How to Conclude or Terminate With Families

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This article reviews the process of concluding or terminating with families by examining the decision to terminate when it is initiated by the family, the nurse, or as a result of the context in which the family members find themselves. Often, the nurse's decision to terminate with a family does not necessarily mean that the family will cease contact with all professionals. Therefore, discussion also includes the process of referring families to other health professionals. Specific suggestions and family interviewing skills for how to phase out and conclude treatment are given, as well as suggestions for evaluating the effects of the treatment process. Just as other aspects of family interviewing are conducted in a collaborative manner, it is also essential that the termination phase conclude with full participation and input from the family whenever possible.

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Learning how to successfully conclude clinical work with families is as important as figuring out how to begin. Perhaps it is even more so. When nurses part from families, termination needs to be done in a manner that leaves families with hope and confidence in their new and rediscovered strengths, resources, and abilities to manage their health and their relationships. If the family has been suffering with illness, then at the conclusion of the clinical work, a most desired outcome would be reduced or alleviated suffering and increased healing.

To end professional relationships with families in a therapeutic fashion is one of the most challenging aspects of the family interviewing process for nurses. However, there is a dearth of writing in the family nursing literature about how to end our clinical work with families. Reed and Tarko (2004) make the interesting observation that in nursing, "the issue of termination has been often discussed in psychiatric nursing texts, making it seem as if no other nursing situations have issues surrounding termination" (p. 266). Termination has been the least examined of the treatment phases in clinical work with families (Roberts, 1992).

An important aspect of the termination stage is not only to end the nurse-family relationship therapeutically but to do so in a manner that will sustain the progress that has been made. Nurses often establish very intense and meaningful relationships with families and, therefore, frequently feel guilty or fearful about initiating termination. This is especially evident in nursing practice where the relationship has been a long-standing one for months or even years, such as in nursing homes, extended-care facilities, and clients' homes. Nurses conclude their work with families in a variety of settings, whether on a brief inpatient visit or on an outpatient basis. The ideas in this article can be adapted to what is appropriate for the context in which the nurse works with families.

This article reviews the process of termination by examining the decision to terminate when it is initiated by the family or the nurse or as a result of the context in which the family members find themselves. Often the nurse's decision to terminate with a family does not necessarily mean that the family will cease contact with all professionals. Therefore, we will discuss the process of referring families to other health professionals. Specific suggestions and specific family interviewing skills for how to phase out and conclude treatment are given, as well as suggestions for evaluating the effects of the treatment process. We must emphasize that just as other aspects of family interviewing are conducted in a collaborative manner, it is also essential that the termination phase conclude with full participation and input from the family whenever possible.

DECISION TO TERMINATE

Nurse-Initiated Termination

It is important to emphasize that it is not necessary that a total "cure" or complete resolution of the presenting problem or illness be evident. Rather, it is the family's ability to master or to live alongside problems or illness, hopefully with diminished emotional, physical, and /or spiritual suffering, that initiates termination (Wright, Watson, & Bell, 1996). It is often not realistic or pragmatic to attempt to eliminate the presenting concern or illness, and such a goal can frequently leave families more discouraged and hopeless and nurses feeling inadequate or unhelpful. It is the reduction of suffering with illness or increased healing and awareness that enables a family to live with their problems or illness in a more peaceful and manageable way. If the family has been seen for health promotion, then greater knowledge or increased expertise by the family might be an indicator for termination.

The termination stage evolves easily if the beginning and middle stages of engagement, assessment, and/or intervention have concluded successfully (Wright & Leahey, 2000, 2002).

However, the most difficult decision for any nurse to make in regard to termination is the question of time. When is the right time for termination? The question of when one should begin to think about termination is directly related to what new views, beliefs, ideas, or solutions have been generated by the family and nurse to resolve current problems. If new solution options have been discovered and, consequently, the family functions differently, it is time to terminate because change has occurred. The skills necessary for nurse-initiated termination are given in a later section of this article.

When the nurse and family have collaboratively decided that additional meetings are not necessary, then the termination phase of treatment has begun. First and most importantly during this phase, we prefer to help families expand their perspective to focus on strengths and positive behaviors and changes in beliefs or feelings that have occurred or reemerged rather than an exclusive focus on troublesome behaviors. We try not to have the families connect these new behaviors to our work with them but rather to their own efforts. For example, we ask them what positive changes they have noticed during the last 3 months rather than asking what positive changes they have noticed since working with the nurse.

Another useful clinical idea when terminating is one generated by White and Epston (1990) in which they recommend that the interviewer "expand the audience" to describe and acknowledge the family's unique outcomes and progress. For example, we often ask a family to tell us what advice they would have for other families confronting similar health problems. Sometimes, we have families write letters to other families to offer their suggestions of what has or has not worked in coping with a particular illness. One woman, who was experiencing Multiple Sclerosis (MS) but was successfully living alongside her illness, wrote a letter to a young woman who was, as yet, not as successful. The letter gave hope and encouragement to this young woman. In the writing of the letter, the older woman expressed the thought that it was a very "cathartic" experience for her. She also went on to say, "MS is still here, but it does not dominate our lives and occupies only a small space over in the corner. I did experience a minor flare-up after Christmas but it cleared quickly. I remain optimistic." The nurse highlights and becomes enthusiastic about the family's ideas and advice as a way of reinforcing their positive ideas for change and new beliefs about themselves and of generating useful information for other families. Thus, the family's competencies, resources, and strengths are overtly acknowledged.

The emphasis throughout the termination process when initiated by the nurse is to identify, affirm, amplify, and solidify the changes that have taken place within family members. Consequently, it is essential that change be distinguished to become a reality (Wright et al., 1996). One way to distinguish change is to obtain the perspective of other family members. The nurse can ask such questions as "What changes do you notice in your wife since she has adopted this new idea that 'illness is a family affair?'" or "What else would your family or friends notice that is different in you since your depression about experiencing cancer has dissipated?"

Termination rituals can also emphasize change and give families courage to live their lives without the involvement of health care professionals (Roberts, 1992). If the initial concerns have been with children, we often have a party (balloons, cake, and all) to celebrate a child mastering a particular problem such as enuresis. In addition, the child is given a certificate indicating that he or she has overcome his problem, whether it is enuresis, fighting fears, or putting chronic pain in its place. This helps families to acknowledge change through celebration.

Other families have been given something by the clinical nursing team to symbolize their progress. For example, one family was given a videotape of one of their family meetings where family members shared what they appreciated about one another's ability to cope with a serious illness in the family. It was wrapped with a card offering the idea to the family that the ideas on this video were a gift that they gave themselves. It is essential to mark family strengths and problem-solving capabilities as families fully integrate back into their daily lives (Roberts, 1992, 2003) without the involvement of nurses.

At the Family Nursing Unit, University of Calgary, a closing letter is routinely sent at the end of the clinical work to each family highlighting what the clinical nursing team has learned from the family and what ideas the team offered the family (Moules, 2002; Wright, Watson, & Bell, 1990, 1996). These therapeutic letters serve as a closing ritual. They provide the opportunity to highlight the family's strengths and document in a personal way the family and individual interventions that were offered. The letters also acknowledge that family nursing is not a one-way street with nurses assisting families. Rather, by stating what the nurse and clinical team have learned from the family, the nurse honors the reciprocal and relational influence between the family and the clinical nursing team.

Family-Initiated Termination

When a family takes the initiative to terminate, it is very important for the nurse to acknowledge their desire and then to gain more explicit information regarding their reasons for wanting to terminate. This information will help the nurse to understand the family's responses to the interviewing process. Has the family discovered new solutions to their problems or challenged their beliefs to reduce their suffering? For example, have they found a way to have respite from caring for their ill child without feeling excessive guilt? Has the family challenged some of their constraining beliefs about the illness experience (Wright et al, 1996)? For example, have they now stopped blaming themselves because the husband suffered a coronary in part because of having

to work two jobs? Are the family and nurse able to identify and agree on significant changes that have occurred in both individual and family functioning? Is the family also aware of how to sustain these changes? For example, if a son again refuses to give his own insulin injections, what would the family do differently?

If the family specifically states that they wish to terminate but the nurse believes this would be premature or even enhance their suffering, it is important for the nurse to take the initiative to review the family's decision. In so doing, the nurse reconceptualizes the progress that has been made by the family and recognizes what problems remain and what goals and solutions might yet be achieved. One way to do this is to have family members discuss with one another their desire to continue or discontinue sessions and explore who is most in favor and who not. Also, the specifics of the decision may be helpful, such as when the family decided and what prompted them to decide on termination. After establishing who is most keen to continue, the nurse can invite that family member to share with the other family members the anticipated benefit of further sessions. It is helpful for families to be specific and emphasize the benefits that could be achieved if family interviewing were to continue. However, there are times when termination is inevitable. At such a point, it is reasonable and ethical to accept the family's initiative to terminate and to do so without applying undue pressure even though the nurse may disagree with their decision.

We strongly urge nurses not to engage in linear blame of either families or themselves when they believe that families have prematurely or abruptly left treatment. Rather, we encourage nurses to hypothesize about the factors that may have contributed to the termination. These factors may include such nurse-related behaviors as being too aligned with children, too slow to intervene, too "married" to a particular hypothesis about the family's functioning, not attending to the family's main concern, and so forth. Family-related behaviors, such as concurrent involvement with other agencies and so forth, should also be considered.

There are times, however, when the family states that they want to continue treatment but initiate termination indirectly. Indications may be late arrivals for the sessions, missed appointments, and the absence from sessions of certain family members who were asked to attend. Another indicator that families are perhaps considering termination is their expression of dissatisfaction with the course of treatment or complaints about the logistical difficulties of attending or the loss of time from work. Again, we suggest that the same steps be taken as when the family initiates termination directly.

The challenge of family-initiated terminations is to determine if they are premature or not. In the nursing literature, there is a dearth of research to provide insights into reasons for premature terminations. Therefore, it is an area that currently relies on the nurse's clinical hunches to ascertain if the termination is premature or not.

Hopefully, future research studies will address this area in nursing practice with families who are seen on an outpatient basis. From our clinical experience, we have found that families who miss the first treatment session are at high risk of dropping out during the course of treatment. The implication of missed appointments refers back to the importance of the engagement stage and even to the initial contact with families on the telephone.

We have also found that the nature of the referral source has a direct correlation with the family's continuing in treatment. Families who are referred by institutions (e.g., school, court) tend to discontinue treatment more frequently before achieving treatment goals than families who were individually referred (e.g., physicians, mental health professionals). Most families who are self-referred tend to complete the treatment process.

It is critically important to help families understand the nature of the treatment contract. Many families have a certain understanding of what takes place in family interviewing that is a markedly different understanding held by the nurse. Therefore, they may relate to the nurse as they do to physicians or clergy, whereby they use the services as they wish and discontinue when they so desire. This is why we find it particularly useful when seeing families on an outpatient basis to contract for a certain number of sessions and then reevaluate as one way to try and avoid premature or abrupt termination.

Context-Initiated Termination

In some settings, such as hospitals—particularly, managed health care systems—it is not the nurse or the family who initiates termination but the health care system or insurance company. In these situations, it is very important for the nurse to assess whether the family needs further treatment or can continue to resolve problems and discover solutions on their own. If the family needs to be referred, the nurse requires some specific skills in this area. The referral process will be discussed in a later section of this chapter.

PHASING OUT AND CONCLUDING TREATMENT

Review Contracts

For families seen on an outpatient basis, we strongly encourage periodic review of the present status of the family's problems and changes. The use of a contract for a specific number of sessions provides a built-in way not only to set a time limit to the meetings but also to ensure periodic review. For example, at the Family Nursing Unit, University of Calgary, all families

contract for four sessions and then evaluate change. Sometimes all four sessions are not necessary and families can put them "in the bank" to be used at a later time if so desired. If further sessions are desired by the family at the conclusion of the four-session contract, then another contract is made between the family and the nurse and another reevaluation at the end of those sessions will occur. It has been fascinating that families who contract for more sessions rarely want another 5 or 10 sessions but usually request just 1 or 2 more sessions.

The contract also helps nurse interviewers to be mindful of the progress and direction of their work with families rather than seeing them endlessly and without purpose beyond the vague good intention of "helping." We prefer a designated number of sessions to open-ended sessions. However, nurses need to be flexible as to the frequency and duration of sessions. Normally, the frequency decreases as problems improve. Periodic reviews allow family members to have the opportunity to express their pleasure or displeasure with the progress that is being made.

Decrease Frequency of Sessions

If adequate progress has been made, this is an ideal time to begin to decrease the frequency of sessions. In our experience, we have found that families are able to work toward termination more readily and with more confidence when they recognize the improvement in their own ability to solve problems. Many families, however, find it difficult to acknowledge changes. In these circumstances, we suggest the use of a question, such as, "What would each of you have to do to bring the problem back?" to elicit a more explicit understanding or statement from family members regarding the changes that have been made.

Another very significant time to decrease the frequency of sessions is when the nurse has inadvertently fostered undue dependency. We have had many family situations presented to us in which nursing students or professional nurses provide "paid friendship" to mothers. These nurses have become the mother's major support system because they have not mobilized other supports, such as husbands, friends, or relatives. In situations in which this dependency has occurred and is recognized, we strongly suggest that the nurse help foster other supports for the family and decrease the frequency of sessions.

If a nurse encounters hesitancy or reluctance to decrease the frequency of sessions or to terminate completely, the nurse should encourage a discussion of the fears related to termination and solicit support from other family members. It has been our experience that family members frequently fear that if there are fewer sessions or if sessions are discontinued, they will not be able to cope with their problems or their problems will become worse. Thus, asking a question, such as, "What are you most concerned would happen if we discontinued our meetings now?" can get to the core of the matter very quickly. By clarifying family members' fears openly, other family members (who may be less fearful) have an opportunity to provide support.

Give Credit for Change

Nurses have frequently chosen the profession of nursing because they have a strong desire to be helpful to individuals and families in obtaining optimal health. Their efforts are usually helpful, and they are often given all or much of the credit for the changes and improvements. However, it has been our experience in family work that it is vitally important that the family receive the credit for change. There are several reasons for this necessity of stressing to the family they are responsible for the change.

1. Families experience the tension, conflict, suffering, and anxiety of working through problems related to their health/illness and relationships and therefore deserve the credit for improvement.
2. If the identified patient is a child and the nurse accepts credit, the nurse can be seen to be in a competitive relationship with the parents.
3. Perhaps the most important reason for giving the family credit for change is that this increases the chance that the positive effects of treatment will last. Otherwise, you may inadvertently convey the message that the family cannot manage without you, and they will become indebted or too dependent. Termination provides an opportune time to comment on the positive changes that have already happened during the course of treatment.
4. Praising the family for their accomplishments in having helped or corrected the original presenting problem will provide them with confidence in handling future problems. Specific statements, such as "You did the work" or "You people are being far too modest," can reinforce to the family members the idea that their efforts were essential in making the change.

It is never possible to really know what precipitated, perturbed, or initiated the change that occurs within families. Often, nurses create a context for change by helping family members to explore solution options to their difficulties or suffering. Wright et al, (1996) suggest that creating a context for change "constitutes the central and enduring foundation of the therapeutic process" and further suggest that "it is not just a necessary prerequisite to the process of therapeutic change, it is therapeutic change in and of itself" (p. 129). Sometimes, the very effort of bringing a family together in a room to discuss important family concerns can be the most significant intervention (Robinson & Wright, 1995).

If families present themselves at termination with concerns about progress, we must express our appreciation for their positive efforts to solve problems constructively even when there has been no significant improvement. When such is the case, we strongly recommend that nurses discuss with their clinical supervisors some hypotheses about why the interview sessions do not seem to have been effective. Perhaps the goals of the family or the nurse have been too high or demanding. If the family does not progress, this is usually the result of our inability to discover an intervention that is a fit with the family. Too often, we excuse ourselves from making further efforts to intervene when we label families as noncompliant, unmotivated, or resistant (Wright & Levac, 1992). It is very important, however, that the nurse believe that the family has worked hard despite minimal progress, and it is important to praise them for having done so.

We do not mean to imply, however, that because we are encouraging nurses to give families the credit for change that the nurse cannot enjoy the change. Family work can be very rewarding, and certainly, the nurse is part of the change process.

Evaluate Family Interviews

It is important to provide a formal closure to the end of the treatment process with a face-to-face discussion whenever possible. During this final session, it is very valuable to evaluate the effectiveness of the treatment process and the effect of changes on various family members. We recommend evaluating the effect not only on the whole family system but also on various subsystems, such as the marital subsystem and individual family member functions. Such questions as, "What have you learned about yourself and MS?" "What have you come to appreciate about your marriage?" or "What have you come to understand is the most effective way you can live with your grief?" invite reflections from the family about its changes. An even more dramatic evaluation can occur by having each family member and the nurse write about their reflections on the family meetings, emphasizing what they learned, what has changed, and what new ideas or beliefs they have about their problems or illness. One such family clinical-nursing team wrote poignant descriptions about dealing with their grief (Levac et al., 1988).

We also suggest asking family members the following questions: "What things did you find most and least helpful during our work together?" and "What things did you wish or were hoping would happen during our work together but did not?" In this way, it demonstrates that the nurse is also open and receptive to feedback. It is important at this time that the nurse not be defensive to any of the feedback. Rather, the nurse can express appreciation to the family and inform them that this feedback will assist and educate him or her to be even more helpful in work with future families.

> For too long evaluation has been a one-way process—from the dominant to the dominated. Participatory evaluation research turns the traditional evaluation process on its head. Outsiders are no longer the "experts" but instead empower the consumers of services to become leaders in evaluation and change. (Piercy & Thomas, 1998, p. 165)

We strongly concur.

Extend an Invitation for Follow-Up

Nurses often place themselves or are placed in situations of "follow-up." However, the follow-up is often *a* negative experience for both the nurse and the family. For example, community health nurses (CHNs) have reported that they are frequently requested to "check" on family members to assess their functioning. But those who request the visit (e.g., physician, Department of Child Welfare) have made no clear statement to the family about the purpose of the visit. Therefore, the nurse is in a very awkward position. We strongly discourage nurses from placing themselves in these kinds of situations unless there has been clear, direct communication with the family by the requesting party. Follow-up in this manner can give a very unfortunate and unpleasant message to the family that we anticipate further problems. It is better to make clear to the family that progress has been made and that the sessions are finished. However, if they would like input again in the future, indicate that you would be willing to see them. Families usually appreciate knowing that backup support by professionals is available to them in times of stress.

For nurses employed in hospitals, a follow-up session is usually not possible, but referral can be made to a CHN or homecare if deemed appropriate. Our experience has been that families do appreciate knowing whether they will have future contact with the nurse who has worked intimately with them.

Write Closing Letters

Another way to positively punctuate the end of treatment is to send the family a letter giving a summary of the family sessions. This letter provides the opportunity to highlight the family strengths, reinforce the changes made, offer the family a review of their efforts and what they have accomplished, and list the ideas (interventions) that were offered to them. At the Family Nursing Unit, University of Calgary, closing letters are routinely sent to each family on completion of treatment (Moules, 2002; Wright, 2004; Wright et al, 1996). Many families have commented about how much they appreciate the letters and how they frequently refer back to them. An example of a typical closing letter follows.

Dear Family Barbosa:

Greetings from the Family Nursing Unit. We had the opportunity to meet with various members of your family on eight occasions. I have also had several phone conversations with both Venicio and Fatima in recent months.

What Our Team Offered Your Family: Throughout our work together, our clinical nursing team has been very impressed with your family. Although a great many challenges have been presented to all of you over the past years, your family was able to overcome many obstacles and search for ways of helping each other through these difficult times.

We offered you the idea that most families find it very difficult to talk openly about an impending loss or death of a family member but that talking can be very healing. You have shown us that this was the case in your family.

We offered you a few books to read about other families who have experienced a similar tragedy as yours.

We offered you the idea that resolving issues in a relationship that has been conflictual can bring great peace and comfort, and particularly following the death of a loved one.

What Our Team Learned from Your Family. Our experience with your family has taught our clinical nursing team a great deal. The following is a synthesis:

1. Families dealing with a life-shortening illness in one of its members have the strength to deal with unresolved issues of blame, guilt, and shame. Even though there has been a great deal of pain and hurt in a family, they can heal their relationships and move on.
2. Although it can be a common, response for family members to distance themselves from the possibility of death with a life-shortening illness and to be afraid of dying, it is possible for them to make peace with each other and find peace in themselves, giving them the courage to go on.
3. Although a mother and son may reside in different places and may not see each other often, they can still play a significant part in each other's lives. No matter how old a child and parent are, the knowledge that they love and accept each other for what they are can make a significant difference in their lives.
4. The uncertainty involved with a life-shortening illness can be the most difficult thing for families to handle. Family members can help each other with the uncertainty by discussing the situation openly among themselves.
5. Grandparents and grandsons have very special relationships that are different from those of parents and sons.

As you all continue to face the many challenges that are ahead, we trust that you will draw on your own special strengths as well as on more open communication to help you meet these challenges. It was truly a privilege to work with you. We wish you continued strength for the future.

Should you desire further consultation at any time, you can arrange this by contacting the Family Nursing Unit's secretary. A Research Assistant will be in contact with you in approximately 6 months to ask you to participate in our outcome study to ascertain your satisfaction with the Family Nursing Unit.

Sincerely,
Jane Nagy, R.N., Masters Student

Lorraine M. Wright, R.N., Ph.D., Professor Emeritus of Nursing, University of Calgary

Therapeutic letters, whether sent during clinical work with families or at the end of treatment, have proven to be a very useful and often potent intervention to invite families to reflect on ideas offered within the session as well as to reflect on changes they have made during the course of sessions (Hougher Limacher, 2003; Levac et al., 1998; Moules, 2002; Watson & Lee, 1992; White & Epston, 1990; Wright, 2004; Wright & Nagy, 1993, Wright & Simpson, 1991; Wright & Watson, 1988; Wright et al., 1996).

Refer to Other Professionals

Referrals to other professionals may be advisable for a variety of reasons. We will list some specific tasks that are required to make a smooth transition for the family from one professional to another. First, however, we will discuss some of the more common reasons for nurses to refer families to other professionals.

With the expanding specialty areas within nursing, including family nursing, it is becoming impossible and totally unrealistic to expect nurses to be experts in all areas. Therefore, there are times when it is most appropriate for nurses to seek the input of additional professional resources when problems are quite complex. A nurse may refer families or specific family members for consultation or ongoing treatment. For example, if a senior within a family is experiencing temporal headaches, it is very important that any organic or biologic origin of this problem be ruled out. Therefore, a nurse might refer the family for consultation with a neurologist and may suspend treatment until the consultation is complete.

In other instances, the nurse may discover that a particular child has a learning disability that is out of the realm of the nurse's expertise. The nurse may suggest referring the child to an education center where personnel have greater expertise in dealing with children with learning difficulties. Nurses need to be open to referring individuals or entire families for consultation. It is inappropriate to perceive this as an inadequacy in their repertoire of skills. To refer wisely, nurses need an extensive knowledge of professional resources within the community.

Another reason for referring to other professionals, but not as common as the ones above, is when the family moves or is transferred to another setting or is discharged before treatment is finished. It is very important that the nurse, especially in hospital settings, maximize the opportunities to do family work. A beautiful illustration of this was given by one of our graduate nursing students. After some university seminars on the importance of family involvement, this student, who was working part time in a rural hospital, invited the parents of an asthmatic child to a family interview. The student obtained much valuable information regarding the interrelationship

of the child's asthmatic problem with other family dynamics. Shortly thereafter, the child was discharged. The nursing student ascertained that the family was interested in changing the recurring problem of frequent admissions for this young child. The student made an appropriate referral to the mental health services within the community. This highlights the point that with only one family interview, an assessment can be made and a significant intervention completed through referral for a recurring problem.

Prepare families. It is most important to adequately prepare families so that they understand the nature of the referral to a new professional. This can be done by explaining directly to families the reason for the referral and why the nurse feels that the family would benefit from such a referral. Another method that can be useful for ensuring openness and clarity about the nature of the referral is for the nurse to write a summary and then to review this summary with the family. This summary can then be sent to the new professional and a copy made available for the family. In this way, the family is not left wondering what information will be shared with the new professional. Also, an important implicit message is given that this information is confidential and private about them, and therefore, they have a right to know what is shared.

Selecting a new professional can sometimes pose a challenge. If a nurse is known in the community, it is wise to solicit the help of colleagues for ideas and advice on which agencies or professionals are best for the type of treatment needed or to seek information from community information directories and booklets.

Meet the new professional. It has been our experience that the transition to the new professional is much more effective and efficient if the nurse can be present with the family at the first meeting. In this way, a more personal referral is made. It often reduces the fears and anxieties that families may have about starting "fresh" with someone new. Before the referral, opportunities should be given to the family to express concerns or ask questions about the referral. At the first meeting, the family may wish to clarify with the new professional their expectations and understanding of the reason for the referral, and any misconceptions can be dealt with at that time. A conjoint meeting with the family, nurse, and new professional can also serve as a "marker" for the end of the nurse's relationship with the family.

Keep appropriate boundaries. Despite increased interdisciplinary collaboration in health care, it is still very important that when a family has been referred, boundaries of responsibility be clear. Otherwise, there is a potential for the nurse to inadvertently become triangulated between the family and the new professional.

For example, a homecare nurse regularly visited an elderly patient who lives with her adult daughter. The purpose of the visits by the home care nurse was to assist with colostomy care. The nurse observed and assessed the interaction between the elderly parent and the adult daughter as a severe and long-standing conflict. This conflict was having a negative effect and deterring the elderly patient from assuming more responsibility for her physical care. Because of her family assessment skills, the nurse was able to make an important referral to a family therapy program where more in-depth work on the intergenerational conflict began. However, in future visits with the elderly patient, the nurse was listening to complaints about the adult daughter that the patient was not discussing in the family meetings. Also, the family therapist called the nurse and asked the nurse to apply pressure on the elderly parent to be more cooperative in attending sessions. Thus, very quickly the nurse had become "caught in the middle" between the family and the therapist. The nurse dealt with the situation by requesting to join in a meeting with the family and the therapist to clarify expectations of all parties. In this one session, the nurse was able to "detriangulate" herself from any alliance by clarifying her present role with the family and the new professional.

Reading Transfers

In our more than 30 years of clinical experience, we have not found the practice of transferring families from one nurse to another to be very successful. We view the process of transfers as very different from referrals. A referral is usually made to another healthcare professional with different expertise. A transfer, on the other hand, is usually made to another colleague of similar expertise and competence. We recommend, if possible, that nurses conclude treatment with the families they are working with rather than transfer them to another colleague. In our experience, families frequently disengage with the new nurse through missed appointments, not showing up, or not stating any particular concern. It is understandable that families do not wish to "start over" with another nurse. We hypothesize that transfers are frequently made to assuage the nurse's feelings about leaving versus the family's desires about continuing treatment.

If, however, a transfer is necessary, we recommend that the "old" nurse use language indicating an ending of her relationship with the family. For example, she can say, "Now that my work with you is coming to an end, what would you like to work on with Sanjeshna (the 'new' nurse)?" In addition, we encourage the new nurse to directly ask the family about their relationship with the previous nurses. Questions such as, "What do you anticipate will be different in our work together versus your work with Li?" are useful. This type of conversation punctuates a change rather than a continuance of the same work. It fosters engagement and is important for the new nurse and the

family in establishing a collaborative relationship.

Another way to increase engagement is for the current nurse to ask the family to take a break between contacts before the family initiates setting up an appointment with the new nurse. This again emphasizes the change in the working relationship and encourages the family to be self-directed in initiating the new contact rather than simply responding to the professionals.

FAMILY INTERVIEWING SKILLS FOR CONCLUDING OR TERMINATING WITH FAMILIES

The above skills for concluding or terminating with families can be conceptualized as perceptual/conceptual and executive skills (see Table 1). The skills that have been identified fit within the context of our particular practice models, namely, the Calgary Family Assessment and Intervention Models (Wright & Leahey, 2000). Perceptual and conceptual skills are paired because what is perceived is so intimately interrelated with what is thought. It is often difficult to separate the perceptual from the conceptual component. These perceptual and conceptual skills are then matched with executive skills. We have demonstrated the actual practice of these skills in live clinical interviews in our "How to" Family Nursing Video Series: *How to Engage, Assess, Intervene and Terminate with Families* (Wright & Leahey, 2002).

Perceptual skills refer to the nurse's ability to make relevant observations. The nurse's own ethnicity, gender, sexual orientation, race, and class are but a few of the factors influencing his or her perceptions. There is a major shift from the perceptual skills required in individual interviewing to those required in family interviewing. This shift can be explained in that the nurse is involved in observing multiple interactions and relationships simultaneously. The interaction among family members and the interaction between the nurse and the family are simultaneous.

Conceptual skills involve the ability to give meaning to observations. They also involve the ability to formulate one's observations of the family as a whole, as a system. We are always cognizant that the meanings derived from observations are not "the truth" but represent one nurse's effort to make sense of his or her observations.

We believe that the student entering the nursing field has intuitive perceptual and conceptual skills that have been learned in other roles in previous life experiences. The student, however, is often unaware of many of the skills. The nurse needs to develop an overt awareness of the perceptual process. The perceptual and conceptual skills are the basis of the executive skills.

Executive skills are the observable therapeutic interventions that the nurse actually carries out in an interview. These skills or therapeutic interventions elicit responses from family members and are the basis for the nurse's further observations and conceptualizations. As can be readily seen, the interview process is a circular phenomenon between the nurse and family. The process is highly influenced by the nurse's and the family's particular ethnicity, class, and race. Of course, the types of therapeutic interventions offered by the nurse are highly dependent on his or her clinical expertise and experience in working with families.

SUCCESS IN FAMILY NURSING PRACTICE

Although interventions may obtain positive and possibly dramatic results during treatment, the real success of family work is the positive changes that are maintained or continue to evolve weeks and months after nurses have terminated treatment with particular families. We strongly encourage professional nurses and nursing students to make it a pattern of practice to obtain data from the family as to the outcome to determine the best practices. When there is a focus on outcome, it directs the nurse to orient his or her work toward change, focus on problems that can be changed, and think of how the family will cope without the nurse in the future. We also suggest that in any follow-up with families, the nurse can explain that this is a normal pattern of practice (e.g., "We normally contact families with whom we have worked within 6 months to gain information on how things are evolving"). It is also important to use this follow-up with specific goals in mind. Thus, a very useful reason for follow-up can be for research purposes. In our experience, beginning family nurse interviewers tend to be more focused on what is going on in the family, whereas more experienced nurses focus on quite specific goals for treatment.

To facilitate evaluation, we suggest formalizing follow-up of families, particularly those seen on an outpatient basis, by live interview, questionnaire, telephone, or even e-mail. At present, we favor the use of a face-to-face discussion and questionnaire that is answered by all available family members.

At the Family Nursing Unit (FNU), University of Calgary, families are routinely interviewed 6 months after the last session by a research assistant who has had no previous contact with the families (Wright et al, 1990,1996). This outcome study is designed to evaluate the services provided by the FNU. The variables examined by this study are the family's satisfaction with the services provided, satisfaction with the nurse interviewer, and change in the presenting problem and family relationships. A semistructured questionnaire designed for this study asks for each family member's perspective on each of the variables. Questions are asked in relation to two periods: at the conclusion of the family sessions and at the time of the survey. Results from the survey indicate that the most helpful aspects of family sessions were the opportunity to ventilate family concerns, thereby increasing communication among family members and obtaining support

from the FNU clinical-nursing team. Families ranked the interview process and the suggestions from the FNU clinical-nursing team as the second most helpful aspects (Bell, personal communication April 15,2004).

Family members reported satisfaction with the nurse interviewer, who was a master's or doctoral student or a faculty member specializing in family systems nursing. They indicated that the friendly, professional, and nonthreatening manner of the graduate nursing students made them comfortable.

More than 75% of the family members reported the presenting problem was better at the time of the survey. Regardless of the presenting problem, positive changes in the marital relationship, such as increased communication, improved relationships, and decreased tension, were also reported (Bell, personal communication April 15, 2004), suggesting support for the systems theory tenet that change in one part of the system affects change in other parts.

This type of outcome study suggests that assessing change should be evaluated at the individual, parent-child, marital, and family system levels. We believe that a higher level of positive change has occurred when improvement is evidenced in systemic (total family) or relationship (dyadic) interactions than when it is evidenced in individuals alone. That is, individual change does not logically require system change, but stable system change does require individual change and relationship change, and relationship change requires individual changes.

Family treatment does appear to be having creditable success as reported by outcome studies in family therapy. Specifically, marital and family therapy has shown to be significantly and clinically more effective than no psychotherapy or individual treatments for adult schizophrenia, adult alcoholism and drug abuse, adult hypertension, elderly dementia, cardiovascular risk factors in adults, adolescent conduct disorder, adult obesity, anorexia in young adolescent girls, chronic physical illnesses in adults and children (asthma, diabetes, and so forth), child obesity, cardiovascular risk factors in children, and depressed outpatient women in distressed marriages (Campbell & Patterson, 1995; Pinsof & Wynne, 1995; Sprenkle, 2002). Nurses could contribute significantly to family outcome research by focusing on follow-up with families in which particular family members experience a health problem. This area of family work is just beginning to be researched and lends itself beautifully to the active involvement of nurses in its evolution.

CONCLUSION

It can be seen that the matter of concluding treatment in a therapeutic and constructive way is a challenge for any nurse working with families. Unfortunately, much more has been written in the literature about how to begin with and treat families than how to effectively and therapeutically terminate with them. However, we want to emphasize the extreme importance of terminating contact with families in a manner that will increase the likelihood that diminished suffering will be sustained and that changes in family relationships will be maintained, celebrated, and expanded.

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Table 1: Family Interviewing Skills for Concluding or Terminating With Families

Perceptual/Conceptual Skills	*Executive Skills*
A. If consultation or referral is necessary. 1. Recognize that families appreciate additional professional resources when problems are quite complex. That is, nurses cannot be expected to have expertise in all areas.	1. Refer individuals and/or family members for consultation or ongoing treatment. For example, “I feel that your family needs professional input beyond what I can offer for Tracey’s learning disability. Therefore, I would like to refer you to the learning center in the city. They have more expertise in dealing with these types of problems.”
B. If family interviewing with nurse continues 1. Recognize the importance of evaluating the family interviews at regular intervals. That is, evaluating the progress of family interviews leads to more focused and purposeful time spent with the family.	1. Obtain feedback from family members about the present status of their problems and initiate termination when the contracted problems have been resolved or sufficient progress has been made. Families do not lead problem-free lives. Rather, what is important is their feeling of confidence to cope with life’s challenges and stresses.
2. Recognize when dependency on the nurse inadvertently may have been encouraged. That is, many interviews during a prolonged period can foster excessive dependency.	2. Mobilize other supports for the family if necessary, and begin to initiate termination by decreasing the frequency of sessions. For example, nurses can inadvertently provide “paid friendship” to mothers in particular unless they mobilize other supports such as husband, friends or relatives.
3. Recognize family members’ constructive efforts to solve problems. It is the family’s perception of progress that is more significant than the nurse’s perception.	3. Summarize positive efforts of family members to resolve problems whether or not the nurse believes significant improvement has occurred. For example, nurse may comment, “Your family has made tremendous efforts to find ways to care for your elderly father at home while still attending to your children’s needs.”
4. Recognize that backup support by professional resources is appreciated by individuals and families in times of stress.	4. End the family interviews with a face-to-face discussion when possible. If appropriate, extend an invitation for further family meetings should problems recur or if the family desires consultation.