

The Family APGAR: A Proposal for a Family Function Test and Its Use by Physicians

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Understanding family function is an important aspect of patient care, yet a practical approach to the evaluation of family function by the physician has not been devised. This paper introduces a brief questionnaire that is designed to test five areas of family function. The acronym APGAR has been applied to the functional components of Adaptability, Partnership, Growth, Affection, and Resolve. The use of the Family APGAR is discussed, as well as ways of assessing family resources and reporting data in a family problem-oriented record. These guidelines are offered for the management of the family in trouble, so that the physician may view the use of the Family APGAR in the context of clinical practice.

Richardson, in 1948, was among the first to stress the necessity for physicians to view the patient in the context of family. In his seminal book on family dynamics in health care he noted,

To say that patients have families is like saying that the diseased organ is part of the individual. Both facts seem too obvious to discuss, yet for a long time neither received due recognition from the medical profession.¹

The significance of the patient as a family member was elaborated further by Minuchin who wrote,

The family, as an open socio-cultural system, is continually faced by demands for change. These demands are sparked by bio-psychological changes in one or more of its members. . . .²

Today, although the concept of the patient as an interacting member of a family unit is well accepted, a practical method still has not been devised for the physician to use to collect data that will facilitate managing the family in trouble.

A host of examinations and tests is available to the physician for evaluating a diseased organ's functional state. Similarly, in evaluating the family, many questionnaires and procedures have been devised to establish the state of functional integrity of the family.^{3,4} However, none of these methods for testing the family has proven of practical value for daily use in the physician's office.

This paper will introduce a brief screening questionnaire called Family APGAR, which is designed to elicit a data base that will reflect a patient's view of the functional state of his or her family. It will also discuss ways of assessing family resources and the use of a family problem-oriented record that may be used by the physician to improve family study, diagnosis, and management.

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Table 1. Definitions of Family APGAR Components	
Component	Definition
<u>A</u> daptation	Adaptation is the utilization of intra and extrafamilial resources for problem solving when family equilibrium is stressed during a crisis.
<u>P</u> artnership	Partnership is the sharing of decision making and nurturing responsibilities by family members.
<u>G</u> rowth	Growth is the physical and emotional maturation and self-fulfillment that is achieved by family members through mutual support and guidance.
<u>A</u> ffection	Affection is the caring or loving relationship that exists among family members.
<u>R</u> esolve	Resolve is the commitment to devote time to other members of the family for physical and emotional nurturing. It also usually involves a decision to share wealth and space.

Definition of Family and Family Function

When the physician interviews a patient for a health problem, the usual procedure is to gather only information concerning the patient's family that is pertinent to understanding a particular complaint. In most instances, the physician needs minimal or no family data to handle the complaint. Nevertheless, in some situations, knowledge of the structure and function of the patient's family may be required to resolve the health problem. For example, in evaluating a middle-aged man with chest pain, it is important for the physician to inquire whether anyone in the patient's genetic family has had coronary artery disease as well as to determine the structure and the function of the family to which the patient will return.

Since family structure and function play a part in understanding and managing the complaint of the individual patient as well as of the family in trouble, the following operational definition of family is recommended for the physician involved in family analysis: *The family is a psychosocial*

group consisting of the patient and one or more persons, children or adults, in which there is a commitment for members to nurture each other.

In this definition, family structure is defined simply as the patient and one or more persons. Because structural or institutional relationships among members are not specified, there is room for a wide range of family life-styles, including the traditional nuclear family, communal groups, and nonmarried partners, whether heterosexual or homosexual. Also in this definition the process of nurturing is equated with family function that promotes emotional and physical growth and maturation of all members.

In order to establish the parameters by which a family's functional health can be measured, five basic components of family function were chosen. These components, which are defined in Table 1, were elected by the author since they appear to represent common themes in the social science literature that deals with families. This empirical decision allowed the development of a family function paradigm that may be likened to the

Table 2. Open-Ended Requests for Family Function Information

Component	Relevant Open-Ended Questions
<u>A</u> adaptation	How have family members aided each other in time of need? In what way have family members received help or assistance from friends and community agencies?
<u>P</u> artnership	How do family members communicate with each other about such matters as vacations, finances, medical care, large purchases, and personal problems?
<u>G</u> rowth	How have family members changed during the past years? How has this change been accepted by family members? In what ways have family members aided each other in growing or developing independent life-styles? How have family members reacted to your desires for change?
<u>A</u> ffection	How have members of your family responded to emotional expressions such as affection, love, sorrow, or anger?
<u>R</u> esolve	How do members of your family share time, space, and money?

body's organ system, in that each component has a unique function, yet each is interrelated to the whole. The family in health may be considered to be a nurturing unit that demonstrates integrity of the components of (1) Adaptability, (2) Partnership, (3) Growth, (4) Affection, and (5) Resolve (APGAR).

Family Function Questionnaire

When a family member reports the history of a crisis to a physician, the general status of this family's function can usually be discovered. Considerable information about family function may be obtained when the patient describes how family members eat, sleep, and carry out home, school, and job responsibilities. Evidence of dysfunction in these activities should alert the physician to the need to evaluate family function in greater depth.

To obtain more definitive data, the physician must use questions that are likely to elicit pertinent information on the five components of family function. Table 2 lists some relevant open-ended requests for information on family function. Although open-ended questions are preferable because they can lead to the most detailed flow of information, they often require more time than the physician has available. Consequently, closed-ended questions, while limiting the scope of the patient's responses, can give data in a few minutes that highlight the quality of the patient's interaction with his or her family and do not overburden the busy clinician.

In 1973, Pless and Satterwhite introduced a Family Function Index (FFI) that was developed as a "simple, easily administered test to reflect the dynamics of family interaction."^{4,5} The FFI consists of 15 questions and requires about 15 minutes

Table 3. Family APGAR Questionnaire			
	Almost always	Some of the time	Hardly ever
I am satisfied with the help that I receive from my family* when something is troubling me.	_____	_____	_____
I am satisfied with the way my family* discusses items of common interest and shares problem solving with me.	_____	_____	_____
I find that my family* accepts my wishes to take on new activities or make changes in my life-style.	_____	_____	_____
I am satisfied with the way my family* expresses affection and responds to my feelings such as anger, sorrow, and love.	_____	_____	_____
I am satisfied with the amount of time my family* and I spend together.	_____	_____	_____
<p>Scoring: The patient checks one of three choices which are scored as follows: 'Almost always' (2 points), 'Some of the time' (1) point, or 'Hardly ever' (0). The scores for each of the five questions are then totaled. A score of 7 to 10 suggests a highly functional family. A score of 4 to 6 suggests a moderately dysfunctional family. A score of 0 to 3 suggests a severely dysfunctional family.</p> <p>*According to which member of the family is being interviewed the physician may substitute for the word 'family' either spouse, significant other, parents, or children.</p>			

to administer. It estimates family function by evaluating areas of nuclear family interaction such as marital satisfaction, frequency of disagreement, communication, problem solving, and feelings of happiness and closeness. The reliability of the FFI was established by comparing index scores with ratings of the same families by experienced case workers. The FFI has been used to study the nuclear families of children with chronic physical disorders, and it is claimed by its authors to identify accurately which chronically ill children are likely to experience secondary psychological difficulties.

The Family APGAR, a questionnaire that features five closed-ended questions, is introduced by the author as a screening test to give a rapid overview of the components of family function. Table 3 demonstrates this new questionnaire. It is designed so that it may be given to members of either

nuclear or alternative life-style families. The APGAR acronym has been applied since it is felt that the familiarity that physicians have with the Apgar⁶ evaluation of the newborn will encourage them to remember a similar format that scores the functional status of a family. Field tests with the Family APGAR are presently being conducted and early results are promising. A validity index for this questionnaire is now being established utilizing both Pless and Satterwhite's FFI and the evaluation of family function by social workers and psychologists.

What Does the Family APGAR Measure?

The questions in the Family APGAR are designed to permit qualitative measurement of the family member's satisfaction with each of the five basic components of family function. Table 4 lists the functional components of the Family APGAR

Table 4. What is Measured by the Family APGAR?

Component	
<u>A</u> adaptation	How resources are shared, or the degree to which a member is satisfied with the assistance received when family resources are needed.
<u>P</u> artnership	How decisions are shared, or the member's satisfaction with mutuality in family communication and problem solving.
<u>G</u> rowth	How nurturing is shared, or the member's satisfaction with the freedom available within the family to change roles and attain physical and emotional growth or maturation.
<u>A</u> ffection	How emotional experiences are shared, or the member's satisfaction with the intimacy and emotional interaction that exists in a family.
<u>R</u> esolve	How time (and space and money*) is shared, or the member's satisfaction with the time commitment that has been made to the family by its members.
*Besides sharing time, family members usually have a commitment to share space and money. Because of its primacy, time was the only item included in the Family APGAR; however, the physician who is concerned with family function will enlarge his/her understanding of the family's resolve if he inquires about family member's satisfaction with shared space and money.	

and indicates the qualitative data that may be gained.

The following vignettes are examples of patient problems that have been evaluated by the Family APGAR.

Case 1

Family crisis: A 40-year-old father died as a result of metastatic lung cancer after a hospital stay of three months. The physician record indicated a Family APGAR score of 10. The questionnaire was completed by both spouses prior to the husband's hospitalization. The physician anticipated that existing resources would maintain the family's nurturing functions. Investigation of the APGAR components revealed the following:

Adaptability: The mother spent most of her time in the hospital during the father's illness. Relatives were called in as resources, and the four

children, ages 8 to 15, participated in household chores and mutual support activities.

Partnership: There were weekly family meetings to discuss problems such as allowances, borrowing clothes, and household responsibilities.

Growth: Roles in the family were well defined and rather classical for a nuclear middle class family; however, all family members had the opportunity to discuss change during Sunday night meetings.

Affection: A great deal of warmth and understanding was demonstrated by the parents with an open display of affection. The children were afforded much physical touching and reassurance when needed.

Resolve: The family functioned well as a unit. Parents demonstrated a commitment of time, space, and money, and they clearly indicated to the children that the family came before work re-

sponsibilities.

During the crisis period that followed the father's death there was a rapid gathering of resources, eg, minister, relatives, and friends. Family dysfunction was minimal. The children remained at home to assist the mother during the funeral and memorial services. The grief process was shared by all members of the family.

This family required little in the way of support from the family physician. Intra and extrafamilial resources continued to maintain the family unit during the post crisis period.

Case 2

Family crisis: A 16-year-old daughter was arrested for shoplifting. The juvenile officer recommended individual counseling for the daughter. The family physician was consulted by the mother. At the time of consultation a severely dysfunctional family was anticipated when a Family APGAR score of 1 was obtained from the daughter, while the mother, age 39, scored 3. The father refused to see the physician or complete the APGAR questionnaire. The physician foresaw a family that would require much aid in the way of extrafamilial resources.

Investigation of the APGAR components of this family revealed the following:

Adaptability: The mother was in charge of the family, but she claimed she received little or no support from her daughter or husband. A son, aged 10, was cooperative but his assistance was limited since he had cerebral palsy and required a wheelchair for ambulation. Father and daughter did their own "thing" and left mother to manage most of the home problems. There were no extended family members in the community.

Partnership: Mother and daughter shared opinions, but their differences were so marked there was little cooperation. Daughter and father were usually at odds. Father indicated that he would like to see the daughter removed from the home (especially after the shoplifting episode). Mother and son had a close relationship and exchanged ideas and feelings. The husband made decisions regarding his activities, but he left household decisions to the wife.

Growth: Daughter had been allowed much freedom outside the home since age 12; however, her home activities were restricted by the father. For example, he did not allow her to watch television.

Shoplifting was the third arrest experienced by the daughter. Her previous two experiences with the police were for drunken and disorderly conduct and being a runaway. Mother had high educational goals for the children; however, daughter had a D average, and although the son tried, his educational accomplishments were limited.

Affection: There was no evidence of physical affection when family members were together. Husband and wife apparently related well at a sexual level, but there was little else in the way of emotional interchange. Mother and son seemed to demonstrate some measure of intimacy.

Resolve: Husband helped meet physical needs of home and family, but he tended to spend as little time at home as possible. He shared most of his paycheck with his wife. The daughter spent much of her time either isolated in her room or out of the house with her peers.

The Family APGAR scores of 1 and 3 obtained from the daughter and mother indicated to the physician the gravity of family dysfunction. The physician elected to act as a facilitator and refer this family to a mental health clinic for family therapy. The father initially would not cooperate with the counselor, but he was finally convinced by the physician and juvenile officer to participate in a family discussion. Roles were discussed and a more equitable distribution of household tasks was arranged. The 16-year-old daughter was assigned an advocate (college student as role model) by the juvenile officer. The advocate reported that after three months the daughter had demonstrated some improvement in her school work and claimed to have established an improved relationship with both her father and mother.

When Should the Family APGAR Questionnaire be Used?

Three situations have been identified in which the physician may need information on the functional state of the patient's family.

1. Functional information is needed when the family will be involved with the patient's care. All illnesses and injuries represent some measure of stress to the family. An understanding of the baseline level of family function is necessary whenever the physician wishes to involve the family in the care of the patient. In the case of a patient with coronary artery disease, information on family function would assist in ascertaining the

patient's ability to return home and play the role of a passive convalescent. A high Family APGAR score would suggest that the family could adapt to the crisis of the patient's illness and role change. A low score would warn the physician that the home environment might be stressful to the coronary patient. The physician might then wish to take a closer look at family member interaction before sending the patient home.

2. Family function data may be needed when a new patient is introduced into a physician's practice. There is merit in seeing the family as a unit on at least one occasion,⁷ since such an encounter allows the physician to meet the family members and gain some insight into family interaction. While the interview process does not usually allow the physician time to gain an adequate view of the status of family function, giving the Family APGAR questionnaire to the whole family permits the physician to establish a baseline view of family function (See Case 3). Just as the pediatric Apgar uses one and five-minute evaluations to judge the progress of a newborn infant, the family physician may wish to administer the Family APGAR at the first visit and repeat it in five years to judge the changes in functional status of a family under his/her care.

3. Family function information is essential when the physician is involved in managing a family in trouble. When a patient reports a family crisis to the physician, it usually indicates that the family's resources are inadequate to cope with the problem. In this situation the Family APGAR questionnaire can highlight specific areas of weakness in family function that interfere with the ability of family members to communicate or identify resources. Furthermore, the family member's response to a given item may provide a lead in initiating a discussion. For example, if the patient scores 0 on the question of "I am satisfied with the amount of time my family and I spend together," the physician could use an open-ended question such as, "I see that you have a problem with the amount of time that your family spends together. Tell me about it." Thus, the questionnaire serves as a timesaving device that will help the physician focus on the critical problems of the family in trouble.

What Are Family Resources?

The family's ability to adapt to or cope with a

crisis depends largely on its resources. Since the physician is usually consulted only when the family members are unable by themselves to identify or utilize resources to meet a crisis situation, the physician who wishes to give supportive therapy or make an appropriate referral for the dysfunctional family will need to help family members identify and assess their resources. The major family resources are Social, Cultural, Religious, Economic, Educational, and Medical. The acronym SCREEM may serve to remind the physician of the family resources. These resources are considered effective in a family when the following conditions are met:

1. Social interaction is evident among family members. Family members have well-balanced lines of communication within areas of extrafamilial social interaction such as friends, sport groups, clubs, and other community organizations.

2. Cultural pride or satisfaction can be identified, especially in distinct ethnic groups.

3. Religion offers satisfying spiritual experiences as well as contacts with an extrafamilial support group.

4. Economic stability is sufficient to provide both reasonable satisfaction with financial status and an ability to meet the economic demands of normal life events.

5. Education of family members is adequate to allow members to solve or comprehend most of the problems that arise within the format of the life-style established by the family.

6. Medical care is available through channels that are easily established and have previously been experienced satisfactorily.

Pathology in the various family resources is considered to exist when the following conditions are present:

1. Social: The family is socially isolated from extrafamilial groups. If extrafamilial aid is required the resource-poor family may not know whom to turn to for assistance. This situation is not uncommon when a family undergoes a crisis shortly after moving to a new community. At the other end of the spectrum of social activity is the problem of overcommitment. Under these circumstances family members are so involved with activities outside the home that they become disassociated from their own family and may be unavailable as resources in times of family need.

2. Cultural: The family has feelings of

cultural-ethnic inferiority or shame, often as a consequence of having been subjected to years of ghettoization as well as vocational and educational discrimination.

3. **Religious:** Dogma and rituals are so rigid that they limit the family's problem solving capacity. The physician must consider ethical questions when a crisis involves religious beliefs. Difficulties often arise when dealing with questions such as contraception, abortion, and blood transfusions. Overcommitment to religious activities by one family member may limit his/her value as a resource to the rest of the family.

4. **Economic:** Financial problems may make it difficult for the family to meet the monetary demands of a crisis. The physician must be aware of the family's ability or inability to meet the economic requirements of any plan that he designs. If the physician's plan, however ideal for the problem, is economically inappropriate, the plan is useless.

5. **Educational:** Handicaps limit the ability of family members to comprehend the problem or the recommended solution. Unless the physician or an appropriate counselor can explain to the family the nature of the problem and its solution, the family members cannot be expected to participate as resources in problem solving.

6. **Medical:** A family has not established lines of medical care or is unable to use health-care facilities due to problems such as unwillingness to seek care, inadequate finances, language barriers, absence of transportation, refusal of care by a local practitioner, or long-term or recurrent illnesses that deplete family reserves.

How Should a Data Base on the Family in Trouble be Collected?

In practice, of course, the family is rarely interviewed as a unit. The family data base, obtained from as many family members as possible, will therefore be a cumulative record that must be modified as various members of the family contribute to the account of the family's crises, functions, and resources.

The workup of the family in trouble requires (1) identifying and evaluating the family's crises, present and past, (2) determining the level of family function through the Family APGAR, and (3) ascertaining the family's resources through the assessment of family resources. This information

should be noted in a practical and graphic recording system.

The problem-oriented record has been chosen by increasing numbers of physicians as an effective method of recording a patient's health status. To make this concept useful for family study and diagnosis, the problem-oriented record for the individual is modified so that the format (data base, numbered problem list, titled plan, and follow-up) may be applied to the family. The goal of the Family Problem-Oriented Record (Family POR)⁹ is to provide a vehicle that will systematize the study of the family and enhance the exchange of information among health science students, teachers, and practitioners.

The *data base* of the Family POR is a record of three areas: the present and past family crises, the intra and extrafamilial resources, and the APGAR components of family function.

The *assessment* is a report of (1) the significance of various crises to family members,^{9,10} (2) the level of Family APGAR function, and (3) the status of family resources (SCREEM items).

The *plan* should note the intra and extrafamilial resources the physician will recommend to assist members in improving family function.

The *follow-up* will record whether the plan was effective or not, as well as the physician's future plans for the family.

Guidelines for the Management of the Family in Trouble

The primary responsibility of physicians involved in family therapy is to match their personal resources (skills, knowledge, and attitudes in family counseling) against the severity and complexity of a family's functional disability. The Family APGAR serves as a screening test for functional disability; however, as in all phases of medical investigation, the test must be put into perspective by the physician. In family therapy this is done by assessing the overall pattern of family function.

Mild functional disability exists in a family whose life-style may be adversely affected but which remains functionally intact; that is, there is a continuation of most nurturing activities. In these circumstances the plan requires that the family be given assistance in improving communication and identifying those resources needed to help resolve the crisis episode. Supportive coun-

seling may also be instituted to assist the family members most affected by the crisis.

Case 3

A family was evaluated as a unit as new members of a practice. The Family APGAR scores were as follows: Father, age 58, 7; mother, age 54, 9; son, age 22, 8; daughter, age 20, 9; and son, age 16, 6. The physician recognized that with the exception of the 16-year-old son, and perhaps the father, the Family APGAR scores suggested a family that functioned well.

The physician elected to speak with the parents about the test results. The father indicated that he had been having some disciplinary problems with his 16-year-old son. Permission was granted the physician to invite the son to the office to discuss the Family APGAR test. The son was initially hesitant but he did comply. After an introductory discussion about the son's routine health status and activities, open-ended questions were asked related to the items that were scored low on the Family APGAR, eg, "You indicated on your questionnaire that you were not entirely satisfied with the way your family accepted your desires to take on new activities." This question led to a discussion of how strict the father had been regarding the son's social activities, dress, homework, and television use. The 16-year-old claimed that he was responsible for most of the yard work, yet he received little recognition for his efforts. Father-son arguments had apparently been escalating for about a year, and according to the son, in recent months the father seemed to be critical almost all the time.

Permission was granted to the physician by the son to talk over the situation with the father. One 40-minute session was held during which time the father ventilated his feelings regarding his attitudes about his youngest son. The physician spent an equal amount of time counseling the father on parenting a teenager. Major emphasis was given to offering recognition and rewards for positive accomplishments, drawing up limited guidelines for behavioral expectations, and giving the teenager that degree of independence that seemed appropriate for his age. The father was able to arrange a "contract" with his son. A three-month report indicated improved communication between father and son, and apparently an improvement in family function (son's three-month Family

APGAR was 10).

This family had a limited problem. Total family involvement was not necessary. In this case the consequences of the resolution of the father-son conflict was improvement of total family function.

Severe functional disability, in which all or most members of the family no longer fulfill nurturing activities, requires that therapy be initiated for the entire family. It is essential that the physician recognize the gravity of such situations and not offer placebos or unrealistic interim solutions (See Case 2).

Consultation with a family therapist for families with severe functional disability will frequently be recommended. The physician's decision to obtain consultation requires examination of such factors as (1) the wishes of the family members, (2) the severity of the family's dysfunction, (3) the physician's interest and training in family counseling, (4) the physician's time commitments, (5) the resource needs of the family, and (6) the resources available in the community.

Physicians should recognize that not all families are salvageable. When the processes of diagnosis, therapy, and consultation have failed to evoke an improvement in family function, separation or divorce may have to be accepted as an appropriate solution. But, to the extent physicians can identify and respond specifically to family problems, they should benefit many families in which these problems are a major contributor to difficulties with family nurturing and effective health care.

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