

Systemic Therapy and Nursing Practice: The Importance of Using the “Right” Language to Enable Family Healing and Learning

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Throughout nursing's history, family involvement has always been part of our health care profession, but it has not always been labelled as such. Because nursing originated in patients' homes, family involvement and family-centered care were natural occurrences. With the transition of nursing practice from homes to hospitals during the Great Depression and World War II, families became excluded not only from involvement in caring for ill members, but also from major family events such as birth and death. After having undergone all these developmental changes, the practice of nursing has now come full circle, with an obligation to invite families once again to participate in their own health care. However, this invitation is being made with much more knowledge, research evidence, respect, and collaboration than at any other time in nursing history.

At this moment, nurses have an ethical and moral obligation to involve families in their health care practice. This bold statement is due to evidence in nursing practice and research that the family has a significant impact on the health and well-being of individual family members and can also have a considerable influence on the illness of its members. This evidence compels and obligates nurses to consider family-centered care an integral part of nursing practice. Therefore, nurses are obliged to think systemically and interactionally to understand the reciprocal influence between family dynamics and illness. However, family-centered care is achieved responsibly and respectfully only by relational practices that include collaborative nurse-family relationships that are strengths based (Gottlieb, 2012) and embedded within sound family assessment and intervention knowledge and skills that enhance family healing.

But words and language in nursing can invite or inhibit the adoption, usefulness, and implementation of systemic and interactional ideas. Over 35 years of teaching, guiding, consulting, and supervising nursing students and practicing nurses in their clinical work with families, I had to replace words such as “systemic therapy”, “family therapy”, and “therapist”, with more compatible language for nurses such as “family interviewing”, “relational practice” or “nurse interviewer”. I have had countless nurses practicing in various specialty practices and contexts (eg paediatrics, oncology, geriatrics, cardiac to name a few) convey to me that they are *not* “therapists” but nurses and do not want to learn about “therapy”. Initially, I disrespectfully labelled these nurses as resistant, oppositional, and not open to change. However, I came to realize that it was *me* who was resistant and reluctant to change. As a nurse educator, I had not recognized the larger systems context of nursing's historical culture and professional beliefs of what constitutes being a “nurse”. Once I became more systemic in my own thinking, suddenly I found myself describing nursing educators, students and practicing nurses as keen, open, receptive, and passionate to learn how to assist families who were suffering with serious illness and how they provide enable healing. It was now clear to me that I needed to appreciate the most important aspect of systemic thinking and therapy is *not* that I convince nursing students and practicing nurses that they must learn systemic ideas and therapy skills but rather that they recognize and learn how to skilfully assess, and intervene. This meant learning about systemic ideas about interactional patterns between family members and/or family members and the nurse that enhance suffering rather than healing but to be presented in a way that was fit their contexts and beliefs. Therefore, the most important intention became teaching knowledge and skills that could soften the suffering of families by offering a language that was compatible with their professional beliefs about nurses' role and competencies. I wish I could say that I came to this learning quickly and easily about the importance of language in knowledge translation of systemic ideas in nursing. But alas, that was not the case.

Although nursing was my first professional discipline, I completed doctoral studies in marriage and family therapy. Therefore, I was very comfortable with language and words such as systemic

therapy, interaction, reciprocity, therapist, and/or family therapy. And I realized that ideas from systems, cybernetic theory and family therapy could be very useful applied to nursing practice when involving families. But I had sought out learning systemic therapy and desiring to be a competent therapist as well as nurse. However, this was not the case for the nurses that I was teaching and nor did it need to be. I realized (after a slow learning process) that nurses are as equally keen as other health professions to learn knowledge and skills that would soften suffering and promote family healing. What I came to realize was they were also equally open to learning systemic ideas if more palatable words were used that fit their professional “beliefs” about what it is to be a nurse and what is nursing practice (Wright & Bell, 2009; Wright & Leahey, 2009). Thus the majority of my writings and books for nurses and other health professionals embed systemic and interactional ideas but limit the use of terms such as systemic therapy, family therapy, and/or therapist and refer instead to family interviewing, consulting, softening suffering, and family healing (Wright, 2005; Wright & Bell, 2009; Wright & Leahey, 2009). This has proved to be a very useful, successful, and productive change in my beliefs, behaviour and pedagogical practices. Nursing educators, nursing students, and practicing nurses have readily embraced the knowledge and skills of how to involve families in their practice with the use of language that fits their culture and beliefs. Consequently, nursing literature is filled with language and phrases such as family nursing, family interviewing, family systems nursing, family centered care, and family health care. New words and language have emerged through naming, describing, and communicating about the involvement of families in nursing that fits our larger systemic context and our nursing beliefs. This new language has resulted in a rich tradition of nursing texts about the involvement of families in nursing care (Wright & Leahey, 2009; Feetham et al, 1993; Kaakinen, Gedaly-Duff, Coehlo & Hanson, 2010; Gilliss et al, 1989; Svavarsdottir & Jonsdottir, 2011; Wegner & Alexander, 1993). Perhaps the most significant publication about family nursing is the monograph published by the International Council of Nurses titled *The Family Nurse: Frameworks for Practice* developed by Madrean Schober and Fadwa Affara (2001). It is a convincing validation for an emerging new role and specialty to have the influential International Council of Nurses identify the “family nurse” and “family nursing” as one of the important new and ongoing movements in nursing.

The other major development in nursing that gives evidence to the evolving importance of family nursing was the establishment of the *Journal of Family Nursing* in 1995. Nurses now have a home to share theory, research, and practice of how systemic ideas and practice are taken up around the world by nurses who are assisting families experiences of illness, disability, and/or loss.

Also, ten International Family Nursing Conferences have been held every two to three years from 1988 onward in Canada, Chile, Iceland, Thailand, Japan, and the United States that further honors the importance and obligation of nurses caring for families from a systemic viewpoint.

As nurses theorize about, conduct research on, and involve families more in health care, they modify their usual patterns of clinical practice. The implication for this change in practice is that nurses must become competent in assessing and intervening with families through collaborative nurse–family relationships. Nurses who embrace the belief that illness is a family affair can more efficiently learn the knowledge and clinical skills required to conduct family interviews (Wright & Bell, 2009). The belief that illness is a family affair invites nurses to thinking interactionally or reciprocally, yes, systemically, about families. The dominant focus of family nursing assessment and intervention must be the reciprocity between health and illness and the family.

It is most helpful and enlightening for nurses to assess the impact of illness on the family and the influence of family interaction on the cause, course, and cure of illness. Additionally, the reciprocal relationship between nurses and families is also a significant component of both softening suffering and enhancing healing.

Of course it has been very heartening that the Calgary Family Assessment Model (CFAM) (Wright & Leahey, 2009) that I co-developed with my colleague, Dr Maureen Leahey, was one of the four models identified in *The Family Nurse: Frameworks for Practice* monograph by the International Council of Nurses (Schober & Affara, 2001). The CFAM is a multidimensional framework consisting of three major categories: structural, developmental, and functional. The

model is based on a theory foundation involving systems, cybernetics, communication, and change. The model is also embedded within larger worldviews of postmodernism, feminism, and biology of cognition. Diversity issues are also emphasized and appreciated within our particular model.

However, any model is only useful if it can be comprehended by nurses and then hopefully transferred into their generalist practice with families. The Calgary Family Assessment Model is now taught in 45% of nursing programs in the United States where family courses are taught. Nursing is also making progress in its knowledge of the distinctions between generalist and advanced practice with families. To further knowledge development in advanced practice, I have co-developed the Illness Beliefs Model (IBM) (Wright & Bell, 2009) and solo developed the Trinity Model (2005). The IBM continues to embed systemic and interactional thinking by recognizing the influence of illness beliefs between nurses, patients, and family members. The Trinity Model expands the notion of illness beliefs to include the interaction/reciprocity between illness beliefs, suffering, and spirituality.

Systemic ideas and therapy can either be foreground or embedded within traditional practices such as nursing. The most important aspect is that health professionals, particularly nurses, are able to transfer knowledge to their practice and to contribute to softening the suffering of families experiencing serious illness (Bell & Wright, 2011; Duhamel & Dupuis, 2011). This is the gift that nursing and nurses can and do offer.

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