Editorial
**Encouraging Nurses and Families to Think Interactionally: Revisiting the Usefulness of the Circular Pattern Diagram**

The year is 1978, and I am leading a seminar discussion with undergraduate nursing students at the University of Calgary who are learning to work with families in a community setting. The families have been assigned by the local community health center and are considered to be *multi-problem families* experiencing a variety of health problems and involved with many larger systems-the welfare system, the legal system, the health care system, the school system, and so forth. The students make home visits and talk in the seminar about the challenges of providing nursing care to these families. In the Faculty of Nursing, we decide to invite collaboration and consultation with a group of family therapists who operate an outpatient clinic through the Faculty of Medicine.

Dr. Karl Tomm, a psychiatrist who directs the program, offers a faculty development workshop about the ideas of general systems theory (von Bertalanffy, 1968) and cybernetics (Weiner, 1948). He and his colleagues teach us about circularity and reciprocity and how to observe for the interrelatedness and interdependence between family members, and between family members and ourselves as nurses. We learn to record our observations using a circular pattern diagram (CPD).

In 1980, Tomm first wrote about the CPD and recommended its usefulness in understanding and locating interactional patterns in relationships. The specific affect, cognition, and behavior of an individual or system is observed and/ or inferred with linkages made to the mutual influence these have on another person or system's affect, cognition, and behavior (see Figure 1). Although the limitations of using systems theory to understand families have been identified (Yerby, 1995), diagramming the recursive influence each person/ system has on the other offers not only" a more complete description, but also offers more alternatives for therapeutic intervention" (Tomm, 1981, p. 86). Depending on the theoretical orientation and preferences of the clinician and family members, efforts might be directed to changing the behavior, altering the cognition and/ or modifying the affect.
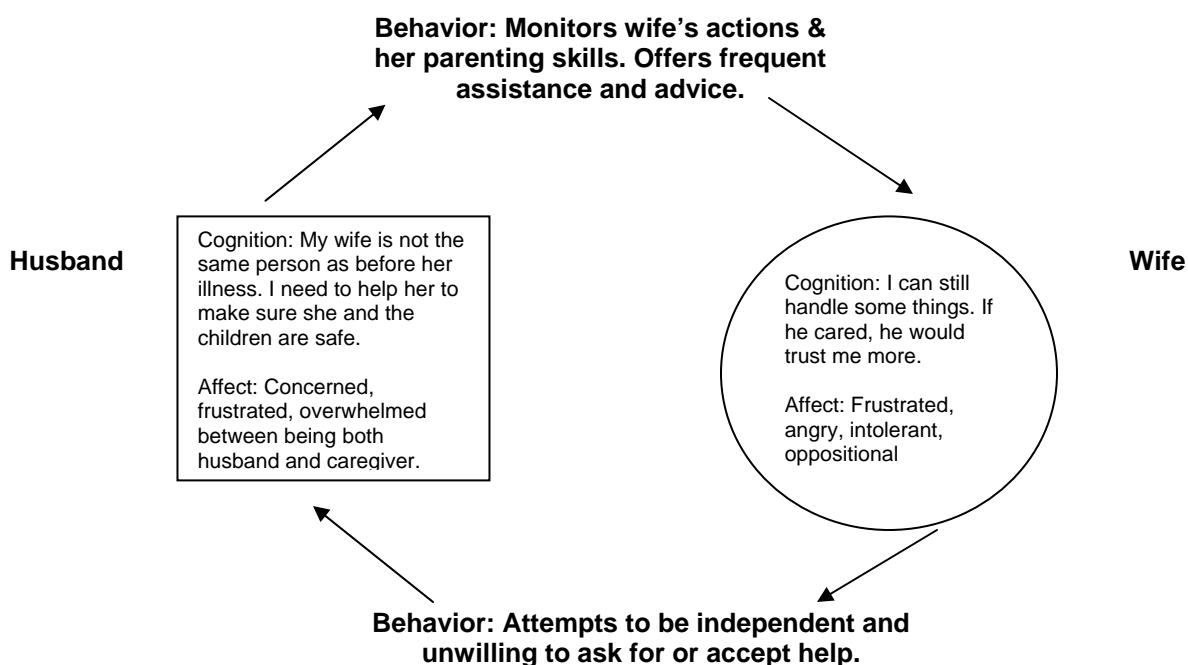
Figure 1: Circular Pattern Diagram
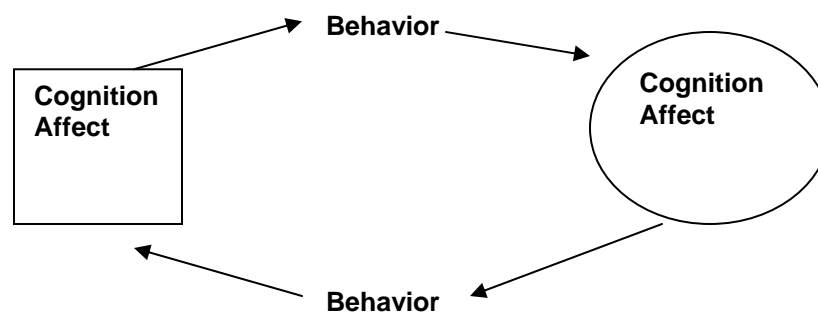
Doctors Lorraine Wright and Maureen Leahey were both colleagues of Karl Tomm and worked with him in his program. When Lorraine joined the Faculty of Nursing at the University of Calgary in 1980, she and Maureen began writing about the usefulness of the CPD in understanding the circular communication between family members. Several years later, the first edition of *Nurses and Families: A Guide to Family Assessment and Intervention* by Wright and Leahey (1984) was published by F. A. Davis and included a description of the CPD as an integral part of the Calgary Family Assessment Model. Although the CPD has been around for at least 20 years, it continues to be an incredibly useful way of conceptualizing and documenting interactional patterns (for more information see Wright & Leahey, 2000, pp. 133-139).

Maturana (1988) has offered the idea that human beings are observing systems who distinguish through language: "Everything said is said by an observer to another observer that could be him or herself" (p. 27). To flush out the CPD, a series of interventive questions (Loos & Bell, 1990; Tomm, 1988; Wright & Leahey, 2000) is used by the clinician to uncover the behavior, cognition, and affect and the influence each has on the other (e.g., how does an individual family member's cognition influence his or her own behavior? How does a nurse's cognition influence his or her feelings?). Questions are posed to the individual and other family members about their observations. The clinician may begin the CPD with any family member and with the information that is most readily accessible (e.g., behavior might be most easily observed; the related cognition or affect may be less readily apparent). A recent clinical exemplar is used to illustrate the questions that could be used to uncover the CPD. A couple with two small children sought assistance for their suffering related to the recent diagnosis and treatment of the young woman's malignant brain tumor (see Figure 2). They reported more conflict and less closeness between them since the illness began.

Figure 2: Interactional Pattern Between Husband and Wife

Behavior: Monitors wife's actions & her parenting skills. Offers frequent assistance and advice.

Husband

Cognition: My wife is not the same person as before her illness. I need to help her to make sure she and the children are safe.

Affect: Concerned, frustrated, overwhelmed between being both husband and caregiver.

Wife

Cognition: I can still handle some things. If he cared, he would trust me more.

Affect: Frustrated, angry, intolerant, oppositional

Behavior: Attempts to be independent and unwilling to ask for or accept help.

Questions used to flush out the CPD in Figure 2 may include the following:

- To husband: "You mentioned that you are spending a great deal of time and energy monitoring your wife's behavior. When you are watching her so closely, what are you saying to yourself?" (Clinician attempts to understand linkage between behavior and cognition). Another way to elicit this information is to ask the wife an observer perspective question: "What do you think your husband says to himself about you and your illness?"
- To husband: "When you find yourself believing that the illness has limited her ability, how does that make you feel?" (Clinician attempts to understand the linkage between behavior and cognition). To wife: "How is your husband feeling these days, in relation to your illness?"

Once a family member's experience (cognition, affect, and behavior) has been distinguished, the clinician uses a series of interventive questions to uncover the effect of one family member's behavior on another member's behavior, cognition, and affect. The CPD can be drawn on a piece of paper or on a blackboard so that all family members can visualize the information as they participate in generating a variety of observations. Questions which may be helpful to flush out the reciprocal arc of the CPD include the following:

- To wife: "When your husband monitors your behavior, what do find yourself saying to yourself about that? How does that make you feel?" Behavioral effect questions to the husband may also elicit the following information: "When you find yourself monitoring your wife's behavior, what impact have you noticed that has on her? What do you think she says to herself? What you think she feels?" Observations from family members not participating in the interview can be elicited. To wife: "What do you think your mother would say she has noticed about how your husband's monitoring behaviors have affected you?"
- To wife: "When you find yourself wondering why can't your husband trust you more, what do you do?" (Clinician attempts to link cognition with behavior.) To husband: "Your wife says she feels misunderstood and frustrated: What do you notice her doing?"

By including multiple perspectives as the clinician flushes out both arcs of the CPD, a healing environment is created where family members learn that differing ideas are valued and no one member has access to "truth." The CPD allows for a new understanding of the reciprocal connections between family members and offers the possibility that family members will hear each other in a different way and have a greater understanding and appreciation of the other's experience.

In our current work in the Family Nursing Unit at the University of Calgary with family members suffering from serious illness, we encourage our student clinicians not only to use the CPD within the therapeutic conversations they have with families, but also to use the CPD as they prepare to conduct therapeutic conversations with families. Given the information that is available from the family themselves, from the referring person, from the previous family session, from the literature, and/or from the students' previous experience

with families, the students offer their hypothesis (Cecchin, 1987; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980) or best guess about what the interactional pattern might look like. Because we use the Illness Beliefs Model in our advanced practice (Wright, Watson, & Bell, 1996), the importance of the cognition or belief is emphasized. The students are invited to first hypothesize about the core beliefs of family members, the nurse, or other larger systems that are constraining or facilitating and that serve to perpetuate this family's problem or contribute to its solution options (Wright et al., 1996). To maintain a systemic perspective, the student clinician is also asked to consider how the problems / solutions might perpetuate the beliefs. In this clinical model, these beliefs are central to the relationships between family members, between the family and the clinician or clinical team, or between the family and other larger systems. The student then generates interventive questions which would help to validate or discard the belief hypothesis. Examples of CPD from recent clinical practice and student documentation are provided below.

For another clinical session with the family described earlier, the student hypothesized about the reciprocal impact between societal and health care professionals' beliefs and the grieving experienced by the couple (see Figure 3).

In another CPD, the student offers a possible adaptive interactional pattern between the nurse and the family members when facilitating influence beliefs in their interaction (see Figure 4).

In conclusion, an old clinical tool called the CPD continues to have a very powerful effect on both nurses and family members. It alters the view from a linear to a systemic perspective, offers multiple realities about the mutuality of relationships, and provides many more options for change and healing within the frame of collaborative therapeutic conversations.

Figure 3: Interactional Pattern Between Health Care Professionals and Couple (constraining beliefs)
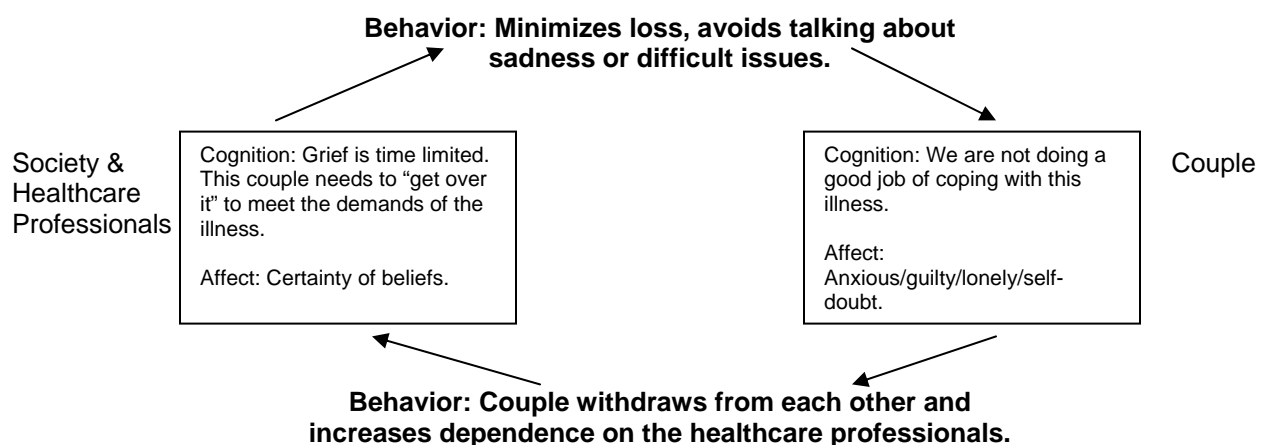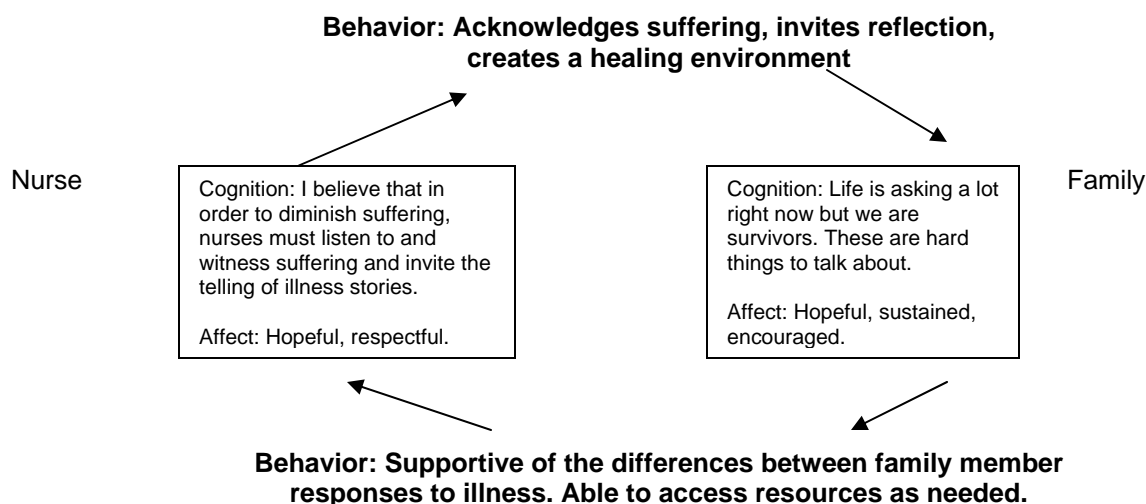
Figure 4: Interactional Pattern Between Family and Nurse Clinician (facilitatory beliefs)

Behavior: Acknowledges suffering, invites reflection, creates a healing environment

Nurse

Cognition: I believe that in order to diminish suffering, nurses must listen to and witness suffering and invite the telling of illness stories.

Affect: Hopeful, respectful.

Cognition: Life is asking a lot right now but we are survivors. These are hard things to talk about.

Affect: Hopeful, sustained, encouraged.

Family

Behavior: Supportive of the differences between family member responses to illness. Able to access resources as needed.

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