The Calgary Family Assessment Model

Learning Objectives
- Describe the three major categories of the Calgary Family Assessment Model (CFAM), structural, developmental, and functional, and their associated subcategories.
- Define terms used in the CFAM.
- Identify questions to ask families to obtain information and how they apply to each category of the CFAM.

Key Concepts
- Circular communication
- Circular pattern diagrams (CPDs)
- Developmental assessment
- Ecomap
- Family life cycle
- Functional assessment
- Genogram
- Structural assessment
- Family development

The Calgary Family Assessment Model (CFAM) is an integrated, multidimensional framework based on the foundations of systems, cybernetics, communication, and change theory and influenced by postmodernism and the biology of cognition. This text includes a discussion of the distinction between using the CFAM to assess a family and using the CFAM as an organizing framework, or template, for working with families to help them resolve health-related problems or other issues.

The CFAM has received wide recognition since the first edition of this book in 1984. It has been adopted by many faculties, schools of nursing,
and other health science disciplines. It has been referenced frequently in the literature, especially the *Journal of Family Nursing*. In addition, the International Council of Nurses has recognized it as one of the four leading family assessment models in the world (Schober & Affara, 2001). Originally adapted from a family assessment framework developed by Tomm and Sanders (1983), the CFAM was substantially revised in 1994, 2000, and 2005.

The CFAM consists of three major categories:

1. Structural
2. Developmental
3. Functional

Each category contains several subcategories. It is important for each nurse to decide which subcategories are relevant and appropriate to explore and assess with each family at each point in time. That is, not all subcategories need to be assessed at the first meeting with a family, and some subcategories need never be assessed. If too many subcategories are used, the nurse may become overwhelmed by all the data. If the nurse and the family discuss too few subcategories, each may have a distorted view of the family’s strengths or problems and the family situation.

It is useful to conceptualize these three assessment categories and their many subcategories as a branching diagram (Figure 3-1). As the nurse uses the subcategories on the right of the branching diagram, the nurse collects more and more microscopic data. It is important for nurses to be able to move back and forth on the diagram in order to draw together all of the relevant information into an integrated assessment. This process of synthesizing data helps nurses working with complex family situations.

It is also important for a nurse to recognize that a family assessment is based on the nurse’s personal and professional life experiences, beliefs, and relationships with those being interviewed. It is useful for nurses to determine whether they are using CFAM as a model to assess a family or as an organizing framework for clinical work with a specific family to help the family address a health issue. When learning the CFAM, students and practicing nurses new to family work will likely find the model helpful for directly assessing families. Similarly, researchers seeking to assess families will find the model useful. This use of the model involves asking the family questions about themselves for the express purpose of gaining a snapshot of the family’s structure, development, and functioning at a particular point in time.

However, how we have used the CFAM is not in a research manner but rather in a clinical manner. Once nurses become experienced with the categories and subcategories of the CFAM, they can use the CFAM as a clinical organizing framework to help families solve problems or issues.

For example, a single-parent family in the developmental stage of families with adolescents will have many positive experiences from earlier
developmental stages to draw from in coping with the teenager’s unexpected illness. The nurse, being reminded of family developmental stages by using the CFAM, will draw forth those resiliencies. The nurse will ask questions and collaboratively develop interventions with the family to enhance their functioning during this health-care episode.

Families do not generally present to health-care professionals to be “assessed.” Rather, they present themselves or are encountered by nurses while coping with an illness or seeking assistance to improve their quality of life. The CFAM helps guide nurses in helping families.

In this chapter, each assessment category is discussed separately. Terms are defined, and sample questions relevant to each CFAM category are proposed for the nurse to ask family members. We do not suggest that nurses ask these questions in a disembodied way. Rather, real-life clinical examples
are provided in Chapters 4, 7, 8, 9, and 10 to further describe how to use the sample questions and apply the CFAM. The use of assessment and interventive questions will be discussed in Chapter 4 (The Calgary Family Intervention Model [CFIM]). We wish to emphasize that not all questions about various subcategories of the model need to be asked in the first interview, and questions about each subcategory are not appropriate for every family. Families are obviously composed of individuals, but the focus of a family assessment is less on the individual and more on the interaction among all of the individuals within the family.

**STRUCTURAL ASSESSMENT**

In assessing a family, the nurse needs to examine its structure—that is, who is in the family, the connections among family members vis-à-vis those outside the family, and the family’s context. Three aspects of family structure can most readily be examined: internal structure, external structure, and context. Each of these dimensions of family structural assessment is addressed separately.

**KEY CONCEPT DEFINED**

**Structural Assessment**

One of the categories of the Calgary Family Assessment Model (CFAM) that nurses use to identify who is in the family, the connections among family members in regard to those outside the family, and the family’s context.

**Internal Structure**

Internal structure includes six subcategories:

1. Family composition
2. Gender
3. Sexual orientation
4. Rank order
5. Subsystems
6. Boundaries

**Family Composition**

The subcategory *family composition* has many meanings because of the many definitions given to family. Wright and Bell (2009) define family as “a group of individuals who are bound by strong emotional ties, a sense of belonging, and a passion for being involved in one another’s lives” (p. 46).
There are five critical attributes to the concept of family:

1. The family is a system or unit.
2. Its members may or may not be related and may or may not live together.
3. The unit may or may not contain children.
4. There are commitment and attachment among unit members that include future obligation.
5. The unit caregiving functions consist of protection, nourishment, and socialization of its members.

Using these ideas, the nurse can include the various family forms that are prevalent in society today, such as the biological family of procreation, the nuclear family (family of origin), the sole-parent family, the stepfamily, the communal family, and the lesbian, gay, bisexual, queer, intersex, transgender, or twin-spirited (LGBQITT) couple or family. Designating a group of people with a term such as “couple,” “nuclear family,” or “single-parent family” specifies attributes of membership, but these distinctions of grouping are not more or less “families” by reason of labeling. Rather, attributes of affection, strong emotional ties, a sense of belonging, and durability of membership determine family composition.

Nurses need to find a definition of family that moves beyond the traditional boundaries that limit membership using the criteria of blood, adoption, and marriage. We have found the following definition of family to be most useful in our clinical work: the family is who they say they are (Wright & Leahey, 2013). With this definition, nurses can honor individual family members’ ideas about which relationships are significant to them and their experiences of health and illness.

Although we recognize the dominant North American type of separately housed nuclear families, our definition allows us to address the emotional past, present, and anticipated future relationships within the family system. It is important to note that our definition of family is based on the family’s conception of family rather than who lives in the household. Family configurations continue to evolve in society, for example, LGBQITT families, adoptive and foster families, stepfamilies, multigenerational families, and sole-parent families.

Changes in family composition are important to note. These changes could be permanent, such as the loss of a family member or the addition of a new person into the family home, such as a new baby, a nanny, a boarder, or an elderly parent who can no longer live independently. Changes in family composition can also be transient. For example, stepfamilies commonly have different family compositions on weekends or during vacation periods when children from previous relationships cohabit. Families with a child in placement or those experiencing homelessness often temporarily live with other relatives and then move on.

Losses tend to be more severe depending on how recently they have occurred, the younger some of the family members are when the loss occurs,
the smaller the family, the greater the numerical imbalance between male and female members of the family resulting from the loss, the greater the number of losses, and the greater the number of prior losses. The circumstances surrounding the loss may be of exquisite concern for the nurse. For example, some parents of severely mentally ill children have reported that they were encouraged to give up custody of their children to foster care as a way of securing intense health-care treatment for them.

Serious illness or death of a family member, violence or war, and natural disasters can lead to profound disruption in the family and have long-term impacts. These situations often result in aunts and uncles raising nieces and nephews, or grandparents raising grandchildren, or friends or faith-based communities raising children and are often overlooked in regard to family structural arrangement. The extent of the impact of a member’s death on the family depends on the social and cultural meaning of death, the history of previous losses, the timing of the death in the life cycle, and the nature of the death (Becvar, 2001, 2003).

Every family touched by tragedy faces the task of making sense of what happened, why it happened, and how to adjust to the changed landscape. Families can find inspiration from many sources to cope with unprecedented tragedy.

The position and function of the person who died in the family system and the openness of the family system must also be considered. We have found it useful to note the family’s losses and deaths during the structural assessment process, but not necessarily to make an immediate assumption that these losses are of major significance to the family. By taking this stance, we disagree with the position taken by some clinicians who assert that it is important to track patterns of adaptation to loss as a routine part of family assessment even when it is not initially presented as relevant to the chief complaints.

In our clinical practice with families, we have found it useful to ask ourselves these questions to determine the composition of families:

- “Who is in this family?”
- “Who does this family consider to be ‘family’?”

Questions to Ask the Family.

- “Could you tell me who is in your family?”
- “Does anyone else live with you, for example, grandparents, boarders?”
- “Has anyone recently moved out?”
- “Is there anyone else you think of as family who does not live with you? Anyone not related biologically?”

**Gender**

The subcategory of gender is a basic construct, a fundamental organizing principle. We believe in the constructivist “both/and” position—that
is, we view gender as both a universal “reality” operational in hierarchy and power and as a reality constructed by ourselves from our particular frame of reference. We recognize gender as both a fundamental basis for all human beings and as an individual premise. Gender is important for nurses to consider because the difference in how men and women experience the world is at the heart of the therapeutic conversation. We can help families by assuming that the differences between women and men can be changed, discarding unhelpful cultural scripts for women and men, and recognizing and attending to hidden power issues. However, nurses need to consider that not all couples want to equalize the imbalance of power and that some may prefer traditional roles.

In couple relationships, the problems described by men and women commonly include unspoken conflicts between their perceptions of gender—that is, how their family and society or culture tell them that men and women should feel, think, or behave—and their own experiences.

We argue on behalf of the integration of male and female attributes in each person. Human development is a process of increasingly complex forms of relatedness and integration rather than a progression from attachment to separation. Gender is, in our view, a set of beliefs about or expectations of male and female behaviors and experiences. These beliefs have been developed by cultural, religious, and familial influences as well as by socioeconomic status and sexual orientation.

It’s important to understand the difference between gender and sex. Sex is defined as the physiological difference between the male and female, whereas gender references social and cultural distinctions, such as social relationships and their symbolic meaning. Gender identity is related to how one identifies oneself as being masculine or feminine (McDowell, 2018).

According to the World Health Organization (WHO, 2015), gender is increasingly being recognized as an important determinant of health, and issues such as gender inequality and lack of understanding of gender norms and roles can lead to poor health outcomes. Sharma, Chakrabarti, and Grover (2016) reviewed recent studies on gender difference in caregiving among families with mental illness and found that women are predominately the caregivers and, as a result, experience physical burdens and higher levels of psychological distress. The authors found that women tended to have multiple roles, such as wives, daughters, sisters, mothers, and employees, which increased pressure on them and caused role strain and conflict. These role strains and conflicts had major adverse effects on families, including fatigue and burnout, leading to emotional disturbance and depression.

Levac, Wright, and Leahey (2002) recommend that assessment of the influence of gender in the family is especially important when societal, cultural, or family beliefs about male and female roles are creating family tension.
this situation, couples may desire to establish more equal relationships, with characteristics such as the following:

- Partners hold equal status (e.g., equal entitlement to personal goals, needs, and wishes).
- Accommodation in the relationship is mutual (e.g., schedules are organized equally around each partner’s needs).
- Attention to the other in the relationship is mutual (e.g., equal displays of interest in the other’s needs and desires by both partners).
- Enhancement of the well-being of each partner is mutual (e.g., the relationship supports the psychological health of each equally).

In our clinical supervision with nurses doing relational family practice, we have found it useful to have them consider their own ideas about male, female, intersex, twin-spirited, and transgender persons. Bjarnadottir, Bocketing, and Dowding (2017) conducted an integrative review of patient perspectives when answering questions about sexual orientation and gender identity and found that nurses need to be mindful of heteronormative assumptions. The evidence from this review also identified the patients’ willingness to answer questions about sexual orientation and their perceptions of its importance.

Questions to Ask the Family.

- “What effect did your parents’ ideas have on your own ideas of masculinity and femininity?”
- “If your arguments with your male children were about how to stay connected rather than how to separate, would your arguments then be different?”
- “If you would show the feelings you keep hidden, Harry, would your wife think more or less of you?”
- “How did it come to be that Mom assumes more responsibility for the dialysis than Dad does?”

Sexual Orientation

The subcategory of sexual orientation includes sexual majority and sexual minority populations. According to the American Psychological Association (2015), sexual orientation is “a component of identity that includes a person’s sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others” (p. 6).

Nurses need to reflect critically on attitudes about sexual orientation when working with families. We believe that nurses should be able to
support a patient along whatever sexual-orientation path the individual takes and that the patient’s sense of integrity and interpersonal relatedness are the most important goals of all. The United Nations (2015) further supports this in identifying that societal discrimination against lesbian, gay, bisexual, and transgender (LGBT) people is a direct threat to their health and well-being. We agree with Yingling, Cotler, and Hughes (2017) that there is a global need for nurses to develop their knowledge and skills in a culturally sensitive manner to appropriately provide care for LGBT people and their families.

Questions to Ask the Family.

- “Elsbeth, at what age did you first engage in sexual activity?”
- “When LaCheir first told your mom that she was lesbian, what effect did it have on your mom’s caregiving with her?”
- “When your brother, Lee, announced that he was gay and leaving his marriage, how did your parents respond?”
- “What did your parents tell you, Lilah, about your ambiguous genitals?”

Rank Order

The subcategory rank order refers to the position of the children in the family with respect to age and gender. Birth order, gender, and distance in age between siblings are important factors to consider when doing an assessment. Toman (1993) has been a major contributor to research about sibling configuration. In his main thesis, the duplication theorem, he asserts that the more new social relationships resemble earlier intrafamilial social relationships, the more enduring and successful they are. For example, the marriage between an older brother (of a younger sister) and a younger sister (of an older brother) has good potential for success because the relationships are complementary. If the marriage is between two firstborns, a symmetrical competitive relationship might exist, with each one vying for the position of leadership.

The following factors also influence sibling constellation: the timing of each sibling’s birth in the family history, the child’s characteristics, the family’s idealized “program” for the child, and the parental attitudes and biases regarding gender differences. Although we believe that sibling patterns are important to note, we urge nurses to also remember that different child-rearing patterns have emerged as a result of increased use of birth control, the women’s movement, the large number of women in the workforce, and the great variety of family configurations. We hold the view that sibling position is an organizing influence on the personality, but it is not a fixed influence. Each new period of life brings a re-evaluation of these influences. An individual transfers or generalizes familial experiences to social settings outside the family, such as kindergarten, schools, and clubs.
the availability and powerful influence of the Internet, the universe of available relationships and experiences is greatly expanded. As an individual is influenced by the environment, his or her relationships with colleagues, friends, and spouses are also generally affected. With time, multiple influences in addition to sibling constellation can affect personality organization.

Prior to meeting with a family, we encourage nurses to hypothesize about the potential influence of rank order on the reason for the family interview. For example, nurses could ask themselves, “If this child is the youngest in the family, could this be influencing the parents’ reluctance to allow him to give his own insulin injections?” Nurses could also consider the influence of birth order on motivation, achievement, and vocational choice. For example, is the firstborn child under pressure to achieve academically? If the youngest child is starting school, what influence might this have on the couple’s persistent attempts with in vitro fertilization? We urge clinicians not only to consider rank order when children are young but also its relevance when working with siblings in later life. Overlooking the fact that individuals may be influenced by old or ongoing conflicts may lead to missed opportunities for healing.

**Questions to Ask the Family.**

- “How many children do you have, Amber?”
- “Who is the eldest? How old is he or she?”
- “Who comes next in line?”
- “Have there been any miscarriages or abortions?”
- “If your older sister, Gerda, showed more softness and were less controlling of your mom, might you be willing to talk more with your mom?”
- “Would you be willing to talk about difficult issues, such as her giving up driving because of her macular degeneration?”

**Subsystems**

*Subsystems* is a term used to discuss or mark the family system’s level of differentiation; a family carries out its functions through its subsystems. Dyads, such as husband-wife, wife-wife, or mother-child, can be seen as subsystems. Subsystems can be delineated by generation, gender, interest, function, or history.

Each person in the family belongs to several different subsystems. In each subsystem, that person has a different level of power and uses different skills. A 65-year-old woman can be a grandmother, mother, wife, and daughter within the same family. An eldest boy is a member of the sibling subsystem, the male subsystem, and the parent-child subsystem. In each of the subsystems, he behaves according to his position. He has to concede the power that he exerts over his younger brothers in the sibling subsystem when he interacts with his stepmother in the parent-child subsystem. An only child living in a single-parent household has different subsystems.
challenges when she lives on alternate weekends with her mother, her new wife, and their new baby. The ability to adapt to the demands of different subsystem levels is a necessary skill for each family member.

In our clinical practice, we have found it useful to consider whether clear generational boundaries are present in the family. If they are, does the family find them helpful or not? For example, we ask ourselves whether one child behaves like a parent or husband surrogate. Is the child a child, or is there a surrogate-spouse subsystem? By generating these hypotheses before and during the family meeting, we are able to connect isolated bits of data to either confirm or negate a hypothesis.

Questions to Ask the Family.

Some families have special subgroups—for example, those who identify that women do certain things, those who identify that men do certain things, and those who identify that children do certain things.

- “Do different subgroups exist in your family? If so, what effect does this have on your family’s stress level?”
- “When Mom and your sister, Nora, stay up at night and talk about Dad’s use of crack, what do the boys do?”
- “Who in the family is most affected by Cleve’s crack problem, and how does it affect them?”
- “Who gets together in the family to talk about Shabana’s self-mutilating behaviors?”

**Parent-child:**

- “How has your relationship with Caitylin changed since her diagnosis with severe acute respiratory syndrome?”

**Marital:**

- “How much couple time can you and Simon carve out each month without talking about the children?”

**Sibling:**

- “On a scale of 1 to 10, with 10 being the most, how scared were you when Alex developed congestive heart failure?”

**Boundaries**

The subcategory boundaries refers to the rule “defining who participates and how” (Minuchin, 1974, p. 53). Family systems and subsystems have boundaries, the function of which is to define or protect the differentiation of the system or subsystem.

For example, the boundary of a family system is defined when a father tells his teenage daughter that her boyfriend cannot move into the household. A parent-child subsystem boundary is made explicit when a mother tells her
daughter, “You are not your brother’s parent. If he is not taking his medication, I will discuss it with him.”

Boundaries can be diffuse, rigid, or permeable. As boundaries become diffuse, the differentiation of the family system decreases. For example, family members may become emotionally close and richly cross-joined. These family members can have a heightened sense of belonging to the family and less individual autonomy. A diffuse subsystem boundary is evident when a child is “parentified,” or given adult responsibilities and power in decision making.

When rigid boundaries are present, the subsystems tend to become disengaged. A husband who rigidly believes that only wives should visit the elderly relatives, and whose wife agrees with him, can become disengaged from or peripheral to the senior adult-child subsystem. Clear, permeable boundaries, on the other hand, allow appropriate flexibility. Under these conditions, the rules can be modified. We do not support the pathologizing of coalitions or subsystems just because they exist. In working with families from different cultures, races, and social classes or those from rural settings, we have found that fostering other central ties may be most beneficial for the family.

Boundaries tend to change over time. Boss (2002) suggests that family boundaries become ambiguous during the process of reorganization after the acquisition or the loss of a member. This is particularly evident in families experiencing separation or divorce. As couples make the transition to parenthood, they may experience the desired child as a family member who is psychologically present but physically absent. This is particularly relevant if there is a surrogate mother or a known sperm donor involved during the pregnancy. Other variations include the ambiguity experienced by some families when a family member is in prison, or overseas fighting in a war, or living in a rehab hospital following a tour of duty or some other traumatic event, or when a family member has dementia or is undergoing gender transition. Boss (2016) uses the term ambiguous loss “to describe a situation of unclear loss that remains unverified and thus without resolution” (p. 270) and discusses how ambiguous loss leads to boundary ambiguity, that is, not knowing who is within or out of a family system.

Boundary styles can facilitate or constrain family functioning. For example, an immigrant family that moves into a new culture may be very protective of its members until it gradually adapts to the cultural milieu. Its boundaries regarding outside systems may be quite firm and rigid at first but may gradually become more flexible.

The closeness-caregiving dimension of boundaries is another aspect for nurses to consider. The relative sharing of territory can be assessed along aspects of contact time (time together), personal space (physical nearness, touching), emotional space (sharing of affects), informational space (information known about each other), private space (shared private conversations separate from others), and decisional space (extent to which
decisions are localized within various individuals or subsystems). The
closeness-caregiving dimension of a boundary may be very significant for
nurses to assess when dealing with older people with chronic illnesses and
their adult children.

In our clinical supervision with nurses, we encourage them to consider
how each family differentiates itself from other families in the community
and in the city. The nurse considers whether there is a parental subsystem,
a marital subsystem, a sibling subsystem, and so forth. The nurse should
consider the following questions:

- “Are the boundaries clear, rigid, or diffuse?”
- “Does the boundary style facilitate or constrain the family?”
- “If there are multiple stepfamilies, which boundary predominates?”

Questions to Ask the Family.

- “Is there anyone with whom you can talk to when you feel stressed by
your upcoming retirement?” (The nurse can ask family members the
same question.)
- “To whom would you go if you felt happy? If you felt sad?”
- “Would there be anyone in your family opposed to your talking with that
person?”
- “Who would be most in favor of you talking with that person?”
- “What impact might it have on your mom’s ability to deal with your
dad’s illness if she had more support from your grandparents?”

External Structure

External structure includes two subcategories:

1. Extended family
2. Larger systems

Extended Family

The subcategory of extended family includes the family of origin and the
family of procreation as well as the present generation and stepfamily mem-
bers. Multiple loyalty ties to extended family members can be invisible but
may be very influential forces in the family structure. Special relationships
and support can exist at great geographical distances. Also, conflicted and
painful relationships can seem fresh and close at hand despite the extended
family living far away or not being in frequent contact. How each member
sees himself or herself as a separate individual yet part of the “family ego
mass” (Bowen, 1978) is a critical structural area for assessment.

Levac, Wright, and Leahey (2002) recommend assessment of the quan-
tity and type of contact with extended family to provide information
about the quality and quantity of support. The importance of social media
connections cannot be overemphasized. A young man paralyzed following a sports injury may be connected with many people through Facebook, Twitter, and blogs, which is a helpful way for the family, friends, and colleagues to link to the patient and to each other. Such connective interaction “does hope,” a notion we support and find healing. In our clinical work we consider whether there are many references to the extended family. How significant is the extended family to the functioning of this particular family? Are they available for support in times of need? If so, how? By mobile or land phones, e-mail, webcam, Skype, iChat, and Internet chat groups? Are they in close physical proximity?

Questions to Ask the Family.

- “Where do your parents live?”
- “How often do you have contact with them?”
- “What about your brothers, sisters, and step-relatives?”
- “Which family members do you never see?”
- “Which of your relatives are you closest to?”
- “Who phones whom? With what frequency?”
- “Whom do you ask for help when problems arise in your family?”
- “What kind of help do you ask for?”
- “Would your family in Ireland be available if you needed their help?”
- “Would you feel more comfortable contacting your family by e-mail or in a chat room?”

Larger Systems

The subcategory larger systems refers to the larger social agencies and personnel with whom the family has meaningful contact. Larger systems generally include work systems, and for some families, they include public welfare, child welfare, foster care, courts, and outpatient clinics. There are also larger systems designed for special populations, such as agencies mandated to provide services to the mentally or physically handicapped or the frail elderly. For many families, engagement with such larger systems is not problematic and can be life-affirming. We believe that larger professional systems can be an appreciative audience that supports families’ narratives of hope and preferred new lives. We encourage nurses to use language carefully in discussing clients with larger-system helpers so as to support family stories of courage, growth, and persistence instead of perpetuating stories of hopelessness and problems.

Some families and larger systems, however, may develop difficult relationships that exert a toll on normative development for family members. Some health-care professionals in larger systems contribute to families being labeled “multiproblem,” “resistant,” “noncompliant,” or “uncooperative.” Health-care professionals limit their perspectives by using these labels.
Another larger-system relationship that nurses should consider is the computer network. Electronic bulletin boards, chat rooms, text messaging, and discussion groups are increasing. The Internet can offer families valuable assistance in terms of information, validation, empathy, advice, and encouragement; however, it can also provide inaccurate and misleading information, and thus it is important for nurses to support families to access reliable information. Some have used e-mail to augment, extend, deepen, inform, enrich, and prepare for in-person psychotherapy. However, online dialogues can sometimes be more sustaining than transformative. Vigorous attention should be given to ways that professional expertise and electronic connectivity can be combined. Telenursing is one such example. Nurses need to consider how they can ensure that the voices of all family members are part of the discussion between the nurse and the family when using tele-health care. Using videoconferencing to gather all the larger-system helpers in one space with the family to discuss, plan, and evaluate care can be a solution.

In our clinical supervision with nurses, we encourage them to discover whether the meaningful system is the family alone or the family and its larger-system helpers.

Nurses can ask themselves questions such as the following:

- “Who are the health-care professionals involved?”
- “What is the relationship between the family and the larger system?”
- “How regularly do they interact? Is their relationship symmetrical or complementary?”
- “Are the larger systems overconcerned? Overinvolved? Underconcerned? Underinvolved?”
- “Does the larger system blame the family for its problems?”
- “What do the helpers desire for the family?”
- “Is the nurse being asked to take responsibility for another system’s task?”
- “How do the family and helpers define the problem?”

One young woman suffering from metastases from breast cancer, when asked, “Who do you think of like family?” answered, “I have three families: my own family, my church family, and my ‘family’ at the cancer center.”

Questions to Ask the Family.

- “What agency professionals are involved with your family, Mr. Rajwani?”
- “How many agencies regularly interact with you?”
- “Has your family moved from one health-care system to another?”
- “Who most thinks that your family needs to be involved with these systems?”
- “Who most thinks the opposite?”
- “Would there be agreement between your definition of the problem and the system’s definition of the problem?”
• “How about between the definitions of the solution?”
• “What has been the best or worst advice you have been given by professionals for this issue, Atul?”
• “How is our working relationship going so far, Laura? If it were not going well, would you tell me?”

Context

Context is explained as the whole situation or background relevant to some event or personality. Each family system is itself nested within broader systems, such as neighborhood, socioeconomic status, region, and country, and is influenced by these systems. The connectivity experienced by persons using the Internet is another context to be considered. Because the context permeates and circumscribes both the individual and the family, its consequences are pervasive. Context includes but is not limited to these five subcategories:

1. Ethnicity
2. Race
3. Social class
4. Spirituality and/or religion
5. Environment

Ethnicity

Ethnicity refers to the concept of a family’s “peoplehood” and is derived from a combination of its history, race, social class, and religion. It describes a commonality of overt and subtle processes transmitted by the family over generations and usually reinforced by the surrounding community. Ethnicity is an important factor that influences family interaction. We believe that nurses must be aware of the great variety within as well as among ethnic groups. Some people are second-, third-, or fourth-generation immigrants, with ancestors who were born in a foreign country. Others may be from “recently arrived” immigrant families, either legally arrived or undocumented, of whom some are refugees.

Ethnic differences in family structure and their implications for intervention have often been highlighted in a stereotypical manner. For example, some families may have strong extended family connections and loyalties, others may have flexible family boundaries, and some may include other family members in child-rearing. There may be emotionality between relatives and between generations, whereas other families may have strictly defined boundaries between generations.

We believe our own cultural narratives help us to organize our thinking and anchor our lives, but they can also blind us to the unfamiliar and unrecognizable and can foster injustice. For example, the importance of learning...
their histories and experiences when caring for refugee immigrant women is invaluable because it provides context and a greater understanding of their situations.

Nurses should sensitize themselves to differences in family beliefs and values and be willing to alter their “ethnic filters.” We believe it is important for nurses to recognize their own ethnic blind spots and adjust their interventions accordingly. We are never “expert,” “right,” or in full possession of the “truth” about a family’s ethnicity. Also, if we engage a translator to assist us with family work, we should not assume that the translator is an “expert” on this particular family’s ethnicity. Rather, both we and the translator should strive to be informed and curious about ourselves and others’ diversity as we collaborate in health care. The importance of participatory models of knowledge transfer and exchange cannot be underestimated.

Questions that we have found useful to ask ourselves include the following:

- “What is the family’s ethnicity?”
- “Have the children and parents had periods of separation in their immigration experience? If so, with what impact?”
- “Is their social network from the same ethnic group? Do they find that helpful or not?”
- “If the available economic, educational, health, legal, and recreational services were similar to the family’s ethnic values, how would our conversation be different?”
- “Are the assessment and testing instruments we use in our clinic relevant for this ethnic group? Do they match the values and beliefs of this particular family?”

Questions to Ask the Family.

- “Could you tell me about your Japanese cultural practices or traditions regarding illness?”
- “How does being an immigrant from Afghanistan influence your beliefs about when to consult with health professionals?”
- “What does health mean to you?”
- “How would you know that you are healthy? How would I know that you are healthy?”
- “As a second-generation Chilean family, how are your health-care practices similar to or different from those of your grandparents?”
- “Which practices seem most useful to you at this point in your family’s life?”

**Race**

The subcategory of *race* is a basic construct and not an intermediate variable. Race influences core individual and group identification. Race intersects with mediating variables such as class, religion, and ethnicity. Racial
attitudes, stereotyping, and discrimination are powerful influences on family interaction and, if left unaddressed, can be negative constraints on the relationship between the family and the nurse.

There is a dearth of literature on potential relationship strengths in intercultural and interracial relationships. We encourage nurses to elicit strengths rather than challenges in working with these couples.

Racial differences, whether intracultural or intercultural, are not problems as such. Rather, prejudice, discrimination, and other types of intercultural aggression based on these differences are problems. For some persons, whether of the majority or minority race, the word “race” is very distasteful because we are all members of the human race. They feel that the word itself implies harsh borders between groups of people in the human race and is therefore not very constructive in binding us together.

It is important for nurses to understand family health beliefs and behaviors influenced by racial identity, privilege, or oppression. In our clinical work with families, we have found it very useful to critically reflect on our own ideas about our race, marginalization, invisible and visible minorities and to vigorously pursue the differences between and within various racial groups. We believe health professionals should be racially and culturally sensitive.

Questions to Ask the Family.

- “What differences do you notice between, for example, your relatives’ child-rearing practices and your own?”
- “Could you help me to understand what I need to know to be most helpful to you?”

Social Class

Social class, or socioeconomic status, shapes educational attainment, income, and occupation. Each class, whether upper-upper, lower-upper, upper-middle, lower-middle, upper-lower, or lower-lower, has its own clustering of values, lifestyles, and behaviors that influence family interaction and health-care practices. Social class affects how family members define themselves and are defined; what they cherish; how they organize their day-to-day lives; and how they meet challenges, struggles, and crises. For example, middle-class seniors may be more likely to help their adult children, whereas working-class older adults may be more likely to receive help.

Social class has been referred to as one of the prime molders of the family value and belief system. Much of the sociological and psychological research has been confounded by social class differences among ethnic groups. We believe that, in a racist and classist society, class and race are not inseparable.

Just as nursing has often been presented as intercultural, it has also been presented as interclass and nonpolitical. We believe that many nurses have
pursued sickness in families to the exclusion of obtaining the *meaning* people give to events; their day-to-day living standards; and their access to employment, income, and housing. Social class issues have often been considered to be of little consequence to the “serious talk” about illness. This viewpoint has enabled nurses to sidestep many class issues associated with inequality and injustice. However, treatment must take into account the cultural, social, and economic context of the people seeking help. From factory workers to farmers to business executives, families are trying to cope with higher health-care costs and threats of losing insurance coverage. They continually make decisions based on which health care they can afford. With higher prescription drug costs and growth in the aging population, many families are anxious about their long-term care and ability to provide for their loved ones. Economic uncertainty, conflict and war, and fears of terrorism have created increased difficulties for the working poor.

Assessment of social class helps the nurse understand in a new way the family’s stressors and resources. Generally speaking, women move down in social class following a divorce, whereas men do not. Recognizing differences in social class beliefs between themselves and families may encourage nurses to utilize new health promotion and intervention strategies. It is important for health-care delivery that nurses be aware of such influences as the “glass ceiling” and part-time temporary work versus full-time permanent work with benefits. In our clinical work we have often asked ourselves how a family’s social class might influence their health-care beliefs, values, utilization of services, and interaction with us. Serious illness can intensify financial problems, diminish the capacity to deal with them, and call for solutions at odds with conventional financial wisdom. We have wondered about the intrafamilial differences with respect to class and how these might help or hinder a family coping with, for example, chronic illness.

**Questions to Ask the Family.**

- “How many times have you moved within the past 5 years?”
- “Have these moves had a positive or negative influence on your ability to deal with your son’s HIV?”
- “How many schools has your daughter, Frances, attended?”
- “How does your money situation influence your use of health-care resources?”
- “What impact does Neil’s shift work have on your family’s stress level?”

**Spirituality and/or Religion**

Family members’ spiritual and religious beliefs, rituals, and practices can have a positive or negative influence on their ability to cope with or manage an illness or health concern. Therefore, nurses must explore this previously
neglected area. Emotions such as fear, guilt, anger, peace, and hope can be nurtured or tempered by one’s spiritual or religious beliefs. Wright (2017) encourages distinguishing between spirituality and religion for the purposes of assessment and believes that doing so has the potential to invite more openness by family members regarding this potentially sensitive domain of inquiry. Spirituality is defined as whatever or whoever gives ultimate meaning and purpose in one’s life and invites particular ways of being in the world toward others, oneself, and the universe (Wright, 2017). Religion is defined as an affiliation or a membership in a particular faith community that shares a set of beliefs, rituals, morals, and sometimes a health code centered on a defined higher or transcendent power most frequently referred to as God (Wright, 2017).

Levac, Wright, and Leahey (2002) recommend that assessment of the influence of religion is most critical at the time of diagnosis of a chronic or life-threatening illness. Assessment is especially important and relevant when crises have occurred that may cause extreme suffering, such as a traumatic death caused by a motor vehicle accident; sudden death due to illness, violence, or abuse; or a life-threatening diagnosis. In these situations, it is critical that the nurse ascertain what meaning the family gives to their suffering due to these tragic events and ultimately how family members make sense of their suffering (Wright, 2017). We think that beliefs, spirituality, and transcendence are keys to family resilience.

Spirituality and religion also influence family values, size, health care, and socialization practices. For example, individualism can be intricately related to religious ideals and work ethic. Community and family support, on the other hand, can also be evident in certain religions, and this can foster intergenerational and intragenerational support. Folk-healing traditions that combine health and religious practices are quite common in some ethnic groups. In some spiritualistic practices, a medium, or counselor, helps to exorcise the spirits causing illness. Such healers, religious leaders, shamans, and clergy can be invaluable resources for families dealing with crises and with long-term needs such as caregiver support.

Spirituality and religion are hidden and commonly underused resources in family work. We encourage nurses visiting families’ homes to note the presence of signs of religious influence in the home—for example, statues, candles, flags, and religious texts, such as the Bible, Torah, or Koran. We have been curious about dietary restrictions and habits as well as traditional or alternative health practices influenced by religious beliefs. We have been cautious, however, not to assume that strong spiritual or religious beliefs enhance marital happiness or interaction, although they may diminish the possibility of divorce.

Our clinical work with families has taught us that the experience of suffering frequently becomes transposed to one of spirituality as family members try to find meaning in their suffering (Wright, 2017). If nurses are to be helpful, they must acknowledge that suffering, and in many cases the
senselessness of it, is ultimately a spiritual issue. Therefore, in our clinical work we have asked ourselves about the influence of religion and spirituality on the family’s health-care practices.

Questions to Ask the Family.

- “What meaning does spirituality or religion have for you in your everyday life?”
- “Are you involved with a mosque, temple, church, or synagogue?”
- “Would talking with anyone in your church help you cope with Pierre’s illness?”
- “Are your spiritual beliefs a source of support for you in coping with your illness? A source of stress for you? For other family members?”
- “Who among your family members would most encourage your use of spiritual beliefs to cope with Perminder’s cancer?”
- “What are your sources of hope?”
- “Have you found that prayer or other religious practices help you cope with your son Surinder’s schizophrenia? If so, may I ask what you pray for?”
- “Have your prayers been answered?”
- “What does your religion say about gender roles? Ethnicity? Sexual orientation? How have these beliefs affected you, Davinderpal?”

Environment

The subcategory environment encompasses aspects of the larger community, the neighborhood, and the home. Environmental factors such as adequacy of space and privacy and accessibility of schools, day care, recreation, and public transportation influence family functioning. These are especially relevant for older adults, who are more likely to remain in a poor environment even if it has become dangerous to live there.

In our clinical work with families, we have asked ourselves and the nurses with whom we work to consider whether the home is adequate for the number of people living there. Does our perception differ from the family’s perception? What health and other basic services are available within the home? Within the neighborhood? How accessible, in terms of distance, convenience, and so forth, are transportation and recreation services? How safe is the area? By asking in an open-ended way what other contextual forces may influence the family, it is possible to obtain a much broader range of responses. These can vary from “belief in politics” to “shopping at the mall” to “music.”

Questions to Ask the Family.

- “What community services does your family use?”
- “Are there community services you would like to learn about but do not know how to contact?”
“On a scale of 1 to 10, with 10 being most comfortable, how comfortable are you in your neighborhood?”

“What would make you more comfortable so that you can continue to function independently at home?”

Structural Assessment Tools

The genogram and the ecomap are two tools that are particularly helpful in outlining a family’s internal and external structures. Each is simple to use and requires only a piece of paper and a pen. The genograph designed by Duhamel and Campagna (2000) can also be used to draw the genogram. Alternatively, some computer programs have genograms as a feature.

**KEY CONCEPT DEFINED**

**Genogram**

A structural assessment tool that shows a diagram of the family constellation.

The *genogram* is a diagram of the family constellation. The *ecomap*, on the other hand, is a diagram of the family’s contact with others outside the immediate family. It pictures the important connections between the family and the world. We are aware of the arbitrariness of the distinction for some cultural groups between a genogram and an ecomap. For example, the standard genogram may be difficult to complete with families who do not solely believe that family is strictly a biological entity. We encourage nurses to develop a fit between these tools to depict specific family compositions.

**KEY CONCEPT DEFINED**

**Ecomap**

A structural assessment tool that shows a diagram of the family’s contact with others outside the immediate family and illustrates the important connections between the family and the world.

These tools have been developed as family assessment, planning, and intervention devices. They can be used to reframe behaviors, relationships, and time connections within families, as well as to detoxify and normalize families’ perceptions of themselves. By pointing to the future as well as to the past and the present, genograms facilitate alternative interpretations of family experience. They can help both the nurse and the family see the
larger picture and view problems in both a historical and current context. Genograms can also be used to foster the training of culturally competent clinicians and for nurses to increase their self-awareness.

Darwent, McInnes, and Swanson (2016) adapted the genogram to develop an Infant Feeding Genogram to map the family structure of women who were the first in their families to breastfeed their children. This unique use of a genogram resulted in setting the context for discussions about women’s experience of breastfeeding within their family culture by helping to identify strengths and possible deficits in social supports.

We agree with McGoldrick, Gerson, and Petry (2008) that although much can be said about expanding genograms to include issues from larger social contexts (the sexual, cultural, religious, or spiritual genogram), realistically such mapping is extremely difficult to accomplish. Gendergrams have been developed to map gender relationships over the life cycle. At best, we can probably explore only a few dimensions at a time, and we recommend that these dimensions be directly connected to the purpose of the family's encounter with the nurse. For example, a nurse meeting with a couple in a rehabilitation treatment center for sexual addiction might reasonably explore a family’s sexual and addiction history on a genogram. This content area would likely not be appropriate for a nurse meeting with a family in an intensive care unit. McGoldrick et al (2008) have outlined important issues that are difficult to capture on genograms:

- Family members involved in family business
- Family members’ relationships to the health-care system
- Cultural genogram issues
- Family secrets
- Particular family-relationship nuances, including power, patterns of avoidance, and so forth
- Patterns of friendship
- Relationships with work colleagues
- Spiritual genograms
- Community genograms
- Tracking medical and psychological stressors

Genograms don’t typically show the emotional connections among family members, present or past. The complex relationships of those who have warmed our hearts, mentored and nurtured us, aggravated us, or caused us severe trauma generally are not depicted. This is both a limitation of genograms and an asset; genograms tend to be a quick snapshot of the present.

With the help of computers, we can make three-dimensional maps that enable us to track complex genogram patterns. Our caution for practicing nurses is to use the genogram as a clinically relevant tool, not as a map or data-collection sheet. Computerized genograms enable us to explore specific family patterns, resiliencies, and symptom constellations. Gathering,
mapping, and tracking family history is much easier using a computer database. We urge nurses to ask themselves: “What is the purpose of collecting vast amounts of information about this family’s history, and how will this information be helpful for the purpose of my work with this family?” Using computers and genogram information will provide rich data for family research, but it is unknown how useful this will be for immediate family care. Of course, by using computer genogram software, there will be many more possibilities for depicting family issues at different moments in family history. Clinicians and family members will have the opportunity to choose what aspects of a genogram they want to display for a particular purpose and at the same time create a database of a family’s whole history.

**Genogram**

Genograms convey a great deal of information in the form of a visual gestalt. When one considers the number of words it would take to portray the facts thus represented, it becomes clear how simple and useful these tools are. Genograms, when placed on patients’ charts, act as constant visual reminders for nurses to “think family.” As an engagement tool, the genogram is helpful to use during the first meeting with the family. It provides rich data about relationships over time and may also include small amounts of data about health, occupation, religion, ethnicity, and migrations. The genogram can be used to elicit information helpful to both the family and the nurse about development and other areas of family functioning. It is a tool that enables clinicians to develop hypotheses for additional evaluation in a family assessment.

The skeleton of the genogram (a blank genogram is shown in Figure 3-2) tends to follow conventional genetic and genealogic charts and depicts the internal family structure:

- It includes at least three generations.
- Family members are placed on horizontal rows that signify generational lines (a marriage or common-law relationship is denoted by a horizontal line).
- Children are denoted by vertical lines.
- Children are rank-ordered from left to right beginning with the eldest child.
- Each individual is represented.

Some authors differ slightly in the symbols they use to denote the details of the genogram. The symbols in Figure 3-3, however, are generally agreed on. With the increased use of computer genograms, symbols and color coding will become standardized.

The person’s name and age should be noted inside the square or circle. Outside the symbol, significant data gathered from the family (e.g., “travels a lot,” “depressed,” “overinvolved in work”) should be noted. If
a family member has died, the year of his or her death is indicated above the square or circle. When the symbol for miscarriage is used, the sex of the child should be identified if it is known. A small square is used to denote a sperm donor (McGoldrick et al, 2008). It is helpful to draw a circle around the different households. We find that when children have lived in several contexts (e.g., immediate biological family, foster family, grandparents, adoptive family), separate genograms can help to show the child’s multiple families over time.

The following is an example of a nuclear and extended family genogram (Figure 3-4):

**The Lamensa Family**

- Raffaele, age 47, married to Silvana, age 35, since 2000, lived common-law for 2 years prior to their marriage.
- There are two children: Gemma, age 14, in grade 8, and Antonio, age 7, repeating grade 1.
- Raffaele is employed as a machinist; Silvana refers to him as “an alcoholic.”
- Silvana is a homemaker and states that she has been “depressed” for several years.
- Both of Raffaele’s parents are deceased; his father died in 2010, and his mother died in 2008 of a stroke.
- Raffaele’s older brother Antonio also has a drinking problem; Antonio was named for his grandfather.
- Silvana’s mother, Nunziata, age 54, has arthritis and is getting progressively worse since her husband died in 2007.
- Silvana has two older sisters and a brother.
The following is an example of a family genogram for a lesbian couple with a child born to one of them (Figure 3-5):

**Jennifer and Amanda**

- Jennifer (age 30) and Amanda (age 28) have lived as a couple since 2016 and have been married since 2018.
Jennifer’s biological son, Griffin (age 8), was conceived by artificial insemination (the unknown sperm donor is depicted as a small square).

Jennifer’s mother, Adrienne, a retired nurse (age 65), divorced Jennifer’s father in 1991; remarried in 1993; had another daughter, Mitzi, by her second husband; and became a widow when he died in 1999.

Mitzi (age 24) is considering transgender surgery.

Amanda’s parents are separated, and her father is living common-law with Dan, his business partner.

Amanda has no siblings.

Jennifer has a younger brother, Spencer (age 28), and a half sister, Mitzi.

**How to Use a Genogram** At the beginning of the interview, the nurse engages the family by informing them that they will be having a conversation so that the nurse can gain an overview of who is in the family and their relationships.
The nurse can then use the structure of the genogram to discern the family’s internal and external structures as well as context. Thus, the nurse gains an understanding of the family’s composition and boundaries.

Initially, the nurse starts out with a blank sheet of paper and draws a line or circle for the first person in the family to whom a question is directed.

The following is a sample interview with the Manuyag family:

**Nurse:** Elena, you said you were 23, and Matias, how old are you?

**Matias:** Thirty-four.

**Nurse:** How long have you been married?

**Matias:** This time or the first time?

**Nurse:** This time. And then the first time.

**Matias:** Just 2 years for Elena and me.

**Nurse:** And the first time?

**Matias:** Ten years for the first one.
Nurse: And, Elena, have you been married before?

Elena: (Laughs nervously) I’m only 23.

Nurse: Sure, it’s just that many people have lived together in common-law marriages or married when they were very young.

Elena: No. I lived with my parents till I met Matias.

Nurse: Do either of you have children from prior relationships? (Turns to both Matias and Elena)

Matias: Yes, I have two sons.

Elena: No.

Nurse: In addition to Teresita here (Looks at baby on couch), do the two of you have any other children?

Elena: Yes, there’s Manandro.

Matias: Old stinko, you mean.

Nurse: Old stinko?

Matias: He isn’t toilet trained yet.

Nurse: Oh, I see. And he’s how old?

Elena: He’s almost 3. I’ve been trying to train him since I knew I was pregnant with Teresita, but he just doesn’t seem to want to be trained.

Nurse: (Nods) Mm.

Matias: Yeah, old stinko!

Nurse: And Teresita is how many weeks now?

Elena: She’ll be 21 days tomorrow (Smiles at baby).

Nurse: Does anyone else live with you?

Matias: No. Her parents live next door.

The nurse now has a rudimentary genogram of the Manuyag family (Figure 3-6) and has gathered information that may or may not be significant, depending on the way in which the family has responded to various events in the history of their family, such as the following:

- Manandro was conceived before the marriage.
- Manandro is unaffectionately called “old stinko” by his father.
- Elena has been trying to toilet train Manandro since he was 24 months old.
- Elena lived with her family of origin before the marriage; they now live next door.
- Matias has been married before and has two other sons.

After inquiring about the nuclear family, the nurse can continue to inquire about the extended family. It is generally not very important to go into
great detail about these relatives, but clinical judgment should prevail. If, for example, the grandparents are involved in a child’s colostomy care, then a three-generational genogram should be constructed. On the other hand, if a child has a sprained wrist or something relatively minor, then a two-generational genogram is sufficient. After asking questions about the husband’s parents and siblings, the nurse should then inquire about the wife’s family of origin. It is important for the nurse to gain an overview of the family structure without getting sidetracked or inundated by a large volume of information. Box 3-1 contains helpful hints for constructing genograms.

The same question format used for nuclear families is used for stepfamilies, with one exception. It is generally easier to ask one spouse about his or her previous relationships before going on to ask the other spouse the same questions. This idea holds true especially in working with complex family situations involving multiple parenting figures and siblings. Again, it is unnecessary to gather specific information on all extended family members. It is useful to draw a circle around the current family members to distinguish among the various households. Usually it is easiest to indicate the year of a divorce rather than the number of years ago that it happened.

The following is an example of a sample genogram for a stepfamily (Figure 3-7):

- Michael (age 35) and Melanie (age 33) have had a common-law marriage since 2016.
- Melanie is a part-time waitress.
- Melanie has two children by her first marriage, Kathy (age 12) and Jacob (age 11).
- Jacob has attention deficit-hyperactivity disorder (ADHD) and is in a special class in grade 4.

![Figure 3-6 Genogram of the Manuyag family.](image-url)
**Box 3-1 Helpful Hints for Constructing Genograms**

- Determine priorities for genogram construction based on the family situation.
- A three-generational genogram may be useful when the child’s health problem (physical or emotional) is influenced by or affects the third generation.
- A brief two-generational genogram is generally most useful initially, especially for a family that has preventive health-care needs (immunizations) or minor health concerns (sports injury). The nurse can always expand to the third generation if needed.
- Invite as many family members to the initial meeting or visit as possible to obtain each family member’s view and to observe family interaction.
- Engage the family in an exercise to complete the genogram.
- Use the genogram to “break the ice,” provide structure, and introduce purposeful conversation.
- Ask family members how an absent significant family member might answer a question.
- Avoid discussion that is hurtful or blameful, especially of absent family members.
- Take an interest in each family member, and be sensitive to developmental differences.
- Tailor questions to children’s developmental stages so that they become active contributors.
- Notice children’s nonverbal and verbal comments.
- If some members are shy or seem uninterested in participating directly (such as adolescents), ask other family members about them.
- Begin by asking “easy” questions of individuals, followed by an exploration of subsystems.
- Ask concrete, easy-to-answer questions of individuals (especially children) about ages, occupations, interests, health status, school grades, and teachers to increase their comfort levels.
- Move the discussion about individuals to subsystems to elicit family relational data. Inquire about parent-child or sibling relationships, depending on parenting concerns.
- With stepfamilies, ask questions about contact with the noncustodial parent, custody, the children’s satisfaction with visits, and stepfamily relationships.
- Observe family interactions.
- During genogram construction, note the content (what is said) and the process (how it is said).
- Move from the discussion about the present family situation to questions about the extended family if it seems relevant (for example, “Are Ruhi’s parents able to help with the baby’s tracheostomy care? What about babysitting?”).

*Continued*
Michael married his first wife, Laura, in 2006 and divorced in 2008. Michael and Laura had one son, who is now age 11. Michael is an only child; his father committed suicide in 2008; his mother is still alive. Melanie is the youngest of three daughters, and both of her parents are living.

David (age 36) is a mechanic who is presently living in a common-law marriage with Camille and her three sons.

Camille and her first husband, Rob, divorced in 2007, reconciled in 2009, and then divorced in 2010.

There are no specific guidelines for drawing genograms illustrating complex stepfamily situations. Generally, however, what works best is for the nurse to start by gathering information about the immediate household. After this, the nurse draws each family’s constellation. Whenever possible, it is best to show children from different marriages in their correct birth order, oldest on the left and youngest on the right. We agree with McGoldrick et al (2008) that the rule of thumb is, when feasible, that different marriages follow in chronological order from left to right. We have sometimes found it helpful to indicate the number of the relationship or marriage in the lower left-hand corner when there have been several relationships. See Figure 3-5, where Adrienne’s husbands are indicated as #1 and #2. It can be useful to draw a circle around each separate household. If one member of a couple is involved in an affair, then their relationship is depicted with a dotted rather than a solid line. Additional pertinent information, such as children moving between two households, can be written to the side of the genogram. It is important for the nurse to remember that the purpose of drawing the genogram is to obtain a visual overview of the family. The genogram is not meant to be an exact chart for genetics.

Other problems arise when there are multiple marriages, intermarriages, and remarriages within the family. For example, when cousins or stepsiblings marry, the clinician should use separate pages to clarify intricacies. With complex family situations, the nurse needs to choose between clarity and level of detail. When computers are used to diagram genograms, complexity can be reduced by zooming in on relevant significant information. We advise nurses to let practicality and possibility be their guide.

Develop a genogram that is useful rather than one that is overly inclusive and too confusing. Sometimes the only feasible way for pediatric nurses to clarify where children were raised is to take chronological notes on each child and draw multiple genograms through time to show the various family constellations the child experienced. With software, specific genograms can be created for specific moments in a person’s life. When discrepancies exist in information shared by various family members, we advise nurses to note this on the genogram but not to take on an investigative role. There can be multiple truths and recollections of information.

Another example of a stepfamily genogram is depicted in Figure 3-8.

The Faris Family

David (age 42) is a software designer living common-law since 2015 with Patti (age 40), a part-time retail associate.
David and Patti have a daughter, Madison (age 3), recently diagnosed with juvenile diabetes.

David’s twin sons, Jack and Ben (age 9), spend alternate weeks at their mom’s townhouse and at David and Patti’s apartment.

David was divorced in 2010; his former wife has a daughter, age 3.

Patti has a son, Dan (age 20), by her first husband, Jim, whom she divorced in 2000.

Dan lives alone and works several part-time jobs in bars.

Patti has two other daughters: Tamika (age 16), who recently dropped out of school, and Shannon (age 14), in grade 8, from her second marriage, to Lloyd, which ended in divorce in 2009.

Tamika and Shannon live with their mom and visit Lloyd and his family for 2 weeks most summers.

The current health concern is Madison’s juvenile diabetes.

The current household consists of David, Patti, the three girls, and on alternate weeks, the twin boys.

David’s mom has diabetes, as does his older sister.
An example of a family in which a child lives with the grandmother and her husband is provided in Figure 3-9:

**The Fitzgerald-Kucewicz Family**

- Sophia Kucewicz (age 8), lives with her grandmother, Patricia Fitzgerald (age 45); Vincent, Patricia’s common-law partner of 10 years; and Sophia’s aunt, Susan.
- Patricia was previously married to Steven Fitzgerald for 14 years.
- Patricia and Steven had three children: Susan (age 19), Douglas (age 23), and Joan (age 25), who is Sophia’s mother.
- Joan became pregnant with Sophia when she was 16.
- Sophia’s father, Michael Kucewicz, and her mother had a brief relationship, through which she was conceived.
- Michael was aware of the pregnancy; he left the city shortly before Sophia was born, never meeting her.
- When Sophia was 2 years old, Joan had another child, Kayla, who subsequently went to live with her natural father when she was 4.
- When Sophia was 3, her mother moved in with Ben, whom Sophia came to know as her father.
- Joan and Ben had difficulty providing a stable environment for Sophia and Kayla and, from time to time, moved in with Patricia and Vincent.

![Figure 3-9 Genogram of the Fitzgerald-Kucewicz family.](image-url)
Patricia reports that both Joan and Ben used drugs and alcohol and were often unemployed.

Ben was physically and verbally abusive to Joan, and after a particularly frightening episode between Joan and Ben that took place in the basement of Patricia’s home, Joan called the police. The child welfare department became involved, leading Patricia and Vincent to take guardianship of Sophia.

Joan and Ben moved to a place of their own, agreeing to take Sophia every other weekend.

The health concern for this family is Sophia’s nightmares, especially after returning from visits to Joan and Ben’s trailer home.

Most families are extremely receptive to and interested in collaborating with the nurse to complete a genogram. For some, it is the first time that they have ever seen their family life pictured in this manner. Therefore, the nurse needs to be aware that the family may have a reaction to significant events. One family, for example, may express some sensitive material in a very blasé fashion. If divorce is common in their families of origin, they may not hesitate to discuss their several marriages and those of their siblings. On the other hand, a devout Catholic family may be exquisitely sensitive to seeing the nurse write the word “divorce.”

**Ecomap**

As with the genogram, the primary value of the ecomap is in its visual impact. The purpose of the ecomap is to depict the family members’ contact with larger systems. Hartman (1978) notes:

> The eco-map [sic] portrays an overview of the family in their situation; it pictures the important nurturant or conflict-laden connections between the family and the world. It demonstrates the flow of resources, or the lack of and deprivations. This mapping procedure highlights the nature of the interfaces and points to conflicts to be mediated, bridges to be built, and resources to be sought and mobilized. (p. 467)

Ecomaps shift the emphasis away from the historical genogram to the current functioning of the family and its environmental context. This focus on the present is an important message in our outcome-based health-care climate. The ecomap depicts reciprocal relationships between family members and broader community institutions such as schools, courts, health-care facilities, and so forth.

**How to Use an Ecomap**

As with the genogram, family members can actively participate in working on the ecomap during the assessment process.

The family genogram is placed in the center circle, labeled “Family or household.” The outer circles represent significant people, agencies, or...
institutions in the family’s context. The size of the circles is not important. Lines are drawn between the family and the outer circles to indicate the nature of the connections that exist. Straight lines indicate strong connections, dotted lines indicate tenuous connections, and slashed lines indicate stressful relations. The wider the line, the stronger the tie. Arrows can be drawn alongside the lines to indicate the flow of energy and resources. Additional circles may be drawn as necessary, depending on the number of significant contacts the family has.

An ecomap for the Lamensa family is illustrated in Figure 3-10:

- Raffaele, Silvana, Gemma, and Antonio are placed in the center circle.
- Raffaele has strong connections with his workplace, where he is a foreman and a union representative. He has moderately strong bonds with his “drinking buddies.” These relationships, however, are stressful for him.
Silvana’s connections are mainly with her mother and the health-care system. She sees her family physician every week “for nerves” and sees a community health nurse (CHN) once a week. Silvana’s mother, Nunziata, visits Silvana every day from 11 a.m. to 10 p.m. There is a strong connection between Silvana and her mother, but Silvana says she really “doesn’t like Mom coming over so often.”

Antonio has a few friends, most of whom set fires. He is in a special class for his learning disability and enjoys both the teacher and the school.

Gemma is in junior high school, where she maintains an average grade of D. She frequently does not attend school, and when she does attend, she participates little. She spends about 6 hours a day with her boyfriend.

When the CHN completed the ecomap with the Lamensa family, Mrs. Lamensa (Silvana) commented, “I seem to spend all my time with medical or health people.” Mr. Lamensa (Raffaele) then said, “You’re also so busy with your mother that you don’t have time for anybody else.” The nurse was able to use this information from the ecomap to discuss further with the family the types of relationships they wanted both with those inside their household and with those outside the immediate family.

In summary, the genogram and the ecomap can be used in all health-care settings, especially in primary care, to increase the nurse’s awareness of the whole family and the family’s interactions with larger systems and their extended family. Box 3-2 gives helpful hints for drawing ecomaps.

**DEVELOPMENTAL ASSESSMENT**

In addition to understanding the family structure, the nurse must understand the developmental life cycle for each family. Most nurses are familiar

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**Box 3-2 Helpful Hints for Drawing Ecomaps**

Pose questions that explore the family’s connections to other individuals or groups outside the family, such as:

- “What community agencies are you involved with now? Which are most and least helpful?”
- “How would you describe your relationship with school staff?”
- “How did you first become involved with Child Protective Services? What is the nature of your current relationship with them?”

with the stages of child development and the literature in the area of adult development. Many are becoming interested in the burgeoning literature about development in the senior years, an interest that has been fostered by the aging of the baby boomer generation. But what of family development? It is more than the concurrent development at different phases of children, adults, and seniors who happen to call themselves “family.” We believe families are people who have a shared history and a shared future.

**KEY CONCEPT DEFINED**

**Developmental Assessment**

One of the categories of the Calgary Family Assessment Model (CFAM) that nurses use to identify the developmental life cycle for each family.

Family development is an over-arching concept, but each family has its own developmental path, influenced by its past and present context and its future aspirations. McGoldrick, Garcia Preto, and Carter (2016) believe that “individuals and families transform, and need to transform, their relationships as they evolve, to adapt to changing circumstances over the life course” (p. 7). There is no single family developmental life cycle or model. This is especially evident as our population ages. The natural sequential phases of generational boundaries are not as clear as in the past with, for example, children maturing at earlier ages but living at home longer, the trend toward later marriages, and seniors continuing to work well into their 60s. This blurring of boundaries can sometimes lead to tension and confusion within families.

**KEY CONCEPT DEFINED**

**Family Development**

The unique path constructed by a family that is shaped by predictable and unpredictable events and societal trends.

In keeping with postmodernist ideas, we believe that there are limits to describing family development in precise, absolute, universal ways. Postmodernists differ from modernists in that exceptions interest them more than rules; specific, contextualized details more than grand generalizations; difference rather than similarity. We are not concerned with authoritative truth, facts, and rules but rather with the meaning a family gives to its particular story of development over time.
We have found it useful to distinguish between family development and family life cycle. Family development emphasizes the unique path constructed by a family. It is shaped by predictable and unpredictable events, such as illness, catastrophes (e.g., terrorist attacks, fires, earthquakes, hurricanes, floods), and societal trends (e.g., Internet and cell-phone usage, stock market fluctuations, company mergers, changes in crime and birth rates).

Family life cycle refers to the typical path most families go through. The typical life-cycle events are connected to the comings and goings of family members. For example, most families experience certain events in their life cycle, such as birth, child-rearing, departure of children from the household, retirement, and death. These events generate changes requiring a formal reorganization of roles and rules within the family. The life-cycle course of families evolves through a generally predictable sequence of stages, despite cultural and ethnic variations. Although individual variations, timing, and coping strategies exist, biological time clocks and societal expectations for events such as entrance into elementary school and retirement from work are relatively typical in North America.

KEY CONCEPT DEFINED
Family Life Cycle
The typical path most families follow; generally predictable sequence of stages connected to the comings and goings of family members, such as birth, child-rearing, departure of children from the household, retirement, and death.

Given our keen interest in a particular family’s specific development over time, it might be questioned why we include a family developmental section in the CFAM at all. We take the position that an informed “not-knowing” stance is useful when working with families. That is, we seek to be informed by the literature, research, and other families’ stories of development. Yet, we are “not knowing” but curious about this particular family’s developmental story in terms of how the family members progressed through time.

A rich history about family development still pervades clinicians’ thinking. It is useful for nurses to have some understanding of this history. The early proponents of the family life cycle (Duvall, 1977) developed a four-stage model that was subsequently expanded into an eight-stage model featuring successive stages in the progression of primary marriages. With the increase in various family forms, more complex designs were created. Most recently, the Multicontextual Life Cycle Framework for Clinical Assessment developed by McGoldrick et al (2016) has become a helpful framework for conceptualizing the complexities of the life cycle. It provides a visual of the individual within the context of the multigenerational family
system, which is embedded in the larger social context, all moving through
time simultaneously.

In the field of family therapy, there were “pioneers” in applying the family
development framework. Much was written about the interface among fam-
ily development, functioning, and therapy. Carter and McGoldrick (1988)
believed that the family life-cycle perspective viewed symptoms in relation
to normal functioning over time and that “therapy” helped to reestablish
the family’s developmental momentum. Family therapists such as Haley
(1977), Minuchin (1974), and Selvini, Boscolo, Cecchin, and Prata (1980)
noted the frequency of symptom appearance with the addition or loss of a
family member. These therapists worked with families that did not move
smoothly or automatically from one stage in the family life cycle to another,
and they focused on the stressful transition points between stages. In doing
an assessment and in planning interventions, these therapists paid consid-
erable attention to life-cycle events as markers of change. Although their
approaches differed, they similarly sought to understand the relationship
between psychopathology and the family’s developmental life-cycle stage.

Family development is now seen as an interactive process in which the
historian influences which stories of development are told and emphasized.
All of these changes have required a critical rethinking of our assumptions
about “normality” and the idea of “family” development. The relationship
between demographic changes and alterations in the prevalence, timing, and
sequencing of some key family transitions must also be noted.

In our clinical work with families presenting in various forms and at all
stages of development, we have found it useful to adopt Falicov’s (2012) ideas
about family development. She emphasizes culture and gender relativity rath-
er than universality, transitions rather than stages, dimensions and processes
rather than markers, and a resource rather than a deficit orientation. We con-
cur with her idea that a systems approach to family development calls for a
dialectical integration of two tendencies: stability and change. The emphasis
is on both tendencies rather than one or the other. Change and stability must
be addressed simultaneously. We do not find it clinically useful to think of
families as “stuck” and unable to bring about change. Rather, we find it clini-
cally useful to look for patterns of continuity, identity, and stability that can
be maintained while new behavioral patterns are changing.

There is much evidence to support the position that nurses will find heu-
ristic value in the family development category of the CFAM. They should
be aware, however, of some of the problems in its indiscriminate adoption
and application. We find it indefensible for some nurses to make sweeping
generalizations such as, “The family life cycle is genetically determined,” or,
“The family life cycle is culturally universal.” We urge nurses to carefully
consider the implications of a family’s ethnicity, race, and social class in
applying the family development category.

We also caution nurses against indiscriminately applying the family develop-
ment category and overemphasizing smooth progression. Contradictions
and difficulties inherent in progressing through the life cycle are normal. Families are complex systems that need to deal with many different progressions at once—that is, there are biological, psychological, sociological, and cultural progressions. Tensions and continuing change brought about by contradictions between these progressions are normal. Family life is seldom smooth or bland; rather, it is zestful and active. We therefore encourage nurses, when using the family development category, to have families discuss their joys and satisfactions as well as their tensions and stresses. The family developmental story told by one family member is from that member’s “observer perspective” (Maturana & Varela, 1992).

In addition to delineating stages and tasks implicit in the family life cycle, we have found it useful to notice the attachments between family members. Attachment refers to a relatively enduring, unique emotional tie between two specific persons. Each person has the need for emotional connection while also remaining secure in his or her own individuality.

Bowlby (1977) notes:

Affectional bonds and subjective states of a strong emotion tend to go together…Thus many of the most intensive of all emotions arise during the formation, the maintenance, the disruption and renewal of affectional bonds which for that reason are sometimes called emotional bonds. In terms of subjective experience the formation of a bond is described as falling in love, maintaining a bond as loving someone, and losing a partner as grieving over someone. Similarly the threat of loss arouses anxiety and actual loss causes sorrow, while both situations are likely to arouse anger. Finally the unchallenged maintenance of a bond is experienced as a source of security and renewal of a bond as a source of joy. (p. 203)

Although the terms bonding and attachment are sometimes used to describe different relationships, we have chosen in this book and in our clinical work to make no distinction between these terms. We recognize the complexity of relationships that arise from international connections between family members and the relationship stresses and the hard choices economic and social immigrants face with separations and reunions of parents, young children, and elderly family members. When working with a family, we tend to pay the most attention to the reciprocal nature of an attachment and the quality of the affectional tie.

We illustrate these bonds between family members by drawing attachment diagrams. The symbols used in these diagrams (Figure 3-11) are similar to those used in the structural assessment diagrams. It is important for us to emphasize that there is no one right level of attachment or best attachment configuration.

We are partial to the idea of the network paradigm as a useful base to integrate attachment and family systems theories. Such a paradigm integrates dyadic and family systems as simultaneously distinct and yet interconnected. The clinician holds multiple perspectives in mind, considers each system level as both a part and a whole, and shifts the focus between levels.
as required. We like this concept because it expands attachment to include multiple system levels and networks, which is especially important as the baby boomer cohort increases in age. Attachment theory is relevant to more than just parent-infant bonding; it is important for all ages. The key elements of attachment processes (affect regulation, interpersonal understanding, information processing, and the provision of comfort within intimate relationships) are as applicable to family systems as they are to individual development.

In the CFAM developmental category, we discuss family life-cycle stages, the emotional process of transition (namely, key principles), and second-order changes—the issues dealt with and tasks often accomplished during each stage. In an effort to emphasize the variability of family development, we discuss six sample types of family life cycles:

1. Middle-class North American family life cycle
2. Divorce and post-divorce family life cycle
3. Remarried family life cycle
4. Professional and low-income family life cycles
5. Adoptive family life cycle
6. Lesbian, gay, bisexual, queer, intersex, transgender and twin-spirited family life cycles

**Middle-Class North American Family Life Cycle**

We are grateful to McGoldrick et al (2016) for delineating six phases in the North American middle-class family life cycle (summarized in Table 3-1). We highlight the expansion, contraction, and realignment of relationships as
### TABLE 3-1 Phases of the Family Life Cycle

<table>
<thead>
<tr>
<th>FAMILY LIFE CYCLE PHASE</th>
<th>EMOTIONAL PROCESS OF TRANSITION: KEY PREREQUISITE ATTITUDES</th>
<th>SECOND-ORDER TASKS/CHANGES OF THE SYSTEM TO PROCEED DEVELOPMENTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerging young adults</td>
<td>Accepting emotional and financial responsibility for self</td>
<td>a. Differentiation of self in relation to family of origin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Development of intimate peer relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Establishment of self in respect to work and financial independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Establishment of self in community and larger society</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Establishment of one’s worldview, spirituality, religion, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>relationship to nature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. Parents shifting to consultative role in young adult’s relationships</td>
</tr>
<tr>
<td>Couple formation: the joining of families</td>
<td>Commitment to new expanded system</td>
<td>a. Formation of couple system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Expansion of family boundaries to include new partner and extended family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Realignment of relationships among couple, parents and siblings, extended family, friends, and larger community</td>
</tr>
<tr>
<td>Families with young children</td>
<td>Accepting new members into the system</td>
<td>a. Adjustment of couple system to make space for children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Collaboration in child-rearing and financial and housekeeping tasks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Realignment of relationships with extended family to include parenting and grandparenting roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Realignment of relationships with community and larger social system to include new family structure and relationships</td>
</tr>
<tr>
<td>Families with adolescents</td>
<td>Increasing flexibility of family boundaries to permit children’s independence and grandparents’ frailties</td>
<td>a. Shift of parent–child relationships to permit adolescent to have more independent activities and relationships and to move more flexibly into and out of system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Families helping emerging adolescents negotiate relationships with community</td>
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<td></td>
<td></td>
<td>c. Refocus on midlife couple and career issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Begin shift toward caring for older generation</td>
</tr>
</tbody>
</table>
### TABLE 3-1 Phases of the Family Life Cycle—cont’d

<table>
<thead>
<tr>
<th>FAMILY LIFE CYCLE PHASE</th>
<th>EMOTIONAL PROCESS OF TRANSITION: KEY PREREQUISITE ATTITUDES</th>
<th>SECOND-ORDER TASKS/ CHANGES OF THE SYSTEM TO PROCEED DEVELOPMENTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launching children and moving on at midlife</td>
<td>Accepting a multitude of exits from and entries into the system</td>
<td>a. Renegotiation of couple system as a dyad</td>
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<td></td>
<td></td>
<td>b. Development of adult-to-adult relationships between parents and grown children</td>
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<td></td>
<td></td>
<td>c. Realignment of relationships to include in-laws and grandchildren</td>
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<td></td>
<td></td>
<td>d. Realignment of relationships with community to include new constellation of family relationships</td>
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<td></td>
<td></td>
<td>e. Exploration of new interests/ career, given the freedom from childcare responsibilities</td>
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<td></td>
<td></td>
<td>f. Dealing with care needs, disabilities, and death of parents (grandparents)</td>
</tr>
<tr>
<td>Families in late middle age</td>
<td>Accepting shifting generational roles</td>
<td>a. Maintaining or modifying own and/or couple and social functioning and interests in the face of physiological decline: exploration of new familial and social role options</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Supporting more central role of middle generations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Making room in the system for the wisdom and experience of the elders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Supporting older generation without overfunctioning them</td>
</tr>
<tr>
<td>Families nearing the end of life</td>
<td>Accepting the realities of family members’ limitations and death and the completion of one cycle of life</td>
<td>a. Dealing with loss of spouse, siblings, and other peers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Making preparations for death and legacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Managing reversed roles in caretaking between middle and older generations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Realignment of relationships with larger community and social system to acknowledge changing life cycle relationships</td>
</tr>
</tbody>
</table>

entries, exits, and development of family members occur. Although the relationship patterns and family themes may sound familiar, we wish to emphasize that the structure and form of the North American family are changing radically. It is important for nurses to have a positive conceptual framework for what is: dual-career families, permanent single-parent households, unmarried couples, homosexual couples, remarried couples, and sole-parent adoptions. Transitional crises should not be thought of as permanent traumas. It is imperative that the use of language that links us to previous stereotypes be dropped. For example, we try to eliminate such phrases as “children of divorce,” “working mother,” “out-of-wedlock child,” “fatherless home,” and so forth, from the language we use about families. Also, we urge nurses to critically reflect on how culture, ethnicity, gender, race, and sexual orientation influence a family’s developmental stages and tasks as well as attachments.

**Phase One: Emerging Young Adults**

In outlining the phases of the middle-class North American family life cycle, we have chosen to start with the stage of young adults. The primary task of young adults is to come to terms with their family of origin by remaining connected and yet separate, without cutting off or fleeing reactively to a substitute emotional source. The family of origin has a profound influence on who, when, how, and whether the young adult will marry. There have been sharp increases in the proportion of never married, primarily among men and women in their late 20s and early 30s who continue to live in the family home.

This phase may last for several years in a family’s development. It is an opportunity for young adults to sort out emotionally what they will take along from the family of origin, what they will leave behind, and what they will establish for themselves as they progress through succeeding stages of the family life cycle. For both men and women, this is a particularly critical phase. During this stage, men sometimes have difficulty committing themselves to relationships and form a pseudoindependent identity centered on work. Women may choose to define themselves in relation to a man and postpone or forgo establishing an independent identity. We find it helpful to be curious in our clinical work and try to understand the client’s views and legacies regarding marital status and the flexibility of the young person’s expectations about pathways to adulthood.

**Tasks**

1. **Differentiation of self in relation to family of origin.** The young adult’s shift toward adult status involves the development of a mutually respectful form of relating with his or her parents in which the young adult’s parents can be appreciated for who they are. The young adult adjusts the view of the parents by neither making them into what they are not nor blaming them for what they could not be. The complexity of this task is not to be underestimated. Each ethnic and racial group has norms and
expectations regarding acceptable ways to be attached and connected to family and about issues of dependence versus independence.

2. **Development of intimate peer relationships.** The emphasis is on the young adult’s passing from an individual orientation to an interdependent orientation of self. There is no single template of social experience for young adults to follow as they develop intimate relationships. During this task, young adults strive to bridge the gap between autonomy and attachment as they share themselves with others rather than using others as the source of self. With the increased use of Internet dating sites, social media, and chat rooms, the young adult will be exposed to a wide variety of personal styles and personalities.

3. **Establishment of self in respect to work and financial independence.** In a young adult’s 20s and 30s, the “trying on” of various identities to test or refine career skills and interest is typical. The young adult who is committed to a career path or occupational choice by his or her late 20s or early 30s is less vulnerable to self-doubt or decreased self-esteem than the young adult without direction. Issues of competitiveness, expectations, and differences regarding work and financial goals require sorting through by the young adult and his or her family of origin.

4. **Establishment of self in community and larger society.** The future of how young adults relate to others as a responsible citizen depends on the development of self management.

5. **Establishment of one’s worldview, spirituality, religion and relationship to nature.** The social responsibility gets determined in this phase where young adult’s development of self management shifts.

6. **Parents shifting to consultative role in young adult’s relationships.** The relationship between parents and the young adult changes. Parents role shifts as the young adult develops new ways to relate.

**Attachments**

There are no right or wrong attachments for young adults in stage one. Rather, it is important for the nurse to draw forth from family members their beliefs about attachment to one other and how they regard these attachments. These beliefs are influenced by culture, gender, race, sexual orientation, and social class as well as by whether the young adult lives at home. Some sample attachments for phase one are given in Figure 3-12. The first diagram illustrates a young adult who is bonded equally with her father and mother. The second diagram illustrates a young adult who is more closely attached to each parent than the parents are to each other; the parents are negatively bonded. Of significance in the second diagram is that there was a death of a sibling during the childhood of the young adult. It could be hypothesized that his difficulties in establishing his own identity are related to the family’s hesitancy to come to grips with his deceased sister and the parents’ living alone without children.
Questions to Ask the Family.

- “Which of your parents is most accepting of your career plans? How does he or she show this?”
- “What does your sister, Maria, think of your parents’ reaction to your career plans?”
- “If your father were more accepting of your desire to move into an independent living situation with people not of the Jewish faith, how do you think your mother would react?”
- “If you continue to wear hijab because it is integral to your religious beliefs, would this reassure your parents?”

Phase Two: Couple Formation: The Joining of Families

Many couples believe that when they marry, it is just two individuals who are joining together. However, both spouses have grown up in families that have now become interconnected through marriage. Both spouses, although in some ways differentiated from their families of origin in an emotional, financial, and functional way, carry their whole family into the relationship. This is particularly relevant if the marriage is an arranged one. Marriage is a two-generational relationship with a minimum of three families coming together: one spouse’s family of origin, the other spouse’s family of origin, and the new couple. Given the current prevalence of stepfamilies, the likelihood of several families coming together is increased exponentially. Also, the certainty that the couple will be heterosexual is not evident because, in both the United States and in Canada, same-sex marriages and civil unions have increasingly been formally recognized.

Tasks

1. **Formation of couple system.** The new couple must establish itself as an identifiable unit. This requires negotiation of many issues that were previously defined on an individual level. These issues include routine matters such as eating and sleeping patterns, sexual contact, and use of space and time. The couple must decide which traditions and rules to retain from
each family and which ones they will develop for themselves. They must develop acceptable closeness-distance styles and recognize individual differences in adult attachment styles. Although the majority of studies on the quality and stability of marriage focus on couple communication, we believe that love is the decisive factor for quality and stability. For some cultures, however, the concept of a “love marriage” as compared to an arranged marriage is quite different.

2. Expansion of family boundaries to include new partner and extended family.

3. Realignment of relationships among couple, parents and siblings, extended family, friends, and larger community. A renegotiation of relationships with each spouse’s family of origin has to take place to accommodate the new spouse. This places no small stress on both the couple and each family of origin to open itself to new ways of being. Some couples deal with their parents by cutting off the relationship in a bid for independence. Other couples choose to handle this task of realignment by absorbing the new spouse into the family of origin. The third common pattern involves a balance between some contact and some distance.

Attachments

Figure 3-13 illustrates a sample attachment for a couple in phase two: the development of close emotional ties between the spouses. The first diagram illustrates how they do not have to break ties with their families of origin but rather maintain and adjust ties with them. The second diagram illustrates a different type of attachment that can occur if both members of a couple do not align themselves together. The wife is more heavily bonded to her family of origin than she is to her husband. The husband is more tied to outside interests (such as work and friends) than to his wife. We have found that negative attachment-related events occurring early in the marriage are especially distressing for the couple. These and other attachment injuries can be characterized by a betrayal of trust during a critical moment of need.

Figure 3-13 Sample attachments in phase two.
Questions to Ask the Family.

• “Which family members were most in favor of your marriage?”
• “How did you incorporate Greek and American traditions in your marriage?”
• “How did your siblings show that they supported your marriage?”
• “What does your spouse think of your parents’ marital relationship?”
• “If you two as a couple were to model your marriage on your parents’ marriage, what would you incorporate into your marriage?”
• “How did the diagnosis of multiple sclerosis influence your bonding as a couple?”

Phase Three: Families With Young Children

During this stage, the adults now become caregivers to a younger generation. The birth and rearing of a baby present varying challenges. Moreover, taking responsibility for and dealing with the demands of dependent children are challenging for most families when financial resources are stretched and the parents are heavily involved in career development. The disposition of child-care responsibilities and household chores in dual-career households is a particular struggle. We have found that men and women often differ in the coping strategies they use to deal with this issue. Women with young children tend to use cognitive restructuring, delegation, limiting of avocational activities, and social support significantly more often than do men. The work-family issue of juggling child care and other household accountabilities is a social problem to be dealt with by the couple, not a “woman’s problem” for her to struggle with alone.

Tasks

1. Adjustment of couple system to make space for children. The couple must continue to meet each other’s personal needs as well as their parental responsibilities. With the introduction of the first child, challenges for personal space, sexual and emotional intimacy, and socializing exist. Both mothers and fathers are increasingly aware of the need for emotional integration of the child into the family. Children can be brought into three types of environments: (1) there is no space for them, (2) there is space for them, or (3) there is a vacuum that they are expected to fill. If the child has a disability, the couple may face more stress as they adjust their expectations and deal with their emotional reactions. We have found that normal family processes in couples becoming parents include shifts in the sense of self, shifts in relationships with families of origin, shifts in relation to the child, changes in stress and social support, and changes in the couple.

2. Collaboration in child-rearing and financial and housekeeping tasks. The couple must find a mutually satisfying way to deal with child-care responsibilities and household chores that does not overburden one partner. Balancing the budget and juggling family and other responsibilities is a
major task. The emotional and financial cost of solutions to deal with child-care responsibilities must be addressed. Parents contribute to the child’s development and can do so in different or similar ways. Physical and playful stimulation of the child complements verbal interaction. Parents can either support or hinder their children’s success in developing peer relationships and doing well academically at school. Some families, responding to intense pressure from the school system, tend to stress the values of academic achievement and productivity, whereas other families may respond to this pressure with feelings of alienation. Recent immigration experiences and whether the children are documented or undocumented can also influence peer and school interaction.

3. Realignment of relationships with extended family to include parenting and grandparenting roles. The parents must design and develop their new parenting roles in addition to the marital role rather than replacing it. Members of each family of origin also take on new roles, for example, grandfather or aunt. In some cases, grandparents who perhaps were opposed to the marriage in the beginning become very interested in the young children. For many older adults, this is an especially gratifying time because it allows them to have intimacy with their grandchildren without the responsibilities of parenting. It also permits them to develop a new type of adult-adult relationship with their children. Opportunities for intergenerational support or conflict abound as expectations about child-rearing and health-care practices are expressed.

4. Realignment of relationships with community and larger social system to include new family structure and relationships.

Attachments

Parents need to maintain a marital bond and continue personal, adult-centered conversations in addition to child-centered conversations. Space for privacy and time spent together are important needs.

Children require security and warm attachments to adults, as well as opportunities to develop positive sibling relationships. We believe teaching interdependence is a central goal of parenting, helping children see themselves as part of a community and living cooperatively with others.

In Figure 3-14, sample attachment diagrams are given for this phase. A competitive, negative relationship (illustrated by the wavy line) exists between the children and spouses in the second diagram. The mother is overbonded to the daughter, and the father is underinvolved with the daughter. The father is overattached to the son, and the mother is underinvolved with the son. This is an example of same-sex coalitions existing cross-generationally.

Questions to Ask the Family.

- “What percentage of your time do you spend taking care of your children?”
- “What percentage do you spend taking care of your marriage? Is this a comfortable balance for the two of you?”
Phase Four: Families With Adolescents

This period has often been characterized as one of intense upheaval and transition, in which biological, emotional, and sociocultural changes occur with great and ever-increasing rapidity. Peers; Internet technology, such as instant messaging, social media, pornography, and sports; and other activities all compete for the adolescent’s attention. This stage is highly influenced by socioeconomic level. Adolescence can begin early within poor, inner-city, or rural communities where, at a very young age, children are often faced with pressures related to sexuality, household responsibility, drugs, and alcohol use. In many middle-class families, adolescence can last well into the young adult’s 20s and 30s, with the young person being financially dependent on the parents and continuing to live in the family home.

Tasks

1. Shift in parent-child relationships to permit adolescent to have more independent activities and relationships and to move more flexibility into and out of system. The family must move from the dependency relationship previously established with a young child to an increasingly independent relationship with the adolescent. Growing psychological independence is frequently not recognized because of continuing physical dependence. Conflict often surfaces when a teenager’s independence threatens the family. For example, teenagers may precipitate marital conflict when they question who makes the family rules about the car: Mom or Dad? Families frequently respond to an adolescent’s request for increasing autonomy in two ways: (1) they abruptly define rigid rules and recreate an earlier stage of dependency, or (2) they establish

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**Figure 3-14** Sample attachments in phase three.
premature independence. In the second scenario, the family supports only independence and ignores dependent needs. This may result in premature separation when the teenager is not really ready to be fully autonomous. The teenager may thus return home defeated. Parents need to shift from the parental role of “protector” to that of “preparer” for the challenges of adulthood. The challenge for parents to shift responsibility to their teens in a balanced way is often complicated if there are health problems.

2. Families helping emerging adolescents negotiate relationship with community.

3. Refocus on midlife couple and career issues. During this stage, parents are often struggling with what Erickson (1963) calls generativity, the need to be useful as a human being, partner, and mentor to another generation. The socially and sexually maturing teenager’s frequent questioning and conflict about values, lifestyles, career plans, and so forth can thrust the parents into an examination of their own marital and career issues. Depending on many factors, including cultural and gender expectations, this may be a period of positive growth or painful struggle for men and women.

4. Begin shift toward caring for older generation. As parents are aging, so too are the grandparents. Parents (especially women) sometimes feel that they are besieged on both sides: teenagers are asking for more freedom, and grandparents are asking for more support. With the trend of women having children later in life and seniors living longer, this double demand for attention and resources most likely will intensify. Celebrating the wisdom of seniors and intergenerational reciprocity are key tasks.

Attachments

All family members continue to have their relationships within the family, although teenagers become increasingly more involved with their friends than with family members. These transitions through the family life cycle can be stressful because they challenge attachment bonds among family members. We advocate open communication and the addressing of primary emotions. A decrease in parental attachment is normative and developmentally appropriate for adolescents. The young person’s widening social network, however, does not preclude strong family relationships, although family relationships are altered. The husband and wife need to reinvest in the marital relationship while this is taking place.

An example of an attachment pattern is illustrated in Figure 3-15. In the second diagram, the mother is overinvolved with the eldest son and has a negative relationship with the husband. The father tends to be minimally involved with all family members. There is conflict between the two sons.

Questions to Ask the Family.

- “What privileges do your teenagers have now that they did not have when they were younger?”
Ask the adolescents:

- “How do you think your parents will handle it when your younger sister, Nena, wants to date? Will it be different from when you wanted to date?”
- “On a scale of 1 to 10, with 10 being the highest, how much confidence do your parents have in your ability to say no to marijuana?”

Phase Five: Launching Children and Moving On at Midlife

Many middle-class North Americans whose children are grown up used to assume they would have an empty nest. However, this expectation is in the process of change. Adult children may return to the family home after graduating from college; they may return, along with their children, after their marriages end; or they may never have moved out. Rising housing costs and beginning pay rates that have not risen as fast as those of more experienced workers have been singled out as some of the causes of this trend. A different explanation is that young North Americans are having difficulty growing up and are unwilling to go out on their own and settle for less affluence than their parents afford them.

Tasks

1. Renegotiation of couple system as a dyad. In many cases, a thrust to alter some of the basic tenets of the marital relationship occurs. This is especially true if both partners are working and the children have left home. The couple bond can take on a more prominent position. The balance between dependency, independency, and interdependency must be re-examined.

2. Development of adult-to-adult relationships between parents and grown children. The family of origin must relinquish the primary roles of parent and child. They must adapt to the new roles of parent and adult child. This involves renegotiation of emotional and financial commitments. The key emotional process during this stage is for family members to deal with a multitude of exits from and entries into the family system.
3. Realignment of relationships to include in-laws and grown children. The parents adjust family ties and expectations to include their child’s spouse or partner. This can sometimes be particularly challenging if the parents’ expectation is for a heterosexual son-in-law or daughter-in-law of the family’s race, religion, and ethnicity and the child chooses someone different. The once-prevalent idea that the time after a grown child marries is a lonely, sad time, especially for women, has been replaced. Increases in marital satisfaction have frequently been noted.

4. Realignment of relationships with community to include new constellation of family relationships.

5. Exploration of new interests/career, given the freedom from child care responsibilities.

6. Dealing with health needs, disabilities, and death of parents (grandparents). Many families regard the disability or death of an elderly parent as a natural occurrence. It can be a time of relishing and finding comfort in the happy memories, wisdom, and contributions of the elder. If, however, the couple and the elderly parents have unfinished business between them, there may be serious repercussions, not only for the children but also for the new third generation. The type of disability afflicting the seniors determines the effects on the immediate family. For example, caregivers who do not understand Alzheimer dementia and its effects on cognitive function and behavior often attempt to deal with inappropriate or disruptive behavior in ineffective and counterproductive ways. Thus, they inadvertently intensify their own stress.

We recommend that health professionals, in addition to attending to the family’s multigenerational legacies of illness, loss, and crisis, also note intergenerational strengths and wisdom. Tracking key events, transitions, and coping strategies helps elicit resiliencies.

Attachments

Each family member continues to have outside interests and establish new roles appropriate to this phase. Sample attachment patterns are illustrated in Figure 3-16. A problem may arise when both husband and wife hold on...
to their last child. They may avoid conflict by allowing the eldest child to leave home and then focusing on the next child.

Questions to Ask the Family.
- “How did your parents help you to leave home?”
- “What is the difference between how you left home and how your son, Zubin, is leaving home?”
- “Will your parents get along better, worse, or the same with each other once you have left home?”
- “Who, between Mom and Dad, will miss the children the most?”
- “As you see your child moving on with a new relationship, what would you like your child to do differently than you did?”
- “If your parents are still alive, are there any issues you would like to discuss with them?”

Phase Six: Families in Later Life
This stage can begin with retirement and last until the death of both spouses. It is hard to say, however, when the stage actually begins for each family because it is dependent on social, economic, and personal factors relative to each family. Potentially, this stage can last 20 to 30 years for many couples. Key emotional processes in this stage are to flexibly adjust to the shift of generational roles and to foster an appreciation of the wisdom of the elders.

Tasks
1. Maintaining or modifying own and/or couple and social functioning and interests in the face of physiological decline: exploration of new familial and social role options. Marital relationships continue to be important, and marital satisfaction contributes to both the morale and ongoing activity of both spouses. We have noted that the husband’s morale is often strongly associated with health, socioeconomic status, income, and to a lesser extent, family functioning. The wife’s morale is most strongly associated with family functioning and, to a lesser extent, with health and socioeconomic status.

As the couple in later life find themselves in new roles as grandparents and mother-in-law and father-in-law, they must adjust to their children’s spouses and open space for the new grandchildren. Difficulty in making the status changes required can be reflected in an older family member refusing to relinquish some of his or her power, for example, refusing to turn over a company or make plans for succession in a family business. The shift in status between the senior family members and the middle-aged family members is a reciprocal one. Difficulties and confusion may occur in several ways. Older adults may give up and become totally dependent on the next generation, the next generation may not accept the seniors’ diminishing powers and may continue to treat them as totally competent, or the next generation may see only the seniors’ frailties and may treat them as totally incompetent.
2. Supporting more central role of middle generations.
3. Making room in the system for the wisdom and experience of the elders. The task of supporting the older generation without overfunctioning for them is particularly salient because, in general, people are living longer. It is not uncommon for a 90-year-old woman to be cared for by her 70-year-old daughter, with both of them living in close proximity to a 50-year-old son and grandson. The “young-old” age group, those between 55 and 75 years of age, are often highly motivated to participate in self-help groups and are generally interested in improving their quality of life through counseling, traditional and alternative health activities, and education. Many have found “new” family connections through the use of e-mail, social media, and cell phones. They do not live by the aging myths of the past. Rather, as consumers, they expect and demand a good quality of life. Many grandparents continue to be involved in child-rearing.
4. Supporting older generations without overfunctioning for them.

Attachments
The couple reinvests and modifies the marital relationship based on the level of functioning of both partners. This phase is characterized by an appropriate interdependence with the next generation. The concept of interdependence is particularly important for nurses to understand when working with families with adult daughters and their parents. Middle-class older men and women seem equally likely to aid and support their children, especially daughters. Frequency of contact, however, tends to be higher with daughters than with sons. Thus, the possibility of strong intergenerational attachments between a daughter and her parents exists. In the attachment patterns illustrated in Figure 3-17 and shown previously in Figure 3-16, the couple project their conflicts onto the extended family. This causes difficulty for the succeeding generations.

Questions to Ask the Family.
- “When you look back over your life, what aspects have you enjoyed the most?”

![Figure 3-17](image-url) Sample attachments in phase six.
“What has given you the most happiness?”
“About what aspects do you feel the most regret?”
“What would you hope that your children would do differently than you did? Similarly to what you did?”
“As your health is declining, what plans have you and your daughter, Aminah, made for her because of her schizophrenia?”

Phase Seven: Families Nearing the End of Life

During this phase, one has to deal with the realities of family member’s limitations and death and completion of one cycle of life.

1. Dealing with loss of spouse, siblings, and other peers. This is a time for life review and taking care of unfinished business with family as well as with business and social contacts. Many people find it helpful to discuss their lives, review life events, and enjoy the opportunity of passing this information along to succeeding generations.

2. Making preparation for death and legacy.

3. Managing reversed roles in caretaking between middle and older generation.

4. Realignment of relationships with larger community and social system to acknowledge changing life cycle relationships.

Divorce and Post-Divorce Family Life Cycle

Many changes in marital status and living arrangements are prevalent in North America today, such as increased divorce rates and single-parent families. Whether divorce rates or the number of single-parent families will level off, climb, or decline is a matter of speculation that can be backed up by various theories. Families experiencing divorce are often under enormous pressure. Single-parent families, whether a result of divorce or unmarried parents separating, must accomplish most of the same developmental tasks as two-parent families but without all the resources. This places extra burdens on the remaining family members, who must compensate with increased efforts to accomplish family tasks such as physical maintenance, social control, and tension management. We caution nurses, however, not to assume that single-parent status alone will influence family functioning. We have found that family composition alone is too broad a variable to predict health outcomes, and we recommend a focus on more specific variables such as parental cooperation in parenting following divorce.

Single-parent households generally experience challenges in managing shortages of time, money, and energy. Some parents voice serious concerns about the failure to meet perceived family and societal expectations for living “in a normal family” with two parents. Some women feel they must display behaviors that are contradictory to those they assume they should exhibit if they were to remarry. They perceive ongoing pressure from family, friends, and possibly their faith community to marry again to give their children a “normal” family. These women report being caught in a double-bind, trying to demonstrate behaviors...
such as compliance that might attract a new husband while trying to use seemingly opposing behaviors such as assertiveness to successfully manage their lives. We encourage nurses working with single-parent families to explore the parent's feelings about opposing expectations. This is a way of helping these parents plan their responses to various paradoxical situations.

It is also important for nurses engaged in relational family nursing practice to focus on the positive changes experienced by many separated spouses. Separated women often use growth-oriented coping, such as becoming more autonomous and furthering their education, and experience positive changes, such as increased confidence and feelings of control, in the post-separation phase.

Resilience in the post-divorce period is another focus for nurses. Resilience commonly depends on the ability of parents and children to build close, constructive, mutually supportive relationships that play a significant role in buffering families from the effects of related adversity. Factors that promote resiliency and positive adjustment to divorce include those associated with children's living arrangements. Whether family relationships post-divorce improve, remain stable, or get worse is dependent on a complex interweaving of many factors.

In our clinical supervision with nurses, we encourage focusing on the siblings, a subsystem that generally remains undisrupted during the process of family reorganization. Siblings are often the unit of continuity. We also try to notice and support cooperative post-divorce parenting environments such as mutual parental support; teamwork; clear, flexible boundaries; high information exchange; constructive problem solving; and knowledgeable, experienced, involved, and authoritative parenting. Because many fathers are not used to taking care of their children without their wives orchestrating things, fathers often fade out of their children's lives. They want to avoid ex-wives and conflict and may feel uncomfortable if they have an unclear role of authority in their children's lives. Nurses can be extremely helpful in intervening in these situations and fostering mutually agreeable post-divorce arrangements for the benefit of the children. For families locked in intractable disputes, we encourage them to develop a good-enough climate in which parents maintain distance from one another and conflict and triangulation are minimized.

Divorce may occur at any stage of the family life cycle and with any family, irrespective of socioeconomic status, ethnicity, or race. However, it has a different impact on family functioning depending on its timing and the diversity of individuals involved in the process. The marital breakdown may be sudden, or it may be long and drawn out. In either case, emotional work is required so that the family may deal with the shifts, gains, and losses in family membership. Some additional phases involved in divorce and post-divorce are depicted in Table 3-2. Column 1 lists the phase. Column 2 gives the prerequisite attitudes that will assist family members to make the transition and come through the developmental issues listed in column 3 en route to the next phase. We believe that clinical work directed at column 3 will not succeed if the family is having difficulty dealing with the issues in column 2.
## TABLE 3-2

The Developmental Tasks for Divorcing and Remarrying Families

<table>
<thead>
<tr>
<th>PHASE</th>
<th>TASK</th>
<th>PREREQUISITE ATTITUDE TRANSITION</th>
<th>DEVELOPMENTAL ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce</td>
<td>Decision to divorce</td>
<td>Acceptance of inability to resolve marital problems sufficiently to continue relationship</td>
<td>Acceptance of one's own part in the failure of the marriage</td>
</tr>
<tr>
<td></td>
<td>Planning breakup of the system</td>
<td>Supporting viable arrangements for all parts of the system</td>
<td>a. Working cooperatively on problems of custody, visitation, and finances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. Dealing with extended family about the divorce</td>
</tr>
<tr>
<td>Separation</td>
<td>a. Willingness to continue cooperative co-parental relationship and joint financial support of children</td>
<td>a. Mourning loss of original family; b. Restructuring marital and parent–child relationships and finances; adaptation to living apart c. Realignment of relationships with extended family; staying connected with spouse’s extended family</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>b. Working on resolution of attachment to spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-divorce family</td>
<td>Single parent (custodial household or primary residence)</td>
<td>Willingness to maintain financial responsibilities, continue parental contact with ex-spouse, and support contact of children with ex-spouse and his or her family</td>
<td>a. Making flexible visitation arrangements with ex-spouse and family b. Rebuilding own financial resources c. Rebuilding own social network</td>
</tr>
</tbody>
</table>
### TABLE 3-2 The Developmental Tasks for Divorcing and Remarrying Families—cont’d

<table>
<thead>
<tr>
<th>PHASE</th>
<th>TASK</th>
<th>PREREQUISITE ATTITUDE TRANSITION</th>
<th>DEVELOPMENTAL ISSUES</th>
</tr>
</thead>
</table>
| Single parent (non-custodial)|                           | Willingness to maintain financial responsibilities and parental contact with ex-spouse and to support custodial parent’s relationship with children | a. Finding ways to continue effective parenting  
b. Maintaining financial responsibilities to ex-spouse and children  
c. Rebuilding own social network |
| Remarriage                   | Entering new relationship| Recovery from loss of first marriage (adequate emotional divorce)       | Recommitment to marriage and to forming a family with readiness to deal with the complexity and ambiguity |
| Conceptualizing and planning new marriage and family | Accepting one’s own fears and those of new spouse and children about forming new family  
Accepting need for time and patience for adjustment to complexity and ambiguity of:  
1. Multiple new roles  
2. Boundaries: space, time, membership, and authority  
3. Affective issues: guilt, loyalty conflicts, desire for mutuality, unresolvable past hurts | a. Working on openness in the new relationships to avoid pseudo-mutuality  
b. Planning for maintenance of cooperative financial and coparental relationships with ex-spouses  
c. Planning to help children deal with fears, loyalty conflicts, and membership in two systems  
d. Realignment of relationships with extended family to include new spouse and children  
e. Planning maintenance of connections for children with extended family of ex-spouses |

*Continued*
Wright and Leahey’s Nurses and Families: A Guide to Family Assessment and Intervention

### TABLE 3-2

The Developmental Tasks for Divorcing and Remarrying Families—cont’d

<table>
<thead>
<tr>
<th>PHASE</th>
<th>TASK</th>
<th>PREREQUISITE ATTIITUDE TRANSITION</th>
<th>DEVELOPMENTAL ISSUES</th>
</tr>
</thead>
</table>
| Remarriage and reconstruction of family | Resolution of attachment to previous spouse and ideal of original family; Acceptance of different model of family with permeable boundaries | a. Restructuring family boundaries to allow for inclusion of new spouse-stepparent  
b. Realignment of relationships and financial arrangements to permit interweaving of several systems  
c. Making room for relationships of all children with all parents, grandparents, and other extended family  
d. Sharing memories and histories to enhance stepfamily integration. | |
| Renegotiation of remarried family at all future life cycle transitions | Accepting evolving relationships of transformed remarried family | a. Changes as each child graduates, marries, dies, or becomes ill  
b. Changes as each spouse forms new couple relationship, remarries, moves, becomes ill, or dies | |


Questions to Ask the Family.

- “How do you explain to yourself the reasons for your divorce?”
- “Who initiated the idea of divorce? Who left whom?”
- “Who was most supportive of developing viable arrangements for everyone in the family? How did your ex-husband, Luis, show his willingness to continue a cooperative co-parental relationship with you? How did you respond to this?”
- “As you changed your attachment to Luis, what changes did you notice in your children? What would your in-laws say about how you have fostered your children’s relationship with them? What would your children say?”
“What methods have you found most successful in resolving conflicting issues with Luis? What advice would you give to other divorced parents on how to resolve conflictual issues with their ex-partners?”

“How have your children helped you and your ex-spouse to maintain a supportive environment for them?”

Remarried Family Life Cycle

The family emotional process at the transition to remarriage consists of struggling with fears about investment in new relationships: one’s own fears, the new spouse’s fears, and the fears of the children (of either or both spouses). It also consists of dealing with hostile or upset reactions of the children, extended families, and ex-spouse. Unlike biological families, in which family membership is defined by bloodlines, legal contracts, and spatial arrangements and is characterized by explicit boundaries, the structure of a stepfamily is less clear. Nurses must address the ambiguity of the new family organization, including roles and relationships.

We have found it helpful to use attachment theory as a framework for conceptualizing the impact of structural change and loss on stepfamily adjustment. We believe nurses can assist stepfamilies in increasing emotional connectivity and stability.

Ahrons and Rodgers (1987) have advocated for models of healthy, well-functioning binuclear families. Having been angered by a predominant emphasis on pathology in the divorce literature, Ahrons began to study what she calls “binuclear families.” This term not only refers to joint-custody families or to families in which the relationship between ex-spouses is friendly but indicates a different familial structure, without inferring anything about the nature or quality of the ex-spouses’ relationship. Ahrons (1999) advocates a normative process model of divorce rather than focusing on evidence of pathology or dysfunction.

We encourage nurses working with divorced and remarried families to bring to their patients research knowledge of what works and does not work to foster continuing family relationships. Nurses should be cautious, however, because complex problems seldom have simple answers. For example, predictors such as a child’s age and gender, the frequency and regularity of father/mother-child visitation, father/mother-child closeness, and the effect of parental legal conflict on the child’s self-esteem have different implications for different groups of 6- to 12-year-old children and for children in different situations.

We also encourage nurses working with stepfamilies to increase their knowledge about stepfamily issues and respect the uniqueness of complex stepfamily life. We encourage nurses to educate themselves about the beliefs of a particular stepfamily because uninformed clinicians may unwittingly increase rather than decrease family tensions if they communicate to stepfamilies that they should be like biological families.
Questions to Ask the Family.

- “Reeves, what were the differences between you and your wife, Lily, in how you each successfully recovered from your first marriage?”
- “What most helped each of you deal with your own fears about remarriage? About forming a stepfamily?”
- “How did Lily invite your children to adjust to her?”
- “What do your children think was the most useful thing you did in helping them deal with loyalty conflicts?”
- “What advice do you have for other stepfamilies on how to create a new family?”
- “What are you most proud of in how you have helped your stepfamily successfully make the transition from what they were before to what they are now?”

Professional and Low-Income Family Life-Cycle Stages

We align with Madsen (2013), who uses the term “families living in poverty” and who states that progression throughout the family life-cycle phases is often more accelerated for those families living in poverty than for those in working-class and middle-class families. As such, the family life cycle of families living in poverty can be organized into three stages (McGoldrick et al, 2016):

Stage 1: Adolescence and emerging adulthood
Stage 2: Coupling and raising young children
Stage 3: Families in later life

We encourage nurses to consider the effects of ethnicity and religion, socioeconomic status, race, and environment on when and how a family makes transitions in its life cycle. This is especially important in relational family nursing practice in primary care.

Adoptive Family Life Cycle

In adoption, the family boundaries of all those involved are expanded. Reitz and Watson (1992) define adoption as

a means of providing some children with security and meeting their developmental needs by legally transferring ongoing parental responsibilities from their birth parents to their adoptive parents; recognizing that in so doing we have created a new kinship network that forever links those two families together through the child, who is shared by both. (p. 11)

We agree with this definition. As with marriage, the new legal status of the adoptive family does not automatically sever the psychological ties to the earlier family. Rather, family boundaries are expanded and realigned. We believe that nurses should be aware of the trends and special circumstances in forming adoptive families. For example, most agencies offer adoption services
along a continuum of openness. Some potential benefits of open adoption for birth parents include increased empathy for adoptive parents, reassurance that the child is safe and loved, and a reduction of shame and guilt. For adoptive parents, benefits include increased empathy for the birth parents, reduced stress imposed by secrecy and the unknown, and an embracing from the start of an affirmative acceptance of the child’s cultural heritage. For the child, benefits include increased empathy for the adoptive parents, enriched connections with them, and reduced stress of disconnection. Simultaneously, the child experiences increased empathy for the birth parents, a reduction in fantasies about them, and—with clear, consistent information—increased control in dealing with adoptive issues. We believe that these potential benefits are very significant, especially for families adopting babies from different cultures and races. Adoptive families can include divorced, single-parent, married, or remarried families as well as extended families and families with various forms of open dual parentage.

The adoption process, including the decision, application, and final adoption, can be a stressful as well as joyful experience for many couples. During the preschool developmental phase, the family must acknowledge the adoption as a fact of family life. The question of the permanency of the relationship sometimes arises from both the child and the parents. In our clinical work with adoptive families, we have found it useful to consider many aspects of the adoption, including the following:

1. Genetic, hereditary factors in the child
2. Deficiencies in the child’s prenatal and perinatal care
3. Adverse circumstances of adoption, including the child’s having had multiple disruptions in early life
4. Conditions in the adoptive home, including pre-existing and current family resiliencies, problems, and strengths
5. Temperamental similarities and differences between the adoptee and the adoptive parents or family
6. Fantasy system and communication regarding adoption, including parental attitudes about adoption
7. Difficulties establishing a firm sense of identity during adolescence
8. Greater age difference than usual between parents and adoptees

We believe that it is important in relational family nursing practice to recognize adoptive families’ strengths and resources as they deal with challenging issues. During the adolescent stage of family development, a major task is to increase the flexibility of family boundaries. In adoptive families, altercations may give rise to threats of desertion or rejection. During the young adult or launching phase, the young adult may “adopt” the parents in a recontracting phase.

As the adopted child proceeds to develop his or her own family of procreation, the integration of the adoptee’s biological progeny can be a developmental challenge for everyone. Adoptive parents may be delighted with the
psychological and social continuity. Simultaneously, they may mourn the loss of biological grandchildren and the pain of genealogical discontinuity. For the adoptee, reproduction includes the thrill of a biological relationship and possibly some fears of the unknowns in their own genetic history.

We believe that nurses can play an important role in helping families navigate the complexities of the adoption process and life cycle. When complexity is accepted, when the losses are acknowledged and resolved, when parents and their children feel satisfied with adoption as a legitimate route to becoming a family, and when the community of family, friends, and professionals who surround them is affirming, then the outcomes for adoptive families are very positive.

Lesbian, Gay, Bisexual, Queer, Intersex, Transgender, Twin-Spirited Family Life Cycles

Until recently, popular culture has ignored LGBQITT people in couple or family relationships or has portrayed them as part of an invisible subculture. Much of what we see, read, and hear in the media and society at large expresses a patriarchal, Anglo-Saxon, white, Christian, male, middle-class, ableist, and heterosexual view of the world. More recently, with open discussion about same-sex marriage or union, more attention is being focused on these relationships and their structures, developmental life cycles, challenges, strengths, and issues. We believe that the popular family life-cycle model may not apply to lesbians and gays because it is based on the notions that child-rearing is fundamental to family and that blood and legal ties constitute criteria for definition as a family.

Furthermore, the transmission of norms, rituals, folk wisdom, and values from generation to generation is not typically associated with lesbian and gay life. In many cases, the family of origin may not know what name to call their daughter’s partner or spouse.

We believe, however, that more differences exist within traditionally defined families than between LGBQITT families and those families designated as traditional. There are also many differing beliefs within diverse couples. For many clinicians, sexual nonexclusivity challenges fundamental beliefs. Our view of family life is socially constructed, as is the view held by each nurse. Managing multiple views of relationships is an important task for nurses working with families.

The stages of the traditional family life cycle can be applied to lesbians and gays, with some unique differences. During adolescence, which can be a tumultuous time for most families, gays and lesbians face similar identity and individuation tasks as heterosexuals but often without the support of such rituals as proms or “going steady.” Parents frequently struggle more with parenting to “protect” than to “prepare” the young person to live in a homophobic social environment.

The stages of leaving home, single young adulthood, and coupling present challenges for the young person who needs to learn from the
gay/lesbian world about dating and cannot rely on the family of origin for modeling in this area. Couch-surfing and seeking hospitality from friends’ parents, LGBTQITT-friendly shelters, and transitional living programs are examples of the living-arrangement options for what some have called “throwaway” youth (i.e., LGBTQITT youth in crisis). These are young people who have “come out” to their families and were then pushed out of the family home.

In discussing their same-sex relationship with their parents, many lesbian and gay couples have found it useful to focus on the strengths of their relationship. When parents see that the relationship has such strengths and can be beneficial for their son or daughter, they often adjust more easily. Dealing with the core issues of coupling—money, work, and sex—involves addressing gender scripts. During midlife and later life, the LGBTQITT family continues to adapt and renegotiate with their families of origin. These relationships may be influenced by illness within either the aging family or the midlife chosen family. Intergenerational responsibility for caregiving and legacy issues may need to be addressed. We believe nurses engaged in relational practice can be helpful in providing a context for these conversations between family members.

We recommend an oppression-sensitive approach to working with LGBTQITT families. This approach invites a stance of respectful curiosity for exploring domains of convergence and difference.

Questions to Ask the Family.

- “In what area do you feel privileged? Oppressed?”
- “How do you as a couple deal with these similarities and differences?”
- “How does the more privileged one respond to the other’s sense of oppression?”
- “How does each member of the couple deal with heterosexism? With your families of origin? With the dominant gay culture?”
- “What are your strengths as a couple?”
- “How does spirituality influence your relationship?”

We encourage nurses to avoid the alpha bias of exaggerating differences between groups of people and the beta bias of ignoring differences that do exist. In their privileged role in working with families who are dealing with health issues, nurses can play a significant part in modeling inclusivity and respect for diversity.

In this CFAM developmental category, we have presented six sample types of family life cycles. Nursing is beginning to recognize the special characteristics of diverse family forms, such as lesbian and gay couples. We encourage nurses to broaden their perspectives when interacting with various family forms. What we do know is that great variety exists: the poor and homeless family, the lesbian or gay couple, the single parent, the adopted child with parent, the stepfamily, the divorced family, the separated family, the foster family, the nuclear family, the extended family, the household of children raising children without a parent present, and so forth.
FUNCTIONAL ASSESSMENT

The family functional assessment deals with how individuals actually behave in relation to one another. It is the here-and-now aspect of a family’s life that is observed and that the family presents. There are two basic aspects of family functioning:

- Instrumental
- Expressive

KEY CONCEPT DEFINED

Functional Assessment

One of the categories of the Calgary Family Assessment Model (CFAM) that nurses use to identify how individuals actually behave in relation to one another; the here-and-now aspect of a family’s life that is observed and that the family presents.

Instrumental Functioning

The instrumental aspect of family functioning refers to routine activities of daily living, such as eating, sleeping, preparing meals, giving injections, changing dressings, and so forth. For families with health problems, this area is particularly important. The instrumental activities of daily life are generally more numerous and more frequent and take on a greater significance because of a family member’s illness.

Examples:

- A quadriplegic requires assistance with almost every instrumental task.
- If a baby is attached to an apnea monitor, the parents almost always alter the manner in which they take care of instrumental tasks. (For instance, one parent will leave the apartment to do a load of wash only if the other parent is sufficiently awake to attend to the infant.)
- If a senior family member is unable to distinguish what medication to take at a specific time, other family members often alter their daily routines to telephone or drop in on the senior.

The interaction between instrumental and psychosocial processes in clients’ lives is an important consideration for nurses. For example, nurses can pay attention to a family’s routines around eating and bedtime rituals and incorporate new health-care practices into the family’s routine rather than “adding on” to the family’s already busy schedule.

We recommend that health professionals understand that caregiving, whether given to a spouse who has cancer by an elderly spouse or to a...
parent by his or her partner, constitutes a major challenge in adaptation. Elderly spouses often rate the overall burden of caregiving and personal strain (the subjective component) as heavier than do their children and the cancer patients themselves. The importance of family nursing care is thus highlighted.

As the nurse hypothesizes about the family’s possible stage of health and illness and inquires into their ordinary routines of living alongside illness, the nurse and family will discover resiliencies and areas for possible assistance. Effective assistance consists of a series of events rather than single interactions. The trajectory of cardiac illness, for instance, suggests that interventions may be most effective when provided during all stages of illness and may best be tailored to meet the specific needs of individuals and families in each stage.

**Expressive Functioning**

The expressive aspect of functioning refers to nine categories:

1. Emotional communication
2. Verbal communication
3. Nonverbal communication
4. Circular communication
5. Problem solving
6. Roles
7. Influence and power
8. Beliefs
9. Alliances and coalitions

These nine subcategories are derived in part from the Family Categories Schema developed by Epstein, Sigal, and Rakoff (1968) and later published by Epstein, Bishop, and Levin (1978). These categories were expanded by Tomm (1977) and later published by Tomm and Sanders (1983). Early work (Westley & Epstein, 1969) suggested that several of these categories distinguished emotionally healthy families from those that were experiencing more than the usual emotional distress.

We have expanded on these works in our earlier editions of *Nurses and Families* to include nonverbal and circular communication, beliefs, and power. However, we do not use any of these categories as determinants of whether a family is emotionally healthy. Rather, it is the family’s judgment of whether they are functioning well that is most salient. With the exception, of course, of issues such as violence and abuse, we encourage nurses to find ways to support the family’s definition of health versus imposing their own definition on the family.

Before discussing each subcategory, we would like to point out that most families must deal with a combination of instrumental and expressive issues.

**Example:** A 79-year-old woman has a burn. The instrumental issues revolve around dressing changes and an exercise program. The expressive
or affective issues might center on roles or problem solving. The family might be considering the following questions:

- “Whose role is it to change Gram’s dressing?”
- “Are women better ‘nurses’ than men?”
- “Whose turn is it to call the physical therapist?”
- “Why is it that Jas never gets involved in Gram’s care?”
- “How can we get Jas to drive Gram to her doctor’s visit?”

If a family is not coping well with instrumental issues, expressive issues almost always exist. However, a family can deal well with instrumental issues and still have expressive or emotional difficulties. Therefore, it is useful for the nurse and the family together to delineate the instrumental from the expressive issues. Both need to be explored when the nurse and the family have a conversation about family functioning.

Although both past behaviors and future goals are taken into consideration in the functional assessment, the primary focus is on the here and now. It is helpful for both the nurse and family to identify a family’s strengths and limitations in each of the aforementioned subcategories. We find it helpful to remember that the very conversation the nurse and family have about the family system shapes that system. People continually and actively reauthor their lives and stories. Our commitment to families is to show curiosity, delight, interest, and appreciation for their resiliency. Naturally, this does not mean that we condone family violence or abuse. Rather, it means that we recognize that families are trying to make sense of their lives and stories. Our job is to witness this.

Patterns of interaction are the main thrust of the expressive part of the functional assessment category. Families are obviously composed of individuals, but the focus of a family assessment is less on the individual and more on the interaction among all of the individuals within the family. Thus, the family is viewed as a system of interacting members. In conducting this part of the family assessment, the nurse operates under the assumption that individuals are best understood within their immediate social context. The nurse conceives of the individual as defining and being defined by that context. Each individual’s relationships with family members and other meaningful members of the larger social environment are thus very important. If we do not attend to ideas and practices at play in the larger social context, we run the risk of focusing too narrowly on small, rather tight, recursive feedback loops. We have found this to be especially important considering current social, political, environmental, and economic trends because families may struggle to adapt to constant changes.

By interviewing family members together, the nurse can observe how they spontaneously interact with and influence each other. Furthermore, the nurse can ask questions about the impact family members have on one another and on the health problem. Reciprocally, the nurse can inquire about the impact of the health problem on the family. If the nurse thinks “interactionally” rather than “individually,” each individual family member’s behavior will not be considered in isolation but rather will be understood in context.
It is important for nurses to remember that if they embrace a postmodernist worldview, they will not be able to conduct an objective family evaluation. Rather, the nurse and the family, in talking about the family’s patterns of interacting, will bring forth a new story, rich in contextualized details. Particular attention is paid to the ways that even the small and the ordinary—single words, single gestures, minor asides, trivial actions—can provide opportunities for generating new meanings. Unlike modernist nurses who define themselves as separate from the family with whom they are working, nurses with postmodernist views assume that each participant in the family interview—wife, husband, partner, nurse—makes an equal and often different contribution to the process. It is the nurse’s task to help family members engage in conversations to make sense of their lives rather than to explain their behavior.

**Emotional Communication**

This subcategory refers to the range and types of emotions or feelings that families express or the practitioner observes. Families generally express a wide spectrum of feelings, from happiness to sadness to anger, whereas families with difficulties commonly have quite rigid patterns within a narrow range of emotional expression. For example, some families experiencing difficulties almost always argue and rarely show affection. In other families, parents may express anger but children may not, or the family may have no difficulty with women expressing tenderness but feel that men are not permitted to express it.

**Questions to Ask the Family.**

- “Who in the family tends to start conversations about feelings?”
- “How can you tell when your dad is feeling happy? Angry? Sad? How about your mom? What effect does your anger have on your son Noah?”
- “What does your mom do when your dad is angry?”
- “If your grandmother were to express sadness about her upcoming chemotherapy to your parents, how do you think your parents would react?”
- “When your brother Henry was killed in the accident, what most helped your family to cope with the grief?”

**Verbal Communication**

This subcategory focuses on the meaning of an oral (or written) message between those involved in the interaction. That is, the focus is on the meaning of the words in terms of the relationship.

Direct communication implies that the message is sent to the intended recipient. An elderly woman may be upset by what her husband is saying but corrects her grandson’s inconsequential fidgeting with the comment, “Stop doing that to me.” This could represent a displaced message, where-as the same statement directed at her husband would be considered direct.
Another way of looking at verbal communication is to distinguish between clear versus masked messages. In a clear message, there is a lack of distortion in the message. A father’s statement to his child, “Children who cry when they get needles are babies” may be masked criticism if the child is fighting back tears at the time of his injection. The old child management strategy of “say what you mean, and mean what you say” is a good guideline for clear, direct communication.

Questions to Ask the Family.
• “Who among your family members is the most clear and direct when communicating verbally?”
• “When you state clearly to your young adult son that he has to pay rent to you, what effect does that have on him?”
• “When your teenagers talk directly to each other about the use of condoms, what do you notice?”
• “If your adolescents were to talk more with you and your husband about safer sex, what do you think your husband’s reaction might be?”
• “What ways have you found for you and Manuel to have good, direct conversations? In person? On the cell phone? By e-mail? Through text messaging?”

Nonverbal Communication

This subcategory focuses on the various nonverbal and paraverbal messages that family members communicate. Nonverbal messages include body posture (slumped, fidgeting, open, closed), eye contact (intense, minimal), touch (soft, rough), gestures, facial movements (grimaces, stares, yawns), and so forth. Personal space, the proximity or distance between family members, is also an important part of nonverbal communication. Paraverbal communication includes tonality, guttural sounds, crying, stammering, and so forth. Nurses must remember that nonverbal communication is highly influenced by culture. Nurses should note the sequence of nonverbal messages as well as their timing.

Example: When an older man starts to talk about his terminal illness and his adult daughter turns her head and casts her tear-filled eyes toward the floor, the nurse can infer that the daughter is sad about her father’s impending death. The daughter’s sequence of nonverbal behavior is congruent with sadness and the topic of conversation. Note, however, that this behavior sequence may not necessarily be the most supportive for her father.

Nonverbal communication is closely linked to emotional communication. We encourage nurses to inquire about the meaning of nonverbal communication when it is inconsistent with verbal communication.
Questions to Ask the Family.

- “Who in your family shows the most distress when your foster father is drinking?”
- “How does Sheldon show it?”
- “What does your foster mother do when your foster father is drinking?”
- “When your sister Seema turns her head and stares out the window as your stepfather is talking, what effect does it have on you?”
- “If your dad were to stop talking at the same time as your stepmother, would you think she might move closer to him?”

Circular Communication

Circular communication refers to reciprocal communication between people (Watzlawick, Beavin, & Jackson, 1967). A pattern exists in most relationship issues. For example, a common circular pattern occurs when a wife feels angry and criticizes her husband; in return, the husband feels angry and avoids both the issues and her. The more he avoids, the angrier she becomes. The wife tends to see the problem only as her husband’s, whereas the husband identifies the wife’s criticism as the only problem. This type of pattern is often called the demand/withdraw pattern. The circularity of this pattern is the most important aspect in understanding interaction in dyads. Each person influences the behavior of the other. More information about this topic is available in Chapter 2.

KEY CONCEPT DEFINED

Circular Communication

Reciprocal communication between people; a subcategory of expressive functioning in the functional assessment category of the Calgary Family Assessment Model (CFAM).

Circular communication patterns can also be adaptive. For example, an older parent feels competent and negotiates well with the landlord; the adult son feels proud and praises his parent. The more reinforcement the adult son gives, the more confident and self-assured the senior feels. This pattern is diagrammed in Figure 3-18.

Circular pattern diagrams (CPDs) concretize and simplify the repetitive sequences noted in a relationship. This method of diagramming interaction patterns, first developed by Tomm in 1980, may be applied to relationships between family members or between the nurse and the family. Because the nurse and the family also mutually influence each other, the nurse is encouraged to think interactionally about situations and offer the family an opportunity to think interactionally.
The simplest CPD includes two behaviors and two inferences of meaning. The inferences can be cognitive, affective, or both. Inferences about cognition refer to ideas, concepts, or beliefs, whereas inferences about affect refer to emotional states. Affect and/or cognition propels the behavior. Figure 3-19 illustrates the relationship between these elements. As noted by Tomm (1980), “The inference is entered inside the enclosure and represents some internal process (what is going on inside each interactant). The connecting arrows represent information conveyed from each person to the other through behavior. The circular linkage implies an interaction pattern that is repetitive, stable, and self-regulatory” (p. 8). CPDs encourage a position of curiosity rather than a passion for particular values and a stand against others.

Although CPDs can be used to foster circular thinking, one must be mindful of their limitations. CPDs can tempt us to look within families for collaborative causation of problems. This may distract from personal responsibility for unacceptable behavior such as violence. Small, tight feedback loops may be highlighted, and the “big picture” of the negative influence of particular values, institutions, and cultural practices may be forgotten. Another limitation of CPDs is that they may encourage nurses to believe that they are outside the family system. As a participant observer in the larger system, the nurse is shown and hears about circular
patterns reflecting family functioning. The interdependence of the nurse interviewer and family must be recognized. Both the nurse and family members cannot be decontextualized from their social and historical surroundings.

In what has come to be called the “feminist critique” of systems, some have taken exception to the simplistic causation ideas advanced by a circular perspective. CPDs, by virtue of their neutral context, ignore power differentials and imply a discourse or relationship between equals. These writers criticize circularity for not being transparent about responsibility and minimizing power differentials in relationships. Of particular concern are such issues as incest, abuse, violence, intimidation, and battering.

Despite these valid criticisms, we believe that it is still useful in clinical work with families to subscribe to the notion of circularity but simultaneously hold to the idea of personal responsibility. An example of a circular argument is illustrated in Figure 3-20. Each party blames and threatens the
other. An example of a supportive relationship is illustrated in Figure 3-21. The husband trusts his wife and reveals his needs and fears. She is concerned and, in turn, sustains and supports him. This leads him to trust her more, and the relationship progresses.

Sample Conversation With the Family

Nurse: You say your wife “always” criticizes you. (Nurse conceptualizes Figure 3-22). What do you do then? (Nurse tries to fill in the husband’s behavior in Figure 3-23.)

Niz: I don’t like to discuss things. I avoid conflict. I leave. I go in the other room. What else can I do? She is always telling me what I did wrong. I go to the computer.

Sustains/Supports

Expresses his needs/fears

Figure 3-21 CPD of a supportive relationship.

Criticizes

Figure 3-22 Beginning conceptualization of CPD.
Nurse: So she expresses her needs, and you leave. How do you think that makes her feel? *(Nurse tries to fill in the inferred emotion in the wife’s circle in Figure 3-24.)*

Nurse: So you’re annoyed when he leaves and ignores you. And then you become more critical. Is that right?  
Zara: Well I don’t really criticize, I just...  
Niz: Yeah, you got it, Nurse.  
Nurse: So, when you try to express your concerns, how do you think it makes him feel? *(Nurse tries to fill in the inference in the square in Figure 3-24.)*  
Zara: I don’t know.

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**Figure 3-23** CPD illustrating husband’s and wife’s behaviors.

**Figure 3-24** CPD illustrating wife’s emotion.
Nurse: If he thinks you’re lecturing and avoids the issues by leaving the room and going to the computer, what effect do you think your talking might be having on him?

Zara: Well, I suppose he could be feeling frustrated. He sulks.

Nurse: So the pattern seems to be that, no matter who starts it, the circle completes itself. Sometimes you’re annoyed and you criticize. Your husband feels frustrated and ignores you. He sulks in another room. Other times he avoids issues, and this arouses your frustration and criticism. *(Nurse explains Figure 3-25.)*

Zara: It’s a vicious circle.

Niz: I don’t want it to go on this way anymore. We both get too upset.

Once the nurse has elicited a CPD, the nurse should ask the family members to contextualize their discussion. One context might be that Zara is exhausted by her factory job and all the housework and child care. Niz does not see why he should change his life because his wife has a stressful job and works long hours. They may engage in this particular negative circular interaction pattern every night while caring for their 3-year-old child with asthma.

**Problem Solving**

This subcategory refers to the family’s ability to solve its own problems effectively. Family problem solving is strongly influenced by the family’s beliefs about its abilities and past successes. How much influence the family
believes it has on the problem or illness is useful to know. Who identifies the problems is important. Is it characteristically someone from outside the family or from inside the family?

Once the problems are identified, are they mainly instrumental (routine, day-to-day logistics) or emotional problems? Families sometimes encounter difficulties when they identify an emotional problem as an instrumental one. **Examples:**

- A mother who states that she cannot get her child who has food allergies to maintain the diet is really discussing an emotional issue rather than an instrumental one; she has difficulty influencing her child. As more families cope with issues such as childhood obesity, this is a particularly important distinction for nurses to notice. Is the obesity an instrumental or emotional problem? An individual, family, or societal problem?
- A couple dealing with the wife’s myeloma might decide to harvest stem cells as a proactive measure. What are the family’s solution patterns? Are they proactive in planning for issues that might arise?
- Older parents move to a retirement community. The wife breaks her hip. The husband is used to being self-reliant or, in a pinch, depending on his middle-aged daughter. The older couple know few people in their new community. The husband is reluctant to accept help from the visiting nurse. He states that he can manage all of his wife’s care despite the fact that he is losing weight and getting insufficient rest. The husband’s solution pattern conflicts with that of the nurse. Many close-knit extended families rely on relatives for assistance in time of need. Others tend to seek help from professionals. Knowing a family’s usual solution style can give the nurse insight into why this family may seem to be “stuck” at this particular time with this particular issue.
- A 68-year-old grandmother tells Katherine, the nurse, “I can’t afford to let myself cry about the death of my son’s newborn baby. I have to go on for the sake of my other children.” Knowledge of whether a family evaluates the cost of its solutions can be helpful to the nurse. Katherine was able to evaluate with the grandmother the cost of her solution pattern. Neither the grandmother nor the son discussed the baby’s death with each other. The grandchildren’s questions about why the baby did not come home from the hospital were left unanswered. There was considerable tension between the son and the grandmother, and the son was particularly overprotective of his 4-year-old boy (the only surviving male child). By gently exploring the cost of the solution (tension and over-protection), the nurse was able to suggest other solution patterns (e.g., shared grieving).

**Questions to Ask the Family.**

- “Who first noticed the problem?”
- “Are you the one who usually notices such things?”
“What most helped you to take the first step toward eliminating the addiction and violence pattern?”
“What effect did it have when Toya also took steps to stop the cycle of violence in your family?”
“How did the relationship between your son, Jeremiah, and your husband change when the violence stopped? When the addiction stopped?”
“If a violent episode were to occur again, how do you think you and your daughter would deal with it?”
“If his cocaine addiction were to flare up again, what steps would you take to protect your family?”

**Roles**

This subcategory refers to the established patterns of behavior for family members. A role is consistent behavior in a particular situation. Roles, however, are not static but are developed through an individual’s interactions with others. Roles are thus influenced by culture, race, and others’ sanctions and norms. In Hispanic families, for example, *machismo* can be very significant for the hierarchical male role, and *simpatía,* or the avoidance of conflict and the ability to get along well, is often highly valued in the female role.

The psychological cost of providing care for a parent with Alzheimer disease is often anxiety, depression, guilt, and resentment in the caregiver. The fact that women dominate as adult caregivers reflects a North American pattern. The gender differences clearly profile women’s more frequent, intensive, affective involvement with the caregiver role.

Women’s roles have changed in recent years and are now less defined by the men in their lives. The birth rate has fallen below replacement levels, and many more women are concentrating on jobs and education. In many cases, a husband’s income is negatively related to role sharing, and a wife’s education is positively related to role sharing.

Although role change is increasingly prevalent for both men and women in today’s society, what is important for nurses to assess is how family members cope with their roles. Nurses should consider the following:

- Does role conflict or cooperation exist?
- Are roles determined solely by age, rank order, or gender?
- Do additional criteria, such as social class and culture, influence roles?
- Are the women in the family more involved with a wider network of people for whom they feel responsible?
- Do the men hear less than the women in the family about stress in their family network?

Formal roles are those for which the community has broadly agreed on a norm. Examples include the roles of mother, husband, and friend. Informal roles refer to the established patterns of behavior that are idiosyncratic to particular individuals in certain settings. Examples include the roles of “bad
“kid,” “angel,” and “class clown.” These serve a specific function in a particular family. If Dad is the “softie,” most likely Mom is the “heavy.” If Giffy is the “good daughter,” Kweisi is probably the “black sheep.” The roles of “parentified child,” “good child,” and “symptomatic child” have been identified in many families. Auxiliary roles of “child advocate,” “analyst,” “peacemaker,” and “therapist” have also been described.

It is helpful for the nurse to learn how family roles evolved, their impact on family functioning, and whether the family believes they need to be altered. It is important for nurses to conceptualize the functional assessment category of roles in a family-oriented rather than an individual-oriented way. According to Hoffman (1981):

The individual-oriented approach badly misrepresents the subject. For instance, to speak of the “role of the scapegoat” is to present the deviant as a person with fixed characteristics rather than a person involved in a process. “Scapegoating” technically applies to only one stage of a shifting scenario—the stage where the person is metaphorically cast out of the village. After all, the term originates from an ancient Hebrew ritual in which a goat was turned loose in the desert after the sins of the people had been symbolically laid on its head. The deviant can begin like a hero and go out like a villain, or vice versa. There is a positive-negative continuum on which he can be rated depending on which stage of the deviation process we are looking at, which sequence the process follows, and the degree to which the social system is stressed.

At the time, the character of the deviant may vary in another direction, depending on the way his particular group does its typecasting. Which symptoms crop up in members of a group is itself a kind of typecasting. Thus the deviant may appear in many guises: the mascot, the clown, the sad sack, the erratic genius, the black sheep, the wise guy, the saint, the idiot, the fool, the imposter, the malingerer, the boaster, the villain, and so on. Literature and folklore abound with such figures. (p. 58)

Questions to Ask the Family.

- “To whom do most of you go when you need someone to talk to?”
- “What effect does it have on Maxine when Ken helps with the baby’s care?”
- “When Maxine and Ken collaborate instead of competing, who would be the first to notice? If Ken were to be more responsible for initiating contact with the relatives around Cherie’s day-care arrangements and babysitting, how do you think Maxine would feel?”

Influence and Power

This subcategory refers to behavior used by one person to influence or affect another’s behavior. Power is the ability of a person to regulate the criteria by which differing views of “reality” are judged and resources...
apportioned. Power addresses hierarchical and egalitarian positions in relationships. In a hierarchical relationship, a person can be in a one-up or a one-down position in the relationship and can be dominant in one context and subordinate in another. In an egalitarian relationship, there is equality in the relationship. In an egalitarian relationship, a give-and-take negotiation of individual needs, goals, and desires with an expectation of reciprocal attunement to the needs of the relationship or each other occurs.

Gender, race, and cultural issues are frequently intermingled with power issues. For example, in many relationships, women tend to raise issues and draw men out in the early phase of a discussion, whereas men tend to control the content and emotional depth of the later discussion phases and largely dominate the outcome. Shifts in power are preceded by changes in “reality,” an expansion from a single perspective to a multiverse. We encourage nurses to adopt a postmodernist worldview because it offers useful ideas about how power and “truth” are socially constructed, constituted through language, organized, and maintained in families and larger cultural contexts.

A nurse who is unaware of power differences among family members, in terms of roles, gender, economics, or social class, can inadvertently encourage family members in positions of less power to accept goals that decrease their power and constrain their choices.

Whether all family members contribute equally to problems and share responsibility for resolution is something that the nurse can pose for consideration. We believe that the most clinically useful stance to take with regard to the idea of power is to say, “Power is….” It can be used positively or negatively, overtly or covertly, to enhance or constrain options. Power relations exist among family members, their health-care providers, and institutions. McGoldrick et al. (2008, p. 78) have depicted a negative power and control pyramid that includes eight levels and combines racism, heterosexism, and sexism:

1. “Isolation, controlling whom she can see and when and where
2. Sexual abuse, abusive touching, sexual acts against her will, having affairs, exposing her to HIV
3. Using children, being abusive, controlling, guilt-inducing or under-responsible regarding visitation, etc.
4. Physical abuse, hitting, shoving, choking, kicking, grabbing, etc.
5. Economic abuse, controlling her financially, not sharing financial information or resources, challenging her every purchase
6. Threats and intimidation, threatening to hurt her physically, to commit suicide, have an affair, divorce, report her to welfare, take away children or cut off her emotional support system, putting her in fear by looks, actions, destroying property, stalking, driving car too fast
7. Using immigration status, using her undocumented status to threaten deportation, loss of children, job, healthcare, etc.
8. Emotional abuse and use of male privilege, putting her down, name calling, making her think she’s crazy, playing mind games, stonewalling, treating her like a servant, assuming right to make all major decisions or to neglect ‘2nd shift’ home responsibilities such as housework and childcare.”

Instrumental influence, power, or control refers to the use of objects or privileges (e.g., money; television watching; computer, car, or cell-phone use; candy; vacations; and so forth) as reinforcers. Psychological influence or power refers to the use of communication and feelings to influence behavior. Examples include directives, praise, criticism, threats, and guilt induction. Corporal control refers to actual body contact, such as hugging, spanking, and so forth. It is important to note the positive and negative influences used in the family, especially with infants and seniors. Abuse of seniors by informal and sometimes formal caregivers is not infrequent, and abuse by family members may occur as well.

We have found that the most important positive predictors of compliance for children are consistency of enforcement of rules, encouragement of mature action, use of psychological rewards such as praise and approval, and play with the child. The most important negative one is the amount of physical punishment. The use of praise is positively related to success, whereas physical punishment and verbal, psychological punishment are constraining influences.

Questions to Ask the Family.
- “Which of your parents is best at getting Nirvana to take her medication?”
- “When Devin dominates the conversation, what effect does that have on Jamie?”
- “What does your mother feel about how your stepfather disciplines your sister?”
- “If your stepfather were to be more positive with your sister Tiffany, how might his relationship with your mother change?”
- “Whose interests are most reflected in major decisions in the Veliz family?”
- “Who is more likely to accommodate to the other person, Gustavo or Fines?”

Beliefs

This subcategory refers to fundamental attitudes, premises, values, and assumptions held by individuals and families. Beliefs are the blueprint from which people construct their lives and intermingle them with the lives of others. Families co-evolve an ecology of beliefs that arise from interactional, social, and cultural contexts (Wright & Bell, 2009). When illness arises, our
beliefs about health are challenged, threatened, or affirmed. During times of illness, nurses may assess the beliefs of patients, family members, or even their own beliefs to be constraining or facilitating. Constraining beliefs can enhance suffering and decrease solution options, whereas facilitating beliefs can soften illness suffering and increase solution options for managing an illness (Wright & Bell, 2009). Which illness beliefs are determined to be constraining or facilitating is determined by the clinical judgment of the nurse in collaboration with the family.

Beliefs and behaviors are intricately connected. Every action and every choice that families and individuals make evolves from their beliefs. Consequently, beliefs shape the way in which families adapt to chronic and life-threatening illness. For example, if a family believes that the best treatment for colon cancer is a nontraditional approach, it makes good sense for the family to pursue acupuncture. Because North American culture tends to use a paradigm of control about symptoms (it is good to be in control and bad to be out of control), nurses might find it useful to explore family members’ beliefs about control and mastery over their symptoms.

Beliefs are intricately intertwined with familial and socioeconomic contexts.

Examples:

• The meaning of pregnancy loss is intricately intertwined with the woman’s emotional needs at the time of the loss. If a mother was very happy about being pregnant and felt devastated by her miscarriage, then her emotional needs would differ dramatically from those of another mother who did not want to be pregnant and felt relieved by her miscarriage. Feelings about pregnancy loss can range from feelings of devastation to relief.

• A 51-year-old father of two teenage girls wrote to a nurse about his beliefs about his chronic pain:

I think each person has a different threshold of pain. Every day I try to disassociate the pain…. I try to “get into” my work and life. I am not always successful … but I try as hard as I can. The why, is because of my family, friends, and faith (gusby, eh?, but it’s true). I think you have to find out what is important in your life and let it motivate you, as terrible as this will be to say, there are always thoughts of “ending it all” … but then you think about the sadness you would leave with the ones you love … it keeps you going. I really think the key is to find one important thing as a start, and let that be the fuel that keeps you motivated to do the things you would like to do. I wish there were more I could say…. It’s a day to day struggle.

Wright and Bell (2009) have suggested that the most relevant beliefs to explore with patients and their families are beliefs about etiology, diagnosis, prognosis, healing, and treatment; spirituality and religion; mastery and control; role of family members; and role of health-care providers.
Box 3-3 provides a list of areas for nurses to explore when assessing family beliefs about the health problem.

Questions to Ask the Family.
- “What do you believe is the cause of your sexual addiction?
- “How much control do you believe your family has over chronic pain?
- “How much control does chronic pain have over your family?
- “What do you believe the effect, if any, would be on chronic pain if you and your wife agreed on treatment?
- “Who do you believe is suffering the most in your family because of the changes in your family life due to your multiple sclerosis?
- “What do you believe has been the most useful thing health professionals have offered to help you cope with your suffering from fibromyalgia? What has been the least helpful?”
- “Have any of your Buddhist beliefs helped you to cope with the tragic loss of your son?”

Box 3-3 Beliefs About the Health Problem

A. Beliefs about:
   1. Diagnosis
   2. Etiology
   3. Prognosis
   4. Healing and treatment
   5. Mastery, control, and influence
   6. Religion and spirituality
   7. Place of illness in lives and relationships
   8. Role of family members
   9. Role of health-care professionals

B. Influence of the family on the health problem
   1. Resource utilization
      a. Internal (to family)
      b. External
   2. Medication and treatment

C. Influence of the health problem on the family
   1. Client response to the illness
   2. Family members’ responses to illness
   3. Perceived difficulties and changes related to the health problem

D. Strengths related to the health problem at present
E. Concerns related to the health problem at present

Adapted from Family Nursing Unit records, Faculty of Nursing, University of Calgary, Calgary, Alberta.
Alliances and Coalitions

This subcategory focuses on the directionality, balance, and intensity of relationships between family members or between families and nurses. Complementary and symmetrical are terms used to describe a two-person relationship (see Chapter 2). A term commonly used to distinguish a three-person relationship is triangle, a term first coined by Bowen (1978). Bowen, a psychiatrist and family therapist, explains:

The two-person relationship is unstable in that it has a low tolerance for anxiety and it is easily disturbed by emotional forces within the twosome and by relationship forces from outside the twosome. When anxiety increases, the emotional flow in a twosome intensifies and the relationship becomes uncomfortable. When the intensity reaches a certain level the twosome predictably and automatically involves a vulnerable third person in the emotional issue. The twosome might “reach out” and pull in the other person, the emotions might “overflow” to the third person, or the third person might be emotionally programmed to initiate the involvement. With involvement of the third person, the anxiety level decreases. It is as if the anxiety is diluted as it shifts from one to another of the three relationships in a triangle. The triangle is more stable and flexible than the twosome. It has a much higher tolerance of anxiety and is capable of handling a fair percentage of life stresses. (p. 400)

Most family relationships are organized around threesomes or triangles. Triangular alliances can be helpful or unhelpful. We have learned that in families of combat veterans experiencing post-traumatic stress disorder, the veteran can sometimes become triangulated with a dead buddy without the spouse’s knowledge. With soldiers returning from the Iraq or Afghanistan War, the ongoing impact of their military alliances may be a useful area for the nurse to explore if the family is having difficulty realigning as a unit. Restless days, fractured relationships, and vials of pills that help with some types of pain, but not all types, have commonly been reported by these families. Relationships are not unidirectional, even if one member of the triangle is an infant, an older person, or a person who has a handicap. The intensity of each relationship and the total amount of interaction are often fairly balanced. If one relationship becomes more intense, another one or two become less intense. Also, if one member of a threesome withdraws, the other two become closer.

We believe that it is important for the nurse to note the degree of flexibility and fluidity within the family as they adjust to new arrivals, death, or illness. Experienced community health nurses have often noticed triangulation in infancy support. For example, if the father acts intrusively while playing with his baby, the infant often averts and turns to the mother. The regulation of this intrusion-avoidance pattern at the family level sheds some light on the couple alliance. When co-parenting is supportive, the mother
validates the infant’s bid for help without interfering with the father. Thus, the problematic pattern is contained within the dyad of father-baby. If co-parenting is hostile/competitive, the mother ignores the infant’s bid or engages with her in a way that interferes with her play with her father. In this case, triangulation occurs and tension is lessened, but at a cost. The nurse can identify these patterns with the couple and then collaborate with them to design effective interventions.

As nurses address this functional subcategory of alliances and coalitions, they will be aware of its interconnection with structural and developmental categories. The structural subcategory of boundaries is an important part of the alliance or coalition subcategory. The boundary defines who is part of the triangle and who is not. Of course, there are many triangles and many shifting alliances and coalitions within families. What is important for the nurse and family to note, therefore, is whether these are problematic or enriching.

An example of what can inadvertently occur in a family is if a patient’s illness is seen as “his problem” versus “our challenge.” If the condition becomes defined as the affected patient’s problem, a fundamental split occurs between the patient, the well partner, and other family members. By introducing the concept of “our challenge” early on, the nurse can provide an opportunity for all family members to examine cultural and multigenerational beliefs about the rights and privileges of ill and well family members. An alternate example of a positive coalition is when family members join together to help another family member stop smoking or stop drinking alcohol. They collectively voice their concerns to the individual and their intent to provide support and help.

We have observed that cross-generational coalitions sometimes coincide with symptomatic behavior. In addition to noting the connection between the structural subcategory of boundaries and the functional subcategory of alliances and coalitions, nurses should be aware of the interconnection with the developmental subcategory of attachments. Family attachments, or underlying emotional bonds that have an enduring or stable quality, are similar to alliances in that they are both unions. Attachments tend to differ from coalitions, however, in that the latter implies an alignment between two members, with a third member being split off or opposed.

Questions to Ask the Family.
- “When Deanna and Logan argue, who is most likely to get in the middle of the fight?”
- “If the children are playing very well together, who would most likely come along and start them fighting? Who would stop them from fighting?”
- “What impact has Don’s brain tumor had on family members coming together or becoming further distanced?”
CASE SCENARIO: JOHN AND VALERIE

John and his wife, Valerie, were very excited about having their first baby. Valerie’s pregnancy was uneventful, and the labor and delivery were normal. They happily welcomed Hannah, a beautiful baby girl. Valerie was doing well at the hospital with feeding Hannah and, with the exception of a couple of unexplained crying spells that the nurses explained to her as “the baby blues,” she was coping well.

Two weeks after they got home with the baby, John started feeling down. He was tired and feeling useless in helping Valerie and in caring for her and their new daughter. John was feeling as though he couldn’t be the father and husband he dreamed of when Valerie was pregnant. John was trying to balance long hours at work, helping Valerie around the house, and spending time cuddling his new baby. Valerie’s mother lives a distance away and planned to come for a couple of weeks, but unfortunately, Valerie’s father fell ill, and her mother had to stay and take care of him. As the weeks went by, John was feeling overwhelmed, useless, and anxious about not fulfilling his role. One night, John told Valerie that he thought they had made a mistake in having the baby. “I am just not a good dad,” he said, “and I’m afraid that you and Hannah are going to hate me.”

Valerie and John have brought Hannah to the well-child clinic for her 2-month appointment. During the infant assessment, John shares his thoughts about being a failure as a father with the public health nurse. Valerie tells the public health nurse that she is concerned about John. She did not expect this to happen. John has always been such a competent, strong husband who wanted nothing more than to have a family. She was sure he would be happy and would be a wonderful dad. She did not know what to do to help him.

Reflective Questions

1. How would constructing a genogram and ecomap with John and Valerie be helpful for the nurse?
2. What questions could the nurse ask John and Valerie in order to assess the structural components of their family, such as roles, subsystems, and boundaries?
   a. How can the nurse use this information when working with John and Valerie?

CRITICAL THINKING QUESTIONS

1. Identify a family in your clinical practice and complete the three major categories of the CFAM:
   a. Structural (including a genogram and ecomap)
   b. Developmental
   c. Functional
2. What are three questions you would ask the family from each of the categories in order to obtain information?