

Trends in nursing of families

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The authors describe their observations of three trends in the nursing of families namely, increased diversity in nursing practice, increased research, and increased family content in academic settings. These trends have major implications for nursing practice, research and education. The authors speculate on the implications and their effect on the families for whom nurses care.

FAMILY CENTRED NURSING

Family centred care has always been a part of nursing but is now receiving unprecedented attention. The purpose of this paper is to discuss three major trends occurring in the nursing care of families: increased diversity in clinical practice, increased family research, and increased family content in academic settings. Implications for the future of the nursing of families will also be addressed.

TREND: INCREASED DIVERSITY IN CLINICAL PRACTICE

Nurses are theorizing about and involving families more in health care. Partial evidence for this statement is found in the nursing literature (Leahey & Wright 1987a, 1987b, Wright & Leahey 1987), conference programmes and interviews with clinical staff. Such terms as 'family centred care' (Cunningham 1978), 'family nursing' (Friedman 1986, Leahey & Wright 1987a, 1987b, Wright & Leahey 1987, Gilliss *et al* 1989), 'family focused care' (Janosik & Miller 1979) and 'family interviewing' (Wright & Leahey 1984) are frequently cited in nursing journals and textbooks.

As nurses theorize about and involve families more in health care, they are altering and/or modifying their usual

patterns of clinical practice. The outcome of this change in behaviour is the trend of increased diversity in clinical practice with families. One way to determine how and if patterns of practice are changing is to analyse *how* nurses are involving families in health care. From our observer perspective and from our own clinical practice, two major types of nursing practice involving families now exist. The present trend in nursing is to either focus on the individual in the context of the family or to focus on the family with the individual as context. However, there is an emerging trend of family systems care, i.e. where the family is the unit of care. The senior author has made a distinction between these two clinical nursing practices and named them *family nursing* and *family systems nursing*.

Family nursing

Family nursing can be conceptualized in two ways. It is the focus on the individual in context of the family, i.e. where the individual is the figure and the family is the ground (Figure 1). An alternative conceptualization is the focus on the family with the individual as context, i.e. the family is the figure and the individual is the ground (Figure 2). Family nursing practised in either of these ways is normally based on developmental theory, social-learning theory and family studies.

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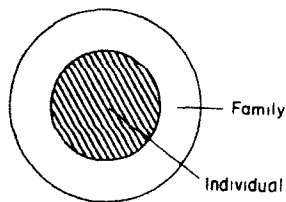


Figure 1 Family nursing individual as focus

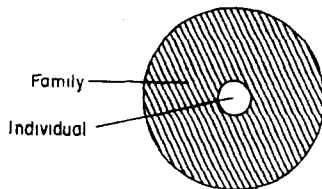


Figure 2 Family nursing family as focus

Example of family nursing individual as focus

An example of this approach occurs when a nurse interviews a diabetic patient in the context of the family. The nurse focuses on the individual's experience with a particular illness in his family. Some questions that the nurse might ask the individual and the family include the following:

To the patient: What is your understanding of the insulin? The diet? How do you explain your diabetes to others? How is your life different now that you have been diagnosed as diabetic? What is your experience coping with diabetes in your family?

To the mother: What is your understanding of John's diabetes? His diet?

To the father: What is your understanding of John's diagnosis? The amount of exercise that he can tolerate?

Example of family nursing family as focus

An example of this type of family nursing occurs when a critical care nurse interviews family members to discuss their experiences as caregivers coping with their family member's coronary. Some possible questions that the nurse might ask family members include the following:

To the wife: What is your experience in coping with your husband's heart attack? How has it been for you to have your husband in hospital?

To the adult daughter: What is it like for you to assist your father with his physical care?

Family systems nursing

In contrast to family nursing which focuses on either the individual or the family, family systems nursing can be conceptualized as focusing on the whole family as the unit of care (Figure 3). Concentration is on both the individual

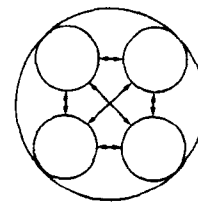


Figure 3 Family systems nursing family as unit of care

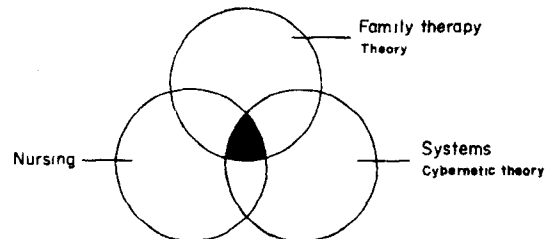


Figure 4 Family systems nursing

and the family simultaneously. The focus is always on the interaction and the reciprocity. It is not 'either/or' but rather 'both/and'. Family systems nursing is the integration of nursing, systems, cybernetics and family therapy theories (Figure 4).

Example of family systems nursing the family as the unit of care

This type of nursing practice occurs when nurses focus on interaction among family members. To gather information about the interaction between all family members, the nurse will ask questions that focus on relationships. It may be relationships or connections between family members' behaviours, beliefs, or affect. For example:

To the patient's older sister: What happens between your parents when your younger brother forgets to take insulin? What does your brother do when your parents remind him about his insulin? What does he do when they don't remind him? How does this affect you? Other family members?

To the patient: Who worries the most in your family about you and your diabetes? Do you think they worry the right amount, or should they worry more or less?

Implications of increased diversity in clinical practice

The first general implication of the trend towards increased diversity in clinical practice with families is that more nurses will involve families in health care. It is our prediction that this will occur irrespective of which type of family practice nurses choose. As nurses begin to discuss the distinctions between family nursing and family systems nursing, there will be a ripple effect. Nurses who previously dismissed nursing care of families as nothing new and

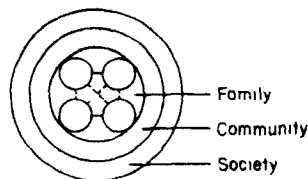


Figure 5 Systems embedded within systems

suggested that 'we have been doing this all along' (e.g. Lillian Wald at the Henry Street Settlement, births in the home, etc.) will now need to examine the diversities that presently exist in family practice. In so doing, they will begin to analyse their own practice with families to either defend, expand or abandon it.

It is also our prediction that nurses will exert more leadership to invite families to interviews. These will likely not be seen as threatening either to the family or to other health professionals' sense of territory. Rather, the family will welcome the opportunity to come to a meeting not 'because something is wrong with us' but rather 'because the health care agency is interested in us'. Furthermore, nurses will begin documenting their clinical work with families. Charts, kardexes, computer print-outs, etc., will all have space for family data. As nurses gain confidence and skill in family work, they will document more of their nursing practice with families which in turn will lead to increased ideas for family intervention.

A more specific implication of increased diversity in practice is that nurses involved in family systems nursing will conceptualize and assess interaction at all systems levels. Just as it has been commonplace for nurses to accept multiple systems levels within an individual (molecule, organ, organ system, interaction between organ systems, etc.), it will become common for family systems nurses to conceptualize the interaction between an illness and the individual patient. They will understand the reciprocal influence of the patient in maintaining, aggravating or ameliorating the illness. Family systems nurses will concentrate on the interconnections between illness, the individual and the family. They will reflect on studies (Minuchin *et al* 1975, Selvini-Palazzoli *et al* 1978) which illustrate these interconnections and will conduct research to explore, explain, and support their work. Interaction at all systems levels, as well as across systems levels, will be assessed by family systems nurses, i.e. from the micro level of fluid and electrolytes to the macro level of the family, the community and society (Figure 5).

Having assessed a health problem from an interactional perspective, family systems nurses will intervene at the system level with the greatest leverage for change. For example, if the presenting problem is electrolyte imbalance,

then the primary unit of treatment would be the individual patient with attention to the cellular level. If the presenting concern is a husband's understanding of the diabetic regime, then the primary unit of treatment would be the family for health teaching about diet, exercise and insulin. If the diabetic patient is a school-aged child, then the primary unit of treatment might also include, in addition to the family, the community (i.e. school) because this is where the child spends a large majority of time.

Another implication of the trend towards increased diversity in clinical practice is that family systems nurses will request more one-way mirrors in their facilities in order to work collaboratively with other disciplines and to receive feedback on their clinical work from their nursing colleagues and other health care professionals who specialize in systems practice.

One implication having negative consequences for family practice would be potential competition between nurses involved in family nursing and those involved in family systems nursing. There is presently a phenomenon in nursing of becoming so committed to focusing on the family as the unit of care that focusing on the individual in the context of the family or focusing on the family is viewed as an inferior or a secondary level of practice. In our view, this constitutes a serious epistemological error. The practice of family nursing as compared to family systems nursing is no less inferior, no less important, only different. More often, the type of family practice will be determined by the context of nursing care and the competency level of the nurse. For example, in emergency rooms, intensive care units, and some adult care units, family nursing is the appropriate practice of choice.

TREND: INCREASED FAMILY RESEARCH

Despite families being so important in health care, they have often been neglected in research. However, nursing has awakened to the need to understand the connection between family dynamics and health and illness. Within nursing, there is an enthusiastic increase in the clinical and theoretical interest in the family. In addition, there is a beginning trend to increase the amount of family nursing research (Murphy 1986). This has not been an easy task when both nursing and North American society have been primarily focused on the individual. Since the 19th century, North Americans have developed a culture of individualism whereby the welfare of individuals supercedes commitment to social groups. Yet the family is the most intimate social environment, being both a major source of stress and social support.

Research on the family and mental health is much further advanced than that on the family and physical health (Campbell 1987). This is an area where nurse researchers could and are beginning to make a significant contribution.

Studies of the family's impact on physical health have predominantly been from a social epidemiological view. Family interactions have only been examined in studies of diabetes (Campbell 1987). Poor diabetic control is associated with chronic family conflict and poor organization, but studies disagree as to whether these families have low or high cohesion. In a more recent study by a nurse family researcher, Duhamel (1987) examined family interaction and hypertension. One of the significant hypotheses generated from this study was that hypertensive patients suppress anger and hostility and the suppression of these feelings leads to unresolved marital conflicts that reciprocally reinforce the suppression of anger and hostility.

Other recent studies on family and physical health have identified marital status and support by the spouse as the most potent family factors affecting overall mortality and cardiovascular disease. Family support, especially by the spouse, has a protective effect that is not specific to any disease process (Campbell 1987).

Family interventions, such as involving a spouse in the care of a coronary patient, can have a major impact and have been demonstrated to lower overall mortality. In hypertension the effect of family involvement is primarily increased compliance with antihypertensives and diet (Campbell 1987).

An interactional phenomenon that is needing study is how family members' reactions influence the course of an illness. Nurses and other health care professionals know that individuals' responses to a life-threatening illness vary (for example, denial or anger). However, some family clinicians now propose that patients respond more to their family's responses to the illness than to the condition itself (Wright *et al.* 1989, Wright & Watson 1988). The research of Reiss *et al.* (1986) suggests that affected families who are too emotionally close may precipitate death in the sick family member. Death represents an 'arrangement' between the family and the patient — the patient dies so that 'the family may live'. This is often an extreme but perhaps the only 'reasonable' patient response to the family's feelings of grief and burden.

Implications

Three implications of this trend of increased family research are

- 1 Family assessment techniques will be further developed. In the family research literature, less than 5% of the articles on family and health are empirical studies (Campbell 1987). Therefore, nursing can make a tremendous contribution to this neglected area. Attention should be given to self-report methods as well as direct observation methods, and the results of these two approaches should be compared.
- 2 Research on the reciprocal relationship between family functioning and the course and treatment of an illness will gain prominence. This will be partly due to the difficulty of demonstrating that family factors precede the development of an illness but mostly due to nursing being more aware of this important connection.
- 3 The efficacy of family treatment will become paramount as health care providers become more concerned with what type of health care services are most appropriate for specific situations. For example, family nursing interventions, such as education and providing family support, should be compared with other types of nursing interventions. As well, more complex interventions, such as 'prescribing a ritual' or 'externalizing the symptom' should be examined for their effectiveness for treatment of family conflicts related to health problems.

This increase in nursing research will profoundly expand knowledge of the impact and long-term consequences that serious illnesses have on family members and on the family unit. As well, the far-reaching influence that family interaction has on the development, perpetuation, aggravation or amelioration of physical illness will be better understood and in turn more effective and comprehensive family care will be given.

TREND: INCREASED FAMILY CONTENT IN ACADEMIC SETTINGS

Family content has been substantially integrated into nursing curriculums over the past 10 years. Until now, however, very little information has been available to provide evidence about the quantity and quality of family content in university nursing curriculums. Even less has been known about nursing students' clinical practice with families or the methods of supervision of family interviewing skills. However, two recent studies, one by Hanson & Bozett (1987) conducted in the United States and another by Wright & Bell (1988) conducted in Canada suggest similar preliminary findings and substantiate this trend.

Family content in nursing curriculums

Although family content varies dramatically from school to school, it has become an integral part of most undergraduate programmes. Many nursing programmes teach about families within the parent/child, community health or mental health part of the curriculum. Also, family content is frequently embedded in other courses. There is a wide variance of family content in graduate programmes, with many providing only cursory attention while others are providing specialization in family nursing.

One very interesting finding in the preliminary results of these two studies is that nursing adopts a variety of family assessment models. These models tend to be eclectic, wide ranging and often list specific concepts from family development and family therapy. A few nursing authors have taken on the challenge of integrating significant concepts from nursing, family developmental theories, communication theories, systems theory, cybernetics and family therapy (Friedman 1986, Gilliss *et al* 1989, Leahey & Wright 1987a, 1987b, Wright & Leahey 1984, 1987).

Clinical practicums involving families

Clinical practicums, as reported in the Wright & Bell (1988) study, presently focus on family nursing with emphasis on either the individual or the family. Very infrequently is the focus on family systems nursing, where the family is viewed as the unit of care. Family nursing practicums address various family dimensions such as roles or problem-solving abilities, whereas family systems nursing practicums focus on relationships and interaction. Baccalaureate level nurses tend to experience family nursing practicums, whereas masters and doctorally prepared nurses tend to experience specialized practicums in either family nursing or family systems nursing.

Methods of supervision

From the two surveys conducted (Hanson & Bozett 1987, Wright & Bell 1988), it is apparent that students receive clinical experience working with families in a variety of settings (e.g. home, clinic and hospital). However, the amount and type of supervision varies dramatically. The Wright and Bell study reports the predominant method of supervising the student's family interviewing skills is clinical case discussion and/or verbal and written process recordings. In the authors' experience, these methods have been the least effective for aiding the development of executive skills, i.e. the therapeutic interventions that the nurse actually carries out in an interview (Wright & Leahey

1984). The new trend emerging is audiotape and videotape supervision and in a few instances, live supervision. Audiotape supervision is extremely valuable in that it corrects the distortion of traditional verbal and/or written content. However, it omits extremely valuable data concerning non-verbal behaviour.

Although direct observation has been a common method used for the development of nurses' psychomotor skills, live supervision of interactional skills has not been pursued as vigorously. The underuse of live supervision, even though the most effective method for the development of executive family interviewing skills, is due in part to a dearth of one-way mirrors in many facilities.

At the undergraduate level, nursing students more often receive supervision of their family nursing skills through case discussion rather than audiotape or videotape supervision. Rarely do undergraduate nursing students have their work with families supervised directly. The result is that the most inexperienced nursing students receive the least powerful and effective methods of supervision. Graduate students receive more audiotape and videotape supervision and, in a few instances, live supervision.

Faculty practice

Whether faculty members practise family nursing or family systems nursing, it should be at an advanced level. The knowledge and skill level of the advanced practitioner should approximate each other (Calkin 1984). At the present time it appears that a gap exists between the knowledge and skill level of faculty working with families. However, clinical practice by faculty members would decrease this gap (Stanton *et al* 1989). As there are few nurse educators/clinicians who specialize in family nursing or family systems nursing, most nurses have to go outside of nursing to receive supervision in family assessment and intervention skills. The implication for students, who are not supervised by a competent faculty member in a nursing context, is that they will likely not internalize the significance of the family within the discipline of nursing (Wright & Leahey 1988).

However, there does appear to be a trend that increasing numbers of nurse educators are seeking advanced family work by studying in programmes outside of nursing such as family studies, family social sciences, and family sociology. In addition, there is a growing movement within nursing to establish departments of family nursing at the graduate level within universities. Whether these programmes be in nursing or in other disciplines, emphasis tends to be on family theory and research and only secondarily or not at all on clinical practice. However, it is

encouraging to speculate that within a few years there should be a substantial increase of faculty members with advanced family theory and research knowledge and skills. The next step will be to strengthen faculty resources within nursing to become advanced family clinicians. In so doing, the gap will be reduced between knowledge and clinical skills in faculty practice with families.

Implications

Preliminary findings in the Hanson & Bozett (1987) and Wright & Bell (1988) surveys are that nursing courses seldom identify family content as such in the course titles. However, the trend of more nurse educators being proficient in family nursing and/or family systems nursing will result in more nursing courses titled to accurately reflect their family content and increased integration of concepts from the social sciences, family development, biology, etc.

Another implication of evolving faculty competence in the practice of family nursing and/or family systems nursing is that more focus will be given to interventions as well as assessment. Despite the proliferation of family assessment models within nursing curricula, little emphasis has been given to family intervention and the processes by which change takes place. Sound interventions are based on sound assessment and clear identification of problems/concerns/risks, but most nursing curriculums and texts stop at this level. Very few nursing texts consider what types of interventions are appropriate for what types of families with what types of health problems (Leahey & Wright 1987a, 1987b, Wright & Leahey 1984, 1987). As more nurse educators become advanced family clinicians, the nursing literature will reflect this significant development with more emphasis on family interventions.

Finally, as the trend continues for more clinically competent nurse educators to work with families, the implication will be that more direct supervision, either videotape or live, will be provided for both undergraduate and graduate nursing students.

CONCLUSIONS

Family-focused care has always been a part of nursing but now needs to further entrench itself in academic and clinical settings. Whether nurses elect to involve the family as the context for care or as the unit of systems care, their nursing practice must be real, observable and teachable. Whether nurses choose to integrate family nursing or family systems nursing into academic or clinical settings, they must demonstrate their work to students, families and colleagues. In faculty and family meetings, student and clinical inter-

views, academic and clinical family conferences, nurses need to discuss the work that they are and have been doing for years with families. As the trends discussed in this paper become more commonplace, major contributions to nursing knowledge will accumulate, further research ideas will be generated and clinical practice with families will be more efficacious.

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