Chapter 1   Children and Families: Models for Assessment and Intervention

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The family is considered to have the most profound and lasting influence on a child's life. It is a vital support system that shapes the child's biopsychosocial and spiritual development. It is imperative that practitioners working with children include the child's family in health care. When families are viewed as the unit of care, practitioners may better understand the child's needs and devise interventions to promote positive and desired change both within the child and the family and between them. Freidman advocates several reasons why working with families needs to be a central focus of nursing care:

- All family members and their relationships with each other can be affected by and can profoundly affect a problem experienced by a child member.
- Families can be of enormous assistance in health and illness management.
- By improving the wellness of the whole family, each individual member's health is enhanced.

Wright and Leahey emphasize the following:

- The nursing of families should focus on the whole family (versus its individual parts), relationships, patterns and interactions.
- By considering the whole family as the client, practitioners recognize and respond to the impact of a health problem on the family *and* the impact of the family on the health problem.
- The practitioner-family relationship also can have a profound effect on the child's and the family's functioning.

This chapter describes and applies Wright and Leahey's Calgary Family Assessment Model (CFAM) (Fig. 1-1) and Calgary Family Intervention Model (CFIM) to families with children/adolescents experiencing health problems. These models provide a systematic framework for working with families.
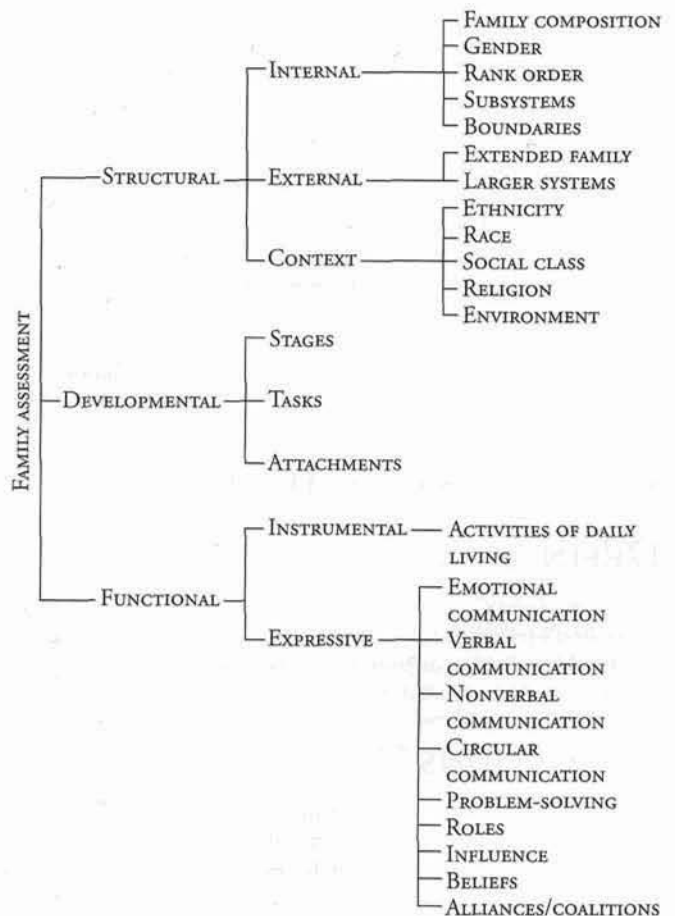
Fig. 1-1   Branching diagram of CFAM. (From Wright LM and Leahey M: *Nurses and families: a guide to assessment and intervention,* ed 2, Philadelphia, 1994, FA Davis Co.)

THEORETICAL FOUNDATIONS FOR THE CALGARY FAMILY ASSESSMENT AND INTERVENTION MODELS

Basing their ideas on systems theory, cybernetics theory, and communication theory, Wright and Leahey outline the theoretical foundation for assessing and intervening with families:

- A family as a whole system is greater than the sum of its individual parts (i.e., members).
- A circular/systemic perspective guides the practitioner to understand the reciprocity between family relationships and health status. Unlike a linear perspective, which focuses on the individual, the circular/systemic perspective emphasizes relationships and the reciprocal effects that individuals have on each other.
- A change in one family member affects all others. For instance, an infant's diagnosis of esophageal atresia affects parent-infant relationships as well as other family subsystems, such as sibling, parent-child, marital, and possibly extended family relationships.
- Family members can communicate verbally and nonverbally simultaneously. All communication is relevant. There is no such thing as not communicating—silence is communication.
- Each family member's perspective is valid and legitimate and should be heard.
- Families have abilities and strengths to discover solutions.

FAMILY ASSESSMENT

DEFINITION

Family assessment is a continuous process of evaluating patterns of interaction between family members relevant to the child's health issue/problem; it is an organized framework for documentation of observable and/or reported family data.

INDICATIONS

Whenever a child or adolescent is the identified patient or whenever a family is experiencing emotional disruption related to developmental or situational crises, family assessment is needed.

GOAL

The goal is to assess family structure, development, functioning and identify family strengths as they relate to the health problem. Specific family nursing interventions are then formulated to effect desired change.

PLANNING FOR A FAMILY ASSESSMENT

Prior to initiating a family assessment the practitioner needs to:

- Ascertain the purpose and benefit of a family assessment from the family's perspective.
- Explain why a family assessment may be beneficial to the family.
- Determine who in the family agrees that a problem exists and who might be willing to come to a family meeting.
- Mutually determine with the family when and where a meeting could take place (home, office, school).
- Begin to formulate hypotheses (hunches about connections between the family system and the particular problem).
- Read literature about working with families experiencing similar health problems to better understand the issues/concerns of that specific population.
- Prepare linear and circular questions that will draw forth relevant data about family structure, development, and functioning. (See the discussions of CFAM and CFIM for examples of questions.)

ENGAGEMENT

DEFINITION.
Engagement is the first stage in developing a therapeutic relationship with a family, and it begins with the first contact, whether it is in person or by telephone.

PURPOSE.
Engagement has several purposes:

- To promote a positive practitioner-family relationship by developing an atmosphere of comfort, mutual trust, cooperation, and collaboration between the practitioner and the family
- To recognize that the family members bring strengths and resources to this relationship that may have previously gone unnoticed by health care professionals
- To prevent potential practitioner-family misunderstandings or problems later on in the therapeutic relationship

Thorne and Robinson describe three stages that families may experience in their relationships with practitioners:

Native trust: At the outset of the therapeutic relationship, families typically show cooperative, trusting behavior with practitioners, and practitioners demonstrate a reciprocal trust with families.

Disenchantment: Family expectations of practitioners become unfulfilled and/or the family is disappointed with the practitioner/health care system. The family shows anger, frustration, and resentment towards practitioners. At this stage a family may become labeled by practitioners as "noncompliant," "difficult," or "resistant." Rather than negatively label families, practitioners should show curiosity to understand the source of the difficult behavior.

Guarded alliance: Although guarded, families reconstruct trust with the practitioner. The quality of the relationship varies depending on the degree of reconstructed trust.

Important ABCs for the engagement of families with children are outlined in Table 1-1.

The following are examples of questions used to promote engagement, to provide an implicit message to the family that the practitioner cares about them, and to give the family an opportunity to voice concerns and/or clarify expectations:

- Can you tell me about past experiences that you have had with health care professionals like myself?
- On a scale of 1 to 10 (with 1 being very low and 10 being very high), how well do you think I understand your situation?
- If you become frustrated in our work, would you be open to having a conversation with me about your concerns?
- In what ways was our discussion useful to each of you?

| Table 1-1 | THE ABCs OF ENGAGING FAMILIES | |
A	B	C
Assume an active, confident approach.	**Begin** by providing structure to the meeting (time frame, orientation to the context).	**Create** a context of mutual trust.
Ask purposeful questions that draw forth family assessment data.	**Behave** in a curious manner and take an equal interest in all family members.	**Clarify** expectations about your role with the family.
Acknowledge the importance of all family members perceived as significant whether present or not.	**Build** upon family strengths by offering commendations to the family.	**Collaborate** in decision making and health promotion and health management.
Address all who are present, including small children.	**Bring** relevant resources to the meeting (list of agencies, phone numbers, pamphlets).	**Cultivate** a context of racial and ethnic sensitivity.

CALGARY FAMILY ASSESSMENT MODEL

Wright and Leahey's CFAM is a comprehensive, multidimensional framework that assists practitioners in collecting, organizing, and categorizing observational and family reported data. CFAM includes three major categories—structural, developmental, and functional—along with several subcategories (Fig. 1-1). Because each family is unique, the practitioner may sometimes need to assess some subcategories in more depth than others.

It is important to recognize that a family assessment is based on the practitioner's perspective; thus it is influenced by the practitioner's experience and history. It should not be considered as "*the* truth" about the family, but rather one perspective at a particular point in time.

STRUCTURAL FAMILY ASSESSMENT

This type of assessment explores who is in the family and the connections between family members and between the family and the community. It comprises three dimensions: internal structure, external structure, and context.

STRUCTURAL FAMILY ASSESSMENT TOOLS.

A genogram is a visual representation of the family unit that is used to assess the family members' connections to each other. Geno-

grams are also used for the purposes of genetic evaluation (refer to Chapter 4) and to identify physical health, psychosocial and environmental problems, etc.

An ecomap, a second structural family assessment tool, depicts the family's connections to larger systems in the outside world.

INTERNAL STRUCTURE

Family composition refers to who is in the family. There are many family forms besides the two-parent nuclear family (e.g., single-parent families, adoptive families, gay families, stepfamilies). Significant changes in family composition over time need to be assessed because these changes may affect family functioning. It is also important to explore losses by death and the nature of the lost relationship, especially if the death occurred as a result of violence.

Gender plays a significant role in family relationships and child/family health care. Family roles are often gender based. Gender differences in relation to parent roles with an ill child may exist. For example, most health care concerns and referrals are made by mothers, and they tend to assume stronger caregiving responsibilities than fathers. Assessment of gender is particularly important when there are societal, cultural, or family beliefs about male and female roles that are creating family stress.

Rank order "refers to the position of the children with respect to age and gender." Generally firstborns are expected to become more responsible earlier than children who hold the youngest child position in the family. Assessment of rank order may provide hypotheses about parental expectations of children at various family life cycle stages.

Subsystems are parts of larger systems. Every system can be divided into subsystems. The larger sociocultural context may comprise smaller subsystems, such as school, community, child protective services, church, and so on. The two-parent nuclear family system can be divided into subsystems such as the marital, parental, and sibling subsystems. An important question is, What subsystem is most affected by this problem and how?

Boundary relates to family rules about who participates in the family system and how they participate. Boundaries can be enmeshed (very closely and richly connected at the expense of individual autonomy), diffuse, ambiguous (unclear and confusing), or clear. Assessment of the boundaries between parents and children may be particularly useful when assessing child-rearing–related concerns.

EXTERNAL STRUCTURE

Extended family comprises the family of origin, the family of procreation, the present generation, and steprelatives. Special relationships and social support systems may exist within these relationships even at great geographical distance. Or, conflictual and painful relationships may exist within the extended family, creating intrafamilial stress. Assessment of the extended family and their contact and type of relationship with the family can provide the practitioner with insight about the quality and quantity of family support systems.

Larger systems refer to systems outside the family system, such as the practitioner's office/clinic, school, child protective services, the women's shelter, the place of parental employment, and church. Family relationships with larger systems may be unclear or unstable. Therefore these relationships must be assessed to understand family behavior in this context. Practitioners should assess their relationships with the family since

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Box 1-1   EXAMPLES OF QUESTIONS TO ASSESS INTERNAL STRUCTURE

Family composition

Whom do you consider to be in your family? Are there any family members who don't live with you or who are not blood related that you would consider to be "family"? Has anyone recently entered or left your family?

Gender

How do you respond to Alison differently than to Daniel when both come in late for their curfew? Who puts the cream on Michael's rash? How did it come to be that Mother would assume more responsibility for the tube feedings than Father?

Rank order

Starting from the eldest to the youngest, could you tell me the names and ages of your children? If Francois were the youngest child instead of the eldest, how might your expectations of him be different? When Hank moved in with his kids and you suddenly became the youngest child in the house, how did it feel?

Subsystems

Parent-child: How has your relationship with Dacarla changed since her diagnosis of learning disability?

Marital: How much couple time is set aside each week not discussing the children?

Sibling: On a scale of 1 to 10 with 10 being the happiest, how happy are you to have a new baby brother?

To parent: How does Hector show his happiness about being a big brother?

Boundary

Who is the boss at your house? Whose job is it to implement the rules, your mom's or your older sister's? When your big brother drinks, does your dad get mad or does he drink with him?

Box 1-2   EXAMPLES OF QUESTIONS TO ASSESS EXTERNAL STRUCTURE

Extended family

To the parent: Are your parents living? Do they live close by? In what ways do they show support of you (e.g., instrumental, emotional, financial)? Since your remarriage, do the children have contact with their paternal grandparents?

Larger systems

With what agencies has your family had previous involvement? What has been the best and worst advice you've been given from the social worker, teacher, minister about this problem? What agency will you continue to stay involved with and for what purpose? How are we doing in our working relationship these days?

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they are a "larger system" (i.e., the health care system) in relation to the family and need to avoid potential family-practitioner conflicts.

CONTEXT.   Context encompasses the "whole situation or background relevant to some event or personality." It includes five subcategories:

Ethnicity includes family culture, history, race, and religion. Family functioning may be subtly or obviously shaped by ethnicity, and thus the practitioner needs to assess how ethnicity influences the family and how the family influences ethnicity.

Race is a basic construct referring to biological and genetic differences among people. Racial and cultural differences must be considered in family assessment. In assessing ethnicity and race, practitioners should examine their own beliefs and assumptions. This area of assessment is important because it helps the

practitioner to show racial and cultural sensitivity and to understand family beliefs and behaviors influenced by ethnicity and race.

Social class is depicted by occupation, educational achievement, economic status, and the interplay between these variables. A family's social class is probably the prime molder of family lifestyle, family values, and family members' views of the world. Assessment of social class assists the practitioner in understanding family stressors and resources and in recognizing that social class differences between practitioners and families may invite differences in beliefs about health promotion and management.

Religion influences family members' beliefs about illness and coping strategies. A place of worship can represent a safe haven, one rich with instrumental, emotional, and spiritual support in times of crises. *Religious beliefs can also induce a wide range of*

Box 1-3   EXAMPLES OF QUESTIONS TO ASSESS CONTEXT

Ethnicity

As a second-generation Chinese family, how do you suppose your health care practices are different from or the same as those of your grandparents? Does your community and social network support your practices? How are your beliefs about child-rearing/diet/medication influenced by your Cuban culture?

Race

I am aware that we are of different races. Help me to understand what I might need to know about your race that will assist me to be most helpful to you.

Social class

How did Jorge's job loss impact your family/relationships? What community resources might you use that are cost-free? How has being a practitioner yourself helped or not helped you as a parent of a child with special needs?

Religion

How do your religious/spiritual beliefs help you cope with Pedro's illness? How has your faith helped you during this difficult time? Have your religious beliefs changed as a result of having to deal with this health problem? What are your beliefs about an afterlife?

Environment

On a scale of 1 to 10, how comfortable are you in your neighborhood/home? What would make you more comfortable? Maria, do you walk to school or take a bus? Who does Francesca share a room with? How many schools has Tanya attended since kindergarten? In the last 3 years, how many times has your family moved?

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emotions (peace, fear, guilt, relief, anger, hope) and behaviors. Dietary restrictions/habits, weekly rituals, and alternate health care practices may be directly or indirectly related to religious beliefs. Assessment of religion is most critical at the time of diagnosis of a chronic or life-shortening illness; while working with families experiencing life-shortening illnesses (acquired immunodeficiency syndrome [AIDS], cancer, trauma) and grief; and when the family offers information about their religious or spiritual beliefs.

Environment encompasses aspects of the larger community, the neighborhood, and the home. Practitioners need to assess the accessibility of schools, day care, health services, recreation, and public transportation; family mobility, adequacy of the home (children belong to the fastest growing homeless population in North America); and the home environment—family hygiene, sleep patterns, and adequacy of space, privacy, and safety.

THE GENOGRAM

DEFINITION

- The genogram is a family tree that depicts the internal family structure (using symbols and lines as outlined in Chapter 4).
- It is a useful engagement tool to apply during the first interaction/meeting with the family.
- It provides rich data about family relationships over time.
- It can be used simultaneously to elicit information about other subcategories of a family assessment (developmental and functional).
- It may include data about health status, occupation, religion, ethnic background, and migration date.
- It acts as a continuous visual reminder for the practitioner to "think family" when placed on the child/family chart.

HELPFUL HINTS FOR CONSTRUCTING GENOGRAMS

Determine priorities for genogram construction based on the family situation.

- A three-generational genogram should be constructed when the child's health problem (physical or emotional) is influenced by family functioning in a problematic way.
- A brief two-generational genogram may be sufficient for the family that has preventive health care needs (immunizations) or minor health concerns (sports injury, flu).

Engage the family in an exercise to complete the genogram.

- Use the genogram to "break the ice," to provide structure, and to introduce purposeful conversation.
- Invite as many family members to the initial meeting/visit as possible to obtain each family member's view and to observe family interaction.
- Ask others how an absent significant member might answer a question.
- Avoid discussion that is negative or blameful of absent members.

Take an interest in each family member and be sensitive to developmental differences.

- Tailor questions to children's developmental stages so they remain active participants.
- Assess children's nonverbal and/or verbal comments.
- If some members are shy or uninterested in directly participating (e.g., adolescents), ask other family members about them.

Begin by asking "easy" questions of individuals followed by exploration of subsystems.

- Ask concrete, easy-to-answer questions of individuals about ages, occupation, interests, health status, school grades, and teachers to increase their comfort level.

- Move the discussion about individuals to subsystems that target relational family data. Inquire about parent-child or sibling relationships depending on presenting concerns.
- With stepfamilies, questions about contact with the noncustodial parent, custody, the children's satisfaction with visits, and stepfamily relationships could be asked.

Observe family interactions.

- During genogram construction note the content (what is said) and the process (how it is said) and take observational notes.

Move from discussion about the present family situation to questions about the extended family.

- Once those in the immediate household are discussed, the practitioner may inquire about extended family relationships: "Are Fatima's paternal and maternal grandparents living? Mrs. Teves, you are the eldest of five, and then who follows you, and so on?"
- While discussing generations, practitioners may take the opportunity to ask about psychosocial family health history (i.e., "Is there a history of alcohol abuse/violence/learning problems/mental illness in your family?"). Practitioner questions should be tailored to the particular area (or potential area) of concern.

THE ECOMAP

DEFINITION

- The ecomap portrays the family's connections to larger systems such as the social network, community services, church, agencies, institutions, and the workplace.
- It depicts the flow of energy and the nature of relationships between the family and larger systems (Fig. 1-2).
- It assists the practitioner in developing hypotheses about family functioning.

HELPFUL HINTS FOR DRAWING ECOMAPS

Pose questions that explore the family's connections to other individuals or groups external to the family:

- What community agencies are you involved with now? What agencies have you been involved with in the past? Which was most/least helpful?
- How would you describe your relationship with school staff?
- How did you first become involved with Child Protective Services, and what is the nature of your current agreement with them?

Draw family connections to outside agencies (Fig. 1-2).

DEVELOPMENTAL ASSESSMENT

It is useful for the practitioner to have an understanding of family life cycles since the child's individual life cycle takes place within the family life cycle, the primary context for human development. No longer is there a "normal" family model. Rather, the practitioner needs to view each family with flexibility and the knowledge of various family forms before being able to thoroughly understand the issues and tasks of this family's current developmental stage.

Wright and Leahey make useful distinctions between family development and family life cycle:

Family development is the unique path that families construct. It is shaped by both predictable and unpredictable events such as illness, divorce, death, and societal trends (e.g., more women in the workforce, lower birth rates, and later marriages).

Family life cycle encompasses the typical, predictable life cycle events that families encounter (e.g., births, child's entry into school, launching, marriages, and retirement).

According to Carter and McGoldrick two of the traditional nuclear middle-class North American family life cycles are families with young children and families with adolescents.

FAMILIES WITH YOUNG CHILDREN

Adjustment of the marriage to make space for children: With the introduction of a child, the marital subsystem is likely to be challenged, as there is less time for socializing, personal space, couple intimacy, and sexual relations. The birth of a second child may create even more stress. A marriage that has developed intimacy is better able to respond to the challenges of parenthood.

Joining in child-rearing, financial, and household tasks: Balancing the budget and balancing work and family/home responsibilities become paramount tasks for families with young children. Children begin to socialize outside the home as school and community connections develop. Consequently psychosocial and developmental problems that previously were not addressed are often identified at this stage by school teachers and community/recreation leaders.

Realigning relationships with extended family members to include parenting and grandparenting: Husbands and wives must integrate new roles as mothers and fathers. New extended family roles are created—grandparents, aunts, and uncles. The extended family can prove to be a great support for the family during these years. However, generational influences may also create conflict whereby members of the parents' family of origin express different expectations about child-rearing or health care practices.

FAMILIES WITH ADOLESCENTS.

As within individual adolescent development, this stage of family development brings with it intense transformations affecting at least three generations.

Shift of parent-child relationships to permit adolescents to move into or out of system: Families may experience feelings of loss as adolescents connect with peers and show less dependence on the parental subsystem. Parents may become overwhelmed and respond either by attempting to control their adolescents arbitrarily or by giving up control completely. The once-held parental role of "protector" moves to that of "preparer" for adulthood, where boundaries need to be made more flexible to allow for adolescent autonomy.

Refocus on midlife, marital, and career issues: As the socially and sexually maturing adolescent challenges family values and traditions, parents are faced with evaluating their own marital and career issues. Depending on many factors, this may be a time of either positive growth or of painful, disruptive loss.

Beginning shift toward joint caring for the older generation: At a time when parents are experiencing the growing independence of their adolescent children, they (often women) are negotiating new roles with grandparents who may be growing more dependent. With the growing trend of parents having children later in life, this double demand for attention may grow even greater.

HELPFUL HINTS FOR COLLECTING FAMILY DEVELOPMENTAL DATA

Ask linear and circular questions (outlined in the discussion of interventive questions) about the family life cycle stage:

- How has Mary Ellen's birth affected your marriage?
- What expectations will your parents have of you now that you are able to drive the family car?
- How have you been able to balance work and home responsibilities?

Ask linear and circular questions about family development (marriages, divorce, death, family stressors, etc.) as it pertains to the current family situation or the child's health problem:

- Who was most supportive of Laurie during her pregnancy?
- After the miscarriage, did you and your husband grow closer or more apart?

Draw attachment diagrams to depict the nature of the attachment between family members. A sample of an attachment diagram and attachment symbols are outlined in Fig. 1-3.

FUNCTIONAL ASSESSMENT

Functional assessment explores interactions between family members and family functioning and explores the reciprocal relationship between the family and illness. It comprises instrumental functioning and expressive functioning.

INSTRUMENTAL FUNCTIONING.
Instrumental functioning includes the activities of daily family living (e.g., eating, sleeping, health care regimens such as taking temperatures and giving injections and medications). It can change drastically when a child develops a health problem.

EXPRESSIVE FUNCTIONING.
Expressive functioning focuses on the interaction between family members and assists the practitioner to assess the family strengths and limitations.

Emotional communication refers to the range and types of emotions or feelings that are expressed and/or observed by the practitioner.
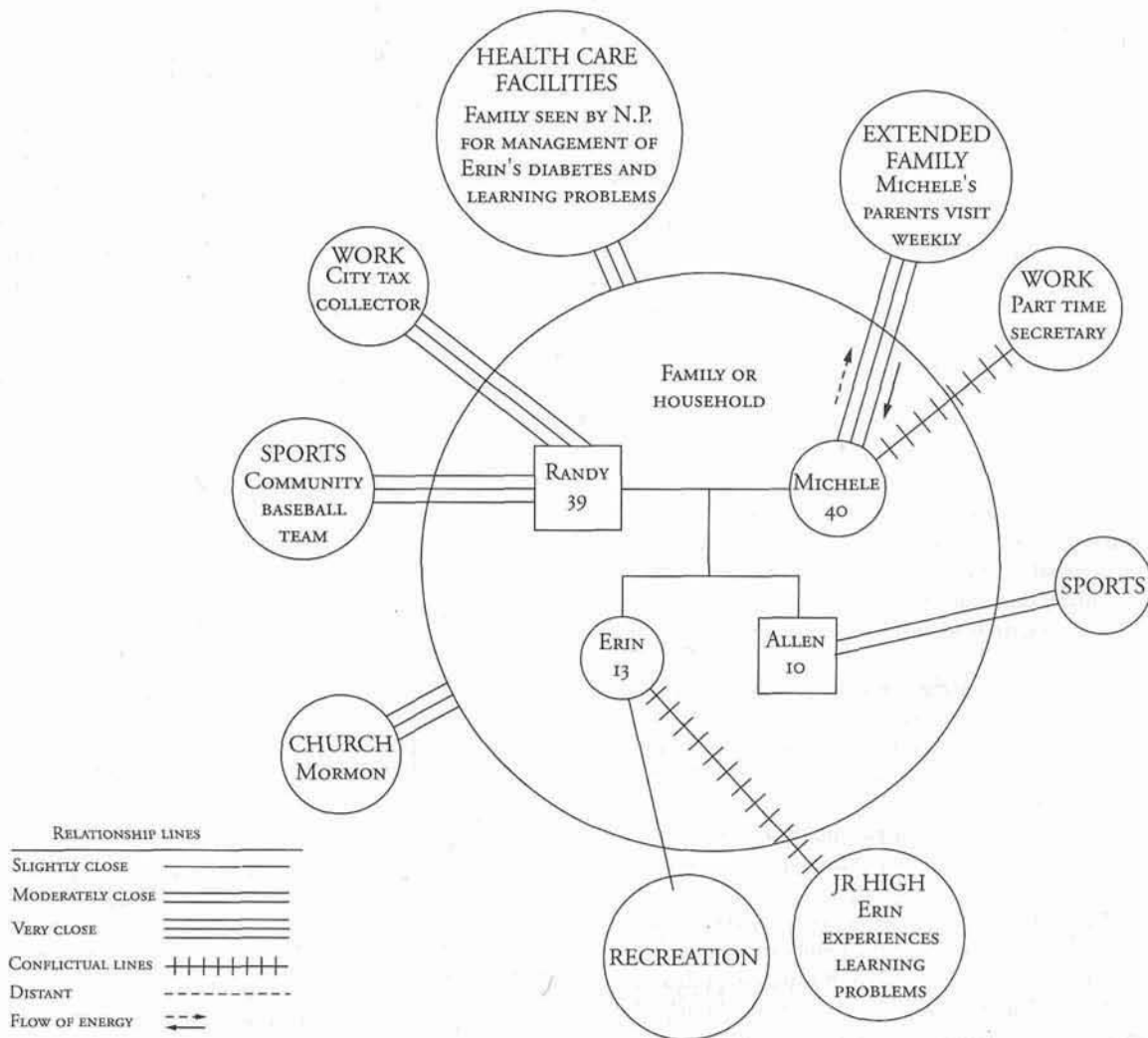

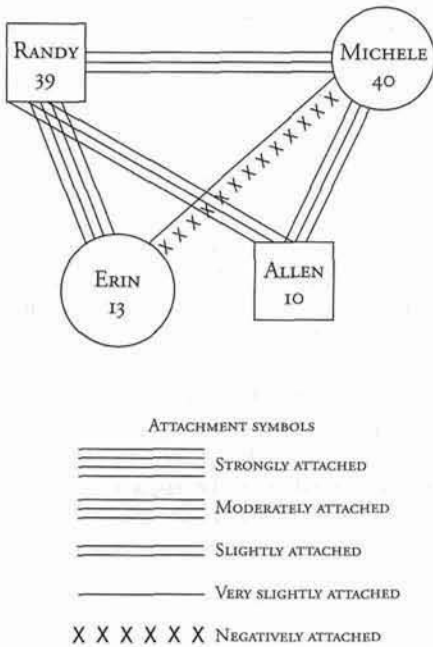Fig. 1-2   Ecomap and relationship lines.

Fig. 1-3 Sample attachment diagram and attachment symbols. (From Wright LM and Leahey M: *Nurses and families: a guide to assessment and intervention,* ed 2, Philadelphia, 1994, FA Davis Co. Used with permission.)

Verbal communication refers to the meaning of a verbal message in terms of the relationship between those involved in the interaction. Verbal communication may be direct and clear or masked and unclear. Experts in child behavior management encourage parents to "say what you mean and mean what you say" so that children receive clear, direct communication versus mixed messages or masked communication.

Nonverbal communication includes all other forms of communication that are not verbal in nature, for instance, body posture (slumped, fidgeting, open, closed), eye contact (intense, minimal), touch, facial movements (grimacing, staring, yawning), and personal space between family members. Nonverbal communication is closely linked to emotional communication. It may be particularly important to inquire about the meaning of nonverbal communication when it is incongruent with verbal communication.

Circular communication refers to the reciprocal communication that may be illustrated by a *circular pattern diagram* (CPD) (Fig. 1-4). A circular pattern diagram has the following characteristics:

- It illustrates a reciprocal positive or negative communication cycle between individuals.
- It outlines the thoughts, feelings, and behaviors of each person within an interaction and their impact on another's behavior.
- It may be applied to relationships between family members or between the practitioner and the family since the practitioner and the family also mutually influence each other.
- It invites the practitioner to think interactionally about problems (and to help the family think interactionally).

CPDs can be drawn with one or more persons by asking behavioral effect questions and other circular questions. (Table 1-2.)

Problem solving refers to the family's ability to solve its problems. Family problem solving may be strongly influenced by the family's beliefs about its abilities and past successes. It may be useful to explore who identifies the problem, who can and/or should solve the problem, and how much influence the family has on the problem.

Roles are established patterns of relating to others within the family. Roles may be formal (husband, grandmother, friend) or informal (class clown, black sheep, bad kid). It is helpful to learn how the family roles evolved, the impact of the assigned and informal roles on family functioning and whether they need to be altered.

Influence refers to behavior used by one person to affect another's behavior. This is a significant area to assess in the parent-child subsystem. One of the biggest tasks for families with children is how to effectively discipline or influence a child. Wright and Leahey outline several measures used by individuals to influence others, including instrumental control (positive or negative behavior reinforcements), psychologic control (use of feelings, talking, threatening), and corporal control (hugging, spanking, hitting).

Beliefs: Wright, Watson, and Bell maintain that "beliefs are the blueprints of our lives" and that "the belief about the problem is the problem." Beliefs drive behaviors—we think (believe), therefore we do—and reciprocally behaviors affect beliefs. Beliefs are one of the most significant areas of assessment. The practitioner may focus on beliefs about etiology, treatment, prognosis, the role of the family, and the role of the practitioner. The reciprocal relationship between family beliefs and the health problem should be assessed.

Alliances/coalitions "focuses on the directionality, balance, and intensity of relationships between family members or between practitioners and families." When one family member becomes strongly aligned with another, it may create problems for a third person and that individual's relationships with the other two.
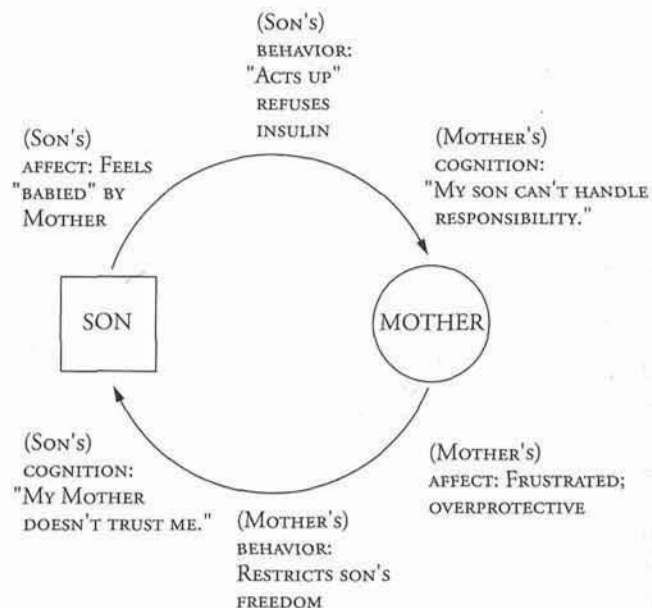

Fig. 1-4 Circular pattern diagram.

Box 1-4   EXAMPLES OF QUESTIONS TO ASSESS EXPRESSIVE FUNCTIONING

Emotional communication

When Mom is sad, how does she show it? How were feelings expressed differently between Mom and Dad before the accident? Who has the most trouble showing sadness about Lucy's autism?

Verbal communication

Does Dad usually talk about what bothers him? Who is the one in the family who gives you the bottom line? Do you ever get confused about what Mom really wants from you?

Nonverbal communication

You seem preoccupied today and not wanting to talk—can you help me understand my observations? When you begin to cry, Leslie, what are you thinking?

Circular communication

When your husband doesn't talk, what do you do? And then when you get mad at him for not talking to you, what does he do?

Problem solving

Who identified Dustin's anxiety? Whom do you go to when you are worried? Do you usually try to deal with the problems by yourselves or do you like to get outside help? What solutions have you tried? How were they helpful?

Roles

Who usually changes the baby's diapers? Who talks about sadness the best in your family? If there is one in your family you would consider the peacemaker, who would it be? Whose job is it to make sure that you get lunch when you come home at noon from school?

Influence

What helps Emmanuel follow your directions? When he disobeys the rules, what do you do? When you show pride in Emmanuel's accomplishments, what does he do?

Beliefs

What do you believe created the tension between you? On a scale of 1 to 10 (with 10 being the highest) how much control do you believe the drug addiction has over your family? How much control do you have over it?

Alliances/Coalitions

When your husband agrees with your teenage son that he should move out, what impact does that have on your marriage? When Mom and Linda talk privately in the bedroom, what does sister Jessica do?

HELPFUL HINTS TO ORGANIZE AND DOCUMENT FAMILY ASSESSMENT DATA

- Identify and document a list of presenting problem(s) and family strengths.
- Create a CFAM document that lists each category and subcategory. Enter reported and observed data in relevant (sub)categories. Note gaps to be filled at a future date.
- Include a genogram, an ecomap, a brief family life cycle and family development data, and an attachment diagram for a significant family relationship.
- Formulate systemic hypotheses.
- Formulate an intervention plan.
- Continue to update the family assessment, using progress notes to document family changes and the impact of family nursing interventions.

FAMILY INTERVENTIONS

DEFINITION

Family intervention is any action or response of the practitioner that includes the practitioner's overt therapeutic actions and internal cognitive/affective responses that occur in the context of a practitioner-client relationship to affect individual family or community functioning for which practitioners are accountable.

INDICATIONS

Whenever a child's health is influencing or being influenced by family functioning in a detrimental way, family intervention is indicated.

Table 1-2	EXAMPLES OF CIRCULAR QUESTIONS TO CHANGE THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL DOMAINS OF FAMILY FUNCTIONING		
QUESTION TYPE	**COGNITIVE**	**AFFECTIVE**	**BEHAVIORAL**
Difference question			
Explores differences between people, relationships, time, ideas, and beliefs.	What information would be helpful to you about managing Ming's night fears?	Who is most worried that Ming won't outgrow the night fears?	Now that you are leaving the light on and his door open at bedtime, what difference is it making?
Behavioral effect question			
Explores the effect of one family member's behavior on that of another.	What do you know about the effects of learning problems on children?	What do you feel when your son Rodney refuses to do his math homework?	What do you do when the teacher complains that Rodney refuses to do his math homework?
Hypothetical/future-oriented question			
Explores family options and alternative actions or meaning in the future.	What would be the worst thing that could happen if someone is not closely watching baby Sandra?	How did family members feel when they realized that Michael had swallowed furniture polish?	What might you do in the future to prevent accidents from happening at home?
Triadic question			
Question posed to a third person about the relationship between two others.	How does your Dad know that your sister needs his support right now?	When your dad shows support to your sister, how does your Mom feel?	What do you think your father needs to do to prepare for your sister and her baby coming to live with you?

Modified from: Wright LM and Leahey M: *Nurses and families: a guide to assessment and intervention,* ed 2, Philadelphia, 1994, FA Davis Co. Adapted with permission.

GOAL

The goal of family intervention is to effect positive change in the child or the family.

HELPFUL HINTS/INTERVENTIONS

- They are the core of clinical work with families.
- They should be devised with sensitivity to the family's ethnic and religious background.
- They can only be *offered* to families. The practitioner cannot direct change but can create a context for change to occur.
- They may fit family members and be useful to them.
- They may not fit family members, and thus practitioners should be open to offering alternative interventions rather than blame themselves or the family because the intervention was not desired by the family.

CALGARY FAMILY INTERVENTION MODEL

The field of family nursing is moving beyond assessment towards family nursing intervention. A recent development in family nursing is the emergence of the CFIM, a companion model to CFAM.

- The CFIM focuses on promoting, improving, and/or sustaining effective family functioning in three domains: cognitive (thoughts), affective (emotions), and behavioral (actions).
- It assists the practitioner in determining which domain of family functioning most needs to be changed and then devising interventions to target that domain.

Wright and Leahey describe a variety of family systems nursing interventions, including interventive questions, commendations, offering information/opinions, reframing, validating emotional responses, storying the illness experience, drawing forth family support, encouraging family members as caregivers, encouraging respite, and devising rituals. The first three family interventions are discussed.

INTERVENTIVE QUESTIONS

Interventive questions are powerful interventions that elicit family assessment data while simultaneously triggering change in the family system by the information they implicitly offer. They can be developed to target any one of the three domains of family functioning. (Table 1-2.) Linear and circular questions are two types of interventive questions.

Linear questions are used to obtain history or factual information, concrete data. They have the following characteristics:

- They are investigative in nature.
- They help to define problems.
- They draw forth cause and content.

(Examples: "How is Mike?" "What is the problem you are struggling with?" "When did it start?")

Circular questions explore relationships, differences, and change as they relate to the presenting concerns of the child/family:

- They focus on patterns, relationship dynamics, interactions, and circularity.
- They require the practitioner to be curious and neutral to all family members.
- They evoke a reflective response by family members because they are thinking about new connections (about relationships, family functioning, the health problem, etc.).
- They assist families in pursuing different explanations for problems.

(Examples: "How are you today compared to when I last saw you?" "When you talk about AIDS, what does your Mom do?" "What is the most difficult adjustment to Clara's seizures?")

Four types of circular questions are difference, behavioral effect, hypothetical future-oriented, and triadic (Table 1-2).

COMMENDATIONS

DEFINITION

- Commendations are "observations of patterns of [constructive] behavior and interactions that occur across time."
- They are statements made by the practitioner to family members about individual and family strengths, abilities, and resources.
- They are powerful when they counteract negative family beliefs.
- They often empower families and create the context for change.
- They are most often targeted to the cognitive domain of family functioning because they invite family members to think differently.
- They may also invite feelings of relief, validation, and affirmation.
- They may simultaneously trigger changes in the affective and behavioral domains of family functioning.

(Example: "I have noticed how you each respect each other despite your differences.", "Your persistence to dealing with the temper tantrums is most impressive.", "Other mothers could really benefit from your knowledge about managing diaper rashes.")

HELPFUL HINTS ABOUT OFFERING COMMENDATIONS

- Be a "family strengths" detective looking for opportunities to commend families.
- Ensure that sufficient evidence for the commendations are provided; otherwise they may sound insincere and ingratiating.
- Use the family's language and integrate important family beliefs to strengthen the validity of the commendation.
- Offer commendations within the first 10 minutes of meeting with a family to enhance the practitioner-family relationship and to increase family receptivity to later ideas.
- Routinely include commendations to families at the end of an interaction/meeting with them before an opinion is offered.

OFFERING INFORMATION AND OPINIONS

The need for information constitutes the most significant need for families experiencing health care problems. Families need to gather and integrate information about developmental issues, health promotion and illness management.

HELPFUL HINTS ABOUT OFFERING INFORMATION AND OPINIONS

- Use language that is relevant, clear and specific.

- Provide easy-to-read literature; write out key points on a small card.
- Inform families of community support groups and resources. Determine if they have been helpful to families who have used them and how.
- Build on family abilities by encouraging them to independently seek resources. Inquire about the family's reactions after seeking resources.
- If possible, take a brief break (10 minutes) from the family meeting and return with some ideas for them written on paper. Families appreciate when practitioners write down their reflections because this signifies caring.
- Offer ideas/information/reflections in a spirit of learning and wondering (e.g. "*I wonder* what would happen if you tried a slightly different approach to talking with Lourdes about sex and birth control." *Perhaps* you might . . .).
- Do not be invested in the outcome; if the family does not apply the teaching materials, be curious about what did not fit for them rather than becoming judgmental and angry with the family.

CONCLUSION

Working with families is essential in pediatric health care. Children cannot be viewed in isolation from their families, and thus family assessment and family intervention are imperative components of pediatric health care.

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