Editorial

Advanced Practice in Family Nursing: One View

Across North America, academics, administrators, and practitioners alike are involved in a dialogue about advanced nursing practice (American Nurses Association, 1992; Calkin, 1984; Cronenwett, 1995; Giovanetti, Tenove, Stuart, & van den Berg, 1996; Watson, 1995; Williams & Valdivieso, 1994). What does advanced practice mean? How do we define it? What is the language used to distinguish specialization that emphasizes competence in nursing assessment and intervention with families experiencing health and illness?

I would like to join the exchange of ideas by offering my view of advanced practice in family nursing. Maturana and Varela (1992) remind us that "the world everyone sees is not *the* world but *a* world which we bring forth with others" (p. 245). Similarly, my definition of advanced practice presented here is not *the* definition of advanced practice but *a* definition of advanced practice. Throughout my 24 years as a nurse, my ideas about nursing practice have been continually changing and evolving-first as a baccalaureate nurse, then as a masters prepared nurse with specialization in mental health, and then as a doctorally prepared nurse who studied within the discipline of counseling psychology. Throughout these changes, what has been conserved is a growing awareness of suffering related to the experience of illness for both the ill person and the people with whom he or she is connected (for the sake of convenience, we call these people *family).* What has also been conserved through these changes are ideas about the ways that nurses acknowledge this suffering and even alleviate suffering for both the ill person and other family members.

How is it that suffering and attempts to acknowledge and relieve suffering for both the ill person and family members have been conserved across my years of living in the domain of nursing? I believe that my genetic makeup, the environment I live in, and my relationships over time have all influenced what I have conserved over time: I am a woman, I am Caucasian, I live in the Northern Hemisphere of the world in a democratic country, I live in abundance, I am a Christian, I am a spouse and mother, a daughter, a sister, and I have suffered in my experience of family member - watching first my mother and then my father deal with chronic illness and assisting them in their interactions with health care professionals. I am also an academic in a university setting and I have had the privilege of working with two gifted clinicians (Dr. Lorraine Wright and Dr. Wendy Watson) in the Family Nursing Unit, Faculty of Nursing, University of Calgary. Together, as a clinical research team for the past 15 years,' we have provided assessment and intervention to family members who are suffering personally with illness or suffering in their relationships around the experience of illness - be it life-shortening illness, chronic illness, or psychosocial problems (Wright, Watson, & Bell, 1990). All these triggers have shaped who I am and how I think about advanced practice today. What has been conserved through this process of living is refinement in ways of thinking about advanced practice in family systems nursing; however, my experiences have also blinded me - such that I am unable to describe advanced practice for any specialization
in nursing other than my own.

What distinguishes advanced practice from generalist practice is the way one thinks, the language one uses, the questions one asks, and the relationships one values. I describe my advance practice in the nursing of families as "family systems nursing." Wright and Leahey (1990) first defined family systems nursing as specialized practice that focuses on the whole family as the unit of care. Wright (personal communication, January 1994) has further conceptualized family systems nursing as knowledge and advanced clinical practice skills which encompass the ability to deal with multiple systems simultaneously (illness, individual, family, larger systems). So what thinking, use of language, questioning, and valuing constitute my view of advanced practice?

1. What first and foremost distinguishes my view of advanced practice in family systems nursing is the ability to think interactionally. Call it interactional, reciprocal, or systemic - the clinician learns to recognize and intervene in the ways in which the experience of illness influences family members and, reciprocally, the ways in which family members influence the illness. Illness is a family affair! However, interactional thinking is not limited to illness and family members. Interactional patterns are distinguished between family members and health professionals with an appreciation that both the nurse and the family change in their interaction and conversations with each other. Reciprocity extends to thinking about relationships between theory, research, and practice, as well. The ability to think interactionally has been described by graduates of family systems nursing as very different from their background experience. On the follow-up study of family systems nursing masters students 1 year after graduation, graduates frequently report that the single largest difference they have experienced as a result of their program of study is a change in their whole way of thinking.

2. What further distinguishes my view of advanced practice in family systems nursing is a preference for collaborative, nonhierarchical relationships with family members. There are many ways of operationalizing this collaborative, nonhierarchical stance, but they all begin with particular ways of thinking - a worldview that acknowledges another person as a legitimate other, even though one may not embrace or agree with his or her opinions. The inherent strengths and abilities that families possess are also recognized in this stance. This respectful, curious, nonoppressive and compassionate relationship created between a nurse and family members provides opportunities for family members to talk about their illness experiences and obtain assistance to decrease their suffering (Wright, Watson, & Bell, in press).

Both the family and the nurse bring specialized knowledge and expertise to this relationship. Family members are expert in their experiences of suffering with the illness; the nurse has expert knowledge about managing illness and alleviating suffering. Within this relationship, many descriptions of family nursing practice can emerge. My hope is that there will be many descriptions of family nursing at both generalist and advanced practice levels in the future literature (published, of course, in the *Journal of Family Nursing!).*

3. In our particular approach to advanced practice in family systems nursing here at the University of Calgary, we have identified beliefs as the core variable of our nursing practice (Duhamel, Watson, & Wright, 1994; Robinson, Wright, & Watson, 1994; Watson, Bell, & Wright, 1992; Watson & Lee, 1993; Wright, Bell, & Rock, 1989; Wright, Bell, Watson, & Tapp, 1995; Wright & Nagy, 1993; Wright & Simpson, 1991; Wright, Watson, & Bell, in press). Reflection on our practice with families has convinced us that it is an individual's beliefs that best explain one's experience-beliefs about the etiology and prognosis of an illness, beliefs about his or her ability to influence an illness, beliefs about the role of family members, and so forth. Our approach to advanced practice centers not just on family members' beliefs but on the intersection between the beliefs of the ill person, the beliefs of family members, and the beliefs of the health care professional. It is here (at the intersection) where the clinical dilemmas emerge and the experience of suffering is best understood. It is also here where healing begins. The work of the clinician is to engage in therapeutic conversations that draw forth and uncover these beliefs, challenge constraining beliefs, and solidify facilitative beliefs (Wright, Watson, & Bell, in press). Therapeutic change involves synergism between the expertise of family members about their experience of illness and the expertise of the nurse about managing illness. The ultimate goal of this advanced practice is to acknowledge and alleviate suffering-be it physical suffering, emotional suffering, or spiritual suffering. These ideas about advanced practice in family systems nursing have arisen from our practice and from our research about the practice. A book which describes our advanced practice approach will be published in October 1996 *(Beliefs: The Heart of Healing in Families and Illness,* Basic Books, New York).

In conclusion, advanced practice is a way of thinking, using language, asking questions, and valuing interaction which conserves a nursing practice that is competent. The conceptual ability gives rise to ways of being and doing in nursing practice that alleviate suffering and promote health across a variety of populations. As such, descriptions of advanced practice are in a constant state of change and evolution. They remain the same only until we see the next family, read the next article, or do the next study. It is my intention that the *Journal of Family Nursing* will be a place where dialogue and reflection about practice with families will continue.

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