending extended (6%), descending extended (6%), and unclassifiable (11%) per the 2005 Mexican Consensus; per DMFHUUANL classification: integrated nucleus (36%), expanded (18%), nonintegrated nucleus (14%), couple (11%), single-person (8%), fraternal (6%), co-resident (6%), and composite nonintegrated nucleus (1%).
- By development: 61% traditional and 39% modern.
- By demography: 100% urban.

According to the Family Life Cycle (FLC), most families were in the expansion phase (35%, Geyman), placement platform (26%, Duvall), contraction (33%, WHO), and end-of-life stage (28%, McGoldrick and Carter). Table 5 illustrates the family life cycle distribution of the 100 families.

A total of 98% of families presented at least one familial repetition pattern: 76 in education, 75 in occupation, 45 in substance use, and 36 in disease history. The most frequent were university education (21%), homemaker occupation (38%), alcoholism (34%), and diabetes mellitus (10%) for each respective category. Table 6 describes these repetition patterns. Thirty-five percent of families met criteria for family work intervention and were scheduled for follow-up in the DMFHUUANL clinic.

DISCUSSION

The family, as a system, is in constant transformation, and the Mexican family is no exception. Over time, it has undergone both structural and sociodynamic changes—a phenomenon documented by psychologists and sociologists but rarely by family physicians. In this study, the family was examined from a family medicine perspective, and the results were consistent with those reported in other disciplines.[25-27]

Ordóñez (2020), Zárate (2022), and Soto (2022) have highlighted the importance of assessing specific family characteristics in certain patient groups, such as adolescents, individuals with breast cancer, migrants, or those with psychiatric disorders, among others. However, in this study, the general patient population was evaluated, with most consultations motivated by biomedical or administrative reasons. Through a systemic approach, information regarding family structure and functionality was collected via the index patient[6,8,26-28].

FAMILY COMPOSITION, FUNCTIONALITY, AND TYPOLOGY

Family composition has been measured by some authors according to household members and the presence of the conjugal or nuclear system plus other relatives or nonrelatives, classifying families as nuclear, single-parent, or extended, for instance. However, this seems closer to a typological classification (which is distinct). Therefore, this study adopted the model proposed

Table 5. Classification of 100 families by Family Life Cycle (FLC)

Family life cycle	Classification	%	Categories
The sequence of stages a family goes through from its establishment to its dissolution	***GEYMAN***	1%	Marriage
		35%	Expansion
		20%	Dispersion
		19%	Independence
		25%	Retirement and death
	DUVALL	2%	I. Beginning of the family
		0%	II. Family with one child (oldest child up to 30 months)
		4%	III. Family with a preschool child (oldest child 30 months to 6 years)
		4%	IV. Family with school-age children (oldest child 6-13 years)
		16%	V. Family with adolescents (oldest child 13-20 years)
		26%	VI. Family as a launching platform (from first to last child leaving)
		14%	VII. Mature families (empty nest)
		18%	VIII. Elderly families
		16%	Not classifiable
	World Health Organization (WHO)	2%	I. Formation
		10%	II. Extension
		26%	III. Full extension
		33%	IV. Contraction
		20%	V. Complete contraction
		9%	VI. Dissolution
	McGoldrick and Carter	8%	Young single adult (leaving home)
		1%	Couple formation
		8%	Family with children
		16%	Family with adolescents
		10%	Family as launching platform
		14%	Midlife family
		28%	Family at the end of life
		15%	Not classifiable

n = 100.

by Ordóñez et al (2022), evaluating family composition based on the index patient's perception. By means of structured questioning, the patient identified those individuals considered part of their family, listing their roles and characteristics in a family composition table. This method allowed the recognition of family beyond contractual or biological bonds, incorporating the patient's subjective dimension and determining composition as defined in health sciences descriptors, ultimately quantifying family

Table 6. Familial repetition patterns in 100 families (98%)

Education (76%)	Occupation (75%)	Substance use (45%)	Past medical history (36%)
Bachelor's degree 21%	Homemaker 38%	Alcohol use disorder 34%	Diabetes mellitus 10%
Secondary school 16%	Homemaker and employees 7%	Alcohol and tobacco use 8%	Hypertension 6%
High school 11%	Mason 4%	Tobacco use 3%	Diabetes and hypertension 5%
Primary school 11%	Merchant 4%		Healthy 3%
Primary and secondary 7%	Homemaker and mason 3%		Cancer 2%
High school and bachelor's 3%	Employees 3%		Stroke 2%
Illiterate 2%	Homemaker and farmer 2%		Diabetes with complication 2%
Other (1) 5%	Homemaker and merchant 2%		Hypertension with complication 2%
	Engineer 2%		Other (1) 4%
	Other (1) 10%		

n = 100.

size. Pets may be included in this composition, though not in family typology, which is an objective component of family assessment[6,12,26,27].

Family dysfunction has been associated with negative impacts on members' health, promoting crises, severe psychological disorders, and risky behaviors. In contrast, proper family functioning acts as a protective factor against various diseases. Family typology and composition may be associated with perceived family functionality. For example, Ordóñez et al found in a case-control study of 437 Mexican families with adolescents that the single-parent typology (OR, 1.7), nonintegrated nucleus (OR, 1.9), and high family poverty (OR, 13.8) were risk factors (with concordant parent and guardian perceptions) for family dysfunction, while nuclear simple (OR, 0.4) and integrated nucleus (OR, 0.5) families were associated with functionality. In the present study, family functionality in relation to composition was evaluated, identifying 81% as functional. However, this result may be biased, as it depends on the patient's perception of their own family composition (eg, whom they consider family). Therefore, we propose complementing this assessment with the Family APGAR applied according to family typology to later compare both approaches[6,26-29].

Family structures have evolved over time; however, the nuclear model with children remains predominant, as observed in this study. Nonetheless, family typology is becoming increasingly diverse, and while kinship remains a stable criterion, forms of cohabitation have changed significantly. Using traditional classifications based on physical presence in the household (PFH) described more than 20 years ago, over 10% of families could not be categorized. In contrast, the PFH classification proposed by the DMFHUUANL allowed classification of 100% of cases, highlighting differences where family composition is perceived very differently from family typology[6,11,20,28,30-32].

Assessing family functionality in relation to both typology and composition is essential, as each implies different needs.

FAMILY LIFE CYCLE

In this study, lengthening of the Family Life Cycle (FLC) was observed: children remain longer in the parental home, delaying independence and the empty nest stage. Additionally, following separations or divorces, it is common for children (single or with offspring) to return to their parents' home. Increasing life expectancy and caregiving needs have also led to older adults cohabiting with siblings or even with their parents. Furthermore, some patients currently have

no children and/or choose not to have them. These dynamics create family configurations that do not always align with the stages proposed in traditional family life cycles.

New family structures do not always fit within the classical FLC stages. For instance, Duvall's cycle could not be applied in 16% of cases – a finding similar to McGoldrick and Carter's model – while Geyman's classification proved inflexible. In contrast, the WHO model showed greater adaptability, as it does not depend exclusively on marriage. We recommend using the modified WHO family life cycle for care purposes, as it allows integration of new family structures and classification of the index patient from either the family of procreation or the family of origin[16,20,22,33,34].

Overall, there remains an urgent need for systematic reviews and expert consensus in family medicine to standardize and update family typology and life cycle classifications, enabling the identification of evolving family structures while remaining inclusive of new family types. Even McGoldrick and Carter's FLC depends on couple formation and the arrival or departure of children. We recommend using different FLC classifications for educational purposes, as they help residents understand the stages and needs corresponding to family developmental tasks. Despite its relevance, few theorists have addressed this topic for contemporary clinical practice, underscoring the significance and value of this study[1,2,6,9,12,20,32].

The genogram not only enabled identification of family typology and life cycle but also of familial patterns – recurrent events across two or more generations. In this study, nearly all families exhibited familial repetition patterns, allowing identification of family risk factors. From a medical perspective, substance use disorders and chronic diseases such as diabetes and hypertension were prominent. Given the high prevalence of these patterns, we recommend conducting association studies to identify family characteristics linked to generational repetition of events, contributing to a better understanding of risk factors and potential preventive interventions[33-36].

Although not the main objective of this study, more than one-third of patients (35%) and/or their families met criteria to initiate the planned "family work" intervention. The ease with which these criteria were identified using the initial family medical assessment proposed by the DMFHUUANL – applied at the first contact with the index patient – was noteworthy[2,9].

CONCLUSIONS

Among 100 Mexican families attending family medicine consultations, most index patients were young, single, female homemakers, Catholic, and residents of Monterrey, who primarily consulted for pain or GI symptoms.

Greater functionality was observed in families with 4 + 1 and 5 + 1 members. The predominant typology was nuclear simple, integrated nucleus, traditional, and service-based urban families. Most families were in the contraction phase of the WHO FLC.

The most frequent generational family patterns were university-level education, homemaker role, alcoholism, and diabetes mellitus.

We recommend analyzing the relationship between family typology and functionality, using the DMFHUUANL classification to identify new family structures by PFH, and employing the Family Life Cycle model best suited to each case to correctly identify developmental tasks. Given the presence of repetition patterns, we suggest conducting case-control or cohort studies to establish associations and design risk-based preventive interventions.

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The authors declare that this study was conducted with their own resources.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

ETHICAL CONSIDERATIONS

Protection of humans and animals. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality, informed consent, and ethical approval. The authors followed their institution's confidentiality protocols, obtained informed consent from all patients, and received approval from the Research Ethics Committee. The study followed SAGER guideline recommendations, in accordance with its nature.

Statement on the use of artificial intelligence. The authors declare that no generative artificial intelligence tools were used in the preparation of this manuscript.

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