Family nursing practice paradigm perspectives and diagnostic approaches

Family nursing practice reflects different belief systems about the nature of the family and family health. Competing belief systems (paradigms) are examined as they relate to the concepts of concern to family nursing. Using a family case study, divergent diagnostic approaches emerging from the paradigms are described and demonstrated. Implications are delineated for the further development of family nursing practice.

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DISTINCT PRACTICE approaches are evident in family nursing.[1] The more traditional, family-centered nursing considers the family to be critical background or context for the individual. Although the nurse involves family members in nursing care, the individual remains the central focus of concern. In the second approach, identified by Wright and Leahey[2] as family systems nursing, the family is the central focus of inquiry and the client of nursing. Neither approach is inherently better than the other; rather each offers a very different perspective for observing, explaining, and predicting health behaviors. Gilliss states that "the failure to differentiate clearly between family–as–context and family–as–client has caused considerable confusion to the further development of the field of family nursing."[3(p19)]

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An area of debate is whether nursing theories can serve as theoretical foundations for family nursing practice.[4,5] Nursing theorists have placed primary emphasis on the individual as the client of nursing. Person serves as one of the discipline's central metaparadigm concepts along with environment, health, and nursing.[6] This emphasis on person creates confusion about where "family" fits in the nursing metaparadigm.[7]

Parse and colleagues[8] identify two competing world views that purport very different belief systems about nursing's central concepts. They classify these world views as the totality and simultaneity paradigms. Nursing's conceptual models emanate from one or the other of these paradigms. Leddy and Pepper[9] consider the nursing models developed by Peplau, Johnson, Orem, King, Roy, Neuman, and Watson to reflect the beliefs of the more predominant totality paradigm. The models of Newman, Rogers, and Parse reflect simultaneity paradigm beliefs.[9]

This article is a response to the challenge proposed by Gilliss[3] to critically dialogue about issues in family nursing. Specifically, this article examines different beliefs associated with family within paradigm perspective and how these beliefs impact on diagnostic reasoning in family nursing practice.

METAPARADIGM BELIEFS RELATIVE TO FAMILY NURSING

Client

Paradigm beliefs about the nature of the client determine the focal system of inquiry and the family nursing approach. The totality paradigm views the person as a "total summative organism whose nature is a combination of bio-psycho-social-spiritual features."[10(p4)] Within this belief system, the family is also considered to be a summative unit whose nature is a combination of its individual members. For example, King views the family as "a social system that is seen as a group of interacting individuals."[11(p179)] Neuman's concept of family is "individual family members harmonious in their relationships."[12(p241)] Roy views the family as the "immediate social environment of the individual."[13(p186)] Implicit is the assumption that the family can be understood through knowledge about its individual members. The person remains the central focus of inquiry, which guides the family-as-context orientation in family-centered nursing.

In comparison, the beliefs of the simultaneity paradigm view the person as a unified and patterned whole, more than and different from the sum of parts.[10(p160),14(p46)] The family is viewed similarly. As Rogers states, "Pattern identifies the family field and cannot be predicted by knowledge of the members of the family. . . . Only as the family is perceived as an irreducible whole does study of the family occur."[15(pp226,227)] Within this paradigm the choice of person or family as client is arbitrary. However, one must be cognizant that, since the individual and family are irreducible wholes, their patterns differ. It is the belief that family is an irreducible whole that guides the family-as-client orientation in family systems nursing.[16]

Environment

In the totality paradigm, the environment is viewed as external factors that influence the individual. The family as part of the external environment (family as context) exerts stressors, forces, and conditions to

which the person reacts and adapts.[8] The environment (including family) can be manipulated to maintain and/or promote balance in the individual.

In contrast, reflecting the beliefs of the simultaneity paradigm, Rogers describes client/environment interaction as one in which both "evolve and change together."[15(p224)] Parse's view purports that "each is a coparticipant in the creation of the other."[10(p162)] When family is client, family and environment are continuously evolving together. Both are instrumental in creating the other.

Health

Within the totality paradigm, health is viewed as "a dynamic state and process of physical, psychological, social, and spiritual well-being."[10(p32)] Inherent is the assumption that there is an optimal state of health with external norms and standards. Deviation from these norms connotes illness, maladaptation, or dysfunction.

In contrast, the simultaneity paradigm views health as the process of becoming.[8] The essence of family health is pattern manifestation, with a focus on quality of life rather than deviation from external norms. According to Rogers, families are characterized by growing diversity and such "diversity is not to be construed as deviancy."[15(p226)] Families are innovative living systems who continuously create patterns to meet ever changing needs and responsibilities.

Nursing

Beliefs about family, client/environment interaction, and health determine the goals of family nursing practice. The current definition of nursing, adopted by the American Nurses Association, describes nursing as the "diagnosis and treatment of human responses to actual or potential health problems."[17(p9)] This definition reflects the beliefs of the totality paradigm. Nursing interventions are directed toward restoring balance between person and environment. The goal is to assist clients to adapt, overcome, and/or prevent limitations and promote abilities.[10]

When family is client, family and environment are continuously evolving together.

In the simultaneity paradigm, nursing actions serve to guide and facilitate pattern recognition and appraisal with the goal of "expanding consciousness"[18(p171)] or "illuminating meaning."[10(p137)] The nurse and family work as coparticipants in assessing family patterns and directing the ongoing change process with the overall goal of enhancing the quality of the family's life as the family defines it. Table 1 compares the central concepts of interest to family nursing that emerge from the totality and simultaneity paradigms.[8-15,18]

DIAGNOSTIC APPROACHES IN FAMILY NURSING

Paradigm perspective governs the diagnostic approach. As a bridge between family nursing theory and practice, paradigm belief and diagnostic approach need to be logically consistent.

Diagnosing is an information processing strategy. As a cognitive process, it addresses what and how information is processed, stored, and retrieved in a problem-solving

Table 1. Comparison of concepts according to paradigm beliefs relevant to family nursing

Concept	Belief	
	Totality	**Simultaneity**
Nature of client	Individual is client in the context of family. A combination of bio–psycho–social–spiritual features whose whole is the sum of parts.	Family as client—an irreducible whole, manifesting pattern and organization, more than and different from the sum of the parts.
Client/environment interaction	Family is external to the individual and is a part of the environment. Individuals act and react to environmental changes.	Mutual and simultaneous interaction with family/environment evolving and changing together.
Health	Composite of family members. State of bio–psycho–social–spiritual well-being based on external norms.	Manifestation of family/environment patterns in the process of evolving, emerging, expanding, and becoming.
Nursing	Restore balance between family member and environment in order to overcome and/or prevent limitations and promote abilities.	Guide family in pattern appraisal and recognition in order to enhance awareness, meaning, and potential.

task. The literature, however, does not address diagnostic process and outcomes emerging from different paradigm perspectives.

In the totality paradigm, health problems are viewed as the individual family members' actual or potential deviations from external norms. The diagnostic goal is to identify these deficits and make judgments as to their nature and etiology. Since the deficits are based on external norms, they can be identified and classified in a diagnostic taxonomy such as the North American Nursing Diagnosis Association (NANDA) system.[19] This taxonomy is consistent with the beliefs about the concepts of concern as described in the totality paradigm.

The nurse assumes primary responsibility for deciding which predetermined deficit provides the best "fit" or explanation for the data at hand. Although nursing diagnoses are validated by family members, the nurse assumes principal responsibility for the diagnostic decision.

According to Carnevali,[20] the "diagnostic reasoning process" includes the nurses' cognitive manipulation of data into manageable data sets (clustering), background and problem-solving ability of the nurse, as well as setting based role expectations. The process involves reducing and ordering data into manageable components that fit preestablished diagnostic criteria with major and minor defining characteristics. The process tends to be sequential and linear. Clustering and ordering data into categorical components based on expected external norms is logically consistent with the totality paradigm.

Emphasis is on the problem-solving process in which the task is managed by the correspondence of assessment data and di-

agnostic categories. Hypotheses are generated early in the process. However, the nature of the task moves the diagnostician toward definitive diagnostic closure in the form of a diagnostic statement. The nursing diagnosis guides nursing interventions toward assisting individual family members to prevent, limit, or adapt to the identified deficit.

In comparison, perceived change in pattern as identified by the family may connote family health concerns in the simultaneity paradigm. The diagnostic goal is "pattern manifestation appraisal."[21(p33)] Relative family experiences are critical to understanding both the meaning the family gives to the health concern and the options associated with resolving or managing the concern.

The nurse is a coparticipant in the diagnostic process, serving as the family guide and facilitator in the exploration of meaning and options. As a circular and fluid process, assessment and intervention often occur simultaneously. The nurse and family both evolve and change together as the process unfolds.

Emphasis is on pattern recognition and appraisal rather than data management and diagnostic "fit." The desired outcome is not to reach diagnostic closure but to expand possibilities through continuous hypothesis generation and validation, an approach used by the University of Calgary family nursing faculty.[22] Because family patterns are unique and creative, the use of a standardized diagnostic taxonomy is not logically congruent with this paradigm perspective. Table 2 presents a summary comparison of these divergent diagnostic approaches.

FAMILY CASE STUDY

In order to fully examine these critically different diagnostic approaches, a case study of a child-rearing family in transition is presented.

Bill Hardy was referred for discharge planning by the nursing staff of the rehabilitation service. Bill, age 16, is status post right-above-the-knee amputation, which resulted from a crushing knee injury sustained in an automobile accident 7 weeks ago. Bill's blood alcohol level was .08 on emergency department admission. No charges were brought against Bill, the driver. There were no other injured persons. According to the rehabilita-

Table 2. Comparison of paradigm diagnostic approaches in family nursing

	Totality	Simultaneity
Health concern	Family member(s) actual or potential deviation from norm	Family's perceived change in pattern
Diagnostic goal	Identify actual or potential deficits	Pattern recognition and appraisal
Diagnostic decision	Nurse → family	Family ↔ nurse
Process	Linear/sequential	Circular/fluid
Emphasis	Data "fit"	Process
Desired outcome	Diagnostic closure (definitive diagnosis, diagnostic taxonomy)	Expansion (ever evolving hypotheses)

tion service records, Bill's physical recovery has been excellent, and he is fully cooperative with physical therapy plans. The staff has noted changes in his affect and behavior. He is experiencing severe mood swings and has become increasingly belligerent and hostile in the past week.

The following data are available from the genogram on the hospital record (see Fig 1). Bill is the younger of two siblings born to Jim (age 47), an athletic director at the YMCA, and Susan (age 45), an elementary school teacher. His sister Lisa (age 18) won an athletic scholarship 6 months ago and is attending college out of state. Bill, a high school sophomore, has maintained a B average and played second string football. He describes himself as sociable, was elected class secretary, and works part-time in an auto supply store.

The following data were gathered on initial interview with Bill and parents present. Bill stated, "I just never measure up to what my parents want." Both parents expressed concern about the recent changes in Bill's behavior. Family history reveals that Jim is the younger of two siblings. His brother, Will Jr., was killed in Vietnam in 1966 at the age of 24. Jim's deceased father, Will Sr., owned and operated a sporting goods store until the age of 60. The cause of death, in 1974, was a myocardial infarction. Jim's mother, Anne (age 74), experiencing an acute exacerbation of rheumatoid arthritis, lives alone.

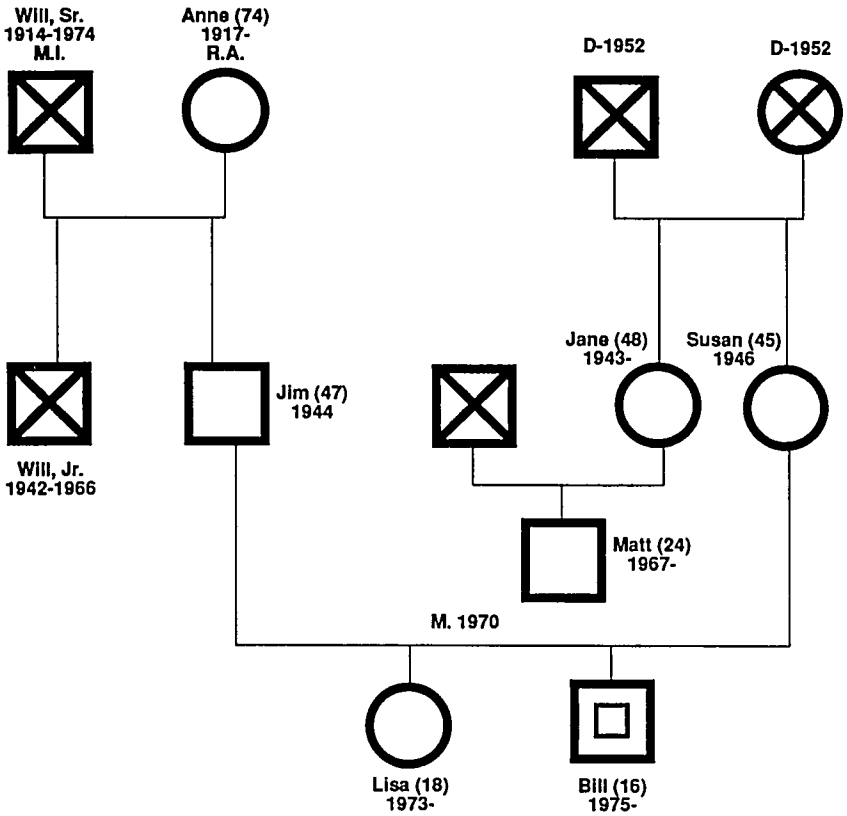

Fig 1. Hardy family genogram (1991).

Susan's older sister, Jane (age 48), a widow, lives nearby and resides with her unmarried son, Matt (age 24), a mechanical engineer. Both sisters were raised by a maternal aunt, following the death of their parents in a 1952 boating accident.

TOTALITY PARADIGM DIAGNOSTIC APPROACH TO FAMILY

In the totality paradigm, the orientation to the data field is focused on Bill's actual or potential deficit. The nurse gathers cues pertaining to deviations from the norm, then clusters and funnels data to arrive at diagnostic closure. A diagnostic statement is then formulated, which, Gordon states, "nurses by virtue of their education and experience are capable and licensed to treat."[23(p8)]

This case study was examined by faculty, senior undergraduate students, and graduate students. The totality paradigm diagnoses were individually focused and concentrated on the loss of a body part. Much of the data were considered irrelevant. There was faculty–student agreement for the following totality paradigm diagnoses:

- ineffective individual coping related to body part loss as manifested by severe mood swings and aggressive and hostile behavior;
- body image disturbance related to recent right-above-the-knee amputation;
- impaired physical mobility related to recent right-above-the-knee amputation;
- knowledge deficit related to musculoskeletal impairment;
- altered role performance related to perceived high parental expectations as evidenced by client statement, "I just never measure up to what my parents want";
- potential for infection related to traumatized tissue;
- potential for impaired home maintenance related to recent amputation;
- potential for ineffective individual coping related to possible alcohol abuse as evidenced by blood alcohol level .08;
- potential for ineffective family coping: compromised related to parents' expressed concern about recent changes in Bill's behavior; and
- potential for altered family processes related to unexpected multiple family losses (deaths of maternal grandparents, paternal uncle and grandfather) and family life-cycle tasks.

SIMULTANEITY PARADIGM DIAGNOSTIC APPROACH TO FAMILY

In the simultaneity paradigm, the orientation to the data field is the presenting concerns of the family expressed in their terms. In this situation, Bill's presenting concern is "I just never measure up to what my parents want." Bill's parents are concerned about recent changes in his behavior, although the specific behaviors are not delineated.

To understand the meaning and significance of these concerns, the nurse examines them within the unique family situation in which they occur. Family patterns are examined in the relative web of past, present, and future, stretching vertically across generations and horizontally in the here and now. Assessment focuses on patterns of family interaction and how these patterns

The nurse gathers cues pertaining to deviations from the norm, then clusters and funnels data to arrive at diagnostic closure.

are influenced by the family's structure, stage of life-cycle development, and functioning.

The nurse hypothesizes about how the family's history and current situation influence perceptions about the injury. The nurse remains curious about the family, always willing to discard hypotheses and formulate new ones as the family's life experiences evolve and unfold. Guiding the family through the new experience of the accidental loss of limb opens possibilities for the family to examine beliefs, expectations, hopes, and fears. The amputation is viewed as a family event, not an individual one.

The following initial hypotheses were generated by graduate students and faculty viewing family as client within the simultaneity paradigm. This list is not meant to be inclusive and will predictably expand and evolve.

- Three of the men in this family have died suddenly; two were killed in accidents. Are the men in the family vulnerable? Are those who are living seen as precious resources who must be protected? Does the family feel that Bill needs to be protected?
- Bill is the namesake for his deceased grandfather and uncle. The family script may be for Bill to carry on the family name or fulfill the hopes and dreams of members of earlier generations. Does the loss of a body part signify that Bill is now less sexually desirable and, therefore, less able to meet the expectations the family has for him?
- This family appears to place special emphasis on physical abilities. The paternal grandfather owned a sporting goods store, father is an athletic director, sister won an athletic scholarship, and Bill played football. Does athletic ability have special meaning in this family as related to the worth of the person?
- The family is in a developmental transition. Unresolved multigenerational issues tend to resurface at this time and may critically impact on the meaning of the current health problem. How will the current problem impact on accomplishment of the family's developmental tasks? In addition, does the premature loss of the maternal grandparents and the paternal uncle place special significance on the physical loss of the limb?
- Two generations occupy younger sibling positions (father, mother, and Bill). Does the family's expectations of the younger sibling influence perception of the abilities of the younger to function independently? How will the family be influenced by Bill's loss of a limb?
- How does the family respond to loss? Are Bill's exaggerated mood swings that exaggerated for this family?

This case study exemplifies paradigm diagnostic differences. Specifically, within the totality paradigm, the family is viewed as the sum of individual members. Diagnostic focus is directed toward bio–psycho–social–spiritual norms, a logical and consistent approach within this paradigm. In

comparison, within the simultaneity paradigm when family is viewed as client, the family is an irreducible whole. Diagnostic focus is directed toward the family's unique and creative patterns.

IMPLICATIONS FOR FAMILY NURSING PRACTICE

Conceptualization of family as context and family as client within paradigm perspective directs nursing practice. Each of the diagnostic approaches that emerge from these two paradigms provide both advantages and limitations for family nursing practice.

An advantage of the totality paradigm is that the prevailing health care delivery system is based on this world view. These views are widely accepted by nurses as well as other health care providers, providing a common and familiar foundation for practice. This paradigm lends itself to diagnostic and intervention classification systems promoting standardized approaches to practice. A limitation is that this belief system promotes a reductionistic and problem-oriented approach to family nursing. It is assumed that family health can be generalized from knowledge about individual members' health and that there are norms that differentiate effective and ineffective family processes and coping. Rodgers cautions that nursing diagnoses create the potential for "the introduction of another source of dogma as the conceptualization of nursing care situations becomes reduced to a preconceived category system."[24(p180)] This may restrict rather than expand critical thinking and innovative family nursing practice.

A limitation of the simultaneity paradigm is that nurses are less familiar with these beliefs. Since this paradigm does not lend itself to a standardized taxonomy, it is not readily embraced by the prevailing health care system. An advantage is that it focuses on the quality of life rather than on deficits. Family–nurse interactions are continuously evolving, fostering creative, innovative, nonconstrictive diagnostic approaches and interventions.

One pandiagnostic system seems improbable given the nature of these divergent world views. Continued paradigm debate will further refine the conceptualization of family as client and the exploration of diagnostic alternatives within practice models.

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