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Nursing and Family Therapy Training

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In the past few years nursing theory has made a dramatic shift from focusing on the individual to focusing on the family. Nursing now considers the family as one of the primary units of health care. The nursing literature is replete with such terms as "family centered care" (Cunningham, 1978), "family nursing" (Friedman, 1986); "family-focused care" (Janosik & Miller, 1979), "family conferences" (Wiley, 1978), and "family interviewing" (Wright & Leahey, 1984). These terms are also evident in many components of undergraduate and graduate nursing curricula, especially in the area of community health.

The involvement of families in nursing is interesting because it has come full circle. Although family nursing has always been part of nursing, until recently it was not labeled as such. Because nursing was first practiced in patients' homes, it was natural to involve family members in providing care. With the transition of nursing practice from homes to hospitals during the 1930s and 1940s, the family was excluded from involvement. Nursing is once again, however, inviting families to participate in both home care and hospital treatment. One example of this trend is the large number of fathers now involved in all aspects of maternity care. Family nursing has come to mean nursing care of the well and sick, and health counseling for all members of the family.

Despite the statement that *family-focused care* is widely accepted within the discipline of nursing, it should be noted that *family therapy* is less widely accepted within nursing. Nursing educators have incorporated family therapy into their mental health nursing programs only as one more treatment method, rather than as a different orientation to human problems.

Some possible explanations for this phenomenon can be offered. First, the majority of nurses are highly committed to maintaining their professional identity within the nursing profession, and therefore have been hesitant to enter into the mainstream of family therapy. Nurses are keen to do "family work," but do not want to be considered family therapists. This difference in professional identity between nurses and family therapists has been further accentuated in recent years by the recognition of family therapy as a distinct profession. Second, there is a dearth of family therapy role models within the nursing profession itself. There are few nurse educators/clinicians who specialize in the practice of family therapy. Therefore, most nurses have to go outside of their profession to receive family therapy training. Nursing students often rely on

psychologists, social workers, and other professionals to serve as prototypes of family therapists. When students are not trained by or do not observe a competent *nurse* engaged in family therapy in a *nursing context*, the likelihood that they will associate the significance of family therapy within the discipline of nursing is lessened. Thus, it can be stated that many nurses are interested in family nursing but few have received specialized training in family therapy.

Perhaps a more compelling reason for the hesitancy of the nursing profession to embrace family therapy is that nurses are often made to feel that once they have specialized in family therapy, they must make a choice between identifying themselves as either nurses *or* family therapists. Our experience has been that *our* identity varies according to the professional context in which we find ourselves. That is, at times we identify ourselves as nurses with special training in family therapy, and at other times as family therapists who have a background in nursing. We believe that a more satisfactory solution to this professional identity dilemma would be the clear distinction of two levels of expertise in nursing with regard to family work: generalists and specialists. The purpose of this chapter is to discuss the issues involved in training both generalists and specialists in family work in nursing. Attention will be given to distinctions between training nurses in family nursing (generalists) and training nurses in family therapy (specialists).

TRAINING ISSUES

To clarify and compare the training of nurses in family nursing and in family therapy, the following issues will be discussed: context of training, education levels, faculty, curriculum, goals of training, supervision methods, and facilities for training. Each will be addressed separately.

Context of Training

Most nurses have an innate "family-mindedness," and some have been taught a conceptual base for family work. Many, however, find it difficult to apply their conceptual model in actual clinical practice. Part of the difficulty is that nurses, understandably, place emphasis on families with health problems.

Interest and emphasis on families with health problems is idiosyncratic to nursing and other health care professions. It has, however, implications for training. Nurses readily pay attention to family members with health problems, whereas family therapists without a nursing background tend to ignore or be uninformed about health issues. Nurses are taught to use a holistic approach in their clinical work, and emphasize *both* the biophysical and psychosocial aspects of health care. Because their orientation is primarily toward physical care, nurses tend to be more aware of the biophysical than the interpersonal aspects of an illness. They easily recognize the impact of the illness on the individual's functioning, but require more training to assess the impact of the illness on *all* family members.

Another significant implication for training is that nurses, because of their employment context, are required to learn first about the physical aspects of illness and only

secondarily about the interactional aspects. For example, in working with a family with cancer nurses must be knowledgeable about both cancer as an illness and its management within the family system. Family therapists, on the other hand, are not expected to know about such physical aspects as colostomies or medication side effects. It is thus a challenge for nurses to try to integrate a family systems approach with their nursing education.

Education Levels

We recommend that the education of a nursing student in family therapy be provided only at the graduate or postgraduate levels, while the training of a student in family nursing may be provided at the undergraduate and/or graduate level (Wright & Leahey, 1984).

GRADUATE AND POSTGRADUATE EDUCATION

Graduate nursing master's or doctoral programs and postdegree institutes specializing in family therapy provide heavy emphasis on family assessment, models of family therapy, and the necessary skills to practice family therapy. Extensive clinical supervision, preferably live, of students' skill development (perceptual, conceptual, and executive) is provided by educators/clinicians. In North America, only a few graduate nursing programs or postdegree institutes offer family therapy courses taught by *nurse* educators (e.g., the Oregon Health Sciences University, Portland, Oregon; the University of Washington, Seattle, Washington; and the Family Therapy Institute, Holy Cross Hospital, Calgary, Alberta). Also rare is the supervision of nursing students in their clinical family therapy practica by *nurse* educators/clinicians.

We will briefly describe two graduate nursing programs that do offer family therapy courses and clinical supervision. These are examples of attempts to incorporate family therapy training into nursing programs. The first is the master's program, Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada. The program is designed to prepare clinical nurse specialists. Students entering the program who desire to specialize in family therapy are able to focus on this area of interest within their clinical practica. Two elective courses are also offered: "Family Therapy Models: Structural, Strategic and Systemic"; and "Families and Illness." The predominant assessment model used is the Calgary Family Assessment Model (Wright & Leahey, 1984), while the predominant intervention model is an integration of the systemic–strategic approach. Live supervision is provided by two nurse educators/clinicians who themselves have specialized training in family therapy. The graduate nursing students also have opportunities to observe their professors interviewing families. Families interviewed by the graduate students are seen at the Family Nursing Unit at the University of Calgary (Wright, Watson, & Duhamel, 1985).

Another example of a graduate nursing program that offers family therapy courses and clinical supervision is the master's program at the University of Washington. This program offers a course entitled "Theoretical Models of Family Analysis and Intervention." The structural family therapy approach is presented in the clinical practica, although students are given the opportunity to select other approaches as well. Students are fortunate to have live supervision provided by a nurse educator/clinician who has specialized training in structural family therapy.