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# CALGARY FAMILY INTERVENTION MODEL: ONE WAY TO THINK ABOUT CHANGE

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*This article defines and describes the Calgary Family Intervention Model (CFIM). CFIM is an organizing framework conceptualizing the intersect between a particular domain (i.e., cognitive, affective, or behavioral) of family functioning and a specific intervention offered by a health professional. Examples and discussion of interventions such as storying the illness experience, encouraging respite, and asking interventive questions are presented. CFIM is one way that health professionals can conceptualize about change.*

In our clinical teaching and supervision with health professionals, we have often observed a phenomenon we refer to as monocular focusing. Specifically, health professionals learning family therapy generally err in one of two ways: either too much focus on family dynamics or too much focus on interventions. The inability to employ binocular focusing (i.e., not focusing on *both* the family *and* the intervention) frequently results in little or no change. To offer a balanced conceptualization of family functioning and interventions that would enhance the possibility of change, we developed the Calgary Family Intervention Model (CFIM). This model emphasizes a "fit" between the interventions offered by the health professional and the domain of family functioning. The model also offers specific ideas for interventions in particular domains of family functioning and the fit between them.

In this article we will define and describe the CFIM. The use of interventive questions to perturb change in family functioning is discussed and examples of questions are given. Interventions to effect change in families in particular domains of family functioning are also presented and discussed. Although our trainee population is primarily health professionals, we believe that other trainees could be taught the model and would find it clinically useful.

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*Definition and Description*

Once a comprehensive family assessment has been completed and family intervention is indicated, the health professional needs to conceptualize where it is desirable to perturb change. The CFIM was developed as a companion model to the Calgary Family Assessment Model (Wright & Leahey, in press). However, CFIM can be utilized following assessment regardless of the family assessment model and/or instrument utilized. CFIM is an organizing framework conceptualizing the intersect between a particular domain of family functioning and the specific intervention offered by the health professional. That is, does the intervention effect change in the desired domain or not? Table 1 offers a visual portrayal of the fit between a domain of family functioning and a particular intervention. The elements of CFIM are interventions, domains of family functioning, and fit or effectiveness. CFIM focuses on promoting, improving, and/or sustaining effective family functioning in three domains: cognitive, affective, and behavioral. We identified these domains in *Nurses and Families: A Guide to Family Assessment and Intervention* (Wright & Leahey, 1984) but now have incorporated them into CFIM.

**Table 1**
**CFIM: Intersect of Domains of Family Functioning and Interventions**

| Domains of Family Functioning | | Interventions Offered by Health Professional |
|---|---|---|
| | Cognitive | "Fit" or effectiveness |
| | Affective | |
| | Behavioral | |

Interventions can be targeted to promote, improve, or sustain functioning in one or all three domains of family functioning, but change in one domain will have an impact on another domain. One intervention can target cognitive, affective, and/or behavioral domains of family functioning simultaneously. However, we believe that the most profound and sustaining change will be that which occurs within the family's beliefs (cognition). Change in the affective or behavioral domains is also mediated through cognition. A significant determining factor of whether change occurs is if the intervention is selected as a trigger (perturbation) for potential change by the family. We believe health professionals can only *offer* interventions to the family. Whether the family opens space for an intervention depends on their genetic make-up and their history of interactions (Maturana & Varela, 1992). It is also profoundly influenced by the relationship between the health professional and the family (Thorne & Robinson, 1989) and the health professional's ability to invite the family to reflect on their health problems (Wright & Levac, 1992).

Second-order cybernetics and the work of Maturana (Maturana & Varela, 1992) have influenced our ideas about effecting change. With regard to interventions, we believe it is unwise to attempt to ascertain what is "really" going on with a particular family or what the "real" problem is. Recognizing what is "real," whether it be the problem or the intervention, is always a consequence of our social construction of the world (Keeney, 1982). Keeney

further states that since family clinicians join their clients in the social construction of a therapeutic reality, the clinician is also responsible "for the universe of experience that is created" (1982, p. 165). Maturana (1988) presents another twist on this critical notion of reality by submitting that individuals (living systems) draw forth reality—they do not construct it, nor does it exist independent of them. This has implications for health professionals' clinical work with families in that what we perceive about particular situations with families is influenced by how we behave (our interventions) and how we behave depends on what we perceive.

Therefore, one way to change the "reality" that family members have drawn forth is to assist them in the development of new ways of interacting. The interventions we use in this endeavor are focused on changing cognitive, affective, or behavioral domains of family functioning. As family members' perceptions and beliefs about each other and their health problems change, so will their behavior. Interventions that are directed at challenging the meanings or beliefs that families give to behavioral events also have an impact on decreasing or eliminating physical/emotional symptoms and suffering (Watson, Bell, & Wright, 1992; Watson & Nanchoff-Glatt, 1990; Wright, Bell, & Rock, 1989; Wright & Nagy, 1993; Wright & Simpson, 1991; Wright & Watson, 1988).

*Interventions*

Interventions represent the core of clinical practice with families. There are myriad interventions that health professionals could choose, but interventions should be tailored to each family and to the chosen domain of family functioning. Particular interventions will vary for each family although there may be occasions when the same intervention is used for several families with differing problems. However, we wish to emphasize that each family is unique and that even though labeling particular interventions is useful, it does not represent a cookbook approach. The interventions we have listed are *examples* of interventions that could be utilized and are not intended to be inclusive. We have also given examples of interventive questions that have emerged from our clinical practice and research that have been found to be very useful. The interventions that we cite are based on several important theoretical foundations: systems, cybernetics, communication, and change theories.

There are several factors which enhance the likelihood that interventions will perturb change in the desired domain of family functioning. These factors are outlined in Table 2.

**Table 2**
**Factors to Consider When Devising Interventions**

- What is the agreed upon problem to change?
- What domain of family functioning is the intervention aimed at?
- How does the intervention match the family's style of relating?
- How is the intervention linked to the family's strengths and previous useful solution strategies?
- How is the intervention consistent with the family's ethnic and religious beliefs?
- How is the intervention new or different for the family?

First, interventions should be related to the problems that health professionals and the family have collaborated and contracted to change. Second, interventions should be derived from health professionals' hypotheses about problems and domains of family functioning. Third,

interventions should match the family's style of relating. Fourth, interventions should be linked to a family's strengths and previous useful solution strategies. We believe families have inherent resources and that the health professional's responsibility is to invite families to use these resources in new ways to tackle problems. Fifth, interventions should be consistent with a family's ethnic and religious beliefs. Sixth, the health professional should devise a few interventions so that their relative merits can be considered. For example, are these new interventions for the family or are they "more of the same" solutions the family has already tried? We do not believe that there is one right intervention, but several useful or effective interventions. In our experience, we have found that health professionals sometimes reach an impasse with families when they persist in either using the same intervention over and over *or* switching interventions too rapidly.

We must also keep in mind the element of timing with regard to interventions. Interventions do not just begin within a particular intervention stage of family work. Rather, they are an integral part of family interviewing, spanning engagement to termination. Normally, interventions used during family interviewing are based upon the health professional's assessment of the family. Adequate engagement and assessment of the family will generally increase the effectiveness of the interventions.

CFIM is not a list of interventions nor is it a list of family functioning. Rather, CFIM provides a means to conceptualize a fit between domains of family functioning and interventions offered by the interviewer. It assists in determining the predominant domain of family functioning that needs changing and what is the most useful intervention that will effect change in that domain. Through therapeutic conversations, the family and health professional collaborate and co-evolve to discover the most useful fit. We use the qualitative term *fit* in a slightly different way than de Shazer (1988) as we emphasize whether or not the interventions effect change in the presenting problem. Fit involves a recognition of reciprocity between the health professional's ideas/opinions and the family's illness experience. Therefore, determining fit may involve some experimentation or trial and error. It also entails a belief by health professionals that each family is unique and has particular strengths.

## INTERVENTIVE QUESTIONS

One of the simplest, but most powerful, interventions for families experiencing health problems is the use of interventive questions. Interventive questions are intended to effect change in any one or all three domains. Health professionals conducting family interviews should remember, though, that knowledge of when, how, and to what purpose to pose questions is more important than simply choosing one type of question over another (Lipchik & de Shazer, 1986).

### *Linear versus Circular Questions*

Interventive questions are usually of two types: linear and circular (Tomm, 1987, 1988). Linear questions tend to inform the health professional while circular questions are meant to effect change (Tomm, 1985, 1987, 1988). The important difference between these kinds of questions is their intent. Linear questions are investigative; they explore a family member's descriptions/perceptions of a problem. For example, when exploring family members' perceptions of their daughter's anorexia nervosa, the health professional might begin with a linear question: "When did you notice that your daughter had changed her eating habits?" "How much does she eat now?" These linear questions, while informing the health pro-

fessional of the history of the young woman's eating patterns, also help illuminate family perceptions of or beliefs about eating patterns. Linear questions are frequently utilized to begin gathering information about families' problems; circular questions reveal families' understanding of problems.

Circular questions are directed more toward explanations of problems. For example, the health professional could ask of the same family, "Who in the family is most worried about Cheyenne's anorexia?" "How does Mother show that she's the one worrying the most?" Circular questions help discover valuable information because they seek out relationships among individuals, events, ideas, or beliefs.

The effect of these questions on families is quite distinct. Linear questions tend to be constraining; circular questions are generative. Circular question introduce new cognitive connections, paving the way for new or different family behaviors. A linear form of questioning implies that the health professional knows what is best for the family; it also implies that the interviewer has become purposive and invested in a particular outcome. Linear questions are intended to correct behavior; circular questions are intended to facilitate behavioral change.

The primary distinction between circular and linear questions lies in the notion that information reveals differences in relationships (Bateson, 1972). With circular questions, a relationship or connection is always sought among individuals, events, ideas, or beliefs. With linear questions, the focus is cause and effect. The idea of circular questions evolved from the concept of circularity and the method of circular interviewing developed by the originators of Milan systemic family therapy (Fleuridas, Nelson, & Rosenthal, 1986; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Tomm, 1984, 1985, 1987). Circularity involves the cycle of questions and answers between families and health professionals that occurs during the interview process. The health professional's questions are based on information that the family gives in response to the questions the health professional asks, and thus the cycle continues (Watson, 1992). The family's responses to the questions provide information for the health professional and the family. Questions in and of themselves also provide new information/answers for the family. In these circumstances, they are considered interventions (Fleuridas et al., 1986). Interventive questions may invite family members to see their problems in a new way and subsequently to see new solutions. Thus, as the family's answers provide information for the health professional, the health professional's questions may provide information for the family (Watson, 1992).

Tomm (1987) embellished the types of circular questions utilized by the Milan systemic family therapy team and identified, defined, and classified various circular questions. Loos and Bell (1990) have creatively applied the use of circular questions to critical care nursing. Watson (1988a, 1988b, 1988c, 1989a, 1989b) demonstrated the therapeutic aspect of circular questions with families experiencing chronic illness, life-shortening illness, and psychosocial problems. The circular questions identified by Tomm (1987) that we have found most useful in clinical practice with families are difference questions, behavioral effect questions, hypothetical/future-oriented questions, and triadic questions. We have expanded the use of circular questions by providing examples of questions that can be asked to intervene in the cognitive, affective, and behavioral domains of family functioning. The type of question, definition, and examples are given in Table 3.

There are four types of circular questions (i.e., difference, behavioral effect, hypothetical, and triadic) that can be used to perturb change in any one or all of the domains of family functioning. Table 4 illustrates the intersect of various types of circular questions