Nursing and Family Therapy Training

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In the past few years nursing theory has made a dramatic shift from focusing on the individual to focusing on the family. Nursing now considers the family as one of the primary units of health care. The nursing literature is replete with such terms as "family centered care" (Cunningham, 1978), "family nursing" (Friedman, 1986); "family-focused care" (Janosik & Miller, 1979), "family conferences" (Wiley, 1978), and "family interviewing" (Wright & Leahey, 1984). These terms are also evident in many components of undergraduate and graduate nursing curricula, especially in the area of community health.

The involvement of families in nursing is interesting because it has come full circle. Although family nursing has always been part of nursing, until recently it was not labeled as such. Because nursing was first practiced in patients' homes, it was natural to involve family members in providing care. With the transition of nursing practice from homes to hospitals during the 1930s and 1940s, the family was excluded from involvement. Nursing is once again, however, inviting families to participate in both home care and hospital treatment. One example of this trend is the large number of fathers now involved in all aspects of maternity care. Family nursing has come to mean nursing care of the well and sick, and health counseling for all members of the family.

Despite the statement that *family-focused care* is widely accepted within the discipline of nursing, it should be noted that *family therapy* is less widely accepted within nursing. Nursing educators have incorporated family therapy into their mental health nursing programs only as one more treatment method, rather than as a different orientation to human problems.

Some possible explanations for this phenomenon can be offered. First, the majority of nurses are highly committed to maintaining their professional identity within the nursing profession, and therefore have been hesitant to enter into the mainstream of family therapy. Nurses are keen to do "family work," but do not want to be considered family therapists. This difference in professional identity between nurses and family therapists has been further accentuated in recent years by the recognition of family therapy as a distinct profession. Second, there is a dearth of family therapy role models within the nursing profession itself. There are few nurse educators/clinicians who specialize in the practice of family therapy. Therefore, most nurses have to go outside of their profession to receive family therapy training. Nursing students often rely on

psychologists, social workers, and other professionals to serve as prototypes of famil therapists. When students are not trained by or do not observe a competent nurs engaged in family therapy in a *nursing context*, the likelihood that they will associate th significance of family therapy within the discipline of nursing is lessened. Thus, it can b stated that many nurses are interested in family nursing but few have received special ized training in family therapy.

Perhaps a more compelling reason for the hesitancy of the nursing profession t embrace family therapy is that nurses are often made to feel that once they hav specialized in family therapy, they must make a choice between identifying themselve as either nurses or family therapists. Our experience has been that our identity vari according to the professional context in which we find ourselves. That is, at times w identify ourselves as nurses with special training in family therapy, and at other times a family therapists who have a background in nursing. We believe that a more satisfactor solution to this professional identity dilemma would be the clear distinction of two level of expertise in nursing with regard to family work: generalists and specialists. Th purpose of this chapter is to discuss the issues involved in training both generalists an specialists in family work in nursing. Attention will be given to distinctions betwee training nurses in family nursing (generalists) and training nurses in family therap (specialists).

TRAINING ISSUES

To clarify and compare the training of nurses in family nursing and in family therapy the following issues will be discussed: context of training, education levels, faculty curriculum, goals of training, supervision methods, and facilities for training. Each wil be addressed separately.

Context of Training

Most nurses have an innate "family-mindedness," and some have been taught a concep tual base for family work. Many, however, find it difficult to apply their conceptua model in actual clinical practice. Part of the difficulty is that nurses, understandably place emphasis on families with health problems.

Interest and emphasis on families with health problems is idiosyncratic to nursin and other health care professions. It has, however, implications for training. Nurse readily pay attention to family members with health problems, whereas family therapist without a nursing background tend to ignore or be uninformed about health issues Nurses are taught to use a holistic approach in their clinical work, and emphasize *bot* the biophysical and psychosocial aspects of health care. Because their orientation i primarily toward physical care, nurses tend to be more aware of the biophysical than th interpersonal aspects of an illness. They easily recognize the impact of the illness on th individual's functioning, but require more training to assess the impact of the illness o *all* family members.

Another significant implication for training is that nurses, because of their employ ment context, are required to learn first about the physical aspects of illness and only

secondarily about the interactional aspects. For example, in working with a family with cancer nurses must be knowledgeable about both cancer as an illness and its management within the family system. Family therapists, on the other hand, are not expected to know about such physical aspects as colostomies or medication side effects. It is thus a challenge for nurses to try to integrate a family systems approach with their nursing education.

Education Levels

We recommend that the education of a nursing student in family therapy be provided only at the graduate or postgraduate levels, while the training of a student in family nursing may be provided at the undergraduate and/or graduate level (Wright & Leahey, 1984).

GRADUATE AND POSTGRADUATE EDUCATION

Graduate nursing master's or doctoral programs and postdegree institutes specializing in family therapy provide heavy emphasis on family assessment, models of family therapy, and the necessary skills to practice family therapy. Extensive clinical supervision, preferably live, of students' skill development (perceptual, conceptual, and executive) is provided by educators/clinicians. In North America, only a few graduate nursing programs or postdegree institutes offer family therapy courses taught by *nurse* educators (e.g., the Oregon Health Sciences University, Portland, Oregon; the University of Washington, Seattle, Washington; and the Family Therapy Institute, Holy Cross Hospital, Calgary, Alberta). Also rare is the supervision of nursing students in their clinical family therapy practica by *nurse* educators/clinicians.

We will briefly describe two graduate nursing programs that do offer family therapy courses and clinical supervision. These are examples of attempts to incorporate family therapy training into nursing programs. The first is the master's program, Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada. The program is designed to prepare clinical nurse specialists. Students entering the program who desire to specialize in family therapy are able to focus on this area of interest within their clinical practica. Two elective courses are also offered: "Family Therapy Models: Structural, Strategic and Systemic"; and "Families and Illness." The predominant assessment model used is the Calgary Family Assessment Model (Wright & Leahey, 1984), while the predominant intervention model is an integration of the systemic–strategic approach. Live supervision is provided by two nurse educators/clinicians who themselves have specialized training in family therapy. The graduate nursing students also have opportunities to observe their professors interviewing families. Families interviewed by the graduate students are seen at the Family Nursing Unit at the University of Calgary (Wright, Watson, & Duhamel, 1985).

Another example of a graduate nursing program that offers family therapy courses and clinical supervision is the master's program at the University of Washington. This program offers a course entitled "Theoretical Models of Family Analysis and Intervention." The structural family therapy approach is presented in the clinical practica, although students are given the opportunity to select other approaches as well. Students are fortunate to have live supervision provided by a nurse educator/clinician who has specialized training in structural family therapy.

UNDERGRADUATE EDUCATION

At the undergraduate level, many nursing programs teach family nursing within the community health or mental health part of the curriculum. An example of this type of baccalaureate program is the School of Nursing at the Oregon Health Sciences University, Portland, Oregon. At the undergraduate level, appropriately, it is not the goal to prepare nursing students to be *family therapists*. Rather, these programs provide theory and skill development in family assessment and intervention. They prepare generalists with adequate skills in *family nursing*. Specifically, these nurses are able (1) to conceptualize human needs and problems in families using systems/cybernetics/communication concepts, (2) to assess normative events using a family assessment model, (3) to intervene with such normative family events as the birth of a child, and (4) to use direct and straightforward interventions such as recommending that parents read a particular book on child rearing. Undergraduate nursing students normally receive supervision of their family interviewing through case discussion and/or audiotape or videotape supervision. Rarely do undergraduate nursing students have their work with families viewed directly.

Many practicing nurses, especially those graduated before 1970, are also interested in continuing education courses in family nursing. Even though these professional nurses received little if any training in family nursing, they are eager for this type of knowledge and training. They seek opportunities for learning family nursing both in their own agencies or institutions and through continuing education courses in academic settings. An example of such a continuing education program offering an introduction to family nursing is the Post-Basic Mental Health Nursing Certificate Program at Mount Royal College, Calgary, Alberta.

Faculty

As mentioned earlier in this chapter, one of the primary obstacles at present to providing more extensive family therapy to nursing students and professional nurses is the lack of sufficient role models. There are very few nurse/educators who bridge the two disciplines of nursing and family therapy.

Although there are few nursing educators who are practicing family therapists, there are several nurses who have expertise in family theory and research, having received their own graduate education in child and family development or family studies. These educators provide leadership in family nursing, and are establishing ties with other health professionals to foster family-focused care. For example, at the annual National Council on Family Relations (NCFR) meeting in 1983, a special interest group for nurses and family health professionals held their first meeting.

The emphasis on the importance of nursing role models is not meant to disqualify the increasing use of interdisciplinary faculty. As a nursing student develops family therapy skills, there are times when it would be highly desirable for the student to receive supervision from other members of the helping professions. At the early stages of graduate training, however, competent role models within nursing are vital and critical if family therapy is to become more accepted within the discipline of nursing.

Curriculum

An examination of the curricula taught to students in family nursing, and to students specializing in family therapy in nursing, reveals three trends that serve to limit the extent to which family therapy can become an integral part of the nursing discipline. The first trend is that family nursing and/or family therapy courses are seldom identified as such. This trend is idiosyncratic to nursing. Within undergraduate curricula, family nursing is often hidden or embedded in other courses. For example, a course called "Clinical Nursing" can contain a significant amount of material concerning the family. Yet the title of the course does not reflect the family focus. Even at the graduate level, courses dealing with family therapy are frequently identified by such general titles as "Special Topics in Health Care." This reflects, we believe, nurse educators' ambivalence about a systems perspective and their lack of articulation of the levels of expertise in family work. However, as more nurse educators adopt a systemic perspective to health problems, this articulation should be reflected in the nursing curricula, with family-oriented courses more readily identifiable.

A second trend in nursing is the adoption of a wide variety of family assessment models (Clark, 1978; Friedman, 1986; Grace & Camilleri, 1981; Horton, 1977; Wright & Leahey, 1984). These models tend to be eclectic, and to incorporate a few family therapy concepts along with many concepts from nursing and sociology. The following statement from Janosik and Miller's work (1979) perhaps best identifies the beliefs of the nursing profession about the need for an eclectic framework. They state that

> focusing on one aspect of family life reveals that aspect but may ignore others of equal or greater importance. To adopt a single framework is unnecessarily restrictive, because it discounts the multiple aspects of family life and confines itself to a reductionistic point of view. Every conceptual framework is advantageous in some respects, but consigning all observations into one theoretical framework results in emphasizing some details at the expense of the others (p. 14).

This belief in eclecticism has enabled nursing to maintain an interest in family theory, but has limited its ability to develop theoretical models integrating family therapy and nursing. There are no specific models of family therapy associated with the nursing discipline. Rather, nurses have generally selected specific concepts (e.g., pseudo-mutuality, double-bind) from a wide variety of family therapy models. Rare mention is made in the nursing literature of the newer family therapy approaches, such as the strategic approach or the systemic (Milan) approach.

One book, *Nurses and Families: A Guide to Family Assessment and Intervention* by Wright and Leahey (1984), does attempt to integrate the most useful concepts from nursing and family therapy. The authors have presented a systematic family assessment model and have offered guidelines for intervention. The assessment model is the Calgary Family Assessment Model (CFAM), which is a multidimensional framework consisting of three major categories (structural, developmental, and functional). The model is based on a systems/cybernetics/communication theory foundation. Although the model has been primarily adapted from the family assessment framework developed by Dr. Karl Tomm and colleagues at the Family Therapy Program, Faculty of Medicine, University

of Calgary, it integrates the work of Carter and McGoldrick (1980), Epstein, Bishop, a Levin (1978), and Minuchin (1974). In their guidelines for intervention, Wright a Leahey have integrated the work of Bateson (1979), Hoffman (1981), Haley (197 Keeney (1982), and the Milan group (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 19 Tomm, 1984a, 1984b). Other nursing authors who have taken on the challenge bringing together significant concepts from nursing and family therapy include Fric man (1986) and Clemens and Buchanan (1982).

A third trend that can be noted in the nursing curricula is the lack of emphasis family intervention. Despite the proliferation of family assessment within nursing curr ula, little emphasis has been given to family intervention and the processes by whi change takes place. Sound interventions are based on sound assessments and cle identification of problems, but most nursing texts stop at this level. Very few nurs consider what types of interventions are appropriate for various types of families wi problems. The specific "how-tos" of family intervention are seldom discussed, either family nursing literature or in family therapy training in nursing. One recent contrib tion to the literature is the three-volume *Family Nursing Series*, which emphasiz assessment *and* intervention for specific health problems (Leahey & Wright, 198 1987b; Wright & Leahey, 1987). Until recently, nurses were limited in their ability to innovative or devise interventions because they were entrenched in a medical hierarc where they were expected to carry out physicians' orders. The majority of nurses who a employed in traditional hospital settings still find themselves unable to take as muc initiative as they would like. However, with the advent of more and more nurses prepar with strong clinical skills at the masters level (e.g., family nurse practitioners and clinic nurse specialists), nurses are seeking opportunities to provide not only sound clinic assessment but intervention as well. An example of this is the Family Nursing Traini Program, established at the Holy Cross Hospital in Calgary, Alberta, where nurses on t inpatient psychiatric units receive live and videotape supervision on their family inte viewing from a family clinical nurse specialist. Many such clinical nurse specialists ha already been integrated into and esteemed by other hospital and community heal settings. Master's-prepared nurses are taking the lead in recognizing the interaction domain as a significant and legitimate aspect of nursing.

Goals of Training

The primary goal of training both family nurses and family therapists in nursing is develop strong *conceptual*, *perceptual*, and *executive* skills. To *conceptualize* health ca at the family level, students must recognize the impact of illness on the family and t influence of family interaction on the "cause" or "cure" of illness (Wright & Bell, 198 To do so, both undergraduate and graduate nurses should use a systemic approach conceptualize needs and/or problems in families.

Perceptual skills include the ability to make accurate observations, and to abstra from those observations the repetitive patterns of interactions among family membe (Goren, 1979). Janzen (1980) emphasizes that the beginning nursing student already h intuitive perceptual/conceptual skills learned in other life experience. Because the studer may not be aware of many of these skills, they need to be emphasized during trainin

Executive skills are required to carry out therapeutic interventions in an interview. Students skilled in family nursing will be able to assess and intervene with normative events in families with the use of direct interventions. Students taking family therapy training in nursing will be able to assess and intervene in both normative and paranormative family events using an identifiable intervention model. Their interventions may be straightforward, or may be more complex and indirect (e.g., use of rituals or reframing). Both family nurses and nurses who have specialized in family therapy will conclude treatment with a therapeutic termination. Nurses skilled in family nursing would most often refer families if further treatment was indicated.

Since nurses more than other health professionals have frequent contact with families, particularly in hospital and community settings, they need to possess strong interpersonal skills to be effective. Family therapy offers many skills that are useful in relating to families. Examples are engagement skills, taking a "one-down position" when dealing with symmetrical families, and maintaining neutrality. Regardless of the level of expertise, all nurses need skills that are unique to work with families.

Supervision Methods

The predominant focus of supervision in nursing is on the development of skills (psychomotor and interpersonal), and not on the personal development of the nurse. The methods used to supervise family nursing and family therapy training in nursing appear to be going through a clearly identifiable, evolutionary process. There is an increasing emphasis on direct observation of the nurse's work. In the past, verbal and written process recordings were used heavily. We believe this method of supervision is the least effective method for aiding the development of therapeutic competence (Wright & Leahey, 1984).

The next evolutionary step, audiotape recording, was important in correcting the distortions of traditional verbal and/or written content. However, the major disadvantage of this type of supervision is that it omits extremely valuable data concerning nonverbal behavior. It is unfortunate that most students engaged in family nursing receive, at best, supervision only on their audiotaped interviews.

Although direct observation has been a common method used for the development of the nurse's psychomotor skills, live supervision of interactional skills has not been pursued as vigorously. The underuse of live supervision can be attributed, in part, to a lack of one-way mirrors in many facilities. Educators, however, can use other methods of direct observation. Supervisors can sit in on the actual interviews and participate minimally, or preferably not at all. Live supervision provides guidance predominantly in the development of executive skills (Wright, 1986).

Training Facilities

To the best of our knowledge, appropriate and well equipped facilities for training nursing students in family nursing or for specialization in family therapy are rare in North America. One excellent facility is the Family Nursing Unit (Wright, Watson, & Duhamel, 1985) at the Faculty of Nursing, University of Calgary. The training facilities have been used predominantly by graduate students and, to a lesser degree, by under-

graduate and continuing nursing education students. The architectural design of th physical space and the use of technical equipment have a significant influence on th nature of training. The suite of five interviewing rooms and one large observation roo provide a high degree of flexibility for the use of one-way screens, telephone intercon and videotape equipment (Figure 17-1). Each room has a one-way mirror so that th interview can be observed and supervised. In addition, three rooms can be viewed nc only from the observation room but also from adjoining rooms. All of the rooms ar equipped for videotape recording. Remote-control color cameras are available in one c the large rooms and are concealed within triangular oak "bookshelves" in three corner of the room. All rooms are connected with an intercom system. A technician in th central control room does all of the recording.

Families seen at the Family Nursing Unit[1] normally receive the benefit of a tean approach; graduate (master's) nursing students conduct the interviews, while a superviso (nursing faculty) and three or four other graduate students observe. All team member have input into both assessment and interventions (Wright, Miller, & Nelson, 1985).

CONTRIBUTION OF NURSING TO FAMILY THERAPY

Nursing can make two unique contributions to the family therapy field. First, nurses can help family therapists become more aware of the health issues with which families cope by making them cognizant of the interrelationship between biological and psychological issues (Leahey & Wright, 1985). Nurses, for instance, are not intimidated by families

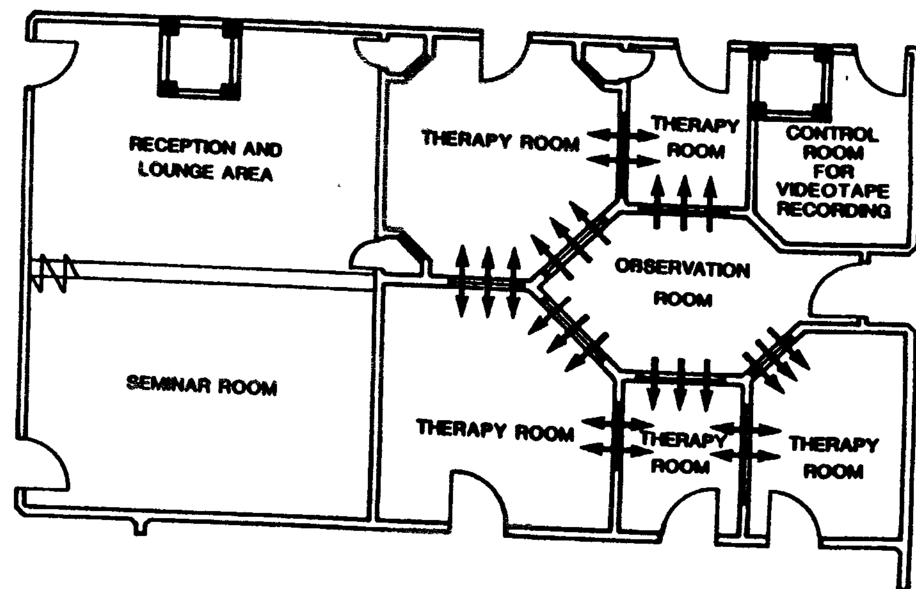

FIGURE 17-1. The Family Nursing Unit, University of Calgary.

dealing with life-threatening illnesses such as cancer, or chronic illnesses such as multiple sclerosis. They are knowledgeable and sensitive about stresses involved in dealing with specific types of chronic illness such as diabetes mellitus, which fluctuates daily, and arthritis, which varies little from day to day. In contrast to family therapists, who may lack knowledge about health problems, nurses automatically tend to include these issues in their family assessment. For example, a family may present with a 5-year-old diabetic boy who is irritable and unmanageable, especially before supper time. Recognizing that hypoglycemia can manifest itself behaviorally as transient irritability, anxiety, or confusion (McArthur, Tomm, & Leahey, 1976), a nurse would more naturally assess this connection between the physiological and behavioral aspects of the presenting problem. Adjustment of the eating schedule or the insulin dosage are appropriate interventions that could be suggested by a nurse to family members (Tomm, McArthur, & Leahey, 1977).

A second contribution of nursing to the family therapy field is the potential for a great influx of family interviewers. There are over 1.6 million practicing nurses in the United States. More than most other professionals, nurses have unique opportunities to work with families because of the number and variety of contexts in which nurses provide health care, such as in hospitals, homes, and occupational health settings. As nurses increase their conceptualization of the family's role in the formation and/or maintenance of symptoms as well as the impact of illness on the family, more families will receive the benefit of a systemic approach to health problems. One of the hoped-for consequences of nurses adopting a new epistemology of health problems is that they will be able to make more accurate and thorough family assessments. In so doing, they will make better judgments as to whether or not family intervention is indicated or desirable (Leahey & Slive, 1983).

Is family therapy open to accepting the contribution of the nursing profession? Particularly, is family therapy ready to address the interrelationship of biophysical and interactional factors in family functioning? There does seem to be a burgeoning interest in the family therapy field in helping families with health problems. The relatively new *Family Systems Medicine* journal is one sign of interest in this area.

Whether the family therapy field is ready to accept *nurses* becoming more involved with families remains to be seen. Within most hospitals and health care settings the issue of territoriality is alive and well! It is our experience that other traditional disciplines, namely social work, psychiatry, and psychology, have difficulty accepting nurses doing family therapy. How a "family problem" and how a "health problem" are defined in a particular work setting can fuel the controversy, because the definitions involve issues of identity and professionalism. If nurses (working with a patient who has had a recent colostomy) invite the spouse to come for instruction on how to assist in changing the colostomy bag, are the nurses treating the family or treating the health problem?

If nursing and family therapy are to bridge camps, then the definition of whether a problem is a nursing or a family issue is a question of semantics. Ideally, the best person to intervene in a situation is the one with the most ready access to the system level in which a problem manifests itself. Nurses may have an advantage over other professionals in sidestepping territorial issues; by a simple reframing they can invite whole families to participate in nursing care rather than family therapy to minimize territorial issues. In this way they can avoid conflict with other professionals, such as social workers, psychologists, and psychiatrists, who may believe that nurses should not work with families. Reframing can also facilitate initial engagement with families. Experience has shown us that families are more receptive when invited for a *family nursing* meeting than for a *family therapy* session.[2]

RECOMMENDATIONS FOR TRAINING NURSES

The following recommendations are based on our seven years of experience in teaching over 1,000 practicing nurses about family assessment and intervention. In addition, it is based on our experience in teaching nursing students in a certificate program, a bachelors program, a master's in nursing program and a family therapy institute. Because we have also taught physicians, social workers, and psychologists, we are aware of the different issues involved in educating nurses.

First, we recommend that trainers be aware of nurses' sensitivities to the discrepancy between their educational level and that of their colleagues. Practicing nurses are aware of the fact that they may not have a master's or even a university degree, and yet may deal with the same types of patients and their families in the same setting as professionals from other disciplines. Thus, nurses may sometimes feel very insecure and unskilled in comparison to other team members, while at other times they may feel very resentful because they are expected to deal with these patients and their families on a day-to-day basis, and they often cope as well as or better than other health professionals.

Second, we recommend that training be offered in the nurses' context using *their* families, *their* presenting problems, and *their* language whenever possible. Nurses respond very well when family interviews are conducted in their own work setting (e.g., the hospital or community health agency). We have gone to acute care hospitals, auxiliary hospitals, and home care and community health agencies to interview families with which the nurses are already working; because the presenting problems were health-related, the nurses were quite able to apply family therapy concepts to situations with which they were already familiar. When problems less familiar to the nurse must be addressed, this can be done by translating the problem into language familiar to the nurse. For example, we have had success in teaching nurses how to deal with "leaving home" issues by presenting a family interview in which this issue was connected with the young adult's chronic illness, which the parents thought should prevent him from establishing his independence.

CONCLUSION

Family therapy in nursing is an evolving new specialty. This specialty fits well in the practice of nursing because of the existing emphasis on the family as one of the primary units of health care. Nursing also has the advantage of providing 24-hour hospital care, which allows nurses to utilize opportunities afforded by family visits (Wright & Bell, 1981). Family therapy can be compatible within nursing if there is more openness within *both* disciplines, and if one doesn't attempt to consume the other.

However, in order for a family therapy specialty to be appreciated and recognized within the nursing profession, more nurses need to obtain training in family therapy both at the master's and doctoral level. Initially some nurses may obtain this training outside the nursing discipline. For others it will, one hopes, be obtained in *nursing* graduate programs. As more nurses possess specialized training in family therapy, and thus are able to teach and train other nurses, the family therapy specialty will become more valued. We see a strong trend in this direction.

Notes

1. The Family Nursing Unit, directed by Dr. Lorraine M. Wright, offers families assistance when one or more family members are experiencing difficulties with a physical and/or emotional illness.
2. The decision to use the name Family Nursing Unit for the training facility at the University of Calgary was a very deliberate and conscious one to avoid potential territorial and engagement issues.

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