

The Family Nursing Unit: A Unique Integration of Research, Education and Clinical Practice

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Introduction

Tracing the historical involvement of the nursing of families could lead to the erroneous conclusion that family centered care is central to the practice of nursing. Upon closer examination, one comes to realize that within nursing practice the involvement of families varies dramatically. Family involvement ranges from non-existent to focusing on the family as the unit of care. This variance in the involvement of families in nursing care is influenced by: the conceptualization of illness and family functioning; the context in which patients and nurses interact; the educational and competence level of nurses; and the commitment of nursing administrators to family centered care.

Over the past ten years, nursing educators have been and are continuing to be instrumental in substantially increasing and integrating family content into nursing curriculums. Two recent surveys (Hanson & Bozett, 1988; Wright & Bell, 1989) of family nursing education in the United States and Canada found that family content is prevalent in most undergraduate nursing programs. However, at the graduate level, there is great variance in family content ranging from minimal attention to specialization in family nursing and/or family systems nursing. Nursing educators/clinicians are also contributing to the increased understanding and importance of family involvement in health care through the publication of nursing textbooks specifically addressing family centered care and/or family nursing (Friedman, 1986; Gilliss, Highley, Roberts, & Martinson, 1989; Janosik & Miller, 1980; Leahey & Wright, 1987a, 1987b; Wright & Leahey, 1984, 1987).

Further efforts by nursing educators have been to enhance nursing students' competence involving families in health care through clinical practicums. Wright and Bell (1989) found that most clinical practicums presently focus on the individual in the context of the family and very infrequently on the family as the unit of care.

Master of Nursing Program, University of Calgary

The Master of Nursing program at the University of Calgary began in 1981 in response to the need for specialists in nursing practice. The aim of the

program is to prepare advanced nursing practitioners. The programme prepares nurses for a variety of advanced practice roles in the health care system. Graduate students select a specific population as their focus of study for advanced nursing practice as a clinician, an educator or a first line or middle manager. Within the clinical specialization focus, one of the areas offered is family systems nursing. Family systems nursing is the integration of nursing, systems, cybernetics and family therapy theories (Wright & Leahey, 1990). The focus is on the family as the unit of care with emphasis on interaction and reciprocity. Both the individual with a health problem/concern/risk and the family are cared for simultaneously. This is in contrast to family nursing which focuses on either the individual or the family members caring for the designated patient (Wright & Leahey, 1990).

The Family Nursing Unit

The Family Nursing Unit (FNU), University of Calgary, is a unique educational and research unit. To our knowledge, this type of unit is unprecedented in North America. The FNU was established in 1982 under the direction of Dr. Lorraine M. Wright for the interactional study and treatment of families with health problems. Dr. Janice M. Bell, Research Coordinator, and Dr. Wendy L. Watson, Education Coordinator are the two faculty members who complete the FNU team which seeks an integration of research, education, and clinical practice. Other faculty expertise is sought in the form of consultations related to specific health problems.

The FNU offers assistance to a family when one or more members are experiencing difficulties with a health problem. Families seen at the FNU are either self-referred or referred by health care professionals such as family physicians or community health nurses. An average of six sessions are provided to each family.

Family Nursing Unit Philosophy

Individual/Family

Individuals are perceived to be structurally determined and operationally and informationally closed (Maturana & Varela, 1987). That is, it is the individuals' structure that determines what and how perturbations from the environment will effect them. There can be no instructive interaction because information cannot be transferred intact between individuals. Individuals are also viewed as bio-psycho-social-spiritual beings where the person as a whole is seen to be greater than and different from the sum of its parts. Families are seen to be a group of individuals who are bound by strong emotional ties and a sense of belonging. A family coevolves an ecology of beliefs that helps each of the individuals to define cognitions, behaviors and emotions. Individuals and families are seen to be unique and autonomous, possessing the strengths and abilities necessary to solve their own problems.

The FNU focus is on "family", even when only one person is involved in treatment because we believe that individuals are best understood in context. This circular/systemic perspective presupposes that all individuals are connected to other persons in recursive and reciprocal interactions.

Health

Health is viewed as a distinction brought forth through relationships and languaging with other human beings. That is, family and individual systems are seen to be in continuous effective adaptation to their unique and changing environment (Maturana & Varela, 1987). Distinctions such as "health" and "illness" are believed to be subjective judgments made by observers about this adaptation. The FNU faculty and students attempt not to make these type of distinctions about individuals/families. FNU personnel believe that family systems make sense and have strengths. When individuals/families come to the FNU with the problems they have identified, the FNU team seek to invite new ways to view the situation (in order to broaden the range of solution options) without making judgments about the problem or solution.

The FNU is most concerned with understanding the recursive interactions between "health/illness/problems" and the family. We respect that each family should function the way that they desire and in a way which they determine is most effective. As part of a larger system, however, the FNU recognizes that it is bound by moral, legal, cultural and societal norms that require the FNU to act in accordance with those norms regarding illegal and/or dangerous behaviors.

Change

Discovering the family's beliefs about a problem provides the nurse with an understanding of that which organizes family behavior. The FNU faculty believe that a family's or individual's problematic beliefs constrain their ability to solve their own problems. By offering alternate ways to view problems, the nurse seeks to create the context for change and to alert the family to the wide range of solution options available to them. Therefore we believe that the family's ability to change depends upon their ability to alter their perception of the problem.

The FNU faculty believe that although nurses are invested in effecting change in family/individual systems, they should not be invested in the direction or pace of change. This stance explicitly acknowledges the family members' autonomy in determining outcome and views the nurse as participant rather than director.

The FNU faculty believe that change is mutual; nurses are also affected by the families with whom they work. Theory and clinical experience direct the nurses' practice and reciprocally practice with families helps to revise theory and future practice.

Nursing

Clinical Practice. Family systems nursing practice is concerned with individual's and family's responses to actual and/or potential "health problems". In the FNU, nurses are **also** concerned with the response of the "health problems" to individual and family systems. This reciprocity between individuals/families and "health problems" constitutes the core of family systems nursing practice. In keeping with our Faculty of Nursing's philosophy, the FNU also seeks to develop and analyze innovative nursing responses (interventions) to family health problems.

Education. We believe that provision of graduate nursing education is an essential role of the FNU. We believe that a wide variety of teaching mediums, recognition of individual learning styles and a milieu of positive support best facilitates the learning process. We believe that nurse educators should be clinically expert and be willing to demonstrate their clinical work. We believe that the student-teacher relationship should be reciprocal and collaborative.

Research. We believe that research is the third essential function of the FNU. Through research, the faculty seek to broaden the scope of family systems nursing knowledge and to examine the effectiveness of the innovative nursing responses developed and taught in the FNU.

Family Nursing Unit Objectives

The primary objectives of the FNU are:

1. to provide a comprehensive assessment of families experiencing physical and/or emotional problems utilizing the Calgary Family Assessment Model (CFAM) as the primary assessment tool (Wright & Leahey, 1984). Although CFAM is a normative model, it must be stressed that we do not subscribe overall to a normative model of family functioning. Rather, we assess each family's unique strengths and desired functioning. From a family systems nursing perspective, symptoms and/or problems represent an interactional dilemma which is derived from constraining family beliefs.

It thus becomes our challenge in family systems nursing to understand the family's present perception of the problem. This includes the meaning attributed to the problem; the perception of the reciprocity between the illness and the family; and the family's views about the cause, course, cure and consequences of the problem.

2. to intervene, when appropriate, in order to assist families at any developmental stage, to resolve their difficulties with their health problems. Conceptually, our intervention approach has been greatly influenced by Bateson's theory of mind (1972, 1979) and Maturana's meta-theory of cognition (1987). Clinical models that have influenced our work have been the Milan Systemic Family Therapy approach (Boscolo, Cecchin, Hoffman, &

Penn,1987) and the White Systemic model (White,1986).

3. to provide a teaching/learning setting in which graduate nursing students learn to assist families who are experiencing difficulties with health problems (Watson, 1987; Watson & Nanchoff-Glatt, 1990; Wright, Bell, & Rock, 1989; Wright, Miller, & Nelson, 1985; Wright & Watson, 1988; Wright, Watson, & Duhamel, 1985). The educational component of the FNU is further discussed in a later section of this paper.

4. to provide a base upon which to conduct research into the family systems nursing approach. The FNU research program is also elaborated on further in this paper.

Family Nursing Unit Facilities

The excellent facilities within which the FNU operates greatly enhance and enable the education, research and clinical practice. The architectural design of the physical space and the use of technical equipment has a significant influence on the type of education/clinical supervision we provide and the research we do. The FNU utilizes a suite of five interviewing rooms, one large observation room and a central control room. Each room has a one-way mirror enabling the observation and supervision of each interview from the large observation room. In addition, three of the five rooms can also be observed from adjoining rooms. Four of the rooms are equipped with a fixed camera for videotape recording. In one of the largest rooms, remote control color cameras are concealed within triangular oak "bookshelves" in three corners of the room. A technician in the central control room assumes responsibility for the recording of all interviews conducted in this larger room with the remote control cameras. All the rooms are connected with a telephone intercom system to the observation room. This enables the supervisor and/or other team members to communicate with the nurse interviewer during the meeting with the family. On occasion, the intercom is also used to communicate messages from the team to family members via the nurse interviewer or to family members directly.

The Education Component of the Family Nursing Unit

Master of Nursing (MN) students may elect the FNU as their clinical setting for one, two or three of their three clinical practica depending upon the level of family systems nursing specialization they require: students specializing in family systems nursing attend the FNU for two or three of the clinical practica; while students requiring generalist preparation in family systems nursing attend one practicum.

Other variations on the theme of selecting one, two, or three clinical placements at the FNU are possible. One option is to choose a clinical practicum at the FNU as one of their two electives in their MN programme. Joint clinical practicums are also an option for MN students. These stu-

dents are concurrently involved in clinical practicums at the FNU and at a hospital or community agency. The student develops her executive skills while working with a particular population in a hospital or community agency. Concurrently she attends the FNU to learn perceptual and conceptual skills of family systems nursing, participating as a member of the FNU team and observing families. No "hands on" work with families at the FNU occurs for "joint practicum" students.

The third and final clinical practicum in the MN programme incorporates the multiple roles (manager, researcher, educator, consultant, clinician) of the clinical nurse specialist. Students who have completed two practica in the Family Nursing Unit have the recent option of choosing to enact the clinical nurse specialist roles within the FNU or within a hospital or community health setting.

Although a clinical practicum at the FNU focuses on learning the perceptual, conceptual and executive skills of family systems nursing, the skills are applied to a variety of populations experiencing a wide range of health problems. Masters of Nursing students who have been accepted for a FNU practicum have had clinical specializations ranging from gerontological nursing to parent-child nursing; from critical care to palliative care; from psychiatric/mental health nursing to community health nursing. Health problems have ranged from diabetes, chronic pain and Alzheimer's to enuresis, schizophrenia and depression.

Teaching methods and mediums

Students enter the clinical practicum at the Family Nursing Unit with a variety of beliefs about families, about health problems, and about how change occurs. Just as families' beliefs can be problematic or facilitative, students' beliefs can also constrain or facilitate students' interaction with families. A student's beliefs inhibit or enhance her ability to help families alter their perception of a problem and thus to solve their own problems.

We believe that a variety of teaching mediums and methods and a milieu of positive support enable and invite students' acquisition of facilitative beliefs for working with families with health problems.

Seminars/Courses

Concurrently with the weekly 12 hour clinical practicum, FNU students attend a weekly two hour theory seminar which focuses on family systems nursing concepts. The weekly seminar presents a variety of topics including: systemic thinking, hypothesizing, circularity, neutrality, family assessment and intervention models, the works of Bateson (1972, 1979) and Maturana and Varela (1987), and interventions ranging from split-opinions to systemic reframes, from reflecting teams to rituals.

Courses within the MN programme which support the development of

conceptual/perceptual skills in family systems nursing include "Families and Illness", a graduate level course focused on the reciprocity between illness and family functioning and the application of a family systems nursing approach to families with health problems. Independent courses of study range from "Models of Family Therapy" to "Family Systems Nursing Interventions".

Direct Family Contact

Two days a week are designated as FNU clinical days during which time students have direct clinical contact with families. Each family session consists of five parts: pre-session, interview, intersession, intervention, and post-session (Tomm, 1984). The five part session provides a structure for the development of family systems nursing skills.

Pre-session. During the initial pre-session (15 - 30 minutes) the student presents genogram and life cycle stage information obtained during the intake call. In subsequent pre-sessions, highlights from the most recent interview and from any interim contacts with the family and/or other relevant systems are presented. During each pre-session the student presents salient aspects of an ongoing literature review of the presenting problem, relevant family dynamics and possible interventions. Students are encouraged to generate two hypotheses for each pre-session, i.e., a constraining belief hypothesis and a systemic/functional reciprocity hypothesis, or a relative influence hypothesis. The student also presents two questions that could be used to explore each hypothesis. During the pre-session the clinical supervisor facilitates a refinement of the hypotheses and questions.

Interview. Each interview (1 hour) consists of engaging the family members in the therapeutic process. While it is typical to think of engagement as being part of the first session with a family, we believe that when a family returns for subsequent sessions they are a "new" family and need to be re-engaged with the interviewer and the team. The interview allows the family members, interviewer and team to: validate or discard particular hypotheses; discover problematic/constraining beliefs; and invite the consideration of alternate facilitative beliefs.

We have evolved in our view of the interview from seeing it several years ago as only a "gathering of information/assessment" session to now seeing the interview as a "therapeutic conversation/intervention". The circular and reflexive questions (Tomm, 1987a, 1987b, 1988) perturb and probe the family system giving the nurse interviewer and the family new information.

During the interview, the clinical supervisor offers the nurse interviewer other hypotheses to explore and questions to ask through the use of a telephone intercom. During the supervision "phone in" the interview is

briefly interrupted while the student answers the phone and receives the message. The student then informs the family of the message/question. Families readily adapt to the telephone input which facilitates the interview process.

Intersession. The intersession discussion (10 - 20 minutes) consists of a major break in the interview during which the interviewer meets with the team while the family waits. At this time information from the session is reviewed, multiple views of the family and of the problem are entertained. The team works together as a systemic mind to evolve an alternate belief/epistemology/opinion about the nature of the problem. A variation of this "behind the one way mirror" process has been instituted at the Family Nursing Unit. Families may be given the option of observing the team intersession discussion. When this choice is made, the team intersession discussion becomes a "reflecting team". Tom Andersen (1987) was the contributor of this unique intervention and training tool. During the "reflecting team" discussion, the family sits behind the mirror with the interviewer and observes the team's dialogue about the family's dialogue. The reflecting teams' dialogue invites the family in a highly palatable manner to consider multiple and alternate views of their situation. Because they express their opinions in front of the family, students rapidly learn how to view problems in a positive frame and to be less judgmental through their participation in the reflecting team.

End of Session Intervention. At the end of a team intersession discussion, the student returns to the family and shares the team's ideas and opinions with the family. We always begin an end of session intervention with a commendation to the family regarding individual and family strengths. Further ideas and opinions may be in the form of a systemic reframe, a ritual, a behavioral task or normalization. However, with the influence of Maturana and Varela (1987) on our clinical work, we have dramatically reduced the prescription of tasks or assignments.

After a reflecting team discussion is observed by the family, the student and family return to the interviewing room while the team returns to their original position behind the mirror. At this point the student pursues the family's reactions to the reflecting team's ideas. Thus, the family dialogues about the team's dialogue about the family's dialogue. The family is then invited to further consider the team's opinions and suggestions in the interim until the next session.

Postsession. The family leaves and the team meets for a review of the family member's reactions to the end of session intervention or to the reflecting team's opinions. Tentative plans for the next family session are made. Finally, the student receives feedback from her clinical supervisor and colleagues regarding her delivery of the intervention and her use of other clinical skills during the session .

Team Membership

Students have discovered that their membership in the FNU clinical team has a profound influence on their perceptual and conceptual skills. They generate hypotheses and questions during the pre-session, inter-session and post-session discussions. Behind the one-way mirror they function as advocates for a particular family member or relationship or as detectives of problematic and facilitative beliefs during the interview and inter-session.

Record Review

While each student is responsible for the recording of her own family interviews, the "team spirit" is part of record keeping at the FNU. Students work in dyads or triads to review the videotapes of their family sessions and formulate their thinking about families. The students then externalize their thinking on paper which becomes the family file.

Supervisory feedback is given to the students regarding their clinical record keeping. The type of information the student enters into the family's chart gives important information to the supervisor about the student's perceptual and conceptual skills. For example, if the student consistently describes problems in a linear fashion at the individual level (e.g. mother is depressed), the student is encouraged to reconceptualize the problem at a higher systems level. In the example given, the individual problem is conceptualized from a systemic, interactional perspective and raised to the level of the marital subsystem (e.g. mother shows depression when father withdraws into his work).

Videotape Group Supervision

The videotaping of each family interview at the FNU allows a replay and review of each session. During videotape supervision short segments of a family session are reviewed. A microscopic view of the interaction between the family and the student is afforded. The videotape technician frames the student in one corner of the large video picture. The student receives feedback from the supervisor, her classmates and the videotape about the impact of her verbal and non-verbal behaviors on the family and vice versa.

Live supervision

We believe that live supervision is the most effective way to assist and monitor therapeutic competence in family systems nursing. While direct observation is the predominant method of clinical supervision for the development of nursing students' psychomotor skills, direct observation of interactional skills has been underutilized (Wright & Leahey, 1984; 1988). Lack of facilities (one way mirrors, telephone intercoms) and a dearth of nurse educators/clinicians who are skilled and experienced in providing this kind of intensive supervision have contributed to the very limited use of live supervision. Again the FNU is unique and fortunate in having both the clinical facilities and qualified personnel.

Live supervision consists of the clinical supervisor and at least one other graduate student observing the interview from behind a one-way mirror. As described in the previous interview section, the supervisor makes supervisory input via the telephone intercom and in the form of hypotheses to explore, questions to ask, supportive comments to "mine" an area further, or directions to move on and shift the focus of the interview.

Demonstration Interviews

Demonstration interviews constitute another important aspect of the family systems nursing education offered at the FNU. One or two families are interviewed during each clinical practicum by one of the clinical supervisors. The demonstration interviews enable the supervisors to model more advanced clinical skills.

Educational Videotapes

Advanced clinical skills are also demonstrated in the series of educational videotapes which have been created from the clinical work of Dr. Lorraine M. Wright and Dr. Wendy L. Watson (Watson, 1988a, 1988b, 1988c, 1989a, 1989b). The five educational videotapes are designed as teaching and review tapes of family systems concepts and clinical skills. In addition to the educational videotapes, students are guided in their review of other videotapes of the clinical supervisors' family sessions. Students are given assignments to identify the interviewer's behavior, the rationale for the behavior and the family's response to the nurse-interviewer's behavior. Students are also encouraged to review selected movies (e.g. "Ordinary People", "I Never Sang For My Father") to enhance their ability to assess family functioning.

Two week Intensive Family Systems Nursing Externship

In response to multiple requests from nurse educators, clinicians and administrators, a two week externship is offered to provide an indepth exposure to family systems nursing. The externship consists of: theory and clinical seminars on the reciprocal influence of illness and family functioning; application of a family systems nursing approach to families with health problems; lectures, simulations and videotape reviews to develop conceptual and executive skills; observation of live family interviews; participation in family assessment and the generation of interventions; and discussion of ways to utilize and/or implement family systems nursing in the participants' work settings.

The Research Program of the Family Nursing Unit

The research program within the FNU centers on the family as the unit of analysis. The current research in progress has three major objectives: 1) to examine the reciprocity between family functioning and illness; 2) to test the effects of family systems nursing interventions with families with health problems; and 3) to examine the training and supervision strategies used to teach nursing students the conceptual and executive skills of family systems nursing.

Several research projects have been completed or are currently being conducted within the three objectives of the research program. The Chronic Illness Project is a study which focuses on the reciprocal influence of illness and family functioning and the effect of family systems nursing interventions on family functioning and the illness (objectives one and two). The Family Nursing Outcome Study is a follow-up evaluation of the services provided by the FNU (objective two). In relation to objective three, several projects are in progress or have been completed. The Master of Nursing Graduate Follow-up Study surveys all master's programme graduates who have completed one or more clinical practicums within the FNU. Dr. Wright has completed an analysis of supervision phone-ins (Wright, 1986). And lastly, Drs. Wright and Bell (1989) have recently described family nursing education in Canadian universities.

Chronic Illness Project

This study is designed to generate hypotheses about: 1) the reciprocal relationship between family functioning and chronic illness, and 2) the influence of family systems nursing interventions on family functioning with families experiencing chronic illness. A multiple case study design is being used with a convenience sample of eleven families experiencing a chronic illness (e.g., angina, chronic pain, heart disease, diabetes, etc.). Self-report instruments (FACES III, FILE, Perceived Stress Scale) are administered to family members over three time periods: baseline, intervention and follow-up. Qualitative analysis of videotaped family systems nursing sessions conducted with each family allows ongoing assessment of family functioning and observation of changes in family functioning over time. The Chronic Illness Project, funded by the Alberta Foundation for Nursing Research, is currently in the data analysis phase. At this time, one of the interesting themes emerging from the qualitative analysis is the importance of family beliefs.

Family Nursing Unit Outcome Study

This research project is designed to evaluate the services provided by the Family Nursing Unit. The variables examined by this study are: the families' satisfaction with the services provided, satisfaction with the nurse interviewer, and change in the presenting problem and family relationships. The sample consists of families seen at the FNU since 1982. An instrument designed for this study asks for each family member's perspective on each of the variables. Questions are asked about two time periods: at the conclusion of the family sessions and at the time of the survey. The family is interviewed six months following termination of the family session by a research assistant who has had no previous contact with the families. Each student in a practicum at the FNU is given the opportunity to participate in the data collection of the outcome study, completing the semi-structured interview with a family for which they were not the original interviewer during family sessions.

The project continues to be in ongoing data collection and data analysis. Funding for a pilot study to test and refine the data collection instrument was provided by the Alberta Association of Registered Nurses. Presently the study is internally funded.

Results from a convenience sample of 50 families, indicated that a range of 61.5% - 100% of family members (mother, father and each child) were satisfied to very satisfied with the services they had received. Among fathers and mothers, over 50% reported that the most helpful aspects were the opportunity to ventilate their concerns thereby increasing communication among family members and obtaining support from the FNU team. The second ranked most helpful aspects were the interview process and the suggestions from the FNU team. Ninety-five percent of family members would recommend the FNU to friends and relatives.

Ninety-four per cent of the family members reported satisfaction with the family clinical nurse specialist (FCNS). They indicated that the friendly, professional and nonthreatening manner of the FCNS made them comfortable. Eighty percent of the family members reported FCNS neutrality toward family members.

Over 70% of the family members reported the presenting problem was better at the time of the survey. This represents a 6-18% increase from the family member's initial reports of improvement in the presenting problem at the conclusion of the family sessions. This increase is consistent with our philosophy of intervening with families, i.e., we do not want to prolong our influence on the family system, preferring to terminate family sessions when the "new views" are beginning to recalibrate the family system. Regardless of the presenting problem, 64.6% of fathers and 66.7% of mothers reported positive changes in the marital relationship such as increased communication, improved relationships and decreased tension, suggesting support for the systems theory tenet that change in one part of the system affects change in other parts.

M.N. Follow-up Study

The purpose of the follow-up evaluation is to conduct a retrospective survey of the clinical skills acquired by Master of Nursing students who have completed one or more clinical courses within the FNU. The study describes the utilization of family systems nursing skills in the graduates' present employment and the long-term impact these clinical skills have on personal and professional development.

To date, the study has surveyed graduates from 1983 to 1988 ($n = 23$). Data are collected using a mail-out, self-report questionnaire developed for the study. Each student is surveyed one year following graduation. This study continues to be in ongoing data collection and data analysis phases with funding from the internal operating budget.

The results to date suggest that family systems nursing skills can be acquired with supervision and maintained in clinical practice, regardless of the employment opportunities for direct, clinical contact with families. The most surprising finding has been the graduates' reports of a dramatic conceptual shift from a linear perspective to a more systemic "world view". The concepts identified as having the most impact on graduates' thinking are: circularity and systems theory concepts; the individual is best understood in the context of the family; the use of circular questions as interventions; and reciprocal influence of illness and family functioning.

Personal and professional changes reported by graduates include many references to "a change in my whole way of thinking." Specific changes in cognitive and behavioral responses to clients and colleagues as well as to their own family members are described. As one graduate reported, "I have learned family systems nursing skills and they have changed the way I practice and think. I am less judgemental. I appreciate the influence my behavior has on others and that others have on me. I view problems more creatively, realizing I have several alternative ways of viewing the situation and responding to it. I am more open-minded!"

Conclusions from this study suggest that the family, as the system of focus, becomes a vehicle for learning systemic concepts and skills which the MN graduates are then able to extrapolate to a variety of other settings and situations.

Case Study

The following case study is presented to illustrate the application of a family systems nursing approach.

A young couple, John aged 31 and Jane aged 27, were referred to the Family Nursing Unit for assistance with problems related to the husband's chronic osteophyte pain. John and Jane had been married 6 years with two children, Kathryn aged 3 and Peter aged 1.

In the first session the couple agreed on very little except that the biggest problem in the family was the husband's anger about his osteophytes. The husband's anger was related to his belief about the etiology of the illness. Two years ago, upon the advice of a physician, he had omitted dairy products from his diet. He now believed the previous lack of dairy products was the cause of the osteophytes. The husband's anger had produced much bitterness, blaming and "almost a nervous breakdown" in the husband and an exacerbation of the pre-existing marital and family problems. While the husband was convinced about the cause of the osteophytes, the wife was committed to her belief that "the cause" was irrelevant. Her suggestion was that "he should just forget it". In fact, when asked what would happen if her husband would never be able to give up his belief about the osteophytes, the wife indicated that she would

leave the marriage. The symmetry between the couple exacerbated the differences in beliefs about the etiology of the osteophytes, the course and cure of the illness. And conversely, the differences in beliefs about the illness exacerbated the marital symmetry.

Through a variety of interventions we sought to unite the couple. One example of a unifying intervention for this symmetrical couple was our "diagnosis" of the "B.A.M. syndrome". Using the language of the family we told the family that through their multiple exposures to the health care system they had contracted the B.A.M. syndrome (Bitterness, Anger, Mad syndrome) related to the cause, course and cure of the illness.

An important step in creating the context for change came when we hypothesized that there were actually three marriages in this family: the marriage of the spouses to each other, the marriage of the husband to his bitterness, and the marriage of the wife to her busyness. We declared our inability to work with three marriages at once and asked the couple to decide which marriage they would like to work on first. The decision would require a collaborative discussion.

The couple decided that the most important marriage was the husband's marriage to his bitterness. However, the husband wanted to work on his bitterness without the assistance of further family systems nursing sessions. The wife returned to the following session requesting assistance with her marriage to her husband. Her experience of being "wife #2" was creating feelings of loneliness, a decreased enjoyment of their sexual relationship and thoughts of other men.

Through the next five sessions we empowered the wife to experience more influence on the chronic pain and within her marriage. The outcome was a deranking of the importance of the husband's "marriage" to his bitterness. That "marriage moved to position #3; while the marriage between the spouses climbed to a lofty #1 position. The wife reported that "our marriage is the best it has been since the birth of our daughter four years ago". The couple decided to build a new home; a "concrete" indication of the spouses' commitment to the marriage. In the final session the wife reported that her husband was talking about his bitterness only 5% of the time whereas in the first session it was 95% of the time. She also reported that his talk of pain had decreased from 100% to 0%-1% of the time.

The couple participated in the Chronic Illness Project. Using a case study design, the couple's results from the quantitative data collected over time were plotted on graphs to examine trends. Several changes were reported by both husband and wife. While the couple presented as a disengaged, extremely flexible family, more cohesion was evidenced during the intervention period and continued through the follow-up time period. The perceived stress scores of the husband were highest before and during the

first month of the family sessions. His perceived stress appears to have decreased over the remaining sessions and was lowest in the follow-up period after the completion of the family sessions. The wife's perceived stress scores followed a similar trend with the highest level reported before the sessions began with a decrease reported during the intervention and continuing into the follow-up time period.

Numerous family life events were reported by both husband and wife as having occurred within the last year. Many of these fell into the intra-family strain category including events such as: increased conflict between husband and wife; increased difficulty in managing preschool age children; and increase in the number of problems or issues which don't get resolved. The wife identified more family life events than did the husband. There was a small decrease in the number of family life events reported by both husband and wife over time. It is interesting to note that although there was little decrease in the number of life events, there was a dramatic decrease in the perceived stress perhaps suggesting that although the stressors were the same, they were experienced differently.

The couple were invited to participate in the Family Nursing Unit Outcome Study six months following the completion of the family sessions. The wife attended the interview and reported she was very satisfied with the services received by the FNU. She perceived that the presenting health problem of her husband was better and that, "He has come to terms with the osteophytes. They are no longer an issue. He is physically and mentally handling his discomfort and we don't talk about it anymore". In terms of individual changes, the wife stated that, "I have more control over things in my life now and have an ability to influence what is happening". In a spontaneous letter sent to Dr. Watson, she summarized by saying, "By focusing on the specifics of what was bothering my husband and perhaps by giving his feelings concrete terms and acknowledgment, he has come to grips with himself and his osteophytes. Although he still is not the way he was, we both are different people now."

Conclusions

This paper provides an in-depth overview of the Family Nursing Unit, University of Calgary. Within its unique philosophy, the clinical practice, education and research of the Family Nursing Unit empowers families to discover their own solutions; enables learners to apply family systems nursing concepts to families and other contexts; and has the potential to advance knowledge about family systems nursing interventions and the reciprocal influence of families and illness.

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