DESCRIPTION OF THE FAMILY THERAPY PRACTICE OF PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS IN THE STATE OF OREGON

by

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CHAPTER ONE

Introduction

Family theory conceptualizes the interrelating members of the family, set apart from non-family, as constituting a delicately balanced, continually changing system (Cain, 1986; Calhoun, 1982; Boyd, 1985). Cain (1986) asserted that emotional illness is a family systems phenomenon and urged that clinical nurse specialists be adequately prepared to function as family therapists.

Viewing the family as an important part of the patient's environment is embedded in nursing history (Whall, 1986a), and therefore nursing has been receptive to two differing conceptions of what constitutes the client system: the individual in the context of the family, and the family system as a client. Nightingale (1859 [1980]) first defined nursing, often performed by a family member, as a discipline concerned with the interaction between the patient and the environment for the purpose of improving the patient's health. More recently, nursing theorists Levine, Rogers, Roy, Neumann, and Johnson (cited in Flaskerud & Halloran, 1980; & Meleis, 1985) have focused specifically on the interaction between the patient and the environment, including the family. While historically nursing theory has supported treating the patient in the environment, or context, that includes the family group, more recent nursing theory has supported nursing care for the patient within the family system (Gillis, 1989a).

Currently, the family can be conceptualized in two ways: family-as-context, and family-as-unit (Gilliss, 1989a). From the family-as-context perspective, the nurse plans care for the individual client. The nurse welcomes other family members and keeps them informed. She becomes aware of family problems and keeps them in mind when planning care for the ill member. "It is in the family-as-context perspective that nursing care has been traditionally offered" (Gilliss, 1989a, p. 16).

Family-as-unit based care, or family systems nursing, is a more specialized position (Gilliss, 1989a; Wright & Leahy, 1984). Interventions from this perspective are basic to family therapy, in which the nurse plans emotional care for the family-as-unit, or the system (Galvin & Brommel, 1986). The nurse becomes aware of reciprocal emotional patterns among members, and plans interventions that will impact these patterns. All aspects of the nursing process - assessment, planning, intervention, and evaluation - are directed toward the patterns of the family unit.

Problem Statement

While many nurses do practice family therapy (Smoyak, 1975; Christman, 1987; Spunt, Durham, & Hardin, 1984; Calhoun, 1982; Goodspeed, 1976; Smalkowski, 1976; Rohde, 1968; Ujhely, 1973; & Lego, 1973), descriptions of how nurse psychotherapists conceptualize their clients are lacking in the literature. Nor have nurse

psychotherapists' use of theories and psychotherapeutic interventions for families been well described. Nurse psychotherapists' definitions of health as expressed in goals for therapy, and descriptions of the contextual settings in which they practice are also sparse.

The purpose of this study is to describe the family therapy practice of psychiatric mental health nurse practitioners in Oregon. Results from this study can provide a base for future research to document the effectiveness of this nursing practice role.

Review of the Literature

The review of the literature is divided into four sections. Each section reviews literature discussing one of four concepts that constitute the conceptual framework of this study: client, nursing interventions, mental health, and context for nursing interventions. In the first section, selected conceptualizations of family as client are reviewed. In the second section, major theories dealing with families, and the interventions derived from these theories, are reviewed. In the third section, health, as the goal of psychotherapy, is defined for each theoretical perspective of the family. In the fourth section the contextual settings that influence the nursing practice of family therapy are described.

The Family as Client

Families are characterized by different authors according to the members included in the family. There are

nuclear, single parent, blended, and extended families; there are communal groups, and partners without children. The "typical American family", in the past has been equated with the nuclear family, composed of father, mother, and children. This type of family is no longer in the majority (Galvin & Brommel, 1986).

Galvin and Brommel (1986), and Boyd (1985) describe increasingly common types of families which encompass other combinations of members. Single-parent families include an unmarried, divorced, widowed, or deserted parent and the children that remain. Extended families are the larger group of relatives, related by blood or marriage, often living in the area (Smoyak, 1975). Blended families add members through remarriage or adoption (Galvin & Brommel, 1986). Communal families are groups of people who share a commitment to each other, and live together. An example includes groups such as those living in a kibbutz (Kaffman, 1985). Partners without children consist of either heterosexual or homosexual couples who either choose not to or cannot have children (Galvin & Brommel, 1986).

Laing (1972) defines family as, "networks of people who live together over periods of time, who have ties of marriage and kinship to one another" (p. 3). Leavitt (1982) and Boyd (1985) define family even more loosely as a human group with significant emotional bonds, usually living together in the same household. The most inclusive view of family may be this one: "Thus persons presenting

themselves to the nurse for assistance will define for themselves who is their family" (Whall, 1986, p. 6).

These different configurations of family imply that there will be multiple structural, communication, and relationship patterns. Relationships among members of a family are viewed as reciprocal, affecting each other's thoughts, feelings and behavior as do feedback systems (Satir, 1968). Symptoms are not thought of as individual, but as "signals of system distress" (Smoyak, 1975, p. 43). The idea of reciprocity, or feedback influence, has been termed "circular causality" to avoid the idea that one person in a family is responsible for symptoms (or "linear causality"). These observations are grounded in von Bertalanffy's (1968) conception of general systems theory and Bateson's (1972) view of cybernetics (feedback systems).

For this research study the family is conceptualized as a unit - as a system. Theory viewing the family as a system was energized by a surge of interest in families during the 1950's (Smoyak, 1975). Role, developmental, and communication theories support viewing the family as a system (Boyd, 1985). Theory viewing the family as a system is sometimes called family therapy theory (Whall, 1986a). Alternatively, it is considered systems theory, or family systems theory (Spunt, Durham, & Hardin, 1984; Calhoun, 1982; Smoyak, 1975), to distinguish it from psychodynamic, cognitive, humanistic, group, play, or behavior theory. To

avoid confusion with Bowen's family systems theory or the Milan group's systemic theory, conceptualizing the family as a unit or system is called family theory. In the following section, various schools of family theory are reviewed.

Family Theories and Interventions

Professionals from several disciplines have participated in conceptualizing family theories. Psychiatrists such as Bowen (Kerr & Bowen, 1988), and Whitaker (Whitaker & Keith, 1981) explicated powerful family theories. Satir was a highly influential social worker (Satir, 1968; Corrales, 1989; & Simon, 1989), who contributed a rich understanding of family to the interactional theory of the Mental Research Institute. Whall (1986a), a nurse, demonstrated that nursing theories were consistent with family theories. Bateson (1972), an anthropologist, provided support for family unit or systems theories with his views on cybernetics. Communication experts shared their findings (Bateson, Jackson, Haley, & Weakland, 1956).

Family researchers have each emphasized different aspects of family relationships, including communication, structure, and symptoms. Separate schools of family therapy have evolved around these different foci. Various schools often share concepts, but may use different language to describe the particular aspect of the human condition they are studying.

Each school also implements different interventions in the change process called psychotherapy. For this study, psychotherapy is defined as a formal individual, family, or group relationship involving a process of planned, structured, consistent psychological interaction between a mental health nurse with at least a master's degree in nursing and supervised training in psychotherapy, and a patient who seeks relief through psychotherapy (Schlesinger, 1985; & Moscato, 1988).

In attempting to capture the essence of family therapy, six primary schools of family theories will be compared against these criteria: types of family pathology grounding the theory, concepts interrelating to form the theory, and the therapist's role and interventions deriving from the theory. The six schools are: Bowen's family systems theory; Whitaker's symbolic-experiential theory; the Mental Research Insitute's interactional theory; Minuchin's structural theory; Watzlawick, Weakland, and Fisch's strategic theory reviewed with the Milan group's systemic theory; and Patterson's behavior family therapy. All these theories view the family as a unit or system. Patterson's (1982) behavior family therapy has been included under family theory because it does involve the parents in working with their children, even though it might at first seem more linear than circular. Actually behavior family therapy is circular, because in changing

parents' management skills, family behavior and emotional patterns are impacted.

In this second section of the review of the literature, concepts building the family theories are reviewed briefly. Comprehensive definitions of concepts are beyond the scope of this study. Goals of treatment for each school are viewed as that school's conceptualization of mental health. Therefore, goals are reviewed in the third section, on mental health, of the literature review.

Family Systems Theory

Type of family. Murray Bowen originated the school of therapy that he named Family Systems Theory. His theory is grounded in his observations and inpatient treatment of families with a schizophrenic member (Kerr & Bowen, 1988).

Theoretical concepts. Bowenian theory assists the therapist to organize family information according to eight concepts: differentiation of self, triangles, nuclear family emotional process, family projection process, multi-generational transmission process, sibling position, emotional cutoff, and societal emotional process. Understanding the first concept, differentiation of self, enables members to use their own strength in healing. Differentiation of self involves a growing awareness of inner signals, needs and feelings as a basis for decisions and actions. Growing awareness is accompanied by decreasing reaction to poorly understood needs and feelings of other family members. Thus, the patient can proact, instead of

reacting, to relationships and patterns of behavior which are described in the other concepts.

Therapist role and interventions. To intervene with the family process, the therapist coaches and teaches the family the theoretical concepts. The therapist keeps separated from the family's emotions, defining and clarifying relationships, and emphasizing family members' individual internal signals. Symptoms are minimized on the premise that they will wither as the family members become more differentiated. Behavior changes as the symptomatic person is no longer targeted with anxiety and learns to differentiate by recognizing his or her own inner signals.

Symbolic-Experiential Theory

Type of family. Carl Whitaker also originally worked with families of schizophrenics (Whitaker & Keith, 1981). His approach is similar to Bowen's in strengthening the individual while changing family patterns.

Theoretical concepts. Whitaker's approach emphasizes concepts of communication, honesty, individuation, and awareness in the present, without forgetting the past (Napier & Whitaker, 1978). In an article reviewing several schools of theory, Madanes and Haley (1977) highlight the value of honesty for the experiential school in expressing views and feelings and the importance of clear communication in solving interactional difficulties.

Therapist role and interventions. As in Bowen's approach, the therapist is a coach, assisting clients to

change behavior based on their understanding of relationships and behavior patterns, and their awareness of their own inner signals (Napier & Whitaker, 1978; Whitaker & Keith, 1981). Hoffman (1981) views Whitaker as a therapist of the absurd, specializing in augmenting the pathology until the symptoms no longer have meaning in maintaining the pathology. Interventions include the separation of generations, and the use of metacommunication, or communication on levels other than verbal. As people improve communication and understanding of family members and themselves, symptoms improve.

The Interactional View

Type of family. The Palo Alto group at the Mental Research Institute (MRI) also studied families of schizophrenics. Members of this group, Gregory Bateson, Jay Haley, Don Jackson, John Weakland, and Virginia Satir, originally published the double bind theory of communication (Bateson, Jackson, Haley, & Weakland, 1956).

Theoretical concepts. The double bind theory postulates that conflicting messages exist at different levels (Hoffman, 1981; Bateson, 1984). These levels include a verbal level, and a behavioral "frame" that defines the meaning of the verbal message. For example, when a son hugs his mother, she might stiffen. He withdraws his arm, only to be asked why he does not love her, which he perceives as threatening. He cannot escape, because he needs her. The primary negative injunction, "if

you don't love me we can't be close", is followed by a secondary negative injunction also enforced by threat, "don't get too close to me". With long-term repeated experience, the victim responds literally to messages, even when inappropriate, as with joking, or loses the ability to differentiate between metaphor and reality (Jones, 1977).

What resulted from this theory was the view that schizophrenia was not really a disease, but a realistic response to an impossible situation (Barnes & Berke, 1973). The mother or the family was then blamed for the impossible situation (Arieti, 1959; & Weiner, 1967). With the discovery of Thorazine in the 1950's and its support of the biochemical causes of schizophrenia, the double bind approach lost favor for a period of time (Torrey, 1983). However, attention to family communication is again gaining favor since family influences, as well as medication, are seen to affect relapse rate (Gurman, Kniskern, & Pinsof, 1986). Steinglass (1987) points out that the home environment is most likely to impact the course of schizophrenia rather that its onset.

Therapist role and interventions. The therapist role has changed, becoming more understanding of the family, without blaming the mother or other family members. One intervention, then, is to teach families how to communicate openly without covert manipulation. Another is the prescription of a therapeutic double bind in which the therapist prescribes a choice between two courses of action

apparently aligning with the patient's resistance, but actually empowering change (Hoffman, 1981). Communication theory has influenced and become a part of other approaches, particularly the structural and strategic schools of thought (Madanes & Haley, 1977).

Structural Family Therapy

Type of family. In contrast to working with families of schizophrenics, Minuchin and his co-workers (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) initially worked with families of delinquent adolescents in the ghetto.

Theoretical concepts. Minuchin and his coworkers needed a theory that would support stronger interventions in a more time limited therapy model than Bowen or Whitaker offered. Concepts in structural theory reflect their need for action. The past is reflected in the present; family history of itself is not a priority. The relationships and sources of support or stress in a family are a central part of changing behavior. Communication patterns change as family members' closeness and distance shift. Identifying the codes that regulate the human relationship provide leverage in shifting relationships. Functions, operations, and transactions that express the organization of relationships are the targets of intervention (Aponte & VanDeusen, 1981).

Therapist role and interventions. According to this therapy model, the therapist is in charge of therapy;

active and personal, creating transactions within therapy, joining the transactions, and finally restructuring the transactions. Structural techniques are aimed at the internal organization of the individual, family, and social system, and the linkages between them (Aponte & VanDeusen, 1981). These relationships and linkages take precedence over symptoms, which may be minimized, although their role in the family system is targeted. The therapist might ask family members to change seating arrangements in order to emphasize subsystems, alter closeness or distance between specific members, or deflect anxiety from a symptomatic person. Certain members may be asked to perform tasks together at home. Such changes in structure and communication produce changes in functioning and behavior similar to those produced by differentiation of self, or perpetual becoming.

Strategic and Systemic Family Therapies

Type of family. The strategic approach is most often associated with the work of Weakland, Watzlawick and Fisch (1974; Weakland, Fisch, Watzlawick, & Bodin, 1974). Milton Erickson had a major influence in developing strategic techniques (Haley, 1973). The Milan approach, devised by Selvini, Boscolo, Prata, and Cecchin, grew from the work of the MRI group and uses strategic interventions, but is classified as systemic (Hoffman, 1981; Gurman, Kniskern, & Pinsof, 1986). Strategic and systemic approaches developed from the work of the MRI group in Palo Alto,

rather than being grounded by observations of families with one type of pathology.

Theoretical concepts. Jay Haley first used the word "strategic" to describe an approach in which strategies to fit the presenting problem are the major focus (Hoffman, 1981). For the strategic approach, history and insight are not a priority. The symptom or problem is conceived to be a way of communicating the identified patient's anxiety or distress, and therapy consists of interventions directed at the symptom. The assumption is that the self-maintaining circle of problems offered by the identified patient and solutions offered by the family, can be blocked by the therapist such that the sequence is disrupted (Hoffman, 1981). In offering the family such an intervention it is crucial to become aware of the coalitions and power balances in the family. The Milan group has extended this work.

Therapist role and interventions. The therapist is in charge of therapy, assessing which family members are a part of the symptom or problem, planning steps of intervention, and giving directives "which will shift the family organization so that the symptom or problem is not necessary" (Madanes, & Haley, 1977, p. 96). Directives may be straightforward or paradoxical. Straightforward directives prescribe changing, or abandoning the symptom. Paradoxical directives prescribe the symptom, resulting in an inability to produce the symptom or in a perceived

increase of control over the symptom (Shoham-Salomon & Rosenthal, 1987; & Watzlawick, Beavin, & Jackson, 1967).

Reframing, or assigning positive value to negatively valued symptoms is an important part of paradoxical direction. The family is told to continue the symptom because of the value it has. For example, in a family, the daughter is rebelling. The father is strong in attempting control, but the mother is weak, and subverts the father's authority by ineffectively resisting the daughter. The circularity of this problem is addressed in the intervention. The parents are told to grate on the daughter's nerves as she is grating on theirs. They are to do this by being unreasonable. When she makes a request, instead of giving reasonable explanations, they are to say, "No, because it's Friday" (Hoffman, 1981, p. 274). The girl is told to maintain her powerful position by arguing even harder. She might end up in detention but, by arguing harder, she will win. As the family members carry out these instructions the parental subsystem is separated from the mother's covert alliance with the daughter, the mother and father are working together to think up new unreasonable ways to confuse their daughter, and the daughter responds to her parents' new position of power by feeling safer and behaving in more satisfying ways. As the family members behave in ways that are incompatible with the symptom or problem, the behavior improves.

Behavioral Family Therapy

Type of family. Patterson and his colleagues at the Oregon Social Learning Center have conducted the most research in this area. They have successfully worked with conduct disordered children and troubled marriages (Gurman, Kniskern, & Pinsof, 1986).

Theoretical concepts. This approach to working with dysfunctional families targets symptomatic behavior. Instead of directives, it uses behavioral principles derived from social learning theory (Patterson, 1982). Parents learn to successfully apply these principles or concepts: limit-setting, giving a command, praising, ignoring, warning, giving time-outs, giving natural or related consequences, managing self (including anxiety control), and giving negative feedback (Barros, 1987).

Therapist role and interventions. The therapist teaches the clients, most often the parents, how to properly apply the principles or concepts listed above as interventions to the symptomatic behavior. Utilizing didactic instruction for parents or spouses, interventions may include reinforcement, punishment, extinction, and behavioral pinpointing of behaviors (Gurman, Kniskern, & Pinsof, 1986). In contrast to the paradoxical injunctions of Strategic Therapy, the clients learn principles of change and apply them straightforwardly to achieve changed behavior in children, spouses, or themselves.

Summary

The differences among the theories seem to be largely matters of individual therapist style, thought, and perception of the therapy process. For example, Bowen's "individuation" and Whitaker's "perpetual becoming" refer to nearly the same condition of increasing inner security, knowledge and confidence. Bowen and Whitaker do emphasize history and insight more than others, but even the Milan group sometimes asks about the early marriage of the parents although history is not considered relevant to their formulations. The concept of triangles is common to all family theories, although Patterson and his behavioral colleagues do not make much use of it. Paradoxical interventions are often thought to be used only by strategic or systemic therapists but, in fact Minuchin and Whitaker use them. Even Bowenian therapists occasionally exagerate an entrenched pattern until it moves and then make a straightforward intervention (Hoffman, 1981).

Given the similarities across theories, it is not surprising that some therapists were associated with more than one school of therapy and freely communicated systemic ideas. For example, Jay Haley worked with the Palo Alto MRI group, with Minuchin at the Philadelphia Child Guidance Center, and with Milton Erickson in Phoenix (Haley, 1973). Thus, one can see that, in spite of the differences in theory, therapist, and intervention, a conceptualization of families as systems characterizes these perspectives.

These six schools of therapy have been discussed according to these criteria: type of family pathology grounding the theory, concepts relating to form the theory, and therapist role and interventions derived from the theory. Goals of therapy will be discussed in the next section, reviewing mental health.

Mental Health - the Goal of Therapy

The goals for therapy idealized by each school of family therapy appear to correspond to a definition of mental health. Some of these goals emphasize insight, whereas others highlight behavior change.

The goal for therapy for Bowen's Family Systems Theory (Kerr & Bowen, 1988) is to have each member of the family develop greater differentiation of self. When that results, firmly held convictions are formed from within the individual that hold steady through criticism and stress within the family. As family members gain inner strength, they are able to relate in different ways to each other. Members satisfy each other's needs while avoiding growth restricting demands on each other.

In Carl Whitaker's view of Symbolic-Experiential therapy, health is defined as perpetual becoming. The goal of therapy is:

> "to establish the member's sense of belongingness and simultaneously to provide the freedom to individuate. In our system of therapy, social adaptation is not a goal; we seek to increase the creativity (what we call

craziness) of the family and of the individual members." (Whitaker & Keith, 1981, pp. 199, 200).

The MRI Interactional group holds the goal of clarifying communication by having congruent messages at different levels. In other words, communication through speech, body language, and behavior should convey the same message (Bateson, Jackson, Haley, & Weakland, 1956; Gurman, Kniskern, & Pinsof, 1986; Hoffman, 1981). Structural therapy goals also include the improvement of family communication systems, structures, and affective systems in the present (Aponte & VanDeusen, 1981).

The goals of strategic therapy entail changing symptoms and solving problems (Madanes & Haley, 1977). Patterson and his group's behavioral family therapy goals are to change troubling behaviors by teaching straightforward methods of behavior change (Gurman, Kniskern, & Pinsof, 1986).

From a synthesis of the above goals, mental health, for this study, is defined as the outcome of families maximizing their potential for change toward valued patterns of emotional interaction and behavior. Mental health results from family members' growth-enhancing examination of their internal dynamics and family relationships, and from their interaction with their therapist.

Contextual Levels of Family Mental Health Nursing

Systems theories about families and the interventions deriving from them have influenced the practice of family therapy by professionals other than highly trained family therapists. Family therapy is practiced by nurses, psychiatrists, psychologists, social workers, school counselors, and clergy. These professionals practice in many different contexts using theory and interventions from the different schools of family therapy at varying levels of sophistication.

Doherty and Burge (1987) present a model for describing contexts of family mental health care and explore how these contexts influence family treatment. They define three levels of care according to the context in which each occurs: primary, secondary, and tertiary. Care at each level proceeds along a continuum of family mental health specialization.

Primary family mental health care is available mainly at primary medical facilities (with generalist practices), religious institutions, and schools (Doherty & Burge, 1987). In these contexts primary care health professionals, clergy, and school counselors serve potentially everyone in nearly universal locations. The primary mental health care professionals mentioned above usually have general but not specialized mental health knowledge. They offer interventions including education, prevention, support, and challenge.

Secondary family mental health care is more specialized, serving distressed families seeking mental health care at mental health clinics, family therapy clinics and private therapy practices (Doherty & Burge, 1987). These contexts are plentiful in urban areas, and often they are regionally-based. They confine services to mental health and social service issues. Therapists with specialized mental health training from nursing, psychiatry, psychology, social work, counseling, and family therapy provide therapy and rehabilitation as well as education and support. An eclectic approach incorporating theory and interventions from several schools of family therapy may be offered.

Tertiary care is the most specialized family mental health care, available only at a few widely-spaced family therapy training and research centers (Doherty & Burge, 1987). Theory and interventions are specific to particular schools of family therapy. Highly trained family therapists treat difficult cases (often referred by regional centers), train novice therapists, and also advance knowledge and technique through research.

Doherty and Burge's (1987) model provides a framework for understanding family mental health nursing. In this fourth section of the literature review, primary, secondary, and tertiary levels of family systems mental health nursing are described. Theory, practice, and research for each level are reviewed.

Family Mental Health Nursing in Primary Contexts

Education. Nurses from various nursing specialties and from different educational backgrounds (diploma or associate, baccalaureate, and master's or doctoral degrees) may provide primary family mental health care. The knowledge base entails a combination of physical and psychosocial sciences, with an inherent family-as-context orientation. This basic nursing education ideally includes a family-as-unit, or family systems nursing orientation.

Context. Nurses at generalist as well as specialized levels may provide primary family mental health care to patients as medical and surgical nurses, liaison nurses, outpatient clinic nurses, school nurses, industrial nurses and community health nurses. The more specialized family systems nursing (Gilliss, 1989a; Wright & Leahey, 1984), emphasizes family systems interventions for family units including a biologically-ill member. Given that these nurses do not provide psychotherapy, they are considered engaaged in the primary level of mental health care.

Roles. The primary nurse has the roles of technical expert, consultant, surrogate family member, teacher, clarifier-interpreter, liaison, participant-observer, and collaborator (Leavitt, 1982). The primary nurse identifies the mental health concerns of clients. In addition to welcoming the family and orienting them to the setting, the nurse assesses family dynamics and interaction patterns (Hoeffer, 1980) and facilitates family problem-

solving (Leavitt, 1982). Such interventions may take place in family meetings on the unit (Harter, 1988). The primary nurse may collaborate with on-site advanced mental health nurses, and refer to off-site mental health specialists (Gage, 1986). The case finding function is important for primary family mental health nursing (Leavitt, 1982, p. 284). Families with dysfunctional patterns may be recognized and referred for appropriate services not available at the primary level.

Research. Family mental health nursing research in the primary health care setting is broadening. Early nursing research did not include families as the unit of analysis but, "in the last decade, nurses have given increasing attention to the relationships of families and nursing as evidenced in the literature" (Feetham, 1984, p. 5). Gillis (1989b) reviewed 76 substantive family nursing research studies published from 1983 to 1986. Nursing investigations addressed adult attitudes toward the illness of child or spouse, parent-child interactions, family life transitions (which were almost exclusively around childbirth), marital interaction, family structure, family care of frail elderly, and attitudes toward mental illness. Findings of these studies described family experiences, and investigators suggested interventions at the generalist level. Interventions included encouraging the development of increased social support or providing information to family members of ill individuals. None of these studies

examined outcomes of family mental health nursing. Gilliss' review supported the assertion that nursing research in family is broadening and improving.

In assessing the current state of research in the nursing discipline, Gilliss (1989b) selected sample articles from state of the art nursing research journals. She analyzed them with regard to primary authorship, major topic of investigation, theoretical orientation, methods employed, relevance to clinical practice, and family aspects addressed. Although this review supports the assertion that primary family mental health nursing research is broadening and improving, "our methods are so primitive that we cannot be sure whether our practiced interventions are effective" (Gilliss, 1989a, p. 21). Gilliss calls for increased research dialogue and improved research methods and tools.

Family Mental Health Nursing in Secondary Contexts

Education. Nurses who practice psychotherapy at the secondary level must have at least master's preparation. The ANA Division of Psychiatric and Mental Health Nursing Practice (American Nursing Association, 1973) has declared that a minimum of a master's degree preparation is necessary for the development of skills and expertise necessary to be an effective family therapist (Calhoun, 1982). At this level of education, the advanced practitioner has the advantage of greater depth of

knowledge of family theory, research, and supervised practice than at the primary level.

Context. This level of nursing care is available at neighborhood mental health clinics, family therapy clinics, county health departments and private therapy practices (Doherty & Burge, 1987). Distressed families seeking mental health services might request care directly, or be referred by schools, the clergy, or health care professionals at the primary level of practice.

Roles. The roles involved in family therapy at the secondary level by nurses in advanced practice include both direct and indirect approaches (Sills, 1983). Direct practice involves providing therapy and information to emotionally troubled families. In providing these services, advanced nurses practice in psychiatric home health settings (Richie & Lusky, 1987), in community mental health centers (Lego, 1973; & Rohde, 1968), in private practice (Durham & Hardin, 1986; Hardin & Durham, 1985; Goodspeed, 1976; Randolph, G. T., 1975; & Hoeffer, 1983), and in hospitals with house privileges (Durham & Hardin, 1985). Indirect services include educating nurses, consulting with peers or other organizations about client families, supervising others' clinical work, and utilizing and generating research. The advanced roles incorporate accountability, leadership, assessment, and management (Ford, 1979).

Research. Advanced nursing roles and current practice were examined by a survey of all nurses in Oregon with advanced degrees in psychiatric-mental health nursing (Porter-Tibbetts & Markel, 1985). Of 89 nurses surveyed in this unpublished study, 44 (50%) responded. In describing direct services, Porter-Tibbetts and Markel (1985) found that 80 - 90% of respondants provided psycho-social assessment, crisis intervention, or individual therapy; 50 - 60% planned discharges, monitored medications, or provided primary care; and 55.8% offered family counseling.

Responding nurses most valued the ability to establish a therapeutic relationship, the ability to develop interventions and evaluate outcomes within the context of the nurse-patient relationship, the ability to base clients' problems on mutuality or negotiated goals rather than labels, and the ability to conduct long-term supportive or reconstructive therapy. Ninety percent of reporting nurses valued the ability to integrate several theories on behalf of the clients. These findings point to the value held for nursing's biopsychosocial perspective and the prominence of family intervention in nurses' practice.

Spunt, Durham, & Hardin (1984) studied reported schools of therapy used, theoretical orientations, and their congruence with direct service interventions used in the practice of psychotherapy by nurses. They mailed questionnaires to 400 masters prepared psychiatric nurses.

Seventy-seven nurses responded (for a return rate of 19.3%); however, the actual return rate is unknown because it is not known how many of the original 400 were psychotherapists. Of the 77 respondants, 32% used patient education, 12% employed "therapeutic use of self", 12% provided support or empathy, and 10% utilized "here and now" strategies.

These 77 nurses also reported on the school of therapy from which their interventions were derived. Sixty-five percent reported using psychodynamic techniques, including confrontation, interpretation, paradox, reframing, and exploration. Twenty-nine percent reported behavioral approaches, and 22% reported using communication techniques, specifying listening, clarifying, feedback, and validating techniques. When describing their conceptual basis for therapy, sixty-nine percent reported most frequently using dynamic models, 46% reported using systems theory, 42% reported using rational/cognitive models, and 27% reported using behavior models.

Few relationships between interventions and schools of therapy or theoretical frameworks were identified. For example, nurses who reported conducting individual therapy also identified the patient as a member of a family system, and nurses reporting a humanistic theoretical base also used cognitive, versus emotional, interventions. According to these results, nurse psychotherapists tend to integrate therapies. In fact, Porter-Tibbetts & Markel (1985) found

integrating therapy to be a value held by over 90% of nurses in their sample. Thus, in these studies, nurses do not strictly adhere to particular schools of family therapy.

The centrality of family therapy to advanced mental health nurse practitioners is further evidenced by Hardin & Durham's (1985) study doing secondary analysis on data gathered in their 1984 study with Spunt. Data for 82 (for a return rate of 20.5%) nurse psychotherapists met criteria for this study asking what kind of continuing education they chose to attend. The researchers found that 30% reported choosing family therapy workshops and institutes; in contrast, 16% reported attending workshops on other training techniques. Smaller percentages reported attending association meetings or working on another degree.

Porter-Tibbetts & Markel (1985) surveyed their sample about their employing agency's theoretical orientation. Twenty-nine nurses (or 32.6% of the sample) responded to that question, reporting single or multiple agency orientations. Behavioral/cognitive orientations were reported by 41.4%; the biomedical orientation by 24.1%; psychoanalytic, rehabilitation, crisis, and family systems orientations each by 13.8%; and humanistic orientation by 10.3%.

Such findings indicate that, in Oregon, family systems theory is not widely encouraged by agencies. Only 13.8% of

the respondents in the Oregon study (Porter-Tibbetts & Markel, 1985) reported an agency family systems orientation. In contrast, a national study revealed that 46% of the respondents used systems theory (Spunt, Durham, & Hardin, 1984), which is comparable to 55.8% of the Oregon respondants who reported conducting family counseling (Porter-Tibbetts & Markel, 1985). Although agency policy may be a potential barrier to nursing practice of family therapy, alternatively, nurse therapists may identify their family practice as "counseling" rather than "therapy". The contextual settings that facilitate or impede nurses' practice of psychotherapy with families are not well described in the literature.

Family Mental Health Nursing in Tertiary Contexts.

Education. Even less is known about nurses at the tertiary level than at the secondary level. Thirty percent of Hardin and Durham's (1985) sample of 82 nurse psychotherapists attended family therapy workshops and institutes during the previous year, but their educational preparation and practices were not described.

Context. Services at this level of specialization are provided only at family therapy training centers. Families served come mostly from nearby areas by referral from primary or secondary care professionals.

Roles and research. Roles at the tertiary level are to provide psychotherapy and conduct research at the doctoral level. Very few nurses practice in tertiary

settings; no references were found in the literature. Probably most RN's at the PhD level are employed at schools of nursing. No nursing research conducted at a tertiary mental health setting could be found in the review of the literature.

The above review of the contextual settings for family systems mental health nursing concludes the review of four concepts in the literature. The next section relates the previous four concepts reviewed in the literature to form the conceptual framework for this study.

Conceptual Framework

Conceptual Framework for Nursing

The concepts reviewed in the literature formulated the conceptual framework for this study. Given that "nursing's perspective is the study and promotion of health of humans as they interact within their environments" (Colling, Davidson, Hall, & Hoeffer, 1984, p. 3), the basic conceptual framework for nursing involves four concepts: person, environment, health and nursing. Colling, Davidson, Hall, and Hoeffer interrelated these concepts in a conceptual model adopted by a university school of nursing. The concept of nursing is primarily represented by its direct service aspect, that is, nursing interventions (this model represents indirect services also). The model is presented in Figure 1.

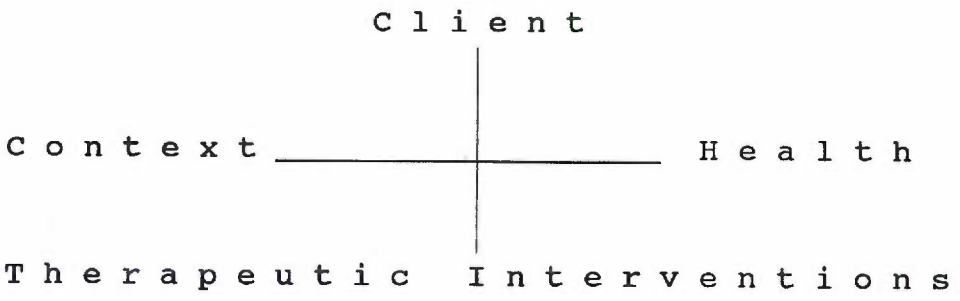

Figure 1. A conceptual model for nursing.

The concepts were defined in the following manner.

Clients: Recipients of direct and indirect therapeutic interventions.

Therapeutic Interventions: Purposeful strategies and actions that enable clients' attainment, preservation, and maintenance of health.

Health: The outcome of clients' maximizing their potential toward change in a valued direction. Health results from the clients' growth enhancing interactions with their internal and external environments.

Context: Multiple interacting internal and external environments. These include biological, physical, psychological, political, economic and cultural aspects which may be supportive or nonsupportive of health.

Conceptual Framework for This Study

These same four concepts were basic to this research, and are defined more specifically for family systems mental

health nursing. The client was conceptualized to be the family. The identified patient, or symptomatic member, relates to the family in a feedback loop of circular causality. Mental health nursing therapeutic interventions were derived from family theory and nursing theory. They impact the individual-family interrelationships, enabling healthier patterns of interaction. For this study of advanced mental health nursing, the four concepts were defined in this way.

Client: The family which receives direct and indirect mental health nursing psychotherapeutic interventions. The family has biological, physical, and psychological aspects which interrelate in circular patterns. The member of the family who has symptoms, or the identified patient, is reacting to family dynamics with which the nurse most effectively intervenes by addressing the family as the client.

Therapeutic Interventions: Psychotherapeutic strategies and actions derived from family theory. These interventions enable families' attainment, preservation, and maintenance of mental health.

Health: The outcome of families' maximizing their potential for change toward valued patterns of emotional interaction and behavior. It results from the family members' growth- enhancing

interactions with their therapist, their internal dynamics, and their family relationships.

Context: The level of mental health care at which the nurse is practicing.

The concepts were related as shown in the model in Figure 2.

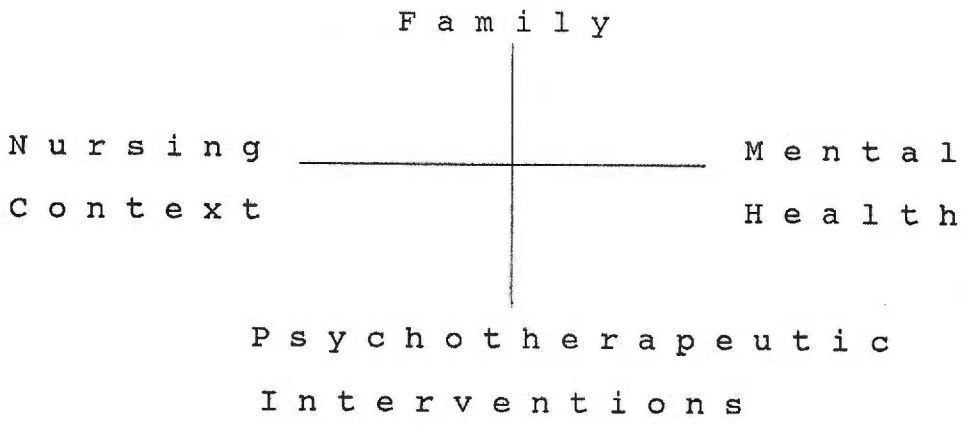

Figure 2. A Conceptual Framework for Nursing Psychotherapy.

Research Questions

The following research question was addressed by the study. The question has four subparts.

What are the characteristic qualities of the family therapy practice of psychiatric mental health nurse practitioners in Oregon?

The subquestions included:

1. How do psychiatric mental health nurse practitioners in Oregon conceptualize families as part of their psychotherapeutic practice?

2. What schools of family therapy guide the practice of psychiatric mental health nurse practitioners in Oregon?

3. How do psychiatric mental health nurse practitioners in Oregon define mental health?

4. In what contextual settings do psychiatric mental health nurse practitioners in Oregon practice family therapy?

CHAPTER TWO

Methods

Design

The purpose of this study was to describe the practice of family therapy by psychiatric mental health nurse practitioners in Oregon. The study was designed as a descriptive mail survey of all 96 psychiatric mental health nurse practitioners certified by the Oregon State Board of Nursing. Surveying the entire population of psychiatric mental health nurse practitioners in Oregon avoids the problems associated with sampling. It meets the assumption of parametric statistics for variables to be normally distributed in the population.

Subjects

All the psychiatric mental health nurse practitioners certified by the Oregon State Board of Nursing constitute the universe of subjects. Characteristics of the subjects were gathered from the demographic portions of their questionnaires. The rate of return of the questionnaires is addressed in Chapter Three. This study was submitted to Human Subjects Committee, and all recommendations adopted.

Confidentiality was maintained by eliminating any identification on the questionnaires except for a code number. The names on the mailing list were assigned code numbers. These code numbers were placed on outgoing questionnaires for the purpose of identifying which nurses had returned questionnaires. After the name was checked

off the mailing list as having returned a questionnaire, the code on the questionnaire was erased. After all mailing procedures were completed, the code list was destroyed. This researcher took responsibility to maintain confidentiality by not identifying any answers with a particular subject.

Data Collection

Tool

Questions. Data collection was done via a questionnaire written by the researcher. Questions were constructed to answer the research questions. Questions were primarily closed-ended, with a few open ended ones. Some questions were taken from the family questionnaire written by Krentz (1989) in the family nursing department of a west-coast university school of nursing. Question construction and questionnaire format followed Dillman's (1978) "total design method" (TDM) which addresses question construction, length of questionnaire, assembling the questionnaire, size of paper and print, cover letters, number of mailings, size of envelopes, and insertion of forms into the envelope. Length of questionnaire was six 6 1/8" X 8 1/4" pages for a total of 48 questions.

Content validity and pretesting. The questionnaire was analyzed for content validity by two experts to ascertain that the questions adequately represent the hypothetical content universe in the correct proportions. The experts selected to analyze the questionnaire are two

practicing nurse psychotherapists who teach in a mental health department of a university school of nursing. The questionnaire was pretested by two potential users of the data. Suggestions, recommendations, and revisions were implemented.

Procedures

Procedures also followed Dillman's (1978) TDM mail survey findings and are outlined next. A cover letter explaining the topic to be surveyed and its importance as well as the individual importance of each respondent was sent with each questionnaire. A stamped self-addressed return envelope was provided. These three items went out in a first mailing. One week later, a post-card follow-up was sent with a thank you to those who had returned questionnaires, and a reminder for those who had not. Three weeks after the first mailing a new cover letter, questionnaire, and envelope was sent to non-respondents. Seven weeks after the first mailing, a final mailing with another cover letter, questionnaire, and envelope were sent to remaining non-respondents. Procedures took eight weeks.

Using TDM methods for mail surveys of homogenous samples (mental health nurses in advanced practice) can be expected to produce response rates exceeding 85% (Dillman, 1978, p. 51). Response rate for this study is reported in Chapter Three.

Data Analysis

Data were entered into a computer file as the questionnaires were returned. The analysis was conducted on the computer using the CRUNCH program. The data was analyzed using descriptive statistics such as frequencies, percentages, means, medians, and modes. Graphs such as pie charts, bar graphs, and line graphs were used to summarize data. The open-ended questions were coded into categories and analyzed qualitatively.

CHAPTER THREE

Results

In this chapter some characteristics of the sample are described. Analyses of responses to the survey are presented. Furthermore, these survey results are described in four sections, corresponding to the four sections of the literature review and to the four research questions. The first section contains findings about how respondents conceptualize their clients in psychotherapy. In the second section, theories and interventions reported by respondents to guide their practice of psychotherapy are analyzed. The third section compares and contrasts respondents' definitions of mental health. And finally, the fourth section describes aspects of the contextual settings in which respondents practice psychotherapy.

Characteristics of the Sample

The universe of possible subjects for this study was composed of the 96 psychiatric mental health nurse practitioners certified by the Oregon State Board of Nursing at the time of data collection. Of these 96, seven were excluded for the following reasons: three had moved out of state, and another four were faculty who helped with the design and construction of this research.

Questionnaires (see Appendix A) were mailed to the remaining 89 subjects and a 77.5% (n = 69) return rate was achieved using the Dillman (1978) method of four outgoing mailings. Of the 20 unusable questionnaires, 12 were not

returned, 5 were returned but incomplete, and 3 were returned too late to compute. The resulting response rate, 77.5% of 89 subjects in the sample, is high enough to suggest that responses are representative of the universe of psychiatric mental health nurse practitioners in the State of Oregon (Polit & Hungler, 1987).

Demographic Characteristics of the Sample

Research subjects are described in terms of gender, age, relationship, number of children, graduate degrees, amount of income, and source of income. The sample ranged in age from 25 - 64 with 52% clustering between 35 - 44. However another 31% were between 45 and 54, thus indicating a preponderance of mature middle-aged respondents. The majority of the sample also indicated experience with marriage or a serious relationship. The number of children reported ranged from 0 - 5, with 53% reporting 1 or 2 children. Thus, respondents bring to the practice of therapy the experience of most of life's developmental stages.

Most respondents, 93%, had earned a master's degree in nursing. In addition, 10% had earned a master's degree in another field, and 13% had earned a doctoral degree. Five of the eight doctoral degrees were in psychology, one was in nursing, one was in marriage and family therapy, and one was not specified.

The majority of respondents earned $30,000 to $39,000 during 1988. Annual income for 1988 ranged from under

$10,000 for part-time work to $80,000 or more. Figure 3 gives the distribution of percents of respondents in each income category.

The majority of respondents received most of their income from their agency salary. About a third of the sample reported income from insurance reimbursements and from cash payments from clients, indicating that these respondents are in private practice. Figure 4 presents sources of nurse practitioner income.

Thus, the typical respondent is described as a married woman approaching middle age with one or two children. She has a master's degree in nursing, and earns about $35,000 to 40,000 per year from the agency where she works. In the next section, respondents' conceptualizations of their clients are presented.

Findings for Research Question One

How do psychiatric mental health nurse practitioners in Oregon conceptualize families as part of their psychotherapeutic practice?

To address this problem, four questions were asked (See Appendix A, questions 3 - 6). The questions about conceptualizations of family as client asked about theoretical conceptualizations of family relationships, the extent to which the family is considered to be the client, and the amount of time in practice spent with family unit interactions. In addition, respondents' comments on

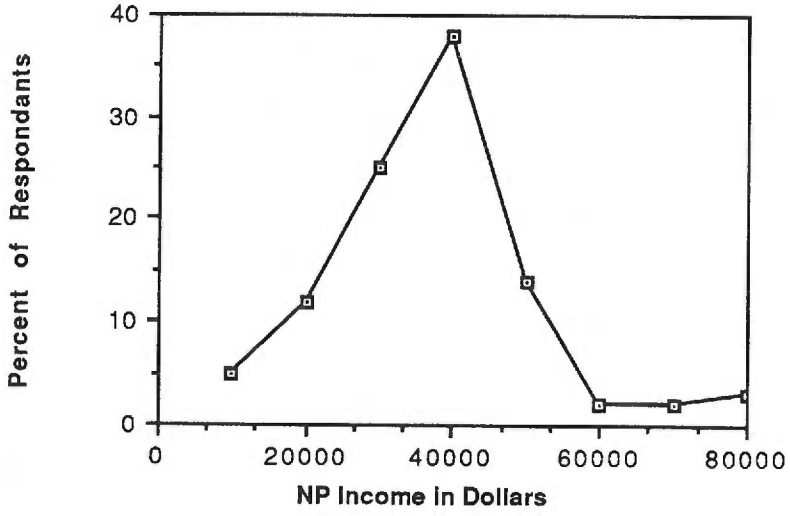

Figure 3. Nurse practitioner income in $10,000 categories by percent of responses. N = 65.

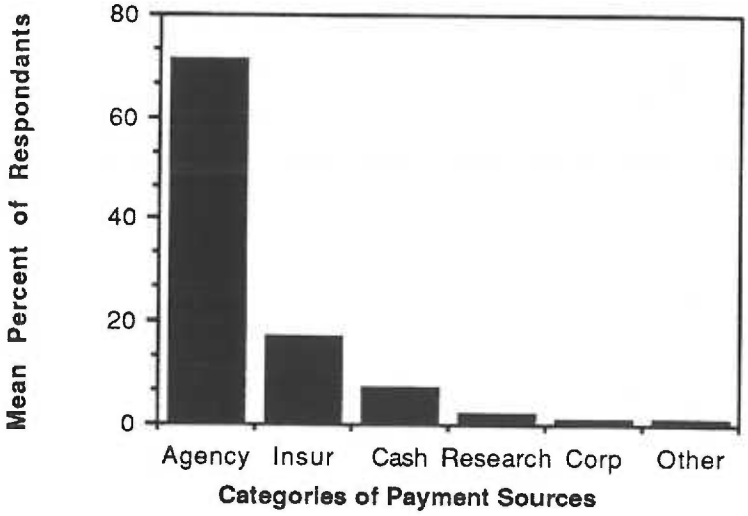

Figure 4. Sources of nurse practitioner income by percent of respondents. N = 63 - 65.

satisfaction with their impact on family patterns provided some qualitative understanding of their views of family therapy. Indirectly, interest in families was also studied by asking about attendance at various conferences or workshops that focused on family as system.

Demographic data about clients also was gathered (see Appendix A, questions 1, 2, 7, 8). These data will be reported first in this section, followed by data regarding conceptualization of client.

Client Demographic Characteristics

Demographic questions about clients were limited to questions about their ages, incomes, and presenting problems. Respondents reported what percent of their practice time was spent with different age categories. The distributions of percents of practice time fell into leptokurtic bimodal skewed curves. Since the distributions are both bimodally peaked and skewed, neither the mode, the median, nor the mean alone give accurate measures of central tendancy (Phillips, 1978). These distributions also prevent standard deviations from meaningfully describing variability. Therefore, all three measures of central tendancy, modes, medians, and means, were calculated to show the differences in averages for client age data. Ranges are given to indicate variability in percents of practice time devoted to different categories.

Respondents spent most of their practice time with adults; small percentages of practice time tended to be

spent with other age categories. Although 60% of respondents saw families and 64% saw the elderly, mean practice times with these age categories were 9 - 12% or less. Only one respondent saw families 100% of the time, and one saw the elderly 100% of the time. Forty three percent of respondents saw adolescents, but devoted not more than a third of practice time to them. Only 22% of respondents saw children at all, and all of these spent 25% or less of their practice time with children. Table 1 presents the client age categories by ranges of percents of practice time and modes, medians, and means.

Respondents most commonly saw clients who earned under $25,000 per year. Client incomes are reported by range of practice time spent with income categories, and total percents of respondents seeing clients in income categories. Table 2 presents income data.

Respondents were asked, when reporting on their clients' presenting problems, to check all conditions they see in practice, and the conditions they most commonly treat. Highest percentages of respondents saw affective disorders, drug and alchohol abuse, and personality disorders. Perpetrators of abuse were least seen. The two most common conditions characterizing respondents' practices were drug and alcohol abuse and affective disorders. Responses for any condition seen are presented in Table 3; for most common condition characterizing respondents' practices, in Table 4.

Table 1

Client Age Categories by Range of Percents of Practice Time and Three Measures of Central Tendancy

		Central Tendancy		
Age	Range of %	Mode	Median	Mean
Adult	0 - 100	80	80	72
Elderly[b]	0 - 100	0	5	12
Family	0 - 100	0	5	9
Adolescent	0 - 90	0	0	6
Children	0 - 25	0	0	2

N = 65. [b]N = 67.

Table 2

Client Income Level by Range of Percents of Practice Time and by Total Percents of Respondents

	Practice Time	Respondents
Income Level	Range, by %	Total %
Under $10,000	0 - 100	72
$10,000 - 24,999	0 - 100	74
$25,000 - 39,999	0 - 80	57
$40,000 - 54,999	0 - 50	38
$55,000 - 69,999	0 - 50	24
$70,000 and over	0 - 80	19

N = 53

Table 3

Presenting Client Conditions by Total Percentage of Responses

Conditions	Total %
Affective disorders	81
Drug and alcohol abuse	78
Personality disorders	72
Chronic mental illness	65
Sexual abuse	57
Physical abuse	52
Couple dysfunction	51
Eating disorders	49
Physical disability	46
Other	35
Perpetration of abuse	14

N = 69

Table 4

Most Common Client Conditions by Percent of Respondants

Conditions	Percent
Drug and alcohol abuse	33
Affective disorders	28
Sexual abuse	14
Eating disorders	9
Chronic mental illness	7
Couple dysfunction	4
Other	4
Physical abuse	0
Personality disorders	0
Physical disability	0
Perpetration of abuse	0

N = 57

Respondents listed other conditions they saw. Cognitive impairment including organic brain syndrome and dementia were mentioned six times; situational stress due to illness four times; grief adjustment, family dysfunction, and post-traumatic stress disorder, three times each; chronic pain, twice; and ritual abuse and financial trouble once each.

Conceptualizations of Family as Client

Subjects were asked to write their conceptualizations of family relationships in light of the following explanations. Family relationships were introduced to the subjects in terms of causal relationship patterns. Patterns were described as either linear or circular. Linear relationships assume specific causes for behaviors, such as: Linda is acting out because dad doesn't understand her. Circular relationships, a systems concept, assume an interrelating system in which all the family members influence and are influenced by each other. Both causal theories guide current nursing practice.

The answers to this question were coded into three categories and percents of responses in each category were calculated. The three categories were interrelating systems, (circular causality patterns); both circular and linear causality patterns; and an individual perspective of internal representation.

The majority, 45 respondents (79%), stated they considered families to be interrelating systems in which

members influence and are influenced by each other. One practitioner commented that "family goes beyond kinship/blood lines. It is a sensitive system involving multiple roles and related activites. Dynamic in nature, it strives for balance and homeostasis". Two practitioners added the concept of open or closed boundaries. Three people mentioned family of origin patterns, multi-generational patterns, or dysfunctional themes and patterns.

The next largest group, 9 respondents (16%), conceptualized families as having both systems, or circular, causality patterns and linear causality patterns. One respondent stated, "The family and I construct a meaning, sometimes linear, sometimes circular". Another explained, "I work from an analytical psychology perspective, which in some ways is related to both systems and object relations theories". A third stated, "In part - client behavior is <u>not</u> relationship oriented. In reference to relationships in families - both models are helpful". Another commented, "I believe in both concepts, i. e., that one person's behavior can affect how another person reacts, but this needs to be conceptualized with the factors from systems that can also be affecting the situation". One person included the biological, or medical, aspect in her view of family relationships. She stated, "In my practice, clients are usually loners - abandoned by their families. I think in my practice illness causes are biological, not

dynamic in origin. With other clients, I think both linear and circular may apply".

Finally, only three subjects (5%) viewed family relationships from an individual's perspective which included internal representations of family. The concept of internal representations of family has not been reviewed in the literature because this research study is concerned with systems concepts. As inferred from the responses, internal representations refer to an individual's inner perception and experience of an external event. The internal representation may seem accurate to an observer, or it may seem wildly inaccurate. Respondents who work with this concept made these statements. "Relationships in the early years, 0 - 5, have tremendous influence on family interactions. Unconscious material can limit change, too. I'm basically individual oriented and see each person with shared and personal issues contributing to the family process". "My belief is - individuals must all come to a point of balance between the relationship with themselves and their internalized parent, and their relationship with others which includes family as a dominant molding force". "As a Jungian, I see the family within the psyche of the individual - i.e., what is external is also internal". The pie chart in Figure 5 summarizes the percentages of responses in the three categories.

Respondents were next asked to what extent they consider the family system as client. The majority

considered the family as their client when seeing individuals as well as when seeing family. Figure 6 summarizes these numbers.

Application of Conceptualizations in Practice

The majority of respondents reported spending highest percentages of practice time with individuals, and only small percents of practice time with family system interactions. Percents of practice time spent with each category of interaction in 10% increments were plotted by the percent of subjects responding. This data in Figure 7 provides a graphic picture of the low place held by family unit interactions in the practices of respondents. Because the curves are not normal, all three measures of central tendancy are reported for comparison purposes. More respondents reported spending time with individuals, fewer with individuals around family context, and least with family system interactions. Table 5 summarizes modes, medians, and means for each category.

Next, subjects were asked to estimate, on a five point scale, the extent of their satisfaction with their impact on family patterns. Space was provided for written comments about their family therapy. The majority of respondents, 89%, were sometimes or usually satisfied with their impact on family system interactions. Only 11% reported never or seldom being satisfied. No one was always satisfied.

Twenty-eight respondents made qualitative comments

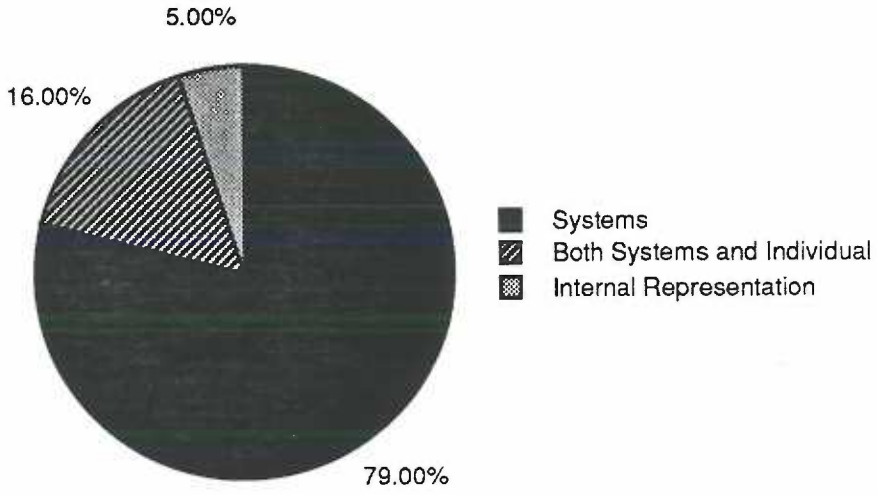

Figure 5. Categories of definitions of family relationships by percent.

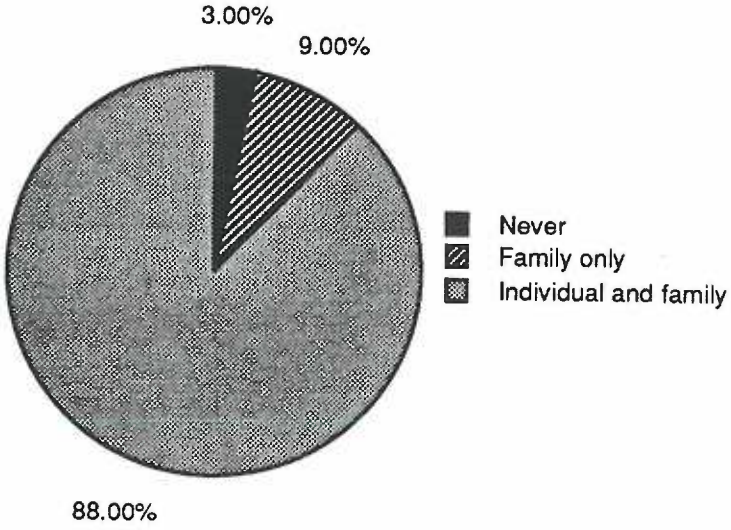

Figure 6. Responses indicating view of family as client, by percent.

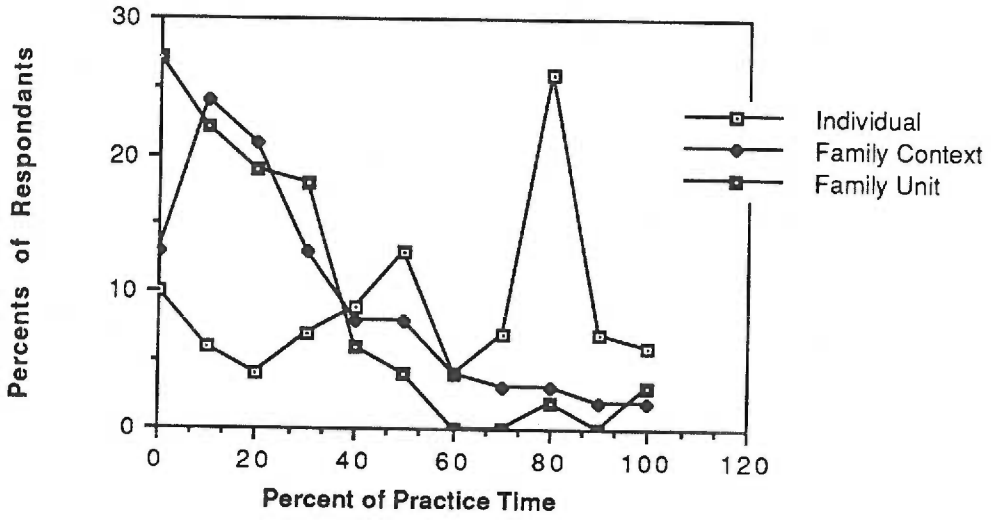

Figure 7. Percent of practice time with client by percent of respondents.

Table 5

Therapy Focus by Central Tendancy of Means of Percents of Practice Time

	Central Tendancy		
Therapy	Mode	Median	Mean
Individual[a]	80	60	53
Individual - family context[b]	20	20	26
Family system interactions[c]	0	15	19

[a]N = 62; [b]N = 58; [c]N = 50

about their satisfaction with therapeutic impact on families. Responses were coded into three categories: difficulty in doing family therapy, change in the system resulting from one changed individual, and role descriptions.

First, fourteen respondents, or 50%, mentioned difficulties in doing family therapy. Comments in this category included these: "families don't always agree they have a problem, or find change difficult"; "funding is limited - many CMI adults are without family"; "large caseloads make it hard to spend enough time on family work"; "[I] work in an agency with a 12 session limit on out-patient family therapy"; and "I work in corrections - families are usually not intact". One respondent described her adjustment to limitations in this way: "I'm satisfied that I've done all I can to help. I don't beat myself for what is beyond my control".

Second, six respondents, or 22%, described how one changed individual can change larger family or social systems. They made these statements: "[I] just completed a case that has eventually made a major impact on 10 unrelated families. It was fatiguing but great"; "Working with AMAC I am astounded when one begins to recover how many others recover as well. Also true of alcoholics"; "[I'm satisfied] when clients describe changes in physical and verbal behaviors in family interactions"; and "My impact is on the individual, which affects the system".

Finally, seven respondents, or 25%, responded in terms of role descriptions, stating that they did not do family work. They listed crisis or individual work, medication monitoring, or stated that others on the team did family work. Two respondents stated, "I provide a lot of problem-solving to caregivers of elderly disabled patients"; and "I do not deal directly with families & do deal with units".

One person, or 3%, answered, "depends on the situation". She did not elaborate further than that.

Interest in family systems was further tested indirectly by asking about attendance at conferences which focus on the family system. It was assumed that nurses interested in family therapy would seek out more information about it. The majority, 64% (N = 66), reported that they did attend such conferences or workshops. Table 6 contains a summary of this data.

Summary

In this section, respondents' conceptualizations of their clients and the reality of intervening with their clients according to their conceptualizations has been described. That nurses in advanced practice have an understanding of and interest in family systems is clear as evidenced by the 87% of respondents who considered the family as client even when seeing individuals; the 79% of respondents who conceptualized families as systems; and the 64% who reported attending conferences or workshops which focus on family systems.

Table 6

Attendance at Conferences or Workshops Focusing on Family Systems, by Percent of Respondents

Type of Conference	% Attendance
Local workshops or conferences	71
Supervision	51
Over coffee	47
Large national or regional conferences	45
Agency meetings	43
Academic classes	22
Peer consultation	6

N = 51. Note. Respondents attended more than one type of conference, such that percents sum to over 100.

Regardless, practitioners reported spending a mean of 53% of their practice time focused on individuals, compared with a mean of 19% focused on family system interactions. Only three respondents, or 4% of the working sample, in their qualitative comments about satisfaction with impact on family systems, referred to the impact one changed individual can have on family and social systems. In the next section, data relating to respondents' choices of theories and interventions to guide their practice of psychotherapy is presented.

Findings for Research Question Two

What schools of family therapy guide the practice of psychiatric mental health nurse practitioners in Oregon?

To describe respondents' choices of theories and interventions, 12 questions were asked (see Appendix A, questions 11 - 22). First, respondents were asked whether or not they offer psychotherapy. Those who do not offer psychotherapy were directed to skip this section, and to answer questions again in the third section on the definition of mental health. Respondents who do practice psychotherapy were then asked to indicate percentages of practice time spent in different therapy formats, with major theories and with family theories chosen to guide practice, and what interventions they tend to use. In addition, respondents were asked to write down their definitions of eclectic therapy.

Subjects who practice psychotherapy comprised 81% (N = 55) of the sample. Respondants were then asked to allocate the percentages of time they spent in the following therapies: individual, couple, family, group, or play. Although 94% of respondents saw families at least occasionally, by far the majority of practice time was spent with adults in individual therapy. Modes, medians, and means for categories of psychotherapy are summarized in Table 7.

Next, these percents of practice time were plotted on a distribution curve for comparison with the curves for client age category and the family unit interactions. The slopes of these curves consistently indicate that respondents tended to spend small amounts of practice time with families. Figure 8 presents those three curves in a line graph.

Theory choices guiding the practice of psychotherapy are presented in the next section.

Respondent Choice of Therapy Theory

Respondents were asked about major categories of theory, and about family theories. Major theories included: psychodynamic, cognitive, existential, behavioral, family, nursing and other theories. Family theories included: psychodynamic family theory, Whitaker's symbolic experiential theory, Bowen's family systems theory, Minuchin's structural theory, the Milan Group's systemic theory, Weakland, Watzlawick and Fisch's strategic

Table 7

Therapy Formats, by Central Tendancy of Percents of Practice Time

		Central Tendancy		
Format	N	Mode	Median	Mean
Individual	68	80, 90%	80%	57%
Group	65	0	0	13
Family	65	5	10	9
Couple	66	0	5	8
Play	65	0	0	1

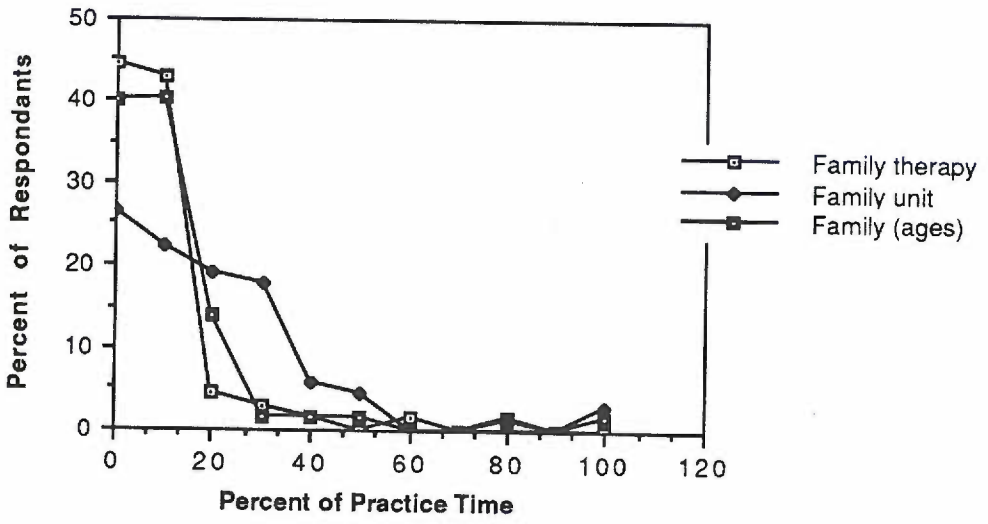

Figure 8. Distribution curves for percents of practice time with family age category, family unit interactions, and family therapy.

theory, the Mental Research Institute's interactional theory, behavioral family theory, and other.

The sample was questioned about which major theories were used and how often they use those theories. Cognitive theory ranked highest in "usually used", and lowest in "never used", whereas nursing theories ranked 2nd lowest in "usually used", and highest in "never used". Table 8 summarizes responses in five categories to this question.

In order to clarify theory choices, responses were summed in two ways. Percents of responses in the "usually" and "always" columns were summed for comparison with "never" and "seldom" sums. Theories were ranked according to "usually" and "always" scores. The three highest ranking theories "usually" and "always" used by respondents were cognitive, psychodynamic, and family theories. Behavioral and existential ranked in the middle. Nursing and other theories ranked last. Table 9 presents the contrasting sums.

Subjects provided qualitative data about two categories: nursing theory and other. Theories specified more than once by respondents under other were developmental, communication, educational, hypnotherapy, addictive or chemical dependance, and medical or biological theories. Listed once each were gestalt, analytical psychology, stress theory and holism, Maslow's hierarchy of needs, Carl Roger's unconditional positive regard, and supportive theories. Interestingly, systems and strategic

Table 8

Major Theories Used and Extent of Use by Percent

	Extent of Use				
Theory	Never	Seldom	Sometimes	Usually	Always
Dynamic[a]	9	11	28	31	20
Behavior[b]	6	17	38	35	4
Family[c]	6	11	42	28	13
Cognitive[d]	2	2	40	36	21
Existential[e]	6	20	59	8	8
Nursing[f]	29	21	26	9	15
Other[g]	12g	6	24	47	12

[a]N = 54; [b]N = 52; [c]N = 53; [d]N = 53; [e]N = 51; [f]N = 34; [g]N = 17. Note. Rounding error ≤ to + or - 1%.

Table 9

Percent of Respondents Selecting Major Theories by Extent of Use

	Extent of Use	
Theory	Never/Seldom	Usually/Always
Cognitive[a]	4	57
Psychodynamic[b]	20	51
Family[c]	17	41
Behavioral[d]	23	39
Existential[e]	26	16
Nursing[f]	50	24
Other[g]	18	59

[a]N = 53 [b]N = 54 [c]N = 53 [d]N = 52 [e]N = 51 [f]N = 34 [g]N = 17

theory are noted by two respondents under other, separately from family theory, indicating that the terms, "family theory", and "family systems theory", may have different meanings to some nurses in advanced practice.

Nursing theories identified by respondents are as follows: Orem's self-care and Martha Rogers' theory were each mentioned by four respondents; Levine and Neuman by two each; and Roy, Peplau, and relationship of mind and body by one each. Two respondents asked, "What is a nursing theory?"

After indicating their choices of major theories for practice, subjects were next asked to indicate their choices of family theories and the extent to which they use these theories. Family theory choice responses are summarized in Table 10.

Seven respondents made comments under other. Three of them specified other family theories. These were gestalt family therapy, Satir, and TA, mentioned once each. Four respondents wrote in comments such as, "What is this?", "I do not know these theories", or "Oh! please!".

Data were analyzed in the same way for family theories as for major theories. In order to rank family theories, the "never" and "seldom" categories were summed for comparison with sums of "usually" and "always" categories. Psychodynamic family theory ranked highest among family theories used, with the highest "usually" and "always" scores and the lowest "never" and "seldom" scores.

Table 10

Family Theories Used and Extent of Use by Percent of Respondants

	Extent of Use				
Fam Theory	Never	Seldom	Sometimes	Usually	Always
Pdyn fam th[a]	15	7	37	26	15
Whitaker[b]	53	14	17	11	6
Bowen[c]	21	14	37	16	12
Minuchin[d]	21	14	36	19	10
Milan Grp[e]	45	16	21	13	5
Wk, Wt & F[f]	61	8	11	16	5
MRI Grp[g]	68	9	9	5	9
Behavioral[h]	31	11	28	19	11
Other[i]	72	0	0	14	14

[a] $N = 46$ [b] $N = 36$ [c] $N = 43$ [d] $N = 42$ [e] $N = 38$ [f] $N = 38$ [g] $N = 35$ [h] $N = 36$ [i] $N = 7$

Behavioral family, Minuchin's Structural, and Bowen's Family Systems theories followed Psychodynamic family theories in rank. The Mental Research Institute's Interactional theories ranked low, with the lowest "usually" and "always" scores, and the highest "never" and "seldom" scores. Other theories were considered to rank lowest with only seven responses. Table 11 presents these data.

In this section were presented respondents' choices of theories to guide their practices. Most often chosen major theories were Cognitive, Family, and Psychodynamic theories. Most often chosen family theories were Psychodynamic family theory, Behavioral family theory, Minuchin's Structural theory, and Bowen's Family Systems theory. In the next section are presented data regarding respondents' choices of therapeutic interventions.

Respondent Choice of Therapeutic Interventions

Subjects next responded to questions about interventions they used in their practice of therapy. Interventions were grouped into clusters corresponding to Behavioral family therapy, Psychodynamic family therapy, Minuchin's Structural Family therapy, Bowen's Family Systems therapy, the Milan Group's Systemic therapy, the MRI Group's Interactional therapy, Existential therapy, and Cognitive therapy. Percents of respondents checking intervention choices in each cluster are provided and compared in Tables 12 - 19.

Table 11

Percents of Respondents Choosing Family Theories by Extent of Use

	Extent of Use	
Theory	Never/Seldom	Usually/Always
Pdynamic Family Therapy[a]	22	41
Behavioral Family[b]	42	30
Minuchin's Structural[c]	35	29
Bowen's Family Systems[d]	35	28
W, W, & F's Strategic[e]	69	21
Milan Group's Systemic[f]	61	18
Whitaker's Symbolic Exper[g]	67	17
MRI Interactional[h]	77	14
Other[i]	72	28

[a] $N = 46$ [b] $N = 36$ [c] $N = 42$ [d] $N = 43$ [e] $N = 38$ [f] $N = 38$ [g] $N = 36$ [h] $N = 35$ [i] $N = 7$

Table 12

Behavioral Interventions Used, by Percent of Respondents

Intervention	Percent
Pinpoint target behaviors	91
Positively reinforce desired behaviors	93
Give time outs	48
Control own anxiety	64
Give a command	36
Set limits on behavior	86

N = 56. Questionnaire instructions were not clear for this cluster.

Table 13

Psychodynamic Family Theory Interventions, by Percent of Respondents

Intervention	Percent
Reveal nothing about myself	5
Interpret client transference to me	59
Request the client to free-associate	21
Ask about the client's childhood	95
Make formulations about transferences to family	59

N = 56

Table 14

Structural Interventions, by Percent of Respondents

Intervention	Percent
"Join" the family	31
Ignore the symptom	16
Ask people to change seating arrangements	38
Direct 2 people to argue longer than usual	18
Direct members to replay an interaction in therapy	64
Reframe behavior to change emotional context	84

N = 55.

Table 15

Family Systems Interventions, by Percent of Respondents

Intervention	Percent
Stay clear of emotional involvement	11
Act as a coach	67
Point out long term relationship patterns	91
Explain relationship patterns since childhood	78
Explain triangles	62
Encourage use of "I" positions	73
Encourage recognition of feelings and needs	98

N = 55.

Table 16

Systemic/Strategic Interventions, by Percent of Respondents

Intervention	Percent
Be in charge of therapy	31
Not concern myself with past history	7
Direct members to change behavior that affects the symptom	44
Give paradoxical injunctions	45
Give homework	84

N = 55.

Table 17

Interactional Interventions, by Percent of Respondents

Intervention	Percent
Describe what the family can expect from impaired member	67
Explain how body language, or the situation, can frame, and either validate or contradict verbal messages	65
Teach how to express emotion non-anxiously	74
Teach members to verify message for accuracy	87

N = 54.

Table 18

Existential Concepts, by Percent of Respondents

Intervention	Percent
Responsibility for own behavior	96
Inevitability of death	55
Ultimate loneliness	38
Finding meaning in life	84

N = 55.

Table 19

Cognitive Interventions, by Percent of Respondents

Intervention	Percent
Teach clients to recognize automatic thoughts	84
Teach clients to recognize resulting feelings	76
Teach clients to verify accuracy of thoughts	89
Teach clients to change behavior based on new thoughts and feelings	85

N = 55.

These data are also presented in two other ways. First, the interventions are ranked to give an indication of the eclectic flavor of nursing psychotherapy. Second, mean responses for intervention clusters are presented for comparison.

The list of 35 interventions originally clustered by theory were reordered by rank according to the percentage of respondents checking them. They are listed in a table in Appendix C.

While respondents selected interventions in all clusters, some clusters indicated heavier use than others. Therefore, mean responses for clusters of interventions were computed. Cognitive interventions ranked highest; mean percentage for psychodynamic family interventions was only 48%, surprising since psychodynamic family theory scored high in theory choice. Unfortunately, the behavioral cluster may not be valid and was not included; instructions for this cluster were not clear. It is not known whether respondents use these interventions themselves, or teach them to clients. Table 20 presents the clusters rank ordered by mean percent of responses.

Respondents gave additional information about their use of theory and interventions in their definitions of eclecticism, analyzed qualitatively. Responses were coded into two sets of categories. The first set of categories grew from the following observation by a respondent who is in private practice and teaches at a school of nursing:

Table 20

Intervention Clusters Ranked by Mean Percent of Responses with Numbers of Respondents

Cluster	N	Mean %
Cognitive	53	84
MRI Interactional	35	73
Bowen's Family Systems	43	69
Existential	51	68
Psychodynamic family theory	46	48
Minuchin's Structural	42	43
The Milan Group's Systemic	38	42

"Eclectic is a term that is going 'out of vogue'. A more accepted term is integrative - combining therapies as they fit client needs and style. Eclectic refers more to therapist use of various therapies". From this observation, four categories emerged: client-centered responses, therapist-centered responses, both client centered and therapist-centered responses, and not specified. The majority of respondents, 61%, gave client-centered responses; 10% gave therapist-centered responses; and 10% gave both client- and therapist-centered response. Responses for 19% could not be classified. See Appendix D for representative comments under each category heading by percent of respondents.

The second set of categories was developed by recoding the responses to the question about their definition of eclecticism. This second coding separated responses into two categories determined by how theories were integrated, that is, whether several theories are combined into a plan for one patient, or whether one theory, from several used by the respondent, was specified for one problem. The majority of respondents, 73%, combine a variety of theories into one plan for a particular patient or situation; a smaller number, 19%, select a particular theory from several available for a particular client. For 8% of respondents, definitions could not be classified. Appendix D presents these categories, responses, and percents of respondents.

The majority of respondents integrated theories to address specific needs of each client. The trend was away from adhering to specific schools of thought regardless of the client situation. Therapists may select a specific school of thought for a situation because research has indicated it is the most promising approach, however, most therapists indicated the need to keep current with new developments and try approaches until results are achieved.

Summary

In general, psychiatric mental health nurse practitioners practiced mostly individual therapy, and spent small amounts of practice time in family therapy. Cognitive, Psychodynamic, and Behavioral were most frequently employed theories, with Bowen and Minuchin leading family theory choices. Most frequent intervention choices were Cognitive, Behavioral, Interactional, and Bowen's Family Systems Theory. Theories were carefully chosen and combined to match patient needs in therapy.

It is impossible to discuss mental health therapy and interventions without some grounding in what constitutes mental health. In this section, some components of mental health were mentioned in definitions of eclecticism, such as goals of solving problems, gaining insight and changing as a result of the application of theories and interventions. The next section specifically addresses respondents' definitions of mental health as a goal of therapy.

Findings for Research Question Three

How do psychiatric mental health nurse practitioners in Oregon define mental health?

For the purpose of describing subjects' definitions of mental health, three questions were analyzed (see Appendix A, questions 23, 25, 26). First, subjects were asked whether they plan therapy with outcomes in mind. Respondents checked either yes or no to indicate planning therapy around outcomes. Second, they were asked how they know when the client is ready to leave therapy, and last, how they define mental health. For the latter questions, respondents gave qualitative answers about when a client is ready to leave therapy and about their definitions of mental health.

Subjects were asked about planning therapy with outcomes in mind in order to find out how they operationalize mental health. The large majority (96%) did plan therapy around desired outcomes. The open-ended question asking how you know when the client is ready to leave therapy was intended to focus on how respondents operationalize mental health. Responses to this question described the reality of having clients leave therapy for various reasons before the therapist thought they are ready. Thus, knowing when a client is ready to leave therapy is not the same thing as desired outcomes. However, these statements about leaving therapy did operationalize mental health in a way. The responses gave

the impression that mental health is a process; that clients may work for awhile and then stop, maybe coming back sometime, or maybe moving to work in a different place geographically and/or emotionally.

Responses to the question, how respondants know when the client is ready to leave therapy, were coded into six categories: when client goals are attained, by client decision, by mutual decision, supportive therapy never ends, when therapist goals are attained, and by funding and agency policy. In general, respondents knew the client was ready to leave therapy when client goals were reached, and next most often when the client decided to go. Few respondents indicated that clients were not ready to leave until therapist goals are met. Responses often fell into more than one category, such that the percentages total more than 100%. Appendix E presents answers coded into six categories.

Finally, the last open-ended question asked for respondents' definitions of mental health. Responses to this question also were qualitatively coded. Responses to this question were more difficult to categorize than responses to previous qualitative questions in this questionnaire. For one thing, only words that were in the response were classified, not implied meanings, but that may not have captured the intended meanings accurately. In addition, answers were short, a function of the small space allowed in the questionnaire and the time to write a longer

answer, so it is possible that respondents did not express a full answer. However, answers were sufficiently rich to give a good representation of the meaning of mental health for psychiatric mental health nurse practitioners in the State of Oregon.

Forty nine practitioners, or 71% of the working sample, responded to this question. Four qualitative response categories grew from comparing responses with the definitions of mental health given in the review of the literature. These four broad categories are: differentiation of self - perpetual becoming (Kerr & Bowen, 1988; & Whitaker & Keith, 1981); creativity and belongingness - satisfying relationships (Whitaker & Keith, 1981); communicating well (Garfield & Bergin, 1986); and finally, behavior change (Madanes & Haley, 1977; & Gurman, Kniskern, & Pinsof, 1986). These four categories were not sufficient for all aspects of the answers given; four additional categories were needed. These four are: accepting reality; altruism; unity and balance of various parts of personality; and resolution of distress. Together, these eight categories are ranked in a table presented in Appendix E by percentage of sample responses; representative responses are included. Some responses fell into several categories, thus the total is more than the number of subjects responding to this question.

The multiple dimensions in definitions of mental health are consistent with respondents' eclectic or

integrative views of theory. Respondents' views of mental health transcend definition from particular schools of theory. The ability of respondents to assist clients to reach these levels of mental health is affected by the contexts in which respondents work. In the next section those contexts will be described.

Findings for Research Question Four

In what contextual settings do psychiatric mental health nurse practitioners in Oregon practice family therapy?

To answer this question, 14 questions were asked (See Appendix A, questions 27 - 39) concerning contextual settings, type of agency employing respondent, theories officially endorsed by agency, extent of agency support of respondent offering family therapy, other disciplines also offering therapy, and current position. Respondents were also asked how many hours per week they work, and how many years of work experience they have.

First, subjects were asked about their agencies. Types of agencies are listed by percent of the sample responding. The four highest ranked agencies, thus, were private practice, hospitals, community mental health agencies, and outpatient clinics or doctor's offices. Some respondents worked for more than one agency, thus percents do not equal 100. In Table 21 are listed the agencies by percents of respondents.

Table 21

Agencies Rank Ordered by Percentage of Responses

Agencies	Percent
Private practice	35
Hospital (general)	31
Community mental health agency	28
Outpatient clinic or doctor's office	22
Other	17
School of nursing	7
Nursing home	2
Public health department	2
Home health agency	2
Primary or secondary school	0
Industrial or corporate health	0

N = 68.

Next, these agencies are classified according to level of mental health care. Classifying family mental health care settings as to primary, secondary or tertiary levels was suggested by Doherty and Burge (1987), and described in the review of the literature. The majority of respondents work for agencies offering secondary level family mental health care. Secondary mental health care is provided at mental health clinics, family therapy clinics and private therapy practices by therapists with specialized mental health training who often integrate theory and interventions from several schools of therapy. None of these agencies offered tertiary care. Though one respondent reported working at a research clinic, her responses were integrative, not limited to one school of theory. She reported that her agency protocols included studies of "osteoporosis, depression in elderly, high cholesterol in children, etc. . . ." Therefore her research clinic could not be classified as offering tertiary mental health care. Agencies classified as to level of family mental health care by percent of responses are presented in Table 22. Several respondents worked for more than one agency, thus percents sum to more than 100.

Another contextual aspect that affects nursing practice of family therapy is the choice of theory endorsed by the agency. Subjects were asked to indicate what theories their agencies endorsed. The majority of respondents indicated that their agency did not endorse a

Table 22

Agencies Classified According to Level of Family Mental Health Care, by Percent of Respondents

Primary Care	Percent
Hospital	31
School of nursing	7
Nursing home	2
Home health agency	2
Primary or secondary school nursing	0
Industrial or corporate health	0
Other	12
Total percent at the primary level:	54
Secondary Care	**Percent**
Private practice	35
Community mental health agency	28
Outpatient clinic or doctor's office	22
Other	7
Public health department	2
Total:	94
Tertiary Care	**None**

N = 68.

particular theory. Of theories endorsed by agencies, behavioral theory ranked high at 22% of respondents, followed by cognitive theory at 19%, and family theory at 13%. Data for 64 respondents are summarized in Figure 9.

Next, respondents were asked to what extent their agency supports their practice of family therapy. The majority of respondents rated their agency as somewhat to very supportive of their offering family therapy. Most respondents who answered," not applicable", volunteered that they either did not do therapy, or were in private practice. Table 23 summarizes responses indicating agency support for nursing practice of family therapy.

In connection with extent of agency support, a qualitative question asked how the agency showed support. Thirty five respondents, or 51% of the working sample, answered this question. The majority, 22 respondents (63%), reported agency support for their practice of family therapy. Support came in the form of staffing, supervision, space, time for training, and verbal support. Thirteen (37%) respondents, described a lack of support for family therapy in terms of "not providing time, resources,supervision, or training"; "does not allow small enough caseloads to put more time into family therapy"; "not staffing families at staff meetings (indirectly); does not give credit for seeing all family members". Six of the 13 respondents reporting a lack of support stated that other disciplines offered family therapy.

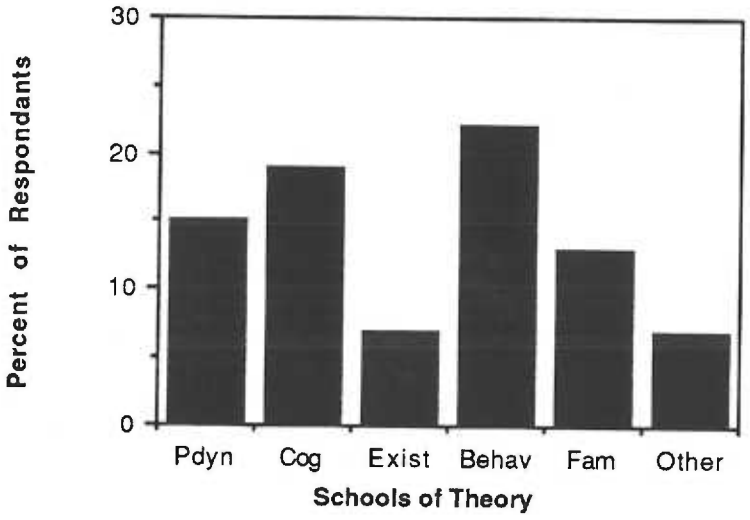

Figure 9. Reported major theories endorsed by agencies, by percent of respondents. N = 64

Table 23

Extent of Agency Support for Nursing Practice of Family Therapy, by Percent of Respondents

Category	Percent
Not applicable	32
Not at all	3
Not very	3
Neutral	8
Somewhat	13
Very	41

N = 63.

Respondents were next asked what other disciplines offer psychotherapy at their agency; 66 respondents, 96% of the working sample, answered. Nursing was reported to offer therapy at the respondent's agency by 73% of the sample, social work by 68%, psychology by 71%, and psychiatry by 64%. Other disciplines mentioned by 9% of the sample were pastors, recreation therapists, psychology associates, and persons at the master's level in education and communication.

Subjects were asked about their employment positions to describe aspects of their work complementary to therapy. Interestingly, though this was a survey of nurse practitioners licensed by the Oregon State Board of Nursing, only 88% stated they were employed as nurse practitioners. Some who were not nurse practitioners may have been included in the 4% working as staff nurses or in the 29% working as clinical nurse specialists. Some respondents, 25%, did consulting part-time, and 20% were in education. Positions held by nurse practitioners at their agencies are summarized in Table 24. Some practitioners held more than one position, such that the percentages sum to more than 100.

The sample was also asked about how many hours per week they worked, and how many years of experience they had. These data had distribution curves that tended to be bimodal and skewed, such that all three measures of central tendancy give a more accurate picture of averages. The

Table 24

Positions Held by Practitioners by Percent of Respondents

Position	Percentage
Nurse practitioner	88
Clinical specialist	29
Consultant	25
Educator	20
Other	13
Supervisor/nurse manager	10
Researcher	9
Staff nurse	4
Nursing administrator	4
Academic administrator	2

N = 69.

means tend to fall toward outliers, such as the person who reported working 80 hours per week, or giving 60 hours of therapy per week, but comparing means with modes and medians increases the understanding of where responses tend to cluster when measured in different ways. Responses are summarized in Table 25.

In this section contextual settings for the nursing practice of psychotherapy have been described in terms of employing agency, theory endorsed by agency, agency support for nursing practice of family therapy, and other disciplines also offering therapy. In the next chapter, findings for each research question will be discussed.

Table 25

Work Hours and Experience of PMHNP's in Oregon by Central Tendancy of Percents of Respondents

	Central Tendancy			
Category	Range	Mo	Md	Mn
Hours per week of MH practice[a]	0-80	40	32	30
Hours per week of psychotherapy[b]	0-60	0	10	13
Years of MH nursing practice[c]	0-41	15	15	15
Years practice as NP[d]	0-24	5	8	8
Years practice of psychotherapy[e]	0-25	10	8	9

[a]N = 65 [b]N = 63 [c]N = 69 [d]N = 69 [e]N = 65

CHAPTER FOUR

Discussion

The extensive data resulting from this survey support a number of findings. First the questionnaire will be discussed with reference to validity and reliability. Then the findings will be listed with each research questions and discussed in relation to the review of the literature.

Reliability and Validity of Tool

The questionnaire, as a self-report measure, has the strength of gathering information difficult to obtain by observation or other objective measure. Its weakness is uncertainty about validity or accuracy (Polit & Hungler, 1987). Though it cannot be known exactly to what degree the scores indicate truth or error, it is possible to discuss reliability and validity and arrive at some degree of certainty.

Two situational contaminants were probable for this questionnaire. One was the length of time required to fill out the 48-item questionnaire. Two subjects wrote that they simply did not have time to complete it at all, and another drew an arrow where it was "starting to take too long". Others made comments about the "lengthy" questionnaire. No one took time to include additional sheets of paper with longer qualitative answers.

Another possible situational contaminant was the awareness of the researcher's review of all responses. Although respondents remained anonymous, this awareness may

have led to a response set bias. A positive or social desirability response set to questions about family theories, or about agency support for family therapy may have occurred. Subjects may not have wanted to appear ignorant of family theories nor to have their agency appear non-supportive. However, the lower number of responses to questions pertaining to family theories, and the number of qualitative comments about agency support seemingly negate such a tendancy, thus making results seem reasonably accurate and free of social desirability.

Instrument clarity was another possible source of error. The instructions for the behavioral intervention cluster were not clear as to whether interventions were carried out by the therapist or taught to the clients. For all the intervention clusters, phrases describing interventions were not tested. Therefore, they may not have been seen by respondents as corresponding to certain theories. Consequently, correlations between intervention clusters and their attendant theoretical orientations were not assessed. Also, when reporting on agency support for family therapy, although the instructions were clear, some respondents appeared to answer for family therapy in general, rather than for their own practice of family therapy. Therefore, those results need to be received with caution.

There was no indication that the instrument format was a problem to respondents except for the introduction to the

qualitative question about conceptualizing family as client. Shaping responses by defining family relationships as having circular or linear causality probably limited answers. Alternatively, answers that were elicited related more precisely to those concepts and served to answer the research questions. Nonetheless, it may be fruitful to ask "How do you conceptualize family relationships?" without any leading definition. Perhaps answers would be richer in different categories of relationships, and, possibly, fewer respondents would mention circular causality.

Measures of reliability and validity are difficult to apply to this questionnaire because it is not unidimensional. Contrary to scales, which measure just one attribute, this questionnaire assessed many attributes. A test-retest reliability measure could have been conducted and would have ascertained the stability of the assessment of practitioners' attitudes over time. The definitions of mental health were not valid for mental health of families; definitions were couched in terms of mental health for individuals. Equivalence reliability was evidenced for the finding regarding low practice times with families. Three questions about time spent with families received comparable responses. Content validity was assessed utilizing two experts who analyzed the questionnaire for adequate content coverage. Content could have included further exploration of insurance reimbursement or other funding for family therapy, and also of what support groups

are helpful to nurse psychotherapists. Otherwise, notable problems with content validity were not identified during data analysis.

Notwithstanding some uncertainty around reliability and validity, and with the exception of definitions of family mental health, the high return rate for this questionnaire, the pretesting, and, to a degree, the equivalent reliability, suggest that the results are adequate for giving a reasonably accurate picture of how psychiatric mental health nurse practitioners in the State of Oregon practiced family therapy at the time of this study.

Respondent and Client Demographic Characteristics

The typical respondent was a married woman, approaching middle age, with a 50% chance of having experienced divorce, and with one or two children. This description is similar to popular descriptions of the baby boomer generation and, as such, might increase the generalizability of study results to groups of nurse psychotherapists outside of Oregon. Porter-Tibbetts and Markel (1985) studied the same population, and, although their age categories were not the same, it appears that ages of respondents have increased. In the present study, 52% (N = 64) of the sample were between 35 and 44, and 31% were between 45 and 54. In fact, in this study only 5% of respondents were below the age of 35. Five years ago, 60% (N = 44) of subjects were under forty years of age. Two

factors may account for this. This may be the same population studied by Porter-Tibbetts and Markel and it is aging, and/or a much smaller number are becoming psychotherapists. The practitioners' own lived experience with a broad range of the family's developmental stages may have an impact on how they implement their therapist role. Age, then, combined with the practitioners' professional education and expertise, may enhance the therapists' knowledge and communication with clients about various family situations.

Respondents tended to receive most of their income from agencies; about one third of income was from private practice. Even though some nurse practitioners served clients with higher incomes, most respondents served clients with low incomes. Considering that 65% of respondents' incomes were received from agencies, one can assume that respondants were providing mental health care through public agencies to clients, mostly individuals, who could not otherwise afford care. Hoeffer (1983) argued that providing care to low-income people equally with others who can pay constitutes distributive justice, and that nursing has a responsibility toward this end. Results of this study indicate that, whether intended or not, the nursing practice of psychotherapy tends to meet the ethical ideal of distributive justice in providing care to individuals with low incomes. Families appear to be less frequently served.

Research Question One

How do psychiatric mental health nurse practitioners in Oregon conceptualize families as part of their psychotherapeutic practice?

The most important finding for this question was the contrast between the conceptualization of family as the client, and the percents of practice time spent with families. The majority of respondents conceptualized family as a system involving circular causality (79%), and considered their client as family (88%), whereas median percents of practice time spent with families ranged only from 5 to 15%. Individuals, on the other hand, received a median 80% of practice time.

Recognition of the importance of family systems to respondents was further supported indirectly by their attendance at conferences and workshops focused on family systems interactions. Out of 66 respondents, 64% reported attending such gatherings. In the only other reference to such attendance found in the literature, Hardin and Durham (1985) found that 30% of 82 nurse psychotherapist respondents reported attending family therapy workshops and institutes. Thus, when measured indirectly by attendance at gatherings focused on family systems, interest in family systems was greater for respondents in the present study than for those responding to the Hardin and Durham study.

It would seem natural to assume that conceptualizing the family system as the client indicates an interest in

family systems. Why do respondents not spend more practice time with clients as they conceptualize them? It is certainly not for lack of interest.

The low percents of practice time with family systems compared to high percents with individuals support the observation that "the arena of psychiatric nursing and family therapy finds psychiatric nursing still very much focused at the individual level" (Sills, 1989, p. 7). The individual focus has changed little from the historical role of nursing, that is, caring for the individual within the context of family (Gilliss, 1989).

Qualitative comments about the satisfaction with their impact on families shed further light on the practitioners' discrepancy between their conceptualizations of family as client and the low percents of practice time with families. Out of 65 respondents, 40% reported being usually satisfied with their impact on family systems. This satisfaction may be due more to an adjustment to limitations than to achieving desired outcomes. One respondent stated explicitly, "I'm satisfied that I've done all I can to help. I don't beat myself for what is beyond my control." Comments on satisfaction were made by about one third of the respondents, and, of these, only 22% volunteered statements about the effectiveness of their work with interactions among family members, whereas 50% of these 28 respondents mentioned difficulties in conducting family therapy.

Several possibilities, not addressed by this survey, come to mind when speculating about reasons for the low percents of practice time with families. Limited reimbursement for family therapy, the traditional nursing focus on the individual, limited educational exposure to family systems theories, limited clinical experience and supervision in dealing with family systems, and personal issues - that is, how practitioners, as women, have learned to deal with their own families - may all impact the difference between the conceptualization of family as client and the amount of practice time devoted to family. Other reasons, addressed by this survey, may include a limited use of family systems theories and/or the support or lack of support for nursing practice of family therapy, offered by the contextual settings. Contextual settings will be discussed in the last section addressing findings for the fourth question. Family systems theories will be discussed in the next section addressing the second research question.

Research Question Two

What schools of family therapy guide the practice of psychiatric mental health nurse practitioners in Oregon?

Among major theories "usually" and "always" chosen by respondents, family theories ranked third (41%), with cognitive (57%) first, and psychodynamic theories (51%) second, yet ahead of fourth ranking behavioral theories (39%). Of the family theories selected, psychodynamic

(41%), and behavioral (30%) theories ranked highest. These theories may have ranked highest because they were modified from older major theories to include systems ideas (Gurman, Kniskern, & Pinsof, 1986), and thus were more familiar to respondents. Other family theories were "usually" and "always" used by only one third of the respondents. The 41% (N = 53) of respondents who usually and always chose family theories was somewhat greater than the 28% (N = 43) of similar respondents in the Porter-Tibbetts and Markel's (1985) study. Thus, it appears that interest in family therapy is growing, although nurse practitioners still devote more practice time to traditional individual theories.

The theory choices of respondents in this study may be compared to those of respondents in a study conducted by Spunt, Durham and Hardin (1984). Of 77 subjects, 69% reported most frequently using dynamic models, 46% reported using systems theory, 42% reported using rational/cognitive models, and 27% reported using behavior models. Thus, the same major theories were used, but they were ranked in a different order. Psychodynamic, family, cognitive, and behavioral were ranked in that order in the older study, whereas cognitive, psychodynamic, family and behavioral were ranked in the present study. The percentage of subjects reporting the use of family theories were very nearly the same, with 41% for current respondents, and 46% for respondents in Spunt, Durham and Hardin's national

study. Perhaps theory choices would have yielded different percentages in the Spunt, Durham and Hardin study if it had a return rate higher than 20%.

It is of interest to examine the numbers of subjects in the present study selecting various theories. More subjects selected major theories (N = 51 - 54) than family theories (N = 36 - 46). It could be that respondents choose family theories less often than major theories because they are less familiar with family theories. In fact, four respondents made margin comments to that effect. This parallels the discrepancy between conceptualizing the family as client, and the lower percents of practice time with families. Perhaps respondents are interested in systems ideas, but need more exposure to, or experience in applying systems theories in practice. Alternatively, this finding may simply reflect the individually-oriented therapies to which most of the practice time is devoted.

Respondents were eclectic in their approach to psychotherapy. Most subjects used interventions from each of the intervention clusters. Understanding respondents' integration of interventions is increased by considering their definitions of eclecticism.

Of 48 respondents, 73% defined eclecticism as combining a variety of therapy strategies into one plan, and 61% made that plan based on the client situation instead of their own theoretical orientation. This tendancy to integrate therapies is consistent with the 90%

of respondents in Porter-Tibbetts and Markel's (1985) study who valued integrating therapy. It is also consistent with Beitman, Goldfried and Cross's (1989) view of the tendancy among psychotherapists from all disciplines to integrate therapies. The clinical significance of this is that nurse psychotherapists use the most effective strategies of which they are capable rather than choosing one theoretical orientation for use with all patients.

Research Question Three

How do psychiatric mental health nurse practitioners in Oregon define mental health?

This question yielded two findings. First, desired goals as outcomes of therapy included the realistic expectation that therapy is a process with ups and downs and some detours. Second, mental health was viewed as a rich way of experiencing life, and seen as a continuum for each person. Responses were couched in individual terms instead of in family mental health terms, again giving evidence of the individual orientations of respondents.

The qualitative question regarding goals as outcomes of therapy, was intended to give information about how mental health was operationalized in therapy. Answers gave the impression that mental health is a process. The respondents reported that clients often seemed to move on before therapy was considered to be finished. Several factors were identified as contributing to this. First, jail inmates, chronically mentally ill clients, and low-

income families all tended to be referred to different agencies as they changed locations, which may limit completion of the therapeutic contract. Another factor included families, fairly settled in one location, who stopped therapy for awhile, and then came back when another crisis arose. Sometimes agency policy was the limiting factor; some agencies limit the number of family sessions. Insurance coverage was also mentioned as a limiting factor that restricted the amount of time a client stays in therapy. Thus, criteria for ending therapy, such as goals of the client and/or therapist, were not always met before therapy ended, for reasons not under the control of the therapist. Of course, it stands to reason that criteria must be identified in order for therapy to have a direction; however, respondents tended to be realistic about circumstances hindering their clients' meeting these criteria.

Respondents also gave realistic and helpful definitions of mental health. Mental health was not seen to include only the highest functioning individuals in society; it seemed to be a continuum for each person. Furthermore, mental health did not depend on whether or not the client had a biochemical defect causing schizophrenia or affective disorder, but, rather, on how well s/he dealt with the limitations and strengths s/he had. If an individual troubled by schizophrenia is compliant with medication and takes advantage of treatment opportunities

and sheltered employment possibilities, that person can be considered to be mentally healthy, according to many respondents to this survey. This concept of "relative mental health" may be a definition of mental health unique to nursing. However, the review of the literature did not yield definitions of mental health from other disciplines.

Research Question Four

In what contextual settings do psychiatric mental health nurse practitioners in Oregon practice family therapy?

Employing agencies were classified as either primary or secondary mental health care settings. Almost all respondents worked at secondary settings, and half also worked at primary settings. Characteristics of the respondents to this study were consistent with those characteristics described for secondary mental health settings. Providing therapy (Porter-Tibbetts & Markel, 1985), working at the master's level (Calhoun, 1982) at mental health clinics, health departments, or in private practice (Doherty & Burge, 1987), integrating theories (Porter-Tibbetts & Markel, 1985), and having an interest in family therapy (Hardin & Durham, 1985) were common to respondents and were characteristics of secondary mental health care settings.

Respondents tended to work at more than one place; about a third had a private practice in addition to working for an agency. Of 68 respondents, 81% held jobs at an

agency such as a hospital (31%), community mental health agency (28%), or outpatient clinic or doctor's office (22%). Almost all nurse practitioners (94%) worked at secondary mental health care settings; in addition about half of nurse practitioners (54%) worked at primary mental health care settings. It is possible that some respondents worked at less specialized primary settings in order to maintain income security while venturing into private practice. Comparable studies in the literature were not found.

Most respondents held positions as nurse practitioners (88%). Clinical specialists (29%) were the other sizeable, but smaller group. In addition, respondents also provided consultation (25%) and education (20%). Perhaps, respondents feel restricted at one job, and need more than one employment setting to have professional fulfillment and creative opportunity. Alternatively, such work patterns may be aimed at income security.

Other disciplines were not identified as inhibiting nurse practitioners in the practice of family therapy. Of disciplines offering therapy at agencies, nursing ranked highest in frequency. Nursing may have ranked highest in this sample because nurses were being studied. At least it appears that, in general, other disciplines were not preventing nurses from practicing family therapy.

Neither did most agencies restrict nurses' choices of theories for practice. Of those that did specify theory,

the highest percentage (N = 64) endorsed behavioral theory (22%), followed by cognitive theory (19%), and family theory (13%). Porter-Tibbetts and Markel (1985) studied the same population and found 4 of 13 subjects (31%) reported an agency choice of family or systems as their theoretical orientation. However, a comparison of results with numbers that differ between that study and the current investigation is not reliable. It remains that few respondents identified their agencies as actively endorsing family therapy as the agency's primary theoretical orientation.

Next, 41% of respondents (N = 63) indicated that the agency was very supportive of the respondents offering family therapy, and another 21% indicated that the agency was neutral to somewhat supportive. These responses were clarified by qualitative comments made by 35 respondents. Of these, 22 respondents (63%) described agency support in the form of staffing, supervision, space, time for training, and verbal support. Thirteen respondents (37%) described a lack of agency support in the form of lack of time, resources, supervision or training, caseloads that were too large, and inadequate staffing. These responses are consistent with comments about satisfaction with the impact on family systems in listing difficulties in doing family therapy. One can speculate that perhaps these limitations were more widespread than reported but that

nurse practitioners adjusted to them and became discouraged with the effort to do family therapy.

In summary, the nursing practice of family therapy, as evidenced by these results, does not seem to be limited by other disciplines; to be only slightly limited by agency choice of theory; and to be supported by the agency for individual practitioners. Less than half of the working sample made qualitative comments describing agency support and, of these, the majority described support in different forms. However, an important minority described organizational difficulties impeding the practice of family therapy. When comments about agency support were examined in light of comments about satisfaction with impact on family systems, it became apparent that difficulties in conducting family therapy are due to difficulties in getting families together for therapy and agreeing on the problem, as well as on agency limitations. Thus, the discrepancy betwee conceptualizing families as systems and the limited practice time spent in family therapy, was apparently not soley due to organizational limitations but also to the difficulties and realities of dealing with families, and of receiving funding or reimbursement for this work.

Perhaps what is called family therapy may tend to be psychoeducation - giving information to families straightforwardly - instead of intervening to change family interactions and emotional feedback systems that are poorly

understood by the family. Nurses do practice family therapy, as evidenced by the 94% in this study who do so at least occasionally and by many citations in the literature (Talley, 1975; Smoyak, 1975; Christman, 1987; Spunt, Durham & Hardin, 1984; Calhoun, 1982; Goodspeed, 1976; Rohde, 1968; Ujhely, 1973; & Lego, 1973). However, as any discipline, nurse practitioners may need increased education about family theories, saturated exposure to family therapy, and skilled supervision to maintain skills at the cutting edge of advances in the field of family therapy. Christman (1987) reasoned that a larger nucleus of sophisticated graduate clinical practitioners would raise the basic competency of psychiatric nursing practice and the quality of psychotherapy. He pointed out the steady increase of graduate students at both the masters and doctoral level as a hopeful sign toward this end.

Nurse practitioners must support their therapy outcomes with some form of outcome research. This is necessary to support improvement in the field, broader inter-disciplinary acceptance, increased funding and third-party reimbursement, and greater political influence.

In this chapter, the findings were discussed in relation to the research questions and relevant citations from the literature. In the next chapter, the study will be summarized, and limitations of the study will be listed, followed by suggestions for future research.

CHAPTER FIVE

Summary

Although many nurses do practice family therapy, descriptions of how nurse psychotherapists conceptualize families as their clients are lacking in the literature. Similarly, nurse psychotherapists' use of theories and psychotherapeutic interventions for families have not been well described. Nurse psychotherapists' definitions of mental health as expressed in their goals for therapy and descriptions of the contextual settings in which they practice are also sparse. The purpose of this study, then, was to describe the family therapy practice of psychiatric mental health nurse practitioners in the State of Oregon. Results from this study can provide a base for future research to document the effectiveness of this nursing practice role.

The study was designed as a descriptive mail survey of all psychiatric mental health nurse practitioners certified by the Oregon State Board of Nursing, following Dillman's (1978) "Total Design Method" of survey methodology with four outgoing mailings. These methods yielded a return rate of 77.5% (N = 69) of the 89 subjects remaining in the sample after 7 exclusions and 13 unusable questionnaires.

The questionnaire was written by the researcher, pretested by therapists in the field, and analyzed for content validity by two experts at a school of nursing at a major western university. As for any self-report measure,

some uncertainty about reliability and validity remains. However, the pretesting, equivalence of some questions, and the number of respondents suggested that results were adequate for a beginning description of the family therapy practice of psychiatric mental health nurse practitioners in the State of Oregon.

Most respondents conceptualized families as systems involving circular causality, and considered the family as client when seeing individuals as well as when treating the family system. However, the majority of respondents report spending most of their practice time with individuals. Although almost all respondents served families at least occasionally, very small percents of practice time were reported as devoted to families. Qualitatively, more respondents mentioned the difficulty in impacting family systems than the satisfaction of effecting change in system dynamics.

Over three fourths of the respondents, (81%) indicated they practiced psychotherapy. The majority of practice time was reportedly with adults in individual therapy. A median of 10% of time in practice was spent conducting family therapy.

The major theories most "usually" employed by respondents to guide their therapy were reported in this order of frequency: cognitive, psychodynamic, family, behavioral, existential, and nursing. The family theories most "usually" utilized by respondents were reported in

this order of frequency: psychodynamic family therapy, behavioral family therapy, Minuchin's Structural therapy, Bowen's Family Systems therapy, Weakland, Watzlawick, and Fisch's Strategic therapy, the Milan Group's Systemic therapy, Whitaker's Symbolic-Experiential therapy, and the Mental Research Institute's Interactional therapy.

Intervention clusters thought by the researcher to correspond to theories, were ranked in this order: cognitive, the Mental Research Institute's Interactional, Bowen's Family Systems, existential, Psychodynamic family theory, Minuchin's Structural, and the Milan Group's Systemic. The majority of respondents were eclectic or integrative in their use of theories and interventions, combining several theories into a plan most useful for a particular client.

Respondents reported they planned therapy around desired outcomes, and considered clients ready to terminate therapy when their goals were reached. Qualitative answers revealed the reality that clients frequently terminated therapy for various reasons before the therapist considered them ready. Agencies may have also placed limits on the number of family sessions allowed.

Respondents tended to be employed mostly as nurse practitioners, usually in secondary mental health care settings, and to hold more than one position. They reported more agency support than lack of support for doing

family therapy, although some listed agency limitations to their practice of family therapy.

Qualitative definitions of mental health were rich and multi-dimensional, consistent with the respondents' integrative views of theory, although phrased in individual terms. They indicated that mental health is a way of using strengths and weaknesses in dealing with life. Thus, mental health was viewed as relative and does not include only the "best-functioning" people in society.

In summary, the nursing practice of family therapy, as evidenced by these results, does not seem to be limited by other disciplines; to be only slightly limited by agency choice of theory; and to be supported for individual practitioners by the agency. When comments about agency support were compared with comments about satisfaction with the impact of therapy on family systems, it became apparent that difficulties in conducting family therapy were due to difficulties in getting families together for therapy and agreeing on the problem, as well as on agency limitations. Thus, the discrepancy between conceptualizing families as systems and the amount of time spent practicing family therapy was apparently not due soley to organizational limitations, but also to the difficulties and realities of dealing with families.

Implications to Nursing

Nurses do practice family therapy, as evidenced by the 94% in this study who do so at least occasionally; also by

many citations in the literature (Talley, 1975; Smoyak, 1975; Christman, 1987; Spunt, Durham & Hardin, 1984; Calhoun, 1982; Goodspeed, 1976; Rohde, 1968; Ujhely, 1973; & Lego, 1973). However, nurse practitioners may need increased education about family theories, and saturated exposure to family therapy and skilled supervision to maintain skills at the cutting edge of advances in the field of family therapy. Christman, referring to therapy in general, not only family therapy, (1987) reasons that a larger nucleus of sophisticated graduate clinical practitioners would raise the basic competency of psychiatric nursing practice and quality of psychotherapy. He points out the steady increase of graduate students at both the masters and doctoral level as a hopeful sign toward this end.

In addition to a greater exposure to theory and family practice and supervision, nurse practitioners must support their therapy outcomes with some form of outcome research. This is necessary to support improvement in the field, greater inter-disciplinary acceptance, increased funding and third-party reimbursement, and greater political influence.

Limitations of the Study

Limitations of the study include the time required by respondents to fill out the 48-item questionnaire and the broad base of the questionnaire. Reliability and validity could have been improved by using several reliable scales

about critical attributes or by constructing scales and achieving a respectable level of reliability instead of asking untested questions about a larger content area. Within the tool, instructions for the behavioral intervention cluster lacked clarity. Also, the psychodynamic school of family therapy was not described in the review of the literature. Further, instructions for the relationship experience question were unusual and perhaps confusing. In addition, the question asking for definitions of mental health did not ask specifically about mental health of families. Finally, phrases describing intervention clusters possibly related to schools of theories were untested.

Two areas would have benefitted from further exploration. One was funding for family therapy, that is, how well insurance policies cover family therapy. Another was nurse practitioner networking, that is, what support groups are helpful to nurse practitioners who conduct family therapy.

Analysis would have been easier if closed responses (i. e. 10% increments of practice time) had been provided rather than the open responses used. Also, when asking about children, simply asking the number of children would have been sufficient, instead of asking for age categories. These items would need attention were the questionnaire to be considered for use in another research project.

Suggestions for Further Research

This study was intended to give a broad picture of the nursing practice of family therapy and to raise more questions than it answers. Questions such as the following come to mind. Why do the majority of respondents conceptualizing families as systems report that they see the family as client even when seeing individuals, and yet devote small amounts of practice time to families? Does conceptualizing families as clients in fact indicate an interest in doing family therapy? How do nurse family therapists define mental health of families? How much clinical experience with families did nurse family therapists have? What theoretical orientations do respondents' schools of nursing have? To what extent does education influence practice? How do nurse practitioners assess the effectiveness of major theories and do they consider one theory more effective than others? In what clinical situations do nurse family therapists choose to use family therapy instead of other major therapies? What kind of support do agencies really give nurse family therapists?

These questions could be addressed were the questionnaire to be expanded for another study. Reviewing the questionnaire in terms of strengthening its relationship with the conceptual framework would be beneficial. The field is wide open for research to support the nursing practice of family therapy.

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Appendix A

Questionnaire for the Survey

Description of the Family Therapy Practice

of Psychiatric Mental Health Nurse Practitioners

in the State of Oregon

1575 SW Dellwood Ave.
Portland, OR 97225
(503) 646-9529
January 3, 1990

^F1^
^F2^

Dear ^F3^:

About four weeks ago I wrote to you asking for information about your advanced nursing practice for a study describing expanded nursing roles in Oregon. This study has been undertaken because of the belief that advanced nursing practice and outcomes need more descriptive support and documentation. As of today, we have not yet received your completed questionnaire.

I am writing to you again because of the significance each nurse's practice has to the usefulness of this study. The number of mental health nurse practitioners in Oregon is small; in order that this study will truly represent the opinions of all advanced mental health nurses in Oregon, it is essential that each nurse return the questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed.

Your help is greatly appreciated.

Cordially,

Heidi Hart,
graduate student

1575 SW Dellwood Ave.
Portland, OR 97225
(503) 646-9529
January 31, 1990

^F1^
^F2^

Dear ^F3^:

I am writing to you about the study to describe advanced mental health nursing practice in Oregon. I have not yet received your completed questionnaire.

The large number of questionnaires returned is very encouraging. However, the importance of an accurate description of the advanced nursing practice of psychotherapy depends upon you and the others who have not yet responded. This is because past experiences suggest that those of you who have not yet sent in your questionnaire may practice quite differently than those nurses who have sent in their questionnaires.

The usefulness of these results depends on how accurately we are able to describe the advanced practice of mental health nursing. It is for these reasons that I am sending this by certified mail to insure delivery. In case our other correspondence did not reach you, a replacement questionnaire is enclosed. May I urge you to complete and return it as quickly as possible.

I'll be happy to send you a copy of the results if you want one. Simply put your name, address, and "copy of results requested" on the back of the return envelope, not on the questionnaire. Research results should be ready by summer of 1990.

Your contribution to the success of this study will be appreciated greatly.

Most sincerely,

Heidi Hart,
graduate student

The Practice of Psychiatric/Mental Health Nurse Practitioners in the State of Oregon

The purpose of this survey is to describe the advanced practice of psychiatric mental health nurse practitioners in the State of Oregon. The questions are designed to gather some general information about advanced practice, and some specific information regarding conceptualizations, theories, and interventions used in advanced practice when assisting families. This information is important in order to provide research support for advanced nursing roles. Please answer all questions about your practice. If you do not like some questions, comment in the margins or the back page, but please return the questionnaire. Your comments will be read and taken into account. Returning this questionnaire constitutes consent to participate in this research study.

Thank you for your help.

Heidi L. Hart, RN, BSN
Graduate Student
1575 SW Dellwood Ave.
Portland, OR 97225

Clients have been understood in different ways: as individuals, as groups, and as families. The first questions focus on characteristics of your clients.

1. What percentage of your practice time is spent providing mental health nursing to the following age categories? (Estimate to the nearest 5 percent.)

___% CHILDREN
___% ADOLESCENTS
___% ADULTS
___% FAMILIES (mixed ages)
___% ELDERLY

2. In what annual income bracket do your clients fall? (Give approximate percentages for each bracket.)

___% UNDER $10,000
___% 10,000 - 24,999
___% 25,000 - 39,999
___% 40,000 - 54,999
___% 55,000 - 69,999
___% 70,000 AND ABOVE

Family relationships can be thought of in terms of causal relationship patterns. Causal relationships can be either linear or circular. Linear relationships assume specific causes for behaviors, such as: Linda is acting out because dad doesn't understand her. Circular relationships, a systems concept, assume an interrelating system in which all the family members influence and are influenced by each other. Both causal theories guide current nursing practice.

3. In terms of your nursing practice with clients, describe in the space below the ways in which you conceptualize family relationships.

4. When thinking about individual or family as client, to what extent do you consider the family system (unit), as your client? (Circle one number.)

1 I NEVER CONSIDER THE FAMILY SYSTEM AS MY CLIENT
2 I CONSIDER THE FAMILY SYSTEM AS MY CLIENT ONLY WHEN SEEING A FAMILY
3 I CONSIDER THE FAMILY SYSTEM AS MY CLIENT WHEN SEEING INDIVIDUALS AS WELL AS FAMILIES

5. What percentage of the time in your total case load do you spend focused on:

___% THE INDIVIDUAL CLIENT
___% THE INDIVIDUAL AROUND FAMILY CONTEXT ISSUES
___% FAMILY SYSTEM, OR UNIT, INTERACTIONS

6. Are you satisfied with the impact on family patterns that you are able to make in your nursing practice? (Circle one number)

1 NEVER
2 SELDOM
3 SOMETIMES
4 USUALLY
5 ALWAYS

COMMENTS: _____

_____

_____

7. What characteristic conditions trouble the identified patients or individual family members you see? (Circle all the numbers that apply, and star the 3 you see most.)

1 SUBSTANCE ABUSE
2 PHYSICAL ABUSE
3 RAPE OR SEXUAL ABUSE
4 PERPETRATING ABUSE
5 EATING DISORDERS
6 AFFECTIVE DISORDERS
7 CHRONIC MENTAL ILLNESS
8 PHYSICAL DISABILITY
9 COUPLE DYSFUNCTION
10 PERSONALITY DISORDERS
11 OTHER (specify) _____

_____

8. What characteristic conditions trouble the families that you see? (Circle all the numbers that apply, and star the three you see most.)

1 ENMESHED FAMILY RELATIONSHIPS
2 INFLEXIBLE, TIGHT BOUNDARIES AROUND FAMILY
3 LACK OF BOUNDARIES, OR DIFFERENTIATION, AMONG MEMBERS
4 "STUCK" TRIANGLES, OR SCAPEGOATING
5 CHAOTIC FAMILY RELATIONSHIPS
6 LACK OF BOUNDARIES AROUND FAMILY
7 INFLEXIBLE, TIGHT BOUNDARIES AMONG FAMILY MEMBERS
8 OVER-ADAPTING, UNDER-FUNCTIONING MEMBERS INTERACTING WITH UNDER-ADAPTING, OVER-FUNCTIONING MEMBERS, OR CO-DEPENDENCY
9 RELATIONSHIP PATTERNS REPEATING THROUGH GENERATIONS
10 OTHER (Specify.)_____

In this survey, questions asking about care-giving, or interventions, refer to psychotherapy. Psychotherapy is defined as a formal individual, family, or group relationship involving a process of planned, structured, consistent psychological interaction between a mental health professional with supervised training in psychotherapy and a patient who seeks relief from that professional.

9. Do you offer psychotherapy to your clients?

1 NO (Go to question 26.)
2 YES (Continue with question 10.)

10. What approximate percentage of your time in psychotherapy is spent in the following format? (Estimate to the nearest 5%.)

___% INDIVIDUAL THERAPY
___% COUPLE THERAPY
___% FAMILY THERAPY
___% GROUP THERAPY
___% PLAY THERAPY

11. Do any schools of therapy guide your practice of psychotherapy?

1 NO (Go to question 14.)
2 YES (Continue with question 12.)

12. Nurses tend to use interventions from several different theories. On a scale of 1 - 5, indicate to what extent you use each theory. 1 = I do not use this theory at all; 5 = I use this theory for every client.

1 = NEVER 2 = SELDOM 3 = SOMETIMES 4 = USUALLY 5 = ALWAYS

___ PSYCHODYNAMIC THEORY
___ COGNITIVE THEORY
___ EXISTENTIAL THEORY
___ BEHAVIORAL THEORY
___ FAMILY THEORY
___ NURSING THEORY (Specify.)_____
___ OTHER (Specify.)_____

13. When you plan your assessments and interventions, to what extent do you use schools of family theory? On a scale of 1 - 5, indicate to what extent you use each school of family theory. 1 = I do not use this theory at all; 5 = I use this theory for every client.

1 = NEVER 2 = SELDOM 3 = SOMETIMES 4 = USUALLY 5 = ALWAYS

___ PSYCHODYNAMIC FAMILY THEORY
___ ACKERMAN'S INTEGRATIVE THEORY
___ WHITAKER'S SYMBOLIC EXPERIENTIAL THEORY
___ BOWEN'S FAMILY SYSTEMS THEORY
___ MINUCHIN'S STRUCTURAL THEORY
___ THE MILAN GROUP'S SYSTEMIC THEORY
___ WEAKLAND, WATZLAWICK AND FISCH'S STRATEGIC THEORY
___ THE MRI GROUP'S INTERACTIONAL THEORY
___ BEHAVIORAL FAMILY THEORY
___ OTHER (Specify.)_____

14. Often, nurses use interventions from several schools of therapy for a particular client. In the space below, please provide your definition of eclectic therapy. What does eclectic mean, and what does it not mean?

Psychotherapeutic interventions are shaped by the shared experience and creativity of the therapist and the client. The next questions name various psychotherapeutic interventions. Nurses might use interventions in some situations, but not necessarily in other situations. In reflecting on your practice, indicate if you tend to use an intervention by placing a check in the blank.

15. Which of these interventions do you use?

___ PINPOINT TARGET BEHAVIORS
___ POSITIVELY REINFORCE DESIRED BEHAVIORS
___ GIVE TIME OUTS
___ CONTROL OWN ANXIETY
___ GIVE A COMMAND
___ SET LIMITS ON BEHAVIOR
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

16. Which of these interventions do you use?

___ REVEAL NOTHING ABOUT MYSELF
___ INTERPRET THE CLIENT'S TRANSFERENCE TO ME AS THERAPIST
___ REQUEST THE CLIENT TO FREE ASSOCIATE
___ ASK ABOUT THE CLIENT'S CHILDHOOD
___ MAKE FORMULATIONS ABOUT TRANSFERENCES TO FAMILY MEMBERS
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

17. Which of these interventions do you use?

___ "JOIN" THE FAMILY IN POSTURE, MUTUAL INTERESTS, ETC.
___ IGNORE THE SYMPTOM
___ ASK PEOPLE TO CHANGE SEATING ARRANGEMENTS
___ DIRECT TWO PEOPLE TO KEEP ARGUING LONGER THAN USUAL
___ DIRECT MEMBERS TO REPLAY AN INTERACTION IN THERAPY
___ REFRAME BEHAVIOR TO CHANGE THE EMOTIONAL CONTEXT
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

18. Which of these interventions do you use?

___ STAY CLEAR OF EMOTIONAL INVOLVEMENT
___ ACT AS A COACH
___ POINT OUT LONG TERM SIMILARITIES IN RELATIONSHIP PATTERNS
___ INTERPRET RELATIONSHIP PATTERNS SINCE CHILDHOOD
___ EXPLAIN TRIANGLES
___ ENCOURAGE THE CLIENT TO CALMLY STATE "I POSITIONS" TO OTHERS
___ ENCOURAGE RECOGNITION OF FEELINGS AND NEEDS
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

19. Which of these interventions do you use?

___ BE IN CHARGE OF THERAPY
___ NOT CONCERN MYSELF WITH PAST HISTORY
___ STRAIGHTFORWARDLY DIRECT FAMILY MEMBERS TO CHANGE BEHAVIOR THAT AFFCTS THE SYMPTOM
___ GIVE PARADOXICAL INJUNCTIONS
___ GIVE HOMEWORK
___ NONE OF THE ABOVE
___ OTHER (Specify.) _____

20. Which of these interventions do you use?

___ DESCRIBE WHAT THE FAMILY CAN EXPECT FROM IMPAIRED MEMBER
___ EXPLAIN HOW THE BODY LANGUAGE OR THE SITUATION CAN FRAME, AND EITHER VALIDATE OR CONTRADICT VERBAL MESSAGES
___ TEACH HOW TO EXPRESS EMOTION IN A NON-ANXIOUS WAY
___ TEACH FAMILY MEMBERS TO VERIFY MESSAGE FOR ACCURACY
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

21. Which of these concepts do you use?

___ RESPONSIBILITY FOR OWN BEHAVIOR
___ INEVITABILITY OF DEATH
___ ULTIMATE LONELINESS
___ FINDING MEANING IN LIFE
___ NONE OF THE ABOVE
___ OTHER (Specify.) _____

22. Which of these interventions do you use?

___ TEACH CLIENTS TO RECOGNIZE AUTOMATIC THOUGHTS
___ TEACH CLIENTS TO RECOGNIZE THE FEELINGS PRECEEDING AUTOMATIC THOUGHTS
___ TEACH CLIENTS TO CHECK WITH OTHERS TO VERIFY ACCURACY OF THOUGHTS
___ TEACH CLIENTS TO CHANGE BEHAVIOR BASED ON NEW THOUGHTS AND FEELINGS
___ NONE OF THE ABOVE
___ OTHER (Specify.)_____

Possibly you plan interventions in your therapy with particular goals in mind. These goals, or outcomes, could be considered to indicate your conception of mental health, at least for particular clients. They can also assist you in evaluating your assessments, plans, and interventions. The next questions are concerned with the outcomes you look for as goals for your clients in therapy.

23. Do you plan psychotherapy with outcomes in mind? (Circle one number.)

1 NO (Go to question 25.)
2 YES (Continue with question 24.)

24. If yes, how do you develop goals? (Circle the number you use most.)

1 THE CLIENT AND I PROBLEM SOLVE TOGETHER TO NEGOTIATE GOALS
2 I DEVELOP GOALS ON THE BASIS OF MY THEORETICAL ORIENTATION AND DIRECT THE CLIENT IN CHANGE
3 I CLARIFY MY OBSERVATIONS TO THE CLIENT, AND THE CLIENT DEVELOPS GOALS.

25. Describe below how you know when the client is ready to leave therapy.

26. In terms of your nursing practice, what is your definition of mental health?

Your work setting quite probably influences your advanced nursing practice. The following questions relate to your work setting and roles.

27. For what kind of agency do you work? (Circle each number that applies.)

1 HOSPITAL
2 COMMUNITY MENTAL HEALTH AGENCY
3 NURSING HOME
4 PUBLIC HEALTH DEPARTMENT
5 OUTPATIENT CLINIC OR DOCTOR'S OFFICE
6 PRIMARY OR SECONDARY SCHOOL NURSING
7 SCHOOL OF NURSING
8 HOME HEALTH AGENCY
9 PRIVATE PRACTICE
10 INDUSTRIAL OR CORPORATE HEALTH
11 OTHER (specify) _____

33. What professions offer psychotherapy at your agency? (Circle all the numbers that apply. If you work for more than one agency, answer for the one that affects you most.)

1 NURSING
2 SOCIAL WORK
3 PSYCHOLOGY
4 PSYCHIATRY
5 OTHER (specify) _____
6 I AM IN PRIVATE PRACTICE; I DO NOT WORK FOR AN AGENCY

34. How many hours per week do you practice mental health nursing? _____

35. About how many hours of psychotherapy do you offer per week? _____

36. Which of the following describes your current position(s)? (Circle the numbers of all that apply.)

1 STAFF NURSE
2 NURSING ADMINISTRATOR
3 SUPERVISOR/NURSE MANAGER
4 CLINICAL SPECIALIST
5 NURSE PRACTITIONER
6 CONSULTANT
7 EDUCATOR
8 RESEARCHER
9 ACADEMIC ADMINISTRATOR
10 OTHER (specify) _____

37. For how many years have you practiced mental health nursing? _____

38. For how many years have you practiced as a nurse practitioner?_____

39. For how many years have you offered psychotherapy to your clients? _____

The following questions ask for demographic information.

40. Have you recived a graduate degree?

1 NO (Go to question 42.)
2 YES (Continue with question 41.)

41. Which of the following graduate degrees have you received? (Circle each number that applies.)

1 MASTER'S DEGREE IN NURSING
2 MASTER'S DEGREE IN OTHER FIELD (specify) _____
3 DOCTORAL DEGREE IN NURSING
4 DOCTORAL DEGREE IN OTHER FIELD (specify) _____
5 OTHER (specify) _____

42. If you hold state or national certification please list the certifying group and date of initial certification.

_____

_____

_____

43. Please describe how your income for 1988 from your mental health nursing practice was distributed among the following sources. (Indicate approximate percentage of total for all that apply.)

___% AGENCY SALARY
___% THIRD PARTY REIMBURSEMENTS
___% CASH PAYMENTS FROM CLIENTS
___% RESEARCH OR OTHER GRANT
___% CORPORATE PAYMENTS FOR CONSULTATIONS
___% OTHER (specify) _____

44. What was your approximate net annual income for 1988 from your mental health nursing practice? (Circle one number.)

1 UNDER $10,000
2 $10,000 - 19,999
3 $20,000 - 29,999
4 $30,000 - 39,999
5 $40,000 - 49,999
6 $50,000 - 59,999
7 $60,000 - 69,999
8 $70,000 - 79,999

45. What is your gender?

1 FEMALE
2 MALE

46. The life stages that people have reached add depth to the experience they bring to practice. What relationship stages have you experienced? (Circle each number that applies.)

1 SINGLE, NEVER IN A SERIOUS RELATIONSHIP OR MARRIAGE
2 SERIOUS RELATIONSHIP OR MARRIAGE
3 SEPARATED OR DIVORCED
4 WIDOWED OR WIDOWERED

47. How many children do you have in each age group?

___ UNDER 5 YEARS OF AGE
___ 5 - 9
___ 10 - 14
___ 15 - 19
___ 20 - 24
___ 25 AND OVER
___ I HAVE NO CHILDREN

48. What is your present age?

1 UNDER 25
2 25-34
3 35-44
4 45-54
5 55-64
6 65 OR OVER

Thank you very much for taking the time to describe your advanced practice of psychiatric mental health nursing. If you wish, please make additional comments here. I will note your comments with interest. If you wish a summary of results, please send me a separate postcard with your name and address. Results should be ready by summer of1990.

Appendix B

Summary of Demographic Data

Relationship Experience by Percent of Respondents

Relationship	Percent
Single	14
Marriage or serious relationship	89
Separated or divorced	44
Widowed	3

N = 62

Number of Children by Percent of Respondents

Children	Percent
0	16
1	29
2	24
3	18
4	10
5	2

N = 63

Appendix C

Thirty Five Interventions Rank Ordered by Percent of Respondents

Interventions	Percent
Teach cl to recognize feelings and needs (Bowen)	78%
Take responsibility for self (Existential)	77%
Positively reinforce target behaviors (Behav)	75%
Pinpoint target behaviors (Behav)	74%
Point out relationship patterns (Bowen)	72%
Verify accuracy of messages (Cognitive)	71%
Set limits on behavior (Behav)	70%
Change behavior (Cognitive)	68%
Verify messages (Interactional)[a]	69%
Find meaning in life (Existential)	67%
Give homework (Systemic/Strategic)	67%
Recognize automatic thoughts (Cognitive)	67%
Positive reframing (Structural)	67%
Interpret relationship patterns (Bowen)	62%
Recognize feelings following auto thots (Cog)	61%
Teach "I" statements (Bowen)	58%
Express emotion non-anxiously(Interactional)[a]	59%
Act as a coach(Bowen)	54%
Teach family what to expect of identified patient (Interactional)[a]	53%
Replay interactions in sessions (Structural)	51%
Explain body language (Interactional)[a]	51%
Explain triangles (Bowen)	49%
Make formulations about family transference (Psychodynamic family)	48%
Process idea of death (Existential)	43%
Use of paradox (Systemic/Strategic)	36%
Direct the family in change (Systemic/Strat)	35%
Accept ultimate loneliness (Existential)	30%
Ask family to change seats (Structural)	30%
Be in charge of therapy (Systemic/Strategic)	25%
"Join" the family (Structural)	25%
Ask the patient to free associate (Psychdyn)	17%
Ignore symptoms (Structural)	16%
Avoid emotional attachment (Bowen)	9%
Not ask about past history (Systemic/Strategic)	6%
Reveal nothing about self (Psychodynamic)	4%

N = 69 for all interventions except interactional ones.
[a]N = 68.

Appendix D

Summary of Qualitative Responses Defining Eclecticism

Definitions of Eclecticism in Four Categories, by Percent of Respondents

Category	Percents
Client-Centered Responses	61

"To me, it means fitting the therapy to the client's needs, abilities & resources".

"I use a combination to relate to the clients and their needs".

"Eclectic means, based on assessment and individual patient needs, choose theory most likely to assist patient with insight and change for healthier responses to life situations".

"You utilize the concepts from a particular theory which fits and makes sense in the context in which the client is framing his discussion".

Therapist Centered Responses	10

"Taking parts of different school of therapy that seem to fit together and that suit your own style and that you've had success with".

"Incorporating personal philosophy with that of the various specific therapies. It means 'all' on the inclusion continuum, taking the best from each theory, from my point of view".

"Drawing from my 20 + years of reading, doing and living life's joys and problems".

"Drawing tools from various schools and incorporating them with one's own beliefs about therapy and performing therapy. It doesn't mean having multiple, changing focus".

Both client and therapist centered	10

"Eclectic means hard work to be constantly current, knowledgeable, and able to use whatever theoretical base that will best help the individual/ family/ group/

corporation, etc. with whatever the presenting problem or need".

"Matching the intervention to the problem and the individual client or family as well as to the personality and beliefs of the therapist".

"Means matching a family with best possible framework and following through with it. Means having command of several basic theories from which to choose".

Not Specified	19

"A combination of a group of therapies, taking the best from each one and utilizing those specific areas".

"The combination of theoretical approaches. For example, I work with a large number of eating disordered patients. Their therapy is often a combination of: Cognitive, Behavioral, and Family therapies".

N = 48

Definitions of Eclecticism in Two Categories, by Percent of Respondents

Category	Percent
Combination of Theories in One Plan	73
"Integrating a variety of theories/strategies into a specific plan for the client. It does not mean taking strategies out of a sophisticated theoretical structure and using them in isolated ways".	
"combining a group of therapies, taking the best from each and utilizing those specific areas".	
"Use whatever works - elasticity, not rigidity".	
Specific Theory from Several Familiar	19
"Sometimes, based on client need, one theoretical stance is more effective than another".	
"It means using specific theories for specific issues - not using several theories to deal with one issue".	
Answers not clear	8

N = 48.

Appendix E

Tables Presenting Responses About Therapy Outcomes and Definitions of Mental Health

Categories of How You Know the Client is Ready to Leave Therapy, by Percent of Respondents

Category	Percent
When Client Goals are Attained	43

"Goals attained - lack of movement or change - stability &/or resolution of symptoms".

"When the client has objectively met the identified goals or subjectively feels comfortable with what has been accomplished and gives some indication that he/she is ready to 'go it alone'".

"Therapeutic goals have been attained, or client has redefined goals in such a way so that we cannot achieve them. (i.e. I work in a brief therapy setting -if client's goal is 'psychoanalysis' or long term Rx, I might/would consider termination".

By Client Decision	33

"Usually the client knows and says so, either because they see how to proceed on their own or because they have become immobilized and need more time".

"I ask them, offering my observations as part of the data".

"They usually know when they are finished - I am no longer making a difference".

"They bring up the subject - sometimessubtly".

"They tell me".

By Mutual Decision	22

"Joint decision with client".

"Mutual agreement of client, group, and I".

"Patient's expression of maximum benefit or my observation of maximum benefit with patient confirmation".

Category	Percent
Supportive Therapy Never Ends	17

"Most of my clients leave therapy purposefully and mutually when they move out of our county. Most need ongoing supportive therapy and periodic help in negotiating systems".

"I work with chronically mentally ill - they are rarely ready to leave at least supportive therapy. For most, extensive psychotherapy is not appropriate either - for some, activities such as socialization, vocational training help more".

When Therapist Goals are Attained	11

"Activity level has increased - they're reaching out to others more; meeting own needs. They're more able to clearly define difficulties and take own steps to address these".

"They have less anxiety overall, and feel in control of themselves. They are able to problem solve situations".

"Demonstrates increased self responsibility and commitment to long-term change".

"Decreased content; increased anger with me - able to process this within context of one to one; missed appointments".

"Experiences less distress, discomfort with issues which brought client to therapy. Able to employ new strategies or ways of effectively addressing interpersonal relationships and issues".

By Funding, Agency Policy	7

"Pragmatic issues of insurance coverage, time off work, etc. often enter this decision".

"Funding and agency policy".

"When admitting problem can be managed as an outpatient".
"Not within my control; when they are released from jail, therapy is over - do much referral for follow-up".
N = 46.

Mental Health Definition Categories Ranked by Percent of Respondents

Category	Percent
Behavior Change - Ability to Meet Own Needs	53

"Balance in coping strategies; utilize variety of coping styles which promote problem resolution".

"Willingness to undergo change to a level of functioning that is optimum for them, the individuals they are associated with, and eventually all of mankind".

"Ability to adapt to changing circumstances, changing strengths and weakness".

"Being able to learn and change based on your own experience".

Unity and Balance of Personality	47

"Unity of various parts of the personality".

"Wholeness and acceptance of being human, including avoided and valued aspects".

"An evolving process whereby a person's internal needs and demands exist in harmony with external realities of individual's environment".

"Integration of spiritual, mental, and physical aspects of the self. Self as defined by Jung, CG".

Differentiation of Self	31

"Experience oneself as loveable and loving".

"Self-esteem in the face of disability".

"Solid sense of self and self-worth".

"Ability to enjoy life and ongoing feelings of self-regard and success".

Communicating Own Feelings Well	14

"Ability to express feelings acceptably".

"Ability to express a range of emotions".

"Flexibility to access and report feelings, thoughts and behavior in appropriate and rewarding fashion".

"Ability to express oneself fully, emotionally at an appropriate developmental level".

Category	Percent
Growth in Satisfying Relationships	10
"Maintaining relationships despite change".	
"Balancing inter- and intra-personal relationships - pleasure and letting go".	
"Satisfaction and enjoyment in relationships".	
Resolution of Old Distress	10
"Resolution of hurts and angers from childhood, etc."	
"Resolving and healing old wounds".	
"Absence of continued distress".	
"Viewing future with anticipation rather than apprehension".	
Accepting Reality	8
"Accept reality".	
"Acceptance of existential dilemma; recognition of neurobiological component".	
"Capacity to define and prioritize life situations clearly".	

N = 49.

AN ABSTRACT OF THE RESEARCH PROJECT OF

HEIDI LOUISE KOENIG HART, R.N., B.S.N.

FOR THE MASTER OF SCIENCE IN NURSING

DATE OF RECEIVING DEGREE: June, 1990

TITLE: Description of the Family Therapy Practice of Psychiatric Mental Health Nurse Practitioners in the State of Oregon

APPROVED: _____

Sarah Porter-Tibbetts, R.N., M.S., Advisor

Although many nurses do practice family therapy, descriptions of how nurse psychotherapists conceptualize families as their clients are lacking in the literature. Similarly, nurse psychotherapists' use of theories and psychotherapeutic interventions for families have not been well described. Nurse psychotherapists' definitions of mental health as expressed in their goals for therapy and descriptions of the contextual settings in which they practice are also sparse. The purpose of this study, then, was to describe the family therapy practice of psychiatric mental health nurse practitioners in the State of Oregon. Results from this study can provide a base for future research to document the effectiveness of this nursing practice role.

The study was designed as a descriptive mail survey of all psychiatric mental health nurse practitioners certified

by the Oregon State Board of Nursing. The tool was a questionnaire written by this researcher and analyzed by four expert nurses in the field. Descriptive statistics were used to analyze results. Eighty one percent of respondents reported that they conduct psychotherapy. Respondents were found to conceptualize families as systems, and to consider the family as client even when seeing an individual; however, they spent small percents of practice time with families. Difficulties in seeing families were mentioned more often than satisfaction with change in family systems. Cognitive, psychodynamic and family theories ranked highest among major theories chosen. Psychodynamic family theory, behavioral family theory, Bowen's Family Systems theory and Minuchin's Structural theory ranked highest among family theorists. Respondents were integrative in their choices of interventions. Outcome goals for therapy were reported to be meeting client goals, although these were limited by client moves among agencies, and by some agency limitations. Definitions of mental health were rich and multi-dimensional, although phrased in individual terms, not limiting mental health only to the highest-functioning members of society. Respondents tended to hold two positions, working at both secondary and primary mental health care settings. They tended to rate their agencies as supportive of family therapy.