2 Families and psychosocial problems: Assumptions, assessment, and intervention

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OVERVIEW

This chapter presents certain basic assumptions about families and psychosocial problems. Guidelines for a systemic family assessment are outlined and examples of circular descriptive questions are given. To help nurses maximize change, both general and specific interventions are described.

INTRODUCTION

Despite significant advances in psychosocial/mental health nursing during the past 20 years, present nursing research offers little help in clarifying and/or verifying this progress. Therefore, nursing assessment of and intervention with patients with psychosocial problems remains wide-ranging, with little confirmation of any one approach; the nurse's own beliefs or assumptions about human nature, the nature of psychosocial problems, and the means of fostering therapeutic change are therefore important determinants of assessment and intervention strategies.

The assumptions described in this chapter are based on current knowledge and research, and on the authors' clinical experience with psychosocial patients and their families. Assessment and intervention guidelines follow a discussion of relevant general assumptions.

BASIC ASSUMPTIONS ABOUT FAMILIES AND PSYCHOSOCIAL PROBLEMS

Psychosocial problems frequently engender fear, misunderstanding, and blame within families. Strong cultural, societal, and religious beliefs and values often influence family members' understanding of such problems. Indeed, such beliefs prompt many people to try to solve a psychosocial problem themselves more so than they would with problems arising from a chronic or life-threatening illness. The authors believe the following assumptions are the most important considerations in nursing families with psychosocial problems.

Assumption #1: Psychosocial Problems in Families Are Best Understood and Treated from a Circular Rather Than a Linear Perspective

In the authors' estimation, this assumption is the most crucial element in family nursing for psychosocial problems, because it forms the foundation for effective assessment and intervention.

Each family member, it is assumed, contributes to adaptive as well as maladaptive interactions. However, only interactions *over time* allow specific patterns to be formed and identified (Hinde, 1976). These long-term series of interactions are commonly called family *relationships,* and they are significantly different from interactions among groups with no common history (e.g. employment groups, therapy groups).

To describe a relationship, one must note not just the interactions that occur within it, but also their content, quality (Hinde, 1976), and the patterns they form over time. This can be done by obtaining information about absolute and relative frequencies—when they occur with respect to each other—and how they affect each other.

Tomm (1981, p. 85) differentiates between linear and circular interactional patterns:

> One major difference between linear and circular patterns lies in the overall structure of the connections between elements of the pattern. Linear patterns are limited to sequences (e.g. ABCA... or AB, BC, CA). A less obvious but more significant difference lies in the relative importance usually given to *time* and *meaning* when making the connections or links in the pattern. Linearity is heavily rooted in a framework of a continuous progression of time... Circularity... is more heavily dependent on a framework of reciprocal relationships based on meaning.

In clinical nursing practice, this assumption affects the nurse's style of questioning during a family assessment. Linear questions usually

identify individual characteristics or events (e.g., "How long have you had a problem with your drinking?"), while circular questions explore relationships or differences (e.g., "Who in your family is most confident you can overcome your problem with drinking?") (Selvini-Palazzoli et al, 1980; Tomm, 1981). Bateson (1979, p. 99) proposed that "information consists of differences that make a difference."

> Differences between perceptions/objects/events/ideas/etc. are regarded as the basic source of all information and consequent knowledge. On closer examination, one can see that such relationships are always reciprocal or circular. If she is shorter than he, then he is taller than she. If she is dominant, then he is submissive. If one member of the family is defined as being bad, then the others are being defined as being good. Even at a very simple level, a circular orientation allows implicit information to become more explicit and offers alternative points of view. A linear orientation on the other hand is narrow and restrictive and tends to mask important data (Tomm, 1981, p. 93).

White (1986) has applied the concept of circularity or reciprocity to family dynamics by describing the relationship between the problem and the family as one of "relative influence." In therapy, he wants to know how much the problem influences the lives of family members. At the same time, he asks how the family members influence the problem—that is, how well they can manage the problem. Linear and circular questions that might be asked during a family assessment are highlighted later in this chapter.

Assumption #2: Families Experiencing Psychosocial Problems Need to Discover Their Own Problem-Solving Abilities

Frequently, families of individuals with psychosocial problems express hopelessness, fatigue, and inadequacy in the face of their problems. A nurse who believes that the family unit *can* solve its own problems will not try to solve the problems for them. By the same token, a nurse who feels responsible for solving a family's problems can inadvertently enhance that family's sense of hopelessness and inadequacy and foster dependence. Nurses can avoid the "responsibility trap" by not becoming overly invested in any particular outcome. For example, if the presenting (psychosocial) problem involves a young teenager who frequently runs away from home, the nurse should resist the temptation to decide on a "best" outcome—that is, to decide whether the child should live somewhere else, with the parents, or have closer supervision when away from home. Any of these outcomes may be reasonable, but a nurse who invests too heavily in one outcome will not help the family explore a variety of alternatives and resolve the problem as *they* deem best.

Alcoholism, for instance, poses a particular nursing challenge in this area. The family and the community usually pressure the nurse to help the family member stop drinking. In such a case, however, the nurse should help family members search for alternative behavioral, cognitive, and affective responses to the problem and to gain confidence that they can discover their own solutions.

Assumption #3: Family Members' Ability to Change Depends Upon Their Ability to Alter Their Perception of the Problem

A family assessment should always ascertain all family members' *perceptions* of the problem. Nurses must test the validity of those individual outlooks and be prepared to offer the family another epistemology. Family members usually build subjective interpretations around problems and base that interpretation on personal beliefs. Normally, family members need help to move from a linear perspective of the problem to a circular one. The nurse can help them only by avoiding linear thinking about family dynamics.

Avoiding linear conceptualization of psychosocial problems means not thinking that any single family member's view is "correct" or "right." By not searching for an "ultimate truth," the nurse can invite each family member's perceptions and provide an *alternate* truth, or perception of reality, that, ideally, will enable the family to solve its own problems. In the authors' experience, when these assumptions are applied, psychosocial problems are usually redefined as interpersonal or relationship problems. In many cases finding out what a family member *thinks* about a relationship may be more important in problem resolution than the interactions that actually occur within that relationship (Hinde, 1976).

How nurses perceive and conceptualize a problem determines how they will intervene.

> Viewing problem behavior not in isolation but in relation to its immediate context—the behavior of other family members—means more than just a specific change of viewpoint, important as that is. This change exemplifies a general shift in epistemology from a search for linear cause and effect change to a cybernetic or systems viewpoint—the understanding and explanation of any selected bit of behavior in terms of its place in a wider, ongoing, organized system of behavior, involving feedback and reciprocal reinforcement throughout (Fisch et al, 1982, pp. 8-9).

The authors' clinical nursing practice with families with psychosocial problems is currently based on a systems/cybernetics/communication theoretical foundation using the Calgary Family Assessment Model (CFAM) (Wright and Leahey, 1984) as an assessment framework. Inter-

ventions are based primarily on a systemic/strategic model (Selvini-Palazzoli et al, 1980; Tomm, 1984a and b; Haley, 1977, Fisch et al, 1982). Some of these interventions will be highlighted in the intervention section of this chapter. A nurse who does not conceptualize a patient's psychosocial problem from a systems/cybernetics perspective will develop interventions based on a completely *different* conception of "reality," one based on different theoretical assumptions.

Assumption #4: Families' Understanding of Psychosocial Problems Does Not Itself Lead to Change

Changes or improvements in psychosocial problems rarely occur through improved family understanding of the problem alone; rather, changes in behavior will precede understanding. From a systems perspective, problems are solved as family interactional patterns change, whether or not this is accompanied by insight.

Historically, psychosocial nursing has tried to understand the "why" of a problem first. Thus, many well-intentioned psychosocial nurses spend many hours compiling masses of historical data that will explain that elusive "why." The patient and/or family will even encourage the nurse in this quest and cooperate freely. For example, family members often ask such questions as, "Why is my wife so depressed?" or "Why do I keep washing my hands so frequently?" or "Why is my young son schizophrenic?" However, finding the "why" is not a precondition for change; rather, it steers nurses away from any effective pursuit of change. The prerequisite for change is understanding not the *why* of a situation but rather the *what.* Therefore, rather than ask: "Why is my client so depressed," the nurse should ask: "What effect does the family have on my client's depression?" "What" questions are much more useful in paving the way for interventions. Nurses should reject the search for causes (linear models) and try instead to understand what can be done immediately to effect change (systems/cybernetic models).

Assumption #5: A Therapeutic Context for Change Must Be Created for Families with Psychosocial Problems

For a family to change, members must find a context that will facilitate change. That context might have to be created. Psychosocial family nursing assessments and interventions must always consider the important variable of context. Nurses must recognize their position in the health care delivery system vis-à-vis the family. Specifically, the nurse needs to know what other professionals are involved with the family and in what roles. Also, how does the nurse's role differ from that of the others? How are the family and the nurse influenced by and influencing the context they are in?

Coppersmith (1983) has analyzed the place of family therapy in the homeostasis of larger systems. She suggests that larger systems (e.g.

the hospital, mental health agency, or public service delivery system) impose "rules" upon families that serve to maintain the larger system's homeostasis. The first rule is the "rule" of linear blame. That is, institutions often blame families for difficulties, label them "resistant," and make treatment referrals designed to "cure" the family. This process resembles what happens when a family sends an identified patient to be "cured."

A second "rule" identified by Coppersmith is the "rule" of overinvolvement. Because members of some larger systems, such as hospital staff, become intensely involved in a psychiatric patient or family member's life, they often go beyond the immediate concerns. The end result is that they usurp the family's own resources. This discourages family members from articulating their perceived needs. The intimacy created by the family assessment process can also establish the nurse as just another irritant in the family's predicament; this is another reason why nurses should carefully assess the larger context in which family and staff find themselves. In some cases, more serious problems arise from the interaction of the family with health care professionals than from circumstances within the family itself. Interventions directed toward the family-professional system should therefore precede addressing problems at the family system level.

Coppersmith's third rule is that of undefined leadership. Families often find themselves enmeshed in a larger system, such as an outpatient mental health clinic, where they receive conflicting advice about their problem (e.g. bulimia). This situation occurs because no single clinic or educational program has definitive decision-making power regarding those families. "In short order, client families may find themselves in a situation quite similar to that of a child whose parents cannot agree" (Coppersmith, 1983, p. 221).

Finally, there is the rule of dysfunctional triads, which states that unacknowledged or unresolved conflicts between larger systems, or between families and larger systems, result from dysfunctional triads that prohibit healthy behavior. For example, a family may wish to send a rebellious adolescent to an outdoor living skills program. The nurse and the program director, however, may not agree on what the treatment goals should be or when intervention should begin. The family thus finds itself in a situation where conflicts in the larger system force them to take sides.

Once the family's relationship to the suprasystems has been assessed, interventions can be directed to the appropriate system level. Change occurs more readily when there is respect for context.

Assumption #6: Psychosocial Problems or Symptoms May Serve a Positive Family Function

The Milan associates (Selvini-Palazzoli et al, 1980; Tomm, 1984a and b) by their landmark contributions to systemic thinking, have compelled family clinicians to rethink their views about psychosocial problems and their symptoms. Traditionally, mental health clinicians have viewed psychosocial problems as something that families want to get rid of; they assumed, therefore, that families who did not pursue change were unmotivated, resistant, or unprepared. However, the work of the Milan associates has taught family clinicians that psychosocial problems often serve positive family functions. A situation might appear "problematic," but it may also be helping the family avoid a worse dilemma.

For example, an adolescent in a single-parent family refused to mix with her peers, remained at home constantly, and did not want to work or go to school. The mother, preoccupied with the task of raising three children, and overwhelmed by financial concerns, job dissatisfaction, and a minimal social network, perceived the daughter's problem as one of low self-esteem, antisocial behavior, and depression. Yet, by staying at home, the daughter provided her mother with valuable companionship and emotional support. The mother would even ask her daughter's advice about her boyfriends and whether she should reunite with the daughter's father. This example illustrates the circular or recursive nature of many psychosocial problems, that is, that each behavior simultaneously causes and effects all other behaviors. The daughter's problems would not have existed unless the mother maintained them, and the mother's ability to cope depended on the daughter's problem. The daughter's depression and antisocial behavior was probably helping to avoid a more serious depression with the mother.

This type of systemic conceptualization has profound implications for nursing. Once the connection between *symptom* and *system* has been established, intervention can be directed toward the system and not just toward the symptom—in short, all family members influencing and influenced by the symptom can be involved in treatment.

Assumption #7: Outcome is More Positive if Psychosocial Problems are Treated from an Ecosystemic Perspective

The goal of psychosocial family nursing is to improve family functioning so that families can solve their own problems. There is increasing evidence to recommend taking a broader systemic view when working with individuals with psychosocial problems. For instance, traditional management of schizophrenia involves frequent hospitalizations, phar-

macotherapy, and individual psychotherapy. However, a research study by Falloon and coworkers (1985) has demonstrated the relative efficacy of the family approach in preventing schizophrenic morbidity. These researchers assumed that environmental stress contributes to the clinical morbidity of established schizophrenias treated with optimal neuroleptic drugs. Over a 2-year period, they compared a family-based approach aimed at enhancing the identified patient/client family's problem-solving capacity to a similarly intense patient-oriented approach. After 9 months of treatment, the family-managed patients experienced fewer exacerbations of schizophrenia, less severe schizophrenic psychopathology, fewer hospital admissions, and a trend toward lower deficit symptoms and reduced neuroleptic dosage. This influential study supports the superior efficacy of a family approach in reducing the clinical morbidity of schizophrenia.

Research also supports the concept of family intervention in managing marital problems. Gurman and Kniskern's (1981) extensive review of marital therapy outcome research indicated that marital problems are more often resolved successfully when both spouses, rather than either one individually, are treated. In a further review of outcome research, the same investigators determined that families tend to remain in treatment and not terminate therapy prematurely when fathers are involved.

To think and work systemically does not mean that all patients with psychosocial problems must be seen in a family context. However, it is much more difficult to resolve psychosocial problems through work with individuals alone, because the nurse is limited to a single perspective on the problem. When other family members are present, their ideas and perspectives can expand the nurse's base for assessment and choice of intervention alternatives.

FAMILY NURSING ASSESSMENT

Family assessment is the evaluation of relationships and behaviors among all members of a family. Thus, the family nurse focuses on relationships rather than on individual members' behaviors. Numerous family assessment models and concepts have been described in recent nursing texts (Jones, 1980; Friedman, 1981; Clements and Buchanan, 1982; Wright and Leahey, 1984).

Guidelines for Systemic Assessment

The authors rely primarily on a systemic model of interviewing (Selvini-Palazzoli et al, 1980; Tomm, 1984b) developed by four Italian psychiatrists. This model was first developed in work with families of patients

with anorexia nervosa and later refined though work with schizophrenic young adults. Three fundamental guidelines—hypothesizing, circularity, and neutrality—provide the context for a systemic interview (Selvini-Palazzoli et al, 1980). A fourth guideline, strategizing, has been proposed by Tomm (1987). All four of these principles are interrelated.

A nurse's basic assumptions about families with psychosocial problems can take the form of hypotheses, which can then help her organize information about a particular family. Before meeting the family for the first time, the nurse should write down her hypotheses about the family and the presenting problem in its relational context. The hypotheses might be parameters or variables already suggested by specific family assessment models, but they can also be based on the nurse's own experience with similar families, problems, symptoms, or situations (Fleuridas et al., 1986). Guidelines for developing hypotheses are given in Table-2.1.

Table 2.1 Guidelines for Designing Hypotheses

- Choose hypotheses that are useful.
- Generate the most helpful explorations of the family's behaviors for the particular time.
- Understand that there are no "right" or "true" explanations.
- Include all family components to make the hypothesis as systemic as possible.
- Relate the hypothesis to the family's presenting concerns so the interview can proceed along the lines most relevant to the family.
- Make the hypothesis different from the family's to introduce new information into the system and avoid being entrapped with the family in their solutions.
- Be as quick to discard unconfirmed or unhelpful hypotheses as to generate new ones.

Adapted from Fleuridas, et al., 1986.

The nurse who uses circular questioning bases her assessment on information about *relationships* (Selvini-Palazzoli et al, 1980). Examples of circular questions that can be used in assessment are discussed in the next section of this chapter. Neutrality, the third guideline, is the nurse's ability to respond without judgment or blame to descriptions of relationships. For example, if a family states that a psychosocial problem (e.g. depression) is genetic in origin, the nurse's reaction should be as neutral as possible. This does *not* mean that she must accept the declared connection. Information about the assigned meaning of family beliefs about psychosocial problems will greatly assist the nurse in intervening. Intervention is only necessary, however, if particular beliefs interfere with or block the family's problem-solving ability.

The fourth interviewing guideline, strategizing, refers to the nurse's clinical decision-making—that is, evaluating the effects of past actions, designing new plans, anticipating the possible consequences of future actions, and deciding how to proceed (Tomm, 1987).

Assessment Questions

Linear descriptive vs. circular descriptive. Assessment questions can function as a recursive loop between nurse and family. Some questions *inform* the nurse and enhance understanding of the family system, while others *effect change* (Tomm, 1985; Tomm, 1987). In this context, linear assessment questions generally inform the nurse, while circular descriptive questions are meant to effect change. The important difference between these kinds of questions is their *intent.* Linear descriptive questions are *investigative;* they explore a family member's perception of a problem. For example, when ascertaining family members' perceptions of their daughter's anorexia nervosa, the nurse would begin with linear descriptive questions: "When did you notice that your daughter's eating habits were different from those of other family members?" "What do you think caused your daughter to stop eating as she normally would?" These questions, while informing the nurse of the history of the young woman's eating patterns, also help illuminate family perceptions or beliefs about eating patterns.

From investigative assessment questions, the nurse moves to more explanatory questioning. To the family just described, the nurse might ask, "Who in the family is most worried about Mavis's anorexia?" ("Mother is because she thinks Mavis is going to get sick if she doesn't start eating more.") "How does Mother show that she's the one worrying the most?" ("Because she keeps checking with the rest of us if we've seen Mavis eat anything and wants us to report to her if we have.") "What does your father do when your mother is so worried?" ("He is not around as much these days. He's working long hours at his office.") The authors have found both explanatory and investigative questions to be useful in gathering information; but the *effect* on families of these two types of descriptive questions can also be quite significant. Linear descriptive questions, for instance, tend to have a liberating effect (Tomm, 1987).

The difference between linear and circular descriptive questions is that circular descriptive questions help discover valuable information because they seek out relationships between individuals, events, ideas, or beliefs. Linear descriptive questions do not.

In psychosocial problems, it is important to assess the family's set of beliefs, since the meaning a family assigns to a psychosocial problem may determine the nursing intervention. A family that attributes a son's enuresis to an organic problem will be managed differently from a family that presumes a psychological origin. Matters become even more complicated and challenging when different family members hold different beliefs about etiology. In one family, for example, the parents were

asked, "Do you think your son's enuresis is of an organic or a psychological nature?" The father responded "organic" while the mother responded "psychological." Therein lay many obstacles to the family's attempts to resolve the problem on its own. The nurse's assignment in such a case is to offer the family an alternate "reality" or epistemology of the problem that would enable them to generate their own solutions. To do this, the nurse has to understand the problem in its larger relational context. Thorough assessment revealed that the parents were contemplating separation but would not separate as long as their son was having difficulties. Therefore, the nurse offered an alternate "reality," that is, that the son had found a way to keep the family together; his enuresis reduced the tension between the parents and delayed separation. This nurse's insight gave the family a new perspective on the problem. The parents admitted that they did not want to separate but could not resolve their marital problems on their own. Surprisingly, their son was less worried about the separation than he was about his parents' fights and the possibility that his father and mother might physically abuse each other. When the nurse told the son that "someone wetting his pants was perhaps better than someone hitting and hurting someone else," he agreed. The parents spontaneously decided to obtain therapy in order to reduce marital tension. Within a month after they began therapy, their son's enuresis subsided from four to six times a week to once or twice a week.

Circular descriptive questions also help assign relative value to the advice that a family receives from extended family members, friends, and community resources. Useful questions might include, "What's the best advice that friends have given you with regard to your son's problem?" "What is the worst advice?" "What advice have you tried?" When the family with the enuretic son was asked to describe the worst advice they had received, they responded, "Our family physician told us that each time our son wet the bed to put his nose in the wet sheets and have him smell them and then change them." They said they agreed to having their son change his own sheets, but adamantly disagreed with such a punitive measure as having their son smell his own urine. Circular questions yield valuable information not only about specific advice, but about the types of guidance a family values and from whom. It also indicates what advice the family has tried to follow, its relative success, and what advice the nurse should avoid.

Following an assessment with descriptive linear and circular questions, the nurse is ready to start developing an intervention strategy. If assessment reveals that family functioning and/or problem-solving is blocked (e.g., because of opposing views on problem etiology), then family intervention is indicated.

FAMILY NURSING INTERVENTIONS

Family nursing interventions can help families who are experiencing psychosocial problems. This section presents interventions—based upon family research and clinical practice—that seem the most essential and useful in resolving psychosocial problems.

Interventive Questioning

Interventive questions are intended to actively effect change. Nurses conducting systemic interviews should remember, though, that knowledge of when, how, and to what purpose to pose questions within the framework of a particular model is more important than simply choosing one type of question over another (Lipchik and DeShazer, 1986).

Linear strategic questions vs. circular reflexive questions. Interventive questions are predominantly of two types: linear strategic and circular reflexive questions (Tomm, 1987). The effect of these questions on families is quite distinct. Strategic questions are constraining, while reflexive questions are generative; the latter introduce new cognitive connections, paving the way for new or different family behaviors.

The following two interventive questions, for example, might be asked of the family of a young adult who has been hospitalized for an acute schizophrenic reaction: "Don't you think you're putting even more pressure on your son when you continually tell him to stop acting crazy?" This particular question is strategic and linear and takes a confrontational, blaming stance. It also sends a strong directive to the parents that *they* need to change their behavior if they want their son to improve. In comparison, a circular reflexive question would be: "If you become even more insistent that your son stop some of his disturbing behaviors, do you think it is more or less likely he will continue these behaviors?" This question is more reflexive and is intended to mobilize the parents to *reflect* on their actions without, however, implying that they should consider their behavior inappropriate or counterproductive. These questions are also intended to allow family members to choose their own position and are consequently more respectful of the family's autonomy. The linear strategic form of questioning implies that the nurse knows what is best for the family; it also implies that she has become too purposive and invested in a particular outcome. Strategic questions are intended to correct behavior; reflexive questions are intended to facilitate behavioral change.

One type of reflexive question, the *future-oriented question,* is useful in nursing families with psychosocial problems. Frequently, such families are so mired in their troubles that they cannot project or speculate about the future; thus their problem-solving efforts or alternatives are

limited. By asking reflexive questions about their future, the nurse can prompt family members to speculate on it (Tomm, 1987). Future-oriented questions for the family of a child with school phobia might include: "What are you worried will happen if your child remains out of school for 6 months?" and "What's the worst thing that can happen?" Such questions help families discuss and affirm or disaffirm catastrophic expectations. A similar strategy was employed with the family of a young woman with bulimia. The parents were asked, "How much longer do you think it will be before your daughter can give up her bulimia?" The daughter was asked the same question, and surprised her parents by saying, "I'll probably give it up when I move out of the house next year." Future-oriented questions introduce not only the critical variable of time, but also the important message that perhaps problems are controllable rather than, as is often believed, that they "just occurred," and will have to "just stay." The connection of time and symptoms can draw forth family beliefs about how long symptoms will occur.

Another type of future-oriented question stimulates discussion about family goals; for instance, a teenaged son might be asked, "How much longer do you think you will have to remain in the hospital before you can return to live with your mother?" The mother might be asked, "How long do you think your son will have to remain in the hospital?" The answers to these questions can be enlightening (in the case just described, the son said 6 months, while his mother said 1 or 2), and may allow the presenting problem to be understood in a larger systems context. In this case, the hospital nursing staff also believed that it would be some months before this child could return to live with his mother. Upon further questioning, the son said that his mother "needed a man," the first indication that he viewed hospitalization as a "holiday" from the job of providing emotional support to his mother.

Frequently, interventive questions *alone* can create a context for and effect change with families who have psychosocial problems.

Offer an Opinion

Nurses frequently offer opinions, assessment, conceptions, or beliefs about psychosocial problems without regarding them as interventions. However, the authors believe that strategically placed opinions can serve as very powerful and useful interventions. The following have been found to be most beneficial in clinical practice.

Commending family and individual strengths. The authors routinely end their interviews by commending families on strengths observed during the session. Families coping with psychosocial problems frequently label themselves as failures because they cannot resolve their problems. In

addition, these families often say that extended family members, friends, and even health care professionals have implied or told them directly that they have failed to fulfill their responsibilities, and that that is why they have problems. Commonly, these families have not been complimented on their strengths or made aware of them for some time. The immediate and long-term positive reactions to such commendations indicate that they are effective interventions.

In one case, a family whose adopted son's behavioral and emotional problems had kept them involved with health care professionals for the past 10 years was told by the nurse interviewer that they were the best family for this boy, because many other families would not have been as sensitive to his needs and would probably have given up years ago. The parents both became tearful and said that this was the first positive statement made to them as parents in many years. An interesting turn of events followed: for many years the parents had been told to be more firm with their son and raise their expectations of him, but they had always been unwilling or unable to do so. Subsequent to interviews with the parents (the son refused to come to the sessions), during which they had been commended for their parenting, the father said that he had talked with his son and told him to cut his long hair and look for a job. To the parents' surprise, their son complied. When they were asked how they could demand such a thing, they said that being told that they were suitable parents had increased their confidence as parents and allowed them to follow through on their actions. They no longer felt unable to manage their son and therefore approached him more firmly. This clinical case exemplifies that reaffirming family competence frees members to behave more spontaneously and to solve problems. The very behavior that professionals requested of these parents for years was now implemented without active direction. In other words, the context for change was created, allowing the family to discover its own solutions.

Commended families also appear dramatically more receptive to new opinions or assignments. The more professionals that family members have seen, the less confident they are about their own skills. Inadvertently, professionals can foster low self-esteem within families and increase dependence on external resources.

Advice and information. Families find advice and information about psychosocial problems valuable. Frequently, information about developmental (e.g. adolescents' needs for privacy and the importance of peer support), medical (e.g. the physiological effects of bulimic binging and purging), and family interactional issues (e.g. how a husband's withdrawal can precipitate a wife's nagging behavior, which precipitates withdrawal, and so on) can free a family to resolve its own problems.

Systemic opinion or reframe. When a presenting problem is redefined as serving a positive family function (Assumption #6), it can be reinterpreted as a solution to another hypothetical or implied problem that could occur were the symptom not present (Tomm, 1984b). Thus the symptomatic behavior is systemically reframed by connecting it to other behaviors in the system. Connections should be based on assessment information derived through circular questioning. When offering a systemic reframe to a family, a nurse should delineate the recursiveness of the symptom, stressing that it serves a positive function for the system at the same time as the system serves a function by contributing and maintaining the symptom. At the Family Nursing Unit, University of Calgary (Wright et al, 1985), the dilemma of a family with the presenting problem of the mother's alcohol abuse was systemically reframed by a nurse who pointed out that the mother's drinking served the positive function of holding this family together because it kept everyone worried about her. Had that worry not been present, family members might have become estranged, as they had been in the past. At the same time, the family "helped" the mother drink by plotting to limit her drinking and by intensely monitoring her drinking.

Split opinion. It often helps to offer a family two or more different and opposing views, one indicating change and another suggesting no change. For a split opinion intervention to be effective, the nurse, during the course of the interview, must show no preference for any particular point of view.

A nurse offered the following split-opinion to a couple at the end of an interview: "My opinion of your situation is divided—part of me believes that the intense competition or symmetry between the two of you spices up your marriage and allows you to express and debate your ideas. Since you do not have many common interests, I would fear that if you were not as competitive you might find your marriage boring and stale, with nothing left to keep you together. However, another part of me thinks that if this competition does not end, your marriage will. Your marriage is in jeopardy as long as each of you holds so firmly to your own ideas; you must learn how to compromise and negotiate. My opinion is split; I will have to leave it with you."

Redefining the context. Redefining the context in which family nursing is provided can have a powerful impact on treatment. A family that objects to attending "family therapy" sessions might be more amenable to treatment if the nurse has labeled them "developmental sessions" (Wright and Watson, 1982). The nature of the work between the nurse and the family does not change; rather, a new context or "name" makes treatment more palatable and promotes change.

Devise Rituals

Families engage in many daily (e.g. bedtime reading) and yearly (e.g. Thanksgiving dinner at Grandma's) rituals. Family therapy can suggest new rituals that are not or have not been observed by the family. Rituals are best introduced when there is a counterproductive level of confusion. Frequently, the confusion is caused by the simultaneous presentation of incompatible injunctions. Rituals serve to provide clarity in the family system.

When parents cannot agree on parenting practices for their children and chaos and confusion reign, the introduction of an odd day–even day ritual (Selvini-Palazzoli et al, 1980) can help. The mother becomes responsible for the children on Mondays, Wednesdays, and Fridays, and the father is given childcare authority on Tuesdays, Thursdays, and Saturdays. On Sundays, they should behave spontaneously. On their "off" days, parents are asked to observe, without comment, their partner's parenting. This strategy isolates contradictory behaviors by prescribing sequence (Tomm, 1984b).

Prescribe Behavioral Tasks

Myriad behavioral tasks can help families improve their functioning when faced with psychosocial problems. Such tasks can be straightforward; for instance, a nurse might instruct parents to read a book on parenting adolescents or ask a family to monitor the number of times they remind a child to eat. Tasks can also be complex and creative. For example, the mother of three alcohol-abusing adult children could be less predictable and responsible toward them to provoke them to more responsible behavior. The mother was assigned the behavioral task of going home and turning all the chairs in the house upside down and writing on the mirrors with lipstick (Wright et al, 1985). She found the task amusing and enjoyable, and the young adults responded by paying more attention to her.

CONCLUSIONS

Treating the family as a unit has gained prominence in nursing management of psychosocial problems. Techniques have evolved from various assumptions about families and psychosocial problems, as well as from family research and clinical practice. Experience demonstrates that family involvement enhances compliance, provides social support, and sustains motivation for health promoting behavior (Barbarin and Tirado, 1985). Family involvement can lead to symptom reduction and overall improvement in family functioning. Nurses are in a key position to help families discover and rediscover their abilities to solve their own psychosocial problems.

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