

Live supervision and family systems nursing: postmodern influences and dilemmas

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TAPP D.M. & WRIGHT L.M. (1996) *Journal of Psychiatric and Mental Health Nursing* 3, 225-233

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Evolving nursing practices in a graduate nursing education programme that offers live clinical supervision in family systems nursing can be conceptualized within a postmodern perspective. Postmodernism is described as a debate about knowledge that questions traditional foundational theories or explanations in science, culture, religion and literature. Practices of a clinical supervision system, i.e. a graduate student, supervisor, and clinical team, illustrate postmodern influences on clinical work with families. Dilemmas posed by contemporaneity of modern and postmodern influences are also explored.

Keywords: family nursing, family systems nursing, live supervision, postmodernism

Accepted for publication: 22 April 1996

Introduction

There is little evidence in the nursing literature of awareness of the influence of postmodern ideas on the ways in which we conduct nursing practice and understand the obligations of our clinical work to alleviate suffering and promote health. Postmodern assumptions have the potential to invite plurality and creativity in our nursing practices. These influences are explored in the following description of a graduate nursing education programme that offers live clinical supervision to students undertaking clinical specialization in family systems nursing.

What is postmodernism?

Debates regarding the nature of postmodernism have flourished over the past two decades. Rose (1992) demonstrated that the use of the word 'postmodernism' dates back more than a century. The early usage implied a 'break with the preceding style' (Rose 1992, p. 127). Current usage implies a movement in reaction to that which is designated as modern. The influence of the break or tension of postmodernism has been demonstrated in art, literature,

architecture, science, culture and philosophy. Jencks (1992) asserted that postmodernism is a reaction to "the three great 'isms' of modernity—reductivism, determinism and mechanism" (Jencks 1992, p. 12). He has also boldly proposed that the 1960s were the turning point for the postmodern movement.

While there is some debate whether postmodernism can or should be bracketed by a specific time period, there is some consensus that aspects of that which is designated as modern and postmodern exist contemporaneously (Jencks 1992, Rose 1992). Jencks stated that

Post-modernism means the end of a single world view and, by extension, 'a war on totality', a resistance to single explanations, a respect for difference and a celebration of the regional, local and particular... Post-Modernism means the continuation of Modernism and its transcendence, a double activity that acknowledges our complex relationship to the preceding paradigm and world view. (Jencks 1992, p. 11)

Thus pluralism is a key focus of postmodernism. Jencks (1992) included feminism (the exploration of issues of gender and power), sciences of complexity (a movement from study of inanimate matter to study of complex living

systems and social groups), and self-organizing democratic movements as other traits of postmodernism.

Lyotard (1991) asserted that postmodernism is not marked by a period of time in relation to modern influences on knowledge, cultures and social worlds, but is rather a debate about knowledge:

Postmodernity is not a new age, but the rewriting of some of the features claimed by modernity, and first of all modernity's claim to ground its legitimacy on the project of liberating humanity as a whole through science and technology. (Lyotard 1991, p. 34)

The status of the assumption that progressive technology will necessarily lead to a better world has become open to questioning and doubt. This debate about knowledge encompasses 'incredulity toward metanarratives' (Lyotard 1991, p. 138). These metanarratives, the foundational theories of our social world, are collapsing and becoming questionable, resulting in a loss of faith in science, religion, and political leadership (Parry & Doan 1994).

As the claims of these grand narratives have been thrown into doubt, space has been created to question sacred traditions, to hear marginalized voices and perspectives, and to value difference and dissensus as well as consensus. At times, questioning the authority of these narratives is freeing, inviting invention, creativity and new possibilities. At other times, holding open questions about truth claims invites uncertainty, indecidability, and indeterminability to predominate. There can be a sense of comfort in certainty, guidelines, warrants, knowledge, and 'truth'. We must contend with the difficulties of daily life that come to meet us, the hard decisions, living in 'the flux' (Caputo 1987), 'surfing along the edge of chaos' (Parry & Doan 1994). It can be extremely difficult to function in a state of suspended 'decidability'. We must keep open even the decidability of the status and legitimacy of postmodernism, lest it become yet another metanarrative to which we thoughtlessly accord preeminent status and privilege.

We must also contend with living well in the face of our difficult day-to-day contingencies and obligations (Caputo 1993, Jardine 1994). These difficulties, obligations, and contingencies are reminders that can constrain us from entertaining these postmodern ideas merely as a form of philosophising or theorizing. In nursing, our obligations and contingencies bear strong connections to people suffering with illness, and persons learning to be of assistance to those who are suffering (both nurses and families). They are obligations that require action and thoughtful choices.

Nursing is only beginning to directly address postmodern debates in the nursing literature (Lister 1991, Cheek & Rudge 1994, Parsons 1995, Reed 1995, Watson 1995). However, there is evidence that nursing has been influenced by postmodern thinking, even if it has not been

labelled as such. Over the past decade, there has been an openness to a plurality of modes of research inquiry as significant contributions to nursing knowledge (Cull-Wilby & Pepin 1987). Nursing science and literature reflect exploration of 'other' ways of knowing outside traditional science (Chinn & Watson 1994, Greene 1994, McIntyre, 1995). Feminist nursing perspectives have questioned gender and power relationships in the health care system, nurses' roles in the system, and in people's experience of health care problems in society and the health care system (Campbell & Bunting 1990, Sampsel 1990). Nurse researchers and clinicians have demonstrated interest in a 'science of complexity' (Jencks 1992, p. 13), which includes reciprocal individual, familial, social, environmental and biological influences on health and illness. As a discipline, nursing demonstrates the contemporaneity of modern and postmodern influences in our clinical practices, educational programs, research approaches, and theories.

Thus, these developments can be situated within a larger perspective of postmodern influences in culture, science, philosophy, art and literature. The remainder of this paper addresses the context for our clinical practice and supervision, the influence of postmodern ideas, and our identification of the efforts to implement these ideas.

A context for nursing practice

The major emphasis of the nursing practices to be examined are assisting individuals and families to alleviate or diminish emotional and/or physical suffering, and teaching graduate students about working with families. Specifically, live supervision of graduate students in a Master of Nursing programme that offers clinical specialization in family systems nursing is described.

The Family Nursing Unit

The Family Nursing Unit (FNU) is an outpatient clinic that was established in 1982 at the Faculty of Nursing, University of Calgary, Canada (Wright *et al.* 1990). The Master of Nursing programme at the University of Calgary offers advanced nursing practice preparation in several clinical focus areas, one of which is Family Systems Nursing. Since 1982, approximately 290 families have received services at the FNU, and 85 graduate students have completed practicums within the FNU. The graduate students are primarily female, and families accessing services at this clinic are predominantly white and middle class. This approach to learning about advanced practice in clinical work with families has also been offered to health professionals as a one week externship programme

since 1987. Externship participants have included clinicians, educators, and administrators from Canada, the United States, Australia, Japan and Taiwan.

The Family Nursing Unit is an educational and research unit that provides services to individuals, couples and families experiencing difficulties with a wide variety of chronic, life-threatening, and psychosocial health problems. The FNU is faculty practice unit. Each family benefits from a clinical nursing team approach, and is interviewed by a graduate nursing student (Masters or Doctoral level) or a faculty member. The interview is observed via a one-way mirror by the clinical nursing team who participate in the therapeutic conversation via telephone intercom with the interviewer (Wright *et al.* 1990). Each interview is videotaped with the family's consent, and an average of four sessions are provided for each family. Families access this service directly or through referral by other health care professionals in the community.

Within this programme of studies, family systems nursing is viewed as specialist practice within the Master of Nursing program at The University of Calgary. The family is emphasized as the unit of care (Wright & Leahey 1994), and the focus is on interaction and reciprocity between the illness and the family, and amongst family members, the clinician, and the clinical team. Theoretical underpinnings of the clinical practice within the FNU include a foundation of systems, cybernetics, communication, narrative, and biology of cognition theories. Students are also introduced to foundational models for assessment and intervention, namely the Calgary Family Assessment Model (Wright & Leahey 1994b) and the Calgary Family Intervention Model (Wright & Leahey 1994a,b). An advanced practice approach focusing on families, beliefs, and illness has evolved from this clinical work over the past decade (Wright *et al.* 1996). Course work for students in the family systems nursing speciality currently include two clinical practica within the FNU. The focus is on the development of conceptual, perceptual and executive skills (Wright & Leahey 1988, 1994). There are also two elective courses on families and illness, and family health research. This approach to advanced nursing practice requires knowledge of family dynamics, family systems theory, family developmental theory, family assessment and intervention.

During the first clinical practicum, graduate nursing students have opportunities to role-play family interviews and observe faculty members conducting clinical work with families. Observing faculty members' practices as clinicians is one example of the influence of postmodern ideas. Mills & Sprenkle (1995) suggested that the very word 'supervisor' implies a hierarchy of perspective not congruent with the postmodern assumption that age, experience or con-

ferred title do not equate with greater validity to individual human perception. As faculty members work directly with families and are supervised by another faculty member, clinical skills are modelled, debriefed and discussed in the same manner as student practices in the subsequent practicum. This reversal of positions helps to demystify the supervisory process (Mills & Sprenkle 1995). During both practica graduate nursing students participate in family sessions as members of a clinical team that observes the family session from behind a one-way mirror. During the second clinical practicum, students work directly with the families and receive live supervision from faculty, with other members of the clinical nursing team observing.

Postmodern discourse invites critique of notions such as specialist practice, theoretical underpinnings, and foundational models of knowledge. The above description of the context for our nursing practices reflects the modern influences of structure and authority in health care system, the university setting, and the nursing discipline. This context illustrates the contemporaneity of modern and postmodern influences as we contend with evolving practices in which we attempt to conduct ourselves well in our obligations to both families and students. Even if postmodern ideas are engaged and entertained as useful, it is difficult to deny that we remain implicated in the linguistic, cultural and social systems that coconstitute our realities. Our practices can challenge the ways in which modern influences may be constraining or subjugating, but we cannot deny that these influences exist. As we describe the interplay between this context and our nursing practices, we are reminded that the modern-postmodern debate need not be one of dichotomous 'either/or' positions, but rather a dialogue that opens a range of possibilities for creating new meaning somewhere in the middle.

In the following, the use of the term 'clinician' will refer to the nurse (who may be either a student or a faculty member) conducting the family interview. 'Supervisor' refers to the faculty member behind the one-way mirror who is responsible for providing phone-ins to the clinician during the interview, and for facilitating the learning of all clinical nursing team members. The 'clinical nursing team' indicates the observing team behind the one-way mirror comprised of the supervisor and approximately 5-8 graduate nursing students.

Live clinical supervision

Within the context of nursing, live supervision has been predominantly used for the development of psychomotor skills. Live supervision in the context of family work is the observation of a trainee's interview with a family by a supervisor, usually from behind a one-way mirror. The

most comprehensive use of and attention to live supervision tends to be found in the work of family therapists. Montalvo (1973) first coined the term 'live supervision' while he was part of the Philadelphia Child Guidance Clinic group, who developed this particular model of training. To date, nursing has not made full use of live supervision to guide and direct nurses learning about family work. A core belief held by faculty in the FNU is that live supervision is the most useful method for development of perceptual, conceptual and executive skills (Wright & Leahey 1988, Wright 1994). Advanced clinical practice with families requires advanced family nursing intervention skills. The primary goal for clinical practice with families is the development of therapeutic competence with families (Wright 1994).

The emphasis on live supervision for development of interpersonal skills is congruent with a postmodern perspective of language as a generative process, and knowledge as socially constructed. There is an underlying belief that we are co-constructing understanding and knowledge with and about families, students and faculty members throughout the clinical sessions. There are explicit attempts in our work to create space to hear many voices or perspectives, those at the margin in addition to those at the centre. There are also attempts to minimize the possible negative impact of hierarchy, authority, and student evaluation.

An obvious asset of live supervision is the possibility of immediate feedback during the session which can increase the student's repertoire of intervention skills (Chesla *et al.* 1993, Wright 1994). Feedback may be received through telephone communication, if such exists, between the observation and interview rooms. The supervisory phone-ins may offer the clinician ideas about how to proceed in the therapeutic conversation (possible questions to ask, alternative beliefs to offer) and about the process (noticing a shift in affect, avoiding escalating symmetry, bringing discussion about implicit conflict into the conversation) (Wright 1986). Students have opportunities to experiment with new behaviours and interventions, and to benefit from the team feedback, discussions and videotape review of interventions.

It is possible to provide live supervision even without a one-way mirror. In this case, the supervisor may 'sit in' on the actual interview process and participate minimally or, preferably, not at all. We prefer to have the supervisor function in the role of a back-up resource rather than actively participating within the session. In this way, the status of the nurse-interviewer is not usurped by the supervisor. In addition, the nurse-interviewer does not become overdependent upon the supervisor's presence in the room (Wright & Leahey 1984).

The clinical work with a small number of families across two clinical terms is intense. There is an underlying belief in 'the fecundity of the individual case' (Gadamer 1989, p. 38, Jardine 1992), that the particular family instances afford knowledge that is at least as relevant and useful as knowledge gleaned from theming of qualitative data or from generalizing statistical probabilities. The therapeutic conversations with the family during the sessions, and the conversations with students before and after the sessions, afford powerful learning opportunities.

Format of the family session

The format of the family sessions described below is the same for both the first and second practica. Immediately prior to each family appointment, the clinical team meets for a pre-session, which lasts approximately 15–30 minutes. The family genogram is reviewed, and primary information about the family or a summary of the previous session interventions and significant conversational events are reviewed. Hypotheses are generated about possible constraining beliefs or interactional patterns. Students use relevant literature either as a starting point for hypotheses about the family and potential lines of questioning, or to support their own ideas about how to proceed in the session. Pre-sessions provide opportunities for the student to articulate their thinking and beliefs about the family and to anticipate possible issues that could arise in the session.

Families are fully informed of the presence of the clinical team behind the one-way mirror, and are offered an opportunity to meet the team members. The one-way mirror is used as a two-way flow of information. The presence of the clinical nursing team is framed as a resource to both the family and the clinician. The intent is to provide multiple ideas to the family in addressing their concerns, and to assist the clinician in conducting the clinical work. Families are often invited to participate in reflecting team conversations with the clinical team (Andersen 1991). Family members exchange places with the clinical team, and observe from behind the mirror while the team discusses their ideas about the dilemmas and suffering confronting the family. The family then returns to the interview room and discusses their impressions of the team comments with the nurse clinician. If a reflecting team is not offered to the family, the clinician usually takes an intersession break about 45 minutes into the interview to meet with the clinical team. Additional ideas and interventions that are co-evolved by the team are then offered to the family by the clinician at the conclusion of the session.

Following the session, the entire clinical team meets for a post-session conversation about the clinical work, usually lasting about 30 minutes. One major focus for this conver-

sation is the team's impressions of the family during the session and ideas about the problem and potential solutions or interventions. The second major focus is feedback for the clinician and discussion of the therapeutic process of the interview. Postsession conversations enable students and supervisors to learn about multiple ways of conceptualizing and understanding the family and the clinical work, and to entertain possibilities for future directions in the work with the family.

Influences of postmodernism and live clinical supervision

We make choices about how to conduct ourselves in our lives as nurse educators and nursing students as we fulfill our day-to-day obligations. The postmodern debate about the nature of knowledge is reflected in our nursing practices. The family systems nursing practices in the FNU are described as 'moves' and interventions (Wright *et al.* 1996). The term 'moves' describes the process and flow that is co-evolved with the clinician and family members. 'Move' has less of a boundary and weaves as a seamless whole, implying intertwining between persons and ideas. The move is an ongoing process, flowing over time, bringing together a series of interventions. One example of a macromove would be 'uncovering illness beliefs' while a micromove within this macromove would be 'drawing forth beliefs about healing or treatment'. A specific intervention within this micromove might be 'offering a commendation' of a family's courage in coping with the long haul of chronic illness. In the description below of the practices or 'moves' of the clinical team, it is assumed that the student and supervisor share responsibility for contribution to the learning of the student, that together they comprise a 'supervision system' (Wright & Coppersmith 1983, Anderson & Swim 1995). Together, they comprise a relational and generative system that operates through language and conversation.

Co-evolving a context of learning

The clinical team attempts to offer ideas about the clinical work and the family in tentative language: 'I wondered if the father might think that...' or 'if we were to believe that...' or 'Another way of understanding this pattern could be that...'. This language embeds the notion to the speaker and to other team members that ideas proposed are not necessarily 'the truth', but that there are several valid ways of understanding the family. This constraint helps individuals to be less convinced of their own ideas, to stay curious about dilemmas in clinical practice, and to be more open to entertaining the ideas of others. Tentative

language also helps to challenge ideas of hierarchy and expertise within the group by acknowledging and valuing the contributors of both students and faculty (Bobele *et al.* 1995). Striving to acknowledge different ideas that are useful, rather than striving for consensus of ideas, invites greater possibilities for the interventions that may be most helpful to the family. A challenge for the supervisors is 'simultaneously participating in multiple and contradictory expressions of viewpoints so that all can be explored' (Anderson & Swim, p. 4).

As students become increasingly familiar with family systems nursing practices, they are more able to articulate aspects of their practice (i.e. skills, behaviours, knowledge, and attitudes) that they are attempting to enhance. The supervisors can facilitate this progress by asking about the student's preferred developments for a particular session: 'What do you want to work on in this session?'; 'What would you like the team to keep in mind as we are observing your work so that our feedback can be most helpful to you?'. Students also become increasingly able to identify areas where they would like assistance. Students often ask directly for tips about how to approach a particular situation in the session. As supervisors, faculty have a responsibility to present building blocks (e.g. theories, research, other clinical experiences) as 'points of departure for exploration and discussions' (Cantwell & Holmes 1995, p. 38). Ideas are presented as options that could provide therapeutic leverage rather than certain solutions.

Co-constructing understandings of the family and the interview process

Clinical team conversations occur in the pre-session, inter-session, and postsession meetings, and explore possible meanings of the reciprocal influences between illness and family members. Exploring the team members' beliefs about the family and the problem usually reveals many different ideas. The supervisor focuses particularly on understanding the clinician's beliefs about the family and the dynamics of their work together. Often a postsession will begin simply by the supervisor asking the clinician to 'Tell us about your experience of the session'. When team members have offered many different explanations, it may be helpful to ask the clinician 'Which of these explanations fits best for you?'. The supervisor attempts to help the team members co-evolve a description or explanation of the family situation and the interview process that provides the most leverage for intervention, with the intent of helping to alleviate the family's suffering. The supervisor facilitates the team's conversations, with clinical team members, the clinician, and the supervisor all offering their impressions, ideas, and observations.

There is often explicit acknowledgement with the families that we learn from them. Sometimes our learnings are very particular to their situation. Sometimes, we identify learnings that could be helpful to share with other families. Students are invited to discuss with the family the ideas they have learned from them, and the ideas that will help them in their work with other families. This acknowledges the family members' contributions to the students' learning, punctuates salient aspects of the conversation, and acknowledges the family members' contributions to alleviation of the suffering of other families that the student will encounter.

Shifting nurses' beliefs about the family

An important focus of attention for the supervisor is the beliefs and views that the clinician holds regarding what she/he is observing and how she/he believes they can be helpful (Wright *et al.* 1990, Wright 1994). Just as families' constraining beliefs can restrict options for solving problems, nurses' beliefs about the family can also restrict possibilities for therapeutic interventions (Wright *et al.* 1996). Examples of commonly held constraining beliefs include: the family must function in a certain manner; the nurse must be helpful to the family and fix their problems; if families do not respond to the nurse's advice, it is because they are non-compliant or resistant (Wright & Levac 1992); and the family has so many problems that it is impossible to know where to begin. This is challenging for the supervisor who must be able to conceptualize multiple system levels simultaneously: 'What are the beliefs of the family system?'; 'What are the beliefs of the family-clinician system?'; 'What are the beliefs of the family-clinician-clinical nursing team system?' (Wright & Coppersmith 1983).

To challenge constraining beliefs, the supervisor attempts to offer alternative perspectives (for example, by phone-in during the interview), or by inviting ideas from other students during pre-session, reflecting team discussion, or post-session. A problem saturated view of the family can be challenged by purposeful attempts to draw forth descriptions of family strengths that have been witnessed or reported in the session. Team members may offer ideas they have encountered in the research literature or their experiences with other families, which can provide a more useful explanation of the family. Students often learn to challenge their own beliefs by recognizing the times when their perspective of the family is not helpful.

Noticing and punctuating new developments in clinical practice

Just as we interested in recognizing and distinguishing changes in families over time, the supervisor strives to

notice and point out differences in the student's clinical work over time. Sometimes, the student is invited to reflect on their own learnings during the post-session by asking them 'What stood out for you about the family?'; 'What stood out for you about the session?'; 'What did you experience differently about today's session?'; or 'How do you think you helped this family today?'. When new developments in clinical skills are noticed, the supervisor can embellish them by inquiring directly about them: 'What do you think made this new development possible?'; 'Is this a significant new development?'; 'What does this say to you about your clinical work?'; 'What might this suggest to you about future directions in your clinical work?' (White 1989, 1990). These reflections invite the clinician to embellish and solidify ideas about significant events that occurred during the session where their own thoughts and actions particularly made a difference.

The graduate nursing students review the videotapes of their family sessions to be able to take a reflective observing position of their clinical work. This has been an extremely useful tool for students to acknowledge differences in their work within sessions and over time. During videotape supervision, the supervisor may invite the student to pay particular attention to a segment of the videotape that demonstrated a new development in the clinician's work.

Post-session conversations provide feedback for the clinician on the development of their clinical skills. Commendations that draw forth student strengths are offered to the clinician by all team members during every post-session conversation by faculty and students. Similarly, suggestions for improvement are also discussed by the entire clinical team, and students learn from each others' experiences. This form of direct and extensive live supervision of clinical work is new to most nurses, and they are often very sensitive to this feedback. Evaluative comments from faculty can be laden with preconceptions of authority and expertise, and shaded by consequences of evaluative outcomes within the university context. Students can ask themselves: 'How might the ideas be helpful in my development of family skills?'; 'Of this feedback, which ideas 'fit' for me, and are useful to me?'; 'How could I modify this advice to accomplish the necessary outcomes and make it more useful to me?'.

As students gain more confidence in their clinical skills, supervisors can help students to develop their own personal style of conducting family work. White (1989/90) cautioned that there may be a risk of succumbing to a 'technology of interviewing' (p. 28) in which there is a privileged frame or model for clinical practice with approved truths, and known and specified interviewing skills to be mastered. Within the supervision system, stu-

dents require space for imagination and creativity as they add family interventions to their own repertoires of nursing experience. Students benefit when they are willing to 'try out' new behaviors in the session to see if and how they experience ideas and interventions as useful. Supervisors can facilitate this development by being sensitive to the benefits and limitations of the privileged frame, and by building upon the individual beliefs and attributes that enhance the effectiveness of the student's clinical work. Students can reflect on the uniqueness of their own personal approach by asking themselves 'What do I like most about my family interviewing style?' and 'What do I most want to change or conserve about my own style of working with families?'

Dilemmas of postmodernism and live clinical supervision

While we attempt to acknowledge postmodern influences on our clinical and teaching practices, we also recognize the influences of larger systems and previous practices upon live supervision. There are many potential dilemmas for the supervision system utilizing live supervision.

The status of 'knowledge'

As educators and as learners, we can most easily embrace the postmodern debate by resisting the 'temptation of certainty' (Maturana 1987, Amundson *et al.* 1993) in what we believe to be truths, knowledge, research, or theoretical underpinnings. In our clinical work, theory and research are of use in generating an understanding of the situations we encounter. However, these ideas can also constrain us from entertaining ideas outside this body of knowledge that might lend even more understanding of family dilemmas, or nurse-family system dilemmas. When knowledge is viewed as socially constructed through language, the balance can shift from privileging content to valuing the process by which knowledge is generated. Traditionally, both educators and students have placed more emphasis on learning *what* we need to know about families, rather than *how* we engage in skillful understanding of families.

Expertize and hierarchy

The clinical supervisor usually has expertize by virtue of extensive study of family theory and research, and extensive clinical experience with families. There are also role expectations of faculty in the university setting that contribute to perceived and real hierarchies in status and power within the learning context. The supervisor has obligations to the university to evaluate the performance of

students, and professional disciplinary obligations to develop competent practitioners. SUPER/vision (Stewart & Amundson 1995) implies a privileging of the knowledge and perspective of the supervisor. The work of the clinical team can take on the flavour of meta/vision. The root 'meta' is derived from Greek, meaning sharing; joint action in pursuit of a quest (Hoad 1986). The role of the supervisor becomes one of opening space to create room for meta-perspectives, for the expertize and voices of others. The goal of these many perspectives is not necessarily to obtain consensus, which implies that there is a right answer or a best answer, but to generate many ideas and answers (Bobebe *et al.* 1995). Ultimately however, the supervisor is in the professionally sanctioned position of taking the ultimate responsibility for alleviating or diminishing suffering of families and for the development of competent clinical skills of students.

The learner also brings expertize to this context of family systems nursing and live supervision. Graduate students present with a wide variety of personal, educational, and nursing experiences. Metaperspectives can only be heard when students are willing to be active, engaged participants. Individual expertize can be shared when both the clinical supervisor and the student value these past experiences and acknowledge different kinds of expertize that contribute to assisting families with their difficulties.

Solipsism and relativity

Each person in the supervision system is entitled to a voice, but this does not necessarily mean that ideas offered are just one person's opinion. Personal opinions or perspectives are not just subjective ideas, but are connected to something in which the person finds themselves in the world that is not reducible to the person. Taylor (1991) drew distinctions between two different senses of authenticity in discourse: feeling a profound connection to what one is writing about, and writing about oneself. 'This writing is recognizably *mine* even though *I* am not its *topic*' (Jardine 1994, p. 4). In the supervision system, there is a network of relations between the supervisor, clinical team members, the interviewer and the family. All their knowledge of the experiences of the participants interweave with the health care system, the university system, and the sociocultural context. These connections create possibilities for new meanings and understandings for learners and supervisors alike.

Jencks (1992) stated that 'post-modern discourse emphasises the interconnectedness of things...but some things are more connected than others' (p. 36). Similarly, Stewart & Amundson (1995) proposed 'not everything is relative all at once' (p. 70). While each participant is enti-

tled to a voice, this does not mean that 'anything goes'. The intent of the supervision system is to enable nurses to develop skills in their clinical work with families. The intent of the nurse-family system is to alleviate suffering related to the experience of illness for family members. The purposeful nature of the clinical work demands that in addition to meeting the needs of the nurse learner, there is also an obligation to effectively address the needs of the families soliciting assistance at the Family Nursing Unit.

Conclusion

Skillful and artful practice in family systems nursing requires that nurses offer families particular beliefs, ideas, options or recommendations through language. A learning context premised on generative language systems and co-constructed understandings of family experiences in health and illness has been very useful in the evolution of family systems nursing practice within the FNU. Postmodern ideas have influenced us to invite multivocality, collaboration, and willingness to address subjugating aspects of our nursing practices. Live supervision is a challenging and dynamic forum for learning to conduct ourselves well in our obligations and commitments to teach and learn about alleviating the suffering of families. But, we are cautioned by Anderson *et al.* (1995) that supervision and training will always lag behind developments in family work because the purpose is to disseminate knowledge that comprises the broader field. Thus, nurse educators will always be 'catching up' in training neophytes about new developments and changes of the content of family systems nursing. This 'lagging behind' phenomena will hopefully be one of the influences, postmodern or not, that restrains supervisors from potential hubris about their role and knowledge.

Acknowledgement

Dianne Tapp would like to acknowledge support of her doctoral studies from a Nursing Research Fellowship provided by the Heart and Stroke Foundation of Canada.

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