Chapter 4

The Calgary Family Intervention Model

Learning Objectives

- Explain the Calgary Family Intervention Model (CFIM).
- Identify the domains of family functioning.
- Describe examples of interventions directed at each domain of family functioning.
- Compare the difference between linear and circular questions.

Key Concepts

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The Calgary Family Intervention Model (CFIM) is a companion to the Calgary Family Assessment Model (CFAM) (see Chapter 3). To our knowledge, the CFIM is the first family intervention model to emerge within nursing. There is increasing evidence of the importance of nursing interventions with families in the literature; more detail can be found...
in Chapter 1. In addition, the focus of health-care providers has shifted from deficit- or dysfunction-based family assessments to strengths- and resiliency-based family interventions. For example, the McGill Model of Nursing developed by faculty and students from McGill University under the guidance of Dr. Moyra Allen states that one of its goals is to “help families use the strengths of the individual family members and of the family as a unit, as well as resources external to the family system” (Feeley & Gottlieb, 2000, p. 11). Gottlieb and Gottlieb (2017) identify strengths-based nursing as family nursing, and it is a growing movement across disciplines.

**KEY CONCEPT DEFINED**

**Calgary Family Intervention Model (CFIM)**

An organizing framework conceptualizing the intersection between a particular domain—cognitive, affective, or behavioral—of family functioning and a specific intervention offered by health-care professionals; a companion to the Calgary Family Assessment Model (CFAM).

The CFIM is a strengths- and resiliency-based model. We believe that this type of shift in emphasis from deficits and dysfunction to strengths and resiliency in family nursing practice greatly influences the types of interventions offered to and chosen by families within our model. It is important to note that Gottlieb (2012) has devoted an entire book to the importance of focusing on strengths in nursing care and continues to advocate for its importance (Gottlieb & Gottlieb, 2017).

This chapter presents our definition and description of the CFIM, examples of interventions in three domains of family functioning, and actual clinical examples using the CFIM. This chapter concludes with intervention ideas for family situations that nurses commonly encounter.

**DEFINITION AND DESCRIPTION**

If a comprehensive family assessment has been completed and family intervention is indicated, a nurse must then consider how to intervene to facilitate change. The CFIM is an organizing framework for conceptualizing the intersection between a particular domain of family functioning and the specific intervention offered by the nurse (Figure 4-1). The elements of the CFIM are as follows:

- Interventions
- Domains of family functioning
- “Fit” or meshing (i.e., effectiveness)
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The CFIM visually portrays the fit or meshing between a domain of family functioning and a nursing intervention; it answers these questions:

- In what domain of family functioning does this intervention intend a change?
- Is it a fit for this family?

The CFIM focuses on promoting, improving, and sustaining effective family functioning in three domains or areas:

- Cognitive
- Affective
- Behavioral

Interventions can be designed to promote, improve, or sustain family functioning in any or all of the three domains, but a change in one area can affect the other domains. We believe that the most profound and sustaining changes are the ones that occur within the family’s beliefs (cognition) (Bell & Wright, 2011; Wright, 2015; Wright & Bell, 2009). In other words, as a family thinks, so it is. In many cases, one intervention can actually simultaneously influence all three domains of family functioning.

We believe that nurses can only offer interventions to the family within a relational stance; they cannot instruct, direct, demand, or insist on a particular kind of change or way of family functioning. Such directive practices by nurses do not result in satisfying family-nurse relationships for either the nurse or the family, nor do they result in beneficial outcomes. Families are more open to the ideas offered by nurses when the relationships are in the context of collaborative interaction (e.g., inviting, asking, encouraging, supporting) rather than instructive interaction (e.g., instructing, directing, lecturing, demanding).

Whether the family is open to an intervention also depends on its genetic makeup and the family’s history of interactions among family members and between family members and health professionals (Maturana & Varela, 1992). Openness to certain interventions is also profoundly influenced by the relationship between the nurse and the family (Bell, 2016; Moules & Johnstone, 2010; Sigurdardottir, Svavarsdottir, Rayens, & Adkins, 2013; Svavarsdottir & Sigurdardottir, 2013; Sveinbjarnardottir, Svavarsdottir, & Saveman, 2011;
Intervening in a family system in a manner that promotes or facilitates change and healing is the most challenging and exciting aspect of clinical work with families. The intervention process represents the core of clinical practice with families. It provides an appropriate context in which the family can make necessary changes that enhance the possibilities of healing. Myriad interventions are possible, but nurses need to tailor their interventions to each family and to the chosen domain of family functioning.

An awareness of ethical considerations is necessary for the nurse. Specific interventions usually vary for each family, although in some instances the same intervention may be used for several families and for different problems. We wish to emphasize, however, that each family is unique and that although labeling particular interventions is an important part of putting our practice into language, it does not represent a “cookbook” approach. We also wish to emphasize that the interventions we list are examples of interventions that can be used; they are not intended to be all-inclusive. The interventions that we cite are based on several important theoretical foundations: postmodernism, systems theory, cybernetics, communication theory, change theory, and the biology of cognition (see Chapter 2).

In summary, the CFIM is not a list of family functions or a list of nursing interventions. Rather, it provides a means to conceptualize a fit or meshing between domains or areas of family functioning and selected interventions offered by the nurse. The CFIM assists in determining the domain of family functioning that predominantly needs changing, usually where there is the greatest suffering, and the most useful interventions to effect change in that domain.

We use the qualitative terms fit or meshing to emphasize whether or not the interventions effect change and/or ease suffering in the presenting problem. Fit involves recognizing reciprocity between the nurse’s ideas and opinions and the family’s illness experience. Therefore, determining fit or meshing may involve some experimentation or trial and error. It also entails a belief by nurses that each family is unique and has particular strengths. In Chapter 7, we outline techniques for enhancing the likelihood that interventions will stimulate change in the desired domain of family functioning.

**INTERVENTIVE QUESTIONS**

One of the simplest but most powerful nursing interventions for families experiencing health problems is the use of interventive questions. These questions are intended to actively effect change in any or all of the three domains. However, nurses conducting family interviews should remember...
that knowing when, how, and why to pose questions is more important than simply choosing one type of question over another (Wright & Bell, 2009).

**KEY CONCEPT DEFINED**

**Linear Questions**
Questions asked by the nurse during family interviews that are meant to inform the nurse about the family’s descriptions or perceptions of a problem.

**Linear Versus Circular Questions**

Interventive questions are usually of two types (Tomm, 1987, 1988):

- Linear (investigative)
- Circular (reveal explanations)

**KEY CONCEPT DEFINED**

**Circular Questions**
Questions asked by the nurse during family interviews that are meant to reveal the family’s understanding of its problems.

The important difference between these kinds of questions is their intent. Linear questions are meant to inform the nurse, whereas circular questions are meant to effect change (Tomm, 1985, 1987, 1988).

**Linear Questions**

These types of questions explore and investigate a family member’s descriptions or perceptions of a problem.

*Example:* When exploring parents’ perceptions of their daughter Cheyenne’s anorexia nervosa, the nurse could begin with linear questions, such as: “*When did you notice that your daughter had changed her eating habits?*” and “*What do you think caused your daughter to stop eating as she normally would?*”

These linear questions inform the nurse of the history of the young woman’s eating patterns and help illuminate family perceptions or beliefs about eating patterns. Linear questions are frequently used to begin gathering information about a family’s problems, whereas circular questions reveal a family’s understanding of problems.
Circular Questions

These types of questions aim to reveal explanations of problems.

*Example:* With the same family, the nurse could ask: “Who in the family is most worried about Cheyenne’s anorexia?” and “How does Mother show that she is the one who worries the most?”

Circular questions help the nurse to discover valuable information because they seek out information about relationships between individuals, events, ideas, and/or beliefs.

The effect of these different question types on families is quite distinct. Linear questions tend to limit any further understanding, whereas circular questions are generative and open possibilities for new understandings. Circular questions introduce new cognitive connections or a change in the illness beliefs of families, paving the way for new or different family behaviors. Linear questioning implies that the nurse knows what is best for the family and is therefore operating under the “sin of certainty” or objectivity without parentheses (Maturana & Varela, 1992). It also implies that the nurse has become purposive and invested in a particular outcome. Linear questions are intended to correct behavior; circular questions are intended to facilitate behavioral change.

The primary distinction between circular and linear questions lies in the notion that information reveals differences in relationships (Bateson, 1979). With circular questions, a relationship or connection between individuals, events, ideas, or beliefs is always sought and in a context of compassion and curiosity. With linear questions, the focus is on cause and effect. The idea of circular questions evolved from the concept of circularity and the method of circular interviewing developed by the originators of Milan Systemic Family Therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Tomm, 1984, 1985, 1987).

Circularity involves the cycle of questions and answers between families and nurses that occurs during the interview process. The nurse’s skillful questions are based on thoughtful assessment, conceptualization, and hypotheses that can foster understanding and that can obtain information the family gives in response to the questions the nurse asks, and thus the cycle continues. The family’s responses to questions provide information for the nurse and the family. The nurse is not an outside interpreter or narrator in this process but rather a participant in the relationship and interaction. Questions in and of themselves can also provide new information and answers for the family, and so they become interventions. Interventive questions may encourage family members to perceive their problems in a new way, which eases their suffering and allows them to see new solutions. Thus, as the family’s answers provide information for the nurse, the nurse’s questions may provide information for the family.
Circular questions have various applications in family nursing and family therapy. Østergaard et al (2018) conducted a randomized multicenter trial to explore the effect of family nursing therapeutic conversations on health-related quality of life, self-care, and depression among outpatients with heart failure. Circular questions were used as an intervention, with a focus on commendations, strengths, and resources within the family, which was beneficial to building family relationships. Wright and Bell (2009) demonstrated the therapeutic aspect of circular questions with families experiencing chronic illness, life-threatening illness, and psychosocial problems. In family therapy, Spain et al (2017) conducted a literature review to evaluate the effectiveness of enhanced communication and coping for individuals with autism spectrum disorder (ASD) and their family members and found that family therapists utilized various interventions, such as circular and reflective questions. Utilizing the CFIM, Duhamel and Talbot (2004) found that nurses considered interventive questioning useful because it stimulated discussion on specific topics: “One of the questions was formulated as ‘What were the most significant changes that occurred in the family since the onset of the illness?’ This question led to the identification of efforts made by the couples to comply with medical recommendations, and of their progress in the rehabilitation process” (p. 23).

KEY CONCEPT DEFINED
Commendations
Comments by the nurse during family interviews and counseling that emphasize observed positive patterns of behavior, such as family and individual strengths, competencies, and resources.

Tomm (1987) embellished the types of circular questions used by the Milan Systemic Family Therapy team and identified, defined, and classified various circular questions. The ones we have found most useful in relational clinical practice with families are as follows:

- Difference questions
- Behavioral-effect questions
- Hypothetical or future-oriented questions

KEY CONCEPT DEFINED
Difference Questions
Questions asked by the nurse during family interviews that explore differences between people, relationships, time, ideas, and/or beliefs.
We have expanded the use of circular questions by providing examples of questions that can be asked to intervene in the cognitive, affective, and behavioral domains of family functioning (Table 4-1).

### Table 4-1: Circular Questions to Invite Change in the Cognitive, Affective, and Behavioral Domains of Family Functioning

#### 1. Type: Difference Question

<table>
<thead>
<tr>
<th>COGNITIVE</th>
<th>AFFECTIVE</th>
<th>BEHAVIORAL</th>
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<tbody>
<tr>
<td>■ What is the best advice that you have received about managing your son's HIV?</td>
<td>■ Who in the family is most worried about how HIV is transmitted?</td>
<td>■ Who in the family is best at getting your son to take his medication on time?</td>
</tr>
<tr>
<td>■ What is the worst advice you have received?</td>
<td>■ Who finds your disclosure of sexual abuse most difficult?</td>
<td>■ When you first disclosed your sexual abuse, what actions by professionals were most helpful?</td>
</tr>
<tr>
<td>■ What information would be most helpful to you about managing the effects of sexual abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Who in the family would benefit most from the information?</td>
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In summary, difference questions, behavioral-effect questions, and hypothetical questions can be used to facilitate change in any or all of the domains of family functioning. Figure 4-2 illustrates the intersection of various types of circular questions and the domains of family functioning. We strongly emphasize that the effectiveness, usefulness, and fit of the question, rather than the specific question itself, are most critical in effecting change.

<table>
<thead>
<tr>
<th>Type: Behavioral-Effect Question</th>
<th>Definition: Explores the effect of one family member’s behavior on another.</th>
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</thead>
<tbody>
<tr>
<td>COGNITIVE</td>
<td>AFFECTIVE</td>
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<tr>
<td>How do you make sense of your husband not visiting your son in the hospital?</td>
<td>What do you feel when you see your son crying after his treatments?</td>
</tr>
<tr>
<td>What do you know about the effect of life-threatening illness on children?</td>
<td>How does your mother show that she is afraid of dying?</td>
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</table>

<table>
<thead>
<tr>
<th>Type: Hypothetical/Future-Oriented Question</th>
<th>Definition: Explores family options and alternative actions or meanings in the future.</th>
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<tbody>
<tr>
<td>COGNITIVE</td>
<td>AFFECTIVE</td>
</tr>
<tr>
<td>What do you think will happen if these skin grafts continue to be so painful for your son?</td>
<td>If your son’s skin grafts are not successful, what do you think his mood will be? Sad? Angry? Resigned?</td>
</tr>
<tr>
<td>If the worst occurs, how do you think your family will cope?</td>
<td>If your grandmother’s treatment does not go well, who will be most affected?</td>
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<tr>
<td>If you decide to have your grandmother institutionalized, with whom would you discuss the decision?</td>
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Other Examples of Interventions

To illustrate the intersection of the three domains or areas of family functioning (cognitive, affective, and behavioral) and various interventions, we have chosen a few examples of interventions that can be used in addition to circular questions. This list is not exhaustive; rather, it is a selection of interventions that we have found useful and effective in our clinical practice and research. Examples include the following:

- Commending family and individual strengths
- Offering information and opinions
- Validating, acknowledging, or normalizing emotional responses
- Encouraging the telling of illness narratives
- Drawing forth family support
- Encouraging family members to be caregivers and offering caregiver support
- Encouraging respite
- Devising rituals

These interventions can influence change in any or all of the domains of family functioning. For example, the nurse can offer information to promote change in cognitive, affective, or behavioral family functioning (Figure 4-3).

The following section describes each intervention and offers a case example illustrating its application. We have grouped the sample interventions around a particular domain of family functioning. However, we do not wish to imply that one intervention can be used to facilitate change in only one domain of family functioning or that one intervention is a “cognitive intervention” and another an “affective intervention.” Rather, these are examples of the fit between a specific problem or illness, a particular intervention, and a domain of family functioning.

![Domains of Family Functioning](Image)
INTERVENTIONS TO CHANGE THE COGNITIVE DOMAIN OF FAMILY FUNCTIONING

Interventions directed at the cognitive domain of family functioning usually offer new ideas, opinions, beliefs, information, or education on a particular health problem or risk. The treatment goal or desired outcome is to change the way in which a family perceives its health problems so that members can discover new solutions to these problems. The following interventions are examples of ways to change the cognitive domain of family functioning.

### KEY CONCEPT DEFINED

**Cognitive Domain of Family Functioning**

Interventions used in the Calgary Family Intervention Model (CFIM) that offer new ideas, opinions, beliefs, information, or education on a particular health problem or risk.

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**Commending Family and Individual Strengths**

We routinely commend family and individual strengths, competencies, and resources observed during interviews. Commendations differ from compliments and are instead an observation of patterns of behavior that occur across time. Example of a commendation: “Your family members are very loyal to one another.” A compliment is usually an observation of a one-time event. Example of a compliment: “You were very praising of your son today.”

Families coping with chronic, life-threatening, or psychosocial problems commonly feel defeated, hopeless, or unsuccessful in their efforts to overcome or live with these problems. We choose to emphasize strengths
and resilience rather than deficits, dysfunctions, and deficiencies in family members.

*Example:* An adopted son’s behavioral and emotional problems had kept the family involved with health-care professionals for 10 years. The nurse commended this family by telling them that she believed they were the best family for this boy because many other families would not have been as sensitive to his needs and probably would have given up years ago. Both parents became tearful and said that this was the first positive statement made to them as parents in many years.

By commending a family’s competence, resilience, and strengths and offering them a new opinion or view of themselves, a context for change is created that allows families to then discover their own solutions to problems and enhance healing. Box 4-1 suggests helpful hints for offering commendations. Further discussion about commendations can found in Chapter 9.

**Offering Information and Opinions**

The offering of information and opinions from health-care professionals is one of the most significant needs for families experiencing illness, especially if the illness is complex.

Adams, Mannix, and Harrington (2017) conducted a literature review on nurses’ perceptions of their role when communicating with families in adult intensive care units (ICUs). This review found that intensive care nurses wanted to help families to understand a broader picture of their patients’

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**Box 4-1 Helpful Hints for Offering Commendations**

- Be a “family strengths” detective and look for opportunities to commend families when strengths are discovered and uncovered.
- Ensure that sufficient evidence for the commendation is present; otherwise it may sound insincere and overly ingratiating.
- Use the family’s language and integrate important family beliefs to strengthen the validity of the commendation.
- Offer commendations within the first 10 minutes of meeting with a family to enhance the practitioner-family relationship and to increase family receptivity to later ideas.
- Routinely include commendations to families at the end of an interaction or meeting and before offering an opinion.

situations and prioritized their role as interpreters of information and plans while also having an active role in providing information to families.

**Example: Families with young children**
Nurses working with families with young children often provide important information to parents about the following:

- Child’s current health situation
- Treatment plans, medications, diagnostic screening
- Health education and promotion
- Physiological, emotional, and cognitive development
- Developmental milestones

In this example, the information provided by the nurse can influence the way in which the parents may think about or understand a situation and in turn impact decisions.

**Example: Families with a chronic or acute illness**
Families with a chronic or acute illness often identify that obtaining information is a high priority. Many families have expressed to us their frustration at their inability to readily obtain information or opinions from health-care professionals. Nurses can offer information about the impact of chronic or life-shortening illnesses on families.

**Example: Families with complex health issues**
A family of two aging parents who are the caregivers of their 34-year-old son, who has severe multiple sclerosis, has not had any respite for several months. The nurse asked the son if he would be willing to challenge his beliefs about his “helplessness.” The nurse asked him to take the leadership role in exploring possible resources for caregivers so that his parents could have a vacation. Because of his search, the son discovered that he was eligible for many financial benefits of which he had previously been unaware, including benefits to hire professional caregivers. Shortly afterward, the son arranged for 24-hour in-home nursing care when his parents took a vacation. His parents reported that they felt much less stressed and that their son was much happier. He began making efforts to walk using parallel bars, which he had not done in several months.

In this example, the nurse was able to empower the son to change his thinking about his current situation. The intervention fit the cognitive domain, and results took place in the affective and behavioral domains of family functioning.

In all of these examples, nurses are able to empower families to obtain information and resources that impact health outcomes. Box 4-2 suggests helpful hints for offering information and opinions.

INTERVENTIONS TO CHANGE THE AFFECTIVE DOMAIN
OF FAMILY FUNCTIONING

Interventions aimed at the affective domain of family functioning are designed to reduce or increase intense emotions that may be blocking families’ problem-solving efforts. The following interventions are examples of ways to change the affective domain of family functioning.

KEY CONCEPT DEFINED

Affective Domain of Family Functioning

Interventions used in the Calgary Family Intervention Model (CFIM) that reduce or increase intense emotions that may be blocking families’ problem-solving efforts.

Validating, Acknowledging, or Normalizing Emotional Responses

Validation or acknowledgment of intense affect can reduce or cushion feelings of isolation and loneliness, ease suffering, and help family members to make the connection between a family member’s illness and their emotional response (Wright, 2008).
Example: Diagnosis of a life-shortening illness

Families frequently feel out of control or frightened for a period of time after learning of this kind of diagnosis. It is important for nurses to acknowledge these strong emotions and to reassure and offer hope to families that, in time, they can adjust and learn new ways to cope. A nurse may say: “Feeling overwhelmed and frightened is common because there can be a lot of emotions and feelings of uncertainty at this time. Let’s talk about some of the changes that are occurring and strategies that might help you cope.”

Encouraging the Telling of Illness Narratives

Too often, family members are encouraged to tell only the medical story or narrative of their illness rather than the story of their own unique experience of their illness, or illness narrative. However, when nurses encourage family members to tell their illness narratives, not only are stories of sickness and suffering told but also stories of strength and tenacity (Wright & Bell, 2009). Through therapeutic conversations, nurses can create a trusting environment for open expression of family members’ fears, anger, and sadness about their illness experience (Sigurdardottir et al, 2013; Svavarsdottir & Sigurdardottir, 2013; Wright & Bell, 2009).

KEY CONCEPT DEFINED

Illness Narrative
An individual’s story of his or her own unique experience of illness.

These conversations are particularly important for complex family types involving multiple parents and siblings. Having an opportunity to express the illness’s impact on the family and the influence of the family on the illness from each family member’s perspective validates their experiences.

Listening to, witnessing, and documenting illness stories can also have a profound impact on the nurse. This approach is very different from limiting or constraining family stories to symptoms, medication use, and physical treatments. By providing a context for family members to share the illness experience, nurses allow intense emotions to be legitimized.

Drawing Forth Family Support

Nurses can enhance family functioning in the affective domain by encouraging and helping family members to listen to each other’s concerns and feelings. This technique can be particularly useful because talking can be
healing. By fostering opportunities for family members to express feelings about a painful or positive experience, the nurse can enable them to draw forth their own strengths and resources to support one another. The nurse can be the catalyst that facilitates communication between family members or between the family and other health-care professionals. This type of family support can prevent families from becoming unduly burdened or defeated by an illness. Intervening in this manner is especially important in primary health-care settings.

**INTERVENTIONS TO CHANGE THE BEHAVIORAL DOMAIN OF FAMILY FUNCTIONING**

Interventions directed at the behavioral domain help family members to interact with and behave differently in relation to one another. This change is most often accomplished by inviting some or all the family members to engage in specific behavioral tasks. Some tasks are given during a family meeting so that the nurse can observe the interaction; other tasks or homework assignments are given for family members to complete between interactions. In some cases, the nurse must review with the family the details of the particular task or experiment in order to verify that the family understands what has been suggested. The following interventions are examples of ways to change the behavioral domain of family functioning.

**KEY CONCEPT DEFINED**

**Behavioral Domain of Family Functioning**

Interventions used in the Calgary Family Intervention Model (CFIM) that help family members interact with and behave differently in relation to one another and are most often accomplished by inviting some or all of the family members to engage in specific behavioral tasks.

**Encouraging Family Members to Be Caregivers and Offering Caregiver Support**

Family members are often timid or afraid to become involved in the care of their ill family member unless a nurse supports them. However, in our experience, we have found that family members greatly appreciate opportunities to help their hospitalized family member. They report that it makes them feel less helpless, anxious, and out of control. Of course, family caregivers are also susceptible to the well-known phenomenon of caregiver burden. Health professionals must be alert to the risks involved in family caregiving and be willing to intervene when necessary by offering caregiver support, which
means providing the necessary information, advocacy, and support to facilitate patient care by people other than health-care professionals (Barbabella et al, 2016; Blanton, Dunbar & Clark, 2018; Ducharme, 2011). In a study about grandparents’ experience of childhood cancer in their grandchildren, grandparents revealed their often unattended and unacknowledged role of both providing and needing support (Moules et al, 2012). Therefore, these authors recommended that an inquiry regarding the resources and support needs of grandparents is essential for optimal family care. We encourage nurses to weigh with family members the ethical, emotional, and physical balance between too much caregiving and not enough caregiving.

**Encouraging Respite**

Family caregivers commonly do not allow themselves adequate respite. Too frequently, family members feel guilty if they need or want to withdraw themselves from the caregiving role. This is especially true of female caregivers. Even the ill member must occasionally disengage himself or herself from the usual caregiving and reject another person’s assistance. Each family’s need for respite varies. Factors affecting respite include the severity of the chronic illness, availability of family members to care for the ill person, and financial resources. All of these issues must be considered before a nurse can recommend a respite schedule. Caregiving, coping, and caring for one’s own health need to be balanced.

**Examples:** The following examples of “time-outs” or “times away” can be essential for families facing excessive caregiving demands:

- A family could buy a less expensive prosthesis and use the extra money for a family vacation.
- A couple with a child with leukemia have the grandparents babysit for a day while the couple spends time together.
- A postpartum mother is extremely exhausted and has her partner take their newborn to a close friend’s house to allow her to rest.

**Devising Rituals**

Families engage in many types of rituals: daily (e.g., bedtime reading), yearly (e.g., vacation), and cultural (e.g., festivals, celebrations). Roberts (2003) defines rituals as

co-evolved symbolic acts that include not only the ceremonial aspects of the actual presentation of the ritual, but the process of preparing for it as well. It may or may not include words, but does have both open and closed parts which are “held” together by a guiding metaphor. Repetition can be a part of rituals through the content, the form, or the occasion.
There should be enough space in therapeutic rituals for the incorporation of multiple meanings by various family members and clinicians, as well as a variety of levels of participation. (p. 9)

The findings of Smith et al (2017) suggest that structure provided through family routines and family rituals creates meaning within the family and can support family health. Santos, Crespo, Canavarro, Alderfer, and Kazak (2016) explored family rituals in relation to financial burden and mothers’ adjustment in pediatric cancer cases. They concluded that the relationship between financial burden and anxiety symptoms was buffered for mothers who reported high levels of family ritual meaning during their children’s cancer treatments and within 5 years after the end of treatment. In our clinical practice, we have observed that chronic illness and psychosocial problems frequently interrupt the usual rituals and routines a family may have. Nurses may want to suggest therapeutic rituals that are not or have not been observed by the family as an intervention to influence the behaviors.

Example: Parents in a new blended family who cannot agree on parenting practices commonly give conflicting messages to their families. This can result in chaos and confusion for their children. The introduction of an odd-day/even-day ritual (Selvini-Palazzoli et al, 1978) can typically assist the family. The mother could experiment with being responsible for the children on Mondays, Wednesdays, and Fridays and the father on Tuesdays, Thursdays, and Saturdays. On Sundays, they could behave spontaneously. On their “days off,” parents could be asked to observe, without comment, their partner’s parenting.

CLINICAL EXAMPLES

The following clinical examples illustrate the use of the CFIM. These examples of interventions were chosen to facilitate change in all three domains (cognitive, affective, and behavioral) of family functioning. Remember, it is not always necessary or efficient to try to “fit” interventions to all three domains of family functioning simultaneously. Whether this can be done successfully depends on how well the family is engaged and on prior assessment of the nature of the illness, problems, or concerns.

Clinical Example 1: Difficulty Putting 3-Year-Old Child to Bed

To illustrate a specific family intervention aimed at all three domains of family functioning, consider a parenting problem commonly presented to community health nurses (CHNs): parents having difficulty putting their young children to bed each night. The parents’ efforts are generally met with annoyance from the child, then anger, and then tears. In their efforts,
the parents also become frustrated and commonly end up angry with each other and with their child. The family intervention offered was in the form of information and opinions. In describing this case example, we will also discuss executive skills the nurse can use to operationalize the intervention. These skills are also outlined in Chapter 5.

**Parent-Child System Problem**

*Parents’ chronic inability to get their 3-year-old to go to bed and stay there at required time.* See Table 4-2 for parent-child interventions.

**Clinical Example 2: Elderly Father Complains His Children Do Not Visit Often Enough**

This example demonstrates the intervention of encouraging family members to be caregivers and offering caregiver support. This intervention entails inviting family members to be involved in the emotional and physical care of the patient and offering support. Again, the accompanying executive skills to operationalize the interventions are given.

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<tr>
<th>TABLE 4-2</th>
<th>Interventions</th>
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<tbody>
<tr>
<td><strong>DOMAINS OF FAMILY FUNCTIONING</strong></td>
<td><strong>INTERVENTIONS: OFFERING INFORMATION AND OPINIONS</strong></td>
</tr>
<tr>
<td>Cognitive</td>
<td><em>Offer information, such as a parenting book that explains what bedtime means to children with suggestions on how to put children to bed.</em></td>
</tr>
<tr>
<td>Affective</td>
<td><em>Discuss with the parents the importance of admitting their frustrations to each other, especially if one spouse made an effort to put the child to bed but was not successful.</em>&lt;br&gt;<em>The other parent may give emotional support (e.g., “You tried really hard; he was being very difficult”).</em></td>
</tr>
<tr>
<td>Behavioral</td>
<td><em>Teach the parents that, when they put their son to bed, they should not respond to his efforts to gain attention (e.g., asking for a glass of water). Rather, parents should be sure that these needs have been attended to as part of his bedtime rituals.</em>&lt;br&gt;<em>Discuss with parents that, before they can change their child’s behavior of leaving his bed or continually calling them to his bedroom, his behavior will worsen for a few nights while he makes greater efforts to get his parents to respond. If the parents continue in a matter-of-fact way to put him back in his room and respond “no” to any further requests, his behavior should improve dramatically in a few nights.</em></td>
</tr>
</tbody>
</table>
**Parent-Child System Problem**

*Elderly father wants his adult children to visit him more often.* The adult children do not enjoy visiting their father at the long-term care center because he always complains that they do not visit often enough. See Table 4-3 for parent-child interventions.

It is important to note that in the examples provided, many other interventions and executive skills could have been offered. There is no one “right” intervention, only “useful” or “effective” interventions. How useful or effective an intervention is can be evaluated only after it has been implemented. The element of time must be taken into account. With some interventions, the change or outcome may be noted immediately. However, in many cases, changes (outcomes) are not noticed for a long time. Most problems do not occur overnight; therefore, their resolutions also require reasonable lengths of time.

**Clinical Example 3: Enuresis and Discipline Problems With a Child**

To illustrate that change is observed over time, we now offer two more actual case examples, from beginning to end, with the emphasis on the interventions that were used.

<table>
<thead>
<tr>
<th>TABLE 4-3</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOMAINS OF FAMILY FUNCTIONING</strong></td>
<td><strong>INTERVENTIONS: ENCOURAGING FAMILY MEMBERS TO BE CAREGIVERS AND OFFERING CAREGIVER SUPPORT</strong></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Discuss with the adult children that their father may have difficulty remembering their visits (short-term memory deficits), a normal change associated with aging.</td>
</tr>
<tr>
<td>Affective</td>
<td>Empathize with the father by saying that you understand that it must be lonely at times being a resident in a long-term care center. The adult children might appreciate knowing that their parent is lonely so that they can respond appropriately.</td>
</tr>
<tr>
<td></td>
<td>Encourage the father to let his children know how lonely he feels at times and that he is happy that they come to visit rather than complaining to the children that they do not visit often enough.</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Encourage the adult children to stop giving excuses for why they cannot visit more often. Instead, obtain a guest book or calendar and write down each visit. Write down who visited, on what day, and perhaps any interesting news so that the aging parent may read this between visits.</td>
</tr>
</tbody>
</table>
A family was referred to one of our graduate nursing students with the complex presenting problems of enuresis and disciplinary problems at school in the elder child, an 8-year-old boy. The family was composed of the father, age 28, self-employed; the stepmother, age 21, homemaker; and two sons, ages 8 and 6. The couple had been married for approximately 1 year. The family was seen (both as a whole family and in various subsystems) for six sessions over 13 weeks from initial contact to termination. A thorough family assessment (using the CFAM model) revealed problems in the whole family system, in the parent-child subsystem, and at the individual level.

Whole-Family System Problem

Adjustment to Being a Stepfamily

When the couple married, a new family was formed, and all family members had to adjust to a new family structure.

After being married for only a short time, the stepmother found herself thrust into a parenting role when she and her husband became responsible for his two children. The birth mother had deserted the children after living with them for 2 years in her home. The children had to adjust to a new set of parents, new surroundings, and no contact with their biological mother. See Table 4-4 for family interventions.

Providing information about the adjustment process seemed to relieve the parents a great deal. Initially, the parents were hesitant about the children having contact with the biological mother, but they later stated that they understood this contact was important for the children. The eldest child’s enuresis was conceptualized as a response to the adjustment to a stepfamily and the loss of his mother. This new opinion, also directed at the cognitive domain of family functioning, had a very positive effect on the family. The enuresis improved dramatically over the course of treatment.

<table>
<thead>
<tr>
<th>TABLE 4-4</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOMAINS OF FAMILY FUNCTIONING</strong></td>
<td><strong>INTERVENTIONS: OFFERING INFORMATION AND OPINIONS</strong></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Acknowledge that the problems the family members are experiencing are a usual part of the adjustment process of stepfamilies and provide them information about the adjustment process.</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Encourage the parents to allow the children to have contact with their biological mother when she again seeks them out.</td>
</tr>
</tbody>
</table>
Parent-Child Subsystem Problem

Maladaptive Interactional Pattern Between Stepmother and Eldest Son (see Figure 4-4) Because of the initial experience of the loss of their father (as a result of the biological parents’ divorce) and then the abandonment by their biological mother, the children, particularly the elder child, feared being abandoned again. Thus, the elder child, hoping to be reassured that he would not be abandoned again, frequently reminded his young stepmother that she was not his real mother.

Initially, the stepmother made efforts to reassure him, but she eventually withdrew in frustration and felt rejected. This encouraged the child to maintain the maladaptive interactional pattern because he perceived this withdrawal as further evidence that he would again be abandoned. The vicious cycle was evident.

In deciding which interventions to offer the family, the graduate nursing student was at first overwhelmed by the complexity of their situation. Then she considered which area had the most leverage for change. See Table 4-5 for parental interventions.

The stepmother reported that when she offered more reassurance to the boy, he stopped rejecting her. With decreased rejection, the stepmother was able to offer even more reassurance. Thus, a virtuous cycle began.

Individual Problem

Elder Child’s Behavioral Problems at School

To further assess this behavioral problem, the graduate nursing student met with the child’s teacher at school and also discussed the problem twice with the teacher by telephone. The stepmother was also present during the session at school.
The main objective of the interventions was to enhance the elder child’s self-esteem by focusing on his positive behavior. See Table 4-6 for interventions.

On termination with this family, the graduate student recommended to the parents some readings on stepfamilies and informed them of a self-help group for stepfamilies. These two interventions of offering ideas and opinions in books and providing information on community resources were targeted at all three domains of family functioning: cognitive, affective, and behavioral.

It might seem that the interventions the graduate student chose in this example were “simple.” However, in many cases, nurses either try to use

### Table 4-5: Interventions

<table>
<thead>
<tr>
<th>DOMAINS OF FAMILY FUNCTIONING</th>
<th>INTERVENTIONS: PROVIDING PARENT SUPPORT AND EDUCATION</th>
</tr>
</thead>
</table>
| Cognitive                     | Encourage the stepmother to stop withdrawing and to offer the child continual and sustained reassurance by stating: “I know I am not your mother, but your father and I love and care for you and want to look after you. We will not leave you.”  
Provide commendations of family strengths to the stepmother for her efforts to fulfill her role. |
| Affective                     | Encourage the stepmother to stop withdrawing and to offer the child continual and sustained reassurance by stating: “I know I am not your mother, but your father and I love and care for you and want to look after you. We will not leave you.” |
| Behavioral                    | Encourage the stepmother to stop withdrawing and to offer the child continual and sustained reassurance by stating: “I know I am not your mother, but your father and I love and care for you and want to look after you. We will not leave you.” |

### Table 4-6: Interventions

<table>
<thead>
<tr>
<th>DOMAINS OF FAMILY FUNCTIONING</th>
<th>INTERVENTION: ENHANCE ELDEST CHILD’S SELF-ESTEEM</th>
</tr>
</thead>
</table>
| Behavioral                    | Encourage the teacher to acknowledge the child’s positive behavior in front of his classmates to give him a different status than “class clown.”  
Recommend that the stepmother minimize her contact with the school and allow the teacher to assume more responsibility for the boy’s behavior in class. |
overly complex interventions to address issues or they have difficulty collaborating with the family to determine areas with leverage for change. In both cases, nurses commonly become frustrated and immobilized by the complexity of the family situation. A thorough exploration of the presenting issue and then an offering of interventions designed to ameliorate that problem generally works best to foster change.

Clinical Example 4: Social Isolation and Physical Complaints of Elderly Woman

During one of our undergraduate nursing students’ field placement in a community-health facility, she encountered a family whose presenting problems were social isolation and frequent physical complaints from the 78-year-old widowed mother. The widow lived in a government-subsidized, one-bedroom apartment. She had six adult children (sons ages 51, 48, 41, 37, and 35 years and a daughter, age 44 years) and 12 grandchildren. Five of the children were married, and all six lived in the same city as their mother. The family was seen as a whole and in various subsystems for eight home visits over a period of 2 months. After a thorough family assessment (using the CFAM model) and individual assessments, the following core problem was identified.

Whole-Family System Problem

The Mother’s Lack of Social Contact Beyond Her Immediate Family.

It became apparent that this older woman was overly dependent on her adult children and, therefore, did not make an effort to be involved with her peers or in social activities appropriate to her age group. This resulted in frequent disagreements between the mother and the children over the frequency of visits with the mother.

The problem was further exacerbated by the fact that the mother had no friends. After the death of her husband, approximately 10 years earlier, she had lived intermittently with some of her children but had been living alone for the past 4 years. At the time of intervention, the youngest son visited most often and did the mother’s grocery shopping.

The nursing student’s first significant intervention was to broaden the context in order to expand her view and understanding of this family’s concerns. Thus, the student initially interviewed the mother alone and then interviewed her with her youngest son (the adult child who visited most frequently). Then the student took on the ambitious task of arranging an interview with the mother and her six children. This was a significant effort on the student’s part to create a context for change by obtaining each family member’s view of the problem. In the interview with the mother and her youngest son, the mother agreed to contact the children. However, when the
student followed up with the mother, the mother said that she had not called any of her children because she expected her youngest son to do it. This was further evidence of the mother’s overdependence on her children. Because the youngest son was anxious to have the meeting take place, he had taken on the task of inviting all of his siblings to an interview with his mother and the nursing student.

At the family interview, all of the siblings were present, and two of their spouses attended as well. Interestingly, the daughters-in-law were more vocal than their husbands and stated that they were very involved with their mother-in-law. In this large family interview, the mother’s social isolation (apart from her family) was discussed. Through the process of circular questioning, the expectations for family contact of both the mother and children were assessed. Initially, the student encouraged the family to explore solutions to their mother’s lack of social activities and peer interactions (an intervention aimed at the behavioral domain of family functioning). To this intervention, the family responded that they had no ideas beyond what they had already tried. Therefore, the student suggested more specific interventions in an attempt to uncover solutions to the mother’s social isolation.

This interview revealed that the woman had always relied on her children for her main social interaction. She had never been a “joiner.” In the past few years, she had even discontinued her attendance at church. Throughout her life, she had few close friends. The assessment also revealed that, collectively, the children had generally been supportive of their mother. Each week, she had lunch with one or more of them. They included her in all special family occasions. However, the children always had to initiate contact. They were genuinely concerned about their mother’s loneliness and lack of additional social contact but had exhausted their ideas for changing her situation.

One of the first interventions the nursing student attempted was directed at both the cognitive and behavioral domains of family functioning: offering information regarding community resources that are available to older people. Specifically, the student made the family aware of the Community Services Visitor Program. The mother agreed to contact this program, and the children agreed to provide support. The mother also expressed interest in becoming involved in a choir again. The student offered to accompany her to a senior citizens’ choir practice and introduce her to other participants.

The final major intervention discussed in that family session was directed at the behavioral domain. The student nurse asked the mother if she would initiate contact with one of her children during the next week. After the contact, the child would ask the mother to come for a visit as soon as possible. This intervention was important because the interest of family members in an older parent’s activities typically increases the parent’s motivation. It is important to emphasize that the mother was involved in and receptive to these interventions.
The effects and outcomes of these interventions were as follows:

- The mother followed through on contacting the Community Services Visitor Program. The coordinator of the program then contacted the mother and arranged for a regular visitor.
- The student nurse accompanied the mother to the senior citizens’ choir. The older woman enjoyed the experience and telephoned two of the other women in the choir afterward!
- The mother took the initiative to contact a couple of her children, and they, in turn, invited her for a family visit, which she accepted. The children reported that they enjoyed having their mother call them, and this new dynamic appeared to increase their own desire to have more frequent contact with her.

In subsequent interviews, the student nurse encouraged the mother to reconnect with her church. The student also solicited the support of the children in this endeavor by requesting that they take an interest in and inquire about their mother’s church and choir activities when they called her.

Because this mother was accustomed to a good deal of family support, it was not appropriate to remove that support totally. However, physical instrumental support (i.e., doing things for the mother) was reduced without the mother feeling abandoned. Verbal (emotional) support for the mother’s attempts at independence was most appropriate. When the mother began to increase her social contacts and activities, her nonspecific physical complaints decreased.

The student concluded treatment with this woman in a face-to-face interview. To involve the children in the termination process, the student sent a therapeutic letter to each of them. The letter highlights the major interventions and solicits further assistance from the children and includes some of the family strengths.

**Dear…:**

I wish to thank you for your help and cooperation in my family assignment. I enjoyed meeting each of you and appreciated your individual input and assessment of your family. Your willingness to work together is certainly an excellent family strength.

I visited your mother on several occasions during my time with the Outreach Program. She continued to express her desire to be more socially independent. She has been able to make some increased community contact. She attended the choir and several of the choir ladies have called her to encourage her in continued participation. She met with the gentleman from the church and spoke with his wife. The coordinator of the visitor program visited; she is arranging for
a friend who will visit with your mother. Hopefully, they will develop some outside interests together. She has also been out to shop on her own on a few occasions.

I did contact Kerby Centre, as well as other seniors from Carter Place who go there, but was unable to find anyone going to the Wednesday lunch or any other suitable transportation. I have discussed this with your mother and she felt it might be something she could pursue on her own in the future.

Your mother expressed positive feelings about her attempts to be more socially active. However, she still looks to her children for her main support. At times, I found she needed more encouragement not to overly worry about her health to the point that she thinks she is unable to participate in any activities. I believe that each of you may help your mother by encouraging her in this area. I might suggest that if she says that she is unwell that she see her doctor. If there is no serious problem, gentle support for her independent activities might be helpful. This may be somewhat difficult at first, but if you are able to present a united front to your mother and support each other in a mutual approach to her being more socially active, she may be more able to accomplish this.

I am very impressed with the cohesiveness of your family and the continued concern and support you show toward your mother. Thank you very much again for letting me work with you.

Yours truly,
Leslie Henderson
Undergraduate Nursing Student
Faculty of Nursing, University of Calgary

This therapeutic letter sent by the student is an intervention in and of itself (Bell, Moules, & Wright, 2009; Moules, 2009; Wright & Bell, 2009). Several interventions were outlined in the letter, and these interventions were aimed at all three areas of family functioning. Specifically, the student offered commendations and opinions directed at the cognitive domain of functioning. She invited the adult children to encourage their mother, which aimed at changes in the behavioral domain. By summarizing the clinical work with the family in the form of a therapeutic letter, the student intended to effect changes in both the affective and cognitive domains of family functioning. This clinical example demonstrates how to effectively involve families in health care by the use of family assessment and intervention models with clear treatment goals.
CASE SCENARIO: HARVEY JOHNSON

Harvey Johnson is an 85-year-old male who lives alone in his own home. His wife of 65 years, Patricia, recently was moved into a long-term care facility after she was diagnosed with Alzheimer disease, and Harvey was no longer able to care for her at home. Patricia’s memory has declined rapidly, and she no longer remembers who Harvey is or where she is. Harvey and Patricia’s four children live 30 minutes away and have families of their own. They visit Harvey regularly but have recently been concerned about how their father is coping at home alone. Their oldest son has requested that a home-care nurse visit Harvey at home. During an initial phone conversation with the son, the home-care nurse was able to find out that Harvey and Patricia had never spent a night apart until Patricia moved to the long-term care facility. They were devoted to each other and mostly kept to themselves. They were like “teenagers in love” even after 65 years of marriage. Their son stated that Harvey has become increasingly irritable, appears very tired, and has lost weight since Patricia was moved to long-term care.

When the home-care nurse arrives at Harvey’s home, there are dishes piled in the kitchen sink and newspapers piled on the kitchen table, and the temperature is very cold in the home. The home-care nurse asks Harvey about how he is coping, and he states: “It doesn’t matter anymore how I am. Patricia doesn’t remember who I am, and the kids are so busy with their own families. What is the point?”

Reflective Questions

1. What are three linear questions and three circular questions the nurse could ask Harvey to gain further understanding of the family’s concerns?
2. Identify a potential intervention and expected outcome aimed at each domain of family functioning.
3. How can the nurse involve Harvey’s children in the development and implementation of the interventions?

CRITICAL THINKING QUESTIONS

1. Reflect on an interaction you had with a family:
   a. How did you use intervention questions?
   b. What linear questions did you ask?
   c. What circular questions did you ask?
2. Consider your own clinical practice to answer the following question:
   a. What interventions do you implement to direct change at the cognitive, affective, and behavioral domains of family functioning?