

The Three Most Common Errors in Family Nursing: How to Avoid or Sidestep

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In this article, the authors offer what they believe to be the three most common errors or mistakes in relational family nursing practice. Each error is described, followed by practical suggestions on how the mistake or error can be avoided. A clinical case vignette for each error is also given, with useful ideas of how the mistakes could have been avoided or sidestepped. By sidestepping and avoiding the most prevalent mistakes, nurses can not only sustain but also improve their nursing care of families and thus prevent unnecessary anguish and suffering of family members and possible shame, guilt, or embarrassment on the part of the nurse.

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Nurses working with families of course want to be helpful and reduce or alleviate suffering whenever possible. However, sometimes, despite nurses' best efforts to offer competent and compassionate care, errors, mistakes, or misjudgments can and do occur. Errors can be many and varied, but we have identified what we believe to be the three most common errors that occur in relational family nursing practice.

THREE MOST COMMON ERRORS

Whether nurses are beginners or experienced clinicians in family nursing, it is helpful to know how to avoid or sidestep errors in family nursing practice. The three most common errors that we have identified and will describe in this article have unfortunately been committed, experienced, or witnessed in our own clinical practice or in the supervision of our students' clinical practice with families.

For each error, we will explain and describe it and discuss in what way we believe it is a mistake and how it can have a negative impact on the family. We then suggest practical ways for avoiding these errors. Finally, we offer a clinical case vignette for each error. It is our hope that by sidestepping the most prevalent mistakes, nurses can not only sustain but also improve their nursing care of families. In addition, we believe it will give nurses more confidence and competence in their nursing practice when they are able to offer a context for healing that is more likely to be helpful.

Error 1: Failing to Create a Context for Change

Every nurse in every encounter and experience with a family, whether for a short 5 minutes or more than 5 years, has the responsibility to create a context for healing and learning:

Creating a context for change is the central and enduring foundation of the therapeutic process. It is key to the relationship between the clinician and family. It is not just a necessary prerequisite to the process of therapeutic change, it is therapeutic change in and of itself. (Wright, Watson, & Bell, 1996, p. 129)

In creating this context for change, both the nurse and the family undergo change. From the first meeting, the nurse and family co-evolve together, with both the family and the nurse changing in response to the other and according to their own individual biopsychosocial-spiritual structures, which have been influenced by their history of interactions and their genetic makeup (Maturana & Varela, 1992).

What must happen to create a healing context for change? Wright et al. (1996) offer some useful ideas, one of which is that before a context for change can be created, all obstacles to change must be removed. Such obstacles can include the following: A family member does not want to be present or attends the session under duress, a family member is dissatisfied with the progress of the clinical sessions, the family has had previous negative experiences with health care professionals, or there are unclear expectations for the meetings.

At the Family Nursing Unit, University of Calgary, a hermeneutic research study was conducted by Drs. Janice M. Bell and Lorraine M. Wright to explore the process of therapeutic change when desired outcomes have not been achieved (Bell, 1999). The focus of this study was to analyze the clinical work with three families who reported negative responses. These were families who suffered from serious illnesses and were seen in an outpatient clinic by a clinical nursing team of faculty and graduate nursing students. Preliminary results of this study provide very helpful feedback to improve family interviews. The most informative learning was that creating a context for change was either ignored or neglected in these families who were dissatisfied with the nursing

team's clinical work. What was most lacking, Bell and Wright discovered, was the clinical skill of being curious on the part of the nurse interviewer (Bell, 1999). For example, there was no clarification of the presenting problem or concern. Also, there was no attention to the fit of the intervention offered in relation to the family's functioning. The nurse interviewer did not ascertain from the family whether the intervention ideas offered were useful. Another example of not attempting to create a context for therapeutic change was the error of the clinical nursing team in becoming too so-called married to a particular way of conceptualizing the family's problems or dynamics, which were not in harmony with the family's conceptualization (Bell, 1999).

These findings strengthen the importance of the common factors that Hubble, Duncan, and Miller (1999) discovered were associated with positive clinical outcomes. These included the following:

- extratherapeutic factors, including client beliefs about change, strengths, resiliencies, and change occurring from positive events in clients' lives (40%);
- the client-therapist relationship experienced as empathic, collaborative, and affirmative in focusing on goals, method, and pace of treatment (30%);
- hope and expectancy about the possibility of change (15%); and
- structure and focus of a model or approach organizing the treatment (15%).

How to not fail at creating a context for change. Ideas for this include the following:

- 1 Show interest, concern, and respect for each family member. The most useful way to do this is to ask anyone who is involved in or concerned about the problem or is suffering to come to a family meeting. After introducing yourself and meeting each family member, the nurse can express her desire to learn from the family about how this problem, or illness has affected their lives and relationships. This can convey to the family that the nurse is interested and is willing to learn about them and their most pressing concerns. This is much easier to do if the nurse embraces the belief that all families have strengths, which are often unrealized or unappreciated (Wright et al., 1996).
- 2 Obtain a clear understanding of the most pressing concern or greatest suffering. Seek each family member's perspective on the problem or illness and how it is affecting their family and their relationships.
- 3 Validate each member's experience and remember that no one view is the correct or right view or the truth about the family's functioning. Be open to all perspectives about the family's concerns.
- 4 Acknowledge suffering and the sufferer. The acknowledgment of being a sufferer and experiencing suffering by health providers can be a powerful starting point for understanding the family's situation and for healing (Wright, 2005). Through these efforts to understand, the nurse-family relationship is enhanced and strengthened. When families encounter nurses who acknowledge their suffering and are compassionate and nonjudgmental, it frequently opens the door for the disclosure of fears or worries not previously expressed. In doing so, the potential for healing, growth, and change increases.

Clinical example. Creating a context for change is often started in the same manner as meeting a stranger for the first time. But in this clinical example, a ritual of introduction, which is usually part of greeting strangers, is omitted by the nurse. She also neglects to determine the goals for this meeting. Therefore, some of the important aspects of establishing a new relationship are omitted, and the therapeutic relationship starts down a slow, slippery slope, resulting in the family not being interested in further meetings.

A nurse first met this family at the bedside in a busy medical unit in a large, urban hospital. Mr. Sanchez had been admitted to the hospital because of chronic obstructive pulmonary disease. A woman visited frequently and was usually crying during the visits. On this one occasion, the primary nurse asked the husband, "Do you know why your wife is crying?" Unfortunately, the nurse did not introduce herself to the woman who was visiting and made the assumption that the woman was his wife. He responded, "No, this is not my wife. My wife and I are divorced; this is my sister." The nurse was somewhat embarrassed but asked again, "Oh, I'm sorry. Well, do you know why your sister is crying? She cries on every visit." Mr. Sanchez responded, "I'm not sure." At that point, his sister stopped crying and looked up but did not speak.

The nurse then made a premature conceptualization and offered her assessment by saying "Well, I think she is crying because she is worried that you are not going to get better if you don't stop smoking, isn't that right?" The sister shook her head.

At this point, Mr. Sanchez stated, "Well, it's too late even if I do stop smoking." The nurse then said she would like to come back at another time to discuss the issue with them more fully. She now addressed the sister for the first time, but the sister replied that she did not want to meet because this was her brother's problem. The nurse accepted this response and did not have any further discussions with this family.

Comments and reflections about the clinical example. There were many golden opportunities that were missed to create a context for change in this nurse-family encounter. First, the nurse needed to introduce herself to the sister; this would have clarified the sister's relationship to the

patient. If the sister had been acknowledged at the start of the conversation, perhaps the sister would have been more forthcoming and more willing to have another meeting. Also, the nurse could have asked if there were any questions they might have about the patient's condition or if they had any worries or concerns. This would have given the nurse an opportunity to validate any concerns they might have. The sister's weeping on each visit indicates that she is suffering, but it is unclear as to the nature or reason for her suffering. Finally, the nurse offered a quick conceptualization of the problem that the sister is worried about the brother's smoking habit and his not getting better. However, the sister disagrees with this conceptualization of her suffering, and unfortunately, the nurse does not ask any further therapeutic questions to ascertain the nature of her suffering.

The findings in the study by Bell and Wright (Bell, 1999) mentioned earlier are clearly evident in this clinical example. There was no clear identification of the presenting concern or suffering; and a conceptualization of suffering was offered too quickly without obtaining the perspective of each family member. Without these ingredients to create a context for change, there was no opportunity for healing to occur. And it is sad that good manners were also missing, as there was no introduction by the nurse to the family.

Error 2: Taking Sides

One of the most common errors in family work is when a nurse takes sides or forms an alliance with one family member or subgroup of the family. This often is done unintentionally; although at times, the nurse may do so deliberately, usually with a benevolent intent. However, joining with one person can often result in other family members feeling disrespected, disempowered, and non-influential as the family pursues its goals with the nurse.

How to avoid taking sides. The suggestions for doing this include the following:

- 1 Maintain curiosity. Be intensely interested in hearing each person's story about the health concern or problem. When each family member's perspective has been revealed, the nurse can generally come to an understanding of the multiple forces interacting together that stimulate or have triggered the problem. Families are very complex, and the complexity is increased when an illness or problem emerges. Be open to experiencing an altered view of the person and situation.
- 2 Remember that the glass can be half full and half empty simultaneously. There are multiple truths and, therefore, many ways to view a problem. The more a nurse can obtain an all-inclusive understanding, the more possible options there are for resolution. However, we wish to emphasize that we do not condone violence or failure to act in dangerous, illegal, or unethical situations.
- 3 Remember that all family members experience some suffering when there's a family problem or illness.
- 4 Give relatively equal time for expression of concerns and interest for each family member. This of course may vary with young children or family members who are only able to minimally contribute verbally, such as those who are disabled or are experiencing dementia.
- 5 Remember that information, as Bateson (1972) described it, is "news of a difference." Therefore, nurses need to treat all information as new discoveries and maintain a systemic or interactional perspective regarding the illness and family dynamics.
- 6 Avoid having phone conversations with one family member telling on another family member. Instead, invite the person to bring the issue to the next family meeting. Another idea is for the nurse to invite one parent to ask the other parent to join in the phone conversation. In this way, the conversation is transparent for all. E-mailing all parties participating in the family interviews also facilitates transparency.

Clinical examples. A clinical example often encountered by community health nurses or nurse practitioners is a mother's troubling report about her toddler's eating habits. In particular, the mother describes how the father gets frustrated and impatient with the baby's messy feedings. "It's like I have two children!" (She only has one toddler but experiences her husband's behavior as child like.) However, when the nurse meets the husband, she hears an entirely different story from the father about how the 2-year-old eats in his presence. He describes how his wife becomes tense, screams, and gets stressed out by the toddler's feedings.

The nurse asks herself, "Who should I believe? Who is telling the truth?" If she sides with one parent, then she alienates the other. She misses opportunities to work with the entire family on helping them adjust to normal developmental child care issues. This trap is especially easy to fall into if one parent negatively labels the other. For example, the husband may say, "You know my wife gets hysterical," or the wife may say, "You know, my husband is so irresponsible; he struggles with depression."

To address this situation, the nurse practitioner could (a) ask the mother, "When your husband shows frustration, what do you do?"

(b) ask the father, "When your wife starts to scream at the baby, what do you find yourself doing?" and (c) invite both parents to come together to talk about the challenges involved in raising a 2-

year-old. Having obtained a circular view of the interaction, there are several possible interventions the nurse could devise. For example, the nurse can look at them both and ask "Which do you think would be harder, for your wife to give up screaming or for your husband to show more responsibility? Who, between the two of you, would find it easier to believe the other might change?"

Another example concerns a family with a teenager dealing with anorexia. Sheena, age 16, is being seen by the unit nurse Karen McTavish, age 51, to help her develop more appropriate eating habits and to increase her socialization. Sheena has successfully begun to conquer the grip of anorexia and is very appreciative of Karen's assistance. She looks forward to individual meetings with Karen and compliments Karen frequently on wearing "fashionable clothes my mother never would wear." Karen believes she and Sheena have an excellent working relationship and is pleased that Sheena likes her taste in clothes.

Karen has agreed to alternate between individual meetings with Sheena and family interviews that include both parents. During a family meeting in which Karen has proudly described Sheena's recent accomplishments on the unit, Sheena's mom starts to downplay her daughter's successes. She tells Karen of the various bad behaviors that Sheena engaged in during a recent pass home. Following this, Sheena bursts out to her mother, "How come you don't treat me as an adult like Karen does?"

By inadvertently aligning too much with the teenager Sheena (i.e., around clothes and a special relationship) and not sufficiently aligning with Sheena's parents (i.e., never seeing them as parents alone to appreciate their challenges in raising a daughter who is in the grip of anorexia), Karen has sacrificed her ability and therapeutic leverage to be multi-partial in the family meetings. Now, the nurse is perceived, by both mother and daughter, to be on the teenager's side. This makes it difficult for the mother-daughter relationship to flourish and for Sheena's changes to be acknowledged by her mother. Rather, the mother may inadvertently feel competitive or usurped by Karen. Indeed, nurses who take the side of one or more family members are not usually or consciously wanting to alienate, compete, or usurp any particular family member. It is often out of the nurse's awareness that she has taken sides, and thus, it comes as a shock when other family members express dissatisfaction or begin to disengage or discontinue family meetings.

Error 3: Giving Too Much Advice Prematurely

Nurses are in the socially sanctioned position of offering advice, information, and opinions about all manners of health promotion, health problems, illness management, and relationship issues. Families are keen and most often receptive to nurses who offer their expertise concerning health and illness issues and management. However, each family is unique, as is each situation, and therefore, timing and judgment are critical for nurses to determine when and how to offer advice.

How to avoid giving too much advice prematurely. Suggestions for doing this include the following:

- 1 Only offer advice, opinions, or recommendations after a thorough assessment has been done and a full understanding of the family's health concerns, illness, or suffering has been obtained. Otherwise, the nurse's advice and recommendations can appear too simplistic or lack an in-depth understanding or compassion. Of course, in crisis situations, or in a busy emergency or intensive care unit, a full family assessment may not be possible. In situations when families are in shock, numb, or overwhelmed, they can benefit from clear, direct advice from a nurse who through professional experience and knowledge can bring calm and structure in a time of crisis.
- 2 Offer advice without believing that the nurse's ideas are the best or better:

Often there is a tendency and temptation among health care providers to offer their own understandings, their own 'better' or 'best' meanings or beliefs for clients' suffering experiences with serious illness. One way to avoid this trap of prematurely offering explanations or advice to reduce suffering is to remain insatiably curious about how clients and their families are managing in the midst of suffering. (Wright, 2005, p. 199)

And especially, what do they believe and what meaning do they give to their suffering (Wright et al., 1996). Health professionals who are insatiably curious put on the armor of prevention against blame, judgment, or the need to be right.

- 3 Ask more questions than giving statements or offering advice during initial conversations with families. Asking therapeutic or reflexive questions (Tomm, 1987; Wright & Leahey, 2000; Wright et al., 1996) invites a person to explore and reflect on their own meanings of their health concerns or suffering, not the nurse's. Hopefully, through those reflections by family members that happen in the therapeutic conversations, healing may be triggered as new thoughts, ideas, or solutions are brought forth about how a family can best live with the illness (Wright, 2005).
- 4 Obtain the family's response and reaction to the advice. After offering advice, it is essential to obtain family members' reactions to the information. Specifically, does this information fit with the family's own bio-psychosocial-spiritual structures.

Clinical example. Nurses frequently encounter families who are experiencing deep suffering and grief because of the anticipated or recent loss of a family member. One such family had recently experienced the loss of their 88-year-old father, who had lived with them for 10 years. He had left Hong Kong following the death of his wife to live with his son and family in Canada. Just 3 weeks following the death of the elderly father, his daughter-in-law, Ming-mei, with her husband Shen, entered a walk-in medical clinic with abdominal pain. When the medical exam was completed and when it was determined that there were no physical reasons for her pain, one of the nurses was asked to meet with the husband and wife. Shen told the story of the recent loss of his father, how his wife had been the primary caregiver, and how she had given up her employment to care for her father-in-law. He then offered his belief that his wife's pain was the result of her extreme grief at the loss of her father-in-law. The nurse, on hearing this story, but without inquiring about the wife's extreme grief or the meaning of her loss and suffering, prematurely offered the following advice to the couple. To the husband, she said the following: "You need to take your wife on a holiday. She is very tired after caring for your father." To Ming-mei, his wife, she said the following: "Your father-in-law was an elderly man, and his time had come. And since he was not your father, you will get over this more quickly."

Comments and reflections about the clinical example. It is understandable that this family did not find the advice of the nurse helpful or comforting. If the nurse had asked a few assessment questions and completed a family genogram (Wright & Leahey, 2000), she would have learned that Shen owns a small coffee shop and is unable to take holidays as he is the sole provider and works 7 days a week. Ming-mei also did not find the nurse's words at all healing but instead felt that the nurse ignored the very close relationship she had with her father-in-law. By offering this type of advice, albeit well-meaning advice, the nurse missed the opportunity to truly offer some opinions and recommendations that would have been more healing.

By not being more curious, not asking pertinent assessment questions, and not being more interested in understanding the daughter-in-law's beliefs about the loss of her father-in-law, the nurse prematurely and inappropriately offered her own best ideas and advice to the family, even though these did not fit this couple. Also, the nurse did not recognize or acknowledge the Chinese culture of this family and their sense of honoring and responsibility to their elderly family members. It is sad that this nurse also missed a golden opportunity to commend this daughter-in-law for her compassionate care of her father-in-law.

CONCLUSION

Working with families in relational nursing practice offers us many opportunities for helping family members live alongside illness, reduce suffering, and increase their sense of wellness. Similar to other professionals, at times, we make errors and mistakes in our practice and are less helpful than we desire. It is our hope that by describing what we consider the three most common errors in relational family nursing practice that nurses will avoid these errors or, if they do make a mistake, will find ways to rectify the situation and recoup with the family. The process of collaborating with families is rich with opportunities for creative healing, even when errors do occur. By sidestepping the most frequent mistakes, nurses can offer a context for healing that is more likely to be helpful than unhelpful.

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