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Understanding the Nature of Family Nursing Practices and Interventions with Families Experiencing Grief

by

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Abstract

Despite a plethora of research and published literature on grief, less is understood about the nature and specifics of the practices in which professionals, particularly nurses, engage in that are helpful to families. In this thesis, nursing practices and interventions with grieving families were examined in the context of an advanced nursing practice, Family Systems Nursing, in an outpatient clinical teaching and research unit. This study was an interpretive inquiry, using a lens of philosophical hermeneutics. Data were collected from records of the clinical interactions and three exemplar families were selected to be interviewed around their experiences of attending sessions to talk to a nurse about their grief. The three nurses who were involved in the clinical work were also interviewed. While the analysis helped to answer some of the initial questions of this study, it also uncovered other aspects of these therapeutic conversations not previously considered. The particular interventions that were offered appeared to be less significant, while the nature of the therapeutic relationship between the family and the nurse stood out. This highlighted the benefits of working with families as a unit of care in grief work, and also has implications for education of nurses and future research.

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Dedication

This thesis is dedicated to my parents, Theo and Margot, for believing in the pursuit of education and for believing in me.

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Chapter One: Call to the Topic

The death of a family member, while an experience inevitable in our lives, is often one of great difficulty and suffering. Families may seek help from professionals around their experiences with grief and, although there has been a plethora of research describing the phenomenon of grief, less is understood about the particularities of the practices in which professionals engage that families find useful. As a nurse in palliative care, I have had the opportunity to work with many bereaved families and those who are suffering with the anticipation of loss of a loved one. Through my graduate studies in nursing, I have focused on the advanced nursing practice of Family Systems Nursing which involves therapeutic conversations, particularly focusing on families who are experiencing grief. I believe that there are opportunities for nurses and families to engage in therapeutic relationships and conversations that have powerful healing effects, leading to an alleviation of suffering. Furthermore, I have become curious about how nurses and other helping professionals have become involved in the practice of helping families with their grief, and about how interventions are approached. An interpretive approach of philosophical hermeneutics is utilized for this research with the intent of understanding the nature of nursing practices and interventions with families who are grieving.

The History

Shifting conceptualizations of grief. Psychotherapy in most of the 20th century was dominated by the paradigm of naturalism, leading to the belief that there were natural laws guiding human behaviour although some were yet to be discovered or understood (Slife, 2004). Research in psychotherapies therefore had the purpose of not only "uncovering" these natural laws, but psychotherapy attempted to legitimize itself by claiming effectiveness at managing the variances from these laws (Kendall, Holmbeck, & Verdun, 2004). Most psychotherapy research of the 20th century reflected the desire to predict, manipulate, and control human reactions, thought and behaviours. Unfortunately, this meant that much of the research on grief turned from generalized descriptions of the phenomenon to prescriptions of how it should manifest in people. This has had implications on how the phenomenon of grief continues to be researched, as well as how interventions with grieving families are thought about.

Many definitions of grief prevail in the literature, and many variations of grief theory exist. Freud's "Mourning and Melancholia" (1917/1957), one of the most influential writings on grief, offered that grief was a cognitive process that involved withdrawal of psychic energy whereby the bereaved confronted their loss and detached from the person who had died. Freud declared that the bereaved had tasks to perform, which is known as "grief work" (Davies, 2004; Matthews & Marwit, 2004). Lindemann (1944) continued ideas of grief resolution with his concept of morbid or unresolved grief, describing those who "failed to achieve the final task of grief work, that is, breaking bonds with the deceased" (Davies, 2004, p. 508). In 1961, Bowlby (1980) first developed a model that described grief through stages, and later through his theory of attachment and loss, offering that grief was a form of separation anxiety. He maintained that grief followed a process of healing that lead "in time to more or less complete restoration of function" (Bowlby, 1980, p. 43).

In his early work, Worden (1982) described the four tasks of mourning that ended with the withdrawing of emotional energy from the relationship. In the second edition of his book, Worden (1991) changed his perspective to include helping the bereaved find an appropriate place for the dead in their emotional lives. In subsequent revision, Worden (2002) emphasized that, while phases of grief may imply a passive movement that mourners go through, describing tasks of mourning implies that it is a call for action from the mourner, and therefore can also be influenced by outside intervention. In the third edition of his book, the last task is redefined not as withdrawing emotional energy from the deceased, but relocating it. This is with the goal of finding a place for the deceased that will enable the mourner to be connected but will not prevent him/her from going on with life (Worden, 2002).

In the last decade, several writings on grief have appeared that offer challenges to the dominant model or discourse of grief that has been adopted in Western culture (Attig, 1996; Moules, 1998; Neimeyer, 2001; Silverman & Klass, 1996; Walter, 1996). The dominant discourse has been described as that which demands that grief be a time-limited process, which involves stages and phases, and results in resolution or an end to grief (Attig, 1996; Moules, 1998; Walter, 1996, 2000). The current critique of these stage theories of grief is that they require that grief be resolved and that the process of grief be completed (Attig, 1996; Silverman & Klass, 1996), hence success in grief work, and the subsequent pathologizing of experiences that are not congruent with this. This has lead to the defining of abnormal, complicated, pathological, unresolved, chronic, morbid, prolonged, dysfunctional, exaggerated, or traumatic grief (Enright & Marwit, 2002; Jacob, 1993; Jacobs, Mazure, & Prigerson, 2000; Prigerson & Maciejewski, 2005; Rancour, 1998; Tomita & Kitamura, 2002).

Alternative theories have been offered that view grief as an emotion and grieving as a process of relearning the world (Attig, 1996, 2000); the continuing of bonds with the deceased (Klass, Silverman, & Nickman, 1996); a lifelong, life changing experience (Moules, 1998); and meaning reconstruction (Neimeyer, 2001). A majority of these newer theories evolved based on experiences of the bereaved and the professionals who were helping them, that were not congruent with the dominant discourse of grief being a passive experience that has an end. Thus, there is a shift from grief being described as an experience that comes to an end with resolution or completion, with a return to normal for the bereaved, to grief being an experience where healing will hopefully occur in such a manner that allows the bereaved person to continue living on in a meaningful way (Klass et al.,1996; Moules, Simonson, Prins, Angus, & Bell, 2004; Moules, Simonson, Fleiszer, Prins, & Glasgow, 2007).

A part of this different understanding of grief has included a shift from only focusing on the individual – thus valuing autonomy and emphasizing separateness – towards focusing on valuing social contexts, relationships, and meaning-making. Grief is described not as an activity of resolution, but rather one of accommodation, which is a continual activity that changes over time, but is never completed (Silverman & Klass, 1996). Rosenblatt (1996, 2008) suggested that many people will never reach a time when they completely stop grieving, but that they will experience recurrent feelings of grief over a lifetime. Attig (1996, 2000) described that the work of mourning is to transition from loving in presence to loving in absence: to relearn our relationships with ourselves, others, and the deceased. Neimeyer (2000, 2001) described how a quest for meaning plays a prominent role in grieving and that this meaning-making should be considered an activity that may change over time, rather than an achievement. Moules (1998) stated that grief is not an experience that needs to be “resolved,” or “gotten over.” The experience of grief brings suffering and sorrow, but it also brings comfort, in the memories of the deceased person that it represents. “Grief becomes a permanent, enduring, sometimes relenting, sometimes poignant, but always present part of the life of a person who has lost” (Moules, 1998, p. 148).

There is a growing consensus that grief is a unique experience to each individual bereaved person, and that it is not possible to say how anyone in particular will grieve. There are thousands of professional articles published on the topic of grief. However on review of several of the recent seminal pieces, there still is a reliance on the philosophy of naturalism guiding the practices of professionals. Thus, there seem to be three beliefs that Western society in general, and helping professionals specifically, hold about grief that are constraining. Firstly, the literature reflects the belief in Western society that phenomenon, such as grief, can be known; that is to say that the truth of grief can be uncovered so that the way grief “really is” can be determined. This is not the way that grief exists in the world, and Gadamer (2004) would have said this is not how any topic of the human sciences exists. That is why, despite the thousands of professional and lay literature on the topic, there still seems to be a need to know more, and know differently about grief. Grief is a topic that is multifarious and contemporary; I would argue one of the most “dis-ordered” (Walter, 2005, p. 77), complicated, and multifarious experiences of life. The complex nature of it often even calls for the use of metaphors when families are talking about their grief, as metaphors help to carry something which is often inarticulate (Moules et al., 2004).

It is dangerous to believe that once the truth and patterns about grief are known, uncovered, and determined, then professionals will be able to predict, manipulate, and control grief. This has lead to the assessing of risk factors, development of diagnostic criteria, and support for the role/need for professionals to help people to resolve or work through their grief, which has only occurred during the last century. Lastly, in Western society at least, there is the belief that if things are done properly, if we know enough about something, and are able to predict, manipulate, and control something successfully, there will be no suffering. It is as if human suffering is a reflection of the failure of the pursuit to successfully control the world. Grief is an interpreted experience, and a topic for hermeneutic inquiry because of the above; it is best understood and researched with a lens of *humanism* rather than *naturalism.*

Grief's Meeting with Professionals

Walter (2000) wrote that the seeking of counselling around grief is a relatively unique phenomenon in the last century and to our Western culture. He attributed it to the bereaved no longer having a support system of family, friends, and neighbours nearby with whom to talk about the deceased. Thus, the bereaved seek strangers to recount their stories.

In terms of who is seeking therapy, or being deemed in need of therapy, there are differing opinions in the literature about who needs intervention related to their grief and what interventions are useful. A traditional approach, through the lens of naturalism, allows for the expert practitioner to determine what the problem is. Thus, there have been suggestions that therapeutic interventions are only needed for those people who present with a pathological response to their grief (Jacobs et al., 2000; Jacobs & Prigerson, 2000; Jordan & Neimeyer, 2003). Kissane and Bloch (2002) suggested that, in palliative care, there should be a screening process to identify families at risk for dysfunction following a loss, and only those families deemed to be at risk should be offered intervention. McBride and Simms (2007) suggested that interventions need to be carefully timed to correspond to the phase of grief that the family is in. Unless mandated to do so, however, therapy tends to occur when family have themselves identified that there is an issue or concern with which that they would like help. They present themselves to a person who they deem has the expertise to help them around this particular problem (Kraemer, 2006). While families may find it beneficial or feel a sense of relief to receive a diagnosis, being labelled with a formal diagnosis of complicated, morbid, or traumatic grief is not necessary, nor always helpful for families or the professionals who are treating them.

A concern has been brought forth that professional interventions with grieving families are not always considered helpful (Jordan & Neimeyer, 2003). It thus becomes important to consider not only how grief is understood, but to understand the practices and interventions that are being offered. In other words, how do professionals approach, work with, or help families experiencing grief? There is minimal research on the nature of the particular interventions for families experiencing grief (Moules et al., 2007) however it is imperative to understand "the character of the intervention itself" (Moules, 2000). Nursing, in particular, has spent much time and energy in researching the phenomena that are encountered in practice, but little in researching the practice/interventions of nurses, particularly with families (Bell & Wright, 2007). This is also true of the phenomenon of grief. The approach of hermeneutic inquiry allows the researcher to "go inside the intervention" (Bell & Wright, 2007), and will allow for an uncovering of nursing practices.

While there continues to be adamant pursuit of differing theories to explain what grief is and ever more personal accounts of how it is *not* like these theories, part of what grief is and how grief works can only be answered by the families we meet in practice who are grieving. In other words, to ask "how do people grieve?" is not a question that can successfully be answered in general, but rather by the individual families that meet us in practice. Furthermore, these descriptions of grief are frequently accompanied by implications for practice, and these suggestions for practice are hugely assumptive based on the description of grief that was "found" in the specific population.

Grief as a Family Affair

Engaging in grief work via a family lens is certainly not the only approach, but when thought to be useful by professionals and family members, can offer something different from the individualistic, psychoanalytic approach that has dominated therapeutic practices. "Coming to terms with this process [loss] is the most difficult task a family must confront in life" (Walsh & McGoldrick, 1991, p. 1). In any significant event in a family's life, such as death, not only are families affected by structural changes, but the beliefs that the families hold will affect the meaning and understanding of the loss, and the support that is provided to each other (Rosenblatt, 1996; Wright, Watson, & Bell, 1996). The social, spiritual, relational, cultural, and functional aspects of a family living with a loss (Moules, 1998) cannot be overlooked. Not only do the beliefs that offer understanding and meaning-making of events, such as loss, often evolve from family, death is also a definitive change to the family system, and thus warrants a family focus in grief work.

Review of Therapeutic Practices

Hermeneutic inquiry, the approach for this research, differs from other research in how the existing literature is approached. Rather than a search of credible resources to find the flaws, gaps, and missing knowledge, or as an afterthought to support the generation of theory, it serves the purpose of offering experience to the researcher about the topic. To be more experienced with a topic then, one must prepare (Gadamer, 2004). The literature review allows for an understanding of how the topic has previously been written about in the world, how it has been understood by others, and the ancestry, kinship, and traditions that may be tethered to it. Engaging with the literature allows an experience with the topic to further develop, which means knowing parts of what has come before, while simultaneously being open to new understandings.

Nurses' History with the Bereaved

Although the topic of grief and intervention research more frequently shows in the psychology literature, and is often seen as the domain of social workers, clergy, or psychologists, nurses have an important role and obligation to be doing grief work and grief research (Cody, 2000; Pilkington, 2006; Reed, 2003). Nursing is in a unique position to address the suffering of families experiencing grief. Of all health care professionals, nurses in palliative/end-of-life care have been identified by the bereaved to likely have the most significant role in bereavement support (Wilson, 2003). Nurses are in an ideal role to be in this type of continued therapeutic relationship with families, particularly in palliative care (Glass, 1993; Kaunonen, Tarkka, Laippala, & Paunonen Ilmonen, 2000).

Nursing is positioned to be helpful to families in different ways than other health care professionals. Nursing does not have the history or mandate to diagnose and prescribe, but rather to understand (Cody 2000; Pilkington, 2006) and to work with families to alleviate suffering they may be experiencing (Wright, 2005). This may allow nurses to work with bereaved families more easily in a non-pathologizing manner; instead a collaborative and cooperative stance is encouraged in family nursing practice (Wright & Leahey, 1994, 2000, 2005a).

In the review of the literature on nursing and grief, it is apparent that nurses consider it important to address loss and grief with surviving family members. Over 100 articles from the previous 15 years were reviewed to understand how grief has been approached and addressed by the nursing profession. In summary, nurses are likely to encounter families who have experienced a loss in a variety of work settings and nurses are frequently present at the time of death. The purpose of the literature review in this area was to further understand the contexts in which nurses come across grief, the theories of grief that nurses were utilizing, and the ideas that nurses had about how to practice or intervene with families who were grieving. While there was a plethora of literature describing the phenomenon of grief in varying populations and contexts, these were often accompanied by suggestions for practice that were vague, not theoretically grounded, and rarely researched. Literature was excluded if it focused on the grief of nurses, anticipatory grief, or educational programs on teaching about grief.

Non-research literature. Numerous theoretical, literature reviews, and case study exemplars were found on nursing and grief. Pilkington (2006, 2008), Florczak (2008) and Cody (1991, 2000) explored Parse's human becoming perspective as a nursing framework to understand the lived experience of grief. They argued that knowledge about grieving that has been largely generated by other disciplines may not be the most appropriate for nursing practice. Suggestions from Cody and Pilkington for future direction of research is to more fully explore the phenomenon of grief because "the way a nurse understands a phenomenon inevitably changes the way the nurse interacts with the persons experiencing it" (Cody, 2000, p. 89). Pilkington (2005) and Cody (2000) have researched grief through the lens of Parse's model. Nursing practice is assumed to be guided Parse's model for human becoming and no interventions are directly suggested or researched as of yet.

Reed (2003) developed a framework for nurses to understand processes and interventions with grieving families based on Neuman's systems model. The goal of nursing practice was to "return the client system to a state of stability" (Reed, 2003, p. 80). Similarly, Kavanaugh and Moro (2006) offered a framework based on Swanson's theory of caring to guide nursing practice for bereaved parents following a stillbirth or neonatal death. Nursing interventions were described as sitting quietly beside the parents, creating cherished memories, guiding decisions about autopsy, and contacting parents through phone calls in following weeks (Kavanaugh & Moro). Egan and Arnold (2003) utilized the "Experience Model of Care" to explain grief, preventions of complications, and practices for nurses.

Moules and Amundson (1997) offered, through a narrative therapy lens, that it is not grief that tends to be the problem for bereaved people, but rather the inertia that is invited into their lives. Further, Moules (1998) and Moules et al. (2004) examined how the *beliefs* about grief in our society, as professionals, and in a case exemplar impact the experience of grief. In a case study, Moules, Thirsk, and Bell (2006) offered that therapeutic letters (Moules, 2000; White & Epston, 1990) and reflecting teams (Andersen, 1987, 1991) were particularly useful interventions in the context of therapeutic conversation between a nurse and a bereaved family member; this therapeutic practice was guided by the Illness Beliefs Model (Wright et al., 1996). The family member described that these two nursing interventions were useful contributors to healing.

Nurses have also written about grief as it is relevant in varying populations, and provided suggestions for practice based on experience and literature reviews. Romesberg (2004), a nurse practitioner in neonatal care, offered suggestions for nursing interventions related to the death of a baby. Ideas for supporting end-of-life care for neonates, and support for the parents included "encouraging them to see, hold, and name their dead baby…retain important mementos such as photographs…[and] connect families to other parents who have experienced this loss" (Romesburg, 2004, p. 165). Also related to neonatal loss, Alexander (2001) offered case studies following parents who had received mementos of their baby to explore the usefulness of this nursing intervention, and in conclusion offered advice and encouragement for nurses' use of photographs of deceased infants. Davies (2004) offered a literature review related to parental grief, concluding with suggestions for possible nursing interventions such as: listening to the parents, helping to construct a biography of the child, establishing monetary memorials, and putting parents in contact with other parents who have suffered a loss.

Perinatal losses, such as stillbirths or miscarriages, were addressed by Brost and Kenney (1992), Callister (2006), and Mori (2006). These were anecdotal accounts of a nurse with a bereaved family and suggestions for practice included taking pictures of the baby and being empathetic. For children who have lost a parent, Kirwin and Hamrin (2005) suggested that nurses provide early support and prevention to help children cope. Clements, Benasutti, and Henry (2001) described the intervention of drawing, or art therapy, to assist children who were exposed to a sudden death. They found this to be a useful tool for engaging children in discussions about feelings surrounding the death, and provided an opportunity to ask questions. Buxbaum and Brant (2001) also described how nurses should assess and intervene with children who have experienced the death of a parent. Suggestions for nursing interventions included providing information, referring to support groups or individual counselling, and creating memory keepsakes. A further suggestion was to care for the surviving parent who can in turn care for the child.

Asaro (2001) offered a literature review of grief related to homicide survivors, suggesting that nurses could assess and refer as necessary, remain in the moment, and assist families in coping with the death. Clements, DeRanieri, Vigil, and Benasutti (2004) described grief therapy following the traumatic loss of a family member. Ideas for interventions were to set goals and allow for a full range of emotions to be expressed. Lev and McCorkle (1998) reviewed loss and grief related to family members of cancer patients. Nursing practices included assessing for high-risk factors offering ideas based on a crisis intervention model. Nurses employed at nursing homes were encouraged to learn about the grief process in elderly residents so they would be of more help to this particular population (Ruler, 1997). Shearer and Davidhizar (1994) described how nurses could appropriately care for elderly widows including assessing grief, explaining grief, and referring as necessary.

In other specific populations, Schattner (2000) offered that nurses could structure a ritual for participants of a cardiac support group when a member dies. Clements, Focht-New, and Faulkner (2004) offered that "active listening" is useful when working with bereaved people with developmental disabilities. Randhawa (1998) described appropriate training for nurses approaching bereaved families regarding organ donation. Finally, Fletcher (2002) reviewed the transcultural assessment model as it would apply to African-American families who are grieving. She encouraged nurses to be mindful of different cultural norms and values when assessing and intervening with the bereaved.

Not specific to a population, but more generally focused on nursing and grief, Greenstreet (2004) encouraged nurses to have awareness of the loss, share narratives, provide basic counselling, be attentive listeners, and offer reassurance to the bereaved. Lindstrom (2002) described the shifting theories of grief, and offered that this should also reflect a shift in thinking about practice, for example, "tell people to accept their emotional and cognitive reactions…reassure them that the simple passage of time usually has a dampening effect on any emotions…do things…reconnect to other things in life" (Lindstrom, 2002, p. 19). Arnold (1996) stated that nurses should promote individual expressions of grief, facilitate communication, validate/normalize emotions, use the therapeutic self, and follow the nursing process. Rodebaugh, Schwindt, and Valentine (1999) encouraged nurses to allow people to grieve in their own way, respect their beliefs, acknowledge the loss, and be sensitive and non-judgemental. Eakes, Burke, and Hainsworth (1998) and Burke, Eakes, and Hainsworth (1999) described chronic sorrow and implied that nurses need to be aware that loss and grief can impact families that they encounter in several contexts at varying times. Nurses are encouraged to be aware of this, assess families, normalize their response, and empathize.

If the representation of these recommendations for practice sounds vague, it is because, in the literature, they are. The theories of grief that guide or substantiate these practices are as numerous as the articles themselves, and unfortunately the nursing literature continues to rely on "grief" theories such as that of Kubler-Ross, which was not originally meant to be a grief theory, but has been erroneously taken up that way. It is encouraging to see at least a few of the suggestions for nursing practice were based on theories or models to guide practice, rather than simple assumptions that nurses are good listeners, can show empathy, and should refer as necessary. Unfortunately, none of the practice suggestions based on these models had been researched.

Research literature. The research literature on nursing and grief was divided into two categories: research about grief as a phenomenon with conclusions and suggestions for nursing practice and interventions, and research about the specific nursing practices and interventions related to grief. The most commonly found research on nursing and grief was related to perinatal loss, including therapeutic abortion, miscarriages, and stillbirths. Williams (2000) argued for the examination and inclusion of grief responses for women who underwent a therapeutic abortion. Implications for nursing practice included asking women directly about abortions, being aware of one's own views on abortion, and referring to counselling if deemed necessary. Hess (2004) explored the long-term post-abortion experience of women, implications for nursing practice included preventing unplanned pregnancies, providing sensitive care, and listening to stories.

Early pregnancy loss, including abortion, miscarriage and stillbirth, was researched by Wheeler and Austin (2001). They concluded that adolescents who experience this type of loss may have physical, emotional, social, and cognitive grief responses and may be at risk for depression. It was suggested that nurses assess adolescents for pregnancy loss, and provide discharge information on grief responses and referral sources. Fisher (2001) examined the experiences of fathers when there is a miscarriage. Conclusions for nursing practice were to include fathers in holistic nursing practice. Hsu, Tseng, Banks, and Kuo (2004) suggested that nurses should make an effort to listen to mothers who experience a stillbirth, and assist them in coming to terms with their loss. Alexander (2001) offered a case study arguing for the incorporation and standardization of nurses taking pictures of stillborn babies for the parents.

There was minimal intervention research on specific nursing practices related to perinatal loss. Malacrida (1997) found that what parents needed was for the nurse to tell them the truth, tell them what to do, tell them what happened, and to tell them what is next for their family. DiMarco, Menke, and McNamara (2001) evaluated the effectiveness of a support group for parents who experienced a perinatal loss. The support group was facilitated by a nurse, however, there was no difference found statistically between the treatment and control group. There was limited description of the nature of the dialogue that occurred during the group sessions. Caelli, Downie, and Letendre (2002) reported on results from nurse/midwife interventions with parents who had a death in a previous pregnancy. The authors explored the participants' experiences of a pregnancy following a miscarriage/stillbirth, and also the experiences of participating in a specialized intervention program with midwives, reporting significant differences between this special care delivery method and standard care.

Kaunonen et al., (2000) conducted a study on the nursing intervention of follow-up telephone calls to bereaved family members from nurses on the oncology unit where their loved one had stayed. Although this intervention was positively received by participants, there was little detail provided on the nature of the conversations that the nurses had with family members. Nurses also recorded their perspectives of the intervention (Kaunonen, Aalto, Tarkka, & Paunonen, 2000). There has also been further research on what nurses believe they did to support families in their grief (Kaunonen, Tarkka, Hautamaki, & Paunonen, 2000). This included providing emotional support, informational support, and concrete support. Rask, Kaunonen, and Paunonen-Ilmonen (2002) argued that effective nursing practice needed to be informed by factors impacting adolescent grief.

In Australia, bereavement practices in intensive care units were surveyed (Valks, Mitchell, Inglis-Simons, & Limpus, 2005). Practices were found to be quite varied, from allowing the family to view the body, providing follow-up via telephone calls, and offering referral services. Lohan (1998) argued that following the violent death of a child, families would be better helped by a family focused nursing intervention, rather than an individual focused practice. Patton (1995) evaluated effects of interventions on survivors of suicide and concluded that there is significant need for intervention with this particular bereaved group. Ferszt (2000) studied the nature of grief for incarcerated women, offering that nurses working with this population needed education around disenfranchised grief. Douglas (2004) offered that the bereaved individual is better helped by nurses when their lived experience of grief is more completely understood, and that bereaved clients can greatly benefit from individual, family, and group therapy.

Mallinson (1999) explored the experience of AIDS-related losses amongst gay men. Implications for nursing practice included providing culturally appropriate care, identifying prejudices, and developing new insights. Also related to HIV-AIDS losses, Simmons (1999) concluded that more needed to be known about grief before appropriate nursing interventions could be developed.

Lastly, Moules and colleagues (2004) explored the beliefs of family members related to their grief. This research was unique in that it provided theoretical explanations of grief *and* was also based on the theory of a nursing practice model. Much of the previously discussed nursing literature failed to account for one or the other. Several implications for nursing practice/intervention were given, however further to this Moules, et al., (2007) have also further examined the specific practice of interventions around grief, albeit not specifically with nurses.

Apparent in this review of the literature is that there is very limited understanding of nursing interventions. While authors do offer suggestions of frameworks and interventions, few of these interventions are researched. When suggestions are offered, they are vague, or not supported well theoretically or with research. More generally, research in nursing has tended to focus on the description of phenomenon, and less on specific nursing practices, or interventions (Bell & Wright, 2007). In grief, as in other areas of nursing, there is a desperate need to understand the practice of nurses, particularly in the practice of family nursing interventions (Bell & Wright). While theoretical writing on grief is useful, nurses need to know more about how to work better and be more helpful to the families who are suffering. Nurses need to also be careful and cautious about the theories of grief that they are adopting in their practices and research because, as has been repeatedly stated in the above literature, what is thought about grief greatly influences how it is that professionals approach helping families with grief.

Grief Interventions

Outcome/efficacy studies have not demonstrated that interventions offered by helping professionals have been useful to the bereaved (Jordan & Neimeyer, 2003; Kato & Mann, 1999; Schut, Stroebe, van den Bout, & Terheggen, 2001). Furthermore, while there is a realm of literature surrounding the human experience of grief, there is very little known about the specific interventions offered to families around their grief (Moules et al., 2007). Most intervention research is still focused on models of practice that involve assisting people to let go of grief and the lost person (Moules et al., 2004), rather than viewing grief as something that is not resolvable, but a lifelong, livable experience (Attig, 1996; Klass et al., 1996; Moules, 1998; Moules, & Amundson, 1997; Moules et al., 2004, 2007; Neimeyer, 2001).

Neimeyer (2000) suggested that the weak showing in outcome studies thus far is that these studies do not draw on the best available theories regarding the nature of bereavement and its facilitation. He further encouraged a shift away from the "implicit paradigm under which grief therapy is practiced, away from a medical model emphasizing the control of disruptive symptomatology, and beyond the well-intended but vague assumption that a sharing of feeling in a supportive environment will promote 'recovery'" (Neimeyer, 2000, p. 548). Furthermore, therapists cannot assume that "one size fits all" in terms of the interventions required (Jordan & Neimeyer, 2003). When grief is viewed as a lifelong experience of a changed relationship with the lost loved one, interventions offered to families, and the hope of alleviating suffering will differ significantly from those offered with the belief that grief is an event which requires recovery and an emotion that needs to be resolved.

While it appears that there is little understanding of what is helpful in terms of relieving suffering for bereaved individuals, the literature showed that there is even less of an understanding of how families, in a relational and interactional context, are best helped after the loss of a member (Walsh & McGoldrick, 1991, 2004). Wright and colleagues (1996) stressed that a significant event, such as a death or grief, is a family affair. The loss of a significant member of the family will affect all family members in many aspects including family function, roles, family support, decision making, and problem solving. "Death poses shared adaptational challenges, requiring both immediate and long-term family reorganization and changes in a family's definitions of its identity and purpose" (Walsh & McGoldrick, 1991, p. 7). There is a need for new and different ways to help families following the death of a loved one (Kaunonen et al., 2000).

Practice and research with family as focus has been increasing over the last decade (Walsh & McGoldrick, 2004). While Walsh and McGoldrick noted an increase in the amount of research and theory focusing on grieving families from the first edition of their book (1991) to the second edition (2004), they still reinforced that "we must challenge the taboo that silenced mental health professionals on the subject of death, obscuring our recognition of loss issues and blocking our communication with families and our ability to help them" (p. xxii). The second edition of their book offered a conceptual framework for therapists working with bereaved families, and the contributors subsequently addressed various topics including ambiguous loss, anticipatory mourning, issues of gender, suicide, major disasters and death in the therapist's own family.

Kissane and Bloch (2002) developed the Family Focused Grief Therapy (FFGT) model in an attempt to address the lack of literature on grieving families. It is a model of brief therapeutic intervention for families identified during palliative/end-of-life care as being at high risk for maladapting to a loss. This model was based on the premise that palliative care should comprehensively involve and treat the family through diagnosis and bereavement, with the goal being to improve family functioning and promote adaptive grieving. The model offered a description of grief and a typology of family's responses to dying and grief. At-risk families are identified as in need of treatment, and ideas are given for conducting family focused grief therapy based on their decade of research on this topic (Kissane & Bloch, 2002). Since the publication of their book on FFGT, there have been further intervention studies examining the usefulness of the model. Kissane et al. (2003) concluded that families identified as more "dysfunctional" during palliative care were likely to have greater psychosocial morbidity in grief. They interpreted this as evidence that families should be screened during palliative care and grief intervention, vis-à-vis the FFGT, should be offered to those families deemed to be at high-risk for morbid outcomes with their grief.

In a comprehensive review of current grief theory and research, Stroebe, Stroebe, and Hansson (2006) identified trends and offered suggestions for future research on grief. In particular, it was recognized that studying families should be considered as an important focus in grief research. Further writing in family therapy literature offered descriptions of practice (Kulic 2003; Mason & Haselau, 2000; Sperry & Sperry, 2004) and frameworks (McBride & Simms, 2001; Vajentic & Calovini, 2001) related to grief. These are somewhat brief, less comprehensive contributions, and are based on theoretical stage models of grief involving resolution.

Family intervention research on grief typically demonstrated positive outcomes, however there are limited studies explaining the nature of the interventions. Family interventions that have been researched include art therapy for parents and children (Webb, 2003; Webb-Ferebee, 2003); music therapy (Gallant & Holosko, 2001); group therapy for bereaved children (Sandler et al., 2003); and poetry therapy (Heninger, 1987).

Moules et al. (2007) recently completed research on understanding therapeutic practices with grieving families. Although not based on the practice of nurses, this research explored the therapeutic interventions from the perspective of clinicians (social worker, psychologist, and clergy) and family members, and offered one of the first pieces of research exploring the nature of therapeutic conversations with bereaved family members. The particular practice context that was researched used a model of individual and group counselling, and rarely sees families as the unit of care.

While the literature on family and grief showed a trend of increased awareness and emphasis on a family systems focus as being beneficial to the bereaved, the research on this area remains scant. Theoretical writing, rather than research, is more commonly found about grief and how to work with grieving families. Few studies offer adequate explanations of the nature of therapeutic interventions, and even fewer describe what families report as being useful in making and sustaining change as they find healing. It was unusual to find research that followed up with family members more than 1 to 2 years after the interventions. Furthermore, because of limited descriptions of the interventions, it was difficult to determine the extent of family involvement; whether it was considered family research because there was more than one family member involved, or because the family system was a focus of the interventions.

The Question

With these changing understandings of grief, further awareness of how and what helping professionals understand about therapeutic practices is imperative. The primary research question is: *How might we understand the nature of family nursing interventions in clinical work with families experiencing grief?* Beginning questions that guide my curiosity around this topic include: How do we understand the usefulness of therapeutic conversations? What did the families find were the most useful aspects of their encounters with nurses during their consultation around grief? Is it the nature of the relationship between the nurse and the family, the specific interventions offered, extratherapeutic factors, or something else that families find useful in these nursing encounters, conversations, and interventions? How was the clinical work that occurred helpful in alleviating the family's suffering? What is the meaning of this work for families as they continue to live alongside their loss? The answers to these questions will not be a method on how nurses should proceed with grieving families, but rather more fully explore what it is that is happening within these conversations and interactions.

The Context: Family Nursing Unit

The clinical work that is examined in this research took place at the Family Nursing Unit (FNU), Faculty of Nursing, University of Calgary. Created by Dr. Lorraine Wright in 1982, the FNU existed for over 25 years under the directorships of Drs. Lorraine Wright and Janice Bell. This outpatient family nursing clinic was a unique environment that focused on education and supervision of graduate level nurses in the art of therapeutic conversations, and research related to families, illness, and nursing. Families were referred to the FNU, free of charge, by themselves, physicians, or other health professionals.

Family Systems Nursing. The particular practice and interventions examined were based on the advanced nursing practice of Family Systems Nursing (FSN) as currently detailed through an advanced nursing practice model, the Illness Beliefs Model (Wright et al., 1996). Several research studies have been completed in the context of the FNU, examining nurses' practice with families. Robinson (1994, 1998) examined the FSN interventions offered to families living with chronic illness, which brought further understanding to the impact of chronic illness on a family, as well as the aspects of clinical work that families found helpful. Wright et al. (1996) examined the nature of therapeutic change related to FSN practice, and subsequently created the Illness Beliefs Model, which developed into the practice model utilized in FSN. Subsequently, Wright and Bell (Bell, 1999; Wright & Leahey, 2005b) also engaged in research examining therapeutic failure within this practice when the families did not find the clinical work with the nurse to be useful.

Tapp (1997, 2000, 2001, 2004) focused on families' experiences of cardiac illness, and the nature of the therapeutic interaction with the nurses. Moules (2000, 2002a, 2003,) examined the specific intervention of therapeutic letters. Limacher (2003; Limacher & Wright, 2003) studied the specific intervention of commendations offered to families in the context of clinical work. McLeod (2003) examined spirituality in the context of therapeutic conversations that occurred between the nurse and the family.

Moules et al. (2004) examined the beliefs about grief that were elicited within the therapeutic process. Wright, Bell, and Moules (Bell & Wright, 2007) are currently examining conversations of illness suffering, specifically the therapeutic practices that bring forth suffering and healing. This research will add to the body of knowledge of this therapeutic practice by examining the nature of advanced nursing practice with families experiencing grief.

The research I have conducted for this thesis is timely considering the poor results of the efficacy research in grief counselling/therapy (Jordan & Neimeyer, 2003; Neimeyer, 2000); the lack of research on grief interventions from a family perspective (Walsh & McGoldrick, 1991, 2004); the changing ideas about the experience of grief (Moules et al., 2004, 2007; Silverman & Klass, 1996); and the lack of nursing intervention research related to grief. Further understanding of nursing practices with families and specifically how families find these encounters useful will be a beneficial contribution to the literature not only for nurses, but also psychology, social work, medicine, and marital and family therapy, as these helping professionals strive to continue to be useful to the people they serve.

Chapter Two: Philosophy and Methodology of Research

This research is hermeneutic or interpretive in nature, as guided by the philosophical hermeneutic tradition of Hans Georg Gadamer (2004). Hermeneutics, which could be described as the philosophy and practice of interpretation, dates back to the 17th century, although it has experienced variations in how it is understood in the world over the centuries, and through different people's interpretations (Moules, 2002b). The process of engaging in hermeneutic inquiry is not an undertaking that can be laid out a priori as a methodology (Fleming, Gaidys, & Robb, 2003; Geanellos, 1999; Jardine, 2006). In hermeneutics, the character of the topic, rather than the methodology, holds a place for the research to occur (Gadamer, 2004). Although hermeneutic inquiry has been described as research that is guided by the topic, this is not to say that hermeneutic researchers do not proceed in a systematic, thoughtful way (Moules, 2000). There are judgments that are made on the part of the researcher, and an awareness of the topic, but it is the topic that will guide the research, "over and above our wanting and doing" (Gadamer, 2004, p.xxvi). This chapter offers the description of the process of the research.

About Hermeneutics

History. Gadamer, a student and colleague of Heidegger, developed his hermeneutics of philosophy, a revival of hermeneutics, to resolve the difficulties he found in the phenomenology from his mentors and the Cartesian, positivist paradigm that was dominating the natural sciences (Gadamer, 2004; Grondin, 2003). He believed that the human sciences utilized knowledge that was not attainable, or understandable, through the methods of the natural sciences. While he argued that the natural sciences paradigm was problematic in its belief in itself as the only form of legitimate knowledge, he was also aware that it had some usefulness and would continue to be prevalent in our world.

Truth, in Gadamer's hermeneutic sense, is found when the topic resonates with the reader. The truth that is uncovered with this philosophical lens is not truth in the sense of finding the right answer, and knowing how things "really" are. Truth in the sense of hermeneutic philosophy is alethia (Jardine, 2000), not the complete unconcealement of things, but the simultaneous exposure and concealment (Gadamer, 2004). "In hermeneutics, objects are not fixed or given; they are interpreted, contingent things...It is always interested in events and how the event opens up what we took to be closed" (Moules, 2002b, p. 14). This resonation, or understanding of something to be true of the text, is not arrived at through method, but rather by the researcher being prepared, and open to what the text has to say about the topic. Subsequent interpretation is therefore not about the accurate representation of the interiority of the participants, but rather what it is they have to say about the topic that points to a new or different understanding.

Position as researcher. Hermeneutic research is not about subjectivity, or valuing the subjective experience of the participants or the researcher. The distinction between most other methods of qualitative research and hermeneutic inquiry is that in hermeneutic inquiry we are interested in the topic, not the interiority of the participants (Gadamer, 2004). Research guided by the philosophy of hermeneutics encourages the researcher to be aware of their prejudices or preunderstandings of a topic (Fleming et al., 2003). Once identified, however, the researcher does not, and cannot set them aside.

> A person who believes he is free of prejudices, relying on the objectivity of his procedures and denying that he is himself conditioned by historical

> circumstances, experiences the power of the prejudices that unconsciously dominate him…A person who does not admit that he is dominated by prejudices will fail to see what manifests itself by their light…A person who reflects himself out of the mutuality of such a relation changes this relationship and destroy its moral bond. (Gadamer, 2004, p. 354)

Indeed it is the prejudices that we are not aware that we have that will most influence us in research (Moules, 2002b).

Our pre-judgments or prejudices are not a negative thing, but rather represent the necessary starting point of our understanding (Maggs-Rapport, 2001; Smith, 1991). "We are always, already affected by history. It determines in advance both what seems to us worth inquiring about and what will appear as an object of investigation" (Gadamer, 2004, p. 30). Moules (2002b) offered that it is indeed our prejudices that allow us to understand the topic in ways that we would not have been otherwise able to. We therefore do not cleanly lie out and suspend our prejudices prior to engaging with our topic (Jardine, 2000).

Hermeneutic inquiry encourages the researcher to reflect upon their own prejudices as this will allow them to move beyond them and into understanding the phenomenon (Fleming et al., 2003). This reflexivity can be defined "as a means of understanding the impact of the researcher's views and values, [that is] increasingly seen as a valid means of adding credibility to qualitative research" (Carolan, 2003, p.10). I am aware of my beliefs in the healing influence of therapeutic conversations. I believe that nursing practices can make a difference to families who are suffering, but in grief, time may also play a role in healing. I am influenced by my education and practice in Family

Systems Nursing, and my experiences in palliative care. I am influenced by my own experiences of death, both personal and professional, and the beliefs that are founded in my family of origin. Rather than hindering my understanding of nursing practices and interventions with grieving families however, these are what will allow me to more fully understand and experience the topic. In describing them, I am hopeful that I will be open to having some of my own beliefs challenged, but am conscious that there are some prejudices that are beyond my awareness.

Gadamer (2004) described experience as not only having previous understanding of a topic, of knowing one's way around, but of also being open to *new* ways of understanding a topic. Thus, previous experience and understanding of a topic does not prevent me from being open to new understanding of the topic, but rather allows me to be more prepared with the topic, to know my way around.

Why Hermeneutics?

Hermeneutic inquiry was deemed appropriate for this research because of its fit with nursing as an interpretive practice (Tanner, 2006), and grief as an interpretive experience (Moules et al., 2004). Knowledge and understanding in nursing is inherently multifarious in nature. Nurses are unique among health care professionals because they work within the domain of both the natural sciences and the human sciences. Understanding and interpretation wholly encompass nursing practice, and therefore hermeneutic inquiry contributes to knowledge and practices in a useful way.

Viewing knowledge, experience, and what we can know in a hermeneutic way has implications for how one carries out research. There is knowledge and truth to be had in thinking of grief, nursing, and interventions in an interpretive manner. If the definition of interpretation is taken up as to explain or tell the meaning of something, or to present something in understanding terms (Merriam-Webster's Collegiate Dictionary, 2003), then it would seem that nursing is inherently interpretive. Our daily practice as nurses includes everything from understanding the significance of vital signs, to explaining or hypothesizing why a family member insists on staying at the bedside of a patient, to exploring meaning with patients and family members who are suffering. Interpretation is not unique to nursing, but rather something that could more generally describe the way humans experience life (Gadamer, 2004). "To interpret, to understand, is not only a process which is practiced in the social sciences, but implies yet more fundamentally the whole existence of a human being" (Grondin, 2003, p. 12). Significant events, such as birth, death, and illness are significant experiences of family's lives, and are all situations where nurses can be involved in some capacity. An interpretive approach to understanding nursing practice that recognizes the nature of human understanding is thus beneficial to nurses' ways of knowing.

Therapeutic conversations represent one of the most artful of nursing practices, and truth and understanding in these conversations are hermeneutic, rather than methodical. Thus, hermeneutic inquiry is highly appropriate for understanding therapeutic conversations because it is "grounded in the metaphors of language, conversation, and dialogue" (Tapp, 2004, p. 564). Language, dialogue, and questions bring understanding in research, and are reflective of the nature of nursing practice.

Interpretive inquiry is fitting for grief, as grief is an experience of family members interpreting the events that have taken place, and trying to understand and make sense of their lives now. Interpretive research is arguably appropriate for the topic of grief, as hermeneutic philosophy allows for an understanding of grief that escapes from someone's *opinion* on grief; rather the *topic* of grief comes to be revealed as multifarious. It is useful to research grief in such a way because ideas are not offered in a sense that the "old ways" are wrong and the "new ways" are right. Hermeneutics requires that an assertion is an answer to a question that always has different answers (Gadamer, 1976/1999), and this is so in grief. Gadamer (2004) argued that there is knowledge and truth to be found that is not arrived at through method. Thus, researching nursing interventions with grief in a hermeneutic way will hopefully keep open the possibilities that it could be understood and interpreted differently.

Ethics Approval and Considerations

Ethics approval for this research was received from the Conjoint Health Research Ethics Board on March 14, 2008. The approval letter can be found in Appendix A. At the request of the chair of the ethics approval board, the potential participants were contacted initially by the principal investigator who explained the purpose of the research and nature of participation in the project. Following the verbal consent of the families, I contacted the family members to arrange an appropriate interview time. The information letter (Appendix B) and consent form (Appendix C) were mailed out to the participants prior to the interview. Informed consent was reviewed prior to beginning the interviews at which time participants signed the consent form and were also given a copy for their records.

During transcription of video segments and interviews, the families were identified numerically for surnames, and with first initials only. In this writing, pseudonyms have been used for all participants. Any material with identifying information has been kept in locked storage. Audio recordings and transcripts will be destroyed upon completion of the research, as identified in the consent form.

During the time of participant interviews, it became apparent that it would also be useful to interview the nurses who worked with these particular families. An amendment letter (Appendix A) and revised consent form (Appendix C) for nurses was sent to the Conjoint Health Research Ethics Board and approval was received on July 19th, 2008 (see Appendix A). The nurse clinicians were initially contacted through email, and all three nurses who were approached agreed to be interviewed. I then arranged an interview with these participants. In the transcription of their interviews, names and identifying information was removed, and pseudonyms are used in this writing.

Generation of Data

Inherently valued in interpretive research is a deep understanding permitted by information-rich exemplars that bring to light the topic under examination (Sandelowski, 1995). "Hermeneutic inquiry involves the selecting of participants or exemplars of practice that can best illuminate the topic and invite an extended understanding of it" (Moules et al., 2004, p. 101). Data for this research was collected through a variety of sources with the intent of thoroughly understanding the clinical work prior to engaging in interviews with family members. Videotapes of clinical work, session documentation, and outcome study data were reviewed for seven families who attended the FNU with the presenting concern of grief, in the last 10 years, and had previously consented to this clinical data being used in research. From the seven identified families, three families were invited to participate in the research. Three of the other families had moved and had not been located, and one family was not approached due to potential conflict of interest.

The remaining three families were contacted by the principal investigator by telephone, and agreed to be interviewed. In total, 21 videotaped clinical sessions, 7 charts, 10 therapeutic letters, and 1 outcome study were reviewed. Data were generated through the transcription of pertinent video segments, written documentation of the sessions, therapeutic letters sent to the families, and outcome study data. The letter of invitation (see Appendix B) and consent form (see Appendix C) were then mailed to them and interviews were arranged.

Review of clinical records. The purpose of reviewing video tapes, charts, and outcome studies was to become familiar with the clinical work that occurred, and begin to analyze the practices and interventions of the nursing team. Typically, a family is advised in the first session that they will be offered four sessions, although that is open to negotiation as the clinical work goes on. A pre-session is conducted prior to the family being seen, at which time hypotheses about the family are discussed, and support is offered to the nurse who is working with the family. During the session, the clinical team is observing behind a one-way mirror, and the supervisor will call in to the session periodically. It is usual practice to offer the family a reflecting team, where the family retreats behind the one-way mirror, and has an opportunity to listen to the clinical team members offer commendations, observations, and questions. Following this, the nurse meets briefly again with the family, and discusses what stood out for the family from what was heard from the reflecting team. Finally, before the family leaves, the next session is negotiated.

After the family leaves, the clinical team meets with the nurse for the post-session. Team members share their thoughts on the session, and there is further discussion about the family and how the session went. The nurse is also given feedback and asked her thoughts on how the session progressed. The supervisor also provides written feedback to the nurse, which becomes a part of the family's file. While not all families will receive a therapeutic letter between the sessions, the clinical team almost routinely considers the advantages, or therapeutic leverage that may be gained by sending a letter. After the last session, a closing therapeutic letter is always sent to the family.

In the last session, as well as in the therapeutic letter, the family is reminded that a research assistant will be contacting them in approximately six months to complete an outcome study. Also, at the end of the sessions, the nurse who was directly working with the family completes an "observer perspective" form, where the nurse's impression of the clinical work is recorded.

In the charts, the clinical work was documented in the format of the Illness Beliefs Model (Wright et al., 1996) by the clinical team members. As I have also been educated and done clinical work through the lens of the Illness Beliefs Model, I found the analysis leaning towards this format. For example, during the review of this work, significant events and practices stood out including the "one question-question" (Wright et al., 1996, p. 137), core constraining beliefs, and interventions - such as reflecting teams, therapeutic letters, and internalized other interviews. This analysis represented what the clinical team and the family believed, at the time of the clinical work, to be beneficial. While it could make for coherent analysis to continue interpretation through the lens of the Illness Beliefs Model, it also became apparent that this prejudice may occlude other ways of viewing the clinical work. Further description of these significant events will be given in subsequent chapters as the analysis of the data.

Family interviews. The intention of the interviews with the family members was to gain understanding of the topic with specific attention to their reports, understanding, and explanations of what was most helpful to them during their clinical work and how the experiences of this interventive practice may or may not have been helpful. Engaging in dialogue with participants is a way in which we can access understanding about our topic of interest. In hermeneutic inquiry, the concern is about the richness of what new understanding of the topic the participants introduce us to, and not about the number of participants. Gadamer (2004) offered that the individual particulars that we encounter in a phenomenon inform our understanding of a phenomenon, and not the collection of several experiences that are familiar and therefore knowable. Within the topic of grief, one case that does not fit with conventional wisdom about grief should tell us more than 999 cases that do fit (Walter, 1996).

The interviews with the family members were conducted in an open-ended manner, with a focus on conversation about the topic of therapeutic practices/interventions with the family. "To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are oriented" (Gadamer, 2004, p. 361). The interviews were initially guided by the research questions previously described in chapter one, with the intent of exploring and being open to accounts of the clinical work from the families' perceptions, rather than that of the clinical team.

In hermeneutics, the topic is placed in the middle, between researcher and informant, and the dialogue is how they can exchange ideas with one another (Gadamer, 2004). Engaging with the participant about the topic allows truth to be revealed, truth in the sense of alethia – of opening something that was previously closed (Jardine, 2000). The important thing is the knowledge that one does not know (Gadamer). In this manner of conversation, it is undeniable that different things will be said about the topic than in any structured, semi-structured, or even unstructured interview that has the intent of accurately representing the interiority of the participant, nor is there a concern that the interviewer is "leading" the participants. The point of dialogue in hermeneutic inquiry is therefore not to "give full expression to the emotional lives" of the participants (Nunkoosing, 2005, p. 705). The purpose of dialogue in hermeneutic inquiry is to explore the topic, to allow it to say something (Gadamer).

The first family member that was interviewed was Dianne. She was referred to the FNU by a friend, and attended the first session 2 months after the death of her husband (see Appendix D for genogram). Four sessions were completed with her over a 4 month period. At the time, she stated that she was looking for all the help she could receive, believing the more the better. She brought her two children to the third session, and attended the other three alone. The research interview took place 4 years after the conclusion of the sessions in the FNU.

The second family member interviewed was Christine. She and her two children, Amy and Ryan, had attended the FNU over three sessions. The sessions occurred 2 years after the death of Christine's youngest son and 1year after the death of her husband (see Appendix D for genogram). Christine was initially contacted to participate in the research, and although she invited her two children to participate as well, they declined. The research interview took place 10 years after the conclusion of the sessions at the

FNU. This was the only family of the three who had completed an outcome study, in which Christine, Amy, and Ryan all participated.

The third family, Edward and Martha, had attended the FNU 2 years 6 months after the death of their daughter (see Appendix D for genogram). There were a total of five sessions with this family, all of which were attended by Edward and two of which were attended by Martha. Although the focus of the clinical work was mostly with Edward, both agreed to participate in the research interview. The research interview took place 6 years after the conclusion of the sessions at the FNU.

The nurses who worked with these three families were also interviewed. They were asked to recall what they could about the clinical work with the particular family, and were asked about specific interventions or times in the clinical work that had stood out from my review of the work. They were then read excerpts of the research interview from the family they worked with, and invited to provide comment, reflection, and further interpretation of the family's account of the clinical work.

Analysis – About Writing

> Hermeneutics does not begin its work by beginning with method. It does not begin by characterizing understanding as an action or set of actions we can marshal. It begins, rather, with *topica* – great image-filled, sensory, alluring *topics* that address us and draw us into their sway and ask things of us. (Jardine, 2006, p. 4)

Analysis began with the review of the videotaped sessions. The purpose of the review was to familiarize myself with the clinical work, and to note the significant events of the sessions. Sections of the sessions were transcribed if they seemed to have significance to the work. For example, if there was a comment by a family member where there seemed to be a shift in thinking, or strong affect in response. It is routine at the end of the sessions for the nurse clinician to ask the family about what stood out for them, and these comments were noted. During this review, several memos were made. These were questions to ask the family, or beginning interpretations and ideas to explore further with the nurse. Overall, the review of the videotapes and charts resulted in a sense of whether or not the therapeutic work was helpful to the family's experience of grief, and I developed some beginning hypothesis about why or why not it was useful clinical work. This will be detailed further in the next chapters.

"There is a beginning of sorts – analysis begins with data collection...the researcher cannot help but begin reading this text (and hence analyzing and interpreting its meaning)" (Cohen, Kahn, & Steeves, 2000, p. 71). The process of analysis/interpretation is metaphorically referred to as the hermeneutic circle where "beginning conjectures are developed and put into play in writing, in practice, and in dialogue to sound out their merit and credibility" (Tapp, 2004, p. 563). Research based on hermeneutic inquiry involves understanding parts of the text in relation to the whole, and understanding the whole as represented and understood through the parts (Cohen et al., 2004).

> [Interpretation] involves careful and detailed reading and rereading of all the text, allowing for the bringing forth of general impressions, something that catches the regard of the reader and lingers, perturbing and distinctive resonances, familiarities, differences, newness, and echoes. Each re-reading of the text is an attempt to listen for echoes of something that might expand possibilities of

> understanding…Hermeneutics, rather, pays attention to the instance, the particular, the event of something that does not require repetition to authenticate its arrival. (Moules, 2002b, p. 30)

Following the transcription of the interviews, I read through all of the data. In this review, I grouped together transcripts and memos from the review of clinical work and research interviews according to the family who was seen. I wrote initial overall impressions of the clinical work after this review and this can be found in the subsequent three chapters. I then thought about the clinical work in general, and noted aspects that stood out for me, that I believed warranted further exploration. These specific ideas, or parts of the clinical work and the interviews, caught my attention for several reasons: they were surprising or unusual, they helped to answer a question that I came into this research with, they helped to answer a question that arose during the review of the clinical work, they shed light on understanding why the clinical work was helpful or not, or they helped to explain what was going on in the clinical work. It is through the further investigation of these ideas that the interpretive analysis took shape.

I fluctuated from segments of the transcript to literature I had previously read, to new literature that I had not previously considered, in an attempt to articulate what was occurring in the clinical work. Literature also has something to say about the topic in the analysis phase of hermeneutic inquiry. In hermeneutic inquiry, the researcher may return to the literature and ask it to help understand what is going on (Jardine, 2006). Literature is not used to support, verify, or confirm findings, but rather literature may be used to further explore, understand, and find meaning and history to what it is that the participants have to say about the topic.

The specific clinical work with each family is considered in chapters three, four, and five. This analysis began with a specific segment or concept that initially struck me in the review of the clinical work, and the analysis was then further developed in relation to the overall clinical work with a particular family. A further analysis and discussion can be found in chapter six, where I returned to the research questions and considered what the interpretations had brought to the larger, broader understanding of therapeutic interventions with grief. Finally, there is a description of the implications for nursing practice, education, and research.

Chapter Three: Dianne and Monica

Dianne was referred to the FNU via a friend who knew of the services offered. Her husband died of cancer 6 weeks prior to her attending her first session; they had two children - twins aged 4. Dianne thought she was managing "alright" doing "what needed to get done." Although she believed she was doing okay, she thought that it would be beneficial to go to counselling. She was focused on doing what she needed to do for her children to make a life for them, and stated she was trying to only think of one day at a time. She wondered if her children understood the permanence of death, and wondered about getting advice about what to do for her children to help them. Monica, a second year masters student, was the clinician working with Dianne.

Session One

Dianne assessed that she was doing "okay", but that there might be something more that she could know to help her children. She was concurrently seeing a counsellor through her own insurance company, and stated she believed "the more the better." She felt that her husband was close to her, and while she still had memories and tears, "*as long as I can pick it up and drop it off, and get done what I need to get done…die is die, and the remaining is what I can do for the kids and myself to make my life.*" Dianne stated that she had kept busy by resuming her routine of working, doing paper work, and going to the gym. She described some concerns with day to day instrumental activities, but thought this was easier since she hired a nanny.

The "one-question-question" (Wright, 1989) is routinely used in this clinical work to help distinguish the problem that the family is most concerned about. It is typically worded as "If you could have just one question answered in our work together, what would that one question be"? (Wright et al., 1996, p.137). Dianne had difficulty thinking of a "one-question-question," but agreed with Monica that learning how to help her children to grow through this and work as a team was important. When asked if she or her children were suffering at this time, she replied "*not too, too much.*" Dianne was not sure if she needed to be at the FNU -- if she was grieving enough to need counselling. She believed she was done with the grieving, and now on her mind was *"how can I make my own plan now*"? She stated did not have time to think about the "backward things," there was only time to think forward.

Reflecting team. The team offered that Dianne was very pragmatic, stating "there is a lot we could learn from her," and "we could also perhaps offer her some help". The team commended Dianne for seemingly moving through her grief with a lot of thoughtfulness and wisdom. It stood out for the team that Dianne had managed to maintain an ongoing relationship with her husband, and that those memories brought her some comfort and wisdom. The team offered the belief that people often suffer when they believe they have to say good-bye to their relationship to the deceased, and wondered how she knew that she did not need to say good-bye. To address Dianne's comment that maybe she did not need to go to counselling, the team challenged the belief that people only need to go to counselling when something was wrong, and perhaps she could use her sessions at the FNU to talk about what was going well, or not well, using the team and sessions as a consultation or sounding board.

In response to the reflecting team, Dianne stated that it gave her strength to go even further. She replied that she did not think that her emotions were anyone else's business and that she was not going to go through her grief doing what people thought she should do. She now believed that because she was making all the decisions she could "just get up and do it." She wondered if she could be of some help to the students' learning and the FNU program and that, in turn, would help her. She agreed it would be useful to have positive feedback and a place to check-in. "*If I can bounce ideas around and see if I am doing the right things, then maybe I can even do more.*"

Postsession. In the postsession, the team reflected that Dianne had many facilitating beliefs regarding her loss. She was very energetic, and was able to be pragmatic as well as sad. The team wondered if there was a language barrier as she had asked to have questions repeated, and English was not her first language. In moving forward into the next session, it was recommended to review some literature about children's experience of loss.

Session Two

Three weeks later, Dianne returned. In the presession discussion, the team reviewed the previous session. The team differentiated between needing help in counselling because something is wrong or needs to change, a pathologizing view, versus going for help as support in a difficult time. There was some hypothesizing about possible cultural beliefs, which may have been impacting Dianne, as she was a first generation Chinese immigrant.

The session began with Dianne stating that the last session had been really helpful, "*it just reconfirmed that what I'm doing is the right track for me…so if I'm on the right track then I can focus more on my kids' behaviour, and start to look more at what I can do for the kids.*" She especially found the reflecting team to be useful "*I think it's a really good idea to do that. It's almost like oh yeah, they're talking about Dianne, oh* *yeah, what she's doing, instead of inside myself, it's a third person seeing myself, so that's really helpful.*" Dianne did question again whether or not she had anything to offer the team, "*am I not upset enough to be here?...Because I have already turned myself around so much.*" She believed that not only did she look fine to others on the outside, but that she was also okay on the inside, and again asked if she had anything to offer the FNU team in her coming. She thought everything from the last session was helpful, but could not describe one thing specifically; rather that it left her with a good feeling in general.

Dianne stated that she had seen quite a few changes with her children. In the beginning, she stated that she needed them to co-operate, and that they were clinging to her, needing her to provide "*double love instead of zero love or negative love.*" She described this as a struggle, believing that sometimes they used their crying as a way to control her. She described it as a struggle to give "*double love*" to her children, thinking at times *"what do I have left for you"?* It was helpful to remind herself that they were not adults. She tried not to take their crying personally, and was cautious about showing anger around them. She reported that her children did not talk about their father, and did not like to see their mom crying. She questioned, at 4 years of age, what they were thinking, and what they would be able to understand.

Several beliefs about grief and living alongside grief were uncovered in this session. Dianne spoke of her belief that she needed to focus on the next day, and make no more plans than that. She believed that, if you put enough effort in, you could overcome anything. Furthermore, she believed that tough times and challenges in one's life were chances to learn and to be stronger. "*If it's all flat, you don't know how down it is, how* *high it is.*" During the last month of his life, she stated that she had spent some very good time with her husband, and that was time that they did not usually get because of the children. This was sharply contrasted to the experience of losing her sister, who had died suddenly as the result of a car accident.

Dianne spoke of pushing away negative thoughts, and Monica asked to clarify if these negative thoughts were different from sad thoughts. Dianne stated that when she feels her husband close to her that her tears come, and did not believe she had control over that: "*if you need to cry, you cry. If my tears come, I just let them come. That's how I know that he's close to me, when my tears come.*" Thus, in her interpretation, her sadness was happiness, because of how she felt close to her husband at those times. Dianne believed that the children interpreted her crying as being upset, and wondered about explaining this to them. Monica asked how the children would know the difference between Mom being upset or angry and mom being sad.

Reflecting team. The team commented on how impressed they were with Dianne's thoughtfulness of her children, in wanting to do the right thing with her kids. The team furthered the idea that, while she had made a great distinction about being upset and being sad, perhaps her children may benefit from knowing what their mother's tears were about. The team offered the observation that Dianne seemed to be grieving well, but not suffering; she was sad with her grief, but did not seem to be suffering with it.

Dianne returned to speak with Monica following the reflecting team and stated that she was still not sure that she was helpful to the team for anything. Monica responded "*You are teaching us about how people grieve, and so remarkable, and courageously confronted this loss and being a great example for us and other families.*"

The postsession was not recorded on videotape as it was done as part of an externship program that was occurring that week.

Therapeutic letter. A letter was sent to Dianne following this session. The letter included an acknowledgment of the sadness of her tragic loss, but that the team was struck by the wisdom she seemed to have about living with grief, of doing what makes sense to her. She seemed to be thinking about herself and her children, looking at different ways to work with her own feelings, thoughts, and ideas. In the letter, the team wondered about the children not knowing how to express their fears and sadness, and wondered about how Dianne might reassure them at this time. The team believed that they had missed addressing the belief that when her children cried, it meant that they were trying to control her; this belief was stated and challenged in the letter.

Session Three

This third session occurred 1 month after the last session. In the presession discussion, the team highlighted the omission from the previous session that Dianne's children were using crying to somehow control or manipulate her. The team discussed how the children were being repeatedly asked by people where their dad is, and to talk about their dad. However, in the literature that was reviewed prior to this session, the team found that children at this age were often overwhelmed by emotion, and did not understand permanence. The children had a need for their primary caregiver to be present. A suggestion was made to focus on the children, as that was what Dianne had been most focused on in the sessions.

Dianne brought her two children to this session, and the beginning of the session was spent engaging the children in the environment. Dianne had received the letter, and said it was something that she would keep forever. She brought up that she was bothered by two behaviours in her children: that they do not want to sleep by themselves, and they say that they do not miss their dad. She interpreted this to mean that she has not done enough to ensure they know he is not coming back. Dianne was advised from her other counsellor that the children should not be sleeping with her all the time, so she had told them that if they have a nightmare they can sleep with her, and ask for a big hug. This has helped her daughter to sleep through the night, and she reported that it is helping somewhat for her son. Dianne also described their routine of saying prayers every night before bed, hoping it would give them all strength and comfort.

Monica uncovered another belief about Dianne's grieving: she stated that when she is with people she would like to give them positive feelings, and not negative feelings, so she enjoys crying when she is by herself, because then she does not have to worry about other people and thus she has more freedom to cry. After she cries, she stated, she feels happy because she believes she has expressed herself like a normal human being.

Simultaneous counselling or therapy has been viewed as an obstacle to change (Wright et al., 1996), and in trying to remove this obstacle, Monica inquired as to what was different about the work Dianne was doing in the FNU, versus what she was doing with the other counsellor. Dianne stated "*Here it is sharing. Over there I expect them to give me a firm answer. Here is more of a learning process for both parties; there is the medication and here is the supplement.*"

Monica did explore what her husband, Bob, would have said if he were present, particularly if he would he be worried about anything. Dianne replied that he would be worried about her parenting the children. She explained how they had very different parenting styles, but she saw parenting by herself as an opportunity. If he were alive, she would need to work on parenting and their relationship. Now she had learned a lot about parenting because there was no one else to hold her up, or back her up. She further explained that now she could just do her own style, instead of worrying how we are going to agree on doing it. "*I just do what I think needs to be done.*" She has connected this with behaviours in her children such as being calmer, listening more, and supporting each other more. Dianne also believed she needed to learn who her children are as different people, and express her love to them in different ways. She requested that the children come back into the room to talk, believing that they needed to "express themselves" more.

The children were not inclined to answer Monica's cognitively focused questions about their father. During the time that the children were in the room, with Dianne watching behind a one-way mirror, the children were laughing, singing, and colouring, not particularly focused on Monica's questions.

Postsession. Monica commented on how exhausted she was from the children, and reflected on what it would be like for Dianne now going home with them. Dianne seemed to have a belief that the children would talk more when she was not present, however this did not occur. The team discussed how they seemed like secure, well-loved, engaging children; and while they were attached to each other and their mother, they did not show any anxiety about her being out of the room. The team wondered about offering Dianne the idea that the reason her children do not claim to miss their dad is because she was doing such a good job filling that void. The team was concerned about the expectations she had of her children, to behave in a more adult-like manner, as this was developmentally not realistic for 4 year olds.

Therapeutic letter. The team sent another therapeutic letter to the family reiterating that the children seemed cheerful, energetic, and well-loved and that this was a credit to Dianne's parenting. It was offered that there were no indications that the children were not adjusting well. Several commendations were offered about Dianne's patience, about how she was caring for everyone's needs, and seeking many ways to do well by her children.

Session Four

This last session was 2 months following the previous session, and occurred after Christmas. In reviewing the work in the presession it was offered that, while Dianne had not specified a specific one-question-question, most of her concern and questions seemed to be around the theme of *"how can I help my children adapt and what can I do to help us grow strong together as a team without Daddy"?*

Dianne described Christmas as going well. She took her children to spend a week with her husband's parents and siblings. While there were some tears and sadness, the family felt her husband's presence and focused on the children and positive energy. In the meantime, Dianne's father had also passed away. She did not see this as significant to discuss with Monica, stating he had been sick for a really long time, and she had some good times with him. Dianne stated that she believed her sessions in the FNU would be completed today because "*someone else probably needs more help than me... it's good to listen and share my feelings, my inside and outside are okay, but maybe there's another family that needs to be seen more than me.*" She reiterated that all the letters were such a good gift "*any time later, in bumpy roads, if I feel bad again, I can read these letters that you guys gave to me, a great gift.*"

In review of the work, Dianne reported that the sessions had been helpful, "*you've asked a lot of questions that I wouldn't have asked myself, and the feedback... it's really helpful, the confirmation I think.*" She commented that it would have been helpful to have more structure during the sessions; this format of a session would be good for someone who really liked to talk, and counselling may be better for someone who did not like to talk as much. It is routinely asked, in closing the work in the FNU, what advice the family would offer to nurses. To this question, Dianne replied: "*the grieving is difficult, but try to open up that there are tons of ways you can see it in a positive way, to have a push, and give positive energy.*" Her advice to other families was this: "*if time is running out with your partner, how much more time do you want to spend being negative*"? Prior to the reflecting team, Dianne asked if it would have been more helpful to the FNU team if the family member was more negative, because there would be more problems or issues "*for you guys to push to think more.*" She stated that much of the time she already had the answer for what was asked and wondered if she was helpful to the team's learning.

Postsession. The team reflected on Dianne's comments about there being a lack of structure. The supervisor of the sessions saw this as a "paradox" because there had been significant structure unbeknownst to Dianne. This clinical work was described by the team as a "very different therapeutic encounter," and questions such as "what the heck were we working on"? arose. One hypothesis for this was that typically it has been Caucasian, middle class families who attended sessions at the FNU, and so perhaps it was the cultural differences and language barriers that resulted in such a "different" therapeutic encounter. The supervisor of the sessions, on the student feedback form, wrote "interesting feedback [from the family]...fascinating therapeutic conversation with a Chinese speaking grieving client who challenged our beliefs about what grieving looks like."

Therapeutic letter. The closing letter reminded Dianne of what to appropriately expect developmentally from children. The team offered that their learning from her was about a mother's need to care for herself, and how children respond to grief differently. Several commendations were also offered.

Nurse's Observer Perspective

At the conclusion of the sessions, Monica reported on her overall impression of the sessions as an "observer perspective." She thought that Dianne's presenting problem was better, and that the thinking about the problem changed a great deal.

> *Dianne's understanding about her children's responses to grief were significantly different in the last session. She showed significant new understanding around what the children needed from her, and important new beliefs about enjoying the moments with them.*

Specific changes that were reported by Monica included Dianne's new beliefs about how to parent the children which were consistent with normal growth and development; Dianne's understanding of children's developmental response to grief; a shift from wanting obedience from her children to being with and enjoying the moment with them; an ability to treasure the moment and have a more patient approach with less anger; Dianne's new belief that expressing her sadness to the children was a positive thing; and her understanding of what the children were thinking and believing. In summary, Monica stated that Dianne reported being less tearful, had more congruence between "the inside" and her "outside"; less concern about getting things done and more concern about the process and how it was impacting the children; and finally she reported that her daughter was sleeping better during the night.

Initial Analysis of Sessions

Following the review of these videotapes, I was left with the impression that Dianne felt that she was providing the clinical team with a learning opportunity, and should not be coming if there was another family who could be helped. This may have been about the clinician being a student, the seeming lack of direction or structure, and the repeated comments about what Monica and the team had learned from her. Dianne appeared bored in her affect during some of the sessions, particularly following some commendations. She requested copies of the videotapes of the sessions, and this was arranged. When the team commented that Dianne was doing very well, that she was very wise in how she was handling her grief, and that she was "teaching us something", it seemed they were acknowledging and praising her for "getting on with things" so quickly.

Dianne's worry about crying in front of other people is interesting. She stated that she preferred to cry when she was by herself, so that she would not have to worry about what other people were thinking, or how they were doing. It is interesting to note that perhaps her worry about others carried over into what was supposed to be a therapeutic conversation; she was continually worried about whether or not she was helping the team to learn. In reviewing the clinical work in the fourth session, Dianne stated that she already knew the answer to the questions that she was asked. This signified that there perhaps really was nothing new for her as she already had the answer; there was thus little sign of reflection, change, or challenge to her beliefs.

Research Interview: Family

Dianne agreed to be interviewed, and a single interview was carried out in her home, approximately 4 years following the completion of the clinical work. I began by introducing my research, and explaining the topic being studied. We began the interview with a very open question about what she recalled from the FNU, or what stood out for her from that time 4 years ago. Dianne had been hopeful that two things may occur in going to the FNU: that she might be able to help others, and *"I might be able to help myself by saying it out loud and letting it out."* However, she did *not* find the sessions at the FNU helpful, and wondered if they had been helpful for the clinical team.

The reason she gave for the sessions not being helpful was around timing.

> *I think the timing's not right also. If I look back, you know because it's so short. Grieving I think it maybe should be the first year you just kind of just accept and digest your shock and not do anything...The real feeling it doesn't come out till a year or two years later. What it's about, the grieving, what it's impacting your life, and in the first year you could never know. You just try to catch up.*

When asked further about the timing of seeing a professional around grief, Dianne said that she thought the timing was wrong for her *"I'm saying timing was wrong, but I'm saying it now. But back then, maybe I felt like it was a support then, and I needed to do it."*

Overall, Dianne could not recall anything specific about the sessions in the FNU. When asked, she said she had received the videotaped recordings of the sessions, but had not looked at these or the therapeutic letters since. She stated the FNU was "*more for helping research, not much in helping me.*" She had the sense that the objective of the sessions was for the team to learn from her so they would know how to better deal with the next family -- that it was more about research and the team's objectives than working on what she wanted to deal with.

When asked what had been the most helpful thing to her in her grief, she replied that what is inspiring her to live on and be positive is that she has no real choice. "*I have two choices I guess. I either just put myself down, and go more down, or just kind of pick myself up and be strong.*" Spiritual resources were significant to her in being able to do that. She had a belief in God, and believed that she had not fulfilled her purpose yet. As well, she felt that her husband's spirit was watching over them. She said about 50% of her motivation to "move forward" and to "be strong" came from her children. When asked if she attributed any part of her motivation to counselling, at the FNU or with the psychologist, she said "*really little…maybe 10%.*" She found that attending a group session through a non-profit organization in the city 2 years ago was very helpful. The children attended a group there with other children who had lost a parent, lead by a facilitator, and simultaneously the parents also met. She described this as being helpful to the children "*because they can explain a little bit better for the kids what death is all about.*" For her, it was helpful because "*all the parents [are] in the same situation, so…we don't feel alone.*" She also described it metaphorically as taking your garbage to the dump, all on one day. "*Just gather it and then dump it. Maybe that's a little bit better,* *than every day you're upset.*" She said in the group, people do not mind sharing, as there is more opportunity for learning and sharing of information. "[*You*] *let loose a little bit because no one is worse, you're the same as me…that you're not alone. So automatically you might feel a little bit more support that way…and also sometimes by knowing the other single parents you can exchange help or something.*"

Dianne reiterated that the FNU was likely not as helpful as it could have been due to the timing.

> *At that time it was not right…yes, I did it, but it doesn't come out, my feelings, as deep as after you've done everything, you settle down. The grief actually hits you more after one year or two…because again you're just so busy, just so busy telling yourself you just can't collapse, you just go on another day.*

Research Interview: Nurse

Monica's interview started in a similar way to Dianne's. I initially asked her what she remembered from the work with this family. She recalled that it was very soon after the death of Dianne's husband that she attended sessions in the FNU. She thought that Dianne's main concern had been around whether or not her children were doing okay. Monica did not think that Dianne herself had thought counselling was something that was needed and wondered about the nature of the referral source.

> *I wonder if it made her feel that she was somehow less than, or that she wasn't doing well. And that it made her question her own capacity, in that. I wonder if she would have come for therapy on her own, if the neighbour hadn't sort of encouraged her to go, because it did set up the question 'am I doing okay?…I*

wonder if it would have been a different therapeutic environment if she had come on her own saying 'I'm not doing well and I would like some help'.

Another aspect that stood out was Dianne's unique presentation during the sessions and, although Monica thought they were engaged, she was "surprised by the energy and positivity" that Dianne portrayed. *"She talked quite fast as I recall...which was kind of a bit of an odd thing for me because often when the topic is grief, it's kind of a lower tone, and a slower pace because it's a tender place."* Monica had interpreted this presentation to mean that Dianne was a very determined woman, and that she was going to take what life had given her and make the best of it. She thought Dianne was "forging through" and this may have been because, as many immigrants learn, she needed to be tough in order to survive.

Monica remembered several facilitating beliefs that Dianne had, such as the importance of being in the present for her children, not getting overwhelmed and also not believing her husband's death happened because of anything she had done. The only constraining belief that Monica thought Dianne had was around her not believing she would know if her children were doing okay or not -- that she did not trust her motherly knowledge to know this herself and wanted to hear it from a professional. She thought, at that time, that maybe Dianne did really have to forge through, to keep things on an even keel for her family, and that perhaps when things settled down, that would have been a more appropriate time for "grief work".

In terms of the repeated questions from Dianne wondering if the team was learning anything from her, Monica wondered if that was what had given meaning and purpose to the sessions for Dianne at the time.

> *In the FNU, we made it very clear that we learn from our patient, our clients, right?...which is a way of sort of lowering the hierarchy, right? And levelling the playing field...we were learning from her so we could be helpful to people who needed help, and she didn't identify herself as really needing help...we weren't meeting an identified need for her.*

This supported Monica's conclusion that it was the timing and the motives for Dianne attending the FNU that had made the conversations perhaps not even therapeutic ones; perhaps what Dianne had needed most was instrumental support.

Another nurse, Suzanne, who was also interviewed in this research for another family, was part of the clinical team for Dianne's sessions. In Suzanne's interview, she commented about the work with Dianne from what she could recall. She believed that Monica and the clinical team were never engaged with Dianne. *"At the time I remember thinking it was more about her [Dianne], but you know I don't think that's a very critical look at our own work and what did we miss in terms of how we might have engaged with her differently."* Two explanations Suzanne offered for the work not being a fit for Dianne around the engagement were the timing of the sessions, and the nature of the referral. Dianne attended the FNU only 6 weeks after her husband's death, *"that's pretty fresh, and you know, she's a mother of two young children who needed to attend to pretty serious pragmatics in her life"*.

The referral source was a neighbour of one of the members of the clinical team, and Suzanne wondered what had been said to get Dianne to come to the FNU. Did the neighbour think that Dianne really needed some help, when Dianne may not have come otherwise? Did she perhaps tell Dianne that it was an opportunity for the FNU team to learn from her, and thus setting up Dianne's expectations quite differently than the expectations of the clinical team? This nurse speculated *"She [the referral source] maybe said you could help them with some research, maybe she set that stage right from the beginning"*. This might have gotten in the way of engagement, as Dianne was not coming there to benefit herself. This may also explain Dianne's response in her interview that she believed she was there to teach us, and it was not for the purposes of helping her.

Analysis: Setting the Stage and Picking up Cues

As was mentioned by Suzanne, perhaps the "*stage was set*" at the point of referral. To set the stage means to provide the basis or background (Merriam-Webster's Collegiate Dictionary's, 2003). In theatre, to set a stage means to prepare "the scenery and other properties used to identify the location" (Audioenglish, n.d.). The intent of the stage set from the view of the clinical team was to conduct a therapeutic conversation with a woman believed to be suffering in her grief. For various reasons, however, the stage was set for Dianne to enter the relationship as a teacher, and for Monica and the clinical team to be learners. However, the clinical team did not seem to address this aspect of the referral, nor did they attempt to reset or adjust the stage, to add or remove props.

Continuing the metaphor of a theatrical performance, it is interesting that there were several *cues* in the sessions that the intentions of the clinical team and the intentions of the family were not congruent. Cues are a signal (as a word, phrase, or bit of stage business) to a performer to begin a specific speech or action, or a feature indicating the nature of something perceived (Merriam-Webster's Collegiate Dictionary, 2003, p. 303). The cues that were apparent to me in the review of the clinical work and the research interviews included the nature of the referral, the incongruence between Dianne's affect and her experience, her statements that she was not suffering, her continual responses that she wanted to be helpful to the clinical team, and the timing of the sessions. These cues might have signalled to the team to perform specific actions, such as addressing what her greatest needs were. What they signalled to me was that the clinical work was not helpful in the format that it occurred.

Cue 1: Who is the customer for change? In the research interview, Dianne wondered "when *do* you help someone?", a question of confusion about the purpose of the sessions at the FNU. In reviewing the clinical work and the research interview with Monica, she came to the conclusion that Dianne really was not the "customer" for change in the session.

> *She was there at the suggestion of someone else. So she wasn't identifying herself as needing our help. [Someone else] was identifying her as needing help, so she really wasn't a customer for therapy...we were offering her things she really wasn't in the market for.*

The concept of "customer" for therapy has been described in the literature as someone who seeks change for themselves (MacDonald, 1994). The alternative descriptions of people who seek therapy are "complainants", those who want others to change, and "visitors" who do not wish to see any change. In addition to the nature of the referral, there were other cues that Dianne was not a customer for change, so why did the clinical team proceed as if she was? This cue, along with others, should have signalled a very different response or set of actions from the clinical team. Monica, who now works in private practice and has more experience as a therapist stated,

> *I don't think she was a customer for the work that we were doing in the way that many people are coming in and saying, okay, I'm stuck, something isn't working...I'm open to some new ideas for change...Because she really wasn't looking for anything, for her not to be able to identify what, what she was coming from, or for, was a pretty good indicator...we were sort of trying to help her come up with something that we can be helpful for.*

In the first session, when Dianne wondered whether or not she needed to be at the FNU, the team offered the belief that perhaps people could go to counselling not only when they were stuck, but also perhaps to receive support and have a sounding board for things that they were doing well in their lives. This would fit more with the 'visitor' definition of a client coming to therapy. Visit has etymological roots from old French in the 1200s and meant come to (a person) to comfort or benefit (Harper, 2001). Certainly this view of the visitor may have been appropriate for what Dianne needed at the time, and this is certainly a common occurrence in therapy, particularly with events such as court mandated counseling. Whether or not, however, this is the context that can lead to *change* for the person is questionable. Monica reflected on this in the research interview:

> *People know when they're stuck...the whole population health kinds of ideas of pre-emptive strikes, to help people stay well, or to give them resources... [but] help that's not perceived as helpful, isn't helpful! And help assumes that this is a need that someone has, and so if people aren't at a place where that fits for them, then...*

This is significant, especially when considering the palliative care field, and the introduction of the idea that helping professionals should assess families for risk factors for complicated grief and offer early intervention (see Kissane & Bloch, 2002). If it is not perceived as being needed, desired, or helpful, *it will not be helpful*. To suggest to families that they need to go to counselling or through a program because they were deemed to be at high risk for some kind of dysfunctional grief seems counterproductive to being helpful or useful because *motivation for change* has been shown to be a factor impacting the success of therapy (Asay & Lambert, 2006). In the theoretical underpinnings of the IBM, there is a belief that families know when they need to seek help, what is the most important thing to seek help with, and what is helpful or not (Wright et al., 1996). The family that *requests* help becomes the problem determined system, and thus the problem "cannot be determined by the therapist on the basis of externally imposed views" (Anderson, Goolishian, & Winderman, 1986, p. 7). The therapist can play a role in noticing and distinguishing change (Wright et al., 1996). If change is to occur, however, and is the outcome that is chosen to be measured, then the desire to change must come from whoever is seeking help, as must the decision that the change has been sufficient.

The desire to assess and determine from a pathologizing stance whether a family is "at-risk" for dysfunctional or complicated grief is supported because of a society obsessed with risk management and the determination to prevent any suffering, while trying to guarantee safety and happiness (Walter, 2005) However, it is impossible to escape grief, and perhaps the suffering that can accompany it is also not entirely avoidable.

Cue 2: Fascination and incongruence. As previously mentioned, Monica reflected that she was surprised at Dianne's positive and energetic presentation. The supervisor commented after the final session that "it was a very different therapeutic encounter." At the time, it was partly attributed to Dianne's cultural background and language barrier. In the written supervision notes, it was noted that this was a "fascinating therapeutic conversation." In my review of the videotapes, I noticed incongruence between what one would expect in affect when talking to a mother of twins whose husband had just died, and how Dianne was presenting. It is not that her response was "wrong" in any way, but it was so different than my experiences of families who have had a loved one die (typically solemn, sad, and quiet) that it may have been at least prudent to ask Dianne about it. Moules et al. (2007) explained that while affect is important, and sadness and sorrow is expected with grief, that it might be more useful to explore the cognitions supporting and resulting from the affect – unless there is an absence of affect and only intellectualization. In these circumstances, it may be very prudent for clinicians to inquire about affect.

Monica had a similar experience and wondering about Dianne's affect.

> *She talked quite fast as I recall, and so sometimes I was pacing, which was kind of a bit of an odd thing for me because often when the topic is grief, it's kind of a lower tone, and a slower pace because it's a tender place…I don't know her previous to this, but it was not what I've come to understand as typical for grief.*

Perhaps at this point it could have been discussed whether or not she was seeking help or change, and whether or not a therapeutic conversation of this nature was even what she needed at that time. It may have been worthwhile to check out this hypothesis rather than assuming it was cultural or language barriers that were creating a "different" or "fascinating" therapeutic conversation. Perhaps the nurse and the clinical team needed to "encourage a dialogue between affect and cognition, allowing each to inquire about the other" (Moules et al., 2007, p. 11).

To fascinate has an etymological heritage meaning to bewitch, enchant, or charm (Harper, 2001). This seems to imply that if a conversation was fascinating, that perhaps there was an aspect of a spell of attraction. There was an indication that the clinical team was intrigued and attracted to what Dianne was saying, but perhaps not entirely sure of the source or reasoning behind it, but recognizing that it was saying something different, or new, to them. To charm also means to protect by, or as if by, spells, charms, or supernatural influences. When something is fascinating, then it is likely to draw interest under its charm. The clinical team was obviously curious about the nature of the clinical conversation, even *fascinated* by it, but did not seem to heed this cue, that perhaps there may be something else going on here, such as poor timing, or needing something else in terms of support.

Gadamer (2004) stated that understanding begins when something catches our attention. However, this is not *all* there is to understanding, rather only the *beginning*. In the clinical work however, the fascination and the interest in understanding the nature of this "unusual" therapeutic conversation did not seem to be further explored, interpreted, or understood. Perhaps when something does not "fit", it should signal that it needs more exploring, whereas often it is easier to label and pathologize what is happening. In this case, the reasoning was because of language and cultural barriers, and thus perhaps not seen as a responsibility of the clinical team to sort out. In the research interview, when asked how she interpreted Dianne's presentation in the session, Monica stated

> *I think I interpreted that as that Dianne was a very determined woman who was taking what life had given her and was going to make the best of it…I also think she felt that if she was emotionally overwhelmed, she wouldn't be as present for her children, and there was lots of energy that was required there, so she had to choose which basket to put her energy in.*

Dianne, in her research interview, had another explanation of the nature of the therapeutic conversation.

> *I think the timing is not right...grieving, I think, it maybe should be the first year you just kind of accept and digest your shock and not do anything, because although I might say a lot, it might not be my real feeling because I'm just trying to cover up. The real feeling it doesn't come out till a year or two years later...in the first year you could never know.*

Although it is very likely a factor, the hypothesis of a language barrier or cultural differences does not seem to hold up as a full enough explanation.

> *Cue #3: Not suffering "too, too much", surviving.*
>
> *Monica: Do you see your children as suffering?*
>
> *Dianne: Not too, too much.*
>
> *Monica: Do you see yourself as suffering?*
>
> *Dianne: Not too, too much.*

If the goal, or outcome, of clinical work guided by the IBM is to alleviate or reduce suffering, and a family reports that they are not suffering "too, too much", then what is the purpose of the clinical work? Was this another cue that the timing was not right for Dianne? If she was too busy with instrumental, pragmatic tasks, how does this affect opportunities for therapeutic intervention to be useful? The clinical team seemed to have an obligation to continue to engage in conversation with Dianne. This was reinforced when Dianne continued to return to the sessions. If the timing was off for this type of clinical intervention, what might the team have been able to offer instead? Nurses certainly have a plethora of skills and knowledge that they bring to practice. The team tried to reframe Dianne's presentation by saying that perhaps someone does not only need to go to counselling when they are having a problem, but that it can also be helpful as support in a difficult time. If that were the case, then perhaps there were other practices that the team could have engaged in to act as this support.

In terms of nursing practices, certainly commendations and circular/reflexive questions were utilized in the sessions. The team assessed for a variety of things such as socioeconomic status and religious values, but what Dianne may have most needed was instrumental: providing information about what to expect developmentally from 4 year olds, where to go to recruit further instrumental support, such as a nanny, or how to prioritize and manage her life as a now single parent. Another potential nursing intervention could have been encouraging respite for Dianne, perhaps by encouraging other family members to be caregivers for the children.

I would describe Dianne as looking bored throughout most of the sessions with a flat affect. To me, that could indicate a number of things such as not being engaged, or not believing that she actually needed help at this time, or being overwhelmed by feeling that she was obligated to help the clinical team with their research. Perhaps the simplest explanation though, was that the agenda of the clinical team was not a fit for Dianne's needs. Dianne was struggling with surviving her new, day to day reality of single parenting. She needed help with the instrumental tasks of raising two toddlers as a single parent.

> *Monica (research interview): I think some of our work was awkward in that we were trying to, not get her to admit, but to sort of touch the places where she was suffering and that really wasn't her agenda.*

However, when the clinical model is focused on reducing, alleviating, healing suffering, then it would make sense, theoretically, that she did not experience a significant change or shift. Within the clinical work, was a constraining belief overlooked? Was it a constraining belief for her to think that she needed to do a lot of things, as much as possible? During the first session, the reflecting team commented on how pragmatic Dianne seemed. In the research interview with Suzanne, another nurse who was present during Dianne's sessions, it was suggested that Dianne had a lot of instrumental things to consider at that point in her life, and related it to the timing of the sessions *"that's pretty fresh, and you know, she's a mother of two young children who needed to attend to pretty serious pragmatics in her life."* To be pragmatic means to be skilled or versed in business or relating to matters of fact or practical affairs often to the exclusion of intellectual or artistic matters (Merriam-Webster's Collegiate Dictionary, 2003). Does pragmatics somehow preclude suffering? How does it impact a therapeutic conversation, or how does it imply what a family may most need from professionals at that time?

If suffering also means to endure (Merriam-Webster's Collegiate Dictionary, 2003), Dianne certainly had a lot to endure – the tasks of filling out and filing paperwork related to her husband's death, life insurance, will, etc., as well as the task of trying to figure out how to be a single parent, and eventually hiring a nanny to help her; inevitably, a lot of business to which she needed to attend. Enduring pragmatically was what she was doing at the time. Is there room for therapeutic conversations while enduring pragmatically? What would the purpose and focus of that conversation be? Was it a therapeutic error (i.e. missed identifying a core constraining belief, and then challenging it), or was it the timing? Perhaps was it something else? Western society relies on people to be pragmatic and productive; this was what Dianne was doing, and this is something the clinical team noticed. There was an attempt to acknowledge that perhaps people do not always need to go to therapy when there is a problem, sometimes it is a sounding board, or a place to check in, to receive reinforcement and encouragement that what a grieving person is doing is okay.

> *Monica: I think she didn't even know what she felt yet, is my hypothesis...She was coping, and surviving and doing the best she could to keep an even keel on her family's ship.*

At the time of the sessions, Dianne seemed to be simply trying to survive from day to day. To be a survivor means to continue to function or prosper despite hardship (Merriam-Webster's Collegiate Dictionary, 2003); or one who has a knack for pulling through adversity (Harper, 2001).

> *Dianne: You're just so busy, just so busy telling yourself you just can't collapse, you just go on another day.*

Perhaps what Dianne needed most at that time, more than counselling, and more than a sounding board, was someone or something to help her to not collapse, to help hold her up and manage the next day.

Cue 4: Who's helping who? Dianne was concurrently attending counselling with a psychologist through her life insurance policy. It was evident in review of the clinical videotapes, as well as in the research interview, that she distinguished the conversations in the FNU as being about what she could teach the clinical team about grief, rather than about the clinical team helping her around grief. Furthermore, the comments from the clinical team that "you should be here, we are learning from you" would have likely reinforced this belief of Dianne's that the purpose of the sessions were for the team's research and education, and not for the purpose of helping her.

There may also be larger system influences on this clinical work - firstly, around the beliefs that the clinical team may have had, and secondly around her involvement with another counsellor. It could have been that, although Dianne did not believe that she needed help of this nature, the clinical team believed that she *did* need help. If the clinical team did truly believe that grief is inevitable, people have legitimate experiences in their grief, and these are not to be pathologized, why was there a determination to continue with this type of clinical work? One explanation may be perhaps there was a belief amongst the members of the team that something useful can *always* be offered, and there are no situations when there is nothing to offer someone. Another explanation may be the constraints of the FNU as a teaching environment, and for the purposes of the student's education, they needed Dianne to continue coming to the sessions. While there was some initial exploration of Dianne seeing another counsellor, this did not seem to ever be resolved. Dianne did view them as two very distinct settings and to have different purposes, but, in the FNU, it is the intention to offer interventions through therapeutic conversations, much in the same manner as a "counsellor" may, and it is acknowledged that seeing multiple professionals can create obstacles to change.

In terms of the relationship between Dianne and Monica, and also with the team, there was an obstacle to developing the necessary therapeutic relationship. The nature of a therapeutic relationship is that its intention is not to help the therapist or nurse. By its very nature, the family needs to *not* be concerned about the therapists' responses, or their feelings. If Dianne was worried about how much she was helping the team - asking if there was not another family who needed more help, or could be more helpful to them, wondering if she was wasting the team's time - then the relationship would be less than therapeutic. Perhaps there was such an attempt to make Monica unrecognizable as an expert and Dianne recognizable as the expert, that the roles, purpose, and "set" of the therapeutic conversation inhibited an actual therapeutic conversation from taking place. In this situation, the relationship was almost skewed too far on the other side, of focusing on Dianne as the expert, and Monica and the team the ones in need of help. What would have happened if the team had voiced their belief about most families benefiting from help, and further that they believed they could be helpful to her? This conversation may have evolved to discovering that Dianne really was not looking for a change right now, perhaps that this was not going to be a fit for her, and perhaps it may have reset the stage to enable a more useful conversation to occur.

This idea was shared by Monica in the research interview when commenting about the different nature of her therapeutic conversation with Dianne. She replied *"I don't even know if it was therapeutic."* The tone for their relationship was set in the first session: that it was a reciprocal relationship, that Dianne was expected to give in this relationship, and that she had an obligation to fulfill to the FNU. The expertise in the relationship is weighing heavily with the family. In the second session, when Monica asked Dianne what stood out from the last session, her response was "*I hope everyone learned something.*" This continued on into the fourth session when Dianne and Monica were discussing whether or not the sessions should be completed. Following the reflecting team in this session, Dianne stated

> *Do you think you guys can share more and learn more with someone who is more negative? ...because more negative, it might not be a bad thing, because there are more problems or issues...a lot of the time I already have the answer myself to tell you guys. [Have I been] helpful in the process of learning grieving for you guys?*

This confusion over purpose of the sessions was made clear in Dianne's research interview when she pondered *"like in what situation [*do*] you guys help somebody"*? She further stated in the research interview that the FNU *"is more for helping research, not much in helping me...you [FNU] want to learn from us, on how to deal with the next one, that is your objective."*

Wright et al. (1996) stated that nonhierarchy between nurse and family is the preferred stance. When the hierarchy is maintained in the relationship, with the professional in the role of expert, the family takes a one-down position. The "rules" in these relationships are that the person in the one-down position never questions the relationship, and the person in the one-down position can be labelled by the expert as resistant if they do not follow advice or are dissatisfied (Wright et al., 1996). Often attempts to acknowledge learning from the family is an attempt to reduce this hierarchy and recognize that both nurse and family are affected and both learners (Moules, 2000). Monica, in the research interview, acknowledged that the portrayal that the team is learning something from the family is a way of *"lowering the hierarchy, and levelling the playing field."* The challenge that then remains is the delicate balancing of roles of expert and learner. With this particular family, however, it appears as though the emphasis was such that the family became the sole expert and put Monica and the clinical team in the "one-down" position of learner. This, then, presented the interesting turn of the clinical team not being able to question the relationship. In the second session, following the reflecting team, Dianne commented

> *Dianne: I'm not sure if I'm helpful for anything.*
>
> *Monica: You are teaching us about how people grieve, and it's so remarkable, and courageously confronted this loss...a great example for us and other families.*

It does seem that a good therapeutic relationship is something more than levelling the hierarchy. There is something about the family not having to worry about pleasing the nurse, and not worrying about conforming to "rules"; and it is also about the nurse not believing that they have to have the answer, but can remain curious about the family's experience. It is about this stance, and not only about knowledge and power of hierarchy per se.

Hierarchy is defined as "the classification of a group of people according to ability or to economic, social, or professional standing" (Merriam-Webster's Collegiate Dictionary, 2003, p. 586). The etymological roots of the word come from *ta hiera* "the sacred rites" and *archein* "to lead or rule"; also having a "sense of ranked organization of persons or things" (Harper, 2001). In this regard, to approach a therapeutic relationship with a non-hierarchical stance is to remove the organization of things such that, perhaps, there is no clear leader, and that the professional skill or ability of the nurse is hidden. In the review of the clinical work, Dianne stated that there was no structure at the FNU, a comment the clinical team thought to be strange, given that the IBM follows a fairly directed structuring of sessions and therapeutic pursuits.

When reviewing the work of the final session, a lack of structure was felt.

> *Monica: Was there anything that wasn't helpful, or could have been more helpful?*
>
> *Dianne: ...It's hard to control, but if I think, more structure, it's hard to be structured because everyone is different. So do you guys have a really general question for interview? I'm just saying, from people you learn from, general questions you can ask most people...in here it would have to be someone who really liked to talk, and in counselling maybe if it was someone who wasn't good at talking, counselling would help them.*

If structure is thought of in terms of ranked organization of things, then when the approach of non-hierarchy is taken up in this way, the therapy loses its structure and organization. It then makes sense that Dianne would think there was not significant structure to the sessions in the FNU, because perhaps the promotion of non-hierarchy left the relationship and the purpose of the conversation without a sense of organization. In the final postsession, the team discussed that this was *"a different therapeutic encounter"* and asked *"what the heck were we working on"*?

In ancient Greek theatre, actors made themselves appear larger than life so that they were recognizable by the audience (Gill, 2008). "They wore long, colourful robes, high head dresses, cothurnoi (shoes), and masks with large mouths" (Gill, para.4). There were also elaborate devices for special effects. All of these made the experience of the play. Just as a play would be quite poor if there was no set, background, or preparation, and the actors were not distinguished at all from the members of the audience, in Dianne's experience, the therapeutic conversation was not set in a way that allowed it to operate correctly for several reasons. Imagine going to a theatrical performance and not recognizing whether or not you are in the audience, or one of the actors. Maintaining a hierarchy or distinction may somehow be necessary to a therapeutic relationship. Allowing the professional to be undistinguishable may indeed undermine the therapeutic effect.

Moules (2000) described how, in the spirit of postmodernism, there has been a tendency to "deny or discount our expertness" (p. 80):

> Although the intention to raise the equally valued expertise of the family is a noble pursuit, however, it is curious why, to recognize the expertise of clients, we need to diminish our own. In some respects, our quest to abandon expertise and assume a non-expert position feels like a wholly contrived posturing, a studied humility, which though noble in intent, is flavoured with duplicity and insincerity. (p. 81)

Moules described, for example, using clinical expertise to know where to strategically place commendations, in the hopes that it would open the family to hearing other things. However, not acknowledging the expertise of the nurse, and thus diminishing the hierarchy, perhaps lead to the commendations being rather ineffective in the work with Dianne. In the commendations offered to Dianne her response was typically quite flat. I wondered if it was because it was odd to hear this type of statement when it was coming from someone you were “teaching”. Perhaps the commendations helped to further buoy the notion that Dianne was indeed the expert or the teacher, and that this was not a therapeutic encounter. A couple of examples of commendations that Monica offered to Dianne were: “*I think you’re so wise in understanding what your children’s love language is, and you’re enjoying being with them in different ways.*” She also offered: *“That is great advice from someone who has been walking this journey.”*

In the postsession discussion following the last session, the team interpreted Dianne’s silence as appreciating the commendations, but in my videotape review of the sessions, I perceived Dianne as looking bored, or maybe confused. Typically, pauses in response indicate an “ah-ha” moment, but there was none of this “sign of reflection”. Again this reinforced the roles of family member as expert, and nurse as learner. It begs the question of whether, with this non-hierarchical stance; can we err on the side of being *too* deferent to families?

In therapy models influenced by postmodernism, the attempt has been made to create a “non-hierarchical” stance with the intent of respecting the expertise of the patient, client, or family who was consulting the professional (Wright et al., 1996). Within a postmodern positioning, no one world view is privileged over the other. However, there is a critique to this: In a therapeutic relationship, there will *always* be a power differential (Moules, 2000), although this does not negate professionals still respecting the family’s expertise. There needs to be distinction in a therapeutic relationship of who is playing what role, and this requires organization and hierarchy. I think the more specific critique, and what the claim of “non-hierarchical” was trying to accomplish, was to challenge the belief that as the expert or professional, "I am right and you are wrong and *you must change.*" This is violence, as described by Humberto Maturana (Maturana, 1992, November), and I think *was* the result of patriarchical relationships born of modernity, and taken up as non-hierarchical stance rather than non-patriarchical/non-violent stance by family therapists claiming postmodernity. As Minuchin (1999) described, it is not necessary that we view all expertise as power and suppression of clients, rather there is a place in therapeutic conversations for benign expertise. There is a need for clinicians to acknowledge that they have skills and knowledge, and share this with the families with whom they work (Moules, 2000).

Final cue: Time and timing. In my interpretation, the cues that Dianne was giving to the clinical team, could point to the timing of the sessions being poor in relation to her husband's death. More specifically, this timing meant that perhaps a therapeutic conversation of the nature that typically occurs in the FNU, could not happen and be useful. Perhaps Dianne was so newly bereaved that she could not teach; she needed to have her resources shored up, not be asked for something. It was not the time for her to be a teacher. Attig (1996) described that the bereaved may immediately be faced with chaos and a sense of powerlessness and helplessness. "They are at a loss as what to do or say that can possibly make any difference" (Attig, p. 18). At this time, Dianne did not need to be asked what she needed, but rather for someone to just do it. She desperately needed help with instrumental tasks, and she needed for someone to anticipate and fulfill the needs of her family, perhaps more so than to engage in anything else.

Dianne's husband had died only about 6 weeks prior to her first session at the FNU. In the research interviews, both Monica and Dianne commented that it is sometimes a year or two before people begin to start to make sense of their grief, and are at a place where they can entertain and engage in therapeutic work around it. Monica wondered if there was something about letting life settle down.

> *My experience with other people who are grieving, sometimes it's 2 years before people even connect with what that was about. That life has settled down...enough so that some of these things can surface...I think that sometimes that grief just gets frozen because it has to, and then when it thaws it's like it's fresh, and it's confusing to people because they don't understand.*

After hearing of Dianne's interview in which she said that it was too early for her to do counselling, that she tried to do everything, and that while her life goes on the impact is so much bigger than she expected, Monica summarized this in saying: *"You put one foot in front of the other, keep going."* In Moules et al. (2004) research, the metaphor of grief being an experience of walking backwards and living forward arose: Is there a time to look back and reflect, and a time when you really need to face forward and put one foot in front of the other? Moules et al. suggested:

> Perhaps the work of health professionals is to learn how to best walk backwards at times with bereaved clients, while keeping a careful watch for bumps on the road. When nurses realize that they do not own a map to grieving, they might be willing to become useful traveling companions with families as they walk backwards. (p. 105)

Professionals need to be sensitive to which direction the family may need to face at any given time in their grief journey and recognize that families "*walk with [grief] every day*" (Monica's research interview). They also need to recognize that there may be times when families need to lie down and rest, there may be times when they need to run (Moules), and there may be times when all they can do is put one foot in front of the other. Monica described how time might impact grief.

> *Once life kind of settled down then there was space for some of the, what we would term the 'grief work' that…she could tend to that one when life wasn't quite so busy…I think we think, oh they've made it through the first birthday, and the first anniversary, and the first Christmas. But it's still just kind of, for many people,* surviving.

This is a very different view than what may be popular in Western society's beliefs about what grief should be. There is a belief that grief should be completed in a finite time period, with certain allowable symptoms, and that any extension beyond these represents a pathological disorder. Furthermore, any variance from this should be corrected as soon as possible (Walter, 2005). From a lens of pathologizing grief, there is no space, and no time for grief to be a life journey. There is no space or time for families to do what they believe they most need to do at the time, or what they believe would be most helpful for them. For example, it has been proposed for the DSM-V that the diagnosis of complicated grief be added to allow for "more accurate identification of bereaved persons at long-term risk of maladjustment to the loss" (Prigerson & Maciejewski, 2005, p. 16). However, it may be that *continual long-term* adjustment to the death is what families are facing – and whether or not professionals intervene would be entirely dependent on the family seeking this assistance.

> *Monica: Maybe it's even more instrumental support that they need people to come alongside them to just help them to cope. And then to get life settled down,*

> *so the storm kind of abates, and then, you know, then exploring with people what is it that's going on below the surface...like the iceberg thing*

During the initial storm, Dianne was trying to survive, and keep her family surviving, by being pragmatic and keeping their ship on an even keel. It was not the time to explore what might be going on below the surface; it was doing the business of weathering the storm. What was needed from professionals during this time was help battening the hatches, trimming the sails; there was not time or energy to discuss where to chart the next course.

The idea of grief as a lifelong experience, and of continuing bonds, has gained more attention in the literature as of late (Klass & Walter, 2001; Moules et al., 2007; Neimeyer, 2005). It seems significant, though, that the *timing* of the interventions be attended to. In models of grief that defined stages or phases, it had been argued that the nature of the intervention, and whether or not there was intervention, was determined by the stage of grief that the person was currently "in" (see McBride & Simms, 2001). Dianne's presentation for counselling would not have fit with the stages as described by McBride and Simms, nor would the prescribed interventions likely have been a fit either. With Dianne, her attendance at the FNU may have been complicated because of the referral source, and her belief about the purpose of the sessions, but it was also complicated because at that time, she was doing all she could to *survive.*

Summary

Family Systems Nursing is considered an advanced practice of family nursing, and its milieu is in therapeutic conversations and interactions with families. It seemed in this clinical work that the concept of being a therapeutic conversation precluded other family nursing practices and interventions that may have been more useful to Dianne at the time. Wright and Leahey (2005a) described that the instrumental functioning of a family is most always affected by illness, and death is no exception. The instrumental aspect of family life can be a significant place for family intervention to occur. It seems however, that in this clinical situation, the full scope of nursing interventions may have been overlooked.

> *Monica: I think that perhaps the neighbour was concerned because it was such a catastrophic loss, and she did have so much responsibility, that she gets support, but I think that support may have been different than therapeutic intervention.*

Walter (2000) suggested that one of the reasons for the trend for people to seek counselling related to their grief is because of the societal shifts of family and friends not living nearby and therefore not being there for support after a death. It is family and friends who may typically carry out these kinds of instrumental tasks such as offering child care, cooking meals, and financial support. However, in a society that values independent and productive individuals, with transient families often living on different sides of a country if not a different continent, some of these fundamental supports have been lost. What is left is to seek professional help, although in the form of therapeutic conversations, this is not always what families may most need at a given time in their grief journey.

It was difficult for Dianne to answer the question from the clinical team "how can we help you?" because in this time of crisis, she did not know what she needed. It was more than not being clear of whether or not she was the actor or in the audience, perhaps with questions like this, asking the family to take the lead, it was as if she was asked to be the director of a play she had no knowledge of. It was during this time that she needed help, but needed someone to know what she needed, to help her meet basic needs. The instrumental support of a nanny was crucial to Dianne and her family at that time (she had just let the nanny go one month prior to the research interview). Monica thought that it was very empowering to hear Dianne say "*we've weathered the storm and we're coming through.*"

As health professionals involved with grieving families, this is learning for us to ensure that the stage is set for *useful* clinical work with families. It is also a call for us not to focus solely on our beliefs about when and what kind of help families need. Furthermore, it asks for us to be attentive to the cues that we are receiving in our relationships with families, and to be open to the idea that our particular kind of help may not be what they most need. What is it that would be most helpful to this family at this time? Do they need someone to walk with them, to hold them up, to weather the storm, or to talk about the next steps, the future territory? What cues would we need to pay attention to so we might know how to proceed, know what to say or do next? How could we be transparent about the cues we are receiving from the families while being reflective and cautious about our own beliefs and motivations? How could we pursue further understanding and perhaps different, more useful interpretations about what is going on?

Chapter 4: Christine, Amy, Ryan and Suzanne

Christine was referred to the FNU by her supervisor at work who became concerned when Christine began experiencing chest pain. Although she was cleared medically, Christine believed that the incident was perhaps related to how she and her two children, Amy and Ryan, had been coping in the previous 2 years. John, the youngest sibling of Amy and Ryan, had been killed almost 2 years prior in a drinking and driving accident. Almost a year to the day of Ryan's death, their father, Duane, had suggested the family all go on a vacation. It was during this vacation that Duane had a heart attack and died. The sessions at the FNU began about 9 months after Duane's death. Suzanne was the graduate student working with this family.

Session One

Christine, Amy, and Ryan all attended the first session; however it was Christine who initiated the referral. While Ryan stated that he came partially out of curiosity about the sessions, he mostly came out of respect for his mother. Amy, however, began the session by explaining that she was not a "big fan" of counselling, that she had a lot going on in her life, and she did not feel *"ready to do this."* The clinician, Suzanne, commended the two children for coming out of respect for their mom. Amy described a fear of "losing control" if she began talking about her father and brother. She described her grief through a metaphor of a house. *"When someone dies all the top gets taken off. The foundation is still there, Dad and John are still there in the foundation, but all the physical manifestations are gone."*

Suzanne, throughout the session, delicately handled some resistance from Amy, and indifference from Ryan, while negotiating with the family what would be most helpful for them.

> *Amy: I write and that's kind of how I've kind of dealt with all of this, is just basically through my writing, you know. Because I find being in a scenario like this just makes me really pissed off.*
>
> *Suzanne: And the writing is helpful around that?*
>
> *Amy: Hmmhmm.*
>
> *Suzanne: Well I just have to say that probably one of my biggest passions in life is writing, so I can see how that could be helpful.*

Suzanne continued exploring and constructing a genogram with the family and Christine showed pictures of Duane and John. Then there was a negotiation of where to take the conversation next.

> *Suzanne: This is where I have to appeal to your wisdom about what might be useful now. I mean there's lots of details around the loss of John and Duane that I don't know. At one level it would be really helpful for me to hear about how each of those events happened, but I don't know if that's something you're okay talking about right now.*
>
> *Ryan: It's just the same story. We've told it so many times.*
>
> *Suzanne: Is that tedious for you?*
>
> *Ryan: No, it's not tedious. I mean it's good in a way but we've talked so much about it between the three of us and between other people, as hard as it is, we're very open with it.*

Christine: For me, it's more of a question of 'where do we go from here?'...it's attempting to find, for me, a sense of family, the three of us, and yet at the same time, being very much aware that my children are ready to launch.

One of the most notable constraining beliefs that was challenged in this session was that Christine believed that she was not available to her children. The clinician facilitated a conversation during which both children challenged this belief, stating that they had always found that she was available for them. As described in chapter three, a routine component of the first FNU session, is the asking of the "one-question-question" (Wright et al., 1996). Ryan responded: *"Where do we go from here? As individuals and as a family, what's the next logical step"?* Amy offered: *"Is there hope? Like across the board, is there hope for good times ahead or is it always going to be tainted"?* Christine asked: *"Where do we go from here"?*

Reflecting team. The team acknowledged the suffering of the family, but suggested that they were struck by the resiliency in how they have coped with the two losses. They reinforced an idea that had been offered by Suzanne in the session about grief not only being about saying good-bye, but also saying hello. The supervisor of the team specifically offered, in addressing Amy's one-question-question, that she did have hope for this family.

Supervisor: I sense a very strong family and am very hopeful for them. There will always be sorrow but I have a lot of hope for them as a family for a better future.

Following the reflecting team, Amy commented that she really liked it. *"They thought we were strong, it was amazing".* What stood out for Christine was the metaphor of saying good-bye, saying hello, and that it was encouraging to hear that the team had hope for their family. *"In my heart I believe that we are on the right track, but I want to do this better. I feel like we've been doing this alone for so long, it's so nice to be able to share"*. Ryan suggested that listening to a whole group of people reaffirmed the things that they had been talking about as a family. A copy of White's *Saying Hullo Again* (1989) article was given to the family, and Christine suggested it would be good homework for her to think about how she was saying hello and saying goodbye.

Postsession. The team commented on the noticeable shift in affect in Amy following the reflecting team – from that of not wanting to participate, to believing it was amazing. It was suggested that perhaps the family needed to have it acknowledged that there will always be sorrow, but they seemed to hear hopefulness in being able to go on. While the focus of the first session is typically engagement, and removing obstacles to change, the team also identified two beliefs that were challenged. The first was about grief meaning one had to say good-bye only, and the second was around Christine's belief that she was not there for her children. When the clinician uncovered this belief of Christine's, Amy and Ryan were quick to tell her that she had been there for them, statements and claims that the clinician encouraged and mined. One obstacle to change that the clinician removed was her careful engagement and negotiation with Amy to stay and participate in the session, but to participate in determining what the topic and pacing of the conversation would be.

Session Two

Ryan reported being surprised at how well the previous session had gone.

> *I didn't know what to expect, I've never been in counselling, so what are they going to ask, and will I be able to talk about a lot of this stuff, be brutally honest,*

> *or not be able to say exactly what we feel...but didn't think twice about it in here.*

Amy explained how while she was still not a big fan of "this", that it was still good and beneficial, although nothing in particular stood out for her from the last session. She negotiated with Suzanne to stay for this session, to see how it went, however she wanted the option to "take off for a bit" if she needed to.

Christine believed that a lot of good things had happened in the last session. She described how the article *Saying Hullo Again* (White, 1989) was very helpful and made her think about her relationship with her husband, and how she may want to continue it. She also believed that this was applicable to her relationship with Amy and Ryan, stating, *"I tend to have either/or relationships with them, and I'm starting to think that it's more about saying hello to them as adults. I'm starting to appreciate them more as adults."*

Christine further reported that, although her children had told her before that she was always available to them and she should not feel guilty about this, for some reason *she heard them say it during the last session.* When asked why she believed it was that she was able to hear it, Christine replied: *"Maybe because I wasn't alone having to hold us all together. I could just be me in a session...I don't have to be in charge, I can just be me."* In further exploration Christine, who was a nurse herself, stated that the previous session had restored her faith in nursing, and given her encouragement that her family could have hope.

Ryan further explained how he was starting to realize that he *could* continue to enjoy things in life, even with these losses. "*It's a new normal. It's not moving on, but* *having things to look forward to again, that not everything's going to be downhill."* Amy, however, reported that her sadness had been replaced with a lot of anger.

> *I sometimes don't think that I can handle all this. It feels like a breakdown, that I'm coming apart at my seams. I used to believe that life had hope, but I'm having a hard time. It's been a long time since I've felt that it was going to be okay.*

She continued, talking about how her mother has been able to support her in this.

> *The most useful thing she [Christine] said to me was, that God knows, he knew me before I was ever born, and although I don't understand, and that it hurts really bad, that he's going to take care of me, because I can't. I don't have a lot of hope here in this world...if he has a plan for me I just have to hang on.*

The remainder of this session focused on Amy telling the narrative of her father's death. This gave an opening for some further discussion about Amy's spiritual beliefs as she interpreted events around her father's death. This also uncovered her belief that all relationships have horrible endings and that she believes that she sabotages relationships. These beliefs were challenged by her brother, Ryan, who explained how he had a different perspective of Amy in relationships, and that she need not *"invent all these hypothetical what-if's."* Another significant aspect of this session was the conversation with Suzanne and Amy about her distinctions between secrets and privacy.

Reflecting team. The team noted that Amy seemed to be a very spiritual person who did not appear bitter. They discussed how different people grieve differently, that this family had a lot of respect for each other's way of grieving, and that for Amy, sometimes silence, and not talking was helpful. The team also commented on the strong presence of Duane in the room during the session. Following the reflecting team, Amy thought that there was too much focus on her, but overall the family thought there were some very positive, strong comments made.

Postsession. The team discussed how the session seemed to focus on the facilitating belief of Christine that she was saying hello to the now adult children in her life. Of significance in this session, was how she was able to hear her children when she was not holding it all together for them. Furthermore, the family's strong facilitating beliefs around spirituality and religion were uncovered, significantly with Amy. The clinical team believed that this was a useful session and a therapeutic letter was sent.

Session Three

In the presession, the team hypothesized that Christine seemed to be benefiting the most from the sessions, whereas Amy seemed to be the least eager to participate, and it was unclear how Ryan had benefited. Amy did not believe this type of work was a fit for her, and had mentioned in the last session that she did not want to be the focus of the conversations. It was discussed how each of the family members seemed to be struggling and dealing with things differently. Suzanne introduced the idea of possibly doing an internalized other interview with Amy. "The idea of an internalized other interview is that each person carries within themselves memories of another that shape our lives" (McCleod, 2003, p. 144). Suzanne explained this type of an interview to be a way to create a spiritual connection with their father Duane. She thought that it may be useful to interview Amy as her internalized father as it may be healing for her. This was offered as one idea for the session, and Suzanne was to determine in the session, depending on Amy's engagement, if she was willing to do this. Suzanne explained that people often hold internalized versions of loved one's within themselves, and that through interviewing Amy as her internalized father, she may find it healing to experience that connection, and to think about how her father would respond. She planned to ask questions to Amy's internalized "Duane". While frequently used in couple's work, Suzanne had an experience of using this intervention with a bereaved mother who had found it very healing for the guilt she was holding around her son's death, and wondered if it might allow Amy to feel connected to her father.

In the session, Suzanne introduced the idea of an internalized other interview, and explained to the family how it would work. While initially Suzanne had thought that it may be useful to do this type of an interview with Amy, Ryan was eager and volunteered to be interviewed as his internalized father, Duane. Suzanne addressed the questions to Ryan, using Duane's name.

> *Suzanne: And just so we can get kind of practiced, I'll ask you some easy questions too. Okay, Duane, do you remember the day that Ryan was born?*
>
> *Ryan (answering as the internalized "Duane"): Of course.*
>
> *Suzanne: And what was that day like for you?*
>
> *"Duane": It was the first son being born so it was something I'm never going to forget.*
>
> *Suzanne: What kind of young boy was Ryan?*
>
> *"Duane": He was, you know he was human, he wasn't a perfect son, but as a young boy he was exactly what I expected. He was into the same things, he reminded me a lot of me when I was young.*
>
> *Suzanne: And what was the greatest joy throughout his whole life that Ryan brought you?*

"Duane": I think the greatest joy would have been that I had such a positive influence on someone, on somebody, from such a young age, and such a close relationships whether it be through sports, or just from a father to a son. (Christine begins crying).

Suzanne: Duane, do you think that your son loved you?

"Duane": Yes.

Suzanne: And did you love him?

"Duane": Very much, and he knew that.

Suzanne: And how do you think Ryan is doing now?

"Duane": Well he's got his struggles and he's got stuff that he's dealing with, but he's doing well. He's working in the business and he's making a name for himself. He was probably hired on my name, but he's making a name for himself, he's growing up.

Suzanne: And what do you think Ryan most gives to his Mom and his sister now?

"Duane": The same kind of nature as when he was a kid - a tender, caring, compassionate nature, worrying about how everyone else is doing. And that's the way I was with Christine, and that's the way he his with her. It's not the same kind of relationship as a husband and wife, but it's the same comforting, dependable day to day relationship.

Suzanne: Duane do you experience that as a gift that he continues to give you?

"Duane": Yes, I see him turning out like me, which is what he wants.

Suzanne: What other gifts does he give you Duane?

"Duane": Just joy that although he's influenced by me, he's still his own person.

And he's still, he's not just a little Duane walking around. He does things differently than I would have done them, the results may be a bit different, just the joy that he's growing into a man that I knew he would be from when he was little.

Suzanne: Do you think that Ryan has anything to say to you that he hasn't had the chance to say?

"Duane": I don't think so, 'cause although he hasn't said it I know I already know it. I already know it because he tells me all the time.

Suzanne: Do you mind me asking, Duane, what that is?

"Duane": Just that he loves me very much and he wishes he could have worked with me, gone into business together, shared a family and you know all the experiences that a man goes through. Whether it be marriage, and children, and stuff like that. But I'm going to be there with him experiencing it the whole time. It won't be person to person, face to face, but I play a big part in his life now, I played a big part in his life in the past, and I will see him again soon.

Suzanne: And Duane, is there anything that you needed to say to Ryan?

"Duane": You guys are going to be okay and you're doing a good job.

Suzanne: Are you proud of him?

"Duane": Very much, I miss him very much.

Suzanne: And Duane, help me out here, do you think there's any other question that would be helpful for me to ask? Or to your family?

"Duane": How's John doing? (Ryan becomes tearful)

Suzanne: And in what ways do you think Ryan might be hurting around that?

> *"Duane": He misses his brother. They were together from the time they were little, and he misses their relationship.*
>
> *Suzanne: And is there anything that you could say that would offer comfort aroundthat hurt for Ryan?*
>
> *"Duane": That his brother loves him very much, and though it will be different, when they're together it's going to be the same (Ryan begins crying).*
>
> *Suzanne: Is there any other question that you wanted me to ask you Duane?*
>
> *"Duane": No. No just for Christine and Amy to know that I love them very, very, very much. That I'm very proud of them and that they're going to be okay, they are okay, and that I haven't forgot about them.*

Ryan described this exercise as being quite hard. Suzanne commented that she was impressed with how quickly Ryan was able to answer the questions as his internalized father. Christine and Amy were present for this intervention, and were both teary throughout the exercise. They agreed they could see Duane responding in the same way that Ryan did. Christine stated *"It reminded me so much of Duane and how much Ryan and Duane are alike. And what a privilege it was just for the moment to be party to their private conversation."*

Reflecting team. The team offered a commendation about how well this family has lived to be able to have said a lot of things that needed to be said to each other. One team member commented *"they did it right, it taught me a lot about that, make sure we're saying the things we need to say."* The team validated that it was okay for the family to feel sad at times, as it was a sad thing, but at the same time they were able to talk about the good things that were going on and what they were looking forward to.

One team member wondered out loud if they should be worried about Ryan, as he had had less *"air time"* than either Amy or Christine.

When the family returned from listening to the reflecting team. Amy quickly responded to the team's worry about Ryan stating that the clinical team did not need to be worried about Ryan, that he was fine. In further exploration of the reflecting team and closing of this session, Amy commented that the sessions at the FNU had facilitated them in reaching out to each other, and that was very beneficial. Ryan thanked the clinical team for the opportunity to come talk together as a family, as he always felt more positive leaving the sessions, even though they were tough and draining. Christine thanked the team for their comments, and to Suzanne for being so sensitive and so kind, *"it's been so healing. And I think it should be our last session. That's my sense."*

Suzanne reviewed the clinical work to discuss the most powerful parts of the sessions for the family. Ryan stated that it was the internalized other interview. Christine commented that she liked how the team and Suzanne were respectful of different people's beliefs, did not have an agenda, and were curious.

Postsession. The team reviewed the clinical work of the current session and overall, commenting that this last session had taken an unexpected twist with Ryan wanting to do the internalized other interview. Suzanne, in reflection on the session, stated that while the session did take a different direction, that it felt like a good swing, as she did not think Amy could have done the internalized other interview. In the session, Ryan had shown the most interest, and that had given Suzanne the sense that it would be the right thing to do to interview him as his internalized father. Amy and Christine did not need to also be interviewed in this manner, Suzanne thought, as they still were present and participated in the internalized interview with Ryan. Suzanne commented that *"sometimes you stumble into what you're supposed to do."*

The overall changes that were noticed by the team were Amy's shift to believing that rather than her crying meaning she was falling apart, that it was okay to "be" with the sadness and crying. The work also affirmed what the family was feeling and had facilitated them talking with each other in a way that they otherwise may not have. Spirituality seemed particularly important to this family in their understanding of the loss and their grief. It was hypothesized that Amy was currently suffering the most, and that Christine was the most relieved in her suffering. The family had given the clinical team a card with a brief note in it, which expressed their thankfulness as it allowed *"us to reflect on our very solid foundation as a family, and the fresh courage of this awareness is helping us build again*". A closing letter was sent to this family after this last session.

Suzanne's Observer Perspective

Upon the conclusion of the clinical work, Suzanne reported her reflections in what is called an "observer perspective" form. She reported that the presenting "problem" for this family was better, and that the thinking about the problem had changed a great deal. She wrote *"the family's suffering involving their beliefs about grief and how one should experience grief, those were significantly challenged and made room for beliefs that did not produce suffering, but offered some peace and healing."* She further commented that, as a whole, the family seemed more able to talk about their experiences of grief in a way that made room for good memories and even some celebration, rather than only suffering. The siblings continued to be supportive but direct with each other – which was likely no change from their previous behaviour. Christine was very open about the fact she was suffering less, and Suzanne attributed this to her spiritual beliefs and the incorporation of the belief that grief is not only about saying goodbye, but also hello. *"Christine was taking up her life again personally and professionally in a way that she and her children recognized."*

In regards to Amy, she was more hopeful about her future, she was reassured that she was doing well, and although she repeatedly said she was not able to talk like this, she had been very thoughtful, reflective and open in conversations. Furthermore, Amy was able to weather feeling pain and crying and recognize that she was okay. With Ryan, Suzanne believed she addressed his sense of loss for both his father and brother, and his strength in recognizing that there is hope and happiness in store for him.

Outcome Study

This family was the only one of the original seven families identified who had an outcome study completed. While it was standard practice in the FNU to complete outcome studies on all families 6-12 months following the conclusion of the clinical work, this was the only family who could be located and was willing to do the outcome study. Christine stated in the outcome study that the most helpful thing was being heard, and she experienced a tremendous amount of empathy. *"At no time was there a sense that we were doing things wrong."* Ryan stated the comments from the reflecting team were the most helpful, while Amy stated it was the objective way of looking at the trauma that was helpful. The family commented that Suzanne was curious, caring, genuinely interested, made them feel safe, did not put an act on, and was a very warm person. The family agreed that Suzanne never pushed an agenda, wanted to know what was important to them, and was very client centred. Christine still recalled a comment from the reflecting team *"I can't think of a family for which I'm more hopeful,"* this has stayed with her and she stated she would always remember it.

Initial Analysis of Sessions

During the sessions and as evidenced in the outcome study, Christine was deemed to be the one who most benefited from the sessions. While Amy and Ryan reported some changes, and the clinical team observed changes in these two family members, their initial apprehension to attend the sessions is of interest. While arguments have been made to have a family focus in grief counselling, the way in which one engages the entire family is a careful and particular practice. Although they did not report it being as helpful for them as it was for their mother, it would not have been as helpful for their mother if they had not attended. The team and Suzanne specifically, were able to recognize and acknowledge that they were all grieving differently, and still manage to keep the attendance of all three of them for the entirety of the work. This is in spite of Amy stating that counselling was "*not her thing*" in the first session, and wondering if she was going to be able to stay during the second session.

The sessions did allow them to have conversations that they may not have otherwise had, and also allowed Christine to hear something differently from her children because she was no longer "*the one having to hold everything together.*" This clinical work would have been much different if it would have been only Christine attending, with a more individual focus of the work. While it may have seemed that Christine benefited the most from this work, the future impact that this would have then also had on Amy and Ryan can not be underestimated. In the long term, the children may have benefited as their worry for their mom was reduced, and perhaps this freed Christine to be supportive and positive to them in different ways over time.

Research Interview: Family

Amy and Ryan declined to be interviewed as participants for this research project, thus only Christine was interviewed, 10 years after the clinical work, approximately 11 and 12 years after the deaths of her husband and son respectively. Christine stated that Amy and Ryan *"just wanted to leave it alone"* when asked about them not wanting to participate in the research interview. What most stood out in this interview was the detail that Christine could recall about the clinical work. She clearly stated that there were a few aspects of the FNU sessions that stood out for her.

> *Christine: I would have to say that what…there's three things that stood out. One was not a thing - it was Suzanne. You know, she was so present in our pain. I don't know how else to describe it. But she was so present, she was with us. And that in itself was so healing, was so validating. And then the interview with Ryan, where Ryan was asked the questions you know, what would he ask his Dad, what would he say to his Dad. That has stayed with me, how his eyes just teared up, and asked about John, his brother. That spoke volumes to me, about the depth of his pain.*
>
> *Interviewer: So the questions that Suzanne asked Ryan about…*
>
> *Christine: Yeah, yeah, and also how she was so accepting of Amy. Amy was going through a little stage where she was rebellious. She was expressing her pain the best way she could. Suzanne was so wonderful with that. And uh, then [the*

> *supervisor], I remember her saying in one of the reflective times that she couldn't think of a family for which she had more hope.*
>
> *Interviewer: Oh, okay.*
>
> *Christine: And that was again, so healing and hopeful.*

In further exploration of what made a difference to her family during the sessions, Christine offered several things. She thought Suzanne and the clinical team acknowledged them as a family, recognized that relationships go on forever, and deeply accepted how the family felt about the two members who had died. She reported feeling confidence in Suzanne and the clinical supervisor, and that they were looking after her. Christine thought the sessions at the FNU had made all the difference to her family.

Research Interview: Suzanne

This family was well remembered by Suzanne. As part of the consent process when families attend the FNU, they are asked if they will agree to allow their session videotapes and records to be used for research as well as teaching purposes. Fortunately this family agreed to this, and Suzanne has been using this in various arenas for teaching of nurses about working with families. Thus, the clinical work was very familiar to her. She also had an opportunity to review the interview with the family prior to our interview. She described this as good clinical work for many reasons, but stated that the bottom line was *"that we just clicked as people, there was a relationship that was formed and sort of a recognition of each other and mutual respect right from the beginning."*

Suzanne described several factors that she thought contributed to the shift in the families thinking that contributed to an alleviation of suffering. A part of it was her background, experience, and interest in the topic of grief. Other significant aspects were the internalized other interview that was done with Ryan, and the offering of hope to the family. Suzanne thought the idea of continuing a relationship, of not only saying goodbye, was what made a huge difference to Christine in her grief. While both Suzanne and Christine commented on the aspect of self and personal characteristics as a component of the clinical work, this was more than a part of her therapeutic intent; it was a genuine, authentic stance in the work.

While some of the stance of being curious and present can be taught, Suzanne thought perhaps some of it is in your "bone marrow". *"It's just about who you are as a person."* It was also helpful that Suzanne, in particular, had a strong interest, and therefore curiosity about grief, and was also open to being taught around it. *"I think that they sensed competence too. It wasn't just that I was warm and nice and present."* Suzanne thought perhaps there was a boldness in the discussion - in particular her work around engaging Amy, keeping her in the session, and then talking to her about her beliefs around secrets and privacy. She thought this was more than being nice it was *"about having the intuition and the therapeutic savvy to take someone somewhere else, to move them along. They're really intentional interventive questions."*

One of these intentional interventive questions was about Christine's belief that she was not present for her children. While the clinician wanted to challenge this belief, it was from her children that she thought Christine most needed to hear this. Yet, while she thought that her children were probably the only ones who could convince her that she had been present for them, it was interesting that Christine said the only reason she *heard* it from them this time was because in the sessions she did not have to be the one holding it all together, that responsibility was part of Suzanne's role. *"I think there was a freeing* *of some of that responsibility of okay somebody else is going to guide the conversation, somebody else is going to take it...I can indulge myself in what I'm feeling."*

Suzanne also recalled the internalized other interview that was done in the last session. She described how she thought it would be a fit for this family, and how she interpreted their responses to it.

> *I remember quite intentionally going into that third session because I felt the Dad's presence so much in the second session because they were talking so much about him, and I was learning so much more about him, that's when I came up with the idea that I'd like to do an internalized other interview of him, because I thought that he would have things to say, the internalized him, would have things to say to his family that would be helpful...it sort of fell out that Ryan was the most intrigued with the idea. And then it got so intense with just asking him questions that it didn't need to be, it shouldn't have been, anybody else. There was quite an emotional release for Amy during that time, just in missing her dad, and seeing him so present. But it was also, and Christine was also really emotional too, but it was also for her about, like I think, she said, sort of giving this window into Ryan, she said Ryan's so busy taking care of other people that it's a real privilege to get a glimpse at his private conversations.*

The family usually responded and appreciated the comments made by the supervisor, in the reflecting teams, which Suzanne interpreted as being reflective of not only the power of the comments that were made, but also about the experience of the people who were offering the comments. She thought that this family in particular had a lot of emotional, psychological, and spiritual sophistication and that the same interventions and conversations may not have been a fit or worked as well with another family. There was one comment made in the reflecting team of the third session that Suzanne recalled all the family members "stiffened at". Having noticed this however, she was then able to address it when she returned after the reflecting team.

> *Suzanne: I think she [Christine] felt a real respect for [the supervisor]...and knew of her reputation. And they were really good reflecting teams for one thing; [the supervisor] was the most active in them, more than the students. So I don't think, if I recall, there weren't any student comments that really stood out for the family. There were a couple that pissed Amy off, I remember. I remember there were a couple of comments made in the reflecting team something about Ryan, something Amy took as being a little insulting toward Ryan, and she got a little defensive after. And then I remember even saying, well, that I wanted to reassure her, after the reflecting team, I said that I didn't see Ryan as [that]...oh I know, "I'm worried about Ryan because he hasn't said a lot"...*
>
> *Interviewer: Yes, I think that was the student comment.*
>
> *Suzanne: Yes...and I guess because I had been behind the mirror with the family, they had all sort of stiffened at that comment. And so that's why I made the comment when I came back 'and I just want to say that I'm not worried about Ryan'. Because I think the word worry, I think, you know...worried about means there's something really wrong, and it suggests a pathology, that there's something more going on.*

Further into the interview, there was a discussion about the different formats of counselling around grief, and some of the differences around group work, individual work, and family work, and when each of these may be appropriate or useful. Suzanne commented that sometimes what needs to be done is *"to rebuild a sense of family,"* and that would be difficult to do individually. What Suzanne took away for herself was that this type of work, seeing families around grief, is important. *"This work [is] really, really important, and you have to do it...you* can *do this kind of work, you can do interventions with family around grief in a short period of time."*

Analysis: The House of Loss, Grief, and Life

> *It's like a house, when someone dies all the top gets taken off. The foundation is still there, Dad and John are still there in the foundation, but all the physical manifestations are gone. That would be helpful to devise plans of ways that we can be in touch still. (Amy)*

The experience of grief with this family was not inherently an individual one. They came as a family to the FNU, found help in the conversations with Suzanne, and also had spiritual beliefs that helped them with their suffering and their healing. The therapeutic conversation brought out many witnesses to this family's grief journey, in a relational and spiritual context. How does a clinician skilfully go about negotiating the attendance and participation of family members who may all be having very different experiences in their own grief, and also very different ideas about what might be helpful? For Christine, the bottom line for the usefulness of the clinical work was the importance of the relationship with Suzanne. "The therapist was everything. Absolute therapeutic use of self." There were several ways in which Suzanne worked with this family to carefully and skilfully manage these concerns.

Eras and epochs of falling apart and rebuilding. Timing was significant as Christine believed that it was time to come to counselling, Ryan believed that perhaps it was too soon, and Amy believed that perhaps, for her, there was never a good time to do counselling.

> *Christine: I'd been having chest pain and went into the ER…I probably have unresolved stuff that would be helpful, and give the kids a chance to talk. Maybe it's time.*
>
> *Amy: I'm not a big fan of counselling, I don't feel ready to do this. I've got a lot going on in my life, and don't need to come apart…I'm trying to be co-operative, so I'm going to try it once and hope I can stay the whole time.*
>
> *Ryan: I thought it might be a bit soon…might be a little too fresh for me, but I knew that down the line it was something that I needed to deal with, because I couldn't keep it all inside…I thought that it would really be a benefit for all of us, especially for Mom.*
>
> *Suzanne: Well I find it quite impressive that both of you would do that, in part for yourself but also for your mom.*

In the first session, Suzanne explored with each of them their reasons for coming. She offered a commendation that acknowledged Amy and Ryan's reluctance, and reframed the session's purpose as being about them coming together out of respect for their mother. At this time then, there was a sense that it was okay for her to proceed. Suzanne had acknowledged some reluctance and concern, but framed it in a way that made it okay for the entire family to stay for the session.

Time and timing are prevalent topics in grief – that there is a "time" that this type of work should or should not be done that would somehow optimize it, or even that the nature of healing in grief has to do with time. When Christine stated it was "time" to do this work, or Ryan thought it was not maybe the right "time" to do this work, and Amy thought there was never a "time" to do this work, what does time allow for, or not, in grief? It has been argued, by several philosophers, that the consciousness of time is the most fundamental level of consciousness (Vessey, 2007). Perhaps no where else but in death and grief, are humans so aware of the temporal nature of life, and thus it would make sense that time is significant to grief. In much of the grief literature, there are prescriptive ideas about *when* counselling should be done, and *when* suffering and "symptoms" of grief should no longer exist. While the timing of interventions may very well be significant, there is a different sense of time. Gadamer made a distinction about time as the scientific, clockwork, "empty" time (Jardine, 2008; Vessey) and the content of things that occur in that temporal space (Jardine), or the experience of an era or epoch (Vessey). "Empty time fragments things, cuts their bloodlines and reduces their multifariousness to singularity – the singular voice of empty, levelling, measurable surveillance" (Jardine, 2008, p. 9).

The measurement of time has somehow become separated from the phenomenon that occurs in temporal eras (Vessey, 2007). Vessey argued that these temporal eras are "not only historical epochs, but personal epochs as well. Our lives are lived epochally – we live through stages and periods marked by often clear transitions such as the birth or death of a loved one" (p. 3). An epochal period is recognized when something that was the case is no longer so (Vessey). In the experience of death of a loved one, it is not the mechanical, empty, clockwork time that is important or significant; it is the recognition of the change of what used to be the case, and the experience of now living with an acute sense of our temporality of being. Whether or not it is the right "time" to go to counselling or to provide interventions has almost solely been taken up as this clockwork, empty time when time and grief are associated to each other through general descriptors such as 6 weeks or 1 year. This has influenced how professionals then determine if it is the "time" to do grief work.

What would happen if, rather than being concerned with clockwork, mechanical time that has passed, the "timing" of intervention was based on the content and the lived experience of what has occurred obviously, but not most importantly, over a temporal period? The timing of interventions should then have to do more with the experience of the family, of what has gone on with them in that time, as an era or an epoch, rather than as the passing of time on a clock or calendar. As health care professionals then, we would not get to say if the timing was right according to our own mechanical, clockwork, empty time, but rather could focus on timing in terms of what had filled that time, and what was filling the family's time now. Knowing their experience of this particular era would be more helpful in determining if it was "time" to do this work.

The witnesses of home. In the first session, Christine talked about John's death and her feelings of responsibility around it. This again raised Amy's resistance to participating in the sessions and wanting to leave, and Ryan also brought up his concerns.

Amy: I'm worried about getting into all of this stuff today. Like maybe it's too much.

Suzanne: It's too much with the crying?

Amy: It's not even that, I'm finding this really difficult to get into all this.

Suzanne: Well we certainly want to respect your wisdom about this.

Ryan: It's hard to set a pace for all this.

Amy: It's hard for me to start talking about this.

Ryan: I know it's hard for you but it's hard to set a pace. Like you came in here with the mindset that you didn't want to get into anything too serious too soon but look where the conversation...

Amy: Like I'm just saying I can't handle this right now. Maybe...I could leave.

Suzanne: Well, there's a couple of ways we could approach that Amy. I mean, yes, if other people, your mom and Ryan wanted to continue and you were uncomfortable you could leave. Or they may be agreeing with you about the pace; that they want to go a different route and talk about something else and maybe you could guide us as to what you think would be most helpful to your family right now. So I mean, what's your sense about that, Christine, what do you think?

Rather than continuing to pursue a particular direction in the session, Suzanne stopped and checked in with the family, respecting and balancing each of their expertise as to what would be the best way to proceed. Suzanne and Amy continued to talk about the difficulty for her in being in the session, and following a phone-in from the clinical team, Suzanne asked to clarify Amy's belief about change. Interestingly, in the uncovering of her beliefs about change, her brother and mother were able to *challenge* this belief, and Amy was able to stay for the remainder of the session.

Suzanne: Are...you the kind of person that believes that growth and change or dealing with things or working them out comes from sort of immersing yourself in

> *a situation? Sort of staying and seeing it through, working it out? Or are you the kind of person that believes that more growth and change comes from leaving and dealing with it on your own?*
>
> *Amy: I would say I'm more like the second; that change is very difficult for me and I have to kind of ease myself into it. If I was to just go into that change right away I would fall apart, is that not right (to her Mom and brother)? I have a really difficult time.*
>
> *Christine: I know that's your* belief.
>
> *Ryan: That's* your *belief.*

Christine and Ryan then provide examples of when Amy *had* been able to embrace change, and not fall apart. For instance, she was able to speak at her father's funeral, and they reminded Amy that *"you're the one who gets through all these things."* How this conversation lead to Amy being able to stay for the remainder of the conversation is perhaps around the clinician engaging her further, and perhaps removing an obstacle to change. It sheds some light on an interesting and useful avenue for uncovering and challenging a person's beliefs – when the people who know them best in the world can offer evidence to the contrary.

As previously mentioned, Suzanne discovered that Christine believed she was not emotionally available to her children. During the research interview, Suzanne recalled this particular aspect of the conversation.

> *Suzanne: I didn't buy for a minute that Christine, just the way she was, was not available to anybody. And so, you know, I had already formulated in my own mind a belief, and I suspected that I could get the kids to corroborate that belief,*

> *that she* was *present. And so, my intention really was to challenge that belief, and I couldn't just say to her 'you strike me as someone who would be very present'. That wouldn't hold a lot of credence; I didn't know her. So I thought that the only portal to that would be through the real witnesses of that, which would be her children...It was much more of 'I suspect they are the ones that can convince her of this'.*

Suzanne saw that there was a portal, or a way in, to challenge Christine's belief, through her children, as they were able to bring in evidence of Christine being present for them. It is interesting that the people that know each other the best (i.e. family members) are likely the ones to have the evidence and experience of a person to generate a different view than what they may have of themselves. A witness is someone who brings evidence and has personal knowledge of something (Merriam-Webster's Collegiate Dictionary, 2003). The Old English root of witness means the "attestation of fact, event, etc., from personal knowledge; originally knowledge, wit" (Harper, 2001).

What do witnesses do in therapy? What is the purpose of them, and how is a witness relevant in grief? We need witnesses to attest to the stories and experiences of life. They often provide either different or multiple views or lenses of events. It is not so much about inviting witnesses to make sure that we "got it right", but rather to expand on understanding of the situation and the experience. In other words, unlike the use of witnesses in legal testimony, the purpose is not to narrow in on the one, singular truth, but rather to perhaps generate multiple alternatives to how the experience is interpreted and thus understood. In this way, witnesses, whether they are family members or the therapist, expand on the understanding or possibilities of the understanding. Witness is described in psychoanalytical literature in relation to the "authentic movement" (Adler, 1999), describing the different roles of the therapist and the client. However, witnesses in this therapeutic work were also the family members.

How would it make a difference to have witnesses versus not having witnesses? In other words, how does it make a difference to have multiple family members present, rather than having an individual focus? It seems that, in this clinical work, the witnesses had a role that was more than simply observing; it was more than having another being to observe an experience or to listen to a story; it seemed to be about the witnesses bringing different understanding that allowed for healing. The witnesses invited different beliefs into the conversation. In thinking of the metaphor of a house in grief work, the witnesses in the room may have been standing on different sides of various walls. While they are all seeing the house, they have different views, and are offering different support. The family members within the house can be useful in offering a different sense of things, rather than only the therapist, as someone external to the family.

Bracing and unburdening. Walter (1996) pondered if processing grief was more of a social process than an internal process and commented that trends in families do affect grief - specifically, that "those who knew the dead person are often physically separated from one another. Families are spread around the country if not the world" (p. 16). He further stated that perhaps this is why people turn to counsellors who, obviously, have no knowledge of the dead person to share with the family, and thus a counsellor may be a poor substitute to aid in the grief process. Further, he suggested that in the absence of someone else who knew the bereaved, a sympathetic listener, such as a counsellor, is often sought. This does support the concept of seeing family members together in counselling, as they obviously know the dead person and can talk about them with familiarity. There is, however, something more that helps explain the important and significant role that a professional may have - someone who has no previous knowledge of the person. At the beginning of the second session, when Christine returns and claims that she no longer feels any guilt around not being available for her children, Suzanne asks why it was that she was able to hear them say that she was available in the session, when she had not been able to hear it when they told her before. She responded:

> *Maybe because I wasn't alone having to hold us all together. I could just be me in a session...I don't have to be in charge, I can just be me.*

In the research interview, Suzanne offered further reflection on this shift of beliefs, about what it might mean to "hold up" someone or something.

> *I think maybe there was a freeing of some of that responsibility of 'okay somebody else is going to guide the conversation, somebody else is going to take it, I don't have to be, I can indulge myself in what I'm feeling'...There had to be some level of trust then that she would know that I would be able to pick up the kids if we went somewhere where they couldn't.*

Christine was also asked in the research interview, why it was that it was helpful to talk to a professional as opposed to having conversations with family and friends.

> *Christine: I felt no real emotional burden that I had to protect anybody, or that I had to be any particular way, you know, I just could really be me. Which I realize that now, over the years...this was very special, you know, because there's not, I can't think of a whole lot of situations where I can totally just be me.*
>
> *Interviewer: So in the FNU that setting was created?*

> *Christine: Yeah. They were looking after me, Suzanne was really looking after Ryan and Amy and I could sort of let that go.*

This is significant in a family where Christine now found herself to be the sole parent and was faced with helping her children with the death of their brother and their father, and also wondering how she was going to help them transition into adulthood. At this time, she did not need someone who knew her husband and her son with whom to commiserate. She needed exactly the opposite, someone who had no relationship with the family, so that she would not need to worry about also caring for them. She needed someone to help brace her and the children so, for even a moment, she could not be the only brace holding up their house. With the temporary relief of this burden she was able to hear what had been said to her before.

In the outcome study, when asked what he recalled from the sessions, Ryan stated:

> *Ryan: Amy and I let her [Mom] know, through the questions that were asked, that we were really proud of her.*
>
> *Christine: Absolutely, I felt like we were really a team.*

It is likely that Ryan and Amy were proud of their mother before the sessions at the FNU. Perhaps this type of therapeutic conversation allowed for a place for them to say it, or allowed for a place where Christine could hear it. The facilitation of the conversation, whether it is in the questions that were asked, or in the confidence that someone else was holding things together, allowed this family to hear one another, and believe it.

These reflections about the usefulness of the clinical work point out something significant - that the shift in beliefs and the family finding some healing would likely never have been *possible* if the family members were not seen together in the sessions, nor would they have been possible without the presence of Suzanne, a professional, being involved in the conversation. All of these people needed to be present, but it was more than just bringing evidence into the conversation, it was what Suzanne and the family created out of this evidence, through conversation, that enabled healing. It was the additional reinforcements that were offered that contributed to an alleviation of suffering.

While I believe that family work *can* be done with only one family member, the significant impact of this clinical work would have been diminished had all three family members not been present at the sessions. Suzanne shared in the research interview that what was reinforced for her, in working with this family, is:

> *This work was very important and you have to do it. But I already knew that...I guess it's just a confirmation of that, makes you more convinced that you* can *do this kind of work, that you* can *do interventions with family around grief in a short period of time...This is a family I would say, that not one of those three would have gotten anything out of a group...This is a family who needed to do this as a family, they needed to have each other as witnesses around it...I believe that grief is individually experienced too...but it affects people at relational levels. So like, for me, family is the exact place that they should be seen. Because I mean, you could see, all that had happened, couldn't have happened without each of them present. Christine wouldn't have been convinced of her emotional availability to John, without having the kids there to reassure her, and me as a witness to that. Amy got all this feedback from her Mom and brother about, you know, trying to*

challenge her ideas that 'I can't handle change'. She also had them as a witness to this.

Families are frequently the most prominent "grief police" (Walter, 2000) and the norms and family dynamics can impose on the bereaved individual in such a way that does not allow them to tell their own story of grief. Walter further offered that if friends, neighbours, and even family members are not willing to listen to the stories of the bereaved, then mourners turning to counsellors seem logical. This may hold true if grief was viewed as an internal experience, and grief counselling as an individual process. With this particular family, however, Suzanne utilized the presence of multiple family members and herself to reduce the family's suffering. It became about the relationships between the family members, and not only their internal suffering. These relationships provided history and substance with which the nurse worked with to support this family.

Returning to the foundation: Witnesses within. In the third, and what would be the final family session, Suzanne introduced the idea of an internalized other interview (Pare, 2001; Tomm, 1998). During the review of the videotapes of this session, there seemed to be a powerful sacredness to this conversation – in Ryan's quiet, yet confident responses as his internalized Dad, and in Amy and Christine's tears. Suzanne, in the research interview, explained how the conversation came about, and her reasons and sense for pursuing what turned out to be a very useful intervention for the family.

This was a sophisticated intervention that not only invited another family member "into" the room, but also became something of a spiritual encounter. It was a way for the family to be connected to each other, whether they were physically present or not. For Amy, who was quite tearful during this intervention, Suzanne believed it was helpful because it was about *"missing her Dad and seeing him so present."* For Christine, who was very emotional as well, this interview stood out as one of the most powerful parts of the clinical work.

> *Christine: Ryan is not one to share an awful lot on demand...it kind of opened up a window into his soul...Ryan is a very private person, and this was like a window into his soul...It made me realize there was a whole side of Ryan that I didn't know, and that felt like a lonely place for him...It reminded me that Amy and Ryan were their own people, and that apart from what I'm able to do, or not able to do, or provide, that they're okay.*

Popularized with use in couples' therapy, the internalized other interview is believed to be helpful as it creates "mindfulness of multiple meanings", of imagining what it may be like to be the other person (Pare, 2001). In grief, it may be helpful for family members as "it will tell them how well they know their loved one", and may be useful when there is a lot of anger or guilt around the death (B. Glasgow, personal communication, 2006). In this particular case, it allowed the family to experience Ryan in a different way, but also brought the presence of Duane and John.

The usefulness of internalized other interviews has been further described with grief by Moules, Glasgow, and Simonson (2009) in their interview with the Reverend Bob Glasgow, a chaplain and coordinator of a local grief support program.

> A lot of people will talk about believing that their spirit of their loved one is inside of them. Some people have beliefs that they connect with their loved ones visiting them at times on earth after they die, they'll feel their loved ones presence. But there are a lot of people that will speak of their healing process as

> continuing to carry their loved one in their heart. And so this is the kind of language that people use that makes me feel that yes, their loved one is somehow embodied within them and it's, in terms of Christian theology, we believe the holy spirit comes within us and lives within us so there is that concept within spirituality and theology of god spirit dwelling in human form. So I think for many people it makes sense that their loved one's spirit has stayed within them in some fashion. And so sometimes I think the interview might reinforce that sense that their loved one is still within them. (pp. 60-61)

The soul has been thought of as "the spiritual nature of humans, regarded as immortal, separable from the body at death" (dictionary.com, n.d.). In gaining a window into Ryan's soul, were Christine and Amy also aware of the other "souls" that were still accompanying their family? Did the window open to other souls who were very much still a part of their lives? The internalized Duane was yet another witness to this family, offering further explanation and perspective. This perhaps was a reminder to Christine, Amy and Ryan that he still was very much in their foundation in a spiritual way. This thought of a spiritual connection may have been very useful to this family because of their religious beliefs, and their beliefs about the life and connections after death.

While spirit does have etymological roots referring to a supernatural being, it also is related to the breath (Harper, 2001). Internalized other interviews with the bereaved do not necessarily have to be linked only with this essence of spirituality, or religious beliefs. Breath is the essence of life. The absence of breath, the last breath, is death. Spirit and breath are both invisible entities, breath most noticeable in its absence. How does the internalized other interview connect with breath in a way that it can bring healing?

Breathing exchanges the life-sustaining element of oxygen with the toxic element carbon dioxide. Does the internalized other interview also allow for an exchange of "breath" that brings in healing elements, while removing harmful ones? People are generally unaware of their breath, until they are challenged by something that causes need for it to become harder, deeper, or faster. This is similar to how people make sense of their day to day lives as well – generally unaware or contemplating the meaning of it, or making meaning or sense out of it. Perhaps a life event such as a death causes one to "breathe deeper" in how they make meaning of life, or make sense of the death. Initial senselessness might lead to suffering with a metaphorical breathing pattern that is not always useful, such as hyperventilation. Other breathing patterns, such as deep controlled breathing, have wonderful calming physiological effects on the body. Perhaps an internalized other interview may be a useful method to control, slow down, and do some deep breathing and thus be effective at healing, not only the body, but the spirit as well. Perhaps how healing in grief occurs is like breathing, an exchange of restorative elements (beliefs) for the injured ones.

Valid and just. When asked in the research interview what stood out for Christine from the sessions, she listed several particular things. Firstly, Suzanne herself; secondly, how Suzanne was with Amy; thirdly, the interview that was done with Ryan; and lastly, that the clinical team had hope for their family.

> *One was not a thing, it was [Suzanne]. You know [she] was so present in our pain. I don't know how else to describe it. But she was so present, she was with us, and that in itself was so healing, was so validating.*

In the outcome study, Ryan reported "*we got the justification that we were looking for, for someone else to tell us we were still normal and still sane.*"

The root word of validate is valid, which etymologically means to support with force or authority (Harper, 2001). Validating for this family meant going beyond acknowledgement of the family and their experience, but actually supporting their experience, from the stance of someone in authority. This seems to point further to the role of the professional as someone external to the family and their previous social system. Suzanne, in her role as a professional, was able to give acknowledgement and support to the family's beliefs about grief, and this aided in their healing.

Valid means well-grounded or justifiable, or logically correct (Merriam-Webster, 2003). Justified has origins from Justus which means "right law," true, correct, in accordance with the standards (dictionary.com, n.d.). With the policing (Walters, 1996) that seems to occur in our society around grief, it is no wonder that individuals and families likely do often feel that their experiences of grief are not a valid experience – that they are not doing it properly somehow, that it is not logically correct or well-grounded, or perhaps not justified.

It has been claimed that nursing has a history of "learning to love the invalid" (Jardine, 2000), in particular that family nursing:

> Has witness to times when suffering and infirmity creep into the lives of families, and in this witnessing, nurses have the daunting and yet tender task of finding room to accept and love the infirmed, to embrace the invalid, and to care for the family where what was once valid and healthy is now challenged and dis-eased with illness. (p. 193)

Christine, a nurse herself, commented during the sessions that she had her faith in nursing restored because of the sessions. *"It was a very respectful process. And I was just so proud to be a nurse, and to rejoice in the fact that nursing took this on."* This was repeated in the research interview -- that Suzanne had restored Christine's faith in nursing. In her conversations with this family, Suzanne was not looking for the ways in which this family was incomplete, failing or somehow invalid in their grief. She was looking at embracing them, accepting them, and finding room for their experiences of suffering. This perhaps allowed them to feel valid and just, just the way they were.

Curiosity. In the outcome study, Christine explained *"Suzanne was so curious; the curiosity was not intrusive but healing; it was possible to feel safe to hurt in her presence"*. In the research interview, when asked for more detail about how Suzanne, as the person, stood out, Christine replied:

> *Christine: Her demeanour towards us, her very accepting, caring, curious...it was amazing for me.*
>
> *Interviewer: And so what difference do you think that made for you? Her character.*
>
> *Christine: All of it. All the difference you know, in how she really acknowledged how as a family, we didn't believe in this business of saying good-bye, that relationships go on forever, and that she awakened me to the realization that there will be different times when there were opportunities for grieving when I would acutely remember...that those were opportunities for me to again greet them, in the other life...And that we are still a family. So that wasn't just permission, it was a deeper sort of acceptance of how we really feel.*

Curiosity has an etymological history relating it to the Latin word "cura", which means care (Harper, 2001). The contemporary definition of curiosity is "eager to learn or know; inquisitive" (dictionary.com, n.d.), but also historically meant "made or prepared skilfully; done with painstaking accuracy or attention to detail; careful" (dictionary.com, 2008). The curiosity that is useful in clinical work reflects caring and being careful, as well as a willingness to inquire. Gadamer (2004) described the characteristic of curiosity is that it is "drawn away by what it looks at, that it forgets itself entirely in it, and cannot tear itself away from it" (p. 123).

This idea of curiosity is described as a theoretical tenet in the IBM (Wright et al., 1996), meant to invite a non-hierarchical stance and a stance of respecting families' expertise. In this particular family, Suzanne was curious about the family in a respectful and open manner, but the curiosity seemed to be more about Suzanne's expertise, rather than the flattening of a hierarchy. She knew how to approach this topic with inquisitiveness, eagerness, skill, and care.

> *Suzanne (research interview): Did it make a difference that this is a topic that I'm really interested in? Absolutely, it really fuels the curiosity, because as much as I have beliefs about it, I also have curiosity and I want to know more about it, I want to be taught around it too.*

Curiosity did not mean that there was no hierarchy in the expertise, in fact, Suzanne described this way of being in a therapeutic conversation of *having* expertise with the topic of grief, and working with families. It was more about having experience with this topic of grief and working with families that enabled the curiosity around it in a meaningful way. Her curiosity was not about her not knowing anything about the topic of grief, but rather knowing how to approach the conversation with this family, respecting their expertise of their own experience.

> *Suzanne (research interview): There was a relationship that was formed and sort of a recognition of each other and mutual respect right from the beginning. I think some of that is about, at the risk of sounding arrogant, what I bring as a person in terms of who I am as a person, in terms of my clinical experience in my background, in terms of my comfort with the topic of grief, and my interest in the topic of grief, and quite absolutely is my beliefs around grief... I think that they sensed competence too. It wasn't just that I was warm and nice and present, you know, but there was a certain...boldness even, of moving them into particular work...some of that's not just about being present and nice, that's about having the intuition and the therapeutic savvy to take someone somewhere else, to move them along.*

Of further interest is that the "dialectical complement of curiosity is becoming bored and jaded" (Gadamer, 2004, p. 123). To approach something without curiosity, then perhaps means to approach it without care, to see yet another grieving family with boredom. This may occur when the professional believes that this particular case has nothing else new to offer (Jardine, 2006). Thus, it is perhaps not so much about the expertise that a professional holds (their amassed knowledge), but the experience of a therapist that curiosity is a part of. Experience, as defined as Gadamer (2004), means also being open to having things experienced differently. The approach of curiosity is not about the family having an equal amount of expertise as Suzanne, but about Suzanne being open to this family's experience of grief being different than what she has encountered before. Thus, in being open to grief being experienced for this family, demonstrated to the family that Suzanne *cared*, and this made it possible for them to share with her their pain and suffering.

Opening Pandora's box. In the very first session Amy offered: *"Is there hope? Like across the board, is there hope for good times ahead or is it always going to be tainted?"*. In the reflecting team, the supervisor commented: *"I sense a very strong family and am very hopeful for them. There will always be sorrow but I have a lot of hope for them as a family for a better future."*

Suzanne further commented on this notion of hope in the research interview.

> *Suzanne: I'm guided by the belief that families, in their time of greatest despair, need hope...That you've got to believe that things are going to be better than they are now, that there's going to be good times ahead. You know, and you can believe that, without believing that you have to say goodbye.*

Hope is the feeling that what is wanted can be had or that events will turn out for the best (dictionary.com, 2008). Similarly the etymological history of hope meant to wish, expect, or look forward to something (Harper, 2001). In Greek mythology, hope is connected to Pandora's box.

Zeus sent Pandora a box, to play a trick on her husband Prometheus (Graf, 1993) knowing that Pandora's curiosity would result in her opening the box (Grant, 1962). The box contained all the evils, maladies, illness, and sorrow that roam the world (Grant, 1962; Morford & Lenardon, 1977). Differing versions report that either Zeus willed her to close the box (Morford & Lenardon, 1977; Nietzsche, 1986) before hope could escape into the world, or that hope remained in the box "since this, for good or harm, remains within our own control" (Grant, 1962, p.109). Nietzsche interpreted hope as the worst of all evils:

> Now man has the box of good fortune forever in the house and is amazed at the treasure he possesses in it; it stands at his service, he reaches for it when he desires to do so; for he does now know that the box Pandora brought was the box of evil and regards the evil that has remained behind as the greatest piece of good fortune – it is hope. – For what Zeus wanted was that man, though never so tormented by other evils, should nonetheless not throw life away but continue to let himself be tormented. To that end he gives men hope: it is in truth the worst of all evils, because it protracts the torment of men. (p. 45)

In the interpretations of this myth, it is debated whether hope is a curse, or whether it is good. Morford and Lenardon (1977) argued that hope does seem to be the one thing that "enables man to survive the terrors of this life and inspires him with lofty ambition" (p. 49), but it is a curious inclusion in a box full of evils.

Undoubtedly, this family had experienced numerous maladies and a great deal of sorrow in their lives. Amy begins the sessions wondering if there is hope, and if so, how does one obtain it. Indeed, hope is the thing that enables people to carry on with their lives, surviving the terrors. How did Suzanne enable them to find hope? How was it that perhaps it was found in Pandora's box? It is interesting that Amy, throughout the sessions, was worried about "coming apart" or "losing control", perhaps she worried what would happen if Pandora's box was opened in the sessions. At the same time, what she most desired was hope, and perhaps it is in the opening of Pandora's box, in the conversation about fears and suffering, that hope was also found. Perhaps Pandora's box needs to be opened for people to find hope. Hope has been found to be a key ingredient in many successful therapeutic encounters. The family member has to believe that there is hope for things to change, and that someone can help them with this (Hubble et al., 1999). How does a therapist actually go about generating hope?

> *Suzanne (research interview): I would argue that the hope might be generated by doing some other good work. Yes, Christine said that [the supervisor] having hope for them was helpful. But it was the other challenging of constraining beliefs that made the biggest difference for them. I think the help people are hoping for is a relief of their pain, their depth of suffering, as [the supervisor] would say, a softening of suffering. I believed I was helpful to them because Christine said that some of her pain had lifted "I'm a lot more at peace".*

These words seem to speak somewhat to the outcome, and how the family defined how they knew they had been helped. It was because they felt more at peace, and the work of Suzanne and the clinical team had challenged their beliefs in such a way that they were suffering less. In this way, the family was able to believe that they were going to be okay, to hope for things turning out okay, or to be able to look forward to something. This confident hope was articulated by Christine in the research interview, when she asked what was the most helpful thing in helping her family find healing, she stated *"just the real confidence that I felt from Suzanne and the team, that as a family, you're going to be okay."*

Change and hope: Something to cling to. During the research interview, Christine was asked what overall impact she thought the sessions at the FNU had had on her.

> *Interviewer: Out of all the things in your life that have helped you in your grief, or you've felt have been healing, or I'm not sure what you would call it, but out of everything that's kind of happened in your life, how much significance or importance would you place on the work that was done in the FNU, on those conversations that you had with Suzanne?*
>
> *Christine: I would put a big percentage on that set of interventions. I grew up in a very difficult home, my parents were not happy and they were abusive, and I really valued some of the relationships that I had with my teachers. And I remember looking back now, that it could have been maybe, I don't know, maybe something that a teacher said, you know, that stayed with me, and I would sort of cling to that, not really realize it, but I would go on the strength of that for years...and this was that kind of a situation. It came at a critical time, and I would say life changing for me.*

What is it about things that are said that people are able to cling to, that stick with someone over years and years? What is the significance of these things, especially opposed to things that people are not able to recall or remember? How does clinging to this thing sustain someone or sustain change? Theoretically in the IBM, this would be explained by "fit" or structural determinism (Maturana & Varela, 1992). This concept explains how a "perturbation" can cause a system to be altered, but whether or not it is a fit is determined by the structure. When there is a change to the "system", in this case Christine's beliefs, the structure was changed in such a way that it stuck – that she was able to recognize it as significant enough that she could continue to articulate the source of the change for her 10 years later.

In this explanation for sustaining change, something external to the system, such as the nurse's questions and comments, fit with Christine's structure in such a way that it caused a change in her beliefs. This seems to reflect a rather passive process however, and there may be more to this explanation of how ideas are able to change people. To cling means to remain attached, as to an idea, hope or memory (dictionary.com, n.d.), to adhere or hold fast (Harper, 2001). What if sustaining change had not only to do with the ideas fitting for the family member, but also the family member's active work of *hanging on* to the idea, the comment, or the question, and the hope that resulted? What if it was their active searching for something to cling to and also about the nurse offering something worthy enough to grasp? It may matter less that the "perfectly fitting" thing was said to someone, to perturb their structure, and matter more that the person was actually actively seeking out something worthy of embracing. I think this implies that there is more work involved in grief, rather than a passive passing of time or conversation. This work was done by the trust that Suzanne could offer something that would be able to hold Christine up for the last 10 years, and that Christine perhaps had the skill and the savvy to be good at holding onto things. Indeed in the story of Pandora, hope being left in the box was related to people's ability to control the presence of this in their lives.

The sessions seemed to be defined as helpful because the family felt more at peace, and the work of Suzanne and the clinical team had challenged their beliefs in such a way that they were suffering less. In this way, the family was able to believe that they were going to be okay. This confident hope was articulated by Christine in the research interview, when she asked what was the most helpful thing in helping her family find healing, she stated *"just the real confidence that I felt from Suzanne and the team, that as a family, you're going to be okay".* Perhaps it is the hope that was left in Pandora's box that enables people to overcome all the other evils and suffering that had been released into the world. The work of the therapist is then to look for this hope, to recognize what beliefs are preventing hope from being present, and help to challenge them in a way that brings the assurance that they are going to be okay.

Place of objectivity. In the outcome study, each family member was asked what had been most helpful to them.

Christine: At no time was there a sense that we were doing anything wrong.

Ryan: The comments from the team.

Amy: The objective way of looking at trauma.

This further explained the unique role that Suzanne played in the conversations with this family. Objective has etymological roots meaning "considered in relation to its object...meaning impersonal or unbiased" (Harper, 2001). What if objective were to mean looking at an event as a neutral thing, as an object or topic, that only becomes a thing of suffering or trauma as a person makes interpretations about it or attaches meaning to it? The topic of grief, by itself in the world, does not absolutely and only bring suffering - perhaps it has brought a myriad of things to different people at different times. What brings meaning to the topic is the meaning or interpretations that people make of it.

In looking at trauma "objectively", was it that Suzanne did not make any assumptions about how the family had or should interpret these events? Is that what was helpful for Amy? Was it that Suzanne was open in allowing her to explain and explore her own interpretations of the events, uncovering some of her own beliefs? It does not seem that, in this clinical work, being objective meant that Suzanne, as the professional, had the "correct" or "true" version of the events, or the "right" way that the family should feel, think, or be. Rather, she was open to the family's interpretation of events, and was skilled at offering and facilitating more helpful interpretations to come forward.

The word objective is troublesome in some regards. It seems to often imply an effort to remove all emotion, history, and intuition from a situation, and value "facts" over anything else. It is perhaps all too common that experts or professionals are seen as being objective, and this automatically means they have some knowledge or power to be able to see things "the way they really are." There is the "objectivity" that reflects the absolute skilled ability of a therapist to not assume they know the interpretations of events for the family members. In this way, life events are simply events, a death is a death, however it is the meaning and interpretations that the family make out of it that determine their emotional response, their suffering, their experience of grief. In being "objective", the nurse was able to then recognize the meaning, beliefs, and strengths that this family had. She was more able to then offer support or change with these beliefs, perhaps not being attached to them herself.

Summary

> *So their family stripped of two members – part of the work that I believed they*
> *needed to do was to rebuild a sense of family with who was left,*
> *and to start building that house back up. (Suzanne)*

Overall in this clinical work, there were likely several other nuances that allowed it to be as effective as it was. Of other significance to this family, which is a topic that seems to go hand-in-hand with conversations about grief, is spirituality. Their beliefs in

God, and the strength and guidance that they spoke about were undoubtedly significant not only during the time of this work, but also as they continue to live alongside their losses. There are also likely further unarticulated practices that contributed to the effectiveness of this clinical work. Although Christine did report that Amy and Ryan were doing well now, with their own families, it would have enhanced this research to have their perspectives, as certainly Amy was not always keen on this type of work.

What this chapter of interpretation does highlight is reflective of what the nurse, Suzanne, also reflected in her research interview: that this type of work with families experiencing grief *can and should be done*. It can be very useful and therapeutic to see multiple family members during a session, although balancing the individual experience in the setting does take skill and expertise. Furthermore, the clinician has to love grief, and love this type of work (Moules et al., 2007) because that is what will support the needed curiosity, respect, and "absolute therapeutic use of self" which is irreplaceable in this type of clinical work. Lastly, hope and healing are not passive processes, and willingness and work between the family and the clinician can lead to sustained alleviation of suffering, allowing the family to find that needed hope to carry them on. This, I believe, may be attached to the character of Suzanne, to herself as a person entering and engaging with this family system; however it also signifies that it was not only a matter of presence, or witnesses, but of work.

Chapter Five: Edward, Martha, and Allison

Edward was referred to the FNU from a psychologist for "major depression related to unresolved grief." Edward and Martha's youngest daughter, Cynthia, had died from a heart attack two and a half years prior to them coming to the FNU. Cynthia's son, Mark, was 4 when she died, and Edward and Martha had full custody of him since. Allison was the second year masters student who was the nurse working with them.

Session One

Edward attended this session alone. He had been seeing a psychologist for depression, but was not able to continue seeing her due to program changes, thus she referred him to the FNU. In the first session, he described how it takes him an enormous amount of effort to do things, and that his only purpose in life was to raise his grandson. "*Losing Cynthia was just so devastating, and we haven't come to grips…you should be able to get over it and get on with your life.*" Edward started taking anti-depressants about three months following Cynthia's death and had a history of alcoholism, but had been sober for a number of years.

Cynthia had been in what Edward described as an abusive common law relationship with Mark's dad. He told of the many times he and Martha would take Mark to stay with them when Cynthia was sick, as his father would not look after him. Edward believed that, if not for this common law husband, Cynthia would still be alive. While Edward had attended church and considered himself to be spiritual, he stated he was having a hard time believing in the afterlife. He had also had a bad experience with the church that he used to attend and wondered if it may be helpful to rekindle his faith. The one-question-question for Edward was "*How is Cynthia doing*"?

Reflecting team. The reflecting team commended Edward for being frank and honest with them, and for the apparent devotion to his family. They were impressed with his strength to master alcoholism, and how he was able to continue with raising Mark. It was acknowledged that he was perhaps already grieving the loss of his daughter to an abusive relationship. The team offered that he seemed to be suffering physically, emotionally, and spiritually, and that these were interconnected. Some beginning ideas were offered about the nature of grief as not resolving, but the anguish around it diminishing. The team had a sense that he had a connection with his daughter as he was able to pray and talk to her, and that embracing this connection may bring him comfort. It was further offered that perhaps seeing Mark could be a reminder of the presence of Cynthia and could bring him comfort instead of sadness.

Edward responded to the reflecting team by saying *"people think I'm doing a good job, but there's so much more that I should be doing."* In response to the team's impression of him being very open and honest, he stated "*I'm coming here because I really cannot see myself living another 10, 15, 20 years struggling the way I am."*. He agreed that his physical, emotional, and spiritual suffering was connected, and thought if he could reconnect with his church that perhaps that would help his spiritual suffering. In turn, he may be able to resume running and improve his physical health. Allison encouraged him not to put too much pressure on himself; while he said he appreciated that, he reiterated that "*I just feel like there are so many things that I should do."*

Therapeutic letter. The therapeutic letter summarized the thoughts from the reflecting team: acknowledging the suffering that he is living with, offering commendations about the love and commitment to his daughter, challenging how he might view his daughter's continued presence in a different way, and exploring spirituality. His wife was also invited to attend the next session with him.

Session Two

One month later, at the second session, both Edward and Martha came, however Martha wanted to be seen by herself first, while Edward waited in another room. At the time, she was seeing a psychologist and a psychiatrist. She had been diagnosed with Lupus; however, the psychiatrist told her there was *"nothing wrong with her except grief."* She described how hard it had been to give up her job, but believed that she could not continue working because *"I'd be falling down, and people would be picking me up."* Martha did not think that Edward understood her.

> *I know he is grieving, but he grieves in a different way, like I cry, and I cry all the time…I see him, you know, going about his business and sometimes I think that he's gotten over it. He doesn't share his sadness with me.*

She further described how they were grieving differently, and that she found that frustrating. They had previously attended a Grief Support Program (GSP), and had met some other couples there who had also had children die. While she kept in contact with these people and believed it to be helpful, she stated that Edward procrastinated about calling anyone from the program and that she felt resentment about telling him to do so. Martha thought Edward became upset with her quite easily, which was why she wanted to come to the session without him – believing if she were honest in the session and he was there, he would get upset. Martha also described how Edward had previously been abusive towards her and had cheated on her when he used to drink.

Allison explored the nature of Martha's discussions with her psychologist, and in contrast, how the FNU might offer some difference. She replied that, with the psychologist, it was not about Edward, rather she could talk about whatever she wanted; she believed that was her domain, and the FNU was Edward's domain. Allison further inquired how the FNU might be helpful to both of them. Martha replied that her grieving for Cynthia was very different. *"He can't tell me to start living life and enjoying life, I can't...I can't tell him how much I miss her, like we just don't talk about it."* When asked if she would be willing to work on some of those issues at the FNU, she felt insulted that Edward thought they were having a bad marriage problem. *"Like it bothers me to the point of saying if it's that bad, why don't you leave"?* When Allison asked if she believed that grief affected marriages, Martha agreed that it did, and taking care of Mark had resulted in significant changes to their lives and their hopes for retirement. They had to become parents again. She believed Edward "*wants the old me back, and maybe part of that can come back, but I'll never be the same...my heart is broken, hopefully part of it mends."*

Allison explored spirituality with Martha, and she stated that she was a very spiritual person. She described how she prayed for her friends, "*that they can all try to be happy, and try not just to count days until we die and go to heaven"*. Martha's response to the one-question-question was "*why has this happened to me? Why did my daughter have to suffer so much and die"?*

Reflecting team. The team commented on Martha's strength, faith and spirituality; and noticed that there were periods of time when her pain was lessened. They questioned if she was struggling with guilt the way many mothers do who have had a child die. The clinical team offered the idea that perhaps she was willing to contemplate working on the marriage because she was willing to honour Edward's request in coming to the FNU. It was normalized that spouses often experience their grief very differently from one another, and that this often pulls marriages apart, and causes one to be critical of how the other spouse is grieving. Regarding the belief that Mark is the only reason that she and Edward want to live, the team offered that perhaps that is a really good motivation, and perhaps that is enough for right now.

Martha responded to the reflecting team saying she was glad the team had noticed her spirituality and her courage. She said she does have some good times and some laughs when she is around her friends, but struggles with Edward when he gives her a "hard time" about her crying. At the end of this session, she agreed to return to another session with Edward.

Allison met briefly with Edward following this. He reported that things were about the same. He thought the letter that was sent had a lot of positive feedback "*more than what I would feel I deserve.*" There was nothing in particular that stood out for him from the last session. He explained how he had hoped that Martha could get some help, and that they could attend as a couple. He explained his perception that Martha believes he has moved further on in his grief, but that he does not think he has. The conversation then shifted and he talked about how he needed to control his diabetes better, and exercise more, and this may prolong his life. Edward believed that he could die imminently. "*I think about it [dying] because I'm wishing it would happen, but on the other hand I don't want it to happen because of Mark.*"

Allison offered Edward an assignment for the following few weeks: once a day he was to tell his wife how much he appreciated her, and acknowledge how difficult it was for her to be grieving and missing Cynthia so much. Edward thought that he could commit to doing this, and stated it was probably something he should have been doing all along.

Postsession. The team hypothesized that Edward's motivation for having Martha attend a session was to work on their relationship. Martha's comment about her psychologist only wanting to see her and refusing to see Edward struck the team as odd, and they wondered if the psychologist was suggesting an element of abuse in their relationship. The team also wondered if Martha believed Cynthia was with her abusive boyfriend because of something that she had seen growing up with her and Edward. The team also noticed that neither of them reported spending any time together, and thought it might be most beneficial to no longer see them individually, but rather as a couple to do work together. Separate letters were sent to Edward and Martha. Included in the letters were invitations for them to return as a couple to talk about their relationship, and there were also comments made about how grief seemed to have changed their relationship.

Session Three

Edward attended the next session, which occurred seven weeks later, alone. He reported that he was able to carry out his "assignment" from the previous session about 55% of the time. When asked how they decided that he would come alone today, he stated that after the last session that Martha attended, she said she was not going to come back. She said she has been "counselled to death." Edward wanted to come to continue to work through some of "his stuff," and thought if he had the opportunity to continue counselling then he should take it. He said he keeps wondering *"what is really wrong with me...like I just want to get over this, just to be happy for myself...instead of putting everything on him [Mark] to make me happy."* Edward described again how he wished he could know that there was "another side" and that Cynthia was there and she was okay. Allison asked what difference it would make to him to know this.

> *It would make a huge difference, but I'm sceptical...If I totally believed that Cynthia was over on the other side, and that she was alright and really happy...I think I would feel so happy. I think that I then could continue on with the rest of my life, and do some things, rather than thinking that everything I'm doing is pointless...I just have such a hard time really totally believing that she's okay."*

Edward further explained how perhaps the idea of heaven was lip service. "*You know a lot of people just pay lip service when someone dies. 'they've gone to heaven'...I guess when it's someone I was supposed to look after, but didn't or couldn't anymore, it's so hard.*". Allison explored this with him, asking *"what is it you feel you didn't do for her"?* He replied that if he could have gotten her out of the relationship she was in that he believed she would still be alive, *"but in my heart I know that I did do everything short of going up there and kidnapping her."* The session then shifted from talking about his beliefs about what he should have done, and the beliefs about why she died, to talking about how he could know that she was okay in the afterlife. At this time, Allison introduced the idea of the internalized other interview.

After some introductory questions, Allison asked Edward's internalized Cynthia about the relationship with Mark, and around the decision to leave Mark with Edward and Martha. The response was that the internalized Cynthia knew she could trust them to raise Mark well, and that would bring her comfort to know he was well looked after. When asked if there was anything Cynthia would like her dad to know right now, the response was "*I would like to tell him that it's okay, that I'm not sick anymore, I'm not suffering anymore, and I would just like to see both him and mom happy.*" Allison asked one question about Cynthia's relationship with her common law husband, Bob, Mark's father, "*Did your dad do everything he could to help you in your relationship with Bob*"? Edward replied, as his internalized Cynthia "*I don't really know, I think he tried to be nice to him, because I know from the first day he was never really happy with him.*"

This seemed to be a powerful segment. Afterwards, Edward described this interview as very intense. "*I guess at the time, I felt like I was Cynthia, I felt that I knew her so well, that I knew what she was feeling, or what she is feeling right now...it's like I was able to see her...I can feel her presence, like she's right here with us.*" Allison attempted to connect this back to Edward's one-question-question about Cynthia being okay. He stated that, while right now he felt close to her, he thought when he left that doubt would sneak back in and he would not be able to hold onto it. At this time the team introduced the idea of a touchstone, so when he needed to, Edward could recall the feeling he had during the interview for reassurance that Cynthia was okay. No reflecting team was offered this session, and the session concluded with Edward saying he would like to continue coming to sessions at the FNU.

Postsession. In the postsession, the clinical team agreed with the sense of powerfulness of the internalized other interview. They commented that there seemed to be a real connection and flow between Allison and Edward in the room, and the team sensed that this intervention had been a good fit for Edward.

Therapeutic letter. A letter was sent to Edward following this session. The letter focused on his spiritual questions and the conversation of the internalized other interview. It reminded him of some of the pertinent segments of this conversation, and also of the idea of the touchstone that he may use to remind himself of the closeness he felt to Cynthia, and the awareness that she was now okay.

Session Four

Both Edward and Martha attended this session, just two weeks after the last session. During the last few weeks, Martha had been given a stone to carry in her pocket to remind herself of Cynthia, and was surprised when Edward came home from the last session and also had a stone that he was using as a touchstone. Martha reported some changes – that since she had been attending some computer classes, she was "neglecting" Edward more, and he in turn was not as touchy as he used to be, nor did he seem to nap as much during the day. She also reported that he was more accepting of her tears over Cynthia, whereas before she believed that he was over his grief of their daughter. She also stated that she has had less contact with her friends from the GSP since she has felt more accepted by her husband. Edward reported a small change - that he is more confident now that Cynthia is okay. Edward said he hoped that Martha could get back to her old self a little bit, and find some peace. Martha responded that she needed to find that in her own way.

This session was also the first opportunity that the team had to address their marital relationship with both of them present. Since Cynthia's death they reported they have had less of a couple connection because they are so focused on Mark. They believed that if they are away from him that they are betraying Cynthia, and so they do not take much time together as a couple. Allison asked for one sentence from each of them that would help them to understand each other better. Martha replied that she would want to renovate her house, as it has a lot of bad memories, and she would like Edward to listen to her about this. Edward stated he wanted Martha to know that he does love her very much, and that he has feelings and thoughts that he wished he could share with her, whether they be about Cynthia or something else. He stated *"I think relationships are the most important things in life, I think Martha is the most important thing in my life, because I do know that if it wasn't for her, I wouldn't be here today."* Prior to the reflecting team, Allison asked if the couple had a question for the team to address. Their response was *"What can we do to make our relationship or our life together better"?*

Reflecting team. The team commented on Edward's connection and comfort when thinking about Cynthia, and some relief of his suffering around this. It was suggested that perhaps the couple had been focused on grieving for Cynthia, and raising Mark, and now they were at a place where they might be able to pay some attention to their relationship. It was also suggested that perhaps seeing Mark might be a comfort and a pleasant reminder of Cynthia, and that raising him was a way that their daughter was able to comfort them.

Edward responded to the reflecting team by saying that although he did not expect the session to be about his marriage, he was glad that it was. Martha stated that she knew that was what Edward wanted in asking her to attend the session with him. Martha agreed that perhaps she and Edward should go out together alone more to talk, and suggested that they go out that evening for supper. Edward stated that he appreciated the time during this session to talk about things that they had not had the opportunity to talk together about before. Arrangements were made for the couple to return together for the next session. No therapeutic letter was sent and it was not clear, in review of the postsession, why this decision was made.

Session Five

Edward attended the next session by himself. He reported a significant change in Martha over the last two months since they were last seen as a couple in the FNU. Martha had apparently stopped taking her anti-depressants, and had now gotten back on them. He stated the last few weeks he had noticed an improvement in her. She was no longer "flying of the handle" like she had been. Edward reported that he still carried the rock around with him; he had forgotten it that particular day and stated he missed it. Another change was that he and Martha had decided to do major renovations on their house, something that Martha had brought up during the previous session. As Edward described how he was worried about Martha, and believed that she would die from a broken heart if not for Mark, the clinician asked what had changed. Edward stated that he thought that something had changed, but was not sure what. He was happy to see his family "come back together," whereas two months ago there was more conflict. He now reported a sense of peace or calmness as he continued to carry the touchstone with him. He recalled the internalized other interview, and wondered if Martha would also benefit from going through a similar experience. Another change he reported was to look at money differently and this lead to them pursuing renovations on the house.

The clinician reviewed the initial one-question-question that Edward asked in the first session. He said that he felt a sense of peace about wondering how Cynthia was doing. The clinician also asked if he believed that his suffering had been diminished or alleviated in some way, to which he replied *"I don't seem as tormented by the question about how she is doing."* There was some scaling questions explored, with Edward stating that he would be 75-80% sure that Cynthia was okay now, whereas when he first came it was about 10-20% thinking that she was okay. He credited some of this to "the conversation and the touchstone." In talking about the internalized other interview, he suggested:

> *I guess if I was able to recommend to other families, I think you have to be ready to go through that...it's a very worthwhile treatment, or whatever you'd call it, other people should try it...And the other thing is when are people ready? I would have no idea when to tell you that people are ready.*

Reflecting team. The team offered Edward some commendations about being open to the ideas and exercises that were offered to him; and about his wisdom in knowing that peacefulness and sadness could coexist in grief. They wondered if sharing some of his experiences and thoughts with Martha would also be helpful to her.

Following the reflecting team, Edward again brought up the idea that the loss of a child was different than any other grief. *"With a child, that grief is something that I've accepted now, that you never get over that grief, it's always going to be there."* In terms of the sessions at the FNU, Edward stated that he would like to come back in 5-6 months to "check in." This was agreed on and the clinician then moved into a review of the clinical work.

Reportedly, what stood out the most for Edward was that no one at the FNU said "I know how you feel", and he thought that kind of a statement would have been very negative. *"Never compare your inside to somebody else's outside, because you don't* *know what's inside."* He thought the compassion, caring, and positive feedback were also helpful.

> *I think it was very helpful rather than telling what you're doing is wrong, maybe suggesting that you're doing something right. It was not strict orders, it was more suggestions. If someone tells us to do something, we usually tell them where to go, but saying, 'would you try this?'.*

He had no comments about anything that was not helpful.

Postsession. In the postsession, the team reflected that the internalized other interview and the touchstone seemed to be the most pertinent parts of the clinical work. Edward did not always recall or talk about the reflecting teams or the therapeutic letters that were sent - these interventions did not seem to stand out to him. A final therapeutic letter was sent in which the team highlighted what they learned from Edward, and what they believed they offered him in the work. The team stated that they learned about the depth of love and anguish that a person can have, and about the uniqueness of the loss of a child. They also learned that it is important to speak openly to families about their spiritual beliefs, and that there can be difficulty in marital relationships when parents grieve differently. The team then wrote about what they believed was offered to Edward in the clinical work: the idea that grief is a lifelong experience, but that it is possible to find peace; the opportunity for a special conversation that allowed him to feel Cynthia's presence; and the idea that increased intimacy in the marital relationship might result in a closeness that might bring some healing in his grief.

Initial Analysis of Sessions

Two aspects of this clinical work that stood out for me were the "core" constraining belief that was focused on and the way in which the marital subsystem was addressed. The focus of the work seemed to revolve around Edward's belief that he had lost connection with his daughter, and therefore the clinical work revolved around reclaiming this relationship. From the first session however, what piqued my interest was his comment that his daughter would still be alive if it were not for the boyfriend that she was with. This was mentioned again when he talked about not knowing if she were okay, and *still* not being able to protect her. It seemed his suffering was about being able to make sure she was okay or not, something that existed while she was living as well as now that she had died. He may have felt some guilt around not being able to protect her while she was alive, and this could be a great source of suffering. The core constraining belief may have been: A good father should be able to always protect his daughter; or if a father has been a good father, his daughter will always be okay. This belief was never directly addressed in the clinical work, but if it had lead to him believing that he had somehow failed his daughter this could certainly contribute to an incredible amount of guilt and add to his depth of suffering.

Although the team tried to reframe the experience of watching Mark walk into the school and feeling great sadness and pain because Cynthia was not there to watch him, this might have been further explored. If both Edward and Martha believed that they could have done something more to help Cynthia or protect her, then this experience may lead to a feeling of guilt because they were still able to see Mark grow up, but his mother was not. It seemed that further exploration of their beliefs around Cynthia's death may have been useful.

The focus on the marital relationship was a topic that the team initially introduced in the session, however both Edward and Martha agreed that their relationship had changed, and they did want to talk about it. This was made difficult by Edward attending all five sessions, and Martha only attending two and this may have been why it never seemed to gain any traction in the session, nor be a focus. After the fourth session, when it was agreed that they would return to talk about their relationship, it was unclear as to why only Edward came, without this follow-up regarding their relationship. It did seem in the last session that there was significant reports of change from Edward, and Allison did explore this and further expand on what he attributed the change to, and what difference it was making.

Research Interview: Family

Both Edward and Martha agreed to be interviewed at their home for the research interview. The interview took place 6 years after the conclusion of the sessions, which was 10 years after their daughter's death. The introductory question asked to each of them was to talk about what they recalled from the sessions at the FNU. Edward asked Martha to go first because he stated he could not remember. Martha recalled that it was a terrible experience, that she felt like she was under a microscope, sitting in a fish bowl, and that no one understood her. She only remembered attending one session. Edward, although he did remember how he was referred to the FNU, did not recall much else about the sessions. Despite several attempts to redirect them to the clinical work at the FNU, there was little they could speak to about this. The majority of the interview involved descriptions of their grief, how losing a child is like no other grief, and then what has happened to them in their lives since. Both of them had continued to be treated for depression, and had been involved with various other counsellors, groups, and treatments.

Edward did comment on the team not focusing on their marriage or talking about what changes they had in their relationship. After the research interview concluded, the couple stated that they had never had the opportunity to sit down together and talk about these things with each other, that this research interview was the first chance that they had. They thought it had been very helpful to hear about how the other person was doing, what they were feeling, and to have someone *"just listen, because that's all you can do, because you have no idea what the person has been through."*

Research Interview: Allison

Allison, the nurse who worked with Edward and Martha, was also interviewed about 6 years following the conclusion of the clinical work. Initially, she was asked to talk about what she recalled of the clinical work and what stood out for her from the sessions. Initially what stood out the most for her over the years was *"his [Edward's] intense grief around the death of his daughter. And that was the major focus of the work."* The work was very distinctive in her mind because of the internalized other interview and the touchstone as it *"seemed to be something that was really powerful for him."* Further questions were asked to explore what it was that made her, and the clinical team, think something was powerful; what was it that they had noticed that made them interpret it as a useful intervention?

> *I think the sense that I had of, between me and him in the room, you know...there was almost a sense of sacredness about it, or that I just felt that he, that he felt a connection with his daughter in a way that was very different than any other way that he'd been able to connect before in anything he'd done in that grief journey.*

The touchstone idea was a way in which he could continue to connect with an experience of closeness felt during the internalized other interview. This sense of an intervention being a fit was further explored, and Allison offered some thoughts around what she may notice in people that tells her something is a fit for them. In this particular instance, it was a feeling of sacredness and quietness in the conversation.

Allison also recalled that the engagement in a therapeutic relationship came quite easily with Edward, but that she did feel less engaged with his Martha. She explained this by saying that the primary work really was around *his* grief over the death of his daughter. Although she did recall that there was tension in the relationship with Cynthia's boyfriend, that it had been a difficult relationship, the core belief that she thought was most contributing to his suffering was his overwhelming sense of grief believing that he had lost the connection with his daughter.

One particular comment that stood out for me in this interview was around the difficult relationship that Cynthia was in prior to her death.

> *Allison: She was in a bad relationship and they didn't like the boyfriend, he was abusive, and I wondered if that was really, that they were carrying some guilt around what they could have done more as parents...One of the things I remember too was the supervisor talking about, and this was probably just part of the pre or post session, because I remember there being a lot of suffering around that, about*

> *their relationship, and I remember the supervisor saying 'at some point he needs to ask himself what it was about his daughter that allowed her to be with this person.*

This struck me because it was not recorded in the pre or post session team discussions, nor was it recorded on the chart, but the supervisor of this clinical work seemed to be aware that his suffering may well have been related to his beliefs about his daughter's relationship with her boyfriend. Allison did not remember this ever becoming part of the therapeutic conversation, but described how that comment has stayed with her and actually quite affected her when she has encountered someone else in similar circumstances.

Overall, Allison had a sense that the sessions were really helpful to Edward. She felt quite strongly that the internalized other interview and the touchstone were what had made a difference for him in helping him in his grief journey. This clinical work continued to influence her current practice in palliative care and grief support. *"I think about the intensity and the depth of grief and how complicated it can be...and I guess the guilt and the suffering that, he particularly, carried".*

In the next part of the interview, I read segments of the family's transcript to Allison, and encouraged her comments, feedback, and interpretations of what the family said. For the most part, Allison was very surprised at the family's response. It was disappointing for her to hear that the clinical work was not as helpful to the family as she had recalled it. Firstly, she did not recall or have a sense that Martha had so much anger, or that she did not want to be in the sessions. She further reflected that Martha probably was not engaged with the clinical team. Allison wondered if this was because Martha was not at the first session, or that perhaps this type of work was not a fit for her. Other reasons why Allison thought it may not have been a fit for Martha were because of significant marital issues, anger, and trauma; she was guessing that these things could get in the way of grief work.

The emphasis that Edward and Martha gave to grieving over a child as opposed to when another family member dies was not surprising to Allison because of her experience in pediatric oncology. Although the marital relationship was not the main focus of the work as she recalled it, she does remember trying to address aspects of the marital relationship, perhaps, Allison thought, something that should have been focused on more.

Analysis: A Quest of the Heart

One of the inherent attributes of counselling or therapy is the questions that are asked. Questions are the significant substance of therapeutic conversations. The main principle of the model of therapeutic conversations practiced in FSN is the focus on beliefs, and often it is the questions that are asked that create engagement and context for change, challenge constraining beliefs, and introduce facilitative beliefs (Wright et al., 1996). Questions invite reflection about the way in which someone's beliefs are impacting their life, and their family's. What stands out in this clinical work is the way in which judgments and decisions were made about the questions that were asked, the conversations that were had, and about the "sense" that the therapeutic work was helpful overall.

Beliefs: The significance of the heart. As the clinical work in the FNU is based on beliefs, I asked Allison in the research interview if she recalled what the core constraining belief was for this family.

> *I think the core constraining belief, in looking back, would be around his overwhelming sense of grief, and that perception that his relationship with his daughter is now over because she has died.*

The Latin root of core is "cor" which means heart (Harper, 2001). To constrain means to restrict the motion of; to force by imposed stricture, restriction, or limitation (Merriam-Webster's Collegiate Dictionary, 2003). If the core constraining belief was thought of to be at the "heart" of the suffering, how does a clinician know that they are dealing with the heart, and not just the periphery? There is a possibility that a problem, a restriction at the heart can cause signs and symptoms in the periphery, and it is even possible that there may be symptomatic, temporary relief from interventions aimed at the periphery. It would make sense that a change at the level of the heart would have more profound and longer lasting impact than changes in the periphery. Is whether or not the change or relief of suffering sustainable the indicator of whether or not the belief at the *heart* had been addressed rather than the peripheral beliefs?

In both the review of the clinical work and in the research interview, a couple of Edward's comments struck me, causing me to wonder if there was another core belief that was not addressed. In the research interview, he stated *"you know a lot of people just pay lip service when someone dies - 'they've gone to heaven'...I guess when it's someone I was supposed to look after, but didn't or couldn't anymore, it's so hard."* The irony in this statement that caught my attention is that perhaps he never believed in life that his daughter was truly okay, and truly happy, and furthermore believed that he should have or could have done something else about that. Now, he is wondering if she is okay in death, and feeling equally unable to change anything. Martha stated that no one seemed to understand *"what a broken heart I have."* What was the heart of their suffering? How could a clinician understand these broken hearts?

A core belief that could be hypothesized for Edward may be: a good father would always be able to protect his daughter and make sure she was okay. What peripheral beliefs, perhaps beliefs that may be easier to access, may arise with this belief as the heart? It could be believed that his daughter was not okay in the "after life" that Edward wanted to believe in, and that he felt disconnected from her. Another peripheral belief may be that if only Cynthia's common law husband had not been around, then she would still be alive. He could also believe that he should be dead, rather than his daughter, because he was the one who had failed, not her. Some of these beliefs could be uncovered, and even challenged. An example of a belief that surfaced, that may have been peripheral, was that Edward was not sure if his daughter was okay now. This belief was certainly challenged in the internalized other interview that Allison did with Edward. It seemed in the session to even bring temporary relief, although how long that relief lasted is not known.

What would be the difference in sustainability of the work if the beliefs that were challenged were not the heart, but rather periphery? Would there be temporary relief of symptoms, only to have the underlying condition resurface and cause further problems? What gives clinicians the sense that they have uncovered the core belief? This may be very tricky work, to determine whether or not we are at the core of something in clinical work, or whether we are at the periphery, especially if there is relief of suffering, albeit temporarily.

Allison recalled one question that her supervisor asked outside of the clinical work that has remained with Allison for several years now. "*I remember the supervisor saying, yeah, at some point he needs to ask himself what it was about his daughter that allowed her to be with this person.*" Why was it though, that this question was not ever asked of him? How would he be able to ask this question of himself? What if the question that still sticks with Allison would have been said out loud to Edward? Allison said that she has been quite affected by this question when faced with other similar situations.

The questions. Wright et al. (1996) described the purpose of questions in therapeutic conversations to invite reflection, invite family members to externalize internalized questions, and inviting family members to ask questions. In the research interview, Edward stated that while he did not know what the right questions to ask would be, he did not think that the right questions has been asked.

> *During the sessions they never said, well how do you get along? They never asked, I can't recall, and maybe they did, about how our life together was. Our life was totally changed... And they never talked, there was never any discussion about what that was, was there?...(Martha: No). And I was sort of hurt in that I thought, wow, shouldn't they be talking about us, you know life, the grief...the right questions I don't think were asked. I think there should have been other questions...I can't recall the questions that they did ask, but they made suggestions about doing this and doing that, and you know you try them and. It certainly didn't help me, you know.*

How do clinicians know what the right questions to ask might be? What gives nurses the sense that they are asking the right types of questions? It seems logical that the families would know when the right questions are *not* asked, but they likely would not be able to specifically say the types of right questions to ask.

A question is defined as an interrogative expression often used to test knowledge (Merriam-Webster's Collegiate Dictionary, 2003) or the act of asking or inquiring; an interrogation or query (dictionary.com, 2009). Gadamer (2004) stated "the essence of the question is to open up possibilities and keep them open" (p. 298). Gadamer is referring to when one's prejudices – which previously operated unnoticed – become questionable. Perhaps this is similar to beliefs: The beliefs that likely most greatly influence us are the ones that we are not aware of, which operate unnoticed; it is through questions that these beliefs are opened up. Gadamer (2004) further stated:

> A question places what is questioned in a particular perspective. When a question arises, it breaks open the being of the object, as it were...To ask a question means to bring into the open. The openness of what is in question consists in the fact that the answer is not settled. It must still be undetermined, awaiting a decisive answer...A question can be asked rightly or wrongly, according as it reaches into the sphere of the truly open or fails to do so. (pp. 356 -357)

Many different types of questions can be asked. The types of questions that will challenge beliefs, or suspend prejudices, must be asked because the answer is truly not known. This is the intent of therapeutic questions according to the IBM as they invite reflection; however the outcome of this reflection is not known. Gadamer (2004) described that conversations are not conducted by people, but rather, in a good conversation, people are conducted by conversation. This would imply that perhaps both the prejudices and beliefs of the family *as well as* the prejudices and beliefs of the nurse need to be opened to being challenged and suspended in order that they may be seen differently.

Was it a reflection of Allison's own belief about grief that Edward was suffering the most because he felt he no longer had a connection or a relationship with his daughter? Was it a prejudice of the clinical team that the loss of connection is what grieving families suffer the most around? It is apparent that many prejudices have influenced how grief is viewed to be "dealt with" and "resolved". Is it also a prejudice to think that the most suffering is related to the loss of connection? The newer, postmodern, grief theories outlined in chapter one, could also lead to prejudices and beliefs about what grief is about, and what is helpful to families, if they are taken up this way. This struck me because in review of the clinical work, as well as in the research interview, I never had the sense that Edward or Martha felt a loss of connection, rather that they still had immense anger and guilt around Cynthia's death.

How do clinician's know that their questions are good? How do nurses allow their own prejudices as well as those of the family to be opened in the conversation? "Questioning makes the object and all its possibilities fluid. A person skilled in the 'art' of questioning is a person who can prevent questions from being suppressed by the dominant opinion" (Gadamer, 2004, p. 361). Although it had been strongly emphasized in the environment of the FNU that grief was not about resolution or completion, or a severing of bonds, did the idea that helping families with grief means regaining connection become the "dominant opinion"? Perhaps this is the caution that clinicians need to be wary of – that we need to ask questions that allow our own prejudices to be laid open much in the same way that we want to lay open the constraining beliefs of the families we are working with. "If we go back *behind* what is said, then we inevitably ask questions *beyond* what is said" (Gadamer, 2004, p. 363). To know that the questions are good and useful questions, however, clinicians also must have a sense that the questions are appropriate, that they have a *sense* of direction (Gadamer). This sense is what will guide clinicians in conversation to ask the good questions.

Sense. When asked what she recalled from the FNU sessions, Martha responded:

> *Well, I think I only went to one. And I was extremely upset, and quite angry. I thought, why am I sitting here behind this glass and being reviewed by people that don't know me, that don't know what I'm going through, and what a broken heart I have, how angry...to be very honest, I didn't get one thing out of that, nothing. Because to me, I was being like, I felt like I was under a microscope, and at that time I was so traumatized and upset that I guess I felt like just curling up in a little ball and being by myself and just letting the world go by...that was the worst experience of my life...I felt like I was being judged.*

When Edward was asked what he recalled, he said that he had gone to other counsellors previously, and one of the first counsellors had told him to get on anti-depressants.

> *I know I've suffered from depression my whole life, but that was the farthest thing from my mind then...they tried everything, different medications, and tried a little counselling, but I didn't find any of it really helpful. None of it was helpful.*

When I read Edward and Martha's opening comments in their research interview to Allison, she responded that she was quite surprised.

> *I didn't have any sense of the intensity of that anger or the sense that she didn't want to be there in such a strong way...It's kind of sad that she felt...judged, or feeling like she was under a microscope...I didn't have any sense of that at the time.*

Allison had a *sense* that the clinical work had been very helpful, especially to Edward. She recalled the internalized other interview and the idea of the touchstone, and described those as very powerful at the time. I asked her why she thought it was so powerful, or what was it that made her think it had been a useful intervention.

> *I think the sense that I had of, between me and him in the room, you know. And there was almost a sense of sacredness about it, or that I just felt that he felt a connection with his daughter in a way that was very different than any other way that he'd been able to connect before in anything he'd done in that grief journey up until that point...There was a quietness about it, that he seemed to be really, I don't know, within himself...I felt that went really well.*

Sense, in the 1400s meant "faculty of perception; meaning or interpretation" (Harper, 2001). How do we interpret what we notice and interpret in therapeutic conversations? Allison noticed quietness, and interpreted that to mean it was a powerful and useful intervention, and thus the clinical team was on the right track. What if the connection with his daughter was not the thing that he was most suffering with? How was it interpreted that this should be the focus of the clinical work? It may very well have been sacred and quiet, but that may not have been what was most needed. Allison further explained the sense she made out of his response to the internalized other interview.

> *I think it's his response to it, so it was the answers that he was giving, and I think the flow of the questions...It was the sense that he was having this conversation with his daughter, or what he had internalized within himself of his daughter. So I guess part of that for me is that it's really back to that feeling that there was a connection between family members, even though the family member, that his daughter had died...I must say that I felt as a team that we had really helped him, I did have that sense about it, and particularly, I really remember feeling quite strongly that the internalized other interview, and the touchstone, were what had made a difference for him.*

Gadamer (2004) described sense as related to Bildung; the sense of whether or not something belongs, or is correct requires judgment or taste.

> Taste was originally primarily a moral, not an aesthetic, term...taste still meant a mode of knowledge or a 'sense' that was not just learned, but which was formed and was essential to social life and human culture. It was also a sense of what was fitting, of standard, and also of fairness. (Grondin, 2003, p. 27)

Knowing what belongs and what does not in a therapeutic conversation is an art, requiring one to be cultured, experienced, and wise with a topic. Cioffi (1997) argued that the intuitive sense that nurses use for clinical decision making has often been discredited by the dominant scientific paradigm, and this has lead to nurses not talking about how they do make decisions. On the other hand, Cioffi stated, this intuitive knowledge is the knowledge that is most frequently used by nurses for clinical decision making in uncertain situations. She described this sense as "a subtlety of knowing operating beneath consciousness that is borne of experience and available in memory for recall with a sense of appropriateness in clinical situations" (Cioffi, 1997, p. 204).

After reviewing the family interview with Allison, she had several other interpretations of why the interventions that she had sensed were very powerful did not result in sustained change. She thought perhaps Martha had felt judged, and left the sessions so angry, because of the engagement that Allison had with her. Allison definitely felt that she was more closely engaged with Edward than Martha, and the relationship that was focused on was between Edward and Cynthia, rather than Edward and Martha. Another hypothesis she had was that not all families find this type of work a fit for them, or perhaps the timing of the sessions were not right for her. Additionally, she wondered if the previous marital problems that Edward and Martha have had made it difficult to *"get at the grief and work with them in that way, I think that is what complicates it as well."* She also wondered about the impact of working with them together versus separately.

> *You wonder if the work had been more with them together, whether they would have been able to hold onto the experience of that intervention in a different way...if they had both experience d that, then there may have been relational changes or ways that that could sustain differently.*

A final interpretation that Allison made of the family's interview was that the element of trauma had prevented grief work. She further wondered if, because the trauma was not attended to, that it affected the interventions related to grief, and how long the apparent changes were sustained. She discussed her beliefs that trauma processing beforehand may have helped this family. She did say that the idea of trauma, and trauma processing, had a more "pathologizing" lens to it, and that was contradictory to the major tenets of the IBM. However, in thinking about decision making, and the "sense" that a clinician must have to navigate the therapeutic conversation, the "process" of a trauma provides a method where there may otherwise only be intuition and sense. Perhaps a "pathologizing" lens, because it allows for a method or lays out a process, reassures clinicians that things are being done that are going to be useful and helpful. This perhaps does not require the sense, or Bildung, that Gadamer (2004) believed was necessary for the human sciences and human understanding.

In terms of intuitive clinical decision making, it would be interesting to know how the sense that this work had been helpful, has since informed Allison's clinical decision making. Furthermore, how would the knowledge that the family did not sustain the changes impact her conduct and clinical decision making with future families that she works with? After hearing that Edward had carried around the touchstone for a few months, and then found it did not help anymore, Allison wondered

> *If grief is really a journey that you have for life, and not that any one thing is going to be the thing that resolves grief, I don't think that, I think there are things that help you walk through life with the grief that you carry...So I think there may be a piece of that in here, yeah, because I really do think that helped him in the short term.*

Allison described grief as a journey, and wondered if Edward had found something useful for this point in his journey. She wondered if perhaps it was not what he needed for his entire journey.

Summary of the Quest

Etymologically, quest and question come from the same Latin word queare (Harper, 2001) which also implies a journey or a search. Edward stated that he kept seeking help, hoping that it would be helpful. He was on a quest, a search for hope that things would be better, that someone could help him. In a similar vein, Allison and the clinical team were also on a quest – a quest for that core constraining belief that was causing Edward and Martha such suffering. Questions were the mode of uncovering this belief, inviting reflection, and looking for healing. Both Martha and Edward had been on quite a quest or a search since the death of their daughter. They had been through numerous variations of counsellors, and still use a psychologist that they "have on retainer." They had been through "all" the anti-depressants, and Edward has had some electric convulsion therapy in the last few years.

After the tape was shut off, Martha and Edward commented on how the research interview had been very helpful. Martha remarked *"you just need to be human – being human rather than having all this knowledge, like the doctors have all this knowledge, and do this, and this, and this; and it's about being human and showing that compassion and that caring side."* Is part of the quest, the questions, the beliefs, and the therapeutic conversation about knowing what to say for who faces you now? They said the research interview was helpful because they had never had the chance to talk about it like this with each other. Interestingly, the intent of the research interview is in no way meant to have any therapeutic outcomes, yet they said this conversation had been the most helpful.

Edward: I don't think all the counselling that I went to that any of it really helped.

> *I think it was, I was going, hoping that it was going to help, but it didn't help. You know, they would give you this strategy, or that strategy to try to work on.*
>
> *Martha: I mean you can't go from a book and say okay I'm going to do this, and this and this, and it's going to help me. It doesn't.*

It was interesting the perseverance that Martha and Edward both had, in continuing for numerous years on their quest to somehow find hope or healing of their "broken hearts". This obviously arduous journey has caused them to wonder what, besides their grandson Mark, would sustain them in their lives. Perhaps the nature of a quest is that it is the seeking for the hopeful, desired outcome that does sustain people. What other roles may nurses have on the quest of a family experiencing grief? Perhaps it is possible that they help to open beliefs through the questions that are asked, and significantly change the path of the search, or even what is being searched for. Perhaps also, it happens that nurses can assist in a small part of the journey, more as assistance along the way, rather than something that changes the path of the quest. Perhaps though, this is a family who functions in the immediacy of a conversation; that useful things occur in the present, and are not sustained or remembered. It brings into the open the idea of forgetting and remembering. What is it that people choose to remember? What is easy to remember? Why do people forget, even when it is something they want to remember? This remembering and forgetting was perhaps an element in all of the families and nurses that were interviewed. Does not being able to remember something mean it was not helpful? On the contrary, do things that were helpful stay with us as memorable?

Chapter 6: Return to the Questions

I began this research with questions that I believed would help in the understanding of therapeutic interventions that nurses provide with families who are experiencing grief. In returning to the questions, the previous analysis comes together in an attempt to answer, uncover, or shed light on the nature of the therapeutic interactions that are useful to families. The question I began this inquiry with was: How might we understand the nature of family nursing interventions in clinical work with families experiencing grief? Beginning questions that guided my curiosity around this topic were: How do we understand the usefulness of therapeutic conversations? What did the families find were the most useful aspects of their encounters with nurses during their consultation around grief? Is it the nature of the relationship between the nurse and the family, the specific interventions offered, extratherapeutic factors, or something else that families find useful in these nursing encounters, conversations, and interventions? How was the clinical work that occurred helpful in alleviating the family's suffering? What is the meaning of this work for families as they continue to live alongside their loss?

An aspect that was not asked in these initial questions, but became apparent in the research interviews was discovering what was *not* helpful to families. What might prevent good clinical intervention from occurring? What might be some characteristics of the clinical setting, the nurse, or the family that do not allow for the healing or peace that is desired as a result of this type of work? A final aspect of curiosity was the sustainability of the changes that seemed to occur during the sessions. The families and nurses that were interviewed were asked to recall and remember the clinical work from 4 to 10 years ago. I chose not to show video clips from the clinical work, because there was an interest in what they would recall as useful. If there was something useful, how did it continue to influence them? If they were still finding the work useful and significant, then should they be able to recall it? Perhaps this was reflective of my belief that if it was significant to them, it would be remembered; if it had been helpful, it should still stand out in memory. Furthermore, however, what is it about things that "stand out"?

Other questions that arose during the analysis included: What is it that would be most helpful to this family at this time? Do they need someone to walk with them, to hold them up, to weather the storm, or to talk about the next steps, the future territory? What cues would we need to pay attention to so we might know how to proceed, know what to say or do next? How could we be transparent about the cues we are receiving from the families while being reflective and cautious about our own beliefs and motivations? How could we pursue further understanding and perhaps different, more useful interpretations about what is going on?

Role of the Professional

It is predominantly a phenomenon of the last century that professionals became involved in caring for those who are grieving (Jordan & Neimeyer, 2007; Walter, 2000). One explanation of this trend is that family and friends are often spread over distance that does not always allow for mourning rituals and support, and another is because of the decrease in involvement with organized religion (Walter, 1996). Another explanation, however, is that the seeking of professionals for help with grief has simultaneously arisen with the field of psychotherapy (Jordan & Neimeyer, 2007). Thus, embedded in our society and cultural discourse, is the presence of professionals who can help with "mental distress of all types" (Jordan & Neimeyer, 2007, p. 213). While Walter (2000) suggested that it is because family and friends are not available to listen to the bereaved, the therapist seems to have a unique role that is beneficial in other ways, besides being an empathetic ear.

The fact that this person, the nurse or other professional, is a stranger is important to the nature of the relationship and for the interaction being therapeutic. While it may be true that "clients often speak of their relief at being able to talk and to weep without fear of judgement" (Walter, 2000, p. 107), it is also the lack of expected reciprocity in therapeutic relationships that changes the nature of these interactions. It is highlighted by the significant difference between social relationships and therapeutic relationships: there is no implied nature of also offering support. In social situations, among family and friends, there is often the implication of not wanting to burden the other person with problems, difficult situations, and emotions. This sensitivity to how the other person is feeling or reacting perhaps precludes disclosure or relief or healing in some way.

This was evidenced in Christine's clinical work, when she emphasized that she was able to *hear* things that had been said to her before because she was not having to hold everyone together; she was not worried or concerned about how this may affect the nurse, although most importantly, she trusted that the nurse could hold things together for her. Perhaps, as was the case with Christine and her family, it is because the nurse was someone that the family members did not need to worry about. In contrast however, Dianne *was* worried about the nurse and the clinical team, particularly if she herself was contributing enough. Edward and Martha found it difficult to talk about their experiences of grief with each other, and found themselves making assumptions about how the other was doing. They both sought out "strangers" to help them.

There is also a dynamic because of the position of authority (as in knowledge and title) that seems to be therapeutic. People have sought out the expertise of professionals to reassure them they are okay, or to diagnose them as not being okay. Thus, it is not surprising that now it is the professional who is able to validate the family's experience in a way that family and friends perhaps cannot. To do this, however, there is a hierarchy and perceived power differential needed to reassure the family that their experiences are valid and legitimate. This perceived differential is also likely necessary to establish that the family does not need to be concerned with how what they are saying is affecting the nurse. Although it may seem unusual to seek out a stranger to talk about one's deepest suffering, it seems as though it is the fact that *it is* a stranger that is of therapeutic value.

It may also be that it *does* matter who the family is, and it is not only the therapist who can make all the difference. Tallman and Bohart (2006) proposed that perhaps the most significant factor in effective therapeutic work is the client's *own* ability to heal, with the therapist acting as a facilitator and resource provider. This hypothesis may be well supported in the interaction between Christine's family and Suzanne. Suzanne commented that part of why she thought the therapeutic work was so effective was because of the family. This, she thought, was a family who was very sophisticated both intellectually and spiritually. Suzanne demonstrated support by leveraging the family's already existing resources – for example the children's insistence that their mother had been available to them. This is not to discredit the expertise that Suzanne brought to the conversation, but rather to reflect that the family members are not passive recipients of the nurse's interventions.

In the IBM, there is an intended focus on strengths, and perhaps this is where families are reminded of, and supported with, their own self-healing capabilities. The idea of therapist as the "hero" may, in part, be what invites grief to be viewed as a pathologized phenomenon.

> The therapist is the "hero" who, with potent techniques and procedures, intervenes in clients' lives and fixes their malfunctioning machinery, be they faulty cognitions, weak and ineffectual egos, primitive defensive structures, conditioned maladaptive behaviours, defective social skills, or poorly working internal self-organizations. (Tallman & Bohart, 2006, p. 91)

The position of power that the nurse or other professional holds is not about objectively knowing the "way things really are" or the way things should be. It seems to be more about recognizing the legitimacy of the family's experience and being able to confidently and compassionately help by recognizing their strengths and supporting them non-judgmentally. Labelling grief as complicated, traumatic, or by any other name, is pathologizing. Often professionals are seen to be in the role of finding out what is wrong, diagnosing the ailment, and then providing the treatment or interventions that will cure this. This approach assumes that professionals have access to some kind of truth that is not available to everyone.

When reading the proposed descriptors for the DSM-V diagnosis of complicated grief, I wonder if it is the rest of society that is often more disturbed with the displayed behaviours of bereaved families than the families themselves. It makes it easier to label someone as having some kind of disorder or problem, than to get into their suffering with them, to find out what it is like to have loved and lost, and to learn how to possibly live again. Walter (2005) reviewed this trend to medicalize the experience of grief.

> The roots of complicated grief lie not just in the individual mourner's psyche, but also in the concern of family and friends to reduce suffering, to get the mourner back to autonomy and happiness, to reduce their own inconvenience and worry, to replace chaos and guilt with order and predictability. (p. 78)

It may also be an uncomfortable situation to go into these conversations knowing that part of what the nurse needs to know in order to help this family resides within the family. It is not something that can be wholly known prior to or outside of the specific family.

It is not clinicians alone, however, who can facilitate and support healing. There is significantly more context outside of therapy that is always at play (Hubble et al., 2006). Therapy happens in a snapshot of someone's life, in the midst of their daily routine, in the context of social networks and their spiritual lives. All these things began many years before and continue on many years after the therapy has finished. There are things that happen in therapy, such as insight and reflection, which happen outside of therapy as well (Tallman & Bohart, 2006). In Dianne's family, it was a year or two before things settled down for her, and she sought out several other resources, and drew on her spiritual beliefs and resources. Christine's family had strong spiritual beliefs that were apparent and discussed as part of the clinical work, but those beliefs also existed prior to the clinical work and likely carried on afterwards. With Edward and Martha, they had previous history that had affected their marital relationship long before the death of their daughter, including struggles with alcoholism, infidelity, abuse, and depression. They also, however, found other supports such as their church community and other parents. These all existed outside of the three to five sessions of clinical work.

In the experience of these three families, their concerns involved other family members in relation to themselves. Dianne wondered how her children were going to understand the permanency of their father's death, and moreover what she needed to be able to function as a single parent. Christine, Amy, and Ryan wondered how it would be possible to ever have hope or happiness again with their family "stripped of two members." Christine wondered how she could say hello and good-bye to all of the members of her family in different ways – her biggest concern being that she had not been available to her children. Edward struggled with the relationships in his life, particularly with his marriage and as he and Martha grieved Cynthia's death in very different ways. He perhaps believed he had failed in other roles in his life in his relationship with his daughter. What I was most struck with by these families was how different the clinical work would have been if they had been seen individually and there had been a focus on their emotional and psychological state. Regardless of how helpful or not helpful the particular clinical work in this research was, it really was about grief being a family affair. It does impact the lives of the loved ones that still surround the family. It is these people who have supported each other before and will likely continue to be in a relationship with them long after the therapy has ended. While there were many apparent benefits with Christine *and* her two children attending the sessions together, it seems there also may have been further benefits if Edward and Martha had been able to attend sessions together. Although the team did invite them to come together, it may not have been the right timing. This was something that, 10 years later, they said they had never had the opportunity to do.

Perhaps a part of what nurses do is fulfill a need for a certain time in the journey, however there is also the possibility that this interaction can be significant enough that it is something that a family clings to in such a way that sustains them for years. This is not likely only due to the nurse, but likely also considerably due to the strengths and healing potential that the family themselves have. What the family brings to therapy is not something that professionals necessarily have control over; perhaps, it is more about how the strengths and hopes are brought forth, examined, nurtured, and encouraged by all involved. Moreover, it may be that other witnesses are needed in the therapy to be able to remind each other about these strengths.

With Christine's family, her and her children shared evidence of each other's strengths. In doing this work together, they not only supported each other in the sessions, but perhaps were able to sustain the change they experienced, because they would be able to still do this for each other long after the therapy had ended. When Suzanne was able to highlight these strengths for the family, it may be that having more than one of them present to hear these made the change more sustainable, more real, valid, or visible. Perhaps she created the context where the strength of their family could be made more visible. This was witnessed by not only the family members, but also all of the members of the clinical team. In this way sustainable support was created perhaps because there was more than just one person holding things together.

Interpretive Sense

Nurses have claimed to have a sixth sense or intuition about clinical situations (Buckingham & Adams, 2000; Cioffi, 1997). This is an awareness or perhaps an art of knowing that something is important and significant, and recognizing when something is not going well or about to not go well. This is how nurses, in their daily interpretations of interactions with patients and family, often decide how to carry out their practice (Tanner, 2006) in hopefully the most beneficial way. Examples of this are the way in which Suzanne responded to Amy's body language, the way that Allison felt a sense of sacredness after the internalized other interview with Edward, and the way that the clinical team interpreted Dianne's silence as appreciative of commendations. There is a great deal of information to be considered in therapeutic conversations outside of what is actually said: the nuances of affect, presentation, and silence. The interpretations that are made from this information is perhaps less widely discussed or understood, even though it may significantly impact the decisions and judgments that are made by the nurse. Tanner (2006) described this as "reflection-in-action" and is often not obvious; it is the nurse's ability to "read" the patient.

There seems to be a large amount of information that clinicians can glean "in the moment" that helps them to make "sense" of the situation, and guides them in their decisions about where and how to proceed next. Where does this sense come from, how is it developed, and more importantly, how can it be developed and utilized in the most beneficial way with families? Is it about the nurse's education, her personal characteristics, her beliefs, or all of this? In advanced nursing practice, Gadow (1995) argued that expert clinical assessment is based on "combining knowledge from nursing theory and research with knowledge about a specific client" (p. 25), uniting general and specific knowledge. Benner (1984) has further explored aspects of intuitive judgments for nurses and also the how the expert nurse's knowledge accrues over time through a nurse's practice. Expertise is gained through experience, and thus problem solving in an expert nurse differs from that of a beginner nurse. "Expertise in complex human decision making, such as nursing requires, makes the interpretation of clinical situations possible, and the knowledge embedded in this clinical expertise is central to the advancement of nursing practice and the development of nursing science" (Benner, 1984, p. 148).

This is where the sense and judgment of the nurse come in to play in therapeutic conversations, and likely where the expertise of the nurse has a generous impact. Benner (1984) claimed that expert nurses acquire clinical knowledge over time, and have the ability to notice nuances and grasp the significance of a situation. In the interpretation that Dianne's unusual reaction to the clinical work was because of her cultural background, this was an attempt to make her presentation and the results of the clinical work somehow make sense. However, there were other interpretations that could have been made, that would have resolved some of the incongruence and altered the nature of the clinical work. Suzanne used her sense of the situation to decide that Ryan and only Ryan should be the one to do an internalized other interview; this decision was made based on what she noticed in the session, likely a gathering of many pieces of information that lead to the decision in the session.

It may be significant that of the three nurses, Suzanne was the nurse who was the most experienced in conversations with grieving families. This is not to imply that students or novice clinicians should not be involved or encouraged to enter these conversations, but perhaps has implications for how they are supported in this learning. In the advanced practice of FSN, there is considerable attention to reflection after the sessions, and considerable feedback given to the student from the supervisor and the clinical team. There is, perhaps, some additional attention that needs to be paid to this student situation. In Dianne's work, it seemed that perhaps although there was mutual agreement for her to return, was there also some pressure to ensure that the student had a family available to work with? With Edward and Martha, there seemed to be an initial appreciation for the work, and relief of suffering, but was it because this was relief at the periphery, and not the core constraining belief, the reason it did not seem to be sustained? There are further questions that this brings up in the supervision of students as therapists that is beyond the realm of this research.

Standing Out: In Memory Of...

Memory is the greatest of artists,
and effaces from your mind what is unnecessary.
Maurice Baring

Why is it that certain things "stand out" to us? What is it about human understanding that recognizes some things as important, and disregards other things almost immediately? In the clinical work in the FNU, there was a culture of asking about things that stood out. In my review of the clinical work, in the research interviews, and in the writing of the analysis, I was considering what it was that stood out. I continually checked to see what was standing out to me, and used that as a guide to help in the analysis and writing. Gadamer (2004) stated that when things "catch us" is when understanding begins. Benner (1984) claimed that situations stand out to us when they change our perceptions or understanding of the world.

This notion of standing out also implies that there is a remembering of this seemingly important thing, and inherently then also a forgetfulness of other things. It brings into the open the idea of forgetting and remembering, and then years after what is recalled. What is it that people remember? What is easy to remember? Why do people forget, even when it is something they want to remember? This remembering and forgetting was an element in all of the families and nurses that were interviewed, considering the length of time that had elapsed from the time of the clinical work.

"Memory is not memory for anything and everything. One had a memory for some things and not for others; one wants to preserve one thing in memory and banish another…forgetting is closely linked to keeping in mind and remembering" (Gadamer, 2004, p.14). It seems that what we remember or recall must have a purpose, although perhaps not always apparent, for staying in our minds, perhaps for us to recall at a later date, and perhaps to somehow serve us in our present time. In memory, is where the recall resides, where the past is stored for future retrieval, or not.

Memory perhaps has implications with grief as well. For example, is there something about suffering that honours the death? Is there something about continuing to feel sorrow and pain that allows a family to recall that person, to ensure they are not forgotten? For example, with Edward and Martha, perhaps their ongoing depression and seeming misery was a way in which they could ensure they always held their daughter in their memory. Perhaps they believed that the alternative to remembering this pain was that they would forget her. Dianne could remember some events around the clinical work at the FNU, for example the hiring of her nanny, and her children's behaviour. Monica could also remember the unusual affect that Dianne presented with, although not specific questions that were asked. Christine had a memory for specific things that were said, such as the clinical team having hope for her family, although this was the clinical work that was done the longest time ago. The truth of the clinical work reveals itself in this recall, in the sense of alethia.

The "Interventions" and the Outcomes

Numerous pieces of literature outline things "to do" to help people experiencing grief. In the IBM, there is a listing of some types of things that may be helpful to families – commendations, therapeutic letters, interventive questions, reflecting teams, etc. The internalized other interviews that were done with two of the families are another example of an intervention, that is described, and done with purpose and rationale. In this research, I do not attempt to provide a "tool kit" of interventions to be tried with families, because as others have known before, there are other factors that impact the usefulness of the clinical work.

To intervene means to occur, fall, or come between points of time or events; to occur or lie between two things (Merriam Webster's Collegiate Dictionary, 2003). What are the two events, times, or things where these interventions for grieving families are occurring? Is it between the event of the death, and the interpretation that the family has made of the event? Is it in the time, the era of suffering after death, and the time when hope returns? Perhaps it is what happens between people – the conversations and silences that cause perturbation or provide something to hang on to, much like a rope, the intervention is between the family and the nurse, and they must both hold up an end. We cannot assume that it is all in our hands. What I think is in this in-between is understanding. The interventions and practices of nurses working with grieving families are useful when they contribute to understanding. Understanding begins when something stands out; it is carried on when previous prejudices (or beliefs) are challenged and changed; when there is curiosity and openness to the understanding of the other; when the only agenda is to understand; and when this in between is significant enough that it can stand in memory.

Change has been conceptualized to be the purpose of therapeutic conversations, the outcome. In the review of the clinical work for this research, all three families reported or were observed to experience some change. One of the challenges of this research was finding a language to describe what it meant when something was helpful, or that there had been change. Within the examined clinical model of the IBM, outcomes are described as alleviating, healing, or reducing suffering; the change is in the suffering. In grief, the easily accessible language seems to be to "get over it", "resolution", or most popularly "dealt with". It becomes easy to say these things because this has been spoken so much in our language that it has become the generally accepted way that grief is understood. The families in this research described a sense of peace, of hope, having something to live for, the absence of depression, and being able to talk about it as useful outcomes. Obviously for each of them, the outcome of the clinical work varied, and so perhaps the outcomes in grief vary, but outcome still implies end.

Perhaps though, there is no outcome as in grief there is no end. In its own way grief is always incoming and we need to create different language entirely to talk about what happens to grief over time. If the family organizes their epochs, their story of a certain time, according to before the death and after the death then the latter is not something that lasts for only a year or two. For therapeutic work to be useful there seems to be a need to pay attention to cues, to call witnesses together, and to consider the quest of the broken hearted. The nuances of clinical judgment, which is closely linked to not only theoretical knowledge but also expertise, likely resides along with curiosity and passion for the topic of grief to co-create something that families can hang on to, that will hold them up.

Chapter 7: Implications for Practice, Education and Research

The intention of this research when I set out was to understand not only better, but differently, about the nursing practices and interventions that are helpful to grieving families. I was hopeful that this research would uncover something that was new or different about therapeutic conversations and interactions between professionals and families. It is by no means exhaustive or comprehensive, and as is true with any new realization: when one thing is uncovered, something else is simultaneously concealed. In this chapter, I highlight what I consider to be these new or different ideas that will hopefully lead to other new and different ideas in the future practice, education, and research regarding this careful, important, and necessary work. I also describe some of the limitations or challenges that should be considered in this research and for the future.

Practice Implications

In terms of practice, this research focused specifically on the advanced practice of Family Systems Nursing, but the particulars that are discussed and described, may also be informative of the topic in such a way that others can recognize it as useful or applicable in their professions or contexts. First and foremost, it matters who shows up in the room. Who the nurse is and who the family is seems to contribute greatly to the nature of the practice and interventions. While this may seem obvious and inherent, it perhaps calls for more reflection on these aspects in our practice; this means being open to what our prejudices and intentions are, while also considering that which the family brings to the conversation. In addition to this, having more than one family member present, and discussing the impact at this familial, relational level is significant. Not only is grief a family affair, but I would argue *therapeutic conversations about grief are a family affair.*

In terms of the family, who they consider significant in their life, as well as the supports and beliefs that they have in their life should be a part of the therapeutic conversation. The finite time that we have to work with families is so brief in terms of clockwork time, but can be elevated to mark an era and experience. Their spiritual beliefs or how they make meaning of the world, as well as the people with whom they have history and will continue to have a future with may help to sustain hope and healing. These things existed with families long before the "intervention" and will be around long after our intervention.

For nurses, it matters that we have expertise, and are in the position where this expertise is acknowledged. We have a responsibility to bring this expertise to the conversation, and use it with tact, wisdom, and judgement. Our expertise is needed especially when families are not able to know what they need. It also matters that we are strangers; or moreover *compassionate strangers* (Robinson, 1996). As "strangers", nurses can be involved in the process, but not involved in the problem (Robinson). A part of what seems to be healing and helpful is that families do not have an obligation towards us – they should not be concerned about what they may be offering us, or how they may be making us feel, or whether or not they are suffering enough for us to learn something from them. The nurse's expertise around families and grief is likely significant, however it is also important to consider the curiosity and attentiveness towards a family's experience of grief. In this way, we should be aware of what else might be guiding our intentions and direction in sessions, perhaps competing demands for student supervision, research, and beliefs.

To also keep in mind for practice is that there is a difference between time and timing. There is an element of timing in this type of therapeutic practice and interventions. There is likely a good "time" for these interventions and times when other things are more important. *When* a therapeutic intervention or conversation may be useful may have little to do with the number of days, months, or years, and more to do with the experience of this time. Furthermore, time may very well have a role to play in healing with grief; however it is more important what the era, the meaning, and the experience are over time that is of significance to healing, more so than time simply passing. The consciousness of time is very apparent in grief – if only there was more time to say good-bye, if only there was more time with the loved one, and then the time since the death, marked by days, weeks, months, and then anniversaries. The timing of interventions should be reflective of what the family is experiencing at that time, and based on what they need – perhaps to help weather the storm and batten the hatches, or perhaps to help charter new territory in a strange and unexpected land. These are the things that are more important to pay attention to than mathematically marked time.

All of the above findings point to what may be considered "extratherapeutic factors" or that of the "therapeutic relationship" as conceptualized by Asay and Lambert (1999). According to Asay and Lambert these factors combined can contribute to up to 70% of the therapeutic change that is experienced in therapy. The factors of who the family is, who the nurse is, who is present in the room, spirituality, and timing stood out as more prominent contributing factors than the particular approach or particular techniques.

On the topic of more particular approaches and techniques however, is the concept of beliefs. There seems to be many peripheral beliefs that are connected to some variation of core beliefs, or beliefs that are at the heart of the suffering (Wright et al., 1996; Wright & Bell, 2009, in press). The focus on beliefs is specific to this therapeutic model of conceptualizing our work, but metaphorically it is useful to think that while peripheral beliefs are easier to access and uncover, and may be easier to initially treat, it is still the core beliefs that may lie at the heart of sustaining change. If therapeutic conversations are conceptualized in this way, as they are with Family Systems Nursing, then it may be useful to further understand how nurses go about finding the core beliefs, how they know they have found one, and then how they may go about challenging or changing it.

Hope is a concept that is frequently discussed in nursing and described in nursing literature. It may be a significant part of many phenomena that nurses encounter, although in the context of this research it seems to be very significant in grief. It may not be that a nurse can give a family hope, but there are particular practices that seem to foster hope in therapeutic conversations, such as challenging beliefs.

Lastly, although previously argued that grief is interpretive, and nursing is an interpretive practice (Moules et al., 2004), this became more apparent and clear through this research. It is even in the use of interpretations that healing in grief, a reduction of suffering and sorrow can occur. This is because the nature of something that is interpreted is that it *can always be interpreted differently*, and this is how suffering can be alleviated. The challenge seems to lie in knowing what the interpretation of an event has been, what the effect of this interpretation is, and then deciding if it would be useful to look at alternative interpretations. Furthermore, however, this means that *all* things need to be open to being interpreted differently, including the beliefs, prejudices, and interpretations that we, as clinicians, are making.

The interactions that were captured in this research reflect an advanced practice in family nursing, and I could not presume that the specific "interventions" that were described through this clinical work are something that the majority of nurses working "at the bedside" will have the necessity or expertise to implement. What I think *is* important is to recognize that nurses do interact with families; they have conversations and they have the intention of being helpful. This is an art, and to be good at this takes practice, but it also takes knowledge. There is not always a language to describe the sense or the interpretations that a nurse makes in the seconds and minutes that go by in a typical day. One thing to keep in mind though, is you never know what might "stick" and what might sustain a family through difficult times ahead, and this asks for an obligation for nurses to be thoughtful and use the sense that they have developed in working with families, and "this family" in particular.

Educational Implications

Several implications for nursing education were discovered throughout the course of this research. During the literature review, it was claimed that what nurses understand about grief makes a difference to their practices around grief (Cody, 1995; Pilkington, 2006). If this is indeed the case, we need to be very cautious about what it is that we are teaching nurses about grief. For example, when theories of grief are being used in nursing that are outdated and still reflective of stage theories, we are perpetuating the dominant discourse of grief being a finite experience. Nurses perhaps should take advantage of their claim to seek understanding and alleviate suffering, and not be invited to pathologize a family's experience.

Grief may not always be seen as being in the domain of nursing. Certainly in this particular context, and this particular practice, conversations between families who are grieving and nurses did occur. Nurses do encounter bereaved families in many different places and many different times. Yet throughout this research, I had countless comments about why a nurse would be studying grief. While this was explainable with my reply that it was an advanced practice, focused in family therapy type work, it does have implications for the nurses who are *not* in advanced practice, who still encounter loss and grief, but are not seen as having any expertise around this. It was apparent and supported in the literature that nurses encounter family members experiencing grief frequently and not only in hospice palliative care; there are the traumatic deaths in critical care areas, the stillbirths and miscarriages, the aging populations in nursing homes and community care, etc. It may seem obvious that nurses should be prepared to be knowledgeable about the topics of death, dying and grief; however this needs to be reflected in nursing education programs. It is within the realm of a nurse's practice to have conversations with families about a myriad of topics, and grief should be included in this. Although not within the scope of this research, perhaps it has implications for future research.

Research Implications

As mentioned in the first chapter, in the plethora of grief literature, grief counselling has been taken up by many professionals. Nurses are the group who seem to have taken this up the least. Nurses, however, are also the largest group of healthcare professionals. They do encounter loss, death, and grief, and while it may not be apparent in their practice that this is in the realm of nurses, it could and should be. It is encouraging to see some nurses, from various settings, beginning to write about grief. The majority of these are written from the perspective of "experts" in an area, or are anecdotal suggestions for practice. Research could be done in a plethora of areas to further expand on this area of nursing knowledge and practice that I would guess is happening in some situations, but not always being articulated. Nurse researchers should be encouraged to be more explicit and more focused on the actual interventions – to describe and articulate the practices that make a difference to families.

Another consideration for grief researchers is how we are languaging the interventions and outcomes of which we hold interest. Is it useful to still measure outcomes of grief counselling through "resolution"? What timelines are considered appropriate and warranted in doing grief research if it is indeed a lifelong experience? With the shift to viewing grief in this way, it would make sense that looking at the usefulness of therapeutic conversations should happen well beyond 1 to 2 years.

Although not within the scope of this research, there is some balancing of all the nuances of the particular practice setting of the FNU. How can we learn further, through research, about the clinical decisions that are made when there are so many other layers to attend to, such as the supervision of the student in the room, and the management of the clinical team behind the mirror? Is it possible to balance these competing demands? Hermeneutically, we should seek out the exemplars that will provide us with the richest data. I wonder if researching (and learning) with expert clinicians, rather than student clinicians, in a therapeutic session would have resulted in different, deeper, or richer research. It was certainly apparent with the one nurse in this research who I would consider an expert, not only in the richness of the data from the sessions, but also the outcomes of the work with the family. In other words, in order to understand the nature of therapeutic practices and conversations, it may be useful to begin with rich exemplars that demonstrate how these conversations and interactions can go well.

However the two families who, at the time of the research interviews, reported little helpfulness from the FNU sessions also still contributed to the understanding of nursing practices and interventions, as well as to understanding therapeutic error or therapeutic failure. Being able to interview families several years after the sessions were completed was unique and exemplary in grief research, and could help us to understand more about what it means to have therapeutic change and to sustain change. It begs the question of whether or not our interventions are only useful if they have long-lasting, permanency. Perhaps it is possible that nursing practices and interventions may be useful to families for a season, a reason, or a lifetime; just because they are not sustained for a lifetime may not necessarily mean that they were not needed and useful at the time.

Chapter 8: Conclusions and Reflections

This research created knowledge not of the methodological kind, but of wisdom to transcend particularities - - to develop the capacity to adapt, not the learning of rules. Therapeutic conversations are a very skilled and artistic activity, requiring competence, wisdom, and judgment. It is not possible to create a recipe, a method, or a precise process that will meet the need of every family. This most artful of nursing practices requires that a nurse not know what to say "in general" to every family who is faced with grief, but rather to know what to say to the particular family who they are working with.

Hermeneutics offers a useful way for interpretation to be taken up by nurses in their practices and research. The intent of this research was not to declare with certainty or finality, the way that grief and nursing interventions occur or should occur. Hermeneutically, we may look at this topic of nursing practices and interventions with grief as one that can always be interpreted differently (Gadamer, 2004). In nursing, hermeneutic interpretation asks nurses to be open to new experiences of grief, through the particularities of the family's experience. This means understanding how the family has come to make meaning out of their situation, for example their loss, and what it means to continue to live with grief.

There is a belief in our society that if we do everything right, no one will suffer. It is supported by the paradigm that believes we can control and manipulate our worlds entirely -- but there is nothing anyone can do to escape grief. Death is not something that we have overcome, and love, lives, and relationships are not something that can be reduced to their controllable parts. Perhaps grief brings the one suffering that we can never escape because it also means we have lived and loved. Perhaps it is in grief that we are still reminded about the nature of our control over our worlds, and the nature of human suffering. The nursing practices and interventions that are offered to families are done so with these things in mind and with the obligation to honour and sustain love lived and living.

The story of La Loba, by Clarrisa Pinkola-Estes (1992), is a useful metaphor to explain the process I have undertaken in the last couple of years during this research.

> The sole work of La Loba is the collecting of bones. She is known to collect and preserve especially that which is in danger of being lost to the world...Her specialty is said to be wolves.
>
> She creeps and crawls and sifts through the montanas...looking for wolf bones, and when she has assembled an entire skeleton, when the last bone is in place and the beautiful white sculpture of the creature is laid out before her, she sits by the fire and thinks about what song she will sing.
>
> And when she is sure, she stands over the critura, raises her arms and sings out. That is when the rib bones and leg bones of the wolf begin to flesh out and the creature becomes furred. La Loba sings some more, and more of the creature comes into being; its tail curls upward, shaggy and strong.
>
> And La Loba signs more and the wolf creature begins to breathe.
>
> And La Loba sings so deeply that the floor of the desert shakes, and as she sings, the wolf opens its eyes, leaps up, and runs away down the canyon. (p. 27-28)

In sifting through the data for this research, I did collect different "bones" or different ideas that stood out to me as significant, that I thought could be used somehow to add new things to the world of grief, or to remind us of things at risk of being forgotten, that would help in understanding the practices of nurses.

Being the first "wolf" that I have constructed from start to finish, although not without considerable preparation and help from others, there were times when I was unsure. I was worried that this would not be good enough or useful enough work - that it would not offer something new or helpful. I was also worried that Hermes may invite me to wander aimlessly away from the topic, caught up in metaphors and interpretations.

There are three things I would like to highlight in my learnings with this wolf. First of all, I think in hermeneutics the topic does need to carry you away a little, in order to get somewhere new, and I hope in the end, that this work is still recognizable as a wolf, that is to say, still on the topic of understanding nursing practices with grieving families.

Secondly, there is a need in hermeneutic interpretation to remain cautious and tentative, knowing that the topic and the text can always be interpreted differently. I found in some areas, that when I became passionate about a certain interpretation or explanation, that I also became more certain about it. While passion is good and necessary not only in hermeneutics, but also in life, I think that this reflection has taught me about the capacity of passion to also get in the way of allowing for the possibility of things to be taken up differently, and has cautioned me to watch for this certainty.

Lastly, at the end of the story of La Loba, the wolf runs away. Perhaps at times she wishes that it had turned out differently, but it is now out in the world. At the end of my writing, I decided that I had said the things that I thought the text had asked of me, I had addressed the things that called me to write, and I wrote what will hopefully stand up as credible, believable, recognizable and useful. In subsequent re-reading of the work, I wondered what else could have been said, or should have been said to flesh it out, and inevitably have found some areas that could use further exploration: what does this mean to Family Systems Nursing? How can this influence undergraduate nursing education programs? How can we further understand extratherapeutic factors with families experiencing grief? Perhaps part of this "ongoing-ness" is the nature of interpretive work, as it will continue to evolve. Part of this need for further exploration will guide me in future writing, research, and practice. This work will therefore continue to be interpreted and to change as it exists out there in the world, not only in this writing but also in other work – my own and that of others.

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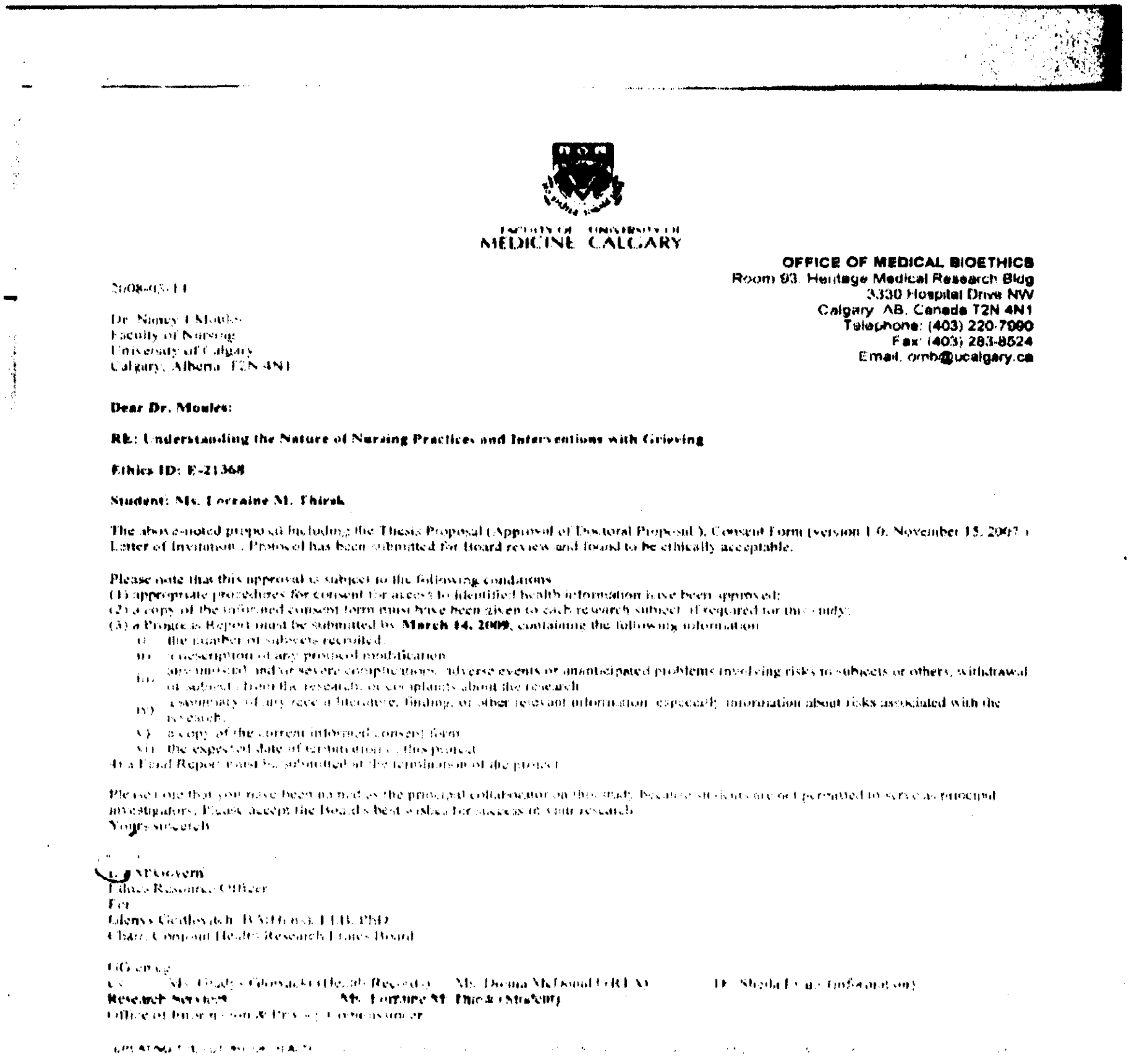
Appendix A – Ethics Approval

Ethics Approval – Family



FACULTY OF MEDICINE UNIVERSITY OF CALGARY

OFFICE OF MEDICAL BIOETHICS
Room 93, Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 283-8524
Email: omb@ucalgary.ca

2008-03-14

Dr. Nancy J. Moules
Faculty of Nursing
University of Calgary
Calgary, Alberta T2N 4N1

Dear Dr. Moules:

RE: Understanding the Nature of Nursing Practices and Interventions with Grieving

Ethics ID: E-21368

Student: Ms. Lorraine M. Thirsk

The above-noted proposal including the Thesis Proposal (Approval of Doctoral Proposal), Consent Form (version 1.0, November 15, 2007), Letter of Invitation, Protocol has been submitted for Board review and found to be ethically acceptable.

Please note that this approval is subject to the following conditions:
(1) appropriate procedures for consent for access to identified health information have been approved;
(2) a copy of the informed consent form must have been given to each research subject, if required for this study;
(3) a Progress Report must be submitted by **March 14, 2009**, containing the following information:
  i) the number of subjects recruited;
  ii) a description of any protocol modification;
  iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
  iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
  v) a copy of the current informed consent form;
  vi) the expected date of termination of this project.
(4) a Final Report must be submitted at the termination of the project.

Please note that you have been named as the principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

L. McGovern
Ethics Resource Officer
For
Glenys Godlovitch, BA(Hons), LLB, PhD
Chair, Conjoint Health Research Ethics Board

[illegible]
cc: Ms. Gladys Glowacki (Health Records)   Ms. Donna McDonald (CHR [illegible])   Dr. Sheila [illegible] (Information [illegible])
Research Services   Ms. Lorraine M. Thirsk (Student)
Office of Information & Privacy Commissioner

[illegible]

Amendment Letter

Glenys Godlovitch
Chair. CHREB
OMB
Room 93, HMRB
403-220-7990

RE: Ethics ID # 21368

Understanding Nursing Practices with Families Experiencing Grief: Exploring the Nature of Therapeutic Interventions

This letter is to request a change to the proposal of the above study. We are wishing to recruit additional participants that were not previously described in the original proposal. We have realized it would be extremely beneficial to invite the nurse clinicians who worked with the grieving families to participate in a research interview regarding the clinical work. Our review of the clinical work through the videotapes and documentation provided data on the perspective of the nurse and the clinical team of what had been helpful or useful to the family. After interviewing the family members who attended these sessions, however, it became apparent that they had experienced the sessions very differently, and remembered them now very differently, than what was presented on the videotapes. Interviewing the nurses would allow for an expanded conceptualization, explanation, and articulation of the interventions and practices that they found to be useful to the family. This would be an invaluable contribution to understanding interventions and practices that occur in the relationship between the family members and the nurse. This would involve the recruitment of three further participants - the nurses who worked directly with the families who have already been interviewed. These participants would be initially contacted by the Principal Investigator to determine their willingness to participate.
Please find attached a revised consent form for the nurse interviews.

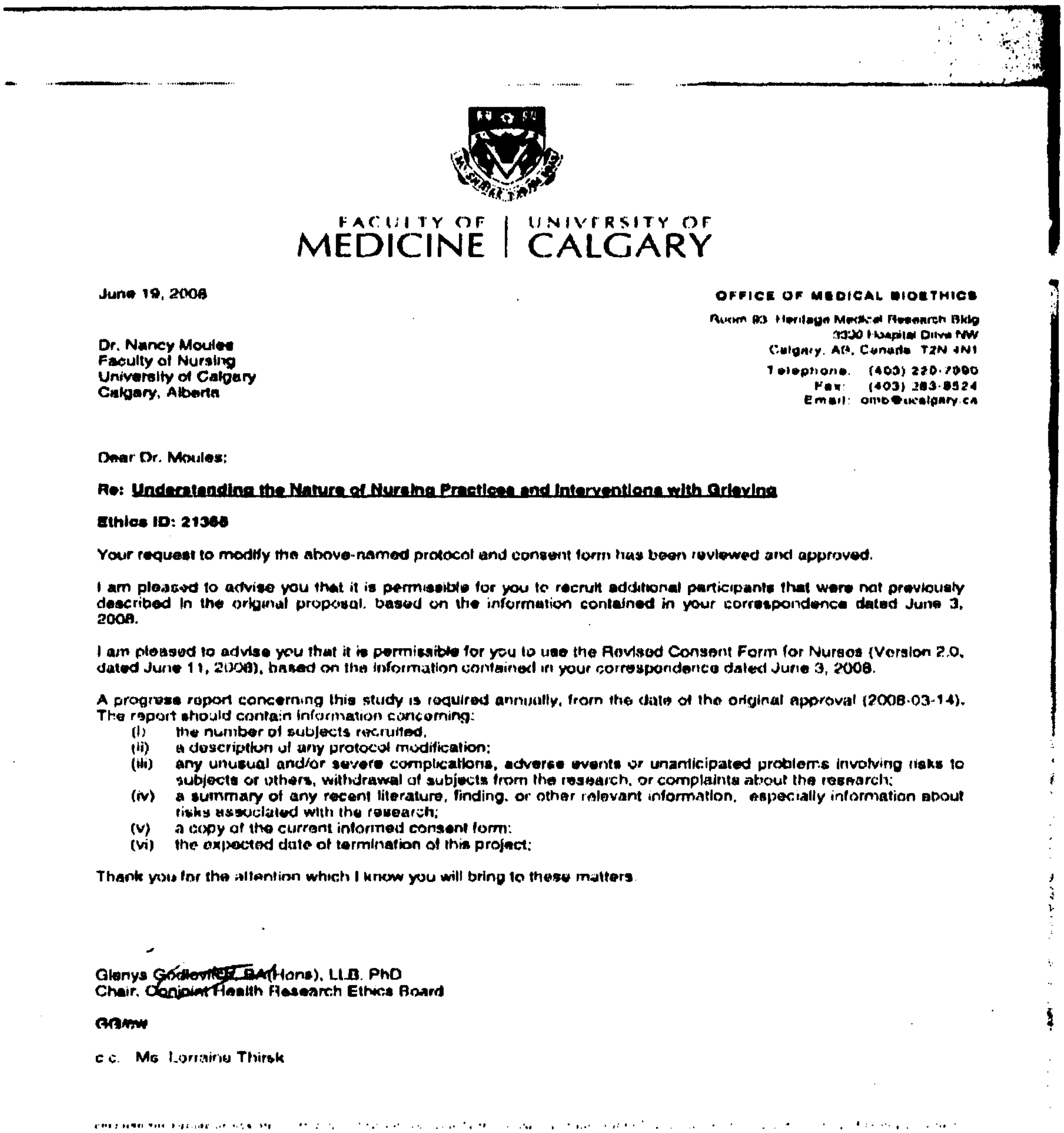
Thank-you for your consideration of this matter,

Nancy J. Moules, RN, PhD, Principal Investigator

Lorraine Thirsk, RN, MN, Doctoral Candidate

Faculty of Nursing, University of Calgary

Ethics Approval – Nurses



FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

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3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
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Fax: (403) 283-8524
Email: omb@ucalgary.ca

June 19, 2008

Dr. Nancy Moules
Faculty of Nursing
University of Calgary
Calgary, Alberta

Dear Dr. Moules:

Re: Understanding the Nature of Nursing Practices and Interventions with Grieving

Ethics ID: 21368

Your request to modify the above-named protocol and consent form has been reviewed and approved.

I am pleased to advise you that it is permissible for you to recruit additional participants that were not previously described in the original proposal, based on the information contained in your correspondence dated June 3, 2008.

I am pleased to advise you that it is permissible for you to use the Revised Consent Form for Nurses (Version 2.0, dated June 11, 2008), based on the information contained in your correspondence dated June 3, 2008.

A progress report concerning this study is required annually, from the date of the original approval (2008-03-14). The report should contain information concerning:

(i) the number of subjects recruited,
(ii) a description of any protocol modification;
(iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
(iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
(v) a copy of the current informed consent form;
(vi) the expected date of termination of this project;

Thank you for the attention which I know you will bring to these matters.

Glenys Godlovitch, BA(Hons), LLB, PhD
Chair, Conjoint Health Research Ethics Board

GG/nw

c.c. Ms Lorraine Thirsk

Appendix B – Information Letter

Dear (family names here),

We would like to invite you to consider participation in a research project. Lorraine Thirsk, a doctoral student at the Faculty of Nursing, University of Calgary, is researching the therapeutic work between nurses and families for families who have experienced the loss of a loved one. The title of this doctoral thesis is: Understanding the Nature of Nursing Practices and Interventions with Grieving Families.

Our records indicate that your family attended sessions at the Family Nursing Unit, at the University of Calgary, related to your experience of grief. In the first phase of this study, we have reviewed session videotapes of families who have attended the Family Nursing Unit to further understand the work in the Family Nursing Unit. Our purpose in the second phase of this study is to interview families some time after their sessions were completed to further understand how, or if, their experiences with the Family Nursing Unit were helpful at the time and if they have continued to influence, be helpful, or not helpful in their experiences of grief.

Although completely voluntary, we are very grateful for your consideration to participate in this study. We are hopeful that this research will help us understand better how nurses can be helpful to families related to their grief. We are curious to know families' experiences of these sessions with the nurse and how, or if, they lead to a decrease in suffering, or healing in grief. Furthermore, we are hopeful this research will allow us to further understand the impact of this kind of clinical work over the years as families continue to live with their loss.

If you choose to participate in this study, you and/or your family will be interviewed by Lorraine Thirsk in a setting and time of your choice. Please contact either Lorraine Thirsk or my supervisor Dr. Nancy Moules for further information or if you would be interested in participating.

Sincerely,

Lorraine M. Thirsk, RN, MN, PhD student
lmthirsk@ucalgary.ca
403-685-4622

Nancy J. Moules, RN, PhD,
Associate Professor, Faculty of Nursing, University of Calgary
njmoules@ucalgary.ca
403-220-4635

Appendix C – Consent Forms

Consent Form - Family

TITLE: Understanding Nursing Practices with Families Experiencing Grief: Exploring the Nature of Therapeutic Interventions

SPONSOR: Faculty of Nursing, University of Calgary

INVESTIGATORS:
Principal Investigator: **Dr. Nancy J. Moules** RN, PhD
Associate Professor, Faculty of Nursing,
University of Calgary
(403)-220-4635
njmoules@ucalgary.ca
Co-Inversitgator: **Lorraine M. Thirsk** RN, MN
PhD (candidate), Faculty of Nursing
University of Calgary
(403)-685-4622
lmthirsk@ucalgary.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Families sometimes find they may be struggling and deeply suffering following the loss of a loved one. Often, people seek the help of professionals, hoping for some help with their grief. Many of the things that professionals have previously thought about grief have not always been useful or helpful to people who have lost someone significant in their lives. Previously, it was thought that grief came to an end or was completed after a certain amount of time; however we now know that people can continue to experience grief, in some manner, for the rest of their lives. Through this study, we can further understand what families who are grieving find useful in their encounters with nurses. This will help nurses and other professionals to better understand how to work with families who have experienced the loss of a loved one.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to further understand nursing practices between families experiencing grief and nurses. We are curious to know what it is that families find useful or helpful in these practices and to further explore and understand this.

WHAT WOULD I HAVE TO DO?

If you agree to participate in this study, you will be requested to participate in an individual unstructured interview, which would involve 1 – 1.5 hours. The researcher will arrange an interview time and place of your convenience, either in your home, or at the Faculty of Nursing, University of Calgary. A second, follow-up interview may be requested. Please also be aware that the video tapes of your meetings in the Family Nursing Unit have been reviewed, and may be used as research data if you agree to participate.

WHAT ARE THE RISKS?

There are minimal risks of participating in this study. As this topic is often a sensitive one, at the conclusion of the interview, the researcher can provide you with contacts to follow-up with any concerns that may have arisen. All participation is voluntary.

ARE THERE ANY REPRODUCTIVE RISKS?

There are no reproductive risks associated with this study.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. You may find it helpful to talk about your experiences but there is no guarantee that this research will help you. The information we get from this study may help us to provide better help in the future to other families who are grieving.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary. You may withdraw from the study at any time by contacting either of the researchers. The researcher may also withdraw your participation from the study at any time if there were any complications that may affect the clarity of data. If any new information becomes available that might affect your willingness to participate in the study, you will be informed as soon as possible.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

Your participation does not involve anything further than what has been described.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

If you agree to participate in an interview, you will be compensated for any parking costs at the University of Calgary. No further payment will transpire.

WILL MY RECORDS BE KEPT PRIVATE?

Following the interview, the interview tapes will be typed out by Lorraine Thirsk. Lorraine will remove anything that would identify you when she types out the interview. Any segments of videotapes that are typed out will also have identifying information removed. The interview audiotapes and transcripts will be secured in a locked filing cabinet in a secure office. The principal investigator, the co-investigator, and the University of Calgary Conjoint Research Ethics board will have access to the typed interviews. The tapes and transcripts will be destroyed when the study is finished. Information and statements from the study may be published in health care journals. Any publications will ensure that all identifying information, as much as possible, is changed to protect your privacy. Even though minimal identifying information will be used in publications, if the publication is read by one of the nurses who worked with you during your sessions at the Family Nursing Unit, they could know that your family was interviewed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the Faculty of Nursing, the University of

Calgary, the Calgary Health Region or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Nancy Moules (403) 220-4635
Or
Lorraine Thirsk (403) 685-4622

If you have any questions concerning your rights as a possible participant in this research, please contact Pat Evans, Associate Director, Internal Awards, Research Services, University of Calgary, at 220-3782.

PARTICIPANT'S NAME	SIGNATURE AND DATE
INVESTIGATOR/DELEGATE'S NAME	SIGNATURE AND DATE
WITNESS' NAME	SIGNATURE AND DATE

The University of Calgary Conjoint Health Research Ethics Board has approved this research study. A signed copy of this consent form has been given to you to keep for your records and reference.

Consent Form – Nurse

TITLE: Understanding Nursing Practices with Families Experiencing Grief: Exploring the Nature of Therapeutic Interventions

SPONSOR: Faculty of Nursing, University of Calgary

ETHICS ID: 21368

INVESTIGATORS:

Principal Investigator: **Dr. Nancy J. Moules** RN, PhD
Associate Professor, Faculty of Nursing,
University of Calgary
(403)-220-4635
njmoules@ucalgary.ca

Co-Investigator: **Lorraine M. Thirsk** RN, MN
PhD (candidate), Faculty of Nursing
University of Calgary
(403)-685-4622
lmthirsk@ucalgary.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Families sometimes find they may be struggling and deeply suffering following the loss of a loved one. Often, people seek the help of professionals, hoping for some help with their grief. Many of the things that professionals have previously thought about grief have not always been useful or helpful to people who have lost someone significant in their lives. Previously, it was thought that grief came to an end or was completed after a certain amount of time; however we now know that people can continue to experience grief, in some manner, for the rest of their lives. Through this study, we can further understand what families who are grieving find useful in their encounters with nurses. This will help nurses and other professionals to better understand how to work with families who have experienced the loss of a loved one.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to further understand nursing practices between families experiencing grief and nurses. We are curious to know what it is that families find useful or helpful in these practices and to further explore and understand this. We are also interested in what nurses perceived as being helpful to the families who came to talk with them.

WHAT WOULD I HAVE TO DO?

If you agree to participate in this study, you will be requested to participate in an individual unstructured interview, which would involve 1 – 1.5 hours. The researcher will arrange an interview time and place of your convenience, either in your home, or at the Faculty of Nursing, University of Calgary. A second, follow-up interview may be requested. Please also be aware that the video tapes of your meetings in the Family

Nursing Unit have been reviewed, and may be used as research data if you agree to participate.

WHAT ARE THE RISKS?

There are minimal risks of participating in this study. As this topic is often a sensitive one, at the conclusion of the interview, the researcher can provide you with contacts to follow-up with any concerns that may have arisen. All participation is voluntary.

ARE THERE ANY REPRODUCTIVE RISKS?

There are no reproductive risks associated with this study.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. You may find it helpful to talk about your experiences but there is no guarantee that this research will help you. The information we get from this study may help us to provide better help in the future to other families who are grieving.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary. You may withdraw from the study at any time by contacting either of the researchers. The researcher may also withdraw your participation from the study at any time if there were any complications that may affect the clarity of data. If any new information becomes available that might affect your willingness to participate in the study, you will be informed as soon as possible.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

Your participation does not involve anything further than what has been described.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

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IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the Faculty of Nursing, the University of Calgary, the Calgary Health Region or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Nancy Moules (403) 220-4635
Or
Lorraine Thirsk (403) 685-4622

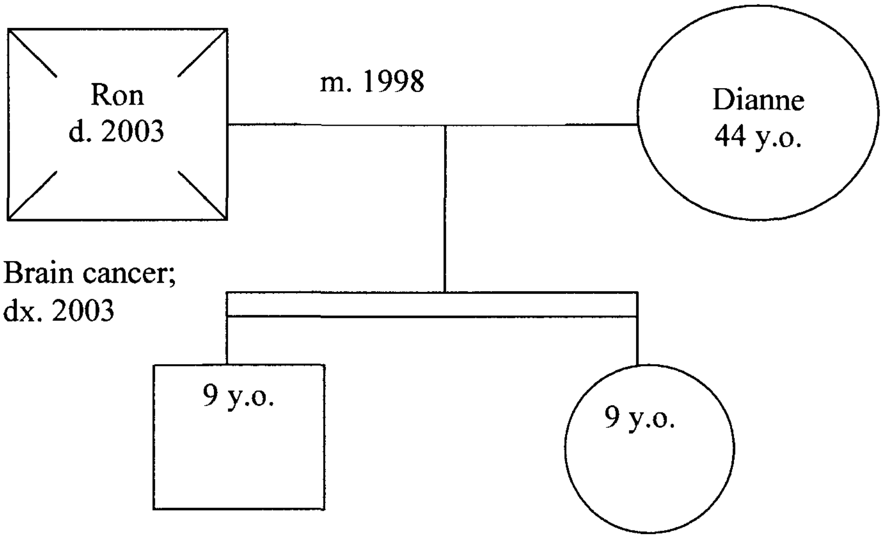
If you have any questions concerning your rights as a possible participant in this research, please contact The Ethics Resource Officer, Internal Awards, Research Services, University of Calgary, at 220-3782.

PARTICIPANT'S NAME	SIGNATURE AND DATE
INVESTIGATOR/DELEGATE'S NAME	SIGNATURE AND DATE
WITNESS' NAME	SIGNATURE AND DATE

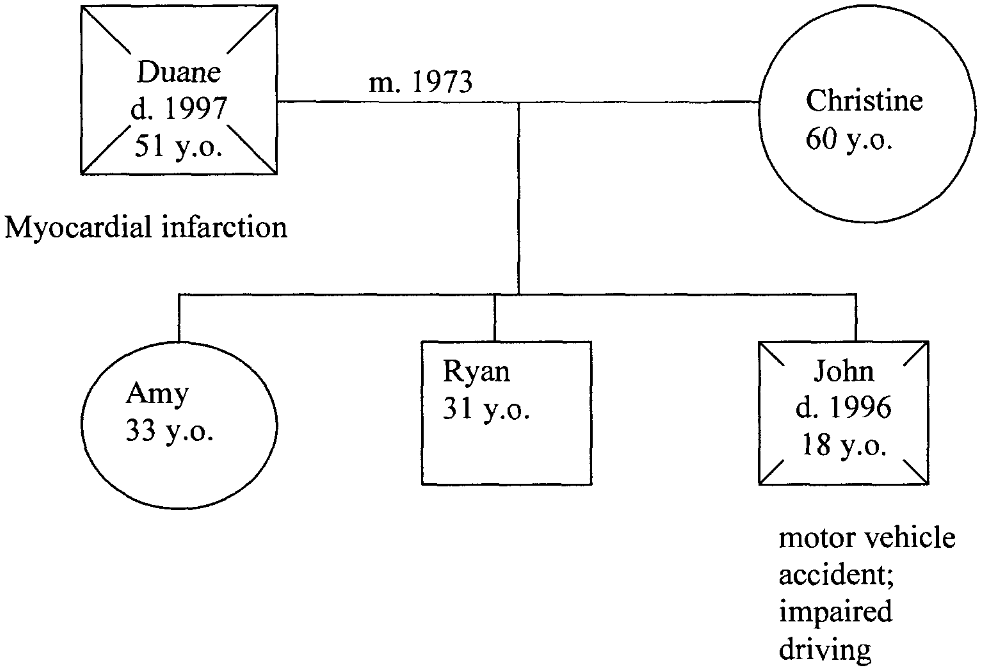
The University of Calgary Conjoint Health Research Ethics Board has approved this research study.A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix D – Family genograms

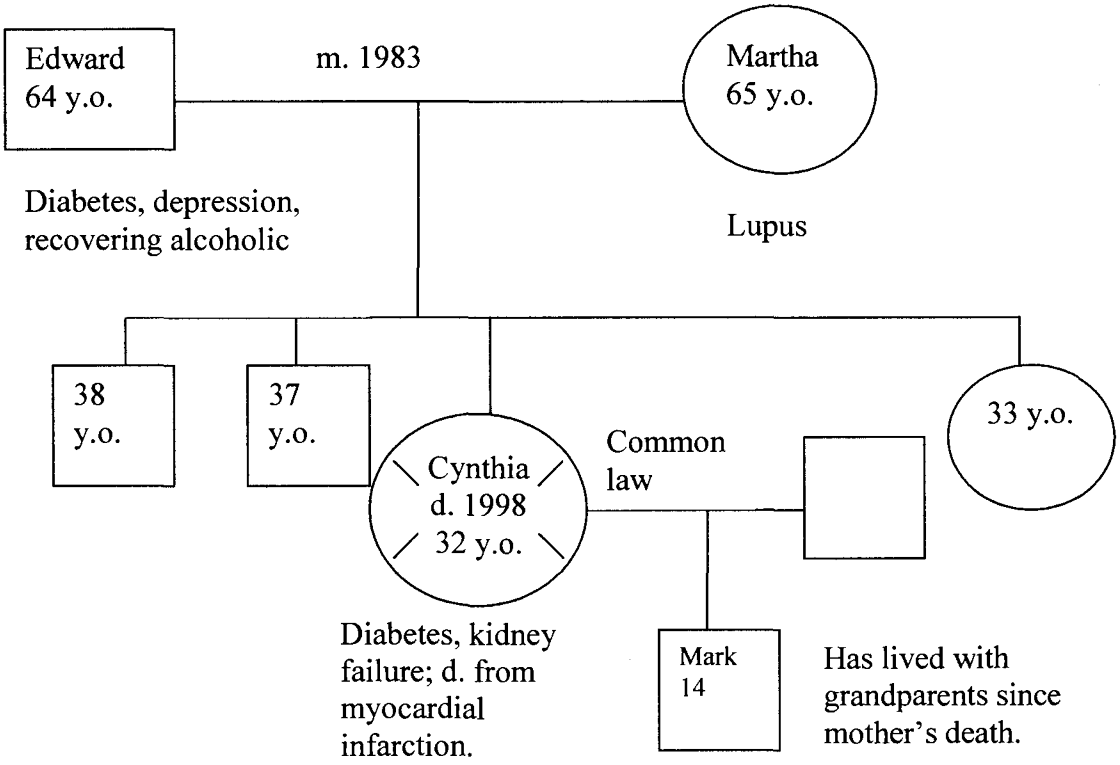
Dianne



Christine (Amy and Ryan)



Edward and Martha



Ages given are at time of research interview (or date of death).