Family Nursing Interventions: What Families Say Makes a Difference

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Within the nursing of families, assessment skills have become more and more sophisticated. However, our ability to intervene in relation to the family problems that are identified has lagged behind. There is growing awareness that it is time to attend to what we do that helps heal family suffering. This article reports on the interventions that one group of families identified and described as making a difference that matters in living with a chronic condition. These families experienced difficulty managing a member's chronic condition and sought assistance in an outpatient nursing clinic. The interventions were illuminated through a grounded theory study designed to explore both the process and outcomes of family nursing interventions. From the family perspective, the intervention process involved two stages (a) creating the circumstances for change and (b) moving beyond and overcoming problems. Examples are given of specific interventions that families found useful within the intervention process.

INTRODUCTION

The most rewarding aspect of the nursing of families is to observe families healing from emotional and/or physical suffering. This healing can occur through families' own efforts or in collaboration with nurses. When healing occurs in collaboration with nurses, it is because families and nurses coevolve useful solutions to particular health problems. Nursing's contribution to this collaborative process is knowledgeable and competent nursing practice with families. This is accomplished through the therapeutic offering of effective and useful interventions.

Only recently have nurses begun to engage in critical dialogue about nursing interventions in general. The identification of family nursing interventions is even more rare. However, collaborative nursing practice invites the question "Which interventions are most useful for families suffering a chronic condition?" If we are to improve our therapeutic practice with families, it is essential that we become more knowledgeable about what interventions families find most useful and that we address the question of how nurses become competent in the offering of those interventions. Toward this end, we first will present our perspective regarding nursing interventions in general and then discuss family nursing interventions. Next we will describe a recent study that examined the process and outcomes of family nursing interventions within the context of a particular family nursing practice. Then we offer thought-provoking ideas and comments from families regarding what they believed were the nursing interventions that made a difference in their emotional and physical healing. We conclude with suggestions of how nurses can learn the family nursing interventions that families claim are so valuable.

NURSING INTERVENTIONS OF THE GENERAL AND SPECIFIC KIND

Many terms have been used to describe the treatment aspect of nursing practice, such as intervention, treatment, therapeutics, action, and activity (Bulechek & McCloskey, 1992b). However, we concur with Bulechek and McCloske's preference for the term *intervention.* The work of Bulechek and McCloskey (1992a, 1992b) shows the most rigorous efforts to develop a standardized language for nursing interventions to date.

Wright and Bell (1990) propose the following definition of a nursing intervention: any action or response of the nurse, which includes the nurse's overt therapeutic actions, that occur in the context of a nurse-client relationship to affect individual, family, or community functioning for which nurses are accountable (p. 3). An important aspect of this definition is the recognition of the interactional or relational aspect of interventions, that is, interventions are only actualized in a relationship (Wright & Leahey, 1994a, 1994b). Interventions are the responses of the nurse that are invited by the responses of the family that in turn are invited by the responses of the nurse (Wright & Leahey, 1994a, 1994b).

Nursing interventions are intended to influence change; however, one can never predict the specific outcome in advance (Wright & Levac, 1992). To be effective, there must be a "fit" between the intervention offered by the nurse and the psychobiological-spiritual structure of the client/family (Wright & Leahey, 1994a, 1994b; Wright & Levac, 1992). It follows that when the fit is absent there is no effect. However, even when the intervention is effective in eliciting change, the outcome may not be what was intended by the nurse. In other words, the intervention does not determine the outcome. Instead, it is the psycho-biological-spiritual structure of the client/family that determines both the fit of the intervention for the family and, when there is a fit, the family's response. This implies that nurses cannot and do not make change happen; rather, change coevolves in the

context of a therapeutic relationship between a nurse and a client/family as interventions are offered that fit with the psycho-biological-spiritual structure of the client/ family (Wright & Levac, 1992). However, it has been the tendency of some nurse clinicians and researchers to predict the outcome in advance of the intervention and thus fall into the trap of becoming invested in a particular response, without regard for the unique structure of the individual or family (Wright & Bell, 1994). In contrast, we have found mat being curious about what interventions are useful, and what outcomes occur, has led us to believe that it is possible to predict the direction of change but it is seldom that we can predict the particular response.

Conceptualizing and Describing Family Nursing Interventions

The identification and description of family nursing interventions is in its infancy. However, significant recent developments are dramatically moving this process along. Craft and Willadsen (1992) are the first nurse researchers to have made an effort to label and define interventions related to family. This is a very commendable effort. Their study identified, defined, and gave critical and supporting activities for nine interventions. However, Wright and Leahey (1994b) suggest that some of the descriptions of critical and supporting activities for each intervention may be more congruent with family assessment than with intervention. This difference in perspectives is further evidence of our struggle to find a common language and understanding of what constitutes family interventions (see also Robinson, 1994). Further, the presence of divergent perspectives supports the importance of continuing critical dialogue.

Hayes's (1993) paper on the state of nursing science in family care verifies our novice development in relation to interventions that target the family. She reviewed the family nursing research from 1984 to 1990 and found only two studies that focused on examining the effectiveness of interventions. One of the factors contributing to this dearth of research has been the absence of family nursing intervention models. However, new developments are also emerging in this domain. The Calgary Family Intervention Model (CFIM), developed by Wright and Leahey (1994a, 1994b), is the first family intervention model, to our knowledge, to appear in nursing. This model is an organizing framework for conceptualizing the interface between a particular domain of family functioning and the specific intervention offered by the nurse. The model offers examples of interventions that could be used to influence change in the cognitive, affective, and/or behavioral domains of family functioning. These conceptual developments are greatly contributing to the much needed expansion of knowledge about family nursing interventions.

FAMILIES, ILLNESS, AND INTERVENTION

The senior author conducted a study about families, illness, and intervention to explore both the process and outcomes of nursing interventions offered to families who were experiencing difficulties with a member's chronic condition. Detailed descriptions were elicited from families of their perceptions about which interventions were effective in alleviating their emotional and/or physical suffering. The families had no trouble identifying specific interventions that both set the stage for and enabled the process of therapeutic change, which subsequently led to healing.

Five Caucasian families joined the study. All of the families were traditional in structure, that is, they consisted of two parents who were joined by marriage and had children. In three families, a child (the children varied in age from preschool to adolescent to young adult) was diagnosed with the focal chronic condition; in one family, the woman/wife/mother experienced the chronic condition and in one family the man/husband/father experienced the chronic condition. The focal chronic conditions were ankylosing spondylitis, chronic fatigue syndrome, depression, diabetes, myocardial infarction, panic attacks, and tetralogy of fallot.

Grounded theory methodology guided the research process. The data were collected over an approximately 2-year period and comprised (in chronological order) demographic information in the form of genograms that were constructed during the
first therapeutic session, videotapes of the therapeutic sessions (12 in total), outcome studies in which the families evaluated the service they had received and commented on its influence over time (four in total), transcriptions of the research conversations with the families (nine in total), and field notes. Thus the data were collected from family members in interaction. This researcher was not involved in any of the therapeutic family sessions.

Constant comparative analysis proceeded concurrently with data collection and resulted in the elaboration of a four-stage mid-range theory that revolves around the women's (wives/ mothers) relationships with the "family member" called chronic illness. The first stage chronicles the evolution of overwhelming illness burden for these women that leads to precarious life balance. The second stage captures a process of women falling down and falling apart that occurs after an illness-related loss, which leads to help seeking. The third stage deals with the therapeutic change process between nurses and families and with the family nursing interventions that enabled the women to move from burden to balance. The fourth stage addresses the women's evolving relationship with self that was commenced in the therapeutic process and that continues as illness is put in its place. Although the theory revolves around the women's pivotal position in the relationship with chronic illness, it is a systemic theory accounting for the relationships and interaction of all involved family members.

This article focuses on the third stage of the theory: the therapeutic change process and the nursing interventions that the five families discussed as making a difference that mattered when living with a chronic condition.

The Family Nursing Unit: The Context of Practice

The nursing practice within the Family Nursing Unit (FNU), Faculty of Nursing, University of Calgary was the context for the examination of family nursing interventions. The FNU is an education and research unit that offers assistance to families who are experiencing difficulties with health problems (Wright, Watson, & Bell, 1990).

The practice theories and models. Two foundational models have been used within the FNU, namely, the Calgary Family Assessment Model and the Calgary Family Intervention Model (Wright & Leahey, 1994a, 1994b). The advanced practice theory and model that has evolved in the FNU over 12 years is a clinical approach that emphasizes beliefs and has come to be known as Systemic Belief Therapy (Wright, Watson, & Bell, 1994). The usefulness of focusing on beliefs has been described in several articles documenting the clinical work at the Family Nursing Unit with families experiencing emotional and/or physical suffering. In particular, the approach has proven effective for families experiencing hypertension (Duhamel, Watson, & Wright, 1994); family violence (Robinson, Wright, & Watson, 1994); osteophytes and chronic pain (Watson, Bell, & Wright, 1992); cancer (Wright & Nagy, 1993); epilepsy (Wright & Simpson, 1991); angina (Wright & Watson, 1988); and suicide (Watson & Lee, 1993).

The most significant prevailing assumption of this practice model is that individuals and/or families who present with difficulties in relation to illness hold beliefs about their problems that either act to constrain or facilitate problem solving. Therefore, this therapeutic approach focuses on identifying, challenging, and/or altering families' constraining beliefs and, at the same time, coevolving more facilitative beliefs. Through this process, family and individual strengths and resources are drawn forth with increased options to discover or uncover solutions.

The setting. Within the FNU, each family benefits from a clinical nursing team approach. The family is interviewed by a nurse who may be a graduate student or a faculty member. The interview is observed via a one-way mirror by the clinical nursing team. This team comprises a supervising faculty member and graduate students who participate in the therapeutic process via a telephone intercom with the interviewer (Wright et al., 1990). From time to time, the supervisor telephones questions or suggestions to the interviewer (Wright, 1994). In addition, each therapeutic session is videotaped.

WHAT INTERVENTIONS MAKE A DIFFERENCE?

The families identified interventions within two stages of the therapeutic change process that they thought were critical to healing. These two stages have been named *creating the circumstances for change* and *moving beyond and overcoming problems.* The stages and interventions are summarized in Table 1.

Creating the Circumstances for Change

The families were clear that change does not just happen. It occurs within a particular context of relationships: between family members, and between family members and the nurse.

Problems that families struggle with over time and are unable to resolve tend to elicit both physical and emotional distance between family members. Distance arises from seemingly unbridgeable differences in perspective about the existence of the problem, the name of the problem, the ownership of the problem, and solutions for the problem. The first useful intervention identified by families in the therapeutic process involved bringing the family together in a new way around the problem. The importance of bringing the family together was emphasized by Jill, one of the mothers:

> I just felt that the family has always been together and it's been because we've always been there for each other that we've gotten through all the things that were going on with us. And I really felt that it was necessary for *me* to go for counseling ... and I thought, okay, it's good for me but, if it's good for me it's good for the family too, you know. Like I'd really like it if we'd be in this together. . . . Our survival has always been because we're together you know.

Table 1: Interventions Within the Therapeutic Change Process

Stage 1: Creating the Circumstances for Change Interventions

1. **Bringing the family together**
2. **Establishing a therapeutic relationship between nurse and family**
   - **a. Drawing forth comfort: making the therapeutic process transparent**
   - **b. Demonstrating trustworthiness: genuine compassion, equal interest in all**

perspectives, nonjudgemental attitude and behavior, and professional posture

Stage 2: Moving Beyond and Overcoming Problems Interventions

1. **Inviting meaningful conversation**
2. **Noticing and distinguishing family and individual strengths and resources**
3. **Careful attention and exploration of concerns**
4. **Putting illness and illness problems in their place**
    a. **Drawing forth a new family story emphasizing the family's influence on both illness and illness problems**

Physically bringing the family together offered the opportunity to engage in new and different conversations that had the potential of bridging family members' sense of isolation. Peter, one of the fathers, was particularly clear about this aspect of bringing the family together.

> Ya, that was a problem too because there wasn't any family discussions [at home]. There wasn't any time that we all sat down. And [the FNU] was a perfect forum for that, you know. It really was because it was a time we set apart, we said, you know, we're going to go there and we're talking. . . . We had committed ourselves that we were going to meet at this time and talk about this.

In this study, bringing the family together specifically offered the women in these families relief from the isolation that arose when they carried the burden of managing a member's chronic condition. As Samantha (another woman in the study) remarked, "I was feeling on my own [with the problem]." The women were enabled to request family support and, at the same time, family members were able to be supportive in meaningful ways. Involving all family members effectively challenged the belief that the problem in question was the woman's problem and that it was her responsibility to solve it. Each family member had a role to play. This altered the families' organization around the problem and opened space for change.

The FNU provided the context in which family members could commit to coming together to talk about difficulties. Bringing the family together was critical whether the problem was initially labeled by the family as a "family" problem or an "individual/family member" problem. According to these five families, bridging the physical distance that had arisen between family members when they were unable to solve their difficulties decreased emotional distance and was a fundamental piece of solving the illness problem. Jill reflected that "I think what it helped us believe was that we weren't really falling apart."

The second intervention that was integral to creating the circumstances for change was establishing a therapeutic relationship between the nurse and the family. In this regard, the families emphasized the development of comfort and trust. Not surprisingly, comfort with the setting and the process hinged on thorough and ongoing explanation as well as on access to persons involved in the therapeutic process, particularly the clinical nursing team behind the one-way mirror. It was helpful for families to have the opportunity to meet the team, but having access to the thinking of the team was even more important. This was provided through the telephone intercom, which enabled the supervisor to call the nurse interviewer and introduce new ideas or questions from the clinical nursing team into the therapeutic conversation. Another potent way of gaining access to the team's thinking occurred when the family exchanged places with the team and observed the team reflecting on ideas pertinent to the family's situation (Andersen, 1987, 1991). In summary, the interventions served to make the evolving therapeutic process as transparent as possible. Comfort with the process was addressed in an ongoing manner rather than just once:

> They always made sure that I knew everybody that was there. If somebody came in during the session, they always—after wards—always made sure that I met them. . . . Nothing was hidden. It was out in the open.

The families explained that establishing a trusting therapeutic relationship required both comfort with the process and a nurse who was deemed trustworthy. Trustworthiness was earned through the demonstration of the following nursing interventions: (a) offering undivided attention, (b) showing genuine interest in the family's situation, (c) showing equal interest in all family members' perspectives, (d) maintaining a nonjudgemental stance, (e) showing respect for the family's beliefs, (f) demonstrating compassion for the family's concerns, and (g) avoiding becoming entangled in the family's web of concerns. This means that the nurse needed to maintain enough emotional and cognitive distance from the family's problems so that a new perspective could be offered that assisted the family to change in a desired direction. Specifically, a particular professional posture needed to be taken. The families wanted a nurse who would work *with* them in their healing endeavors.

> I think what I wanted was somebody to help me find my starting point, you know. Like you've got a whole bunch of threads that are unraveled and there's just the key thread and you have to find it so you can have something to hang onto so you can start.... Not to give you die end answer.

Bringing the family together, eliciting comfort, and demonstrating trustworthiness established the

circumstances in which change could be invited.

Moving Beyond and Overcoming Problems

The families did not expect or desire magical solutions to their difficulties. Instead, they were looking for assistance with the process of change, that is, they sought help in moving beyond a place of being mired in trouble. The first intervention identified in this stage of the therapeutic change process was the invitation to talk about illness problems. The nurse encouraged family members to talk freely about the invasion of illness. All the families remarked on the power of the nurse's invitation
to engage in meaningful conversation about the impact of illness on their lives. As one husband/father remarked, "I still think that the best thing was getting us all together and talking about it." Each of the families noted that such discussions were made possible by the asking of "good questions." The asking of good questions, a critical aspect of advanced practice with families, refers to questions that perturbed family members' thinking about their situation (Loos & Bell, 1990; Wright & Leahey, 1994a). Through these questions, new information was brought to light, differences in perspectives were honored, and what had been unspoken was spoken. As family members gained new appreciation of each others' ideas and behaviors, constraining beliefs were challenged. One of the most problematic beliefs that was challenged was the women's belief that they were alone with both the problem and the responsibility to solve it. Not all families shifted their belief about who owned the problem; however, at the very least, all family members believed they had a role to play in the problem's solution.

The second critical intervention in this stage of the therapeutic process was the noticing of and distinguishing of positive aspects of individual and family functioning. All of the families found the team's orientation to strengths, resources, and possibilities to be an extremely important facet of the process.

> Jill: I think that was really important.... We know we have skills and we *have* had accomplishments.... Like to me, it wasn't an empty thing that was said.
> Peter: She qualified her praise too, you know. It wasn't just, *they weren't platitudes* and you knew that.
> Jill: That's right, 'cause when you're that scattered you really feel like you have no coping mechanisms. I was scattered, that's the only way I can describe it. It's like you couldn't pull it all together and, uh, I'd be talking and I'd still be feeling kind of low and [the nurse] would say, "Well I hear what you're saying but you did this and you did that." And I'm going, ya, I've got it, I can do it.

Thus, to be of value, the focus had to be extremely sharp and clearly specific to the situation. As one family member pointed out, the comments were specific rather than "the big generic cover of all things." Having a nurse notice and comment on what the family was doing *right* was an unusual and uplifting experience. In fact, Margaret, who had managed a child's chronic condition for more than 15 years, exclaimed that "nobody had ever told us we were doing a good job." A meaningful commendation (McElheran & Harper-Jaques, 1994; Wright & Leahey, 1994b) offered the family a view of strengths and resources that had been overshadowed by difficulties. The noticing of strength elicited more strength.

A third intervention was the nurse's careful attention to and exploration of problems. In this study, the women had concerns that were not shared by other family members, particularly by their husbands. Professional support for the women's concerns established those concerns as credible in the eyes of family members, who before had been more dismissive. When problems are seen to "matter" then there is more space for concern, and sharing the responsibility for solutions becomes possible. This shift in perspective can be seen in the following quotes where three husbands discuss their changing sense of the problems experienced by their wives.

> Kevin: 'Cause before it was fine, you know. If you [wife] get out, you get out. Whereas, they said you need to do this so now I was saying, yeah get out and do this. Why don't you do this and why don't you do that?
> Peter: It was an insight to me, because, again, I was sort of rolling along. It made me realize, well maybe I should give her a bit more support, you know. Rather than letting it go ... it let us realize how bad it was for Jill. So that we could focus a little more help for her.
> Scott: I think it made me more aware of some of those issues. And, uh, it's probably kind of a good wake-up call.

Finally, the nurse and family collaborated to put illness problems in their place. Persistent problems had arisen for the women and their families because of the power illness was wielding in the family. Putting illness problems in their place involved exerting a measure of control over illness and developing responses to illness that had previously been absent.

> I think the fact that she would say, "What percentage are you in control?" Well that's a—when I went in

there I wasn't in control [laughs]. But then you'd hear about what degree of control somebody else in the family had and you're going, holy cow, good for you, you know. And we were all sort of different, you know, and then as we would go through the sessions to the end it would be, Maia [ill teenager], like who's in control? And she'd go, well I'm in control, and you go, we've grown.

This intervention entailed challenging constraining beliefs, whereupon a new story was drawn forth that described the family's ability to stand up to the illness. The new story acknowledged both the influence of illness on the family and the influence of the family on illness (White, 1986,1988; White & Epston, 1990). As the family members were able to map their influence on illness, illness problems such as anxiety, depression, panic attacks, hopelessness, and exhaustion became more manageable. Family members, particularly the women, could now see choices about how much influence they were willing to allow illness problems to exert in their lives. Further, family members could now see increased and varied options in terms of their own responses to illness and illness problems. The success of putting both illness and illness problems in their place elicited more success and, at the same time, challenged beliefs that denied the possibility of change. As family members became aware of their own ability to take a stand against illness problems, the changes became more solidified. Thus change invited change.

These six interventions (the two for creating the circumstances for change and the four for moving beyond and overcoming problems) were identified and described by the families as integral to the therapeutic change process. This process assisted each family to heal from the suffering that had arisen in the context of living with a chronic condition. In other words, these interventions were effective in influencing change in a desired direction. How does a nurse learn these interventions and offer them to families who are suffering with illness problems?

Learning Family Nursing Interventions

Interventions do not happen just in the intervention stage of family work (Wright & Leahey, 1994b). They are an integral part of family interviewing from engagement to termination. However, the intervention stage of family interviews is really the core of clinical work with families because this is where the greatest potential for change occurs.

We believe that interventions are not simply tactics or tools that can be randomly pulled out of the hat and applied to our work with families. When nursing families, we must understand the relational context in which interventions are offered and the necessity of fit between the intervention and individual/ family structures. Knowledge about interventions is not sufficient. The offering of interventions rests on the nurse's way of being with families and the nurse's knowledge of each family in particular. Thus, for a nurse to offer interventions that are *effective* in assisting the family to move beyond or overcome problems, there must first be a relational fit between the nurse and the family.

Anything we as nurses say or do with families may influence the system and act as an intervention, but sometimes even our most well crafted interventions may not fit for the family. The consensus among the families in this study of the usefulness of a few specific interventions gives dear direction for practice and education. For example, one of the interventions the families found to be particularly powerful was the noticing of and distinguishing of positive things. Nurses who are reflective practitioners can learn how to notice and distinguish positive things in the following ways: reading professional literature, observing nurses conducting interviews, collaborating with other nurses who are skilled at identifying subtle strengths, and using these interventions in hands-on experience.

The above intervention is known in the nursing literature as offering commendations (McElheran & Harper-Jaques, 1994; Wright & Leahey, 1994b). As already stated, the learning of interventions can be assisted by observation of actual family interviews either conducted live or presented on videotape. However, the surest way of developing therapeutic competence in offering commendations is through live supervision (Wright, 1994). Unfortunately, two recent surveys found that live supervision is one of the least used and thus least available methods of ensuring the development of competent nurses involved in clinical work with families (Hanson & Reims, 1992; Wright & Bell, 1989). This may be one reason why family intervention skills are deficient among students at both the undergraduate and graduate levels.

Therefore, given our current state of development, both nurse educators and practicing nurses need to take the courageous step of learning as they go, in their work with families. In the spirit of experimentation, we suggest observing and listening for family strengths and resources. Some questions that nurses may ask to assist the process include the following: What has enabled the family to manage so well to this point? What are family members doing (or what have they done in the past) to continue functioning as individuals and as a family in spite of the problems they face? How has the family managed to overcome or live alongside other difficulties they have experienced? Present strengths and resources may be hidden under the weight of current problems and are likely to be out of the family's awareness. Therefore, the significant role of the nurse is to draw forth these strengths by bringing them into the consciousness of *both* the nurse and the family. Here is one woman's description of an effective commendation:

It was specific. Like for instance, they started doing the Messiah about that time and we like to sing. And so we got started in the Messiah. Well that was an out for me. I had a place to go. And [the nurse] said, "I'm very impressed that you noticed that you needed to get out. And so you took advantage and

you did that." So that was a specific thing that she said that complimented me ... and it rang true and then it really made me feel better.

When commendations are offered to families, the commendations assist our own learning. Families respond both verbally and nonverbally to a commendation that is meaningful to them. Nurses can also invite family members' verbal response to a therapeutic conversation by asking: "What stood out for you from our conversation today?" (Wright, 1989). The answer to this question will inform a nurse if the commendation offered was meaningful for any or all family members.

CONCLUSION

Nurses conduct satisfactory family assessments (Hanson & Heims, 1992; Wright & Bell, 1989), but assessments are not enough to fulfill our mandate to alleviate the emotional and physical suffering of individuals and families who are experiencing health problems. It is time to systematically and compassionately intervene to help families. Dialogue, theorizing, and research are essential to the process. However, it is only through the courageous step of translating knowledge into the offering of useful family nursing interventions that we will actually assist families to overcome or live alongside chronic conditions. The families in this study have given ideas and examples of interventions that make a difference.

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