Family Skills Labs: Facilitating the Development of Family Nursing Skills in the Undergraduate Curriculum

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This article describes the implementation of family nursing skills labs with undergraduate nursing students at the University of Calgary. The intent of the family nursing skills labs is to facilitate the development of family interviewing skills of students and to apply these skills to a variety of clinical settings. The incorporation of demonstration interviews, role playing, and practice interviews provides students with simulated situations to implement family interviewing skills. Students who participate in the family skills labs are invited to consider therapeutic conversations as interventions and are offered a preferred relational stance for working with families. Specific strategies for implementing the family skills labs are proposed.

With the recent collaborative efforts in nursing education between community colleges and universities there have been opportunities to revise undergraduate curricula to enhance family nursing content. In 1995, at the University of Calgary, Drs. Janice Bell and Lorraine Wright developed a model for leveling family nursing theory, practice, and research across 4 years of an integrated undergraduate curriculum (Bell, 1997). In addition, a specific theory and clinical from the course, called "Nursing of Families," was proposed for the 3rd year of the new collaborative program. Unlike previous undergraduate course structures that were limited by an overemphasis on family nursing theory with few opportunities for concentrated, supervised family nursing practice, the new course allowed new learning experiences to be created. One of these innovations was called the family skills lab.

This article will briefly review the foundational theory and the design of the family skills labs. Two graduate students who served as teaching assistants offer their experience of implementing the family skills lab experience and provide an overview of the clinician's beliefs about the nursing of families they offered to students to guide the development of a preferred relational stance with families.

THEORY AND PRACTICE: BUILDING BLOCKS FOR THE FAMILY SKILLS LABS

There are many theoretical building blocks that assist nursing students to work more effectively with families. In the new course development, Bell and Wright proposed that theory on family structure, development, and functioning be offered to provide a framework for conceptualizing the family. A focus on the reciprocal influences between health, illness, and the family, including the impact of the diagnosis or illness on family members, family responses to the illness, and the family expectations of the nurse (Wright & Leahey, 1994) was also proposed. The models used in this context were the Calgary Family Assessment Model (CFAM) and Calgary Family Intervention Model (CFIM) (Wright & Leahey, 1994). Lecture content taught in the theory course by Bell and Wright introduced a frame-work for family interviewing that focused on therapeutic conversation (Wright, Watson, & Bell, 1996). Lecture content also addressed interventive questioning and offered interventions that may influence family responses to health and illness. For example, interventions such as offering commendations to families about strengths and resourcefulness in past and present coping, offering ideas and opinions, and normalizing family experiences (Wright & Leahey, 1994) were reviewed.

The 18 hours of family skills labs were offered as part of the 156hour clinical course that was offered concurrent to the theory course described above. The original design of the family skills labs was developed by Anne Marie Levac (a graduate of the master's program at the University of Calgary) who was employed at the University of Calgary as a sessional instructor. The intent of the family skills lab was to create a context where students could practice family interviewing skills in role play scenarios. This clinical experience built on the foundation of communication and relational skills that nursing students had already studied and experienced, including topics such as engagement, interpersonal approaches, the therapeutic relationship, problem solving, and counseling skills. Working with families added another layer of complexity to these interpersonal skills. The student learned to attend to the verbal and nonverbal communications of two, three, four, or more family members simultaneously. Consideration of the influence of the illness on each family member was heightened and appreciation of the roles of family members in influencing the illness was increased.

Several features of Levac's original design are central to the experience of family skills labs. Because there are many different right ways to do family assessments, family interventions, and

family interviews, the family skills labs were purposely offered as a nonevaluative experience. The specific content of the family skills labs addressed the family interviewing skills proposed by Wright and Leahey (1994): engagement, assessment, intervention, and termination. Each lab emphasized different stages of the family interview (see Table 1).

Students were provided with opportunities to try out family nursing skills; to watch demonstrations of interviews; to experiment with family conversations, interviews, assessment, and intervention skills; and to learn by observing other students' and faculty members' relational styles and ways of thinking about family conversations.

Table 1: Stages of Family Interview

Engagement
Assessment
Problem identification
Relationship between family interactions and health problem
Attempted solutions
Goal exploration
Intervention
Termination

Source: Wright and Leahey (1994).

The family skills labs used role plays to create opportunities for students to participate as nurse and/or interviewer, family members, and observers. Ideal size for these activities was 8 to 10 students per group. When communication lab facilities were available, interviewing rooms with one-way mirrors were used so that suggestions and feedback could be offered to the nurse interviewer by telephone during the role play. It is also possible to conduct role plays in a classroom with the family /nurse group separating themselves slightly from the observing students.

Scenarios for role plays depended on the population (e.g., children, maternal-child, mental health) and context (e.g., acute care, school, community) of current clinical placements for students. Family scenarios were provided by faculty, were created by students, or were drawn from the current practicum experiences. As a note of caution, the situations enacted by students who are role playing as family members should be simple and should enable participants to improvise and embellish the scenarios in the ways that they think family members might be experiencing the health or illness situation. If family member scenarios are presented as rigid roles, spontaneity for both the family members and the interviewer can be constrained. When role plays were rigidly prescribed, students sometimes thought that there was a right way and a wrong way to proceed. In clinical work, family situations unfold in ways that the nurse cannot anticipate. Students reported learning as much from the experience of role playing family members and observing the relational skills of their classmates as they did in trying out their own interviewing skills.

At the beginning of each lab, an instructor demonstrated a family interview that emphasized the focus of that particular lab. Students

Table 2: *Outline of Role Play Exercises*

A brief family scenario is presented (by faculty instructors or by students). Volunteers are requested to role play as interviewer and two, three, or four family members.

Family members separate from the interviewer and student observing group. For about 5 minutes, family members get into character and discuss possible ways of depicting the family situation.

Meanwhile, the faculty instructor and observing students offer the interviewer hypotheses about the kinds of concerns and challenges the family might be facing.

The nurse interviewer role plays a conversation with the family for about 10 minutes. If the student gets stuck, the faculty instructor may offer ideas about possible lines of questioning.

The entire group convenes briefly after each role play and spends 5 to 10 minutes discussing examples of skills they observed, questions that were helpful, ideas about other questions that could be asked, and offering feedback and ideas to the student interviewer.

participated as family members and observers and often enjoyed creating the scenario to be encountered by the instructor. The format for the role play exercises is summarized in Table 2. Following the interview or therapeutic conversation, the group discussed examples of nurse behaviors and family responses, hypotheses that were explored, and alternative ideas about other

ways of proceeding and offered the nurse interviewer feedback, ideas, and suggestions. The demonstration interview mirrored the process that students were invited to enact. Examples of desired skill developments were modeled, some student anxiety about role play participation was defused, and the faculty interviewer skills were discussed, explored, and critiqued in the same manner that student interviewer skills would be examined following each interview.

Dianne Tapp and Nancy Moules were graduate teaching assistants who taught the family skills lab during the fall term of 19%. Below, they offer the theoretical underpinnings of the family skills labs and their experience of teaching the skills labs.

ASSUMPTIONS AND BELIEFS ABOUT THE NURSING OF FAMILIES

As graduate students at the master's and doctoral level specializing in family systems nursing, we have a passion for clinical practice with families. Our clinical practices are based on postmodern assumptions: Understandings and realities are socially constructed in language and there are multiple legitimate explanations for how we view and experience the world (Anderson, 1996; Tapp & Wright, 1996).

In our approach to implementing the family skills labs, we offered' our beliefs about nursing of families and we invited students to reflect on their own ideas, assumptions, and beliefs. Two concepts that are central to our nursing practices and our manner of relating with families are (a) therapeutic conversations are interventions and (b) a preferred relational stance. These ideas have been uncovered and described through clinical practice and research with families at the Family Nursing Unit, University of Calgary, Alberta, Canada (Wright et al., 1996; Robinson, 1996; Tapp, 1996).

Therapeutic Conversations are Interventions

Students were invited to view therapeutic conversations with families as interventions (Wright & Leahey, 1994). The opportunities for nurses to make a difference in the illness experience of families occur in every practice setting. These interventions occur not only in the structured context of a family interview, but also in therapeutic conversations that occur in planned meetings with families and in happenstance, day-to-day interactions with family members. Therapeutic nursing conversations differ from social conversations in at least two ways (Wright et al., 19%). First, therapeutic conversations are more purposeful than social conversations: They focus on the concerns of the patient and family members. How are family members being influenced by the illness or hospitalization? What are they most worried about? What are the family members' concerns about the diagnosis, treatment, prognosis, or discharge? What has the family found to be helpful in assisting them with the illness or hospitalization? What are the issues that the family needs to have addressed to contend with the situation today, tomorrow, or in the future? Second, in a therapeutic conversation, the intent of the nurse is to offer interventions (suggestions, ideas, or information) that could address the concerns of family members. The intent may be to help family members understand and create meaning out of the illness, to increase possibilities for managing the illness, and to help families make decisions and plans that meet their needs.

Therapeutic conversations are interventions that are offered through the medium of language. Nursing interventions can be viewed as explanations for what it is that we do as nurses that we believe can make a difference in the health or illness concerns of the individual or family. Therapeutic conversations are interventions that invite families into new ways of thinking about experiences, problems, solutions, and about themselves. These interventions offer observations, ideas, thoughts, information, and suggestions with the goal of assisting families to discover their own competencies, resources, strengths, and abilities to create new solutions and alleviate suffering.

A Preferred Relational Stance

Although there are many ways of working effectively with families, in our work with nursing students, we invited students to reflect on a preferred relational stance. Because the influence of postmodern thinking encourages a belief in the validity of multiple perspectives, we offered our preferred relational stance in the form of an invitation to the undergraduate students we worked with. Our preferred stance is one that encourages a worldview of families that is collaborative, nonjudgmental, and nonhierarchical. This stance invites students to be conscious that the world that they bring forth with families is not *the* world but *a* world that coevolved with others (Maturana & Varela, 1992, p. 245). The preferred stance or manner of relating with families includes an interactional view of responses to health and illness, a collaborative approach to working with families, a nonjudgmental view of the family, and an overarching belief in family competencies and strengths.

Interactional View of Responses to Health and Illness

Viewing responses to health and illness as influencing all family members invites consideration

of the many levels of context influencing the illness experience of the individual and all family members. When the problem can be viewed as situated somewhere other than inside the individual, there are many more possibilities for solutions (Wright et al., 1996). An understanding of the family is enhanced by appreciation of the ways in which other family members are influenced by the problem, the ways in which each family member contributes to the maintenance of the problem, and the ways that family members have found to be helpful in challenging the problem.

As the nurse inquires about each family member's experience of the illness, it becomes apparent that each person has a relationship not only with the ill person, but with the illness. Although the ill individual may be experiencing grief, anxiety, loss, or suffering, these phenomena are not contained solely in the individual's experience. Family members may also share in these illness experiences. Nurses are invited to view responses to health and illness as interactional phenomena that influence family members other than the ill person and that influence relationships within the family in both facilitative and constraining ways (Wright et al., 1996).

The belief that the problem does not reside only in the individual can constrain labeling of the problem in an unhelpful manner and reduce unhelpful blaming for the problem (Bell, 1995). Family experiences with health and illness are not necessarily problems. This belief invites careful consideration of the use of language and the potential contribution to the maintenance or the creation of problems that may not have previously existed for the family. When experiences are labeled as problems, the family may inadvertently begin to interpret their experiences as problems.

Thinking interactionally about responses to health and illness shifts the focus from content (when did certain events happen, what was said, what is the cause?) to a focus on process, patterns in relationships and responses, and effects of behaviors (e.g., "What does he do when dad is in pain?" "When she shows sadness, what do you do to comfort her?") (Wright & Leahey, 1994). Thinking interactionally invites us to be curious about the many plausible explanations for making sense of the family situation or dilemma. There are many ways to understand the family, each of which probably bears some truth. The nurse strives to keep these many possibilities open and tries to understand which explanations are preferred by the family. These explanations offer ideas to the nurse about how she might be helpful to them and which interventions might be most useful. Thinking interactionally invites nurses to consider both the facilitative and constraining influences of their own participation in relationships with families (Leahey & Harper-Jaques, 1996; Wright & Leahey, 1994).

Collaborative Approach to Working With Families

We invited students to constrain their passion for their own ideas and their desire to fix the family's problem in offering solutions to families. Students were encouraged to give the family's explanations and understandings as much credibility and legitimacy as nursing and medical explanations. The explanations offered by families reveal the way that they have conserved their existence (Tapp, 1996). This stance invites collaboration with the family and curiosity about the ways in which the family's explanations of their experiences make sense for them (Robinson, 1996). Respect for the family's own explanations is balanced by the belief that as nurses, we can make a difference in the family's suffering and that we do have unique ideas, opinions, and suggestions for change. The combination of the expertise of the family and the expertise of the nurse cocreates increased possibilities for change (Leahey & Harper-Jaques, 1996; Wright et al., 1996).

A collaborative stance invites curiosity about the family's goals, which may be different from the nurse's goals. For example, when a nurse's benevolent intent is to teach family members, it can inadvertently suggest that the nurse knows what information families need. Offering information with the belief that the family knows what is best for them can invite people to recognize their capacity to make wise decisions for themselves (Wright & Levac, 1992).

Nonjudgmental View of the Family

An important aspect of relational skills in the nursing of families is the ability to be nonjudgmental (Robinson, 1996). This includes neutrality and acceptance of other ideas, beliefs, behaviors, and explanations. This position dissuades us from the temptation to pathologize, label, and blame (Bell, 1995; Wright & Levac, 1992). Operating with a nonjudgmental view of the family does not mean that the nurse has no opinions or beliefs. It means that one strives to recognize the ways that one's own beliefs, opinions, and ideas influence actions and possibilities for meaning, understanding, and behavior. This demands an openness to examine our own beliefs and an awareness of beliefs that we are not willing to compromise. Being nonjudgmental does not mean having a consensus with all families about all beliefs. It means recognizing the implications of the intersection or collision between differing beliefs (Wright et al, 1996).

Belief in Family Competencies and Strengths

Nursing has continued to focus on problem identification as part of the nursing process and nursing diagnosis. In our clinical work with families, we have discovered that nurses can get into the habit of looking for and always finding family strengths, not in a patronizing way but within a

stance that genuinely respects each family's uniqueness and wisdom (Wright et al., 1996). Family strengths are often overshadowed by problems so that the family members cannot see them, and both problems and strengths often operate outside their awareness. Commending family strengths helps to make them even more visible and stronger (McElheran & Harper-Jaques, 1994; Robinson, 1996).

In the midst of a possibly problem-saturated description (White & Epston, 1990) of an illness experience, a nurse can attempt to elicit alternate experiences of successes and competencies: What has the family been doing that has been helpful? What is going well for this family? How have they been able to do as well as they have done? What beliefs or previous experiences or relationships are sustaining them and preventing the problem from being worse? What advice would they give to other people in the same situation?

Families are a resource to the nurse (Tanner, Benner, Chesla, & Gordon, 1993). Families know the ill member's normal patterns and ways of being and are often trying to understand how they can be most helpful to the ill family member both in the hospital and at home. Collaboration encourages the wisdom of both and the possibility for reciprocity between the nurse and the family in evolving understandings of the illness experience. Both parties bring a specialized expertise to the therapeutic conversation and relationship (Leahey & Harper-Jaques, 1996; Wright etal., 1996).

CONTENT AND PROCESS OF THE FAMILY SKILLS LABS

Family Skills Lab Number 1: Focus on Engagement and Assessment

In the first lab, students were invited to experiment with the many ways in which they could engage the family to create a context for therapeutic conversations to occur. Students tried out different ways of engaging the family and providing structure for the interview: introducing themselves to the family, discussing the purpose of the interview and anticipated time frame, introducing the genogram to the family, involving all family members by asking questions of each of them, being curious about each family member's experience and perceptions, and maintaining a respectful, nonjudgmental stance to different family members' ideas and opinions. Engagement occurs throughout the entire course of the clinical relationship between the nurse and the family (Wright et al., 1996), and during this skills lab, the emphasis was on setting the stage for continuing engagement with the family.

Students were invited to experiment with questions that would enable them to draft a family genogram. The use of the genogram facilitates engagement by providing opportunities to discuss who is in the family, how they fit together, who is influenced by the health problem, other sources of family support, and other family stressors. The CFAM is an organizing tool or road map that expands students' repertoire of questions. The CFAM and the genogram are not simply data assessment and documentation devices. These conceptualizations help to increase understanding of the influences between health and illness and various family members. Students were encouraged to use discretion and think about the development of clinical judgment that helps them to focus on those aspects of family structure, development, and functioning that might be most pertinent for each particular family.

In this lab, students were encouraged to focus on engagement and asking questions that helped them to understand the family and come to a beginning sense of the concerns of family members. As described in Table 3, students were also prompted to ask questions that help to increase their understanding of family strengths and the ways that

Table 3: Exploring the Problem and Family Strengths

Who first identified the family concern? Who agrees/disagrees that there is a problem?
When is the problem most/least noticeable?
What have the family, physician, nurse, and so on, said or done that supported the continuance of the concern or problem?
What has prevented the problem from worsening?
How have family members been at least somewhat successful in challenging the influence of the problem?
What have been the family strengths in living with the illness? Living well in spite of the illness?

the family had coped successfully with this concern and other problems in the past. Although students usually had a beginning under-Standing of the family's concerns after this brief interview, students were urged to constrain themselves from making assumptions about the problem and trying to fix the problem or offer solutions during this first skills lab. The intent was for students to become skilled at attending to engagement and exploring what the family's situation and concerns were before attempting to offer solutions.

As the role play interviews were reviewed, the instructor invited the observing students to offer examples of engagement or useful ways of inquiring about family assessment that they noticed

during the interview (Table 4). Students role playing as family members were asked to comment on what they had experienced as helpful ways that the interviewer engaged them or less helpful ways that might have interfered with engagement.

Throughout the skills labs, an extremely useful checkpoint in examining the process of the conversation or interview was to stop and ask students about their hypotheses about the family and the interview (see example questions in Table 5). This explored their ideas about what might be happening for the family before entering a room to begin a conversation, or what they thought was happening in the middle or at the end of the interview. Faculty instructors attempted to help students practice entertaining/ exploring, discarding, validating and modifying their hypotheses based on the evolving understandings of the family. Hypotheses were understood as possible explanations, guesses and hunches about families that we bring to the foreground, rather than definitive judgments or nursing diagnoses about the family.

Table 4: Engagement

Examples of Questions to Ask Students

What specific things did you do to facilitate engagement with this family?
How could you tell whether the family and interviewer were engaged?
How did the interviewer demonstrate neutrality, nonjudgmental attitude, and respectful curiosity?
What questions helped to elicit the genogram information?
How was this experience for the students who were role playing family members?
If engagement stalls or is difficult, invite students to address the process directly with the family.
"What has been most or least helpful to you today?"
"What were you hoping would happen here today?"
"What could or should we be doing differently to make this conversation more comfortable for you?"
Ask about other possible barriers, such as time constraints, cultural preferences, and previous negative experiences with hospitalization or health care providers.

Table 5: Hypothesizing

Examples of Questions to Ask Students

What are your hypotheses about what might be happening for the family right now?
What explanations could you offer about what you have observed to this point?
If the student is stuck in a way of thinking about the family that is not helpful, offer the student a different idea about the family: "If you were to believe that... how might you proceed differently in the conversation?"
Help the interviewer and observers to explore the hypothesis by asking "What questions could you ask to explore this idea to see if it *fits* for the family?"

Family Skills Lab Number 2:
Focus on Interventive Questioning

The purpose of this lab was to provide students with opportunities to practice skills related to the identification of circular patterns of communication and to begin to experiment with the use of interventive questions (Wright & Leahey, 1994). Students were invited to continue attending to the ongoing process of engagement, to explore the problem in further depth, and to practice circular questions.

Questions are interventions when they provide new information, ideas, and possibilities for the family and when they invite family members to see their problems and solutions in a new light (Wright & Leahey, 1994). Questions can have an immediate influence on the thinking of family members, and questions can sometimes linger in a way that opens space for future possibilities (Tomm, 1988). The relationship between questions and answers is reciprocal. Questions help the nurse to appreciate how the family understands the situation. The family's answers provide information for the nurse, but the nurse's questions also may provide information for the family (Wright & Leahey, 1994). The intent of questions is not to determine what is true, but to discover what is meaningful to this family at this time.

The intent of linear questions is investigative, and the questions are useful to gather information (Wright & Leahey, 1994). Circular questions are exploratory and are intended to reveal differences in relationships, events, ideas, and beliefs (Wright & Leahey, 1994). Circular questions evolved out of the work of the Milan systemic family therapy team (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980) and have been extensively described in the literature (Loos & Bell, 1990; Tomm, 1985, 1987).

Types of circular questions introduced to students included difference questions, behavioral effect questions, hypothetical and future-oriented questions, and triadic questions (Wright &

Leahey, 1994). Difference questions pursue differences in relationships, beliefs, people, and time. Behavioral effect questions explore the reciprocal effect of behaviors of family members on each other. Hypothetical and future-oriented questions explore beliefs, options, and predictions about possible or future meanings. Triadic questions invite a direct or a speculative observer perspective through the inclusion of a third party. Table 6 illustrates examples of each question type. Before participating in the role plays of this second lab, students found it helpful to discuss a family they had encountered in their clinical practicum and to generate hypotheses about what might be happening for the family. From their hypotheses, students developed examples of each of the different kinds of circular questions that could help validate, discard, or modify their hypotheses. Following this introductory discussion, students again participated in role play situations as described in me first lab.

The second lab was structured in a similar format as described previously. There was less emphasis and time spent on engagement and problem exploration. To facilitate this, we encouraged students

Table 6: Examples of Circular Questions

Difference questions

Who worries the most about the angina attacks, your husband or yourself?

Was there more communication between you before or after the heart attack last year?

Behavioral effect questions

When your husband tells you to stop your housework and rest during your angina attacks, what do you do?

When your husband shows that he is worried about you, what does that say to you and what effect does that have on your own behavior?

Hypothetical and future-oriented questions

If you were to believe that attending to lifestyle changes would make a difference to your cardiac condition, would that make you feel more inclined to quit smoking?

When you think about your health 5 years from now, what is your greatest concern?

Triadic questions

If your daughter were here, what would she tell me about how the heart disease has affected your relationship as a couple?

What would your husband say the physician's greatest concern about your health is at this time?

to continue with one clinical scenario in depth. Students often used exemplars from their own clinical work as starting points for family scenarios. Each student practicing the role of clinician conducted the interview for about 10 minutes. The conversation was reviewed, hypotheses about the family were considered, and another student continued the interview with the same family, intending to simulate the process of moving through all aspects of a therapeutic conversation with the family. In this manner, one family scenario could be used for three or four student interviews.

Family Skills Lab Number 3: Focus on Offering Interventions and Conclusion of Clinical Work

The purpose of the third lab was to provide students with opportunities to practice skills related to family nursing interventions. Interventions are the offering of observations, ideas, thoughts, and suggestions with the goal of assisting families to discover their own competencies, resources, strengths, and abilities to create new solutions. Interventive skills included further exploration of interventive questions, offering commendations, validating and normalizing families' experiences and feelings, offering information and ideas, and drawing forth family support.

The process of engagement, assessment, and offering interventions is ongoing throughout the interview or across continuing encounters of the nurse and family. As the nurse learns more about the family, the nurse has more ideas about which interventions might fit for the family (Wright & Leahey, 1994). As the nurse offers interventions, more information about the family continues to emerge. Relationships with families are never without an impact on the nurse, which in turn influences the interventions that the nurse is inclined to offer the family. What families select as interventions or triggers for change is dependent on the fit between the family and the particular intervention (Wright & Leahey, 1994). Interventions are offered as invitations for reflection and change and can only be an invitation when an intervention can be declined without blame (Robinson, 1994; Wright & Levac, 1992). The use of tentative, nonjudgmental language encourages family members to choose freely among possible solutions and to experiment with solutions in a manner that is most useful to them.

As with the second family skills lab, the same family scenario was often used by three or four students. As the nurse's understanding of the family's concerns and the relationships and dynamics related to the illness were deepened, there were more opportunities to offer a greater variety of interventions and more fitting interventions. Tips for faculty in facilitating and debriefing this lab are offered in Table 7.

This lab also created opportunities for students to reflect on and practice the art of concluding their work with families. Students were encouraged to have a conversation with families that reviewed the clinical work and gave credit to the family for their successes in their own endeavors to address their concerns. Students practiced inquiring about what was most useful or helpful to the family in their clinical work and in what way those ideas made a difference to the family. Understanding of the reciprocity of the therapeutic relationship was fostered by the practice of describing to families the ways in which they had contributed to the student's learning. Nursing students were encouraged to explicitly discuss with the family what the student had learned from them that would be useful in clinical work with other families in the future. Table 8 offers suggestions for debriefing skills related to closure with the family.

Table 7: Questions to Ask Students About Offering Interventions and Examining the Fit of Interventions

What invited you to think that this idea/intervention might be useful to this family?
How did the manner in which the intervention was offered enable the family to freely choose or decline the suggestion?
In what ways did the family indicate that there was some appeal or fit for the intervention (that they had thought about the idea, experimented with it, weighed it as a possibility)?
How could you tell from the family that the intervention was not a fit?
What did you say to yourself to explain why the family declined the intervention or did not think that the suggestion would be useful to them?

Table 8: Questions to Ask Students About Creating Closure With Families

How do you think you will know when your work with this family is done?
In what ways did or could you give the family credit for their efforts in influencing the problem?
How could you find out if this family believes that they have made sufficient progress to continue working on their own?
What did you learn from this family that will be helpful to you in your clinical work with other families in the future?
What do you believe were the most useful ideas or interventions you offered this family?

REACTIONS FROM STUDENTS TO FAMILY SKILLS LABS

Our particular experiences of the implementation of family skills labs with undergraduate students were extraordinary. Many of the students enthusiastically described the process of learning as different, valuable, and relevant to the development of their nursing skills. The students' openness to experimenting with new ideas related to nursing practices with families seemed to be enhanced by the explicit acknowledgment of the labs as a learning context and not an evaluative context. Students' evaluation of the usefulness of the labs included an enhancement of both knowledge and confidence, a broadened repertoire of how to intervene with families, increased skills in moving beyond just hearing a family's story, and a beginning awareness of the collaborative nature of nurses and families.

CONCLUSION

The people we nurse not only come from families, they are families. This belief of person as family is fostered by a nursing education curriculum that values families and the nursing of families, that acknowledges the reciprocal relationship between the nurse and the family, and that recognizes that relational skills with families can be taught and practiced. In the same way that health assessment skill development provides opportunities for students to develop assessment skills and knowledge to nurse individuals, students can be offered a family nursing perspective and a plethora of skills to prepare for family assessment and intervention. This preparation expands students' repertoire of experiences in therapeutic relationships and enhances understandings of clinical practices with families in health and illness.

It has been gratifying to participate with students in their attempts to integrate the ideas of person as family, of family as resource, of problems as opportunities, of change as potential, and of interventions as invitations to change. It is our belief that as students begin to develop their own beliefs in the power of therapeutic conversations, the valuing of relationships with families, and skills of family interviewing, tine nursing of families will shift from being viewed as a specialty to being a integral part of all nursing practice.

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