Psychiatric Home Care and Family Therapy: A Window of Opportunity for the Psychiatric Clinical Nurse Specialist

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This article discusses use of the Developmental-Interactional Model of family therapy by a Psychiatric Clinical Nurse Specialist (CNS) for selected patients receiving psychiatric home care services. This form of family therapy is an integrative approach to working with individuals, couples, and families that combines elements of structural-strategic family therapy with life cycle and intergenerational approaches. Applied to patients and families in a home care setting, this model permits the CNS to assess relational dynamics over time, determining how these transitions relate to a family's problem-solving capability. Case studies are provided to show the application of this model for desired outcomes.

PSYCHIATRIC HOME care services continue to grow as the result of efforts to contain increasing hospital costs, creating a home health environment that offers increased opportunity for the Psychiatric Clinical Nurse Specialist (CNS). As institutions downsize their work forces, many CNS positions are being eliminated or reduced causing the CNS to seek employment opportunities in the community. Psychiatric CNSs are now finding challenging positions in certified home health care agencies, which receive Medicare, Medicaid, health maintenance organization (HMO), and preferred provider organization (PPO) reimbursement for a psychiatric nurse's visit if the client is under the care of a psychiatrist, has a psychiatric diagnosis, and is homebound secondary to his/her psychological or medical status. Psychiatric home care presents a great opportunity for the CNS to provide family therapy interventions based on assessment of complex clinical problems presented by patients living with their families.

Between 1980 and 1996, the number of patients receiving Medicare-sponsored home care increased by more than 400% and the number of agencies delivering that care increased by more than 200% (Montauk, 1999). Individuals most appropriate for home care services include those patients diagnosed with schizophrenia, bipolar disorder, major depression, and anxiety disorder discharged early from inpatient services, those with increasing levels of acuity, and the elderly who are vulnerable to psychosocial crises as well as chronic physical conditions (Iglesias, 1998). Trimbath and Brestensky (1990) report 50% to 70% of elderly patients receiving home care services have affective and/or behavioral disorders. Services may also be initiated for a homebound patient who has not been hospitalized, but has been referred by a psychiatrist in the community for interventions to prevent further decompensation.

There is a paucity of nursing literature on home-based family therapy on which to base effective intervention strategies to assist patients and families in coping with problems of caring for

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a mentally ill family member living at home. This article discusses application of the Developmental-Interactional Model (DIM) (Hanna, 1997) of family therapy used by the Psychiatric CNS in providing psychiatric home care. Case studies are provided to show the application of this model for desired outcomes.

LITERATURE REVIEW

Home-Based Family Therapy

Home-based family therapy has its origin in the 1980 passage of Public Law 96-272. This legislation, also known as the Adoption Assistance and Child Welfare Act, encouraged efforts to keep children in their natural homes by establishing programs designed to provide intensive family intervention for at-risk children and adolescents (Christensen, 1995). Home-based programs are regarded as an alternative to the placement of children in group or foster homes and general or psychiatric hospitals. The underlying philosophy of these programs is that to make significant changes within an individual child, the family system must be considered. Therefore, the family-at-risk is emphasized rather than the individual-at-risk (Zarski, Pastore, Way, & Shepler, 1988).

Home-based service has been reported to be an effective strategy for engaging involuntary clients in treatment (Balgopal, Patchner, & Henderson, 1988); for use with the religious, abusive patient and family who are highly resistant to outside intervention (Dixon & Kixmiller, 1992); and for situations where traditional family therapy models have yielded poor results, such as with lower-income, multiproblem families (Woods, 1988). Woods (1988) found that home-based service can be a less resistant avenue to confront family patterns. A two-tier model for work with high-risk families has been presented by Aponte, Zarski, Bixen, and Cibik (1991), which combines multiple family groups in the community with home-based family therapy for individual families. Cottrell (1994) proposes home-based therapy for families to gain insight into the living conditions of clients to enhance the ability to work with all families.

Psychiatric Home Care

Psychiatric home care has been defined as the provision of psychiatric services in the home on an intermittent basis to individuals who are homebound secondary to their psychological or medical status (Blazek, 1993) with an RN acting as the case manager. The role of the RN includes ongoing assessment of: mental status, the environment, medication compliance, family dynamics, and home safety. The provision of supportive therapy to the patient and family is provided according to the educational preparation of the nurse. Psychoeducation, coordination of all services delivered by other home care staff, and communication of clinical issues to the patient's psychiatrist are also major areas of focus. Patients are usually seen 1 to 3 times a week for 4 to 8 weeks. Maximization of the patient's potential to remain home by stabilizing the course of psychiatric illness is the goal of home healthcare services (Ward-Miller, 1996).

It is during this assessment that the CNS can directly observe the patient and the family in the natural environment of the home and may encounter situations that have evolved as a result of the anger, guilt, burden, embarrassment, and ambivalence involved in the daily care of the mentally ill person. The family of a mentally ill person is frequently the primary caregiver (Anderson, Hogarty, & Reiss, 1981; Anderson, Reiss, & Hogarty, 1986; Marley, 1992; Chafetz & Barnes, 1989). For elderly patients, chronic illnesses can become a major factor influencing their ability to live independently, often signaling the onset of major caregiving roles for the family. Bradley and Alpers (1996) report caregivers may have more unmet needs than the family member receiving home healthcare services. Information about family functioning, which may not have been apparent at the time of referral may be obtained during this assessment. Direct observation of a family in the natural environment of their home quickly brings into focus significant family dynamics and can effectively guide CNS interventions

THE ROLE OF THE CNS

Iglesias (1998) advocates the use of the CNS as an expert practitioner and agent of change in the provision of home healthcare in the next decade as increasing numbers of clients, often elderly, and more acutely ill individuals, require quality care at a lower cost. Use of the community health CNS to enhance illness prevention, health promotion, and wellness has been proposed by Zwanziger et al. (1996). Nursing's Agenda for Health Care Reform (American Nurses Association, 1992) supports the need for community-based CNSs who: (1) en-

hance consumer access to services by delivering primary health care in community-based settings; (2) are the most cost-effective care providers; (3) treat vulnerable populations; (4) reduce health care costs with the use of managed care and; (5) provide long-term care. In community mental health and primary care settings, the Certified Specialist in Psychiatric-Mental Health Nursing analyzes the health needs of both individuals and groups and designs programs that target at-risk groups. The CNS also analyzes cultural and environmental factors, which foster health and prevent mental illness (American Nurses Association, 1994). CNSs are able to meet the challenging demands of caring for a patient with psychiatric needs in the home because of their graduate study. This coursework prepares the CNS to analyze complex clinical situations using a wide range of theory, which then enables them to formulate nursing interventions (Blazek, 1993). Klebanoff and Casler (1986) advocate for the role of psychosocial CNS in home care as a cost-effective alternative to hospitalization. Cain (1986) and McFarlane (1988) propose the role of the CNS as a family therapist based on graduate education, supervised clinical experience, and depth of knowledge, competence, and skill in the practice of psychiatric and mental health nursing.

FRAMEWORK FOR PRACTICE

Overview of the Process

Hanna's DIM (1997) of family therapy was used by the CNS because of the model's integrative approach to working with individuals, couples, and families of all ages with different configurations and diverse cultural and socioeconomic backgrounds by combining elements of structural-strategic family therapy with life cycle and intergenerational approaches. Structural-strategic and life cycle approaches to family therapy suggest that problems develop when families do not successfully negotiate tasks of a new life cycle stage (Haley, 1973; Carter & McGoldrick, 1989). Theoretical assumptions of this model posit that all problems have relational and developmental components and that each person and each family is unique. Applied to patients and families in a home care setting, this model permits the CNS to assess relational dynamics over time, determining how these transitions relate to a family's problem-solving capability.

The DIM (Hanna, 1997) involves 2 to 4 assessment sessions in which relevant information is gathered in a structured format followed by a series of 2 to 4 intervention sessions. Assessment and intervention cannot be delineated as separate stages because proper assessments facilitate therapeutic process, making them interventions as well (Hanna, 1997).

Assessment

Tasks in the assessment stage include: (1) identifying and involving the family hierarchy and (2) learning, reframing, and validating the family story. During the process of identifying the family hierarchy the CNS explores who has the power in the family and will that person or persons attend the first home visit. If the person with the most power is not vocal, efforts are made to engage this person to further explore his/her biases, attitudes, and frame of reference. When leaders of the family or reluctant members are difficult to engage, the CNS explores what relationship is influencing their behavior. Construction of a genogram and a time line of significant family events are strategies in this stage that enable the CNS to learn the family's story from a systemic view. A genogram is a format for drawing a family tree that records information about family members and their relationships for at least 3 generations. Genograms help both the clinician and the family to see the "larger picture," both currently and historically contributing structural, relational, and functional information about the family (McGoldrick & Gerson, 1985). Construction of a genogram also allows the CNS to assess the connectedness of the current family members to each other as well as to the broader system and to evaluate the family's strengths and vulnerabilities in relation to caring for the mentally ill member at home. Circular and reflective questioning as proposed by Penn (1982) are used during genogram construction to allow the family to compare their perceptions and to discuss patterns that shape general family functioning. The circular interviewing technique is an approach that invites clients to bring new information into their awareness by viewing interactions at the relational system level (Cox, 1994).

During validation and reframing of the family's story the CNS works to describe the processes that the family is experiencing in caring for a mentally ill family member. Areas to be explored include the

family's coping style, the amount of stress each family member is coping with, the role played by the identified patient before onset of the problem, and life cycle stages of each member.

Interventions

Tasks in the intervention or problem-solving stage address structural and historical issues. The goal of this stage is to change family behavior by opening alternative patterns of interaction so that the family can solve its problems. In structural family therapy the therapist produces change by joining the family, probing for areas of flexibility, and then activating dormant structural alternatives (Nichols & Schwartz, 1995). Isolation and transitions of power and responsibility are common structural issues with geriatric and chronic mentally ill home care patients. If isolation is an issue, the goal is to help the family members broaden their support network. In those families where there is an imbalance of power and responsibility, the goal involves helping those with responsibility to share it or to help those with power to delegate it (Hanna, 1997). Very often gender becomes an issue in transitions of power and responsibility as women can have primary responsibility for major caregiving tasks, but have no power to make important treatment and medical decisions.

Historical issues are related to the family's history and can be identified during assessment while completing the genogram or time line. Intergenerational approaches can explain how family members develop attitudes, thoughts, and feelings about self and others. These approaches involve adults exploring parent-child-sibling issues from their family of origin that may have developmental bearing on their present family relationships.

Direct or indirect interventions are selected once the nature of the problem is identified. Problems are assessed as situational, transitional, or chronic with situational problems requiring more direct interventions and chronic problems requiring indirect approaches. Direct interventions are those that are more explicit and straightforward and are useful in psychiatric home care situations that involve medical crises, the onset of chronic illnesses, deaths of family members, or recent family conflicts surrounding caretaking responsibilities. Hanna (1997) reports families experiencing situational problems are receptive to structural and intergenerational approaches when they focus on support and education.

In the DIM (Hanna, 1997) transitional problems are related to normative life cycle changes occurring during the family life cycle. Carter and McGoldrick (1989) describe the family life cycle as a process of expansion, contraction, and realignment of the relationship system to support the entry, exit, and development of family members in a functional way. Common normative transitions include adjusting to adolescent children, launching children, retirement, and death. Transitional problems may require direct and indirect interventions, depending on how long the family has been having difficulty.

Chronic problems are those that have their origin in family differences that existed before the onset of problems related to the psychiatric condition and respond to indirect interventions.

The following case studies illustrate use of the DIM (Hanna, 1997) by the CNS during provision of psychiatric home care services to selected patients showing a need for family therapy interventions.

CASE STUDIES

Family 1

Geraldine L., 86, was referred for psychiatric home care services following an inpatient hospitalization for a major depressive episode precipitated by a progressive inability to care for herself and attend a social day program. Chronic obstructive lung disease, bilateral arthritis of the knees, and a large inoperable abdominal hernia were significant comorbidities.

Initial CNS assessment showed Geraldine was experiencing increased difficulty in completing activities of daily living (ADL) and keeping medical appointments. Physical limitations hampered her ability to exit the second floor apartment where she resided with her 48-year-old son, Bobbie, and his girlfriend, with whom she had lived since the death of her husband 8 years earlier. She allowed only her son, a fireman, to transport her down the apartment stairs and to medical appointments. When her son was unavailable, Geraldine would request transportation assistance from her daughter and son-in-law who both had chronic medical conditions and limited strength to assist the patient. Seeking help from private transport services failed because Geraldine refused to be transported to appointments by anyone except her family. Getting Geraldine to medical appointments created family conflicts that lasted for days and provided an opportunity for the CNS to explore family issues.

After identifying and involving key family members for participation in a planned CNS visit, a genogram and time line were constructed to assist in learning the family's story. Information obtained during 2 consecutive home visits showed Geraldine had 6 children, 1 daughter and 5 sons. Her oldest child and daughter, Liz, appeared to have the most responsibility for major caregiving tasks, but had the least decision making power and appeared emotionally and physically exhausted. Liz verbalized feeling "dumped on" by the rest of the family and felt pressured to provide all the care to her aging mother. The genogram showed Liz had a conflictual relationship with her alcoholic father who had given her total childcare responsibilities for her younger siblings, while Geraldine worked full-time in a factory. In fact, during genogram construction, Geraldine became tearful in remembering the enormous burden Liz experienced as a teenager caring for her younger siblings and expressed feelings of guilt for not opposing her husband's demands on Liz to assume childcare responsibilities. Geraldine's youngest child, Bobbie, with whom she lived, had the power when important medical or treatment issues were involved. A third son, who lived a distance from Geraldine, was reluctant to get involved in day-to-day demands of caring for his mother. Three other siblings had significant alcohol abuse histories and had distanced themselves from the family before their father's death 8 years earlier. Consequently, Geraldine had not turned to them for support.

As Geraldine and her children began to share their family story, structural issues of hierarchy and transitions of power and responsibility were identified as problematic areas. Historical issues in the form of intergenerational patterns of thought and behavior were also noted to cause difficulty. Because the structural issues were considered more chronic in nature, indirect interventions were selected with the goal of helping Geraldine's family share decision-making power. Using circular and reflective questioning, the CNS explored family roles to assist Geraldine's family in identifying patterns of communication, power, and behavior. This process was empowering for the family as it was perhaps the first time that Geraldine's daughter, Liz, was able to talk about deep feelings of anger and resentment towards her brother Bobbie for not allowing her to have any decision-making power. A direct intervention using genogram and time line construction facilitated a better understanding of intergenerational patterns in Geraldine's family. This approach explored parent-child-sibling issues from Geraldine's family-of-origin and allowed members to identify needed changes within the family.

After family therapy interventions, Geraldine agreed to home attendant services to assist with ADL and to accompany her to medical appointments. Her son, Bobbie, agreed to allow a professional ambulette service transport Geraldine to medical appointments and was able to approach Liz regarding the sharing of responsibility for medical decisions. The family observed there was better communication between one another.

Family 2

Helen F., 80, was referred for psychiatric home care services after her third hospitalization in 1 year for recurrence of depression and generalized anxiety disorder. A family history showed Helen had been divorced for 30 years and had 2 children, a 53-year-old son who was a physician and a 48-year-old unmarried daughter with whom she lived. Helen appeared to have a close relationship with her son, Arthur, who faithfully visited each day on his lunch hour and whom she called several times a day when she would become anxious. Approximately 3 weeks into receiving psychiatric home care services the CNS observed increased tension between the patient and her 48-year-old daughter, Sheila. Sheila had recently begun dating a man she met at work and would occasionally return home late in the evening after going out for dinner or attending a concert. With the development of Sheila's new relationship Helen became increasingly anxious, somatically preoccupied, and began missing doses of her medications. On one occasion after Sheila had made plans to spend a weekend in a nearby resort, Helen became anxious, developed shortness of breath, and fell in the living room, causing Sheila to cancel her plans and remain at home with her mother.

To initiate assessment, with the goal of addressing the conflict observed between Helen and her daughter, the CNS requested Helen's 2 children be present for a planned visit. Helen's son, Arthur, appeared reluctant to attend, stating, "my mother has been this way all her life and talking about the family isn't going to change her." Once aware of her brother's reluctance to participate in a meeting,

the conflict between Sheila and her mother escalated bringing Helen to the brink of hospitalization.

In an effort to explore the dynamics of nonattendance by Arthur, the CNS scheduled a visit with Helen and Sheila to facilitate developing a cooperative, positive relationship with the family and to gather information that would provide a systemic view of the family's story.

The genogram and time line of important events showed Sheila had returned home 30 years earlier after spending 1 year at college. Sheila's return occurred immediately after Helen's divorce and subsequent to her psychiatric hospitalization for depression. Sheila's brother, Arthur, then 21, had just entered medical school. The family history further showed Arthur became a successful physician and established his own family, while Sheila remained at home living with Helen. After many years of caring for her mother, Sheila developed anger and resentment as her personal and social life dwindled. From the genogram the CNS observed patterns of repetitious behavior in which men in Helen's family became educated and professionally successful, while women often remained at home and had less opportunity for higher education. It was also significant that only women, Helen and her mother, suffered from depression and anxiety.

Hierarchial issues, as well as intergenerational patterns of thought and behavior, were readily identified in this family. Arthur's reluctance to participate in a family meeting was an entry point for the CNS to empower Sheila to break this impasse by using a combination of psychoeducation and paradox. With CNS assistance, the direct intervention of teaching Sheila communication and negotiation skills was helpful to engage Arthur in addressing the conflict between herself and Helen. To address intergenerational issues, labeling patterns as they were identified on the genogram, exploring each person's sense of entitlement, and negotiating family-of-origin work to target needed changes within Helen's family were direct interventions used. Paradox was chosen by the CNS as an indirect intervention to assist Sheila in feeling validated and understood, and to allow her to feel the anger and resentment towards Helen that she may have been ashamed to express openly.

The CNS found when Helen's family viewed their history together, they were better able to understand what was happening to them and were able to uncover family strengths that aided in resolving some of the conflict between them. On discharge from psychiatric home care, Helen was less anxious, verbalized a decreased need to constantly call her children, and had begun attending a neighborhood day program for seniors that encouraged socialization. She took great pride in being able to establish friendships with other women her age. Sheila reported that the therapy had increased her self-confidence in dealing with Helen and her brother and she was finding new ways to decrease the stress at home.

Positive assessment of the use of the DIM (Hanna, 1997) model of family therapy with selected patients in a psychiatric home care setting was based on patient and family reports of a decrease in family conflict involving caregiving issues and a decrease in rehospitalization.

CONCLUSION

With the ever-increasing shift to community-based care, the necessity to view the home of the patient and the family as an effective setting for intervention is growing. The CNS in a psychiatric home care program of a certified home health agency, using the DIM (Hanna, 1997) model of family therapy, has described opportunities for the CNS to create a new role in the community to meet the needs of psychiatric home care patients living with their families. Using this model of family therapy, the CNS has focused on interventions that work jointly with the home care patient and the rest of the family with the goal of helping significant relationships function in a way that resolves the presenting problem. These interventions recognize the unique experience each family undertakes when attempting to provide care for their ill family member.

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