Family Assessment Instruments

6th International Workshop

Learning and Teaching about Family in General Practice

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Family Assessment Instruments

1. When should a family physician assess family function?

Though some authors consider assessing the family function as a basic task that should be performed with every family, according to common sense and practical experience most physicians agree this to be an unthinkable duty. There are some situations where the presenting symptoms and signs advise the doctor to search deeper in the relationships and interactions between family members for clues and explanations that can relate the pattern of illness to an existing family dysfunction. [1,2]

Some situations should be considered as suggested by Janet Christie-Seely: [3]

- ill-defined symptoms in patients with high consultation rates
- severe emotional and behavioural problems in any member of the family
- marital and sexual problems
- diseases related to life styles
- anxiety related to a change in the family life cycle
- whenever the traditional biomedical model seems inadequate or insufficient

According to Gabriel Smilkstein [2]

- When a new patient enters into a practice
- When family members are called upon to assist in patient care
- When a patient's history overtly or covertly suggests family dysfunction as the aetiology of a health problem

2. Models that have been used to aid in the clinical understanding of family function:[4]

Several models have been used to aid in the clinical understanding of family function; some of those are:

- The Systems Model of Family (Beavers, 1981)
- The Circumplex Model (Olson, 1979)
- The Cycle of Family Function (Smilkstein, 1980)
- The Family Epidemiological Model (Medalie, 1981)

The Systems Model of Family [4]

This model, developed by Beavers in 1981, integrates family systems research in healthy and disturbed families covering a period of nearly 20 years. It provides a tool for a cross-sectional, process-oriented assessment of family competence, task performance, and operating style. There are two dimensions of family structure and function in this model: adaptability, depicted in the horizontal axis, and style, in the vertical axis (Figure 1).

The Circumplex Model [4, 5]

The Circumplex Model is a two dimensional model developed by Olson and co-workers in 1979 to address the psychosocial interior milieu of the family.
According to the authors, there are five basic functions that are performed by all families; an outline of these functions serves as a basis for a discussion of how to assess family fiction.

1. Families provide **support** to each other;
2. Families establish **autonomy** and independence for each person of the system, which facilitates personal growth of individuals within the family;
3. Families create **rules** that govern the conduct of the family and of the individuals within the family; rules deal mainly with privacy, interaction patterns, authority, and decision making;
4. Families **adapt to changes** in the environment (for example, moving, or a birth in the family);
5. Families **communicate** with each other;

The authors of this model believe that the clustering of numerous concepts from family therapy and other social science fields reveals that adaptability and cohesion are two significant dimensions of family behaviour. The model proposes that a balanced level of cohesion and adaptability is most functional to marital and family development. (Figure 2, Table 1)

The Cycle of Family Function [4, 6]

In 1980, Smilkstein presented a model that synthesises major theories and definitions to integrate information gained from family studies in the educational matrix of family medicine. The conceptual model includes components that have been identified as basic to the recognition and understanding of the family in trouble. It is proposed that knowledge of family function as represented in the model, the Cycle of Family Function, will, in turn, help the physician assess and manage problems presented by patients who are victims of stress related to family problems. (Figure 3).

The Family Epidemiological Model [4, 7]

In 1981, Medalie et al. developed a conceptual model for use in practice, education, and research drawing on knowledge from various behavioural science disciplines and epidemiology. This model uses three overlapping circles to represent the host (family system), the environment, and the agent (stressor) systems.

Figure 1.

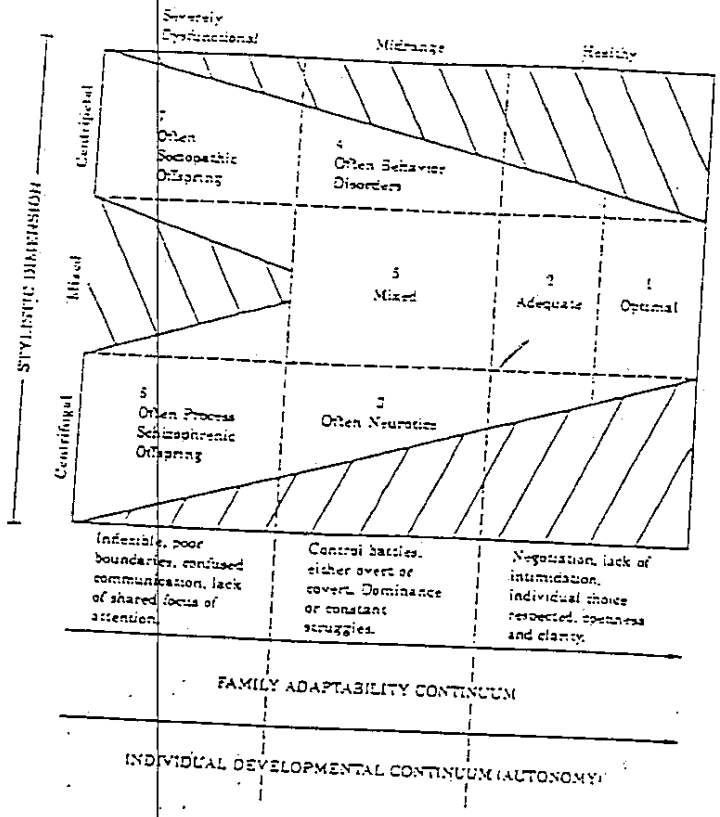


Table 1 FAMILY ADAPTABILITY DIMENSIONS: INTERRELATED CONCEPTS*

	Chaotic (Very High)	Flexible	Structure	Rigid (Very Low)
Assertiveness	Passive and aggressive styles	Generally assertive	Generally assertive	Passive or aggressive styles
Control	No leadership	Egalitarian with fluid changes	Democratic with stable leader	Authoritarian leadership
Discipline	Laissez-faire, very lenient	Democratic, unpredictable consequences	Democratic, predictable consequences	Autocratic, overly strict
Negotiation	Endless negotiation, poor problem-solving	Good negotiation, good problem-solving	Structured negotiations, good problem-solving	Limited negotiations, poor problem-solving
Roles	Dramatic role shifts	Role-making and sharing, fluid change of roles	Some role-sharing	Role rigidity, stereotyped roles
Rules	Dramatic rule shifts, many implicit rules, few explicit rules, arbitrarily enforced rules	Some rule changes, more implicit rules, rules often enforced	Few rule changes, more explicit than implicit rules, rules usually enforced	Rigid rules, many explicit rules, few implicit rules, strictly enforced rules
System Feedback	Primarily positive loops, few negative loops	More positive than negative loops	More negative than positive loops	Primarily negative loops, few positive loops

*Adapted from Olson, D. H., Sprenkle, D. H., and Russell, C. S.: Circumplex model of marital and family systems: I. Cohesion and adaptability dimensions, family types, and clinical applications. Fam. Process, 18:22, 1979.

Figure 2.

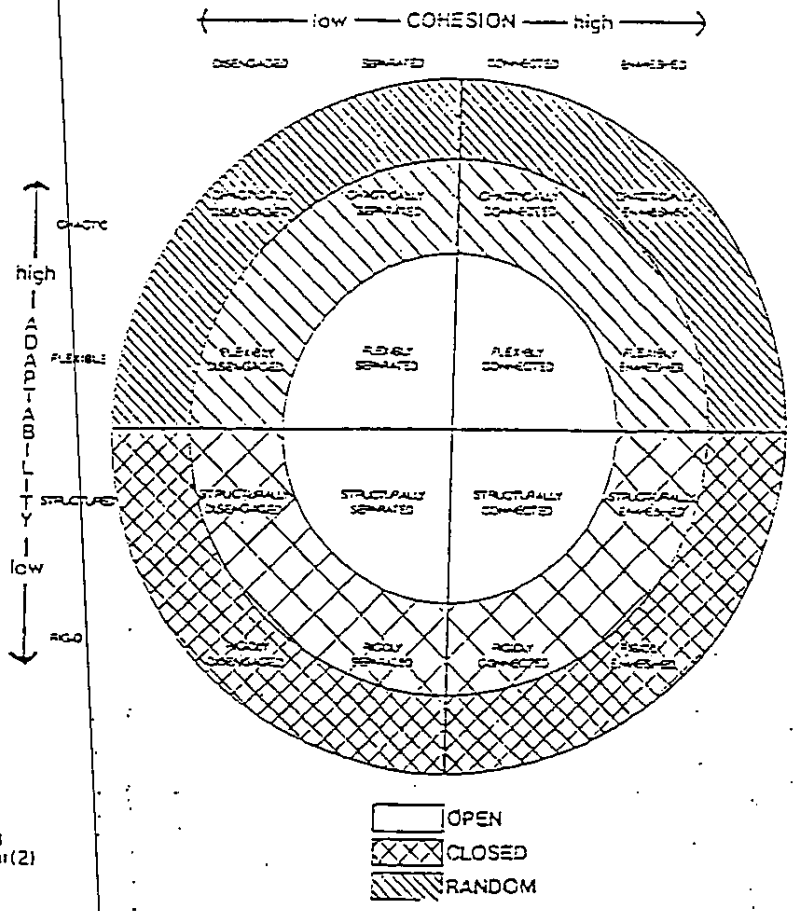


Figure 3.

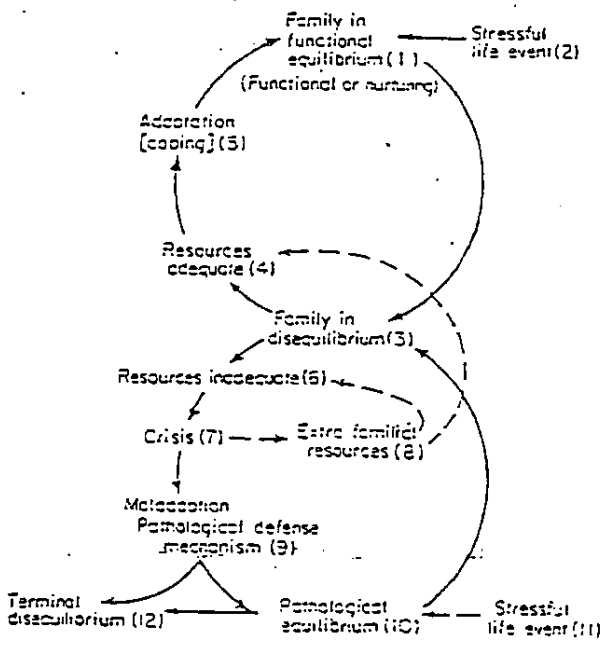
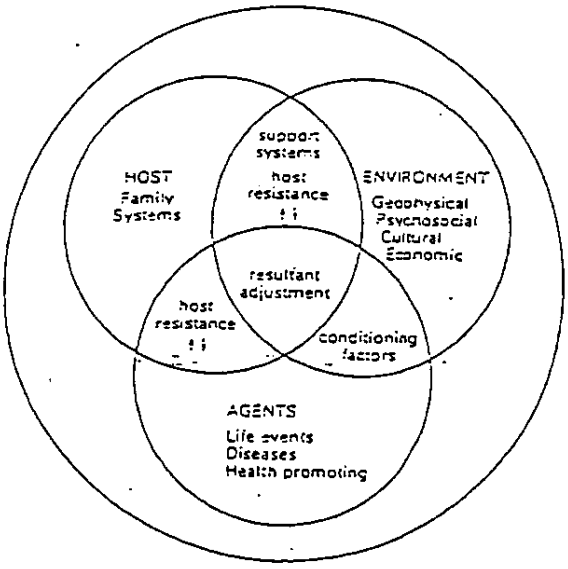


Figure 4.



Family epidemiologic model. (From Medalie, J. H., Kitson, G. C., and Zyzanski, S. J.: A family epidemiologic model: A practice and research concept for family medicine. J. Fam. Pract. 12:79, 1981; by permission of Appleton-Century-Crofts.)

The central overlapping area of the three circles is the "resultant adjustment" of all the multiple interacting variables, and reflects the current state of the family. This concept has been designated the Family Epidemiological Model and is an interactive, multisystem, multivariate model. There are some obvious educational and practical implications of its comprehensive and exhaustive approach. (Figure 4)

3. Methods to understand, describe and assess family function:

There are different methods to describe and assess family function.[8] No single method has proved better than the others to perform this task have. Some well-known tools include:

- The Family Genogram
- The Family Cycle (Duvall)
- The Family APGAR (Smilkstein)
- The Family Circle (Thrower)

Other methods:

- The Social Re-adjustment Rating Scale (Holmes and Rahe)
- FACES III (based on Olson's Circumplex Model)
- The Eco-map
- The Family Profile (Halvorsen)

The Family Genogram: [5, 9, 10, 11]

The family genogram is a tool used by physicians to summarise on one page a large amount of information relating to the family. Although it is very useful to learn about family structure, its benefit in assessing family function is more limited.

It includes a family hereditary background and the risk this places on current members, along with other major medical, social, and interactional influences.

Symbols are used to represent all family members and their relationships and interactions over at least three generations; a box is used to represent a male and a circle a female; a diagonal line crossing across the symbol represents a dead person; dates of birth and death are shown to the left and right above each figure. Lines are used to describe family ties; as a convention the husband is on the left and the wife on the right; a line or lines cutting across the marriage line, with or without the date it occurred show separation and divorce. Children belonging to a couple connect to the line that joins the two adults with the eldest child on the left and the youngest on the right. Members who live together under the same roof may be encircled by a dotted line (Figures 5-7).

The drawing of the family tree should then be completed by the addition of further information that is considered important, for example, occupation, place of living, significant life events, important illnesses or disabling conditions.

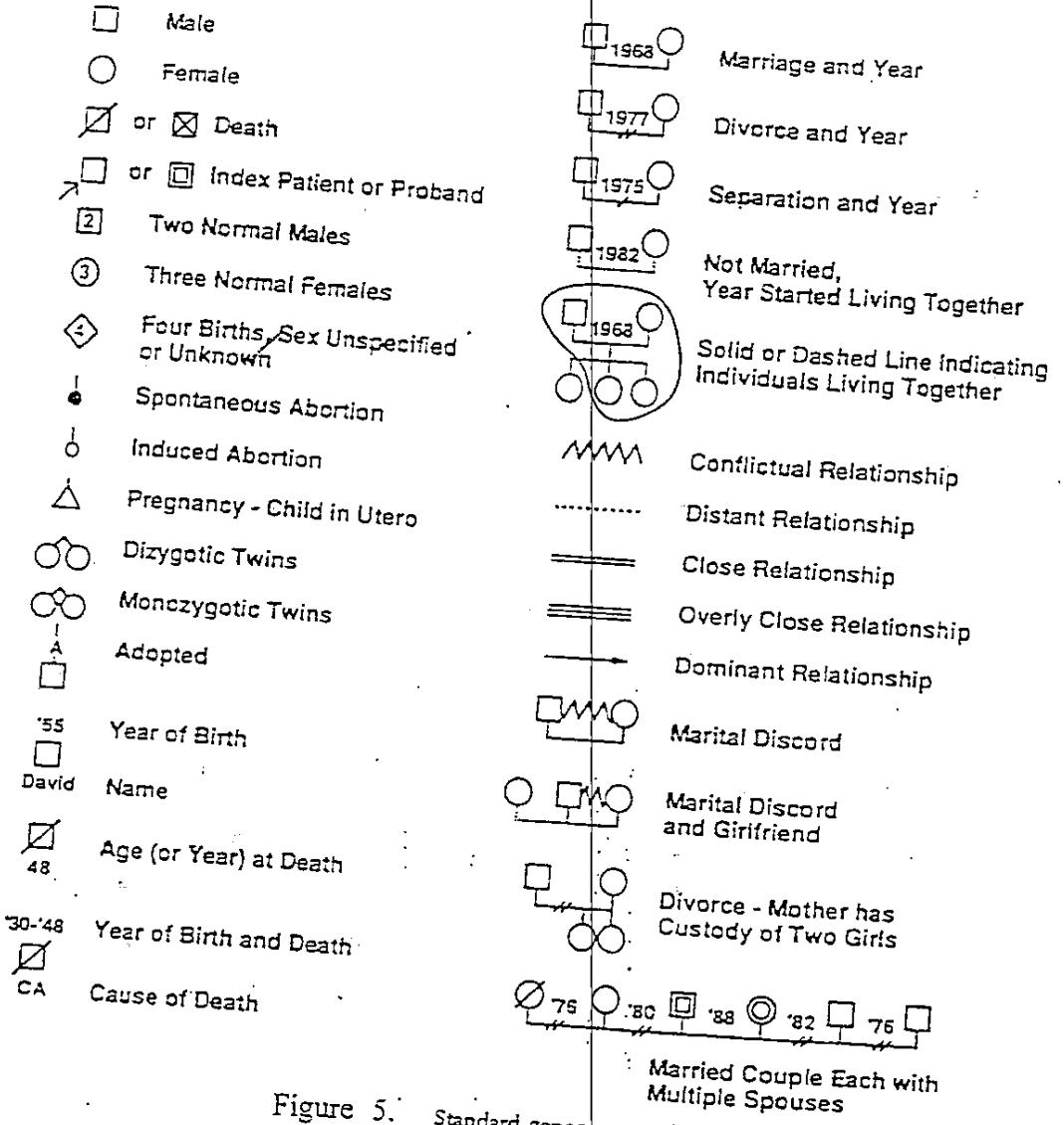


Figure 5. Standard genogram symbols.

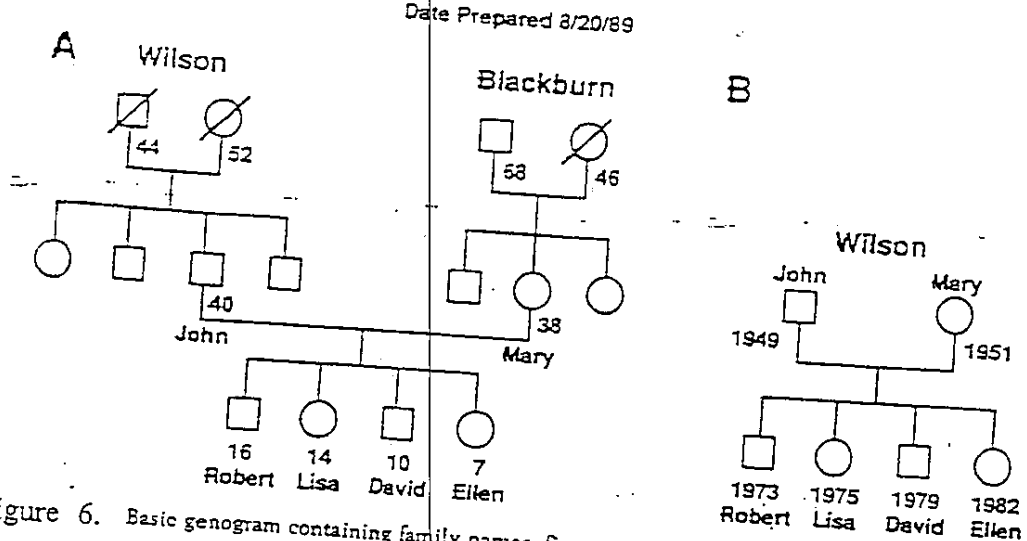


Figure 6. Basic genogram containing family names, first names, and ages (*A*) or birthdates (*B*).

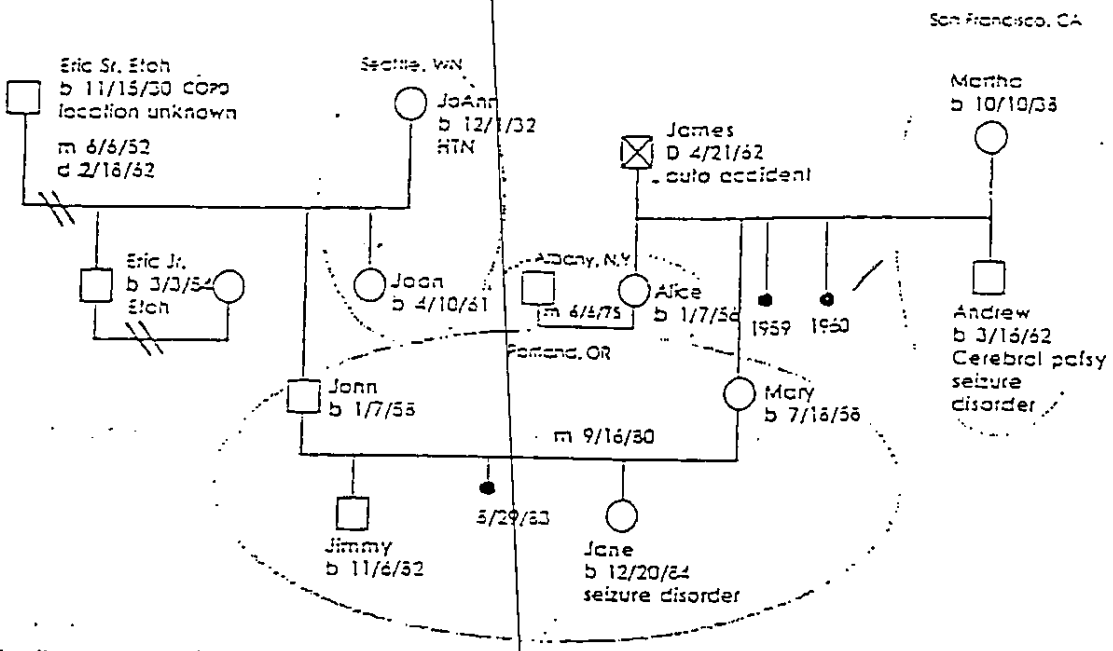


Figure 7. Family genogram of a young family from Portland, Oregon. The family is separated into four households, which are identified by shaded circles.

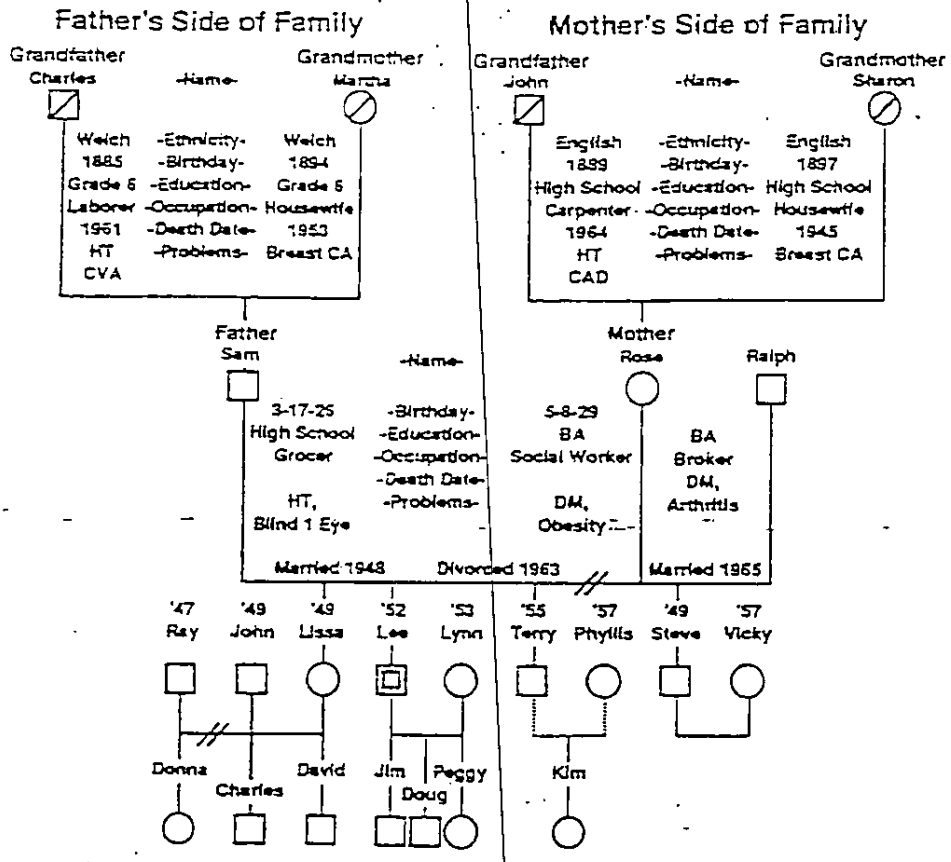


Figure 8. Example of completed self-administered genogram (SAGE).

Some authors enhance the importance of building a genogram in the presence of the whole family; as this seams rather improbable to happen, family doctors should be encouraged to complete the family tree in subsequent encounters gathering information from other members of the family. The date of the last update should clearly be indicated in the genogram.

Classically genograms were drawn by the physician; they are known as PAGE or Physician Administered Genogram. The genogram is far from ideal as an instrument to assess family function. It requires 10 to 12 minutes to complete a basic genogram, with additional time required to obtain data about family function. [5, 10] These difficulties have led to the creation of the Self-Administered Genogram - SAGE (Figure 8).

The SAGE has been developed to increase the use of genograms in clinical practice. It appears to be an efficient tool for obtaining complete and consistent information about family structure, demographics and life events. [12] After some basic instructions that can easily be given either by the physician or by a practice nurse or receptionist, the patient is asked to draw his or her family tree. Later on the physician can complete the genogram while discussing it with the patient. It requires patients that can read and write and with the basic capacities of understanding how to design their family genogram.

The interest and validity of the Family Genogram as a diagnostic test or as a screening tool has been assessed; a study by Rogers and Cohn [13] concludes that though genograms capture more information about family structure, major life events, repetitive illnesses, and family relationships than did the physicians on their own, they fail to act as a screening device for family dysfunction. Another study, the SAGE-PAGE trial,[14] shows no impact of genograms (either administered by the patient or by the doctor) on how physicians think about and deal with clinical problems or how patients view the encounter with their physician, when compared to a control group.

The Family Cycle

Several authors have described the family life cycle proposing different models. All of these models have certain elements in common.

The concept of a family circle rests on two observations:

1 That families experience changes through time in similar and consistent ways.

2 That variations in the degree to which one family member is dependent on another are related to the stage which that family has reached in its life cycle.

Duvall (1977)[15, 16, 17] distinguishes eight stages in a family life circle. The transition between one stage and the next is a potential time of difficulty both for the individual and for the family as a whole. It may involve anxiety, but weather or not problems arise, it will invariably be a time of adjustment for several family members. Within each stage of the family life cycle specific 'tasks' common to each individual can be reorganises. Such tasks need to be accomplished if problems are not to arise later on. (Tables 2-3, Figure 9)

Table 2 *Developmental tasks through the family life cycle*

Stage of the family life cycle	Positions in the family	Stage-critical family developmental tasks
1 Married couple	Wife Husband	Establishing a mutually satisfying marriage. Adjusting to pregnancy and the promise of parenthood. Fitting into the kin network.
2 Childbearing	Wife–mother Husband–father Infant daughter or son of both	Having, adjusting to, and encouraging the development of infants. Establishing a satisfying home for both parents and infant(s).
3 Pre-school age	Wife–mother Husband–father Daughter–sister Son–brother	Adapting to the critical needs and interests of pre-school children in stimulating growth, growth-promoting ways. Coping, with energy depletion and lack of privacy as parents.
4 School age	Wife-mother Husband–father Daughter–sister Son–brother	Fitting into the community of school-age families in constructive ways. Encouraging children's educational achievement.
5 Teenage	Wife–mother Husband–father Daughter–sister Son–brother	Balancing freedom with responsibility as teenagers mature and emancipate themselves. Establishing postparental interests and careers as growing parents.
6 Launching centre	Wife–mother–grandmother Husband–father–grandfather Daughter–sister–aunt Son–brother–uncle	Releasing young adults into work, military service, college, marriage etc., with appropriate rituals and assistance. Maintaining a supportive home base.
7 Middle-aged parents	Wife–mother–grandmother Husband–father–grandfather	Rebuilding the marriage realtionship. Maintaining kin ties with older and younger generations.
8 Ageing family members	Widow/widower Wife–mother–grandmother Husband–father–grandfather	Coping with bereavement and living alone. Closing the family home or adapting it to ageing. Adjusting to retirement.

Source: Duvall, E. M. (1962). *Marriage and family development*, 5th Ed. Reprinted by permission of Harper and Row, Publishers Inc. New York

The physician, by using insight into these changes, can help families anticipate and prepare for them, and at the same time can enrich his or her own understanding of the context of illnesses.

Table 3

The family life cycle

Phase	Family phase	Family description
I	Beginning family	Married couple without children
II	Childbearing family	Oldest child, up to 30 months
III	Families of pre-school children	Oldest child, 30 months to 6 years
IV	Families with school children	Oldest child, 6-13 years
V	Families with teenagers	Oldest child, 13-20 years
VI	Families as launching centres	First child gone to last child leaving home
VII	Families in the middle years	Empty nest to retirement
VIII	Ageing families	Retirement to death of both spouses

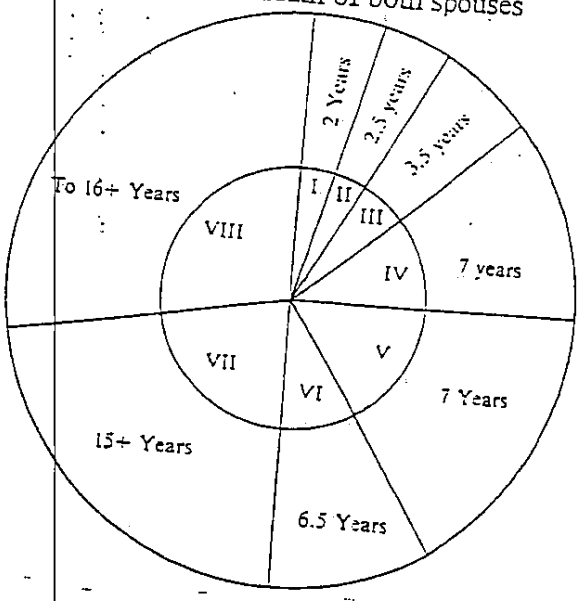


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Figure 9. The family life cycle. Glick, I. D. and Keffler, D. R. (1980). *Marital and family therapy*. 2nd Ed. Grune and Stratton, Inc., p. 36. *By permission of the Psychological Corporation, Orlando, Florida*

The Family APGAR: [2, 5, 17]

One technique, which has received support for the early detection of family problems, is the Family APGAR. First developed by Smilkstein in 1978, [18] it takes the form of a five-item questionnaire given to patients, which is designed to detect problems in family adaptation (A), partnership (P), growth (G), affection (A) and resolve (R).

Each question is scored 2, 1 or 0, depending on whether the person's answer is 'almost always', 'some of the time' or 'hardly ever'.

Total scores of 0 to 3 correlate with severe family dysfunction; 4 to 6 with moderate dysfunction, and 7 to 10 with little or no dysfunction.

Its validity and reliability as a screening device have been tested, [19, 20] and though it measures a person's satisfaction with his or her family's functioning rather than the family functioning itself, it is a test that is useful and easy to administer during the general practice consultation (Table 4).

Table 4. *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.			

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 totalled. 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.

* According to which member of the family is being interviewed the doctor may substitute for the word 'family' either spouse, significant other, parents, or children.

Source: Smilkstein, G. (1978). The family APGAR: a proposal for a family function test and its use by physicians. *Journal of Family Practice*, 6, 1231–9.

The Family Circle (Thrower) [5, 8, 11, 21, 22]

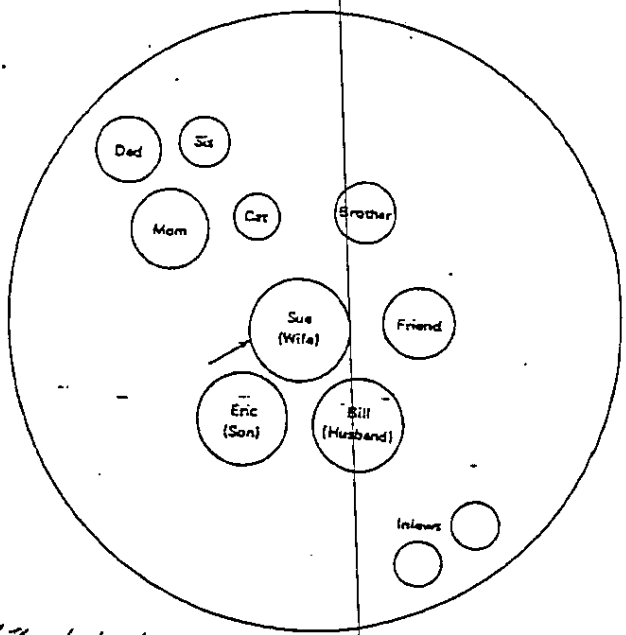
This method has been developed by Susan Thrower et al. in 1982. Its aim is to provide information about the family relationships and interactional dynamics of the family system. Family circles may be collected from one individual, a family subsystem or from all members of a family group in the presence of one another. The family member who draws the family circle explains it to the family physician. The explanation often involves a discussion of the features of the family relationship, hence enabling the doctor to better understand the family.

The physician simply draws a large circle on a piece of paper and instructs the patient as follows:

> As a family physician I am interested in you, your family and what is important to you. Let this circle stand for your family as it is now. Draw in some smaller circles to represent yourself and all the people important to you – family and others. Remember that people can be inside or outside, touching or far apart. They can be large or small depending on their significance or influence. If there are other people important enough in your life to be in your circle, put them in. Initial each circle for identification. There are no right or wrong circles.

The family circle is potentially useful as a part of the clinical data base of every patient in the practice. It is a way to illustrate the emotional relationships of a family as depicted by one member marked with an arrow; the size of the circle indicates importance; the distance from others reflects the degree of emotional attachment or closeness. It is very important to register the date in which the circle was drawn. Patients can also be asked to draw the family circle, as he or she would like it to be (Figures 10-12, Table 5).

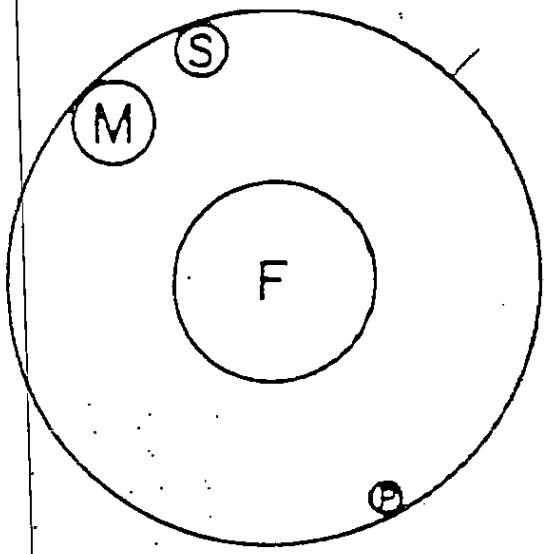
Figure 10.



"My husband, son and I are the most important to me. My mom is also very important, but I don't feel as close to her as I feel to my friend. I feel very distant from my dad."

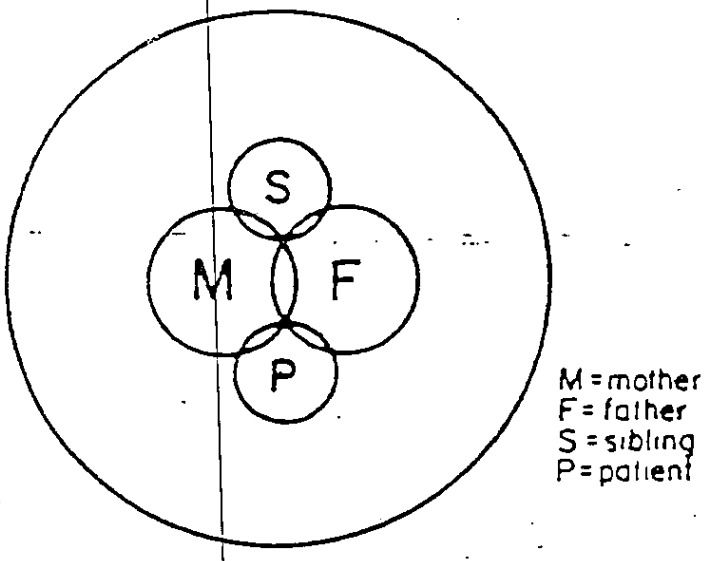
In spite of the considerable amount of time it might consume when it is first collected and discussed, it might reveal itself very useful in the future as a tool to allow a better understanding of the patient's problems and its family in a quick and easy manner.

Figure 11.



P is a 43-year-old, white, single patient whose father dominated the family. Patient had low self-image and rarely used the family as a resourse.

Dysfunctional Family Circle



P is a 25-year-old, Chinese-American student with close family ties.

Figure 12.

Table 5

USING THE FAMILY CIRCLE - CLINICAL TIPS

REMEMBER:

1. This is a process-oriented communications tool useful for self-awareness as well as data gathering.
2. The generation of information is more important than the formulation of theories and plans.
3. Attend to feelings as well as content, being aware of verbal and non-verbal communication.
4. Avoid interpretation; this is a client-oriented tool belonging to the patient.
5. What, where, when, and how questions are useful; why is not.
6. Language is very important. Modify yours to communicate with the patient. "Your language unmodified may be a poor metaphor of the patient's reality and experience."
7. Be sure all symbols are initialed.
8. Let the patient do the work and take a copy home.
9. This can be fun and enlightening for patient and physician.

THINGS TO LOOK FOR WITH THE PATIENT:

1. Personal communication style, patterns, triangles and cut-offs;
2. Personal strengths, successes, and priorities;
3. Sense of balance, control and decision-making abilities;
4. Connectedness and support (number, quality, duration, establishment of);
5. Ripple Effect - the impact upon others of a particular action;
6. Boundaries and alliances;
7. Personal belief systems;
8. How stress is viewed and managed (personal and family patterns);
9. Congruence of feelings, behavior and communication.

(Developed by Susan M. Thrower, MSW, ACSW and Richard F. Walton, MD)

The Social Readjustment Rating Scale (Holmes and Rahe) [16, 17]

In their classic work, Holmes and Rahe (1967) found that the death of a spouse or child, divorce, marriage, and other stressful life cycle events might all have significant negative effects on health. These authors, through their development of the Social Readjustment Rating Scale (SRRS), have created a standardised method for assessing the impact of stressful life span events on health. Ten of the first 15 items on the SRRS are stressful events that occur in the context of the family (see table). Of these 10 items, five are normal family life cycle events: marriage, pregnancy, and gain of a new family member, retirement and the death of a spouse. Scoring over 300 points per year showed a 80% probability of getting any form of physical or psychological illness, > 200 points and ≤ 300, a 50% probability and > 150 and ≤200, a greater incidence of diseases like myocardial infarction, peptic ulcer, infections and psychiatric problems (Table 6).

Rank	Life Event	Mean Value
1	Death of spouse	100
2	Divorce	73
3	Marital separation	65
4	Jail term	63
5	Death of close family member	63
6	Personal injury or illness	53
7	Marriage	50
8	Fired at work	47
9	Marital reconciliation	45
10	Retirement	45
11	Change in health of family member	44
12	Pregnancy	40
13	Sexual difficulties	39
14	Gain of new family member	39
15	Business readjustment	39
16	Change in financial state	38
17	Death of close friend	37
18	Change to different line of work	36
19	Change in number of arguments with spouse	35
20	Mortgage over $52,300†	31
21	Foreclosure of mortgage or loan	30
22	Change in responsibilities at work	29
23	Son or daughter leaving home	29
24	Trouble with in-laws	29
25	Outstanding personal achievement	28
26	Wife begin or stop work	26
27	Begin or end school	26
28	Change in living conditions	25
29	Revision of personal habits	24
30	Trouble with boss	23
31	Change in work hours or conditions	20
32	Change in residence	20
33	Change in schools	20
34	Change in recreation	19
35	Change in church activities	19
36	Change in social activities	18
37	Mortgage or loan less than $10,000	17
38	Change in sleeping habits	16
39	Change in number of family get-togethers	15
40	Change in eating habits	15
41	Vacation	13
42	Christmas	12
43	Minor violations of the law	11

Table 6

The SRRS was developed as an explanatory model and a tool for research about the impact of the family on health. Though it can be used in the family physician's daily activity, it seams rather 'heavy' and time consuming. Because extensive research has validated this instrument, and it might become much easier to employ with the widespread use of computers in clinical practice, it can still be a powerful tool to be considered in family medicine in the future.

FACES III [5, 23, 24]

Olson's Circumplex Model of family Function is the theoretical model for the Family Adaptability and Cohesion Evaluating Scale (FACES). This instrument has been through two versions before FACES III was developed. Because the circumplex model is understandable and the FACES instrument has been extensively tested, this instrument may have a good potential as a future tool in clinical practice. FACES is a self-reported scale, which means that a patient rates his or her own family on 30 items on a 1 to 5 scale.

The Eco-map [25]

The eco-map is basically a pictorial representation of the elements of a patient's environment and of the nature and quality of the interactions between those elements (see figure). The presenting individual is represented in the centre circle and other components of his social environment are clustered around him or her. Eco-maps highlight the supports and the conflicts, the flow of energy either to or from the patient and the quality of interactions. They are also useful in depicting connections to be established or revised and resources to be developed (Figures 13-18).

The Family Profile [26]

The Family Profile is a new self-report family assessment instrument that was developed by Halvorsen. It is grounded in the family theory and designed following a construct validation approach to instrument design that integrated theoretical concepts with test construction and empirical analysis. After the development phases that went thorough rational theoretical design, empirical structural analysis and psychometric validation the instrument was reduced to 90 items that cluster into six main factors: family concordance, family discordance, marital strength, active involvement, religiosity and parental leadership. Population studies to validate the instrument are in progress.

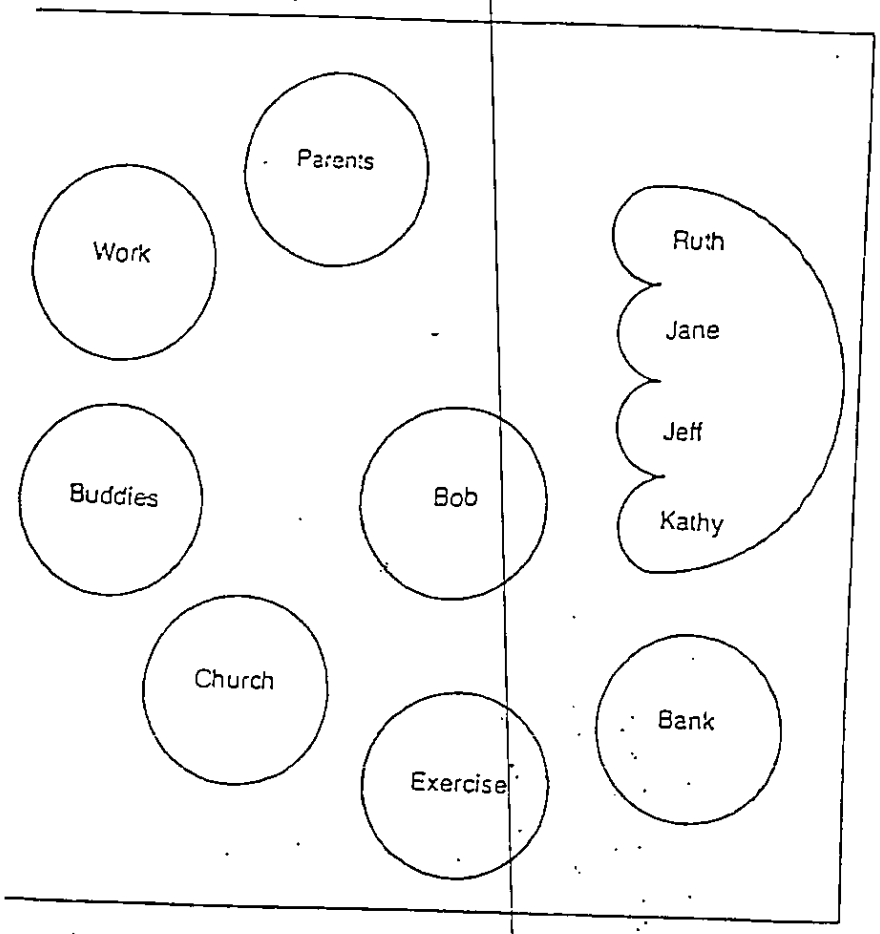


Figure 13.

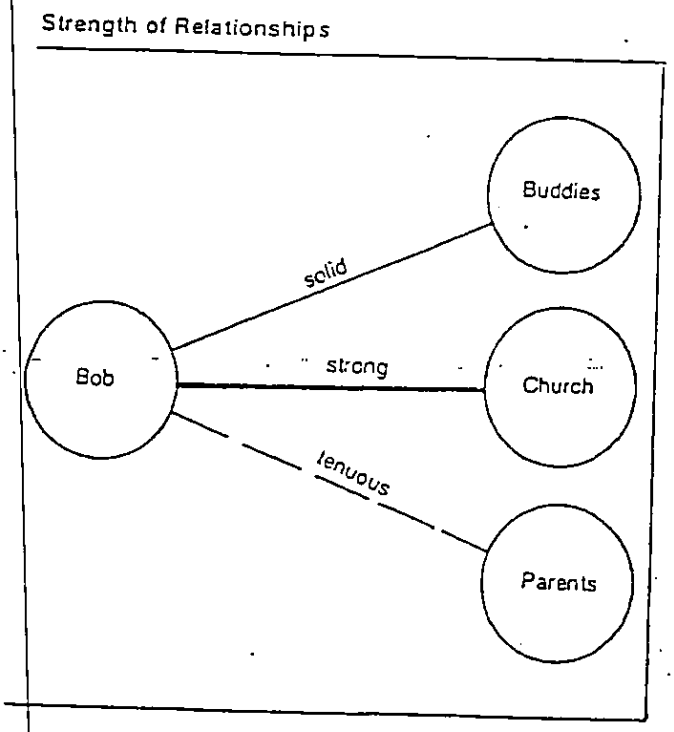


Figure 14.

Figure 15.

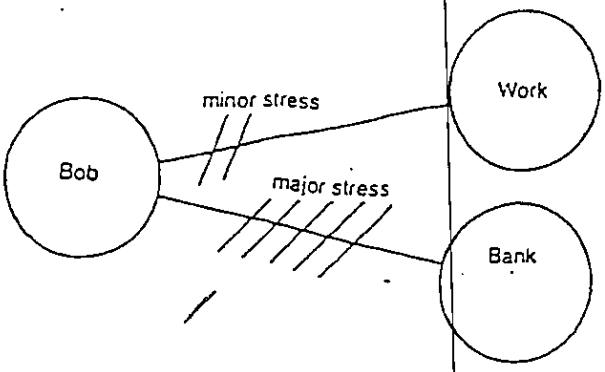
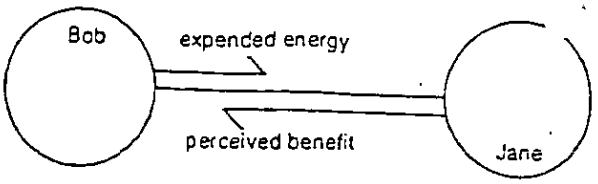
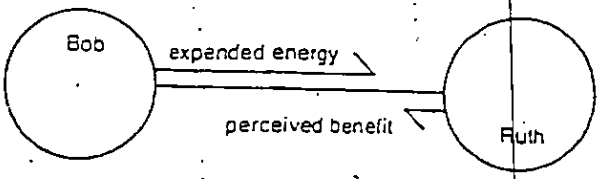


Figure 16. Energy Flow: Supportive Relationships



Energy Flow: Non-Supportive Relationships

Figure 17.



Bob's Final Eco-map

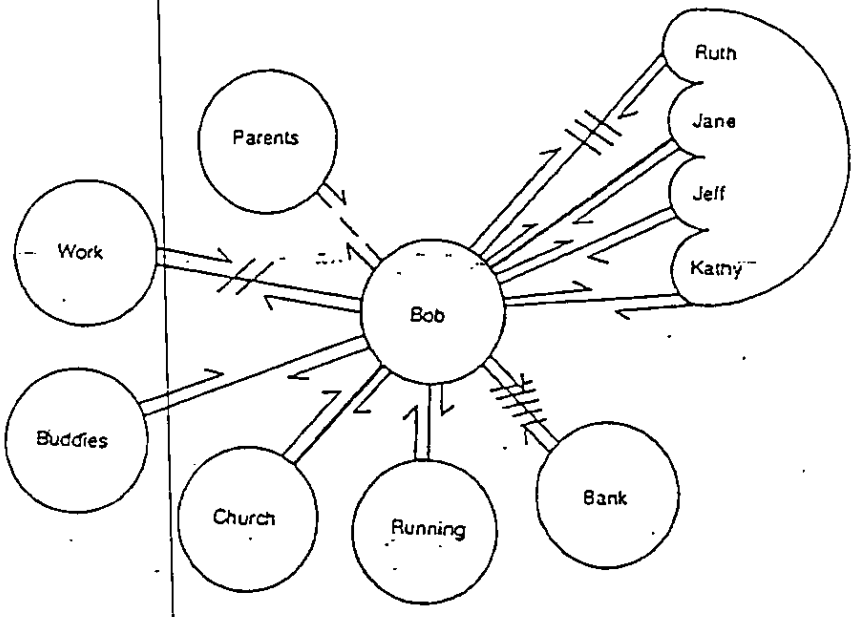


Figure 18.

4. Assessment tools for research or for clinical use

Some of the assessment tools that have been described have been developed for research purposes, while others are meant for clinical use. Many of the methods were created within a certain setting and for a defined purpose, and one should resist the temptation of using it in a distinct context

Several authors have also commented on the usefulness, specificity, sensibility, reliability, and validity of the family assessment methods.[19, 20, 27, 28, 29, 30] It is very important that not only the instruments we decide to adopt have been validated through research, but that validation has also occurred in our own country, since a translated version of a questionnaire might not be appropriate for use within a different social and cultural background.

In spite of a widespread enthusiasm and many expectations, family assessment techniques need further development and remain a fertile research field for family medicine investigation.[31, 32] More sophisticated test construction might be necessary to measure family disfunction in patients who may tend to respond defensively.[33] New methods are constantly being introduced and it may be difficult to follow all the new developments in this area. As in other fields of medicine (new diagnostic tests or new therapies), one must remain prudent and calmly wait for research to confirm the interest of a specific instrument.

5. Assessing Family Function and Working With Families [34]

Assessment of the families under their responsibility is a task for every family Physician. Basic family intervention is mandatory for all, mainly attitudes that facilitate communication and support.

Because working with families is a very specific activity, which cannot be performed based on 'common sense' only, it requires time, 'vocation', and special training. Very often it is a task better accomplished in teamwork with family physicians with family therapy training or other professionals; sometimes working with family therapy specialists is necessary, either in a consulting base or through referral.

6. Limits to the family physician's responsibility - when to refer patients to family therapy

When a family problem or dysfunction has been identified, the family doctor should work with the family members to develop a plan to address the issues. During this period the physician must decide weather the problem can be managed with primary care family counselling or weather the family should be referred to a family therapist. [35]

Some family physicians have acquired the specific competence to deal with the treatment of disturbed relationships in families but few of us are skilled enough to do so; we must, at least, be aware of the risks we may be taking when we initiate family intervention and we should have criteria of when to refer family problems to a family therapist or other mental health professionals.[36, 37]

When should a family doctor refer family problems?

Problems commonly managed by family physicians alone:

- Adjustment to the diagnosis of a new illness
- Other adjustment or situational disorders
- Child behavioural problems

Problems commonly referred to mental health professionals:

- Suicidal or homicidal ideation or behaviour
- Psychotic behaviour
- Sexual or physical abuse
- Substance abuse
- Severe depression or anxiety
- Chronic or severe marital and sexual problems

7. Family Assessment and Record Keeping

Keeping good records of patients is an indispensable activity in family practice. In the context of the development of the modern family medicine in Europe and the World, different systems have generated distinct features of practice. In some countries, specialists other than family doctors work in primary health care and are responsible for the whole or part of the care of members of families that mostly are under our responsibility (children and/or women). This creates additional difficulties for the family physician to keep good medical records containing information about the whole family.

Some recommendations must be made to increase the quality of medical records:

- If possible, keep together medical records from members of the same family
- Create a good Family Folder in your Problem Oriented Medical Record with:
  - ✓ an area for the Family Description including details about the household
  - ✓ another area for the Genogram and for the Family APGAR
  - ✓ some place for other assessment tools
- Share the tasks of gathering information about the family and keeping it updated with other health professionals (nurses, social workers, etc.)

References:

[1] McWhinney I. A Profile of Family Practice. In: McWhinney IR, ed. A Textbook of Family Medicine. New York: Oxford University Press, 1989: 35-42.

[2] Smilkstein G. Assessment of family function. In: Taylor RB, ed. Family Medicine. New York: Springer, 1983: 74-84.

[3] Christie-Seely J. Working with the Family in Primary Care: a System Approach to Health and Illness. New York: Praeger Publishers, 1984.

[4] Ramsey CN, Lewis JM. Family Structure and Functioning. In: Rakel RE, ed. Textbook of Family Practice, 4th ed. Philadelphia: W B Saunders Company, 1990.

[5] Saultz JW. Incorporating a family systems approach into clinical practice. In: McDaniel, Campbell, Seaburn, ed. Family oriented primary care. New York: Springer, 1989: 30-4.

[6] Smilkstein G. The cycle of family function: a conceptual model for family medicine. J Fam Pract 1980 Aug; 11 (2): 223-32.

[7] Medalie JH, Kitson GC, Zyzanski SJ. A family epidemiological model: a practice and research concept for family medicine. J Fam Pract 1981 Jan; 12 (1): 79-87.

[8] Smilkstein G. The Physician and Family Function Assessment. Fam Syst Med 1984; 2 (3): 263-78.

[9] Rakel RE. The Family Genogram. In: Rakel RE, ed. Textbook of Family Practice, 5th ed. Philadelphia: WB Saunders Company, 1995: 20-34.

[10] Waters I, Watson W, Wetzel W. Genograms: practical tools for family physicians. Can Fam Physician 1994; 40: 282-7.

[11] Koch-Hattem A, Berolzheimer N, Thrower SM. Family systems tools for assessing families [handout form version]. In: Sloane PD, Slatt LM, Baker RM, eds. Essentials of Family Medicine. Baltimore, Maryland: Williams & Wilkins, 1988: 3-13.

[12] Rogers J, Hollway R. Completion rate and reliability of the self-administred genogram (SAGE). Fam Pract 1990 Jun; 7 (2): 149-51.

[13] Rogers JC, Cohn P. Impact of a Screening Family Genogram on First Encounters in Primary Care. Fam Pract 1987; 4 (4): 291-5.

[14] Rogers JC, Rohrbaugh M. The SAGE-PAGE trial: do family genograms make a difference? J Am Board Fam Pract 1991 Sep-Oct; 4 (5): 319-26.

[15] McWhinney IR. The family in health and disease. In: McWhinney IR, ed. A Textbook of Family Medicine. New York: Oxford University Press, 1989: 202-27.

[16] Liese BS, Price JG. The Family Life Cycle. In: Rakel RE, ed. Textbook of Family Practice, 4th ed. Philadelphia: WB Saunders Company, 1990: 41-60.

[17] Williams PR. Family Problems. Oxford: Oxford Medical Publications, 1989: 26-31, 38-45, 49-55, 90-91.

[18] Smilkstein G. The Family APGAR: a proposal for a Family Function Test and its use by Physicians. J Fam Pract 1978; 6: 1231-9.

[19] Smilkstein G, Ashworth C, Montano D. Validity and reliability of the Family APGAR as a test of family function. J Fam Pract 1982; 15: 303.

[20] Good MJ, Smilkstein G, Good BS, Shaffert T, Arons T. The Family APGAR index: a study of construct validity. J Fam Pract 1978; 8: 557-82.

[21] Thrower SM, Bruce WE, Walton RF. The Family Circle Method for integrating Family Systems Concepts in Family Medicine. J Fam Pract 1982; 15 (3):451-7.

[22] Thrower SM. Family Circle Method [handout form version].

[23] Olson DH. FACES III: St. Paul: University of Minesota, 1985.

[24] Olson DH. Three-dimensional (3-D) Circumplex Model and revised scoring of FACES III. Fam Process 1991 Mar; 30 (1): 74-9.

[25] Jenson K, Cornelson BM. Eco-Maps: A Systems Tool for Family Physicians. Can Fam Physician 1987; 33: 172-7.

[26] Halvorsen JG. The family profile: a new self-report instrument for family assessment. Fam Pract Res 1992; 12 (4): 343-67.

[27] North S, Maevel MK, Hendricks B, Morphew P, North D. Physicians' Usefulness of Family-Oriented Clinical Tools. J Fam Pract 1993; 37 (1): 30-4.

[28] Hilliard R, Gjerde C, Parker L. Validity of two psychological screening measures in family practice: Personal Inventory and family APGAR. J Fam Pract 1986 Oct; 23 (4): 345-9.

[29] Bellon Saameno JA, Delgado Sanchez A, Luna del Castillo JD, Lardelli Claret P. Validity and reliability of the family APGAR function test [Spanish original]. Aten Primaria 1996; Oct 15; 18 (6): 289-96.

[30] Gil de Morais JC. Validity of the Family APGAR as a diagnostic method in family Medicine [Portuguese original]. Rev Port Clinica Geral 1988; 32: 22-8.

[31] Halvorsen JG. Self-report family assessment instruments: an evaluative review. Fam Pract Res J 1991 Mar; 11 (1): 21-55.

[32] Halvorsen JG. Designing self-report instruments for family assessment. Fam Med 1990 Nov-Dec; 22 (6): 478-84.

[33] Gwyther RE, Bentz EJ, Drossman DA, Berolzheimer N. Validity of the Family APGAR in patients with irritable bowel syndrome. Fam Med 1993 Jan; 25 (1): 21-5.

[34] Doherty WJ, Campbell TL. Families and Health. Newbury Park, California: Sage Publications, 1988: 50-2, 129-33.

[35] Campbell TL. The Family's Influence on Health. In: Rakel RE, ed. Textbook of Family Practice, 5th ed. Philadelphia: WB Saunders Company, 1995: 35-45.

[36] Freeling P, Harris CM. Happy and unhappy families. In: The doctor patient relationship. Edinburgh: Churchill Livingstone, 1984: 80-93.

[37] Newman NK. Family Secrets: A Challenge for Family Physicians. J Fam Pract 1993; 36 (5): 494-6.