Exploring therapeutic conversations between nurses and families experiencing ischemic heart disease

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Exploring Therapeutic Conversations Between Nurses and Families Experiencing Ischemic Heart Disease

by

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Abstract

The advanced clinical practices of nurses teaching and studying in a graduate program offering a specialization focus in Family Systems Nursing (Wright & Leahey, 1990, 1994a) are at the heart of this inquiry. The study explored the experiences of nurses and families with a member diagnosed with ischemic heart disease as they conducted clinical work together at the Family Nursing Unit, an outpatient clinic offered by the Graduate Program of the Faculty of Nursing, University of Calgary, Alberta, Canada. The purpose of the study was to understand how aspects of the family-nurse relationship create possibilities for change in a direction desired by the patient and family, based on the experiences of both family members and the nurse clinician. Three families (10 individuals) and two nurse clinicians participated in the clinical sessions and completed research interviews. An interpretive approach to the research question was based on Gadamer’s hermeneutic philosophy (1976, 1981, 1989). Textual data were generated by transcription of segments of the conversation from videotapes of the clinical sessions, and through research interviews with 6 family members and the nurses following the completion of their clinical work. The emerging understandings are contextualized through interpretive accounts of the therapeutic conversations occurring in each session with the families. Distinctive practices uncovered in this research include: acceptance of the legitimacy of the other by engaging in non-pathologizing discourse and by acknowledging the limitations of expert practices; questioning practices of the nurses which invited family members to reflect on their circumstances; and practices which invited emotional shifts in the conversation. These practices influenced conversations which addressed family suffering related to living with ischemic heart disease, including conversations about healthy lifestyles, conversations about family support and efforts to sustain mutual co-existence, and conversations about uncertainty and death.
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CHAPTER ONE: APPROACHING THE QUESTION

In the course of clinical work, nurses constantly find themselves in conversation with persons experiencing illness and their family members. Sometimes these encounters are brief and the nurse may not know the person or their family well. Sometimes these conversations are protracted over long and difficult encounters with illness, or sporadic and repetitive over months or years with exacerbation of chronic illness. In these instances, the nurse and the family may come to know each other in very personal and familiar ways. Sometimes these encounters are routine, part of the character of nursing practices within a particular context. Other conversations are unforgettable encounters of courage, loss, suffering, healing, and dying. Regardless of the context or duration of their contact, in their conversations together, the family and the nurse are in relationship. In this study, the phenomenon or enigma of interest is the coevolving relationship between the family and the nurse that facilitates therapeutic change.

The topic which has addressed me as a researcher and drawn me into this inquiry has been a concern for the nurse’s manner of conducting herself so as to alleviate the suffering of families experiencing ischemic heart disease. The particular context for this inquiry has been an outpatient clinic, The Family Nursing Unit at the Faculty of Nursing, University of Calgary. The advanced practices of nurse clinicians teaching and studying in the graduate program at this clinic are at the heart of this inquiry. The interpretive task of this research has been to attempt to understand how aspects of the lived experience of the person and family and aspects of the family-nurse relationship create possibilities for change in a direction desired by the patient and family.

I. The Question

The research question has been “What is the meaning of the concerns, beliefs, skills and practices of both the family and the nurse as they coevolved understandings of the problems encountered in the experience of living with the illness, and as they coevolved
interventions to address the concerns of the family members?” In this context for clinical practice, nursing interventions are offered in language, in therapeutic conversation, as opposed to other physical, technological or pharmacological interventions. Punctuation of the interventions as “coevolved” acknowledges that both the family and the nurse offer contributions to address family concerns.

In coming to the research question, some of the questions which were originally posed as starting points for the study included the following:
- What are the background beliefs, meanings and concerns of the family members related to the illness experience of ischemic heart disease?
- How do family members understand the experience of coevolving meanings and solutions to concerns related to the illness experience through therapeutic conversations with the nurse?
- What are the understandings, skills and practices that the family uses to involve the nurse in their care?
- What is the influence of the clinical approach of family systems nursing as a salient background meaning on the interventions offered by the nurse?
- In what ways do nurses and families involve themselves in the coevolving relationship and how does this support changes that occur within the family?
- What changes are perceived by the nurse and the family as salient to the experience of the therapeutic conversations?

Why This Question?

The question of how nurses in this particular context may assist persons and families experiencing ischemic heart disease to alleviate suffering arose from a nursing career grounded mostly in acute cardiac care contexts and a focus during my graduate studies on clinical work with families. Clinical conversations with families in acute cardiac care contexts are often oriented toward the crisis of an unexpected heart attack or a recurrent
heart attack. They are conversations of making sense of the complex ways that these events influence real lives. Throughout hospital recovery, the interplay between conversations of sense-making and conversations of preparation for home usually involves teaching and educative interventions for both patient and family. Yet in my work as a clinical nurse, a nursing instructor and a nurse manager in cardiac care contexts, there was sometimes a sense that these efforts to prepare patients and their families for recovery at home were missing the mark. There was sometimes a sense that the timing was just not right to focus on information needs. Perhaps anxiety was too high for information to be useful. Sometimes there was seemingly little interest in the kinds of information that the nurse could offer. Sometimes there were other concurrent life events that demanded attention for the individual or family. Sometimes there was simply little time as a clinician to engage in conversations with patients and families which could enable more understanding about these contingencies. On occasion, despite good intentions, the ability to understand and assist families simply failed.

The focus in my master’s studies was advanced clinical practice in family systems nursing. My world of clinical conversations changed. I was introduced to ways of thinking and being in clinical work with both individuals and families that challenged my beliefs about how I could or should conduct myself in my clinical practices. These evolving manners of relating made a difference in my clinical work in acute care. I found myself hearing about different chapters in the illness stories of the persons and families with whom I worked that I had not noticed or heard previously. I found myself connecting with persons and families in a different manner in our conversations, and that the people I worked with often commented on their experience of our conversations and our relationship as different.

There was a tension though, in the acute care context, in that nursing conversations with persons and family members were often marginally valued. In this context, time is
often a significant constraint: urgent actions often need to be taken for unstable physiological crises, and the influence of technology for physiological monitoring and treatment is accorded great status. Yet even when time allowed, I would sometimes find a conversation interrupted by a nursing colleague who would call me away from the bedside in case I needed to be “rescued” from an “over-talkative” patient. The merit of what was said in our clinical practices was clearly not valued in the same way as what we did. The tasks that needed to be done were important, and the desire to have a skilled clinician attending to those tasks is understandable. The possibility that what was said at the bedside could also be an intervention, a contribution to healing or to the alleviation of suffering was rarely acknowledged.

Undoubtedly, the contrast in context between the Family Nursing Unit and an acute cardiac unit is significant. I began to wonder about the ways that the extensive emphasis on physiological and pharmacological interventions, and emphasis on cardiac education and cardiac risk factor modification might dominate and pre-empt other nursing practices. I became curious about what could be learned from the practices embedded in the clinical work at the Family Nursing Unit that might enrich nursing practices with persons and families experiencing ischemic heart disease who were accessing health care services in other contexts.

By asking how the family and the nurse coevolve understandings of experiences of living with heart disease: the concerns of the family, the intent is to acknowledge the reciprocity and interactivity between family and nurse that is inherent in therapeutic conversation. The emphasis throughout this inquiry on the skills, beliefs and practices of the nurse underpins a concern to address the nurse’s manner of conducting herself which contributes to the alleviation of suffering. However, the intent is not to specify the correct ways of practicing nursing in these situations in a prescriptive sense. The intent is to move beyond asking how the family or the nurse understand the influence of the illness, or how
nurses help persons to change their lifestyle or to accept the illness, or what particular beliefs about the illness could be constraining or facilitative. The research question is an opening to understanding what happens in the family-nurse relationship that helps participants (both nurses and families) to answer a self-question: "How should I act now?" rather than stating to either nurses or families "This is how you should act now!" (Bergum, 1997, p. 135).

How the Research Literature Informs the Question

The emotional and psychosocial responses of individuals and family members to ischemic heart disease have been the focus of a significant amount of research in several disciplines, including nursing, medicine, psychology and social work. Intervention research has focused on efforts to influence psychosocial risk factors such as stress, anxiety and depression following acute ischemic heart disease. There have also been numerous publications over the past decade describing family systems nursing practices. A brief review of this literature will be described not to justify the asking of the research question or to demonstrate the significance of the question, but to acknowledge the traditions, practices and pre-understandings within which this research inquiry stands. These are understandings which have contributed to the shaping of present nursing practices. These are traditions which may prejudice both the asking and the answering of particular questions about therapeutic conversations and the therapeutic relationship between nurses and families experiencing ischemic heart disease.

Family Systems Nursing Literature

Several case studies in the nursing and family therapy literature have described the clinical practices of nurses specializing in family systems nursing (Duhamel, Watson, & Wright, 1995; Robinson, Wright, & Watson, 1994; Watson, Bell, & Wright, 1992; Watson & Lee, 1993; Watson & Nanchoff-Glatt, 1990; Wright, Bell, & Rock, 1989; Wright, Bell, Watson, & Tapp, 1995; Wright & Simpson, 1991). These case studies trace
the character of family systems nursing practices which have evolved over the past decade. Theoretical underpinnings of family systems nursing practices have also been described in the nursing literature (Leahey & Harper-Jaques, 1996; Leahey & Wright, 1985; Wright & Leahey, 1990, 1994a, 1994b; Wright & Levac, 1992; Wright, Watson, & Bell, 1996).

These nursing practices have also been described in two major research projects. Carole Robinson’s grounded theory research examined the process and outcomes of family systems nursing practices at the Family Nursing Unit with families experiencing difficulties with a chronic illness (Robinson, 1994a, 1996; Robinson & Wright, 1995). Family members were interviewed up to two years after the conclusion of the therapeutic work at the FNU. A four stage theory of women’s evolving relationships with chronic illness included: the evolution of overwhelming illness burden for women leading to precarious life balance; falling down and falling apart that occurred after an illness related loss; the therapeutic process that enabled women to move from burden to balance; and the women’s evolving relationship with self as illness was put in its place (Robinson, 1994a).

The research team of Wright, Watson, and Bell (1996) recently published the findings of their hermeneutic research describing the process of therapeutic change uncovered by extensive analysis of videotapes of clinical work with five exemplar families seen at the Family Nursing Unit. Through this research, a clinical approach to working with families which focuses on beliefs about the illness was described. This research provided rich descriptions and exemplars of the clinicians’ beliefs related to this clinical approach, conceptual underpinnings of the approach to clinical practice, and the interventions or “macromoves” and “micromoves” which illustrated these practices. The key macromoves of the advanced clinical approach which were uncovered in this research included: creating a context for changing beliefs; uncovering and distinguishing illness beliefs; challenging, altering, and modifying constraining beliefs; and distinguishing change by identifying, affirming, and solidifying facilitative beliefs.
The understandings which have been uncovered through the above research program are significant conceptual and theoretical background meanings for nurses practicing at the FNU. The understandings from the previous research influence the nursing explanations and practices which are explored in this research. This research project extends the above program of research by applying the clinical approach to families experiencing a particular illness, ischemic heart disease. The assumption is that there may be particular concerns and dilemmas which could impinge on the conduct of these practices with families experiencing this particular health problem. This study also differs from previous research in two ways. Robinson’s research (1994a) was based on interviews conducted with families following the completion of the clinical work at the FNU. Wright, Watson, & Bell’s hermeneutic research (1996) was based on intensive videotape analysis of the clinical work. This study differs from these two previous studies by including videotape analysis and research interviews with the families and the nurses following the completion of the clinical work. Secondly, this study also included analysis of videotapes of the clinical team conversations about the clinical work, which occurred before and after each session.

**Cardiovascular Research Literature**

Research inquiry on the emotional and psychosocial responses of cardiac patients spans a period of almost three decades. Early medical research explored the psychosocial reactions of both cardiac patients (Bilodeau & Hackett, 1971; Mayou, 1979, 1984; Siegrist, Dittman, Rittner, & Weber, 1982; Stern & Pascale, 1979; Stern, Pascale, & McLoone, 1976; Wishnie, Hackett, & Cassem, 1971) and their wives (Mayou, Foster, & Williamson, 1978; Skelton & Dominian, 1973). These studies demonstrated the significant emotional impact of ischemic heart disease on patients and their wives, and led to early reports examining the effects of counseling and exercise interventions during cardiac rehabilitation on psychosocial outcomes (Hoebel, 1976; Mayou, 1981; Mumford,
Schlesinger, & Glass, 1982; Stern & Cleary, 1981, 1982; Stern, Gorman, & Kaslow, 1983). This early research supported the inclusion of wives of cardiac patients in patient education and cardiac rehabilitation efforts. This research is strongly gender biased, influenced by the prevailing belief of that time that cardiac disease primarily afflicted men. Thus family related research emphasized wives’ responses to their partner’s illness, and unfortunately this trend continues to influence present understandings of family responses to cardiac illness. To date, there has been minimal attention to male partners of women experiencing ischemic heart disease, and even less attention to the influence of the illness on other family members (either school aged or adult children).

The popularity of stress and coping theory in the 1970’s and 1980’s influenced further developments within this area of research. Evolving understandings of stress as a component of the Type A behavior pattern led to incorporation of stress management programs with exercise training as part of cardiac rehabilitation (Baer et al., 1985; Blumenthal & Levenson, 1987; Friedman et al., 1982, 1984, 1986; Kolman, 1983; Oldenburg, Perkins, & Andrews, 1985; Razin, 1982). Stress came to be viewed as a psychosocial risk factor that could be influenced through psychoeducational, counseling and behavior modification interventions.

Over the past two decades, cardiac nursing research has also addressed topics related to emotional and psychosocial responses of individuals and families to ischemic heart disease. A review of nursing research literature published between 1984 and 1993 located 35 studies on the topic of the impact of ischemic heart disease on families (Tapp, 1996a). Most of these studies were descriptive and correlational inquiries regarding emotional responses, stressors, and coping of spouses following an acute cardiac event. There has been consistent support in this literature for the finding that spouses of cardiac patients experience as much or more stress as their ill partners (Allen, Becker, & Swank, 1991; Artinian, 1991; Gilliss, 1984; Moser, Dracup, & Marsden, 1993; Nyamathi, 1988;

These studies have important implications in the recognition of patients and spouses at risk due to unmet needs for information, persistent and severe psychological or stress responses, or needing supplements to social support. However, in comparison to this preponderance of studies describing family member responses to ischemic heart disease, there have been relatively few studies examining nursing interventions which could assist individuals and families experiencing these difficulties following acute cardiac events. In clinical practice, a major emphasis of cardiac nursing care has traditionally been supportive and educative interventions to prepare for the recovery period at home and to assist with lifestyle modifications for cardiovascular risk reduction. This is an area where there have been efforts to implement family-related nursing intervention research (Beckie, 1989; Dracup, Meleis, Baker, & Edlefsen, 1984; Dracup et al., 1984; Gilliss, Neuhaus, & Hauck, 1990; Gilliss et al., 1993; Gortner et al., 1988; Tack & Gilliss, 1990).

A review of research on psychosocial intervention during cardiac recovery reported between 1980 and 1995 in nursing and other health professional journals revealed a dilemma which is not unique to nursing (Tapp, 1996b). In these studies, commonly stated objectives of the interventions were to reduce anxiety, depression, or psychosocial distress; to increase social support, coping or quality of life; or to enhance recovery, compliance, or return to work. These studies suggested that non-specific interventions offered in educative
and supportive programs to individuals or groups can offer some benefits in psychosocial functioning during cardiac recovery. The interventions varied, and included self-help manuals, telephone follow-up, small and large discussion groups, and individual counseling. In these studies as in clinical practice, there was significant overlap between supportive and educative interventions. This made it difficult to account for specific aspects of teaching, counseling and supportive interventions which were most helpful to alleviate distress and enhance recovery. This research contributes little to understanding ways that clinicians might conduct themselves well in clinical practice with individuals and families during cardiac recovery.

The literature review (Tapp, 1996b) also revealed that even after participation in inpatient education programs, spouses of cardiac patients commonly reported a desire for more information in relation to permissible types and levels of physical activity and dietary management following discharge from hospital. They also desire specific information about the meaning of the diagnosis and treatment regime, how to care for the patient at home, problems to be expected after discharge, and the psychosocial needs of the ill family member (Artinian, 1991, 1993; Bramwell, 1986; Hilgenreiner et al., 1992; McSweeney, 1993; Miller & Wikoff, 1989, Moser et al., 1993; Orzech & Staniloff, 1987; Sikorski, 1985; Stanley & Frantz, 1988; Tack & Gilliss, 1990). This persistent request for additional information could suggest that patients and families may have difficulty applying information to their own particular circumstances, anticipating potential obstacles they may encounter at home, and building confidence in health maintenance activities and their ability to influence the illness.

A study by Rudy (1980) sought patients' and their spouses' causal explanations for myocardial infarction. During the acute hospitalization and at one month post-discharge, the three factors rated as most important by both patients and spouses were worry, feeling tense and nerves. Patients with an identifiable biological risk factor did not name that risk
factor at either measurement point. Similarly, a study by Fielding (1987) revealed that MI patients believed the causative factors of overwork, smoking and worry to be the most frequently perceived causes of myocardial infarction. This study also suggested that overwork, worry and stress were perceived as significantly less controllable than the biological and lifestyle risk factors of family history, smoking, lack of exercise, obesity and diet. The researcher suggested that the prevalent focus on biological factors in advice-giving and instructive information by health care professionals during cardiac rehabilitation may fail to address the areas of greatest concern to MI patients and families.

Interventions which focus on individual behavior change for risk factor modification often fail to consider the context in which behavioral change is expected to occur. Practices and behaviors related to eating, smoking, exercise, and stress are intricately woven around family relationships and patterns of family life. A major limitation of many cardiac research studies is the inability to account for the complexity of the patient-spouse relationship, and the context in which the family's concerns, beliefs and practices are embedded. The tendency is to explore specific factors (e.g. anxiety, coping, stressors, spouse support) outside the context of the interactions and relationships in which the illness experience is embedded, or with limited attention to the relational character of recovery. This is partly due to extensive reliance on quantitative approaches to inquiry.

The cardiovascular research literature reflects many traditions, knowledges and practices which inform the research question. Embedded within these traditions has been a significant emphasis on the individual (either the ill person or a family caregiver) rather than on interactional and interpersonal understandings of recovery following acute cardiac events. These traditions operate under tremendous gender bias which has excluded and minimized the experiences of women as ill family members, and the experiences of men as partners to ill family members. Although qualitative inquiry has become increasingly accepted and valued within the nursing community, in general, cardiovascular research
traditions and practices rely extensively on empiricist perspectives of knowledge generation and quantitative approaches to inquiry. These traditions also reflect significant emphasis on educative interventions intended to provide individuals and families with information which could assist them during recovery. The understandings of interventions offered in these studies tend to be non-specific and bear more of the character of program evaluation and effectiveness, rather than particular understandings which might be useful to clinicians engaged in practice.

The traditions, knowledges and practices of family systems nursing are a more recent development than much of the inquiry traced in the cardiac literature above. Graduates of the family systems nursing specialty and participants in externship programs are implementing these ideas in a variety of settings in Canada, Australia, Japan, Finland, Korea, Taiwan and the United States (Wright et al., 1996). However, practice contexts which support family systems nursing practices are more localized than the extensively developed cardiac rehabilitation programs, inpatient and outpatient cardiac programs, and cardiac discharge or home care programs. The practice context at the Family Nursing Unit supports therapeutic conversations as the focus of interventions offered to persons experiencing health problems. The endeavour to understand the ways that these practices could enrich clinical practices with individuals and families experiencing ischemic heart disease in other contexts has been a significant impetus for this inquiry.

II. Contextualizing the Practice Setting

The Family Nursing Unit

The Family Nursing Unit (FNU) is an outpatient clinic which was established in 1982 at the Faculty of Nursing, University of Calgary, Canada (Wright, Watson, & Bell, 1990). The Master of Nursing program at the University of Calgary offers advanced nursing practice preparation in several clinical focus areas, one of which is Family Systems
Since 1982, approximately 300 families have received services at the FNU, and 90 graduate students have completed practica within the FNU. The graduate students are primarily female, and families accessing services at this clinic are predominantly middle class and Caucasian.

The Family Nursing Unit is an educational and research unit which provides services to individuals, couples and families experiencing difficulties with a wide variety of chronic, life-threatening, and psychosocial health problems. The clinical sessions offer families assistance to discover new solutions for their difficulties with health problems. The FNU is a faculty practice unit. Each family benefits from a clinical nursing team approach, and is interviewed by a nursing faculty member or a graduate nursing student (Masters or Doctoral level). For the purposes of this research, family sessions were conducted by faculty members experienced in family systems nursing theory and practice. Typically, the clinical sessions are observed via a one-way mirror by a clinical nursing team which includes graduate nursing students and another faculty member as supervisor (Wright et al., 1990). Each interview is videotaped with the family’s written consent. An average of four sessions are provided to each family over a period of approximately three to five months. Families usually access this service by referral from health care professionals in the community, or by self-referral.

**Participation of the Clinical Team and Live 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 clinician’s interview with a family by a supervisor, usually from behind a one-way mirror. Additionally, the involvement of a clinical team observing from behind the one-way mirror is based on the influence of the Milan team of family therapists (Boscolo, Cecchin, Hoffman, & Penn, 1987; Selvini, Boscolo, Cecchin, & Prata, 1980). During their clinical practica at the FNU, graduate nursing students have opportunities to observe
faculty members conducting clinical work with families, and to conduct family sessions themselves with the assistance of a clinical team behind the mirror. As faculty members work directly with families and are supervised by another faculty member, clinical skills are practiced, debriefed and discussed in the same manner as student practices.

The emphasis on live supervision and clinical team involvement for development of interpersonal skills is congruent with a perspective of language as a generative process, and knowledge as socially constructed (Tapp & Wright, 1996). There is an underlying belief that nurse clinicians co-construct understanding and knowledge with families, students and faculty members throughout the clinical sessions. The clinical team offers multiple perspectives and possible explanations for understanding the family and the clinical work. The presence and participation of the clinical team is explained to the family as a resource to both the nurse and the family throughout the clinical work. An obvious asset of live supervision is the possibility of immediate feedback during the session. Feedback can be offered during the clinical session through telephone communication between the supervisor behind the mirror and the nurse in the interview room. The phone-ins may offer the clinician ideas about how to proceed in the therapeutic conversation (possible questions to ask, alternative beliefs to offer) or about the process (noticing a shift in affect, avoiding escalating symmetry, or bringing discussion about implicit conflict into the conversation) (Wright, 1986).

The Family Nursing Unit is an educational context. The intent of the supervision system is to enable nurses to develop skills in their clinical work with families. Although this is a learning context, the intent of the clinical practices with the family 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 FNU.
Format of the Clinical Sessions

Each clinical session is conducted according to the following outline: a **presession** conversation between the nurse clinician and the clinical team; the **clinical** conversation between the nurse and the family; an **intersession break** (most commonly a reflecting team conversation); an **end-of-session** conversation between the nurse and family; and a **postsession** conversation between the nurse and the clinical team. While this format provides opportunities to attend to the learning of graduate students in the university context, this is also a format which is common in family therapy settings (Tomm, 1984), and which is modeled after the work of the Milan Family Therapy team (Boscolo et al., 1987).

**Presession conversation.** Immediately prior to each family appointment, the clinical team (including the nurse clinician, a faculty supervisor and graduate nursing students) meets for a presession which lasts approximately 15 to 30 minutes. If the team is preparing for a first session with the family, the referral information which was provided by the family to the FNU secretary is reviewed. Otherwise, a summary of the previous session and significant conversational events are reviewed. If a therapeutic letter was sent to the family between sessions, it is also reviewed with the clinical team. Hypotheses are generated about possible constraining beliefs or interactional patterns. Students assigned to the family present 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. Presessions provide opportunities for students to articulate their thinking and beliefs about the family and to anticipate possible issues which could arise in the session.

**Clinical conversations.** At the beginning of the clinical 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 a two-way flow of
information. The nurses learn through the opportunity to view the clinical work, and the intent is to provide multiple ideas to the family in addressing their concerns, and to assist the nurse clinician in conducting the clinical work. Before the clinical session begins, the family is required to sign a consent authorizing videotaping of the clinical work.

During a first session meeting with the family, the nurse attends to engaging the family, providing some structure for the conversation, and answering the family members’ questions about the FNU. Part of the first session ritual is sketching of a genogram. This provides the nurse with opportunities to ask questions about all family members, to ask about family relationships, and about reciprocal connections between all family members, the illness, and their presenting concern. A significant task of the first session is to elicit an understanding of the family’s concern or problem, and a beginning understanding of how the nurse and the family may be able to work together.

During subsequent meetings, the session usually begins with the nurse inquiring about “what stood out” from the previous session (i.e. ideas that the family members had thought about, talked about, or followed up on; their responses to ideas offered in therapeutic letters). The nurse usually inquires about the family’s “new news”, which may be changes or lack of changes noticed by the family between sessions, and other events in the lives of family members which might be related to the topics addressed in the sessions. Beyond these few rituals at the beginning of the session, the flow of the conversations is unstructured and coevolved by directions that unfold within the dialogue.

**Inter-session break or reflecting team conversation.** After 45 to 60 minutes of conversation between the nurse and the family, the nurse usually offers the family the possibility of observing a reflecting team conversation (Andersen, 1987, 1991; Wright et al., 1996). During a reflecting team, family members trade places with the team members. The family members observe from behind the mirror while the clinical team discusses their ideas about the dilemmas and suffering confronting the family.
The intent of the reflecting team is to increase the family members’ possibilities to shift perspectives about their situation as the team offers a variety of ideas for their consideration (Wright et al., 1996). The family is offered a listening position behind the mirror which enables them to reflect differently on their circumstance. The team often begins by offering the family commendations based on understandings about the family generated during the session. Team members offer alternative views about the family’s experiences, relationships, problems or solutions related to the presenting concerns. Sometimes team members offer personal experiences triggered by the family’s story, or experiences from other families they had worked with who had encountered similar challenges. Ideas and opinions are offered in a respectful and tentative manner: “I was wondering about...”, “I noticed that...”, “I was curious about...”, “If they were to believe that...”, or “If we were to believe that...” The suggestions are offered as invitations to the family, with the explicit expectation that the family members will choose those ideas which seem most useful to them, or that they may disregard and counter all ideas offered. The reflecting team conversation usually lasts about 15 minutes, and then the family and the team again trade places.

Alternatively, by the preference of either the nurse or the family, the nurse may take a brief break to meet with the team members to reflect on the circumstances of the clinical conversation, and to consider commendations, impressions, ideas or suggestions to offer the family. Following this conversation with the team members, the nurse then returns to the family, and conveys some of the ideas which had been discussed by the team behind the mirror.

End of session conversation. The nurse and the family reconvene briefly following the reflecting team or intersession break. The nurse usually inquires about the family’s initial impressions of the reflecting team conversation or of the ideas offered by the nurse. The nurse tries to understand which ideas (if any) somehow “fit” for the family at that
point, or to understand the ways that the ideas do not fit. At this point, the nurse may also inquire about the family's experience of the session. The intent is to explicitly address the process of the conversation. Examples of this line of inquiry include the following: In what ways did the family experience the context or process as either comfortable or constraining? Did the family think that they were talking about topics that could be helpful to address their concerns? What might need to happen differently at future sessions to be more helpful to the family? The nurse may also comment on her own experience of the session, and may offer the families explanations of ideas that she learned from them during the session. The nurse concludes the session by inviting the family to determine whether and when they wished to meet again, and which family members might wish to attend a subsequent session.

Postsession conversation. Following the session, the clinical team meets for a postsession conversation about the clinical work which usually lasts about 30 minutes. One major focus for this conversation 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 faculty to learn about multiple ways of understanding the family and the clinical work, and to entertain possibilities for future directions in the work with the family. Occasionally, therapeutic letters (White &Epston, 1990; Wright et al., 1996) are forwarded from the clinician to the family between sessions to highlight aspects of the clinical conversation, or to offer additional understandings that were uncovered during the postsession conversation.
III. Contextualizing Theoretical Assumptions Underpinning Clinical Practices

The Nursing Approach

Family Systems Nursing Practices

"Family systems nursing" is a term that was coined by Wright and Leahey (1990) to describe an approach to advanced clinical practice which focuses simultaneously on both the individual and the family as the unit of care. In clinical work with families experiencing health problems, the emphasis is on interaction and reciprocity between the illness and the family, and amongst family members, the clinician, and the clinical team. Family systems nursing is considered an advanced practice specialization which focuses on understanding relationship and process to enable intervention at multiple systems levels (individual, interpersonal, community, or social systems). Clinical practices of family systems nursing are based on theoretical underpinnings from systems theory, cybernetic theory, communication theory, family therapy theories, and biology of cognition theory (Wright & Leahey, 1990, 1994; Maturana & Varela, 1992). Clinical practice in this specialty is based on understandings of family research, theories of family functioning, family developmental theory, family interviewing skills, and family assessment and intervention skills.

Master of nursing students at the University of Calgary are introduced to models for family assessment and intervention, namely, the Calgary Family Assessment Model (Wright & Leahey, 1994a) and the Calgary Family Intervention Model (Wright & Leahey, 1994a, 1994b). The Calgary Family Assessment Model provides a framework for conceptualization of structural, developmental and functional aspects of families. The conceptualization is intended as an organizing framework rather than an assessment tool. Judgment and discretion are required to determine which aspects of the framework might be most pertinent to a particular family. The nurse must choose which aspects of the framework are most useful to understanding the family, and will often not address each category within the framework.
The Calgary Family Intervention Model (Wright & Leahey, 1994a, 1994b) is an organizing framework for conceptualizing the domain of family functioning targeted by a nursing intervention. The model focuses "on promoting, improving, and/or sustaining effective family functioning in three domains: cognitive, affective, and behavioral" (Wright & Leahey, 1994a, p. 99). It offers language for conceptualizing interventions as relational, and including the actions and responses of both the nurse and the family. The model also describes the effectiveness of the intervention as "fit" between the intervention offered and the family functioning. A core belief of this framework is that the nurse can only offer interventions to the family, and that the family will select a potential trigger for change based on the structure of family members, and the history of interaction between family members and with others. The relationship between the nurse and the family, and the nurse's ability to invite the family to reflect on the health problems are viewed as significant influences on the "fit" of the intervention.

Beliefs at the Heart of Healing

As the clinical work at the FNU evolved, one of the subcategories within the family functioning category of the Calgary Family Assessment Model was found to be particularly helpful in the work with families experiencing health problems: family beliefs. Through the process of conducting a multiple case analysis of videotapes of the clinical sessions with families experiencing chronic illness (Watson, Bell, & Wright, 1992; Wright, Bell, & Rock, 1989), there was a growing appreciation of the ways that beliefs and behavior seemed to be connected to the health concern. Exploring beliefs about the health problem became a ritualized practice within this clinical work and included beliefs about the cause of the health problem, treatment, and prognosis; beliefs about the role of health care providers; beliefs about the influence of the family on the health problem; and beliefs about the influence of the health problem on the family.
This curiosity about the influence of beliefs on families experiencing health problems led to a hermeneutic inquiry which uncovered clinical practices surrounding this focus in the clinical work (Wright et al., 1996). In addition to an articulation of the theoretical and philosophical underpinnings of this approach to clinical practice, the descriptions of the moves and micromoves embedded in the clinical work were elicited. The philosophical and relational stance of these clinicians emerged as they described their own beliefs about families, illness, therapeutic change and clinicians. Throughout these descriptions of clinician beliefs, the influence of the work of Humberto Maturana was acknowledged and explained.

This clinical approach (Wright et al., 1996) needs to be distinguished from the traditions and practices of cognitivist science and cognitive therapies. Varela, Thompson & Rosch described cognitivism as the hypothesis that “cognition is mental representation: the mind is thought to operate by manipulating symbols that represent features of the world or represent the world as being a certain way” (p. 8). Cognitive therapies are based on views of the brain as an information processing structure which operates through measurable psychological processes, and which have causal links to emotion and behavior (Kuehlwein, 1993; Vallis, 1991). Early cognitive therapies (such as Ellis’ Rational Emotive Therapy and Beck’s Cognitive Therapy) both strongly emphasized the importance of beliefs. The goal of both of these therapies is to convince the client that their beliefs, assumptions and meanings are irrational, wrong, invalid or inaccurate. These two approaches vary significantly, in that Ellis’ work focuses extensively on intimidation and confrontive measures, while Beck’s approach is more collaborative and commits more effort to understanding the client’s personal meanings of symptoms and events (Kuehlwein, 1993). The epistemological traditions of these psychological theories about beliefs differ dramatically from the understandings of beliefs offered in the clinical approach of Wright et al. (1996).
Wright et al. (1996) define a belief as

the "truth" of a subjective reality that influences biopsychosocial-spiritual structure and functioning. In our conversations, we speak and listen to one another from these domains of "truths" - explanations, values, and obligations based on our beliefs - that have arisen from the social, interactional, and cultural domains in which we live. (p. 41)

"Core beliefs" were described as those beliefs at the heart of the matter, beliefs at the core of our identity, beliefs that are about the nature of reality, and that are accompanied by intense affective and physiological responses. Wright et al. (1996) describe their preferred explanation of beliefs as a "biological-spiritual explanation" (p. 41), influenced not only by Maturana’s work in neurobiology, but also by the influence of biological understandings of health and illness in nursing. Conversations of suffering often invite consideration of spirituality, for which the language of beliefs is especially conducive.

The notions of "moves", "macromoves", and "micromoves" were used in the descriptions of this clinical approach instead of "interventions". The clinical practices involve a fluid process over time between nurse and family rather than an "encapsulated moment with a beginning and an end" (Wright et al. 1996, p. 154) implied by interventions which describe the observable behaviors of the clinician. In this approach to clinical practice, beliefs were dichotomized as either constraining beliefs which decrease options for solutions, or facilitative beliefs which increase options for solutions (Wright et al., 1996). The four major moves described through this research included creating a context for changing beliefs; uncovering and distinguishing illness beliefs; challenging, altering, and modifying constraining beliefs; and distinguishing change by identifying, affirming, and solidifying facilitative beliefs (Wright et al., 1996).
Creating a context for changing beliefs. This first move is described as central to the therapeutic process, and includes all of the ways that the clinician contributes to the coevolution of the therapeutic relationship. It is explicitly acknowledged that the clinician also changes as she is in relationship with the family, and that creating a context for change continues throughout the relationship. Micromoves include preparing and maintaining the ground (providing structure, explaining the setting and nature of the work, offering an agenda for the session), distinguishing the problem, and removing obstacles to change.

Uncovering and distinguishing illness beliefs. Questions are asked to elicit family members’ illness beliefs about etiology, diagnosis, healing and treatment, influence over the illness, prognosis, religion or spirituality, and the “place of illness in the lives and relationships” (Wright et al., 1996, p. 155). In these conversations, family members are invited into the role of expert about their illness experiences.

Challenging, altering, and modifying constraining beliefs. The purpose of all of the micromoves described within this move is to invite family members to a reflection (Maturana & Varela, 1992). Examples of micromoves described include offering commendations, asking interventive questions, speaking the unspeakable, offering a hypothetical facilitative belief, using reflecting teams, and offering alternative beliefs through storytelling, sermonettes, and research findings.

Distinguishing change by identifying, affirming, and solidifying facilitative beliefs. This final move is intended to make change real through language that distinguishes that change has occurred, and that brings change forward from a background so that family members can more fully appreciate changes that they have created. Micromoves include the passionate persistence of the nurse in pursuing descriptions of change, exploring the effects of change, inviting explanations of change, celebrating change, publishing change, and distinguishing facilitative beliefs.
One is implicated in one’s beliefs, allowing for a claim to be made, “These are my beliefs”. One’s beliefs are connected to one’s inherence in the world. They are related to one’s particular experiences of the past, yet they bear ties and affiliations to the discourses of the present. One’s beliefs are related to the histories and traditions that connect one to this place, this time, and this culture. Beliefs are connected to our anticipations of the future. Beliefs are often accompanied by affective and physiological responses: they are connected to our personhood and our bodyhood. One can reflect on their beliefs. Beliefs may be malleable and tentatively held, or held with great conviction and passion.

Understandings of beliefs as domains of subjectively held “truths” are intimately related to Maturana’s (1988; Maturana & Varela, 1992) explanations of structure determinism and objectivity-in-parentheses or [objectivity].

The Theoretical Contributions of Humberto Maturana

Humberto Maturana is a Chilean neurobiologist whose research on perception led him to develop explanations about reality, understanding and objectivity which challenge many traditional assumptions about science (Maturana, 1978, 1983, 1985, 1988). He suggested (Maturana, 1996) that scientists are people who live under the passion of explaining experiences by proposing generative mechanisms and conducting an inquiry which attempts to replicate the proposed mechanism. He carefully explained the assumptions which guide his style of proposing scientific explanations: one cannot make claims about an objective reality that exists independently of oneself; understanding is a reflection or a distinction made by an observer who is a participant in what is being observed; existence is constituted through the biological operations of the observer; reality is an explanation of the world that we live with others; and there are many multiverses, or domains of realities which we bring forth to explain our experiences (Maturana, 1988; Maturana & Varela, 1992).
The view of science proposed by Maturana and Varela (1992) has a receptive audience in at least some parts of the scientific community. In particular, Fritof Capra (Capra, 1996; Capra & Steindl-Rast, 1992) described this work as “the Santiago theory” of cognition (1996, p. 175):

The Santiago theory provides, in my view, the first coherent scientific framework that really overcomes the Cartesian split. Mind and matter no longer appear to belong to two separate categories but are seen as representing merely different aspects, or dimensions, of the same phenomenon of life....Mind is not a thing but a process - the process of cognition, which is identified with the process of life. The brain is a specific structure through which this process operates. The relationship between mind and brain, therefore, is one between process and structure. (Capra, 1996, p. 175)

Capra (1996) suggested that this view of science is congruent with the shift from objective science to epistemic science, in which questioning and explaining of how we know must be integral to scientific theorizing. He also proposed that the work of Maturana and Varela (1992) has been distinguished by consistent efforts to understand relations between processes, and understanding how living systems are organized rather than specifying the structure of the components of the living system. Capra clearly situated Maturana and Varela’s work at the forefront of emerging sciences of complexity, and with the advent of “a non-mechanistic, post-Cartesian understanding of life” (1996, p. 157).

Structure Determinism

Maturana’s scientific explanations are causal in the endeavour to explain generative processes leading to a phenomenon. Along with his colleague, Francisco Varela, he demonstrated his style of scientific explanation by explaining cognition as a biological phenomenon (Maturana & Varela, 1992). However, their theory of the biology of
cognition stands science on its head by directly challenging the possibility of objectivity. They accomplished this by offering an explanation from biological science for the assertion that one cannot make claims about an objective reality that exists independently of oneself (Maturana & Varela, 1992).

In this explanation, the person or observer is a biological entity. As observers, human beings make distinctions in language. In this view, cognition or the process of knowing includes not only thinking, but perception, emotion, and action. In the human living system, "cognition also includes language, conceptual thinking, and all the other attributes of human consciousness" (Capra, 1996, p. 175). Maturana and Varela (1992) explained cognition on the basis of the operational closure of the nervous system of the biological entity, which is in continuous interaction with the environment and other living systems: "all behavior is an outside view of the dance of internal relations of the organism" (p. 166).

The traditional separation of observer and observed or knower and known is subverted within this biological explanation. As neurologically, operationally closed entities, making distinctions about some thing or some experience in our environment is not dependent on the information, perturbation, or even the sensory stimulus from the environment. The subjective judgment determined, the distinction made, the observation observed, the knowledge understood, and the response to the stimulus depend on the structure of the organism. They asserted that living systems are structurally determined. All changes of a living system are determined by their structure as a result of their own dynamics or triggered by their interactions with the environment or with other living systems. Human beings change through a history of interactions, learned behaviors which depend on a human context, occurring in a social domain and conserved through language. Although living systems are structurally determined, this does not mean that human
responses to stimuli are necessarily predetermined or predictable. The complexity of the human nervous system results in huge capacity for plasticity, creativity, and invention.

The notion of structure determinism has important implications for the clinical approach of Wright et al. (1996). This is a key theoretical underpinning for the belief that nurses can only offer interventions, ideas, information or advice as invitations (Wright & Levac, 1992). Because family members are structurally determined, they will only be perturbed by those suggestions which “fit” their structure. Interactions are not instructive, because the trigger or perturbation does not determine what the effect will be (Maturana & Varela, 1992). How an individual responds will be determined by their structure at that point in time. Changes which occur are determined by the history of interactions and the structure of the living system. The nurse can not specify changes in other individuals through instruction. The nurse is not a change agent, but is responsible for “creating a context for change; creating an environment in which persons change themselves; offering ideas, advice and suggestions that can serve as useful perturbations.” (Wright & Levac, 1992, p. 916). The nurse attempts to discover perturbations or interventions which are more likely to fit for the family members to alleviate suffering, without expecting that they must take up the suggestions offered. “An invitation can be declined without blame, or it is actually a demand” (Maturana, 1992).

[Objectivity]

The second key theoretical underpinning from Maturana’s work is objectivity-in-parentheses [objectivity]. This idea enables structurally determined differences in perspectives, responses, preferences and choices between persons to be respected as legitimate. Maturana (1988) described objectivity as an explanatory pathway in which existence is assumed to be independent of the observer’s doings; in which one makes a claim about what reality is and what is true; and in which reference to an independent
realities is used to validate experience. In objectivity, sufficient explanation of experience is validated by a single domain of reality, such as matter, energy, God, or consciousness.

In contrast, he proposed that *objectivity* is an explanatory pathway in which there is an awareness of *many* domains of explanations and realities. In *objectivity*, the existence of the observer is constituted by the operations of distinctions which bring forth descriptions of experiences, objects and understanding in language. Experience is explained through coherence of experiences rather than attempting to find out what is real. The criterion of validation or acceptability of the explanation is applied by the observer or listener, i.e. does it sufficiently explain or answer the question?

Maturana described explanations as manners of interpersonal relations (Maturana, 1988; 1992; 1996). He asserted that objectivity is not just one of the many realities or explanations of which one is aware in the explanatory pathway of *objectivity*. He described a major distinction between the two explanatory pathways of objectivity and *objectivity* as the type of emotioning which occurs in each of them. A claim for knowledge in the path of objectivity is a demand for obedience, for mutual or self-negation, to accept certain questions, explanations, and truths (Maturana, 1988). All other explanations are deficient, and the other is intrinsically wrong. In *objectivity*, it is accepted that there are structurally determined differences between persons, and thus there will be different explanations for the same situation. There is recognition that persons will operate in different, yet equally legitimate domains of reality or explanations of reality. The experiences of the other are valid experiences because they have arisen through the course of the person’s existence and reflect the way that the person has conserved their existence.

Thus *objectivity* invites the nurse to be open to many plausible explanations of experiences which are equally “real” or legitimate, even if they are not equally desirable. This explanatory pathway invites the nurse to respectful curiosity, attempting to understand the ways that the family members’ explanations are legitimate for them, and the ways that
their beliefs or subjectively held “truths” (Wright et al., 1996, p. 41) are true for them. When the explanations of others are viewed as legitimate, “explanatory disagreement is an invitation to a responsible reflection of coexistence, and not an irresponsible negation of the other” (Maturana, 1988a, p. 31). [Objectivity] invites a collaborative manner of situating oneself within relationship.

With the rise of the modern scientific method, “science” came to take on a specific meaning based on experimentation, quantification, prediction and control (Berman, 1981). While Maturana conserves science as a manner of explaining and replicating generative mechanisms, he defuses the traditional separation of knower and known (Maturana, 1988; Maturana & Varela, 1992). It is an outrageous paradox that Maturana comes to an explanation of the inextricable connection between knower and known by objectifying person to an observing, biological entity with a nervous system of great plasticity for dynamic structural interaction with the environment! Maturana’s scientific view of cognition, knowledge, and language bears an important resemblance to a fundamental assumption of the approach to this inquiry informed by Gadamer’s philosophical hermeneutics (Gadamer, 1989). As will be explained in Chapter 2, Maturana the scientist, and Gadamer the philosopher, agree on one fundamental point: living, understanding, and knowing in language is a fundamental, constitutive mode of human existence.

IV. The Approach to the Inquiry: Informed by Gadamer

In concluding this chapter, the research approach of hermeneutic interpretation will be introduced as the manner of inquiry selected to address the research question. In 1990, almost two years before beginning my graduate studies, I read Patricia Benner’s (1984) book titled From Novice to Expert. I was captivated by this research. As a critical care nurse, her descriptive exemplars of skill acquisition of beginner, novice and expert nurses
in critical care settings rang true to my own experiences. This was the first time I had encountered hermeneutic phenomenology as an approach to nursing research. The research bore a character that I knew was different from my understandings of nursing research at that time.

During my early graduate studies, my curiosity was piqued again in 1991 by Benner and Wrubel’s (1989) *The Primacy of Caring*. I began to appreciate that the character of this research was related to a very different philosophical stance than the quantitative research that I had been taught to believe was the norm in nursing. This was the beginning of a “tectonic shift” (Clifford, 1992) in my thinking, writing, nursing, researching and understanding. The questioning and probing of these understandings was enriched by readings and seminars in 1992 on postmodernism, constructivism and social constructionism. The influence of the work of Humberto Maturana on the clinical practices at the FNU was part of this questioning and opening space for other explanations.

In my doctoral studies, this shift has become even more palpable, sometimes shaking the very foundations of former ways of understanding nursing and research. Seminars with Dr. David Jardine, and readings and discussions about phenomenology, Gadamer’s hermeneutic philosophy, and interpretive research bore marked contrasts to the views explored in seminars with Dr. Susan Gortner regarding the philosophy of science in nursing (Cull-Wilby & Pepin, 1987; Dzurec, 1989; Gortner, 1990, 1993; Gortner & Schultz, 1988; Holden, 1990; Holmes, 1990; Schumacher & Gortner, 1992; Schultz & Meleis, 1988). These contrasts helped to clarify distinctions, to notice the shifting ground, and to understand the different traditions at play in these differing views.

Interpretive research in nursing has often adopted the character and traditions of Husserlian phenomenology as described by Colaizzi, VanKaam, and Giorgi in the field of psychology (Beck, 1994; Boyd, 1993; Jasper, 1994; Koch, 1995; Omery, 1983). Heideggerian hermeneutic phenomenology has been a significant influence on hermeneutic
approaches in nursing (Benner, 1985, 1994; Chesla, 1995; Leonard, 1989). The overwhelming influences on my approach to hermeneutic inquiry have been the writings of Gadamer (1976, 1981, 1989) and Grondin's interpretations and extensions (1994, 1995) of Gadamer's philosophical hermeneutics. Gadamer's work stands in the traditions of German philosophy and phenomenology, and he studied with Natorp, Heidegger, Bultmann, among others (Gadamer, 1985). Nurse researchers are only beginning to appreciate the possible contributions of Gadamer's philosophical hermeneutics (Koch, 1996; Pascoe, 1996) to emerging interpretive research practices within the nursing field. The next chapter will introduce the response to the research question by describing the application of Gadamer's hermeneutic philosophy as the approach to the research inquiry.
CHAPTER TWO: RESPONDING TO THE QUESTION

I. Hermeneutic Interpretation as an Approach to Inquiry

The previous chapter described the research question, the nursing and cardiovascular research literature informing the research question, the context and practices of the Family Nursing Unit as the setting for the inquiry, and the theoretical assumptions underpinning the clinical practices. This chapter will describe in detail the research approach, and the conduct of the inquiry as the response to the research question unfolded.

What is Hermeneutic Inquiry?

The traditions within which we stand - and every tradition that we creatively or appropriating pass on - offer less an objective field for the scientific mastery of a subject matter or for the extension of our domination by knowledge of the unknown than a mediation of ourselves with our real possibilities engulfing us - with what can be and what is capable of happening to and becoming of us. (Gadamer, 1981, p. 166-167).

The word “hermeneutics” has been used to describe various forms of textual interpretation for several centuries, dating back hundreds of years to the interpretation of myth and biblical writings (Grondin, 1994). In this research, I understand hermeneutics as the practice of understanding the said and unsaid life of discourse. Hermeneutics is a practice in the sense that Gadamer retrieved from Aristotle’s practical philosophy by claiming interpretation and understanding to be a “natural human capacity” (Gadamer, 1981, p. 114). The practice of hermeneutics precedes the idea of methodical science, in that understanding is communal and linguistic. Language is by itself the game of interpretation that we are all engaged in every day. In this game nobody is above and before all the others; everybody is at the center, is “it” in the game...This process of interpretation takes place whenever we “understand,” especially when we see through prejudices or tear away the pretenses that hide reality. (Gadamer, 1976, p. 32)
Understanding is an event which occurs in language, through dialogue with others, and through dialogue with oneself (Gadamer, 1989). The hermeneutic task is to reclaim the meaning of both the said and unsaid word, that is, not only the content of what is said, but also the context of the dialogue, the original intent of the question to which the text is an answer, that which exceeds the motivations of the speakers, that which happens to be said, and that which wants to be said but which is not (Grondin, 1994, 1995).

The subject or topic of a hermeneutic inquiry is not something about which one can amass certain information, nor something which is only the subjective perspective of the interpreter. The topic keeps open possibilities for meanings which are motivated by the historical address of the topic itself, by the traditions, practices, and understandings which are handed down and which precede the inquiry (Gadamer, 1989). Postmodern thought often implies a break with tradition, and a distancing from what has come before (Borgmann, 1992; Jencks, 1992). In contrast, hermeneutic interpretation attempts to retrieve past meanings, to acknowledge the familiarities, traditions, and kinships with other understandings that create possibilities for understanding the topic.

The topic of this inquiry, the coevolving therapeutic relationship between the family and the nurse, is contingent, complex and changing—different from each particular family situation to the next. The family-nurse relationship is not reducible to specific, measurable traits or actions of either the nurse or the family members. The practical concern which addresses me and draws me into the inquiry is the concern for the nurse’s manner of conducting herself so as to alleviate the suffering of families experiencing this particular illness. The concern is to understand what happens in the relationship that helps nurses and families to choose courses of action which are therapeutic in a manner which is desired by the family. These understandings are richly influenced by traditions and practices which distinguish nursing as a profession, and by nurses’ passion to alleviate suffering in human
experiences of health and illness. It is a topic which is more congruent with the traditions of the human sciences rather than those of the natural sciences.

### Distinctions between the Natural Sciences and the Human Sciences

A major impetus of Gadamer's *Truth and Method* (1989) was to question the ways in which hermeneutic traditions became bogged down in the quest for credible methods for the human sciences: "How did this tradition become so impoverished and how did the human sciences' claim to know something true come to be measured by a standard foreign to it - namely the methodical thinking of modern science?" (p. 24). Gadamer questioned the very possibility of specifying a method for arriving at hermeneutic understanding. However, Gadamer's intent was to make distinctions not between differences in *methods* of the human and the natural sciences, but between differences in the *objectives of knowledge* of these sciences. He described at least three ways that human sciences differ from other sciences: understandings in the human sciences are confronted with the task of self-application; these understandings are related to the historicity of both the topic and the interpreter; and these understandings bear the character of a logic of question and answer.

The task of self-application. In contrast to the purpose of natural sciences to derive rules or laws based on observable evidence which allow replication, prediction and control of variables, the object of the human sciences

is man and what he knows of himself. But he knows himself as an acting being, and this kind of knowledge of himself does not seek to establish what is. An active being, rather, is concerned with what is not always the same but can also be different. In it he can discover the point at which he has to act. The purpose of his knowledge is to govern his *action*. (Gadamer, 1989, p. 314)

Gadamer (1989) suggested that the human sciences stand closer to practical knowledge, and are akin to moral knowledge (which requires self-deliberation) and technical
knowledge (which serves particular ends) in the common task of self-application. Practical knowledge is directed at the concrete situation which requires grasping "the 'circumstances' in their infinite variety" (p. 21), and which requires pursuit of the right thing to do:

The task of making a moral decision is that of doing the right thing in a particular situation - i.e., seeing what is right in the situation and grasping it....What is right, for example, cannot be fully determined independently of the situation that requires a right action from me. (p. 317)

In the sense that "all understanding is self-understanding" (Gadamer, 1976, p. 55), the practice of the capacity for interpreting requires self-application, recognizing the claim of the text on me, and articulating the event of this understanding in a manner that brings it to life for others. The practice of hermeneutics is not the application of a general rule to a particular circumstance, but the working out of possibilities projected in understanding particular human encounters requiring action (Grondin, 1995). Thus the topic of a human sciences inquiry is concerned with how one "conducts themselves well" (D. Jardine, personal communication, EDPA 695.75 seminar, 1995) in responding to what is required in living out particular human contingencies where action is required.

Historicity of understanding. The natural sciences require efforts to limit external variables which could influence the findings, to isolate the phenomenon of interest, and to minimize or eliminate the bias of the investigator from influencing the resulting understandings. In contrast, Gadamer (1989) asserted that "understanding, as it occurs in the human sciences, is essentially historical" (p. 309). Both the interpreter and the topic of the inquiry belong to history or traditions which contribute to understanding and which make understanding possible. Thus hermeneutic interpretations take advantage of the relatedness of the topic to context, and of understandings handed down through tradition. The interpreter attempts to account for both familiarities and resemblances with previous
understandings, and the manners in which new and different understandings are required in
the present situation. Gadamer (1989) attempted to reclaim the historicity of understanding
by exploring the ways in which basic concepts of humanistic traditions such as common
sense, judgment and taste have become subjectivized, aestheticized and denied cognitive
value. Gadamer (1989) also reclaimed prejudices as necessary fore-structures of
understanding which must be questioned and examined, but which are a necessary
precondition for understanding rather than a contaminating influence or bias to be
eliminated from the process of inquiry.

**Dialogue of question and answer.** In contrast to the propositional logic of the
natural sciences, Gadamer (1989) asserted that “the logic of the human sciences is the logic
of question and answer....We can understand a text only when we have understood the
question to which it is an answer” (p. 370). He suggested that the propositional logic of
modern science posits the ability to reproduce a process by which the text or topic came
into being. The topic which addresses the interpreter in a human science inquiry invites
questioning of the horizon of the topic, the past and present understandings which address
the concerns of the interpreter. The logic of question and answer has the character of testing
of possibilities: “This is the real and fundamental nature of a question: namely to make
things indeterminate. Questions always bring out the indetermined possibilities of a thing”
(1989, p. 375). Gadamer (1989) suggested that the proposition, assertion, or opinion
suppresses questions and propagates itself, and that a person skilled in questioning can
“prevent questions from being suppressed by the dominant opinion” (p. 367). In learning
to see what is questionable in the topic, one must know that one does not know what needs
to be questioned.

In responding to the question posed by this research, I propose that there is
congruence with the traditions of the human sciences as outlined above. The concern which
has addressed me in this inquiry is the concern for the nurse’s manner of conducting
herself so as to alleviate the suffering of families experiencing ischemic heart disease. The topic is the contingent, complex and changing relationship between the nurse and the family. The nurse is clearly called upon in this clinical work to choose courses of action, to conduct herself well, with the intent to “be” therapeutic in a manner that contributes to alleviation of the suffering of the family. The understandings of clinical practices in the realm of cardiovascular nursing and family systems nursing offer important connections, similarities and traditions which inform present understandings of this clinical work. However, the character of the questions asked about this clinical work bears more of the character of the testing of possibilities and meanings available through the dialogue and logic of question and answer, rather than that of propositional logic. By declining an implicit appeal to the criteria of validation of traditional science, the scholarly character of interpretive work must be judged in a manner which accounts for different understandings of truth.

**Understanding and Truth in Hermeneutic Inquiry**

“understanding is no method but rather a form of community among those who understand each other” (Gadamer in the foreword to Grondin, 1994, p. x)

The understanding which is sought in this inquiry has the character of a shared meaning which is revealed in language and which enables the nurse to conduct herself well as she engages in nursing practice. This is very different from a self sufficient propositional statement which could make predictions or prescribe actions and outcomes related to particular concepts related to interventions with the family (e.g. “actions which provide social support reduce anxiety eight times out of ten”). Interpretive understandings have the character of rhetoric, argumentation, and thoughtful reflection and deliberation with oneself. These understandings are in the realm of arguments that are “convincing and persuading, without being able to prove” (Gadamer, 1976, p. 24) than certain or probable conclusions or facts.
Madison (1988) described the important difference between the persuasive or practical reasoning of hermeneutics, and the demonstrative or theoretical reasoning of science. He stated that the only two forms of knowledge considered to have legitimate truth claims in science are the apodictic, absolutely certain truths demonstrated, for example in mathematics, and the probabilistic, conjectural truths based on inductive observation and objective measurement. He contrasted the logic of demonstrative reasoning of science with the logic of argumentation of hermeneutics, in which one adduces reasons to justify or legitimate decisions: “in practical reasoning reasons influence but do not determine; they justify one’s decisions but do not demonstrate the truth or validity of them” (Madison, 1988, p. 32).

Although it might be claimed that there is no absolute truth, Grondin (1994) reminded us that this does not mean that there is no truth: “we make lasting claims to truth - to things that make sense, that are in harmony with the things we experience and for which arguments, evidence, witnesses, and conclusions can be marshaled” (p. 142). Reliance on practical reason is appropriate for the inquiry into the therapeutic relationship between nurses and families experiencing heart disease because “practical reason is concerned with all those situations where one must make a choice, produce something, or decide on a course of action, the outcome of which is contingent in that it depends, precisely, on the subject itself” (Madison, 1988, p. 34).

One of the possible explanations for the difference in the understandings of scholarly work in scientific and interpretive inquiry is that they make different claims to truth. Gadamer (1981) suggested that scientific knowledge is based on “the claim of being able to explain a fact completely through deriving all its conditions; through calculating it from the givenness of all its conditions; and through learning to produce it by artificial arrangement” (p. 105). In this claim, truth is related to verification and control. In contrast, “interpretation is always on the way” (Gadamer, 1981, p. 105). A definitive
interpretation is not possible, as interpretation is assumed to be a plausible and fruitful attempt at understanding, but always an approximation of shared meanings. The truth claim of interpretive understanding is related to our human concerns and situatedness, and “Its purpose is to make us more human, not to yield mathematical laws” (Grondin, 1995, p. 131). Truth takes on the character of revealing or uncovering the subject, letting it show itself without forcing our perspective on it, but working out possibilities projected in understanding, revealing aspects previously hidden from our awareness (Grondin, 1995).

Truth, then, is a “meaningful account” (Grondin, 1994) about which there is “agreement or consensus as to what shall be held to be true” (Madison, 1988, p. 31). The truths or understandings uncovered by hermeneutic inquiry are not private, subjective, perspectival matters. Interpretive understandings are constituted through language and dialogue, by the reciprocity between the questions asked by the text and the interpreter, by the interpreter and the community within which the dialogue is situated, and by the historicity of the understandings which precede the inquiry. Gadamer proposed that understanding could be thought of not as a subjective act or a consciousness of something, but as a mode of being, or “as participating in an event of tradition, a process of transmission in which past and present are constantly mediated” (Gadamer, 1989, p. 290). This is understanding not in the sense of a self-possession or a definitive achievement, but as something that “happens” (Gadamer, 1976, p. 55), in an experience of understanding as “an encounter with something that asserts itself as truth” (Gadamer, 1989, p. 489).

The Complicit Researcher

In this approach to hermeneutic inquiry, the researcher is complicit (from the Latin *plicare*, meaning folded or braided), connected and intertwined in the emerging understandings from the very beginning of the inquiry. In many descriptions of qualitative and phenomenological research, there is great concern to situate the inquirer distinctly outside or at the periphery of the topic, or outside of the participant’s description of their
experience. There are efforts to “bracket” the influence of the researcher’s assumptions and pre-understandings. In other research approaches this is often called investigator bias.

In hermeneutic inquiry, the inquirer is implicated in the topic and connected to the topic. Understanding of the topic requires self-understanding. This connection between the inquirer and the topic is viewed as essential to understanding rather than contaminating the findings of the inquiry. Gadamer (1989) stated that

application is neither a subsequent nor merely an occasional part of the phenomenon of understanding, but codetermines it as a whole from the beginning. Here too application did not consist in relating some pregiven universal to the particular situation...Rather, the interpreter seeks no more than to understand this universal, the text - i.e., to understand what it says, what constitutes the text’s meaning and significance. In order to understand that, he must not try to disregard himself and his particular hermeneutic situation. He must relate the text to this situation if he wants to understand it at all. (p. 324)

The ways in which the inquirer is implicated in the inquiry are not limiting conditions, but ones which make understanding possible.

Thus the hermeneutical conversation begins when the interpreter genuinely opens himself to the text by listening to it and allowing it to assert its viewpoint... To locate the question of the text is not simply to leave it, but to put it again, so that we, the questioners, are ourselves questioned by the subject matter of the text. (Linge in Gadamer, 1976, p. xx - xxi)

Although the researcher is complicit and implicated in the topic, the researcher is not the topic: “This writing is recognizably mine even though I am not its topic” (Jardine, 1994, p. 4). The researcher may be profoundly connected to the topic, but the
understanding which is made possible is not private, subjective understanding. The interpreter belongs to the traditions of the text which she or he is interpreting. The traditions of dialogue with families about living with experiences of heart disease are embedded in previous research on the topic, in the resource materials that we provide to individuals and families to help them understand heart disease, in the social discourse on exercise and low fat diets to encourage healthy lifestyles, in narrative and media accounts of living with heart disease, in the inquirer’s own family experiences with heart disease, in previous nursing experiences with patients during acute hospitalization for heart attacks, and previous nursing experiences as a clinical team member observing and participating in clinical sessions with families where heart disease has been present. These are not only the traditions in which the interpreter stands. They are shared meanings and experiences of heart disease which have evolved in the context of this culture through language. They are traditions in which the interpreter is implicated.

One way in which the scholarly capabilities of the interpreter plays a part in understanding the text is through imagination, which Linge (Gadamer, 1976) described as the capacity to see what is questionable in the subject matter and to formulate questions that question the subject matter further. And the precondition of this capacity is that one is open to be questioned by the text, to be provoked by it to risk involvement in a dialogue that carries him beyond his present position. (p. xxii)

The willingness to risk what one thinks, and the desire and intent to ask fruitful or productive questions reflect the concernful scholarly inquiry of an interpreter engaged in a quest for learning or understanding. Thus the dialogue which is pertinent to the inquiry is not only the research interviews with participants, but also the inner dialogue of the inquirer which reveals understandings of the topic.
The hermeneutic circle is oft cited as a hallmark of hermeneutic inquiry. However, the hermeneutic circle should be understood not as a method but a metaphor for understanding. The notion of circularity refers partly to the oscillation of understanding as an expanding circle of meaning between the part and the whole, and the reciprocity of meanings of the part and whole which can only be discovered from integration into ever larger contexts. Gadamer (1989) explained that a person who is trying to understand a text is always projecting a meaning for the text as a whole as soon as some initial meaning emerges. The interpreter has anticipations and expectations of the text which will influence the initial meanings which appear. These anticipations, prejudices or fore-structures are the possibilities of meaning which are worked out in the interpretation and confirmed by the “things themselves”, replaced by more suitable projections of meaning, or discarded if they come to nothing.

There is an inherent circularity to the projection of prejudices and fore-structures, the return arc of uncovering of the inadequacies of these prejudices, and the forwarding of alternate possibilities of meaning. To view the hermeneutic circle as only the evolving understandings between the part and the whole omits the ontological significance of the hermeneutic circle (Gadamer, 1989). The hermeneutic circle is ontologically significant because as these fore-structures are projected and revised, there is an interplay between the shared meanings handed down through tradition to both the topic and the interpreter. The preunderstandings are not the unique possessions of the interpreter, though the interpreter is profoundly connected to these understandings.

The anticipation of meaning that governs our understanding of a text is not an act of subjectivity, but proceeds from the commonality that binds us to the tradition...Tradition is not simply a permanent precondition; rather, we produce it
ourselves inasmuch as we understand, participate in the evolution of tradition, and hence further determine it ourselves. (Gadamer, 1989, p. 293)

The interpreter shares a bond with the meanings and traditions from which the text speaks and which are shaped in language.

Gadamer is concerned with reclaiming the reputation of prejudices as pre-conditions for understanding. “The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings” (Gadamer, 1989, p. 269). Thus prejudices are not necessarily false, but can also be enabling. The difficulty is that the productive and enabling prejudices cannot be distinguished in advance from those which constrain understanding or lead to misunderstanding. Gadamer suggested that reflection on prejudices or preunderstandings enables one to see “something that otherwise happens ‘behind my back’” (Gadamer, 1976, p. 38). By projecting prejudices, they are put at risk, at stake, or at play, to be able to “experience the other’s claim to truth” (Gadamer, 1989, p. 299).

Thus an important step in “entering the hermeneutic circle” (Packer & Addison, 1991), is to attempt to identify one’s prejudices about the subject of the inquiry. Before beginning data generation through the research interviews with participants and prior to interpretation of videotapes of the clinical sessions, I attempted to describe my own prejudices and pre-understandings pertinent to this inquiry. Each statement below reflects understandings related to the topic of the research which I believed might influence what I saw during the inquiry process, and which I believed could be put at risk or at play during the inquiry to engage in a dialogue with the understandings which emerged in the interpretive process. These are certainly not all of my prejudices, but they are those which I was able to language as beginning understandings informing my early responses to the research question.
(1) Nurses are people who live under a passion for alleviating suffering relating to health and illness. This manner of living requires that we act in our understandings and live in a manner congruent with our knowing to fulfill our own passion for alleviating suffering, and to fulfill our obligation to others.

(2) Suffering accompanies illness, and the distinctions between physical suffering and emotional suffering are manners of punctuating the experience. Suffering is part of our finitude, part of the human experience of living and dying, and as such, we have something to learn from this experience. Nurses cannot expect to remove suffering from the lives of the people we encounter in our clinical practice, but we can bear witness to the courage and integrity of such people and their families in a manner which gives suffering meaning, and which challenges the isolation of suffering. Thus to alleviate suffering does not necessarily mean to remove it, but rather to make it lighter or more bearable.

(3) The common, prevailing discourse between nurses and persons experiencing heart disease is dominated by an individual perspective of the illness, instructive interaction and attempts to coerce lifestyle modification. This approach can be experienced as disrespectful, and does not take into account the complex relationships between the ill person and other contextual influences, such as family, work, and cultural contexts. Cardiac illness is increasingly experienced as a stigmatizing event in which people feel blamed by family and by health care professionals for the development of the disease, and feel excessive responsibility and frustration with attempts to control the disease. These experiences are coached by a social and cultural context which emphasizes individual responsibility for healthy lifestyles, and which blames users of the health care system for expenditures in an environment undergoing constant change due to constraints in health care funding.

(4) The experience of the illness constitutes a common background of concern for family participants. While there is much known about responses of individuals and families to
heart disease, it is anticipated that each family member may have some concerns which are commonly reported in the research literature, but will also have some concerns which are related to their own particular situation.

(5) Meaning and understanding are constituted in language. It is anticipated that families and nurses will be able to reflect on their experiences, and create meanings about the experience of working together through dialogue and language.

(6) Nursing “interventions” are interactional and occur in relationship. Any attempt to account for what happens in the therapeutic relationship to facilitate change in a direction desired by the family requires questioning and understanding of the skills, beliefs, practices and concerns of both family members and the nurse.

(7) The discourse of beliefs (Wright et al., 1996) as a manner of understanding, explaining, conversing, and creating changes and healing with families who are suffering in their experiences of illness will exert significant influence on the perspectives of the clinicians working with the family participants, and also on myself as the inquirer. Along with the influence of the work of Humberto Maturana (1988) and Maturana and Varela (1992), these understandings constitute salient background meanings for the practices of the nurses.

(8) The nursing interventions offered in this approach to clinical practice are offered through the medium of language rather than physical interventions. However, languaging and emotioning are reciprocally related to physiology and can influence the healing of the disease and the experience of suffering.

(9) Just as nurses have practices which have been articulated and which are intended to create a context for change and to invite the family into addressing the problems they are encountering in living with heart disease, the family also has ways of involving the nurse in their care. These family skills, beliefs and practices may or may not be visible to family members. If they could be understood, they could help nurses to better understand some
of the ways in which nurses are reciprocally altered by families in the conduct of the clinical work.

(10) Individuals and families often have not encountered nurses who are so passionately concerned about the influence of the illness on other family members, or who are not so passionately endeavoring to teach them something about the illness. They may be uncertain about how to proceed in the family sessions, or may be even more open to entertaining different ideas because of subtle or blatant challenges to assumptions and beliefs about roles of nurses, patients, authority, and hierarchy.

The dialogue which was initiated between these prejudices and new understandings encountered in the text enabled the inadequacies of some of these beginning understandings to be uncovered, and offered entry points for questioning the text and for responding to the research question.

II. The Soundness of Scholarly Interpretive Work

There are many ways in which the scholarly researcher is called to respond to issues of the soundness of hermeneutic work and to account for the conduct of interpretive inquiry. The interpretation or understanding resulting from a hermeneutic inquiry needs to be sound, based on good grounds, persuasive, and provide convincing reasons and arguments. These sound reasons support the findings of the inquiry, the questions and answers retrieved and recovered, and the ruptures and possibilities marked by the inquiry. The interpretation needs to be sound, because that which is or may be heard as a result of the inquiry has implications for the manner in which we conduct ourselves, in this instance, in our nursing practices.

Madison (1988) proposed that there are two reasons why hermeneutics must allow for "method" in some sense of the word. Firstly, "only the individual, human, conscious, reflecting subject can be held responsible for what he or she says or does" (p. 27). The
interpreter must be able to justify their words and deeds, to provide convincing arguments, to be able to respond to queries about the manner and process of pursuing the inquiry, and to account for the manner in which they conducted themselves and the inquiry. Secondly, he suggested that there must be a way to arbitrate between conflicting interpretations. Although Madison (1988) agreed with Gadamer (1989) that there cannot be any interpretation that is correct in itself, he argued that if there are two interpretations of the same text which conflict, there must be some means or criteria by which to judge which is better. Packer and Addison (1991) agreed that evaluation of interpretive accounts is desirable to illustrate that the interpretation is not just conjecture, but “the working out of possibilities that have become apparent in a preliminary understanding of events” (p. 277). However, they cautioned that many approaches to evaluating interpretive accounts are based on a hidden application of validation based on a correspondence theory of truth. They suggested that there may be merit in seeking participant validation of findings, or attempting to obtain consensus among a group of researchers. However, they also noted that the attempt to achieve such validation often hides an implicit intent to ensure that the interpretation corresponds to the way things “really” are. They proposed that a good interpretation that gives a meaningful account “is the one that answers the concern that motivated our inquiry in the first place” (p. 290).

The manner in which researchers conduct themselves in the research process reflects on the character of scholarly work. This is evident in the ability to be addressed by the concern, to be able to hear the concern motivating the inquiry and to apply it to oneself, to take it up, and to entertain it as important. The self-application of the understandings, offering interpretive conjectures, risking prejudices, and projecting of pre-understandings requires the researcher to be open to risking what one believes they know, and putting it into play, and taking it back, revising it, or seeing what appears. The scholar must be willing to let what they know be undecidable rather than certain in order to be open to
questioning. Gadamer (1976) suggested that the decisive function of the scholar is imagination, the "ability to see what is questionable" (p. 13). This is the scholarly ability to pursue a question, to call something into question, to know what is open to question, to know what needs to be broken open by question to reveal the topic, or "to reveal the questionability of what is questioned" (Gadamer, 1989, p. 363). There is a scholarly character to making distinctions and recognizing what is undecidable or ambiguous, what is suggestive of something else which should be pursued, or which could uncover fertile meanings and generate new understandings.

There is a scholarly character to interpretive writing which is sound and based on good grounds: persuasive, convincing, and providing reasons and arguments which support the findings of the inquiry. Scholarly interpretive writing takes advantage of the multiplicity, creativity, and traditions of language to reveal and uncover questions, answers, ruptures, and possibilities in all of the complex, connected and contingent circumstances of human life. Interpretive writing invites the reader into a dialogue with the text, invites them to direct questions to it, invites them to be questioned by it, and demonstrates the soundness of the findings by creating the possibility of self-application by the reader.

Koch (1996) proposed that interpretive work requires that the researcher must show attempts to address rigor or integrity of the inquiry, and that the reader must decide if it is believable. In the remainder of this chapter, the integrity of the inquiry is addressed as I attempt to outline the conduct of this project as my response to the research question. The recruitment of participants, the process of data generation, the dilemmas of writing, and the evolution of the writing will be traced based on a trail of process memos written throughout the project. The process memos addressed issues and dilemmas in the conduct of the research throughout the inquiry. The remaining chapters will then present the interpretive findings of the study, the attempt to invite the reader into dialogue with the topic.
III. The Research Participants

Recruitment of Participants

Participant families were sought within the local community. Families in which a member had been diagnosed with coronary artery disease, with at least one other family member willing to participate in the family sessions at the FNU and in subsequent research interviews were solicited for the study. Families were to have self-referred or sought referral from other health care professionals related to difficulties they were experiencing in relation to living with ischemic heart disease following myocardial infarction (MI), or treatment by coronary angioplasty or coronary artery bypass graft surgery.

Initial efforts to recruit participants focused on approaches to colleagues practicing in the nursing and medical community related to cardiac care. Colleagues in a variety of settings agreed to make brochures about the Family Nursing Unit and the research project available to clients. These colleagues included clinical nurse specialists, nurse managers, and a cardiologist practicing in acute care locations; nurses practicing in cardiac rehabilitation; and a psychologist at a women’s resource center. Posters inviting self-referrals were displayed on public bulletin boards at local libraries, malls, and on the university campus. As response to these efforts was minimal, an advertisement was placed in a local newspaper. Over a one year period, a total of five families contacted the FNU to arrange for clinical sessions and participate in the research. Genograms of the three families who participated in all phases of the research process are included in Appendix A.

Introduction to the Participants

One family responded to the newspaper advertisement and booked a session at the FNU, but declined participation after the research project and the clinical work was explained to them. The wife had initiated contact with the FNU and came with a detailed list of questions about diet, exercise, lifestyle, and wonderings about “getting over” the heart problem. However they were uncomfortable with the videotaping of the clinical
sessions. The husband was most hesitant to participate. His wife explained that he was humiliated by this first experience with heart disease, and believed that the longer they sustained connections with the health care system and with health care providers, the longer the stigma of this experience would be with them.

A second family was referred to the study by a research nurse from a clinical drug trial. The husband had participated in the drug trial for five years following his first MI. The couple attended five sessions at the FNU over ten months, and included their two teenaged daughters in the final session. Attempts to arrange research interviews with the couple in the months following the conclusion of their clinical work were complicated by their marital separation under very unusual circumstances. Although the husband reaffirmed his desire to have the videotapes of the clinical work included in the research, the wife passively withdrew from the study by declining to return phone calls to arrange an appointment for a research interview.

There was a possibility that written materials describing the couple’s clinical work could have become entangled in a difficult legal disagreement related to the couple’s separation. In early drafts of the dissertation, I initially attempted to include this family by offering a brief overview of the clinical work. This was in contrast to the intensive interpretive writing about the clinical sessions as offered for each of the other family participants. The intent was to concisely contextualize the subsequent offering of exemplars from this clinical work. The result was that the writing about this family was cautious and constrained. The interpretations were flat and shallow, and could not be allowed to speak to “the heart of the matter” as addressed in the clinical sessions with the family. The exemplars lacked the depth and the character of the richly contextualized particulars which emerged from the writing about the other family participants. It also became clearer that even brief descriptions could allow the couple to identify themselves in this writing, and possibly to use this writing in an unintended manner in their legal proceedings. Rather than
contributing inadvertently to this matter, the interpretations of the clinical work with this second family will not be included.

**Alex, Georgina and David**

Alex and Georgina obtained a brochure about the research project when they attended an information session at an acute care hospital a few weeks after Alex's discharge following a heart attack. Alex also had a kidney transplantation about three months prior to the heart attack. This couple had previous experiences as lay-counselors, and part of what compelled them to participate in the research was their comfort with their own previous experiences as counselors. They were very curious about what these sessions could offer them as "dedicated students" of chronic illness. Georgina made her altruistic motive for participation in the research very clear: she wanted to help health care professionals to learn about how illness experiences influence people and their family. They attended four sessions at the FNU. Their adult son, David, accompanied them to one of the sessions but did not participate in the research interview.

**Alice, Jeanie and Grace**

Alice was referred to the FNU by a nurse from a clinical drug trial. Alice had participated in the drug trial for five years. The research nurse with the drug trial had suggested that family sessions might be helpful to Alice because her involvement with the study nurses was ending, and the wait for cardiac bypass surgery was an ongoing stressor for Alice. The research nurse with the drug trial briefly explained the research project at the FNU to Alice, and asked for her permission to forward her phone number to the FNU researcher for further information. The influence of the referring source and uncertain expectations for participation in the clinical work and the research project was noticeable during the first session conversations between the family and the nurse. Alice attended three sessions at the FNU over six months, two of them with her daughter, Jeanie, and one with her best friend, Grace.
Cecile, Mark, Jonathan, and Josie

Cecile had contacted the FNU after reading the newspaper advertisement for the research project. She knew of another family who had done clinical work together when the mother was suffering a terminal illness, and had heard positive reports of the helpfulness of their sessions. Her husband, Mark, agreed to come to the sessions because he thought that it would be helpful to Cecile. In the research interview, the nurse who worked with this family commented that she did not think this family would have come if it had not been in the context of a research project. The nurse believed that Cecile had come to the first session alone, and carefully “checked out” the setting before choosing to involve other family members. This family came for a total of five sessions over a period of ten months: Cecile came alone to the first session; Cecile, Mark, and Jonathan (their 25 year old son) attended the second session; Mark, Jonathan, and a 30 year old daughter, Josie, attended the third session; Mark came alone to the fourth session, and Mark and Cecile attended the final session.

With each family, I respected that not all family members would choose to participate in research interviews following conclusion of the clinical work. For this family, there were three failed attempts to meet with Cecile and Mark for a research interview. These efforts were complicated by the fact that the primary residence of the couple was several hours from the university, by the interference of hazardous winter driving conditions, and by scheduling constraints due to Mark’s demanding work commitments. The couple declined offers for the researcher to travel to their home for an interview, and eventually did not return a call to schedule an appointment. I believed that this constituted a passive refusal to participate in the research interviews, and I respected the right of participants to choose this option at any point in the process. The family had already contributed a significant amount of time and energy toward this endeavour. It was possible that the couple wished to maintain privacy regarding subsequent family developments, or
may have been concerned that the researcher might have expectations about changes or family outcomes. At the conclusion of the fifth clinical session, the nurse and the couple had thoroughly discussed their impressions of the overall clinical work (i.e. what the couple believed had been helpful, new developments in the family that they related to the clinical work, and whether their expectations had been fulfilled in coming to the FNU). In addition to these impressions of the clinical work from Cecile and Mark’s fifth session, both of their adult children who lived locally, Josie and Jonathan, did participate in research interviews.

Nurse Participants

The two nurse participants who conducted the clinical work with the family participants were members of the Faculty of Nursing. Both nurses have indicated a preference to include their initials throughout this work rather than an anonymous pseudonym. One nurse clinician (identified as LMW within this text) worked with Cecile and Mark’s family. Dr. Lorraine M. Wright established the FNU in 1982, and has many years of experience in clinical work with families presenting with a variety of health and illness related concerns, including several families experiencing heart disease. Dr. Wright is one of the originators of the theoretical framework of a family systems nursing and beliefs approach to clinical practice with families.

Sylvia Streitberger (identified as SS within this text) was the clinician who worked with the remaining 3 families. She is a former graduate of the Master of Nursing program at the University of Calgary, with a clinical focus specialization in family systems nursing. She has practiced for several years as a clinical nurse specialist in family systems work at an outpatient mental health clinic, and has an active interest in narrative therapies. At the time of the research project, she was a part-time sessional instructor with the FNU.
Ethics Approval and Informed Consent

Certification of institutional ethics review was approved by the Committee on the Ethics of Human Studies at the University of Calgary in December of 1994. Copies of the certification and the participant consent forms which were approved by the committee are included in Appendices B and C. Informed consent was explained to each participant family at the beginning of the first clinical session and signed by each family participant at that time. The terms of the informed consent were reviewed with family participants and copies were provided again just prior to the family research interviews several months later.

Prior to commencement of the research project, the procedures for videotaping of the clinical work were altered at the FNU. The practice of routinely videotaping the presession and postsession conversations of the clinical team was incorporated as an adjunct to the learning of graduate students. Graduate students were aware that all videotapes relating to the clinical work would be reviewed as part of this research project, and that the videotape library could be used for other research in the future. Informed consent for participation of the nurse clinicians who worked with the family participants were obtained immediately prior to the research interviews conducted following the completion of each family’s clinical work.

In the transcript materials, only first initials of family members’ names were used, and in the interpretive writing, pseudonyms were assigned to family participants to preserve their anonymity. The codebook of participants’ contact information, transcripts and audiotapes were stored in a locked filing cabinet. The codebook will be destroyed upon approval of the dissertation, and audiotapes and transcripts will be retained for three years following the completion of the research as per the policy of the University of Calgary.

Possible Influence of the Practice and Research Context on Participants

There were many ways that the university context may have influenced the family participants. The Family Nursing Unit is located at an on-campus site at the University of
Calgary, which is not directly linked to the health care system. It is outside the usual domain of hospitals, clinics, and public health offices. While nurses practice autonomously in this setting without influences from other health care providers, there was also a risk that collaboration with other physicians and community resources could be more difficult. Families in this study indicated that they had not encountered nurses in clinical practice outside the hospital setting, except one family who had been visited by a home care nurse. This may have created uncertainty for family members regarding roles of nurses and expectations of family members.

For some families, perhaps because the context was so different, family members were very open to other ways of working with nurses than they had experienced in other acute care contexts. For another family, the unusual context (one way mirrors, clinical team participation, telephone contact during the session) was uncomfortable and constraining, particularly as the clinical work began. Knowing that this was an educational setting, family members were sometimes more attentive to reciprocities in their relationship with the nurse. Sometimes, family members expressed concern about their ability to be helpful to the nursing students. In this instance, families knew of their participation in the research study before beginning the clinical sessions with the nurse, and were sometimes curious about whether they were meeting expectations of the researcher as well. When these concerns arose, the nurse clinician assured the family that the clinical team was learning from them, and usually inquired about whether and how the clinical work was benefiting the family.

In two instances, participation in the research project also influenced the nurse and the clinical team, particularly in the first session with the families. The nurse and the clinical team were somehow more inclined to ask themselves and each other whether the family really needed to come to the FNU, and how they believed that they might be most helpful to the family. This questioning was most evident with Alex and Georgina, who did not
present with a particular “problem” that they wanted the nurse to assist them with, and with Alice and Jeanie, who were referred by a nurse from a clinical drug trial.

IV. Generation of Data

Koch (1996, p. 178) boldly stated that as the researcher, “I participate in making data” in interpretive work, but added that the researcher must address their role in shaping the account of the text. The implicit interpretive researcher participates in generating data in many ways: by asking questions of participants; by highlighting particular responses from these conversations; by engaging in dialogue about the text with others; and by writing about particular aspects of the text that was generated by the participants. From Gadamer’s perspective (1989) the task of self-application is a necessary pre-condition for understanding rather than a source of bias. Thus the many sources of data in this research project, and my participation with these sources will be described.

Videotape Data

Firstly, all of the clinical conversations between the nurse and the family members were videotaped. The videotapes of the clinical work are a form of text about the conversations between the family and the nurse. The clinical conversations could be more fully contextualized as the videotapes preserved many of the nuances of both verbal and nonverbal intimations that may be difficult to convey in written text. During the clinical sessions, family members were aware that as the researcher, I was participating as a member of the clinical team behind the mirror. Although I participated in the presession and postsession conversations with the clinical team, I did not participate in the reflecting team conversations which were observed by family members. I believed that this would confuse both the family’s understandings of my role as researcher, and would complicate my own interpretations through this direct involvement in the clinical work.
Secondly, the presession and postsession conversations of the nurse clinician and the clinical nursing team were also videotaped. As a solo interpretive researcher working without the benefit of a research team, these conversations of the clinical team’s coevolving understandings were a rich resource of multiple views and perspectives: of the family’s difficulties and strengths; of possible explanations or possible solutions; of turning points in the conversations; of the nursing interventions offered during the interview; and of the family’s contributions and responses throughout the interview. This was a source of many different ideas about plausible explanations of the clinical work which reciprocally challenged, complemented or embellished my own understandings and interpretations. My participation in these presession and postsession conversations of the clinical team was a very helpful opportunity to float conjectures and try out beginning understandings of the family and the clinical work.

Transcripts of Videotape Segments

Each of the videotapes of the clinical conversations between the family and the nurse were reviewed at least twice. As I watched the videotapes, I tried to stay attuned to conversation which was helpful to uncover aspects of the family-nurse relationship and which seemed to make a difference in the clinical work. I also tried to stay attuned to ways that this conversation might be unique to the experience of living with heart disease. I audiotaped segments of the videotape conversation, which I later transcribed for more detailed review as written text. The following are examples of patterns in decision-making around selection of these segments:

- Conversational events that conveyed meanings of relational aspects of the clinical work were selected (i.e. What does the nurse say or do that facilitates engagement? How does the family invite the nurse to be interested in them? How does the family convey an interest in the nurse? This included overt conversations of the therapeutic process, such as, “How did you experience our work together today?”)
- Portions of the conversation that seemed particularly perturbing to either nurse or family were selected. This often included family comments at the beginning of the session as they responded to “What stood out?” from the previous session, and family responses to reflecting teams.

- Ideas, beliefs or themes were selected when segments echoed, reverberated or repeated across the clinical work from one session to the next. Sometimes the repetition or reverberation occurred between the clinical conversations and the research interviews. The videotapes of the presession and postsession conversations of the clinical team were similarly reviewed. The postsession conversations were often audiotaped and transcribed in almost their full entirety because of the richness of the multiple perspectives offered in this dialogue.

As the audiotapes were recorded from the videotape segments, I occasionally stopped the videotape and commented briefly on the audiotape recording about impressions or understandings that stood out for me at that time. These comments were then typed directly into the transcripts as additional notations, and were embellished with other comments during the typing. In this way, evolving understandings or conjectures were inserted throughout the text for consideration during subsequent readings of the text. The typewritten transcript also had a wide margin for additional hand-written comments to be included with each future reading of the text.

Throughout this process of videotape review and selection of particular segments of text, highlighting and interpretation was already beginning. The very selection of one segment of the videotaped conversation rather than another began a process in which the researcher’s understandings influenced the directions and possibilities which were yet to come from the emerging understandings. This is clearly an example of the researcher participating in the generation of the data.
**Dialogue with Participants**

Research interviews with the family following the completion of the clinical work constituted a third source of data. Research interviews were not conducted with family members during the period of the clinical work at the FNU. The sequencing was intended to avoid possible confusion between the family's experience of the therapeutic clinical conversations, and the experience of the interviews between the nurse researcher and the family. Family members were invited to choose the location for the interview (one family selected their home, and the remaining families chose to come to the university). Similarly, a fourth source of data was the research interviews with the nurse clinicians following the completion of the clinical work. All of these interviews were audiotaped and transcribed verbatim.

The interviews with the family and with the nurse were unstructured. The character of the clinical work was very different for each family, as were the family members' concerns or difficulties, and the relationship which evolved with the nurse. The interviews with family members attempted to elicit understandings that were particular to their circumstances. Although the intent during the research interviews was to become engaged in a conversation which supported the questioning in an actively involved, curious and non-judgmental manner, the stance differed from a clinical approach in that there was no conscious attempt to be therapeutic to the family in any way.

The character of the dialogue between researcher and nurse and family participants bore important implications for the possibilities for understanding which would unfold in this research. This dialogue is another example of the ways in which the interviewer is complicit in the generation of data. Within the interview, there were times of open listening to hear the participants' shaping of the telling of their story. There were times of questioning to clarify understandings of their story. But there were also times of actively engaged negotiations of meaning, recycling of descriptions, and bouncing understandings...
or interpretations off participants. The questions that are asked are important, because they bear the character of the "testing of possibilities" (Gadamer, 1989, p. 375), but the questions that might show themselves to be important could not be predicted in advance. Sometimes the importance of a question or a response would not be realized until much later in the process of attempting to understand these meanings. Important questions and answers sometimes became evident much later in the process of interpretive writing.

Scholarship in this domain is constituted by the ability to actively engage in fruitful conversation with participants, taking advantage of one's prejudices, traditions, and domain of experiences, and to be able to put into play a domain of question and answer which enables the topic to be uncovered and revealed. This statement is not intended to imply that the interviewer is in control of the conversation:

We say that we "conduct" a conversation, but the more genuine a conversation is, the less its conduct lies within the will of either partner. Thus a genuine conversation is never the one that we wanted to conduct...No one knows in advance what will "come out" of a conversation. (Gadamer, 1989, p. 383)

The understanding which emerges through the dialogue is not something that the participant possesses that the researcher must learn from them. The researcher and participant engage in dialogue about the subject matter before them, their experiences of the coevolving relationship between the family and the nurse. The interview really is something between them, happening in their midst, which creates new views and possibilities of seeing and understanding. In this dialogue, "something emerges that is contained in neither of the partners by himself" (Gadamer, 1989, p. 462). Something emerges in language which reveals the traditions of this illness, and these families, and these nursing practices which creates greater possibilities for understanding how to conduct ourselves as nurses in manners that are helpful to these families.
Each family and nurse was interviewed once. It was originally anticipated that multiple interviews with each family might be useful. However, in many ways, the research conversations were a continuation of a conversation already begun between the family and the nurse clinician. As a research conversation, the context was different. The family members had different expectations of the research interviewer. However in many ways, the content of the research interview was a continuation of the plot. The family members knew that as the researcher, I was already very familiar with their story through my participation as a clinical team member behind the mirror. They did not expect a clinical conversation about their concerns, but the topic of the research conversations was very evident: the research interview was yet another opportunity for both family and nurse to reflect back (separately) on what happened in the clinical work. The family reflected on their relationship with the nurse, and the nurse reflected on her relationship with the family. The family reflected on how the nurse was helpful to them, and how they participated in the changes which occurred across the course of their work together. The nurse reflected on her understandings of the family, her understandings of the nursing interventions offered to the family, and her explanations of the process and outcomes of their work together.

The repeated contacts with the family over an extended period of time enabled me to be more convinced that the accounts offered in the interpretation were the most coherent, thorough, comprehensive and contextual accounts of the experiences of the family members and the nurses which I could offer at this point in time. As understanding is always "on the way" (Gadamer, 1981, p. 105), this is not meant to imply that these accounts are "true" as either the family or the nurse might have presented them themselves. If that were the intent, it would make sense to return the accounts to participants for validation. Alternatively, this approach could also be undertaken to generate more data. The multiple sources of data from the videotapes of the clinical sessions, the videotapes of the clinical team presession and postsession conversations, and the interviews with both the
nurses and the family members increase the credibility of the interpretations as meaningful accounts.

I transcribed each of the audiotapes from the research interviews, and as I typed the transcripts, I often had questions or wonderings triggered by the research conversations which I again embedded and noted within the transcripts. Upon completion, each transcript was reviewed again with the audiotape to confirm the accuracy. One margin of the transcript was wide to allow for notes about emerging interpretations to be written with each reading of the transcript. Before the interpretive writing began, a review of all materials related to the clinical work with each individual family was done (i.e. transcripts of all videotape segments and all research interviews). The intent was to revisit the work in its entirety before beginning the writing about particular understandings related to the clinical work with each family.

**Therapeutic letters**

A final source of data was the therapeutic letters which are occasionally sent to the family at some point during the clinical work, and which are routinely sent upon completion of the clinical work with the family. These letters may highlight or emphasize ideas or suggestions which had been offered during the session, or offer additional perspectives and suggestions which arise during the postsession team conversations. The medium of written language between the nurse and the family is another form of text which may shape the nurse-family relationship which facilitates change.

During the process of interpretive writing, the content of these letters was rarely explicitly addressed. This pattern contrasts with my own belief about the influence of therapeutic letters on families. In the clinical conversations and in the research conversations, the sending of therapeutic letters was occasionally raised by family members, but the specific content of the letters was rarely discussed in any detail. Research conversations described more about how letters were used by family members (i.e. to
distribute ideas to family members who had not attended the session) than what the content of the letters was actually about. Thus the content of the therapeutic letters was reviewed and interpreted as text which shed light on the therapeutic conversation and relationship in a manner similar to the text of the transcripts from the clinical sessions and the text from the research interviews with participants.

V. The Process of Interpretive Writing

As the review of the videotapes and the interviewing of participants and typing of transcripts came to a close, the process of interpretive writing began. The writing of the interpretations of the clinical work was complex because of the many sources of text to be considered. The process was a weaving of perspectives from the transcripts of the videotape segments from the clinical sessions and the clinical team conversations, and the transcripts of the interviews with the family members and the nurses. Initially, the writing began as a session by session summary which included highlights from the transcripts, followed by additional perspectives from the research interviews, and then by writing about at least one other aspect from the clinical work which spoke loudly in the particular instance. At this point in the writing, the intention was to stay very close to the data, and there was little effort to include other literature or sources of text unless for some reason a connection seemed strongly pertinent.

Beginning Interpretations of the Clinical Work

As the writing progressed, I constantly asked myself questions about aspects of the clinical work which were unique and particular to each individual family, and aspects which connected across the work with all of the families. Eventually, I chose to retain the session by session interpretations of the clinical work, because this format richly conserved the contextual aspects of the clinical conversations while allowing particular aspects to be more fully explored. Throughout this process, there was a continual moving back and forth
between the writing and the transcripts, highlighting, demonstrating, selecting exemplars, eliciting descriptions and understandings. The intent was to offer explanations of the movement of the clinical work across individual sessions for each family, and across the clinical work as a whole for each family. The writing was not based on previously identified themes selected before the writing began. The transcripts had been reviewed repeatedly, and the instances which were highlighted addressed particular aspects of the clinical work. The writing itself was the working out of the understandings and interpretations of the text of the transcripts.

Identification of themes within the data is a commonly accepted approach to "data analysis" in qualitative research methods which has been undertaken in a variety of ways (Denzin & Lincoln, 1994; Jasper, 1994; Koch, 1996; Munhall & Boyd, 1993). Themes are often understood as concepts which are notable in the frequency of their recurrence in the text, and which reflect a way of indicating or describing the topic. However, if experiences are understood not as objects, but as events which are contingent, messy, particular and notable in their contradictions, to portray experiences as thematic concepts strips them not only from their context, but from their meaning: "The meaning of the word cannot be detached from the event of proclamation. Quite the contrary, being an event is a characteristic belonging to the meaning itself" (Gadamer, 1989, p. 427). Gadamer used the example of the curse to illustrate the way that the statement or words of the curse cannot be separated from the utterance, the event of the curse which occurs in the statement. Themes are concepts which are intended to reflect the patterning and order of the things themselves, but unfortunately, this ordered arrangement of concepts often "takes precedence over the living metaphoricity of language...the spontaneous and inventive seeking out of similarities by means of which it is possible to order things" (Gadamer, 1989, p. 432). In this research, the readings of the text were sensitive to echoes of familiarity and common meanings across the text, but the text was not broken down into semantically discreet word
objects. The resemblances and familiarities allowed for what was the same also to be
different, and for the variation and differences to count in a way that was not necessarily
numbered. In this way, differences may have merit and significances even in the singular
instance. Interpretive writing should sustain the connections between the topic, the events
that experiences and understandings are, and the interpreter. The wholeness and richness of
language enables the interpreter to convey the similitudes and verisimilitudes, the
semblances and resemblances of the event of understanding uncovered by the
interpretation. This increases opportunities for others to be similarly addressed by new
possibilities of meaning which are brought to language in interpretation. Thus although the
text was not conceptually coded and themed, the writing about the text was intensive.
These writings constituted early interpretive conjectures which were circulated to
supervisory committee members and other readers for further dialogue on the evolving
interpretations.

Floating Interpretive Conjectures

The interpretive writing and dialogue with others about the interpretive writing were
manners of testing interpretive conjectures to see how they bore out. Floating of
interpretive conjectures could be considered the return arc of the hermeneutic circle, as a
manner of uncovering the inadequacies of the pre-understandings projected in the forward
arc. Gadamer (1989) described this as follows:

Explicating the whole of meaning towards which understanding is directed forces
us to make interpretive conjectures and to take them back again. The self-
cancellation of the interpretation makes it possible for the thing itself - the meaning
of the text - to assert itself. (p. 465)

This is part of the circular process by which prejudices and pre-understandings either bear
out in the interpretive process, or by which they are modified and discarded to create space
for alternate meanings to emerge. It is a process of posing or risking interpretive
conjectures to others, putting them into play with others, and hearing them read back by
others to discover the ways in which the interpretations either do or do not hold or float
(personal communication, D. Jardine, EDPA 695.75 seminar, Fall, 1995).

Throughout the interpretive writing, opportunities were sought to have colleagues
read this work in progress, and to invite them to offer their impressions and understandings
of the interpretive writing. Examples of questions posed to readers included the following:

- In what ways does this account of the clinical work ring "true" to you, remind you of
  similar encounters, convey the nature of this clinical work? In what ways does the writing
diverge from your understandings of this kind of family work?
- Are there other explanations you might offer that could embellish those in the writing, or
  that could counter or question those offered?
- Did the writing offer you any perturbing ideas that you had not encountered previously in
  your thinking about this clinical work or this population?
- Are there some descriptions or explanations which are particularly convincing while
  others are not?

Two people consistently read along throughout the writing and offered many conversations
about the emerging interpretations. One was the faculty supervisor (Dr. Janice Bell), and
the other was a colleague (Nancy Moules) who was a master's student in the family
systems nursing clinical specialization at the University of Calgary. Both of these readers
were very familiar with the theoretical and practical background of this approach to clinical
practice, and both of them had been present as clinical team members during most of the
sessions with the research participants. Other nurses agreed to read portions of the
interpretations and offer feedback. These included two colleagues who were cardiovascular
nurses (one practicing in an acute care hospital, and the other in a community health
Both of these nurses were familiar with hermeneutic interpretation as an approach to inquiry.

Opportunities for dialogue about interpretive conjectures were sought through this somewhat formal process of circulating emerging interpretations within the writing. Throughout the entire period of interviewing, transcribing, and writing, emerging understandings were posed in many informal conversations with friends, family, nursing students and colleagues. These included conversations exploring pressures of healthy lifestyle messages in the media and in our culture; conversations of illness experiences which resulted in implicit and explicit blaming for illness; conversations about family systems nursing practices in seminars and family nursing skills labs with undergraduate and post-RN students; and conversations with surgical nurses practicing in an acute care hospital during a workshop on the topic of therapeutic conversations with families. This dialogue constituted a scholarly practice in that emerging understandings are repeatedly "tested", critiqued and examined in a community of peers, and in a community of interested participants. The understandings are held up to the scrutiny of others, trialing arguments, and trying them out to see which of them bear useful possibilities.

Presentation of the Interpretive Writing

As the writing about each of the families was completed, several outlines were drafted to frame the presentation of the writing for the format of the dissertation. This effort was an attempt to connect interpretations across the clinical work with all of the families, making sense of the particulars across the broader contexts within which this work is situated. At this point, there was more effort to connect or contrast the interpretations with other understandings from the nursing literature. The question which I found myself posing most consistently at this point in the writing was "What is happening in the family-nurse relationship that makes a difference in these therapeutic conversations?" This writing was extremely slow and difficult. There was constant movement between the original
transcripts, the interpretive writing about each family, and the literature (including nursing and cardiac research, family therapy literature, and first person accounts of living with heart disease and chronic illness). In understanding what was going on here, in this clinical work, there were efforts to contrast this work with other clinical practices in nursing and family therapy. This was slow work which challenged patience. It was demanding work that challenged creativity to do justice to the topic.

Just as the process of interpretation always involves the self-application of the topic to the interpreter, the interpreter demonstrates scholarly capabilities by finding language which conveys meanings and invites the reader to a similar self-application of the interpretation. Thus the explanation must “touch the soul of the listener” (Grondin, 1994, p. 61) and invite the reader to enter into a dialogue or conversation with the interpretation, to direct questions to it, and to allow themselves to be questioned by it. The language and meaning of the interpretation must invite the reader to apply the meaning to their own situation, to raise questions that the reader wants answered, and to engage in acts of self-application. Sound scholarly work responds to the concern which motivated the inquiry by evoking the reader’s reflection on the interpretation, and giving it a hearing which resonates. The remaining chapters attempt to speak to understandings of this clinical work through interpretive writing which uses the rich traditions of language to speak eloquently and persuasively to the explanations and understandings offered by the text. The explanations are not intended to delineate or reproduce underlying generative mechanisms, but to offer invitations to understanding a topic which enables us to live well in the tenuous human contingencies and obligations of our nursing lives.
CHAPTER THREE:
INTERPRETIVE ACCOUNTS OF THERAPEUTIC CONVERSATIONS

The descriptions of the clinical work in this chapter are interpretations of the therapeutic conversations which were coevolved between nurses and family members. The videotapes of this clinical work provided a rare glimpse of the family-nurse relationship, as both the process and content of these conversations unfolded. The videotapes of the pre- and post-session discussions of the clinical team members who observed each session from behind the one-way mirror provided rich embellishment of understandings of the family and of the interventions offered by the nurse from multiple perspectives. In the research interviews, nurses and families reflected back on meanings and understandings of the clinical work and the situation which they addressed in the clinical conversations.

The interpretive accounts of the therapeutic conversations which are described in this chapter attempt to convey the particulars of the engagement between the nurse and the family, the coevolving understandings of family members’ suffering and experiences of the illness, the responsiveness between family and nurse and within the family, and explanations of the ways that these experiences were coherent to both family members and the nurse. The interpretations address the unfolding understandings from each session across the entire course of the clinical work with each of the families.
I. The Recovery of Health

Most often we neither know what is coming upon us nor see its origin; it therefore remains a secret. We are afraid of the fear, we anguish over the anguish, and we tremble. We tremble in that strange repetition that ties an irrefutable past (a shock has been felt, a traumatism has already affected us) to a future that cannot be anticipated; anticipated but unpredictable; apprehended, but, and this is why there is a future, apprehended precisely as unforeseeable, unpredictable; approached as unapproachable. (Derrida, 1995, p. 54).

Alex leaned forward slightly to look at the monitor in the cardiac catheterization lab. The screen showed the picture of his heart and his arteries during the coronary angiogram. He was having a heart attack! The doctor was having difficulty passing the angioplasty catheter which would clear the blockage that was threatening his life. A nurse went to the hallway just outside the lab and spoke briefly to Alex's 38 year old son, David. She said that the procedure wasn't going well, that it didn't look like they would be able to clear the blockage, and that Alex might not "make it". Alex's wife, Georgina, had been urgently phoned to come to the hospital, and she wasn't sure if she was going to make it "in time".

What a shock! Alex had always been told he had a strong heart, the heart of a 16 year old. He had never had heart troubles in his life. Even now, at the very moment of this catastrophe, he wasn't really having much pain. Since his kidney transplantation three months earlier, he had been bothered by aches in his left shoulder, elbow and wrist, and also in his hips, ankles and knees. But no one, not even the doctors, really thought that he had heart problems.

Half an hour ago, he had been down the hall having an electrocardiogram done. He was in the hospital for routine tests following his kidney transplant surgery. As the ECG printed out, the technician became alarmed, opened the door of the room, and called to a cardiologist who was passing by. He looked at the ECG, and Alex recalled him saying "See that he gets three doors down, there's a team waiting there. The guy that was going to be operated on can wait. Get him in there!"
The procedure eventually was successful, and Alex recovered quickly because there was very little damage to his heart muscle. Over the weeks that followed, he found that it seemed as though it was all a dream, it was so unreal, he couldn’t really have had a heart attack. But he wasn’t bothered by those mysterious pains anymore. Alex recalled that at a two month check-up, the cardiologist gave him a clean bill of health, saying “Alex, we can’t find a single solitary thing wrong with your heart. I don’t want to see you again unless you’ve got problems, and I’ll find that out from your family doctor. In the meantime, behave yourself.” When Alex spoke of his difficulty believing that this really happened to him, the cardiologist apparently said “Let me assure you young man, you had a massive heart attack. I know, I was there!”

For Georgina, the feeling of shock persisted. No one had guessed that Alex had heart disease. Alex had polycystic kidney disease. This had been their burden for the past several years. Initially, Alex had hemodialysis treatments at the hospital three times a week. Eventually, they learned how to do the hemodialysis at home. This was both a relief and a source of great stress. Although they no longer had the inconvenience of traveling to the hospital for dialysis treatments, they both had to learn the highly specialized technical skills around managing these treatments at home. They had to contend with the constant presence of this equipment as a reminder of the illness in their home and in their daily lives. Much of this responsibility fell on Georgina’s shoulders. She, too, had to learn all about hooking up the tubings, purging the dialysis fluids through the machine, sterile techniques to prevent infection, dealing with possible blood loss, and trouble shooting when unexpected problems arose. The couple agreed that when Alex could no longer perform the venous puncture to access the fistula site in his arm, they would give up this home hemodialysis venture. There were no other couples in the city doing this procedure at home. They had heard from other kidney patients that marriages seemed to fall apart under the stress of managing this procedure on top of living with kidney disease.
Polycystic kidney disease is a hereditary disease, though Alex did not develop kidney failure till his mid-life years. His mother died of this disease as a young woman, when Alex was only five years old. At the time of his own diagnosis, he vividly recalled standing by her bedside, overhearing conversations of her poor prognosis, and watching her rapid decline and death over the following 30 days. These memories contributed to his determination to become a dedicated student of the illness. He wanted to know everything about it to live as normal a life as possible, and to stay alive by taking advantage of every new technical advance and research available. Georgina wholeheartedly supported this endeavour. Alex wanted to understand what the doctors were talking about, and what alternatives were possible. He would not tolerate health care providers who couldn't make this information understandable in layperson’s terms. Georgina and Alex had been trained previously as lay-counselors, and they were invited to participate as facilitators in a support group with the local Kidney Foundation. Although the recovery from the kidney transplantation a few months previous to the MI had been complicated by an eviscerated incision, the couple had been feeling that they were closing an old chapter. At last, there was a possibility for a future unencumbered by dialysis treatments, intensive follow-up with medical and hospital personnel, and intrusive lifestyle and dietary restrictions.

And then the shocking event struck. Alex almost died from a heart attack, and the couple was trying to understand what this meant for their future. However, they approached the experience of heart disease with an extensive track record of negotiating health care systems and providers, ravenously learning how to gain every edge of influence over the illness, and accommodating their lives to include a life-threatening chronic illness. Now the couple was trying to figure out what they should be doing about managing the heart disease in the same skillful manner which had served them well in living alongside kidney disease.
They were attending post-discharge information sessions at the hospital to learn about the dietary restrictions for cardiac disease, and to learn about what to expect for an exercise program. They contacted the researcher after picking up a brochure which described the research project at this information session. The opportunity to participate in a research project was intriguing to them. They thought that the nurse at the FNU might be able to provide them with information that they still felt they were lacking in regard to diet and exercise. The researcher explained that this was not the kind of work that was conducted at the FNU, but the family persisted in their interest to come. They were not sure what to expect, but wondered whether they might get other kinds of answers that could be helpful to them. The first clinical session with the couple was about two and a half months following Alex’s MI.

Session 1

Early in the first session, the nurse asked the family what they were hoping they could talk about and how to make good use of their time together. Alex suggested that they were still struggling with “the confusion with the food, with the diet, with the exercise program, it was the whole thing, and there didn’t seem to be anybody who had time over there to sit down with us.” The nurse explained again that this was not typically the kind of work that was done with families at the FNU, and offered to talk about where they could get that kind of information. This family had a great deal of experience working with nurses in acute health care settings. The family’s expectations of this particular nurse in the context of the FNU perhaps reflected stereotypes of nurses encountered in hospital settings and patient education contexts. The family was unsure what to expect of this nurse. They later described themselves beginning these sessions with “absolutely no fear, and a kind of excitement on, hey, we’re going to learn something new! It’s going to be a new venture for us”. The welcome anticipation and openness of this family was quite extraordinary.
The nurse elicited the couple’s story of their illness experiences with both the kidney disease and the heart disease. The shock of the acute MI in the hospital was still very present for the couple, and this portion of the story was tearfully told by Alex. He explained that his emotional lability was a problem related to side effects from one of his post-transplantation anti-rejection medications. As the nurse persisted in attempting to understand the intensity of affect around telling this portion of the illness story, Alex expressed concern for how Georgina would manage after he died, and concern for them to get “back to a normal living situation where we’ve got this freedom”. Georgina agreed that they had been hoping to have more of a life together now. When asked about their beliefs about the future, Georgina reported less worry since the kidney transplant, and Alex was very optimistic.

Alex: I see the future as extremely rosy, and just fantastic. Prior to getting the kidney, it was a pretty bleak situation...But it’s a transition into that, balancing out your life to a good active life.

The story of the heart attack was already shifting more to the background. The freedom from the day to day burden of kidney disease and hemodialysis was dominant as a huge relief, alongside which the recent heart attack was a seemingly minor concern.

Before the nurse offered the family an opportunity to hear the team’s ideas through a reflecting team, she asked each of them the “one-question question” (Wright, 1989): If there was one question that we could answer in our work together, what would that question be? In retrospect, the family responses to this question reflect the character of the entire clinical work together.

Alex: I guess, to assist us in getting our thinking on line, to balance our life out. If that’s possible...the actual how to take our life from when we get up in the morning and help us to put a program together to organize our life that day, each day. So that I can follow that program exercise-wise, diet-wise, and not to put something together, but to assist us and show us how, if that’s possible.

SS: To keep a balance in your life?

Both: Yes, yes.
Georgina was very clear in her response to this question and throughout this work that she hoped to be helpful to others by participating in the sessions and the research. She believed that their experiences with doctors and nurses would be helpful to other health care professionals, so that professionals could understand the people they were working with better.

**Reflecting Team**

The nurse offered the family a reflecting team, and they accepted. They thought this could help them to “see all the wrong things...what they expect us to do”. They expected the team to offer them criticisms, suggestions for change, comments about things that the nurses thought they had been doing wrong. Instead, the reflecting team members began with commendations to the family, saying that the family had a lot to teach them, that the team members were privileged to hear about their illness story, that Alex was a man of the 90’s who was able to share his emotions in the session, and that this couple was ready to rise up to the celebration of this new freedom from kidney disease. Then the team wondered about whether it was okay to be worried about the future, or whether the couple felt pressured to be positive about the future. The team concluded their comments by explicitly giving the family the option of either continuing or deciding not to continue with further sessions at the FNU.

The family was perturbed by the team’s comments, and responded with emotion. The reflecting team conversation is different than many other types of conversations by health care professionals. First of all the team members’ impressions are offered directly to the family instead of only to other health care professionals. The commendations reflecting the team members’ ideas of what was going well for this family contrasted with the usual advice, information giving, and problem focused conversations of many health care professionals. The team members’ use of tentative language, “I’m wondering about ...”, “I’m curious about ...”, “it really struck me that ...” can invite the family to feel less
criticized in relation to possible concerns, problems or solutions that are raised for
discussion by the reflecting team. During the end of session conversation, the family
reported that the team’s comments were not what they had expected.
SS: So what were your impressions of what the team had to say, things that you
liked, that you didn’t like?
Alex: I was very impressed with their comments (choking with emotion). I was
expecting more of a negative criticism of (pause) our comments, and the way
we kind of think. And I didn’t expect the positive aspects of what they said
around the table. It shocked me.
Georgina: Yes it was wonderful to be able to (pause) help them in what they’re going to
do, to work with other people.
Alex: (taking Kleenex and wiping eyes) And to be able to share, you know, our
problems, where else do you do it? How can you do it? You can’t do it among
the whole family (waved right arm at the genogram on blackboard). You can’t
get the family together and start sharing like with nobody to prompt the
questions the way you were doing. And like the group were doing from behind,
on the telephone (points to mirror). That has never happened before.
Georgina: No. And we do share with the family and the kids you know.
....
Alex: Where else could we go as a couple to prompt that? Certainly not to our
doctors, certainly not to our friends.
Georgina: Nor our pastors.
Alex: Nor our pastor, they don’t have enough time. Nobody has enough time. You
people have devoted, what, 3 hours to organizing this thing, many many hours
between your whole team, to us.

The couple experienced something very differently in this session. This experience
was another “shocking” event! They commented on how the conversation was conducted,
and the helpfulness of being prompted by the nurse’s questions to talk about their
experiences. They wondered about who in the world families can have these conversations
with, and they ruled out their family and kids, their friends, their doctors, even their
pastors! The conversations helped them to take the discussion about the illness even
further than they dared to go, even between themselves. This was the first hint that the
character of the illness talk between the nurse and the family was distinctive, perturbing,
and somehow useful to the family: Who in the world one can talk to in this manner? What
is it that we need or want to talk about? How can we have these discussions?
**Postsession**

During the postsession conversation, the clinical team was very unsure about how to explain what happened in the session. A presenting problem was not obvious. The family did not appear to be suffering. Unlike other families who often seem to be burdened, overwhelmed, or exhausted by problems, this family challenged the clinical team's usual way of attempting to distinguish the problem and beliefs about the problem (Wright et al., 1996) in the first session. The family was engaged, comfortable, open, believed that the conversation was useful to them and wanted to return for another session. The nurse commented that the presence of strong affect (tears and weeping, particularly by Alex) during the session were palpable indicators to her that the conversation was important to the family. This affect was noticeable during the description of the acute infarct; during the conversation about beliefs about the future and hopefulness to have more of a life following the kidney transplant; and during Alex’s sobbing behind the mirror as he listened and watched the reflecting team conversation. The team struggled with their attempts to make sense of what happened in the session that was useful to the family.

The team hypothesized about the presenting problem for this family. Did they really just need more information about diet and exercise? Were they worried that Alex was going to die soon? Was Georgina’s explicit intent to be helpful to the team’s learning and to the research project part of her own attempt to create meaning for the illness? If we are not sure about what the problem is, how will we gauge our progress in our work or know when our work together is done? Perhaps team members shared a constraining belief: What can we, as nurses, offer the family if we do not identify the problem we are addressing? The *problem* was that the team was having difficulty identifying a family problem to work on at the FNU.
Session 2

During the next presession conversation, a graduate student offered the clinician an idea that became a helpful focus for the remainder of the clinical work. In the first session, the family had not identified particular problems in living with heart disease or chronic illness. Based on Imber-Black's work (1991) the student hypothesized that the family had long-standing relationships with health care providers and health care systems. The work at the FNU might be understood as helping the family to say good-bye to these involvements, and to mark their transition to their own autonomy.

Transition from Illness to Health

Most of the second session was a conversation exploring and embellishing the couple's resourcefulness in dealing with the illness and the health care system, and introducing the language of the couple's "transition to health". The clinician began with a conversation about the family's experience of the previous session. They again said that they had experienced the first session as different, that they had talked about themselves in a different way, and that they had discussed different topics than they had discussed before. They were delighted by a therapeutic letter that had been sent to the family after the first session, and they had photocopied it and sent it to a niece who was a nurse in the Maritimes.

The nurse wove commendations about their competency and resourcefulness throughout the entire session: for their honesty and openness; for their willingness to face realities or problems that had come up; for challenging old stereotypes about communicating and showing affection; about their ability to keep faith, hope and courage in their long association with doctors; for their wisdom around dealing with the kidney problems and the kidney specialists; and for their wonderful calling to help other people. Her language throughout demonstrated her genuine respect and admiration for their capabilities.
SS: I want to be guided by your wisdom about this [regarding what they should talk about during the session].

These commendations were reinforced later by the reflecting team members, who also commented on the couple's transition from illness to health and independence; the couple's ability to decide for themselves what to do in this transition; and their knowledge of negotiating a formidable health care system and maintaining love, friendships and relationships in the process.

As she wove the commendations throughout the conversation, the nurse posed to the family the hypothesis that had been proposed in the presession.

SS: I wonder as you’re saying good-bye now to illness and to...such close intimate involvement, tied to the building and the health care system so to speak, as you’re saying good-bye to that... is there a way to leave behind some of your knowledge that you’ve learned about?

The reflecting team also asked the family “How do you let go of illness that’s been so much a part of your life, and welcome health into your life?” Some team members admitted to feeling guilty about perhaps prolonging the family’s illness experience even by continuing these illness conversations. They wondered whether their participation in the sessions was keeping the family from celebrating life. The team said that they had already learned a lot from this family, and invited them to go ahead and get on with other plans for travel and adventure if the couple felt that two sessions at the FNU was enough.

In the conversation with the family about the reflecting team comments, the clinician was transparent with the family about the hypothesis about how to be helpful to them:

SS: What did you think about the idea about the transition from moving from illness to health, and...could we, in any way help with that transition?
Alex: I think you already have.
Georgina: yes, yes
Both: Very much so.
Alex: By laying it out on the table and you people discussing it, and we’re over here listening, that helps tremendously, I’m sure of that...We see it in a totally different aspect with you people talking about it.

The illness conversation with this nurse and the comments of the reflecting team had already helped the family to understand the illness differently. By languaging about the
experience, another reality or story about the experience, the resourcefulness, competency
and ability to negotiate this transition from illness to health was becoming even more real, visible, and perceptible to the family.

In the clinical work at the FNU, “problems” are often understood as suffering related to constraining beliefs held by one or more family members (Wright et al., 1996). Many interventions are conceptualized as challenging the constraining beliefs and embellishing facilitative beliefs through questions and conversations which create space for the family to entertain other ideas which might be more useful to them in alleviating their suffering. The clinical approach emphasizes appreciation and acknowledgment of family strengths and embellishment of facilitative beliefs which increase options for solutions and problem solving. With this family, a core belief possibly at the “heart of the matter” (Wright, et al., 1996, p. 41) was a facilitative belief rather than a constraining belief. It was the belief that ‘we are living well alongside illness, and are moving the illness behind us’ that became the prevailing focus of the clinical work with this family. The work with this family was remarkable in that they reported healing in the absence of overt suffering, and in the absence of problems and constraining beliefs about the illness experience.

**Postsession**

In the postsession conversation, the team was still struggling to find a coherent explanation or way of understanding the family’s experience of these conversations as healing. The family wanted to bring some of their adult children to the third session. The team tried to understand why the family wanted to return, how they could explain what was therapeutic to the family, and what else could be done with the family. They hypothesized that the couple might want to bring their adult children to widen the audience for the transition, for their children also to hear “Look how well we’ve done!” from health care professionals, as a way of communicating their accomplishments. One student gently reminded the team “I guess the only problem is that he’s still chronically ill”, even if Alex
did not see it that way, and even if Alex believed he still had 10 to 15 years of good health in his future.

This preferred view of a “healthy” or “rosy” future in the face of two significant chronic illnesses could invite nurses to view this family as operating in “denial”. Even though nurses might believe very much in family strengths and competencies, efforts to define family experiences with illness in terms of problems belies subtle pathologizing. The notion of chronicity implies a consistency or continuity over time, and a future which can not be separated from the illnesses. However, this was not the preferred view desired by this family. They knew that the diseases existed. They knew that there was an ongoing need for medication and follow-up for the kidney transplantation. They knew that there was an ongoing need for anti-rejection medications and efforts to reduce exposure to infection because of these medications. They wanted to understand more about diet and exercise to attempt to influence the heart disease. But more than anything, they wanted a sense of balance back in their lives. They did not want their lives to be defined by the illnesses.

Some team members began to appreciate the dilemma around their own stuckness, that there was still no “problem” to work on and no “contract for therapy”. These assumptions may be related to expert discourses in which the family is assumed to have a problem that the nurse is assumed to be able to fix, and the assumption that the problem talk of professionals will be helpful to the family. The nurse offered the team another belief: that possibly problem talk could be hazardous to the family members’ health, and could perhaps harm the family rather than heal the family. She questioned the necessity of problem definition, and questioned the therapeutic benefit of problem talk.

**Session 3**

**Vital Family Learnings about Illness**

The couple brought one of their sons, 38 year old David to the third session. The conversation throughout this session continued to widen the audience to the experience of
the parents’ transition to health. Notice the nurse’s language as she invited the son and the whole family to witness the remarkable efforts of the parents.

SS: So how do you think everybody’s weathering the transition, from illness being very big, to illness kind of being in the background? Still there, but
David: Oh it’s positive, it’s all positive.

Sometimes family members can be constrained from speaking about difficulties and concerns presented by the illness when there is a shared belief that the positives should be emphasized, that one has to keep a positive attitude, and that it is not helpful to discuss difficulties posed by illness. In this circumstance, the nurse also learned that perhaps Alex and Georgina were both constrained from talking about illness by the belief that other family members were not interested, or had been bored by illness conversations in the past.

David disagreed with this perspective, and spoke of his desire to learn more about his father’s expertise in living with kidney disease.

SS: Well your parents, in particular your Dad, have been through a great deal with this illness, and it sounds like you’d like to learn from that and benefit?
David: Yeah, no question.
SS: They could have a lot of wisdom and knowledge, they’ve been through it with a lot of grace and a real competence. They’ve weathered it very well.
David: I think so.
SS: Yes, and so that would be, there’s a lot to learn there, from them, you’re saying.
David: Especially in situations where Dad was in the renal section of the hospital and there would always be people in the room. He was always much more positive than the people in the hospital bed beside him? And had a much brighter outlook. I think that’s helped his health immensely, to be positive. you know, to go through it with a positive view versus a negative from that standpoint.

SS: So, when you hear that David would like to know more, he’d like to learn from what you’ve learned about dealing with this whole experience, this illness, and chronic illness, and there’s so much he’d like to learn, does that surprise you Alex?
Alex: Yeah it does, because it’s a matter of, I know this even when I go for lunch with my friends, I would rather hear about their problems than for me to dump a whole lot of my medical problems onto them, and let that be the focus of the whole conversation. Because you get so tired of talking about it and talking about it and talking about it. And you think they’re fed up with it, and you don’t want to even meet with you, and have lunch with you or talk with you.

This exploration helped to appreciate the invasive or intrusive character of illness talk into conversations with family and friends. Illness conversations have a different
character than social conversation. Alex worried that other family members would be bored by illness talk, that they would not want to hear it. He did not want to develop a reputation as a chronic complainer. The above conversation gave a hearing to illness talk which could be considered as desirable, helpful, perhaps even vital. Alex’s learnings about his health problems were extremely important to David, who wanted to know about the kidney disease for very personal reasons - to recognize the possibility of a change in his own health. Alex’s expertise could not be learned from the doctors. The nurse embellished the significance of this expertise even more by inviting David to speak to the specifics of what he would like to learn more about:

SS: When you say that you’d like to have more conversations with your Dad about this, is it that you want to know more about the specific things like medications, procedures, or do you want to hear more about what this whole struggle has been like?

David: Well, medications and procedures interest me too. I’m a bit analytical anyway, I like to take all that sort of thing in anyway, but, also, what he felt like. And what he felt like before he went on dialysis, maybe warnings for me. Do you understand what I’m saying?

David helped his father to appreciate the reasons why understanding their experiences was not only important to him, but of vital interest to him in protecting his own health, and in contending with the possibility of kidney disease for himself.

The nurse continued to embellish the parents’ competencies in her language, and the son spontaneously offered numerous commendations about his parents.

SS: One of the things that we’ve noticed, certainly from what you’ve told us and we’ve really appreciated ...is how much your parents have been able to negotiate a health care system, a massively complex and difficult health care system, and

David: They’ve amazed the whole family as well! (laughs)

SS: Is that right? Yes? It’s a skill, it’s an amazingly important skill in coping with a chronic illness. To be able to access the help that you need, get the information that you need, use it, and still live as people in your lives beside a health care system, without letting it come too much in your lives. It’s a lot of information there about how you do that, extremely important information. Is that something do you think that you would also be curious to learn from them about?

David: Yeah, well it’s something I have learned a lot about.
The son continued, commending Alex’s ability to put medical terms into layperson’s terms to make doctor talk understandable, explaining that after a while, his father simply wouldn’t tolerate inadequate explanations by doctors, and that he would walk out of doctors’ offices. He described his father’s determination to find out the reasons for taking medications, and to explore other treatment alternatives.

This conversation helped Alex to appreciate the significance of the illness experience for others in the family, and to entertain other ideas about the ways that he could publicize the illness experience and the transition. He considered writing about it so that the children and grandchildren could “put it in their file” and refer back to it when they wanted to. The nurse explored details of who could help with the writing of this knowledge if they chose to follow through on this. When Alex suggested that they would need someone like the nurse who knew how to ask the questions, the nurse declined the invitation to take credit for eliciting their knowledge. She suggested that the answers are particularly important, and that someone like David best knew what he would like and need to learn.

There were many subtle questions related to beliefs about illness conversations implicit throughout this session: Who can you talk to about what is happening? What can you say - how tough it is, what you are struggling with the most, what you are learning about, what you are coming to appreciate the most about life, how well things are going? How does one know who wants to hear illness talk, or who needs to hear this kind of conversation? What questions need to be asked, and who should ask them?

Postsession

During the postsession discussion, the clinical team commented on the nurse’s skillful sensitivity to the possibility that difficulties or ‘problems’ might coexist within the family’s transition to health. The nurse had used language congruent with the notion of transition, but was careful that this did not preclude or negate problem talk which did arise in the session around Alex’s worries that his grandchildren viewed him as the grumpy old
grandpa, and about David’s possible worries for his own health in the future. As the beliefs about the family’s competence and mastery were embellished, there was a risk that family members could feel constrained to speak of difficulties which might run counter to a preferred view of the situation. The nurse skillfully noticed openings in the conversation when problems were raised, paced with the family in pursuing them, and moved off them when the family did not seem to be particularly troubled by them or wanting to pursue them further in the conversation.

The illness experience of this couple is a compelling story of endurance, life-changing events, and ongoing transitions. There was seemingly something useful to the family about the clinician acknowledging their successes and competencies, and also something useful about the presence of the clinical team to witness this story. However, the very purposeful intent throughout this third session was to widen the audience to this story outside the context of the FNU, to the context of this couple’s immediate family. Inviting the couple’s experiences to be voiced, to be heard, to be audible to the rest of the family through David, the son, made them even more audible, present and visible to Alex and Georgina. Their facilitative belief that they were successfully and competently weathering this transition between illness and health was strengthened, and their illness story was even more compelling as it was witnessed by others.

**Session 4**

The couple returned for their final session about six weeks later. This session continued with a theme of transition to health. Alex and Georgina had been hoping that more of their adult children would be able to come to the FNU. Their daughter, Susan, was living in Vancouver and was unable to get away from work. Susan had issues with her brothers, and was critical of them. Georgina and Alex thought that she expected them to help their parents more because she could not be there herself. This session explored dilemmas of asking and receiving help from their adult children.
Dilemmas of Inviting and Declining "Help"

The nurse asked where the daughter got the idea that the parents needed more help, and whether the parents thought there was any truth in Susan’s criticisms. She wondered about whether there were things that the couple hoped the daughter might be able to tell the sons about now. The couple’s response suggested that the adult children were perhaps lagging behind in making a transition to health.

Alex: My own personal viewpoint at this point is, leave us alone. At this point, leave us alone. Let us plan our future. Be concerned, and we don’t mind you expressing your concern, but don’t run our life! We’re capable of running our own lives.

SS: They kind of lag behind a bit do they, like when there was illness and they could have been a bit more helping and more involved they weren’t? But now that you’re on your road to feeling better, and... not needing as much help

Georgina & Alex: Yes, yes
Alex: They’re trying to criticize and trying to run it eh?
SS: And you’re hoping that maybe she might tell them to back off a bit are you?... Would you agree with that Georgina about wanting to help?
Georgina: Yes, yes. We love for them to be concerned and so on and so forth, but NOT just do it one month and then forget about it for a whole year. You know, we aren’t old.

In this session, the nurse learned about the couple’s dilemmas in helping the rest of their children to appreciate their accomplishments in the transition to health and autonomy. This was another kind of illness conversation. It spoke to dilemmas around wanting to be independent and to be viewed as capable, and yet needing at times to ask for help, wishing you didn’t “have to holler”, wishing others could notice when you needed help, and not feeling entitled to ask for help. Although this couple at times wanted less involvement and helping from their adult children, they were wisely sensitive to what they called “the privilege of helping”. They did not want to deprive their children of the privilege of helping as a way of being able to show caring for one another.

SS: What about for you Georgina... are you wanting to be very independent of your kids now, or are you sort of thinking “No there’s still some things I’d like them to help me with? or help us with?”
Georgina: Yes, yes, because I think if you do that you get closer together in your family and your grandchildren... If you're so independent that you don't want anybody around and you do your own thing, or hire somebody to do it, then your family
feels they’re not wanted....I want them to feel that grandma does need some help once in a while doing some things. I mean because they’d like to do it. Cause I think you get closer... if you do things together.

SS: But how will they know what you need? Because it’s changed so much now...I imagine you are getting to know what it is, how it is at this stage in your life

The nurse invited the couple to appreciate how it might be difficult for others to know, in the midst of this transition, about which areas they would and would not like assistance at this point in time.

As the nurse and the family concluded their work together, the nurse invited the couple to reflect on what was most and least helpful about coming to the sessions at the FNU. This ritual punctuates the learnings of the family and the nurse, and revisits and solidifies their efforts in the clinical work. It is a ritual of celebration (Epston, 1985) that prepares the family and the nurse to end their work together.

SS: So since this is our last meeting...I always like to ask what is it that you found most helpful about coming here? not helpful about coming here? Any recommendations that you have for us or comments?

Georgina: Well with me, it’s really helped bring things out in the open to talk about it. And it’s helped heal me.

SS: In what way? Can you say more?

Georgina: It’s just being able to (tearful and choked voice) bring out things, talk about it, I don’t know (giggles), it’s just, I don’t know, I feel it’s really helped.

SS: It felt useful then and helped healing for you.

Georgina: Yes, yes.

SS: Good.

Alex: I think it’s an opportunity that everyone should have. And I mean an opportunity, you know. Very, very (voice quivering) rare situation in an older couple’s life to have an opportunity like this to have professional people put the hours of thinking, you know just to write those letters. Hey that’s a pretty (blows his nose)

Georgina: We’ve copied them and given each one to our children.

Alex: So, I look at it, I don’t know how you could improve it. I certainly could not openly be critical of it in any way, shape or form. I think it’s fulfilled 500 times more than what we expected of it. You know, so, how could you be critical?

A major theme of this final conversation with the family recurred and continued to be palpable in the research interview four months later. At that time, the couple continued to describe the experience of these conversations as healing, as unique and different, as not having happened to them anywhere else in their experiences with other health care providers.
Another Layer of Reflection - The Research Interviews

The healing character of these illness conversations continued to influence this couple in their relationships with their adult children following the completion of the clinical work. The research interviews revealed the strong reciprocal sense of connection between the nurse and the couple. However, it was not just the relationship that was experienced as positive and healing. The conversations between the nurse and the family were experienced by the family as different. It was not only a matter of "Who in the world can you talk to like this?" or "Where in the world can you talk like this?", but also "What in the world are we talking about here?" and "How are we talking about it that nurtures healing?"

Reciprocal Engagement - The Family-Nurse Relationship

At the beginning of the research interview, Alex and Georgina were eager to speak of their strong sense of admiration for the nurse. Even though it seemed that the reflecting team offered many useful ideas to the family during the clinical work, the family was very clear in the research interview that they deeply respected the nurse’s communication skills, and that the connection with the nurse was most meaningful to them. They appreciated the nurse’s sincerity in asking questions, and her genuine curiosity about them and interest in them. They did not experience her questions as a technique or interviewing strategy. Her questions were non-blaming, and they were confident that what they said to the nurse was not going to be used against them later, nor that “bad things” would be made up about them.

Similarly, the nurse spoke to her own experience of reciprocal engagement with the family, of her admiration for the family. She remembered that the family had made several comments to her in the sessions about her skills as an interviewer, that they had noticed this differently or more so than many other families. The couple had conveyed that they valued her experience and clinical skills. The nurse wondered whether the couple had learned that
to honor, value and respect professional expertise was a helpful way to engage health care professionals.

As lay-counselors in their religious life and as self-help group facilitators, the family also had expertise in communications. They were open to working with the nurse in a novel way, a manner different than their previous experiences with nurses in acute health settings. Their previous experiences as lay-counselors may have helped them to feel less constrained by a counseling context or a talk therapy context. The nurse also hypothesized that the couple was perhaps benefiting in a manner different than many families who come to the FNU, that they were learning from the different kind of conversations that happen at the FNU. The different kinds of questions, the way that questions were asked, rituals around ‘goodness of fit’ conversations, and reflecting team conversations may have helped the couple to learn different counseling skills than they had studied and practiced previously. The nurse hypothesized that this may have elicited ideas for them about other ways of relating to their adult children.

The nurse’s beliefs in family strengths and resourcefulness also contributed to the fortifying character of this clinical work. The nurse believed in and valued the family’s illness expertise, their experience negotiating health care systems, and their capabilities in living with illness. She genuinely respected and believed that the family would teach the nurses valuable lessons about their experiences. She genuinely appreciated their altruism and their desire to help other people to learn from their experiences. The nurse suggested that health care professionals often value laypersons’ illness experiences as helpful or valuable to be shared with other people experiencing the same illness. She distinguished this from the possibility that health care professionals could value the couple’s knowledge about living with illness as worthy or meritorious knowledges of sufficient validity and integrity to inform the understandings of the health care professionals. Just as the nurse described “liking” this family, the couple’s strong sense of connection with her and their
respect for her was heightened by the explicit acknowledgment of their knowledge and capabilities.

**Illness Conversations and Problem Talk**

In the research interview, the couple emphasized that they did not choose to attend the sessions to obtain assistance with a particular problem or concern. Yet they assuredly described the conversations as healing.

Georgina: When we look back on it now, it was wonderful that we was [sic] able to do that because it really healed us. It really brought things out which, you just don’t do that...I didn’t have all the operations and all that, but I still have to go through them, in our family. And it just brought it out in the open and it sort of, you felt better after.

DT: And so when you headed into the sessions, did you have a sense of what needed to be healed?

Both: No

Georgina: Just answering her when she asked us.

Alex: No, there was no, no ultimate goal down here. It was something *happening*. We just happened.

The couple did not have a sense that they *needed* to talk about their illness experiences. They did not begin with the belief that to talk about their experiences would be healing or helpful to them. The acknowledgment of their experiences was healing for the couple, but they did not language about the illness experience as a problem. The nurse and team were challenged *not* to frame the clinical work around problem talk.

SS: Well, I think that most of us experience needing *help* as a one down position, and they don’t *experience* themselves in any way as being one down, either to the illness or to other *professionals*. And to label themselves as *having* a problem that they want help *with*, I think they may have felt they would’ve been in a one down position. It would disempower them. But they could still *experience* their suffering, *show* their suffering, and *talk* about the suffering without labeling that as a (pause)

**DT:** *a problem* necessarily?

**SS:** Yeah, I guess, and *is* it a problem? Or is it just a life experience, you know? In that when we want to define things as *problems*, we inadvertently add to the problem of the *problem*, or we add to the, the difficult experience for them by calling it a problem.

The nurse’s response to the family’s preference and ability not to view themselves as needing or wanting assistance with problems is a hallmark of the clinical work with this family. The nurse was able to accept the family’s lens of “this is an illness experience”,

rather than pushing for a lens of "these are the problems and concerns we have about living with heart disease". She not only was able to recognize this facilitative family belief, she respected it, valued it, and amplified it through the language used in the conversations with the family. It was remarkable that discomfort with the lack of a problem remained such an issue of discussion in the postsession conversations with the team, and in the research interview below.

SS: As much as we talk about we believe families have these, and I think our belief in looking at strengths and resources and competency helped us to do something useful with these people instead of something maybe very useless, unhelpful. But there's still a part of us in our thinking

DT: That we're still struggling with it even now! (laughs)

SS: We are you know. It's like, yeah "What is the problem? What is the problem?" and keep relating the interventions and the conversation back to changing that problem.

DT: It's part of our whole way of explaining what we do and how we are with them

SS: Justifying our practice as nurses....I think there's debate in the literature as well, around, if we see these people as being resourceful and strong, then what do we do, how do we justify our existence?

(both laugh)

SS: How do we justify our jobs and our phoney baloney paycheques?

DT: How do we get funding for programs?

(laughter throughout)

DT: How do you do, exactly!

SS: Just like you need a diagnosis. You don't go in and diagnose strengths and resources. You wouldn't get any funding from government agencies or insurance companies.

The insidious ties to the "expert" professional discourses of health and illness were uncovered in this conversation about problem talk. Diagnosis and pathologizing are connected to the manner in which political and social systems are organized around helping, treatment, and funding of health care services and politics. How do health care providers language about clinical work and explain their practices if there is no demonstration of the effectiveness in eliminating problems or treating diagnoses? It becomes more understandable that we do not then, commit much effort to developing language for strengths, competencies, and virtuous or healing interactional patterns. Efforts continue to focus on labeling those problematic individual or family behaviors and
diagnostic categories which are amenable to demonstration of fundable outcomes. Where do healing conversations fall in this schemata of interventions? How can we explain or justify the merit of our practices in this kind of work with families?

**Illness Conversations are Not Social Conversation**

The couple experienced the FNU as a place where they could talk about the illness, and where people understood the importance of this conversation.

**Alex:** We were both helped very much by the, by the ability to lay all of these things out to someone who understood, or some people who understood. 

**Georgina:** You see you can't talk to people. You can't talk to a certain person about it, because they don't understand. 

**Alex:** Well, we would go out for dinner with groups of our church people, maybe 4 or 6 of us would go out. "How are you Alex?" "Oh pretty good. Yeah, doing pretty good." "How are you doing on the machine?" and then that would start the conversation over.

**Georgina:** And we hated that because we don't want it to be the focus. 

**Alex:** And then this would happen every time we did this, and you knew that you were losing friendships real fast. 

**DT:** So people would ask but they wouldn't like to hear the whole story kind of thing. 

**Alex:** That's right. 

**Georgina:** And we would make it short as we [could], when they asked. I said to Alex, "Well try making it short when they ask." 

**Alex:** But you became a pain in the butt, even for our kids. They would come. We'd be on the **machine**. What're you going to talk about? The day that I wasn't on the machine, I was recuperating, and then the following day I was back on the machine. *My life was down there* (points to basement) on the machine, and *nobody else wanted to hear about it*

**DT:** So the illness kind of leaked into all the other relationships? 

**Georgina:** Right. 

**Alex:** Here's Sylvia [nurse] asking and sincerely wanting to know, totally different ball game. 

**DT:** Just really open to whatever you would happen to say about the illness. 

**Alex:** That's right. So, I'm sure that we lost friends because of the illness. And I'm sure you've ran into a great number of friends "Such and such a friend has got a sore toe and she *continues to tell you about that sore toe!*" 

**Georgina:** ...Like our grandchildren "Oh grandpa's grumpy again today" or something like this. Well it hurts for a grandchild to say that. But they don't understand the illness. No wonder they're grumpy what they have to go through. But, anybody that works with them has to learn that.

The couple wanted to have social conversation with friends and family which was not hampered by intrusive illness talk. There may be a unwanted sense of being different in having the illness take the center stage of social conversations. The couple believed that
friends avoided them because of their discomfort with these conversations, and that friends would ask about his health perhaps out of social nicety rather than really wanting to know how difficult it really was. Alex came to believe that no one really wanted to hear about his story, and worried that he might be viewed as a malingerer. It was hurtful and embarrassing to be misunderstood as “grumpy” by other family members. Illness conversation was clearly different than social conversation. The couple expected that nurses and “anybody that works with them” should learn to understand what people are really going through. Perhaps it was harder to forgive those who saw this illness every day in their work as health professionals, and yet could not understand their experiences and appreciate the impact imposed on their lives by the illness.

“What in the World?” are Illness Conversations About?

The many dilemmas of having illness conversations became more visible. Part of the dilemma is “who in the world?” can you have these conversation with? It is awkward to speak openly of your experiences to immediate family for many reasons: you might bore them; you might worry them; they might misunderstand. It is difficult to have illness conversations with friends: they might really not want to know; it is difficult to stop the illness talk once it starts; you might be seen as a malingerer. The importance of the nurse as a significant third party was that she should understand. Even more than a pastor who might understand the suffering of illness in some ways, the family believed that a nurse would see people living with illness all the time in her clinical practice. She should know what the experience is like, at least in some ways, even if she could not do anything about it. But “where in the world?” can these illness conversations happen? The family described their experience that nurses practicing in the hospital context operate in systems which minimize and undervalue the time necessary for these conversations. “How in the world?” might these conversations happen? The nurse demonstrated genuine interest in the family, and the demonstrated finesse by asking useful questions with sincerity. Her stance was
non-pathologizing, and embellished the family’s view that they were making a transition from illness involvements with health care providers and systems in a manner that demonstrated competence and grace. However, the research interviews also revealed some of the ways that “What in the world?” could be discussed in the sessions as also being very important.

The manner of explaining the conversations in the clinical work with this family led the team to understand the work as conversations which helped the family in a transition from illness to health, from complex involvements with health care systems to renewed confidence in their own autonomy in their lives.

SS: It’s not just the relationship, I don’t kind of buy that. I mean I think that the relationship that develops because of the postmodern thinking is useful, is very important. But I think the things we language about as well are also very important. So this transition to health was a real nice way of trying to put a frame around what our work together was. That we did have a focus, or it was a, therapeutic kind of a relationship here. It wasn’t, I’m not going to go and be their third daughter or their you know?

(both laugh)

DT: You’re not going to shovel their snow?

SS: No, (laughs) so we had a frame on this that was useful to all of us I think, to put some boundaries around what we were doing.

DT: But you had a sense that it was something about the bigger things about the way of taking up the work with this family that was useful to them in a bigger way than even any of the particular things we did?

SS: Yeah, because maybe it allowed them to just talk about what they needed to talk about, even though I didn’t have a knowledge about what they needed to talk about. So it privileged their voice, privileged their experience, allowed them to talk about the things that they’d want to talk about (sigh). And yet that’s not quite true either, because, it was co-constructed, I mean I didn’t let them go off and talk about anything they wanted to talk about! It was like we still kept it within the bounds of a frame of, that it was useful to feeling better, or that helping us (pause). It’s not as clear. This family’s not as clear, to, I don’t, you know. Lot’s of times I have a notion of what was useful and not helpful, and it’s very, I don’t know how to language about it with this family as much.

Although the nurse was more uncertain about how to language about the work with this family, she did have a sense that what was discussed was important. It was more than a therapeutic relationship. It was not only listening to whatever the family wanted to talk about. The “frame” placed around the clinical work, the way of languaging about their
work together, and what they coevolved as the topics of the illness conversation contributed to the usefulness of the work for the family.

Conversations about experiences of all family members. Alex and Georgina did not expect that their conversations at the FNU would be healing. Nevertheless, there was something about the telling of their experiences that was an intervention in itself. During the research interview, the couple described the conversations at the FNU as providing an opportunity for Georgina’s experiences as the partner of the ill person to be acknowledged. Although Georgina was most determined to help the nurses to learn about the experiences of people with chronic illness, the sessions provided her an opportunity to give voice to her own experiences as a partner in illness. Having her own efforts, contributions, and suffering acknowledged was part of her healing.

Georgina: But, I had kidney problems too.
DT: Oh really?
Georgina: Yes because you do. Because if your husband has it so do you. You might not go through the feeling and what’s happening to your kidneys but you sure, you’re
DT: It was as much your health problem as it was his?
Georgina: Yes, that’s right, it’s just as much the wife or the husband whomever has it.

... Georgina: It’s not that there was anything in specific, or whatever, but...we didn’t, I didn’t, I don’t know about him but, I didn’t realize I had all that feeling, you know all bottled up.

Georgina suggested that even if there was nothing that nurses or doctors could do about the impact of the illness on other family members, having an opportunity to talk about her experiences and having those difficult experiences acknowledged by health care providers made a difference.

Strengths, grace and competency. As nurses conceptualize the problems for which they wish to offer nursing interventions, strengths and competencies can be minimized even when there is an intent to take them into account. Expert discourses which focus on fixing problems can minimize the family’s legitimate and merituous understandings of living with illness. The potential learnings of what it means to live well alongside illness are at
risk of being lost to health professionals. But these learnings are also at risk of being undermined, diminished, and unnoticed by the very people who are living with chronic illness.

As the conversations between the nurse and the family unfolded, the nurse sustained a purposeful intent to avoid pathologizing discourse. In respect for the family’s preference and ability not to present themselves as having problems, the nurse’s language consistently and genuinely conveyed her respect and admiration for the family. She embellished and heightened the descriptions of the family’s strengths and competencies, and their grace in the transition to restoration of autonomy and health. She widened the audience for witnessing these developments through inclusion of the son in a session, and by the writing of therapeutic letters which the couple photocopied for their children. Bolstered by this renewed respect for their capabilities, the couple experimented with efforts to be helpful to their adult children in domains of family life outside the realm of illness. The couple reconsidered boundaries and dilemmas about reciprocity in giving and receiving help from their children. The manner in which the nurse participated in the conversations was consistently nonpathologizing. What they talked about, the family’s grace in weathering the transition, was definitely not problem-talk. All of these endeavors were therapeutic in that they assisted the family to retrieve and recover a view of themselves as healthy, even in the face of two chronic illnesses.

Conversations of death and uncertain futures. Alex’s experience of almost dying on the procedure table during the angioplasty was a shocking life experience that cuts “close to the bone” (Bolen, 1996). The telling of this experience was often revisited during the first two sessions, and during the research interview. The repetition of this story was an ongoing reminder of the uncertainty of the future, the experience of the vulnerability and frailty of the body and life itself. During the first session, the nurse was alerted to the
significance of this story by the intense affect and teariness for both partners which persisted around the telling of this story.

Nurses are socially sanctioned to have different kinds of conversations about death than would usually be encountered in social conversations (Mendez, Coddou, & Maturana, 1988). Wright et al. (1996) referred to this ability to raise issues that are implicit and outside the norms of social conversation as “speaking the unspeakable” (p. 177). The experience of ischemic heart disease can invite family members to anticipate catastrophic loss in the future (Rolland, 1990), and uncertainty about the future (Bramwell, 1986; Christman et al., 1988; Hilgenberg et al., 1992) for both the ill family member and their partner. The willingness of the nurse to speak frankly and openly about concerns and fears of uncertain prognosis and death is another hallmark of the expert practices at play in this clinical work.

During the research interview, the nurse offered her understandings about the importance of talking about death with this family:

SS:  I don’t think I recognized how significant it was for them to be able to talk about his almost dying. And, but because in my head I couldn’t see how that was a problem you know, had they not talked about this enough? Were they being stuck somehow because of this experience?

SS:  I don’t know that they had a fear of dying or a fear of the future but they experienced his nearly dying as very powerful anyway. I guess that’s why it was like, I was like looking for a problem like fear of dying or fear of the future! And how did that influence the family, or not talking, but that didn’t seem to be there. But they still seemed to need to talk about that experience.

The nurse came to understand that even if there was not a fear of dying or fear of the future for the family, nearly dying, recognizing one’s own mortality, and the experience of that vulnerability was powerful. The intensity and strength of this family’s spiritual beliefs became more apparent during the research interview. Perhaps their spiritual beliefs helped the couple to counter a fear of dying, or not to experience this as a problem. The nurse invited conversations of uncertainty and death in a manner which was not prognostic. These conversations acknowledged the possibility of death and illness in the future, but
these conversations were laden with possibilities. The nursing knowledge, judgment and skill exemplified in opening, following and pursuing conversations of death is a distinctive practice in conducting oneself well in clinical work with families living with ischemic heart disease.

Recovery of the Hidden Character of Health

An enigma is an obscure or elusive riddle or puzzle. Gadamer (1996) pointed out the enigma of health, or the “hidden character of health” (p. 126) as the recovery of a hidden harmony, of the capacity of life to renew itself, and of the capacity to be actively engaged in the world.

Health is not something that is revealed through investigation but rather something that manifests itself precisely by virtue of escaping our attention. We are not permanently aware of health, we do not anxiously carry it with us as we do an illness. It is not something which invites or demands permanent attention. Rather it belongs to the miraculous capacity we have to forget ourselves (p. 96).

In the experience of illness, he suggested that what is lost is partly the capacity to forget this taken-for-granted ability to be involved in the world.

During the research interview, Alex said “It was something happening” at the FNU. The explanations of the nurses and the family about ‘what happened’ at the FNU are somewhat different, but both reflect a sense of moving from some experience strongly influenced by living with a chronic illness to some other experience of living differently than under the constant influence of illness. The process of recovery seems to have as much to do with covering up and concealing health, with making it transparent, or taken-for-granted again, as it does with moving on or getting past illness. How was the illness concealed or re-covered again in a manner which enabled health to be taken up again, to be forgotten, and to be taken-for-granted in the couple’s manner of daily living?

The couple had just been emerging from a prolonged period of dependency on hemodialysis which had invaded their home and their lives. For a brief couple of months
before the heart attack, they had been freed from the burden of this constant reminder of the vulnerability of the body to failure and dependence on technology to sustain life.

Alex: It’s like we left the old life over there when the kidney machine went out the door, and hey, a whole kind of new life over here.

Just when they were beginning to re-experience the taken-for-grantedness of health following the kidney transplant, their confidence was shaken by the heart attack, their vulnerability was exposed to the very core yet again.

Alex had angina pains which were undiagnosed and untreated for many weeks prior to the heart attack. These were the warnings of un concealment of health. The angioplasty cleared the artery and relieved all of his symptoms.

Alex: The heart attack was a means to an end. It was the end of all my pain. What a relief...I’m so thankful for it.

As he had been pain-free since the procedure, the underlying disease process had been re-covered and hidden from view once again. The heart attack was re-covered by the cardiologist also who told Alex that he had a massive heart attack, but had no permanent damage and gave him a “clean bill of health” and told Alex to “behave yourself”. But then how does one behave or be in a manner that regains or recovers or sustains the concealment of health? How does one forget that one is healthy? He was cautioned to eat healthy and to get regular exercise. How does one remember enough of this experience to take care of oneself to prevent illness in the future? The couple came to the FNU as part of their effort to restore some balance in their lives. In the second session, the nurse offered the family the notion of a transition to health and autonomy as a manner of languaging about their work together, which the family embraced. (Actually, Alex introduced the idea of being in a “transition” of balancing out their life early in the first session. This interplay of words and ideas within the nurse-family conversations is an extraordinary example of coevolving interventions. Perhaps the nurse embraced the family’s idea!) The transition to health was
a time and process of moving back to the concealing of both health and illness, the recovery of health.

These illness conversations revealed life events and experiences which were shocking and perturbing, and which continued to extend their influence from the past into the present, and into anticipations of the future. The couple was very clear that these kinds of conversations had not happened with other nurses and doctors, not with their adult children or their closest friends, not with their pastor, and not with each other. These illness conversations had not happened previously in their home, their hospital room, their church or their friends’ and adult children’s homes. The telling of these illness stories was different than their previous illness talk with friends and families.

In this account, there are many clues of the ways that these illness conversations differed both from social conversations and from pathologizing professional discourses of health and illness. The participation of the family was different than their involvement in illness conversations in other contexts. There were many ways that the family conducted themselves well in this relational narrative: through their openness to a health care context and nursing practices than those which they were more accustomed to encountering in acute care settings; through their remarkable efforts to learn about the illness, to become “dedicated students of the illness”, and to help health care professionals to learn about their illness experiences; through their ability to experiment with different conversations in their relationships with their adult children; and through their enthusiasm and appreciation for the character of the nurse’s practices.

How did the nurse conduct herself well? This family experienced this nurse’s particular engagement with them as potent. They valued her asking of questions and her participation as co-author in their transition to health. She conducted herself well through her ability to value the family’s preference to view themselves as healthy rather than ill, and to weave this valuing throughout their conversations. She conveyed her genuine
recognition and appreciation of the family strengths, resources and competencies through her consistently non-pathologizing language. She questioned and challenged her own beliefs and the clinical team’s beliefs about what it meant to live with a chronic illness. Her openness to the many possibilities of living with chronic illness helped to uncover with the family an understanding of recovery of health which enabled and strengthened the family’s ability to live alongside illness.
II. The Health Care System Gone Deaf

Calgary will get an injection of $70.6 million as part of a $145 million provincial reinvestment in health care announced Monday. ... The new money puts back more than half the money taken from Calgary in government health cuts since 1993-94, said McCaig, adding the city's system is now far more efficient. ... McCaig said Calgary has done about 740 heart bypass surgeries a year. That will now be boosted to 1000, which will "dramatically impact the wait list for cardiac surgery," he said. ... A complete set of performance measures will be in place by early 1997. Waiting time for heart surgery. Target: 5-7 days for urgent inpatients, 2-3 weeks for urgent out-patients and a maximum of 3 months for planned out-patients.


When Alice first came to the FNU, she had already been waiting for "urgent" outpatient cardiac bypass surgery for five months. She had the tremendous misfortune of needing surgical intervention at a time when the health care system was in a state of incredible flux, some might even say chaos. What is so compelling about her particular story of heart disease is the way in which the anonymous health care system and the politics of health care funding contributed to her suffering. The citizens of Alberta have not all paid the same price for the restructuring of the health care system over the past three years. This is a story that politicians, representatives of regional health authorities, government bureaucrats, and possibly even people in communities across Alberta do not want to hear.

Alice was a 58 year old woman who was employed as an office worker. She had worked at the same job for more than twenty years, and was two years away from full retirement. She had two children, Stuart (aged 36) and Jeanie (aged 33). Alice had raised her children as a sole parent after her husband left her destitute when the children were both preschoolers in the early 1960's. She prided herself in her independence and her ability to provide for her family. While she had always met her financial obligations and had no debt, she had never had a chance to earn an income which allowed her to set aside much money for savings. Her son, Stuart, had been living with her for the past year after his own
financial loss in a small business venture, and he was helping to keep an eye on his mom because of her illness. Her daughter, Jeanie, was married and had two small children.

Alice had been healthy until 1989, when she had her first heart attack. She recovered without complications, completed a cardiac rehabilitation program, had an angioplasty done, and was managed on medications. Then suddenly, in the summer of 1995 another heart attack occurred. Initially, Alice and her family were told that coronary artery bypass surgery needed to be done the following day. The urgency alarmed Jeanie, as it suggested the seriousness and instability of her mother’s condition. The surgery was then postponed, but was to be done later in the week. The doctors then decided (for reasons apparently unknown to Alice) to discharge her and to have the surgery done as an urgent outpatient. Before she left the hospital, one of the nurses told her to play sick, to pretend to have some chest pains, and that the surgery would be done sooner. Alice could not bring herself to lie about having angina attacks, partly because “they’d see it all over me” and know that she was lying. But also she said, “I was sick, but I could still survive you know”. She went home and wanted to return to work, but this was forbidden by the doctors until after her surgery was done.

So the wait began. The surgery was to be done within four weeks. Then Alice was told it would be two months before the surgery could be done. At a two month visit to her family physician, Alice lost hope that a doctor might be able to influence the wait. He told her that the delay should not be happening, and that health care was not good because of the cuts. Jeanie thought that doctors wanted to see some action, and were trying to get their patients involved by encouraging them to address complaints to the Regional Health Authority. However, she also thought that it was unprofessional that these comments were made to people who were ill and vulnerable. This stress only added to her mother’s risk during the wait.
When Alice had heard nothing from the hospital about a date for her surgery by November, she phoned the clerk who booked the cardiac surgeries. She was told that with the Christmas holiday season approaching, she might have to wait until the end of January. As December approached, Alice’s sick benefits were running out, and she had to apply for disability benefits, which would reduce her already small income. She would barely be able to pay her monthly bills. Just before Christmas, Alice phoned the booking clerk again, who said that it would be about the end of February, another two months away! Alice fell apart with tears and anger. She hung up the phone, ran downstairs, threw up in the bathroom, and had an episode of angina. This was so confusing! If the surgery was so urgently required, how could it be postponed for so long? There was a sense of being left destitute again, abandoned, bereft of resources by a failure of the system.

For five years following the first heart attack in 1989, Alice had been participating in a clinical drug trial. She had gone frequently for interviews and blood tests, and she felt very comfortable and understood by the research nurses. This research project ended in December of 1995. A research nurse from the drug trial had been approached to assist with recruitment of possible participants for the study of families experiencing heart disease at the FNU. She thought of Alice’s situation and the frustration she was experiencing around the wait for cardiac surgery. The research nurse phoned Alice, briefly explained the project at the FNU, and asked for permission to give her phone number to the FNU nurse researcher. Alice consented to participate in the new research project, and came with her daughter, Jeanie, and 2 1/2 year old granddaughter to the first session in February of 1996. Six months after she had been told she needed urgent cardiac bypass surgery, she was still waiting for the surgery to be done.

Session 1

The interplay between provincial politics and access to the health care system was exposed even before the first session began. During the clinical team’s presession
discussion, based on the available referral information obtained from Alice, the graduate students introduced the presenting problem as issues around waiting for bypass surgery. The team wondered about the possible influence of beliefs that Alice might not survive the wait, and about possible family dynamics related to needs and desires for support from Alice's adult children. One clinical team member jokingly wondered aloud "Should she be seeing us or Premier Klein?"

Creating a Context for Change - What Can We Do Here?

During the session, the nurse began engaging the family by inquiring about genogram information. She invited the family to tell their story of the experiences with heart disease and with the wait for surgery. Alice and Jeanie told of their frustrations in having the surgery repeatedly postponed, and described the ways that angina attacks were interfering with walking and usual home activities. One of Alice's biggest frustrations was her strong desire to return to work.

The nurse inquired about the family's expectations in coming to the FNU and how they were thinking the nurse might be helpful to them. Neither Alice nor Jeanie was sure about this, and both had wonderings about why the research nurse from the clinical drug trial thought that Alice might be a "good candidate" for this study. Did she think that Alice was having problems, or that Alice would be helpful in the research project at the FNU? As the nurse attempted to clarify their expectations of the clinical work at the FNU, a beginning sense of what might be helpful to them was offered by the mother and daughter.

Alice: Well the only thing we don't talk about or haven't or maybe I just don't think about it is what's coming up.
SS: The surgery?
Alice: Yeah. The surgery and go back to work pretty quick. But we haven't, I don't know how they think about it....So I don't know to what extent they worry...We've never really been a family that worried ahead of time that this might happen or that might happen.
Alice suggested that she was curious about what her children thought about the situation and what her children thought about her. She commented on this again three more times during this first interview. She also revisited this idea during the research interview.

**Worries and Dilemmas of Helping**

The nurse wondered whether the influence of worries in the relationship was reciprocal: the mother wondered about her daughter’s worries, and possibly the daughter wondered about her mother’s worries.

**SS:** Do you suspect that your Mom has some worries or concerns that she’s not sharing with you? She thinks you might have some that you don’t share with her....

Jeanie: Well I know she’s **worried** about it, that it’s **bugging** her...I just think sometimes, you go on your **walks** and that, and I’m thinking “Maybe you shouldn’t be **doing** that?” Not that you shouldn’t **go** cause I know you’re supposed to go out on walks but that she goes too far? She’ll go to the store and then I’ll come to visit and she’ll say “Oh, kind of halfway back I had this big **pain** and I had to sit **down**” and I’m thinking “Well maybe you shouldn’t quite **go** that far!” That is really my biggest

**SS:** And when you **have** that thought what do you usually **say** when Mom tells you that this has happened? You don’t say **anything**?

Jeanie: Well no, I just say oh, I guess she

Alice: I won’t do it next time, I won’t **tell** her.

**SS:** Is that what happens?

Jeanie: But then that’s what she’s going to **do**, she’s going to do it **anyway**.

Jeanie was worried that her mother was doing too much, that she would walk too far, that she would not stop and rest enough, and that she would not ask for help soon enough when having chest pain that might be another heart attack. When Jeanie voiced her concerns, her mother chose not to tell Jeanie about the next time a similar situation occurred. Rather than voice these worries and risk that her mother might talk even less about them, Jeanie accepted that her mother would continue to do these activities even though they caused her chest pains.

Jeanie’s concern that her mother was doing too much was connected to resentment that her brother, who was living with Alice, had not been helping her more.

Jeanie: Well we don’t usually tell you not to do stuff **either**, cause I know she won’t **listen** **anyways**

**SS:** Sometimes you’re kind of tempted are you?
Jeanie: Well yeah, when you phoned the other day, and she says “Oh I did my vacuuming” and then she’s panting and puffing. And I’m going like “Well maybe you shouldn’t, you’re not supposed to be doing that are you?” But, get somebody else to do that for you, like Stuart. She’s not supposed to be doing a lot of arm movement things. That bugs me. That bugs me, cause if you do that and he’s not doing it. Or I don’t know if he’s doing it or not, but

SS: So you sort of suspect your Mom’s looking after, more after Stuart than Stuart looking after your Mom? Do you think so?

Jeanie: Oh I know so, yeah. Yeah I know.

Jeanie was also frustrated that her mom always ironed Stuart’s shirts when he could be doing this for himself. The nurse was reminded of the importance of this concern when Jeanie returned to the issue in response to the “one question question” (Wright et al., 1996, p. 137) just prior to the reflecting team: “How can I do something about that whole thing of mom ironing Stuart’s shirts?”

This might appear to be a somewhat trivial issue around managing instrumental tasks in living with chronic heart disease. However, something about this concern was at the “heart of the matter” (Wright et al., 1996, p. 41) for both mother and daughter. Alice was curious about what her children were thinking, and what their worries might be. Perhaps she believed that her children would not talk to her about their worries. Jeanie was very worried that her mother was overexerting herself. She was constrained from voicing her concerns by the belief that her mother might confide in her even less, and that her mother would not listen anyway.

Jeanie commented that her mother’s friend, Grace, was more direct about telling Alice what to do, and nagging her mother about overdoing it. The nurse invited Alice to think about which approach was more helpful to her: Grace’s direct approach, or Jeanie’s approach of resisting the temptation to comment. Jeanie was unsure about how she could be most helpful to her mother. She faced the dilemma of offering unwanted suggestions versus not doing everything possible to help her mother to reduce her risk. Alice suggested that she did not mind her children mentioning their concerns, but she wanted her children to let her choose what to do, and to support her decisions.
Worry about the Risk of the “Unexpected”

There was also a worry that Alice might have another heart attack while waiting for surgery. This could make her less of an ideal candidate for the surgery, and less able to return to work. Implicit in this worry was the belief that mother was vulnerable to premature death. Jeanie repeatedly used the language of “risk” as she tried to make sense of the urgency of the surgery and the senselessness of the wait. Notice the nurse’s manner of asking for the family permission to discuss this difficult topic.

SS: Is it okay to talk about that, I mean, you expect one thing, but is it okay to talk about what might happen if it’s the unexpected?
Jeanie: Is it? (giggles nervously looking at Alice)
Alice: I never looked at that end of it cause it won’t happen.
SS: Is it okay though to talk about it now? As even just a possibility or? Are you okay about that?
Alice: Possible, but I’m just
Jeanie: Or if the outcome isn’t great and you do have a stroke. But I mean, that’s what I don’t understand. What are the risks? You can go in for a tonsillectomy and there’s a whole list of things, but chances of anything happening are, almost zero. What are the chances of this stuff happening? We don’t, we don’t know that, and that’s frustrating.

Both mother and daughter were more concerned about the possibility of the unexpected occurring during the surgery more so than during the wait preceding the surgery. Jeanie was frustrated that the book they were given to read at the hospital did not address the particular risks of her mother’s situation. Although Alice repeatedly denied thinking or worrying about dying, she acknowledged that her papers were in order and that she had written instructions down in case ‘something’ happened. She had cleaned up her bedroom so that her children would not have to clean up a mess as she did when her own mother died. For Jeanie, the unknown risk of death as a troubling worry gradually became clearer.

Jeanie believed that the doctors should be able to specify Alice’s risk during the surgery, in some measurable manner. The influence of Alice’s belief that her children should not discuss worries about the operation become increasingly visible. Regarding the possibility of dying before the surgery, Alice said “I never looked at that end of it cause it won’t happen”, and “No we never discussed that...we’re going into it without worrying”.

About the risk of dying during the surgery, she said “I’m a good healthy candidate...so leave it at that”. These comments could constrain Jeanie from broaching these tough subjects, and deprive Alice from hearing more of what she was most curious about and wanting to know: “What are my children worried about...What do my children think of me?” It is probable that the cardiac surgeon had reviewed the potential risks of the surgery with Alice at some point. Possibly in an endeavour to shield her children from these worries, Alice may have been reluctant to reveal this information, if indeed she remembered having this conversation with the surgeon at all.

Throughout the conversation there was a growing understanding of the connection between the anger and frustration with waiting for surgery, and the belief that the wait was not a fair process. If the risk was so high, and there was urgency for the surgery to be done, surely those people with the highest risk should be at the top of the list. However, there was also evidence to support a belief that some people were bumping into the waiting line and receiving preferential treatment. This was particularly true of a prominent politician, a former premier of the province, whose bypass surgery was urgently done within a week of a severe angina attack. His situation was very much a matter of media attention and of conversations with friends and physicians. Both Alice and Jeanie were angry about the circumstances surrounding his “urgent” surgery.

Alice had done everything that she had been asked to do: she had angioplasties done in the past; she attended the cardiac rehabilitation program; she managed the angina on medications as long as she could. The former politician had somehow bypassed all of these beginning steps, and he hadn’t even had a heart attack, but “might have one”. The belief that this man had unfairly bumped into the waiting list contributed to the frustration and anger of the wait. The possibility that she was bumped out of line in this system of socialized medicine was an insult to Alice’s sense of worth and dignity. This woman had always prided herself in her self-reliance and had raised her children to believe “no one is
any better than you are”. She believed that “I’m just as important to my family as he is to his.” The implicit message that she heard from the health care system was that her life was worth less than that of the politician.

**The Reflecting Team**

The family accepted an offer to go behind the mirror to listen to a reflecting team conversation. The team offered the family many commendations: that they had a positive outlook; that they were willing to help each other; and that Alice’s persistence and determination were remarkable. They commented on the differences of ideas and beliefs about whether worries and fears should be talked about, and whether respect for one another’s ideas might keep them from being more open with each other about worries. The team wondered whether Alice’s positive outlook and efforts to stay active might be a way to protect her children from the effects of the illness. One team member offered that although Jeanie was concerned that household chores and ironing her brother’s shirts might contribute to overexertion, that this might help Alice to feel useful, especially since she was unhappy about being unable to return to work. The faculty supervisor wondered aloud whether the team was forcing an agenda by encouraging the family to discuss worries and concerns about the future. She wondered whether or not this discussion of worries about the future was useful to the family.

**Family Responses to the Reflecting Team**

In response to the reflecting team, the family commented on their surprise that many of the impressions of the family offered by the team had fit, suggesting that the family felt understood by the team. Alice said she was surprised and embarrassed at the good things that were said. The nurse inquired about whether the conversations had been helpful, and whether it would be useful for them to have more of this kind of conversations. Alice commented that it brought out a lot of questions that she had not thought about, and that they probably would not have talked about on their own. The nurse invited them to decide
whether they wished to return for another session. Alice suggested she would like to bring her son to a session, and Jeanie agreed that it would be helpful for her mother to come again. Perhaps the conversations had addressed Alice’s curiosity about what her children were thinking about her and what their worries might be.

**Postsession Discussion**

One of the main explanations which evolved in the team discussion was that the mother’s preference to limit conversations about the future, the possibility of recurrent MI and death was experienced as constraining by the daughter. The clinical team was curious about the many contradictions embedded within the conversation. I never think about dying, but I have all my papers in order. We do not worry about the surgery, but we never talk about our worries. We do not talk about the future, but I wonder what my children worry about. They back me in my decisions, but I wonder what my children think of me. Throughout the session, these paradoxes had been addressed by the nurse. Would it be okay to talk about this? Would talking about death somehow jinx the surgery? Does not talking about worries mean denial of the illness?

SS: That’s what I was thinking...she’s not denying it, she’s doing things that need to be done in case that happens, but it’s not getting in her way. But this idea that it’s not going to happen somehow translates to the kids that they can’t talk about it, or they can’t even ask her if she’s even dealing with things.

Faculty: Well I wonder if her strength isn’t her Achilles heel in relation to those kids, her adult kids. My sense is that she just says, with a very firm upper lip, “No it’s not going to happen, I’m not worried about it”. End of discussion. So it’s like, don’t even think about raising it with her, cause you’re not going to get anywhere, or you’re just going to be too constrained even by that real tough exterior.

The nurse also described her experience within the session of “change happening”. She had a sense within the session that this conversation between mother and daughter was helpful because it was different than they had experienced previously. What they had talked about, and how they had talked about their concerns as they described their experiences with the wait and their concerns for the future was different than conversations they had on their own. The nurse’s questioning had lifted constraints against discussion of worries and the
unexpected possibilities in the future. The clinical team also discussed the many conversational openings in the session which were pursued and created by the nurse in attempts to talk about death. The nurse wondered about whether it might be a constraining nursing belief that we should have “death conversations” in working with families in this population. Although the future and the prognosis are often laden with uncertainty, this particular family did not seem to take up these conversational openings or to show affective arousal around this topic. The possibility was raised that hopefulness might be needed to sustain people through the waiting period, and that conversations of death and uncertainty might be counter to the preference to nurture optimism for successful outcomes from the surgery.

Session 2

The next session occurred five weeks later. Alice was still waiting for her surgery, and it was more than six months since she had been told the operation was urgently needed. Jeanie attended the second session with Alice because Stuart was unable to get time away from work that afternoon.

Despair and “They don’t Care”

It was quickly evident that Alice was more disturbed by the waiting and less optimistic about the future than she had been at the previous session. She had been anticipating a phone call to come for surgery in mid-January. When the date passed and no one contacted her, she phoned the booking clerk again. She was told the surgery would be “no later than February, I promise”. As February wore on and she heard nothing from the hospital, Alice found herself becoming very angry. The cardiovascular surgery program was amalgamating services from two hospitals to one, and Alice was told by the booking clerk in February that surgeries would not be fully in progress until the third week in March. Her lack of trust, frustration, and anger with the system was cresting.
Alice: The way I look at it, they’ve been lying right from day one. If they told me “Here’s when you’re going in”, then I’d have gone back to work, I wouldn’t have stayed home.

Alice said that if she returned to work at this point, she would not have disability coverage following her surgery. At that time, it was very difficult for her financially. The suspicion that the waiting list was not fair had taken on additional incredulity for Alice: “they” would also lie to you and could not be trusted.

The nurse inquired about what the family was hoping might be discussed at this session. Although both said that they were unsure about what to discuss, Jeanie was very clear in her hopes for this session. She wanted direct advice to address dilemmas around the bureaucratic issues related to waiting for the surgery. The urgency and risk continued to amplify over time, as Alice had developed a cardiac arrhythmia which was occurring at rest. Alice had mentioned the arrhythmia during one of her telephone inquiries to the booking clerk about the date of the surgery. She believed that this had somehow been communicated to the cardiologist. His office had phoned to book an appointment with her in two weeks. Alice believed that she had been ignored, perhaps forgotten, by the cardiologist since the fall.

Jeanie: It’s ridiculous that over that time period when they’re telling you you need this surgery, that they don’t see you? How do they know that your situation hasn’t gotten worse? It’s just crazy. So you phone them and probably feel like “Oh I’m bugging these people”, when in fact you shouldn’t feel like that.

In addition to the delays within the hospital system, the cardiologist did not have a mechanism in place to follow the progress of those people who were urgently awaiting surgery. Alice’s family physician of almost thirty years was trusted and respected. He was a person whose counsel had been valued in the past. However he had been undergoing an extensive recuperation himself over the winter months following an accident. His practice was part time and had moved to a different location, and Alice believed that he too was unable to help her as the waiting continued.
During the first session, Alice had been angry and frustrated, but she was optimistic and determined. Now, resignation and despair were painfully present. The nurse persistently asked questions about other possible changes in Alice’s symptoms over time that might help the cardiologist to appreciate the urgency of her particular situation. Alice reluctantly revealed that she now would have angina every day with simple activities, such as making her bed. She had angina three or four times each week during her daily walk to the store. Fifty percent of the time, the angina pains were stronger and similar to the pains she had with her heart attack. She had been needing to take more Nitroglycerin spray, and had to rest longer following the angina pains. Throughout this description of the many ways in which her symptoms had escalated, Alice blamed herself for accidentally overextending some activities and “causing” chest pain, although she estimated that she was curtailing her activity by 80% since the previous summer! She refused to go to the emergency department at the hospital with these more severe pains because the angina would eventually go away and she believed she would be sent home, which would be humiliating.

The curtailment of activity and the increasing presence of the angina pains had taken on a sense of normalcy in her daily life. As it seemed to her that no one else appreciated the urgency of her situation, she too had accepted this as normal, and became more likely to minimize these symptoms. As her anger and frustration increased, so did her determination not to ask for help: “I’m not going to tell anybody”. Alice believed that what she would say to the doctors would not only fail to make a difference, but that “they” did not care about the urgency of her situation. The more that Alice believed that she had been lied to and cheated by others whom she believed to be bumping into the system, the more she sustained her own integrity by refusing to humiliate herself to people who did not care about her own situation. She believed that “they”, the doctors, booking clerks, bureaucrats
and politicians did not care. To elaborate in describing the severity of her symptoms, or to make a fuss about her situation would be humiliating.

The nurse continued to be concerned and curious about this dramatic shift in Alice’s attitude from determination and optimism to despair. She began questioning the ways in which the belief that others did not care invited Alice to suffer and endure without complaint. The nurse then began to question her own complicity in sustaining the wait, in not making a fuss, and in a therapeutic goal of helping this family to cope with waiting for surgery.

SS: But help me understand how you got lulled into the idea that you should be patient. That’s the trouble with the word ‘patient’ is to be patient...How do you think this kind of got encouraged, to be even more patient when you’re a patient woman, to be even more patient and to be quietly patient?

SS: In my head, I’m just thinking to myself “I’m kind of shocked! How did I get talked into the idea that I should be making you quiet in helping you deal with this wait?” then.

Jeanie: Well because you don’t want, the poor nurse, the poor nurses and the poor doctors, they’re getting worked to death.

Alice: They’re getting worked to death but what I got could kill me.

Jeanie: So you think, “If I scream at this nurse, she’s going to forget to change my IV” or something stupid like (giggles).

Alice: Oh no, they don’t scare me that way.

Everyone in the system had been influenced by the funding cuts and changes in many different ways. Although Jeanie was sympathetic to the influence on the workload of the “poor” nurses and doctors, her mother drew attention to the dramatic distinction between being “worked to death” and actually losing your life.

Reflecting Team

The reflecting team members voiced their alarm regarding Alice’s resignation and despair. They also expressed their concern for the physical impact of anger and stress on the illness. Team members offered advice about the need to avoid minimizing the symptoms that Alice was experiencing, and that she might even need to amplify these descriptions a bit to offset her tendency to accept the symptoms as usual. They discussed the art of making a fuss appropriately so that concerns would be more likely to be heard.
They wondered whether it might be helpful to take her son with her to the cardiologist to demonstrate that she had the support and concern of other people, and to allow him to raise a loud, male voice which might be less likely to be discounted. They suggested it might be helpful to keep a log of her activity, angina pains, and use of Nitroglycerin to demonstrate the severe limitations to her activities. It was suggested that the booking clerk who had been bearing the bad news of postponements of the surgery probably was not in a position to influence the waiting list, whereas a cardiologist might be able to prevent future postponements.

The members of the reflecting team also wondered about the ways in which nurses are also persuaded to be patient with the waiting. They wondered aloud about the ways in which nurses were constrained from speaking against the waiting and were also encouraged to accept the waiting as inevitable. One of the comments of the reflecting team that was most perturbing for the family was made by a graduate student. The brutal honesty of this comment could be understood as an example of insensitive self-interest of stakeholders in the health care system. Interestingly, for the family, the comment was perturbing in a helpful manner.

Student:  Something that really affected me in listening to them tell their story today, and I don’t know about the rest of you. My social circle is entirely people who work in the system...and when we get together and talk, what we talk about is how the cutbacks and everything else affect us. And to be fair, I don’t think we ever really once talk about how it affects the people we look after. So it was really good for me to hear the other side of the story and give it some perspective. My friends and I all have our own issues and our own frustrations with the cutbacks and what’s happening in the system and it sucks just as much for us as it probably does for people trying to receive care from the system. It was really really valuable for me to hear that from them.

Other team members, including the researcher, cringed behind the one-way mirror as the student confessed to blatant self-preoccupation during the health care cutbacks. Team members were curious about how these comments might be understood by the family. At one level, the systemic changes of job losses, pay cuts, staff bumping between nursing units, departmental reorganizations, relocation of hospital services, and hospital closures
were difficult for health care providers. Did these pressures make it easier for the suffering imposed on people who were accessing services to go unnoticed? This perspective could reinforce the family’s possibly entrenched view that other people in the system simply did not care.

**Family Responses to Reflecting Team**

When Alice and Jeanie were asked about their impressions of the team discussion, Alice commented that the tips about the visit to the cardiologist were helpful. She was curious about taking Stuart with her because he would not get nasty, but could get politely forceful. She did not believe that she was intimidated by the doctor, but agreed that she would find it difficult to embellish descriptions of her symptoms. Jeanie suggested that the team had heard more about their “real concerns” about the waiting, and was pleased that the team offered some concrete ideas during this session. Both of them commented on the feeling that “We know somebody at least is listening”, and referred to the transcript segment above.

Alice: Even if you, the ones that are here are, like he said, when he’s talking to his friends, they were all talking about how it’s affected them. But there’s a whole lot of other people out there he’s discovered. So I mean, even, even amongst nurses, doctors, why don’t they start discussing it? Figuring out there’s patients out there, they’re not just a number... I don’t usually let things get me this down. I don’t allow it, but this is really pretty

Jeanie: Well it’s cause you can’t do anything about it.

SS: Well cause that’s the feeling, that’s the feeling. And I wonder if that’s the feeling that’s the problem. “There’s nothing we can do about here”.

The nurse offered to write a letter about the understanding of the wait and their particular situation that had unfolded in the sessions at the FNU, and whether Alice might want to take the letter with her to the physician. Alice was skeptical that this might make a difference in the wait, though she thought that it might help to make them more aware of the overall situation for her. The session ended with the agreement that Alice would call for a follow-up appointment once she had seen the cardiologist and knew when she might be available depending on a booking for her surgery.
The team acknowledged their discomfort with the family’s comments that they had not heard the “real concerns” of the family during the first session. They noticed that they had felt invited to give much more direct, concrete opinions and advice during the reflecting team, and that the family seemed to think that this direct advice was helpful. The nurses were all struck by the sense of hopelessness, oppression and depression that were evident in Alice’s demeanor during this session. Team members acknowledged the ways in which they too had been influenced by the constraining belief that nothing would make a difference in the wait, that she simply had to wait, that nurses might help them cope with the wait, but might not be able to influence the length of the wait.

The nurse was still curious about the idea of writing a letter describing the symptoms Alice had been having, and describing the family’s experience of being lulled into patiently waiting for so long. She wondered about how the family might want to use this kind of a letter, and to whom they might want to send it. Again, the subtle threat which can constrain nurses and doctors from challenging the system in a political manner was voiced by a graduate student, who jokingly suggested “Then she could send that into the paper, and then we could get fired!” Nurses and doctors also become lulled into becoming patient with a system that is not working out of a sense of their own vulnerability and self-preservation.

In this session, some of the limitations of healing conversations were uncovered. Talking about the wait within the family, or at the FNU between the family and the nurse was not enough. Talking about the concerns and worries about waiting for surgery does not help access to needed services unless you are talking to the right people. Phoning the booking clerk and being angry and frustrated with the postponement of the surgery date would not make a difference. The kinds of conversations that Alice might have with the cardiologist about her symptoms is an example of a conversation that could make a
difference. Another step could be an intervention in the larger system, seeking out people in the system with the power to make a difference. It seemed that the family, the clinical drug trial nurse, the FNU nurse and clinical team, and the physicians were all constrained by a powerful systemic belief that they could not make a difference.

Session 3

The third session occurred four months later in the middle of summer. There was no clinical team, presession or postsession as the FNU is usually inactive during the summer term of the university. Alice finally had received cardiac bypass surgery about a month following the second session, a total waiting period of eight months. She had breezed through the surgery, which had somehow seemed anti-climactic and very manageable after the prolonged stress of waiting for the surgery. Alice had decided to bring a dear and longstanding friend, Grace, to this final follow-up session.

When asked what she remembered from the second session, Alice immediately described to Grace the reflecting team in which a student commented on how he had learned from Alice about the impact of the changes in the health care system on patients. His comments convinced Alice that someone else had finally heard about her situation, and that someone finally appreciated more than just how the cuts in the health care system had hurt health care workers.

After the last session, Alice had taken her son, Stuart, to the next office visit with the cardiologist. He had raised his voice politely to convey his concern and anger for his mother’s situation. Alice had also allowed herself to get angry during this visit, and she forcefully informed the doctor that if they were not going to do the surgery, she was planning to return to work. Her surgery was booked for a couple of weeks following this visit. It was unclear whether there was anything that Alice or Stuart said about her worsening symptoms or the frustration with the wait that made a difference in expediting the surgery booking. It was possible that she simply made it to the top of the waiting list at
last. During her hospitalization, she encountered three other men whom she had met the previous summer while hospitalized with her MI. These men had also been on the waiting list over the same time period.

After the frustration, anger, economic devastation, and despair of the wait, the surgery itself was totally uneventful. Alice was up walking around within two days of the surgery, and was home one week following the surgery. She had mostly positive comments about the care received while in hospital, though she described herself as feeling scared once she got home. Her children checked in on her frequently during the day, but there was no homecare, community services, or follow-up monitoring of her condition during the first month following discharge.

She had a four week check up with the cardiac surgeon, and was supposed to see the cardiologist as well four weeks post-operatively. Despite phoning the cardiologist’s office twice, she was unable to get an appointment time from the office nurse. She angrily told the cardiac surgeon about this frustration at her three month follow-up appointment. Alice knew of possible complications during her recovery, and she wondered what would have happened if problems developed that she did not know how to recognize. The changes occurring in the system were not changes which provided appropriate health care required by people needing services. The changes reflected services provided on the basis of an economic agenda to manage deficit reduction. The traditional focus on acute care services with medical office follow-up and neglect of community based services had prevailed.

**The Saving Grace of Friendship**

The presence of Alice’s close friend, Grace, was extremely helpful during the third session. It was obvious that the two friends had been able to openly discuss many of the issues and worries that Alice had been reluctant to discuss with her daughter during the previous two sessions. These two friends had talked about the fear of a recurrent MI and
the possibility of dying while awaiting the surgery. Grace understood Alice’s pride in her independence and self-reliance; her desire to return to work as soon as possible; her refusal to ask for financial assistance; her protection of her children from worries; and her severely limited activity during the wait. Grace also knew of the depths of Alice’s despair and depression during the final weeks of the wait. For Alice, Grace was a “Who in the World?” kind of a person whom she could trust, and with whom she could share her worries.

Grace: I said, “Alice the only thing I can say to you is that there must be other people who either have an in (giggles), of course there are. Or there must be people worse off than you that are absolutely critical. You are at least functioning, and if you can function each day and not abuse your body to the point that you cause the angina and the pain, then you just have to sit and wait it out, it’s just a matter of numbers.”

This friendship was a major source of support for Alice, but Grace was also under the influence of the belief that nothing could be done about the wait. Grace’s belief that Alice could control the angina pains by monitoring her activity may also have reinforced Alice’s tendency to blame herself for attacks of angina.

It was particularly meaningful to Alice during this final session to hear the commendations offered by her friend. Alice became teary and embarrassed by her friend’s declaration of her admiration and respect for Alice, her self-reliance as a provider, her ability to protect her children over the years, and her honesty and integrity. The nurse offered both of them commendations about their friendship over the years, but the commendations from friend to friend held a powerful honesty that comes from knowing someone well over decades of time.

**Pride and Self-Reliance**

Much of the major work of this final session was related to discussing the possibility that pride and self-reliance might have prevented Alice from pushing the system harder to get the health care that she needed. Although the wait for surgery was over, constraining beliefs about pride, independence and self-reliance could influence Alice’s efforts to access health care services when needed in the future.
Grace: Alice has protected her family all of her life. Right from the time of her marriage breakdown...it's "I'm strong, I can do it myself." And that is Alice's whole demeanor. Alice does not like help.

SS: Do you think that got in the way, in any way? I mean, it sounds like it's been a very useful attitude in most areas of life, but do you think in any way it may have gotten in the way of getting health care, of getting attention or?

Grace: I think it did, I think so, because she

Alice: No, no I don't (pause). Oh because I said I was okay. I usually would tell them I feel okay, yeah. Maybe it did.

Alice: What has to be done, I will do it. And I won't ask you... I would sooner die than go and ask somebody for help!

The nurse pointed out some of the ways in which the belief in self-reliance and independence which had served Alice well over many years in her success as a provider and a sole parent might have been a liability in this circumstance. This reluctance to complain about her symptoms also hampered her eligibility to collect disability insurance.

SS: Would you say Grace that pride and independence, the, "I'm not going to ask for help" kind of attitude, do you think that may have interfered, I mean it sounds like it's been very useful? Do you think in this case maybe it was not very useful?

Grace: I think it did. Very much, I think it deterred her.

Alice: It's my survival unit.

Grace: Except that in this case, it was counterproductive to what she needed. She needed the financial help to ease the worry that it had, so the pride did her no good at all

SS: It was helpful in many areas of her life.

Grace: Many areas.

Alice: But I was raised that way. You don't ask for help.

Grace: It wasn't asking for help, you deserved this financial help. And this is what I kept saying to her "You've paid for this, you deserve this financial help."

As the possibility of having a recurrent MI or even dying while awaiting surgery loomed larger over time, her confidence was shaken. To be proud is to have a sense of one's value. Alice was a woman of integrity who refused to lie about symptoms to move up the waiting list more quickly. She did not want to bump up higher in the waiting list. She would wait her turn just as others should do as well.

Alice may have begun to question her worthiness, believing that "they don't care", that others lied to her about the booking schedule, and that others cheated her by bumping into the waiting list. Her belief in her pride and dignity was violated by unknown and
unseen others involved in the wait for surgery. This woman who found asking for help to be one of the most difficult tasks she could face somehow came to doubt that she deserved help or was worthy of help. Her pride in her ability to continue with 20 percent of her activity invited the disability insurance company to believe that she was not sufficiently disabled to collect disability insurance. She became even more determined not to ask for help, and had quietly paid her utility bills rather than buying her medications.

The presence of the friend whom Alice trusted and respected enabled a different kind of conversation to occur than might have been possible in the presence of the daughter. Alice could be freer in speaking to her beliefs and actions when she did not have to worry about guarding her comments in front of Jeanie. The perspectives offered by Grace enabled the nurse to pursue a conversation which exposed the downside of a cherished belief about pride and independence. Alice could listen to these comments differently, buoyed by the knowledge of the respect, admiration, and genuine caring of her friend.

As the session ended, the nurse invited Alice to comment on whether and how the meetings at the FNU with her daughter and friend had been useful to her. Interestingly, she echoed a comment made during the first session, her wondering about what her children think of her.

Alice: Well I don’t ever ask, I never think about what people think about me, how to explain it...I never knew about the kids, how they thought about me. I’m bashful. That surprised me. It’s a nice feeling....it was nice to hear my daughter’s remarks.

There was something important about this persistent wondering, which Alice raised again later in the research interview, about “I never think about what people think of me”, and “I don’t usually ask the kids what they think of me in particular”. Again, was it comforting to her to understand what her children thought of her, or how she might be remembered if the unexpected did occur during the wait or the surgery?
The clinical sessions at the FNU may have helped Alice to understand what her children thought of her. The sessions may have encouraged Alice to avoid minimizing descriptions of her symptoms when she visited the cardiologist so that someone in a position of power might influence the waiting period. The sessions definitely challenged the beliefs of the clinical team about the complicity of health care providers in reinforcing the necessity of health care cutbacks, and complicity in patiently not attempting to influence the politics of waiting lists.

Another Layer of Reflection - The Research Interviews

There were many echoes of the clinical conversations which resonated throughout the research interview with Alice and Jeanie which was conducted about four months following the third session. Many of their comments were very similar to those elicited by the nurse during the sessions about their impressions of the clinical work. They offered very direct comments about what was helpful to them about the sessions, and some of their misgivings about the way sessions were conducted.

The Family-Nurse Relationship - “What was that?”

With all of the frustration this family had experienced during the wait for surgery elsewhere in the system, it was hardly surprising that Alice and Jeanie were cautious in trusting and connecting with the nurse at the FNU. Both of them experienced the context at the FNU as very different, and were unsure about what to expect in going there.

Jeanie: I think in the beginning, I didn’t even know, really, I didn’t understand the point of it. Because it was, it was left so vague that when we came in here, I don’t think it was explained to us what the boundaries were enough?...I know you don’t like to guide, but we had no idea what you were wanting. Did you want to know specifically. Do we know the ins and outs of the heart surgery? Is that what you were focusing on?...What are we supposed to be talking [about], and then if you talk about something, are we supposed to be doing this? Or are we wasting your time, and you want to do something else? I felt that it was unclear?

DT: So at first, a lot of struggling around just what are we doing?
Jeanie: Yeah that sort of thing.
Alice: Cause I know Jeanie, when we left and she says “Were we just wasting time in there?”
Jeanie: Yeah, “What was that?”
Mother and daughter were both uncertain about what to expect at the FNU. They had difficulty commenting on particular things that the nurse said or did that they might have experienced as helpful, and they did not remember the nurse’s name. They were uncomfortable with many of the questions asked by the nurse. They said that the questions were often difficult to answer, and that they would have preferred much more direct and pointed questions. Both commented that the nurse had asked some questions that “got the ball rolling”, and that she had asked more direct questions than the clinical team. The family greatly resented the intrusive character of questions phoned in from the clinical team behind the mirror. They believed that these questions took them off track and could have waited until later in the interview.

There was great concern for answering the questions properly for the nurse. These conversations might have been experienced differently for the family because this was not the typical factual, investigative, health history kind of inquiry which they would more likely have encountered in other health care settings. The nurse’s questions are often intended to “invite reflection” (Wright et al., 1996, p. 117). The nurse usually had less desire to find a correct answer than to provide a forum for different perspectives to be heard. The family’s discomfort may belie the expectation that the family’s answers would be judged as right or wrong, and a desire to answer questions appropriately and to perform correctly for the nurse and the clinical team.

Potential Obstacles to Engagement

During the research interview, the nurse also described her understanding of the awkward engagement with this family. Wright et al. (1996) described engagement or the development of a therapeutic alliance with the family as part of a process of creating a context for changes in beliefs to occur. This process includes agreement on the goals of therapy, the topics of the conversation, establishment of structure around the process and frequency of meetings, and development of an ongoing relationship between the clinician
and client. A context for change is created when the family and the nurse distinguish the problem or the experience which is the focus of their conversations, and when obstacles to change are removed. Three potential obstacles to engagement and creation of a context for change may have challenged this nurse-family relationship: mistrust of health care providers, expectations of the roles of nurses, and the influence of the referring source.

Firstly, engagement with this family occurred in the context of Alice’s pride and anger with a health care system which she experienced as violating and cheating her. The nurse hypothesized that mistrust of the health care system influenced the shape of the engagement and connection in the clinical work with the family.

SS: Well, I would understand it as being a couple of things. That the pride, the importance of not being vulnerable with another person ... and the lack of trust... Like who are you?... you can only trust yourself because other people really do you dirty if you really let them know how things are? They’ll take advantage of your vulnerability or your weaknesses, so you better not let them show.

It is understandable that previous experiences with the health care system might influence the family’s willingness to risk telling their story yet again, and to becoming vulnerable yet again to potentially uncaring or insensitive responses of others. The belief that health care providers and the system were deaf could constrain the family from being interested in risking another telling of their story.

Secondly, the nurse hypothesized that the family was influenced by their expectations of nurses in particular. The family expected the nurse to ask them direct questions, and to clearly establish the boundaries of their purpose in coming to the FNU.

SS: I was just thinking about the other thing that may have contributed to that feeling was that the idea or beliefs around what is nursing? Because they come from a medical system, not a mental health system. Now they’ve come from a medical system where the focus is exclusively on their physical symptoms, or on doing checklists or giving information. And to wonder what these nurses, like “What are you doing?”...”What is my role here as a patient in this setting with nurses?” “You’re not doing what I expect of you.”

This nurse did not wear a uniform. She did not provide pills. She did not offer advice and teaching about lifestyle changes. The conversation about symptoms was not the primary
focus of the discussion with the family. This nurse asked different kinds of questions and behaved differently than other nurses the family had encountered, and she hypothesized that this difference in expectations contributed to the family’s sense of discomfort and uncertainty about how to proceed in the sessions.

The expectation that the nurse would be in charge and establish a clear structure could underpin subtle power relations which often operate in health care relationships. When families anticipate that the nurse will be the leader, will provide information for them to follow, and will set the boundaries and rules for their work together, the nurse can be invited into the relationship in a power-inflected manner (McIntyre, 1997).

SS: Well yeah, are they waiting for us to be the leaders? “You tell me what you want, and, and just ask the questions or do your questionnaires, or you tell me your teaching, or whatever it is you’re doing.”

This reciprocity of expectations between the family and the nurse can inadvertently set up power relationships which influence the relationship. The family may prefer the nurse to be more directive, and may prefer more direct advice or opinions from the nurse, who may be perceived to offer some expertise to the family. A caution for the nurse is to avoid abuse of sanctioned power of health care providers, and to find ways to work in the tension between trying to avoid being directive or hierarchical, and being willing to declare one’s own opinions and advice about how to proceed. Unquestioned acceptance of expertise, advice-giving and information-giving, and power-inflected roles can negate both nurse and family. The family is negated when the expectation is conformity with the structure dictated by the nurse. Their own resourcefulness and competency is not recognized or acknowledged. The nurse is also thwarted when the expertise and resourcefulness of the family can not be accessed.

The family also had experiences in other health care contexts which may have supported the belief that nurses do not have time to talk or to attend to emotional needs. The family’s experiences in acute care were primarily with nurses who offered interventions to
address physical needs. Jeanie excused nurses from attending to the "other" needs, or the emotional needs. The clinical work at the FNU offers interventions through language and focuses on relationships and reciprocal influences between health and illness and the family. This was quite out of the realm of the family's previous experiences and may have contributed to their discomfort and uncertainty about how to proceed in this context.

Thirdly, both the family and the nurse described unclear expectations for the purpose of their clinical work. These expectations were complicated by the participation in the research project at the FNU, and by the reason for the referral to the research project by a nurse from the clinical drug research project. Most families who come to the FNU are self-referred. In this instance, the referring sources were additional influences on the process of creating a context for the nurse and family to work together. Both the family and the nurse commented on this influence.

Jeanie: Cause I really had no idea why we were here ... We were recommended here and I thought, "Well, why? What do they mean? Why?" (laughs) "Why were we recommended here?"

Alice: Yeah, what category did we fit into you know?

SS: "Is that what it's about? Is that what you're distressed about why you're here?" I mean isn't that always the way when it's that they're referred by somebody else? In terms of having a self identified need. See I don't, with mother's belief around being so independent and that she's not going to ask for help and need help

DT: She might never have come to that on her own.

SS: Yeah, if she hadn't been referred, or suggested, or encouraged or something, because a nurse felt that she was not dealing with this well. Which is interesting cause how do you deal with this well? Like how do you deal with waiting with a life threatening illness?...Even when you get the surgery it might have gotten so bad that now it's no longer helpful. What did that nurse expect? Cheeriness or resignation...But why this woman and not somebody else that she'd refer?

Both the family and the nurse were curious about the impressions which led the drug trial research nurse and the FNU researcher to believe that the family should come to the FNU.

The nurse's comment that this family may never have sought this kind of clinical work to self-refer for assistance is important. In retrospect, the constraining beliefs at the heart of the matter are all beliefs which could have prevented a family from self-referring to access...
this kind of assistance: you can only rely on yourself; asking for help shows your weakness; and the health care providers and the health care system are deaf.

**What Was Most Helpful to the Family?**

The nurse believed that the conversations between mother and daughter at the FNU had been useful to both of them. However, she was concerned that at the end of the clinical work, although we understood Alice and her situation better, she was less convinced that Alice’s constraining beliefs were really challenged. Indeed, the conversations which explored the nurse’s hypotheses and interventions in the final session were not raised during the research interview with the mother and daughter. The possibility that pride and self-reliance may have interfered with Alice’s willingness to ask for or to accept help was not raised by Alice. It is conceivable that this conversation was similarly censored during the research interview due to the presence of the daughter. Alice and Jeanie both offered other suggestions about the ways that the FNU sessions had been helpful to them.

**Hearing reflecting team comments and feeling heard.** Although they disliked the questions phoned in by the clinical team behind the mirror, the family commented on the helpfulness of the reflecting team. They were surprised to hear team comments which fit for them, suggesting that the team members did understand their situation. During the research interview, Alice commented yet again on the ideas offered during the second session reflecting team.

**Alice:** He said he’d been out that weekend, and they were busy what stewing about oh their wages....what was happening to him. And then he said he didn’t realize until he heard me saying a few things, and Jeanie, what actually was happening to the ‘patient’ as he put it. He said it never occurred to him, because he was busy being his doing his little thing, but he wasn’t reacting with the patient, with the person.

**DT:** And so how did that really strike a chord for you, you remember that really well eh?

**Alice:** I thought “Now, somebody’s listening. Somebody actually heard what I was saying.” So I thought, “Well if one person got that out of it, maybe he’ll pass it along.”
This comment by the graduate student may have been so striking because it supported Alice’s belief that most of the people working in the health care system were profoundly deaf to the suffering created by the changes. The comment may have fit so well for her because it supported her constraining belief that no one heard or cared how this experience had affected her. She was less convinced that other team members ‘got it’. The comment which was so outstanding in its tactlessness, self-interest, and insensitivity was congruent with what Alice believed the rest of the people in the health care system to be like. But the comment was also a source of hope for her: if this student heard what she was saying, it was possible that others might also hear.

The family contrasted their experience of feeling heard at the FNU with other experiences at doctors’ offices and in the hospital in which their experiences or their suffering was not acknowledged by other health care providers. Jeanie thought that the team had listened to them. Alice believed they tried to offer suggestions. Both were hopeful that the graduate students on the clinical team would learn something that might help them to ask questions and listen to other patients in the future.

**Relief of talking about “the unexpected” as a possibility.** During the first session, the nurse followed and offered many openings to discuss beliefs about the surgery, the risk of waiting, and the possibility of death. There were many confusing messages about whether or not Alice and Jeanie had discussed these topics, and whether they believed these topics should be discussed. Alice’s fierce desire to protect her children from worrying about the future had constrained Jeanie from raising these issues at home, and Jeanie commented on the helpfulness of these conversations with the nurse at the FNU.

Jeanie: Yeah, that was a good thing for us though when we were here, because then I said that? She’s like “Yeah, ... that’s a concern”. Like this waiting, don’t tell me that the possibility of it happening isn’t greater because I know it is. So we were able to say that.

DT: With the team you mean?

Jeanie: Yeah

Alice: We didn’t discuss this at home.

Jeanie: “Oh well that’s not going to happen”, ah, (laughs) it might!
Alice: Well no
DT: So between the two of you to be able to say that about 'what if' kind of thing? Is that what you're getting at there Jeanie?
Jeanie: Yeah, yeah
Alice: Like if I was going to die (says very rapidly) more or less.

The nurse and the clinical team were unsure during the first two sessions whether the conversations with the mother and daughter about the uncertainty of the future and the possibility of death were topics that the family wanted to discuss, or whether they were primarily topics on the nurse's agenda. During the research interview, Jeanie was clear that it was helpful for her to be able to say to her mother that she was concerned about the future even though they never discussed it at home.

**Having different conversations in a different context.** Jeanie also commented on the helpfulness of having other kinds of conversations that she had been constrained from having with her mother. In addition to worries about the future, she felt that it helped to relieve stress to talk about other worries that they had not talked about at home, and to vent their anger at the waiting and at the health care system.

Jeanie: Well relieving stress, and I mean it gets that out that you can’t say to somebody else cause even your friends, they don’t understand.
DT: And in what way was that helpful to you? To be able to get it out, what difference do you think it made to you to do it?
Jeanie: Well so she knew that there were things that were bugging us, and not just her you know.
DT: So you thought that it relieved you by knowing that she knew about it?
Jeanie: And that she'd heard. And so she knew that we had said this to somebody else and it had kind of been dealt with sort of.

Perhaps wanting her mother to know that she was also worried was a gesture of Jeanie's caring for her mother. Jeanie wanted to have opportunities to make her concern and caring for her mother known to others. Perhaps she wanted her mother to know that she cared enough about her to stand up against the unfairness of waiting, in spite of the hopelessness about whether this would make a difference in shortening the waiting period. Having a place where this voice was allowed and where the silence of deafness could be broken was experienced as a relief to Jeanie.
Alice commented on the helpfulness of having another person to talk to about her feelings and concerns with the waiting period. The release of the constraint against conversations about worries and about the future was experienced as helpful for both Alice and Jeanie. Alice was able to talk more about some of the things that she was not in the habit of discussing in the family.

DT: Did working with (nurse) make a difference in the overall way that things went for you?...
Alice: I think so. There was somebody else I had to talk to. I mean because I don’t make it a habit of telling the kids how I feel.
Jeanie: No you don’t.
DT: So for you it was helpful to talk about some of the worries?
Alice: It’s (pause). Yeah it kind of got it out on the (pause). Jeanie maybe heard things she hadn’t heard before, but, that’s okay. We were in this session, but I probably never would have done it at home.
DT: How about for you (to Jeanie), do you think it made a difference overall in how things went?
Jeanie: Well yes, and I think the big thing was that change that they saw? I wonder what would have happened if we wouldn’t have come here? Right?

Both Alice and Jeanie believed having someone else to talk to at the time of the second session was very important. At this session, the nurse and the team were very much aware of the shift from the optimism and determination of the first session, to the pessimism, hopelessness, and despair of the second session. However, Jeanie and Alice believed that the nurse and the clinical team did not fully appreciate the depths of Alice’s despair during the second session. During the research interview, Alice admitted to having suicidal thoughts at this time.

Alice: I’m not the type that would’ve gone out and slashed my wrists but there are some people, that would’ve pushed them.
Jeanie: There are some that would (softly).
Alice: I think I had enough support family wise, but then that’s just not an out to me.
Jeanie: Yeah they didn’t offer, I mean like you said, you’re not the type that would’ve done that, but I don’t know if I were listening to that, I’d be, I mean they were concerned. They said ‘’How come you’re so different than you were last time?’”
Alice: They were worried about it, but they didn’t really hear what
Jeanie: I think that light should’ve gone on a little brighter, and said ‘’Maybe you should be talking to this, or doing this or that” and they didn’t.
Alice: Cause had I been a different person, I could’ve gone out of here and pft (makes a cutting motion across wrists), cause I was really getting that bad.
This family thought that the nurse should have been much more direct with them on this issue. In particular, at the end of the session, they thought that the nurse should have been more assertive in arranging to see Alice again soon because of the obvious shift in her outlook, rather than offering her an option to return for another session sometime in the future. Even though they did not feel that the seriousness of this situation was fully understood, mother and daughter were grateful that they could speak more openly at the FNU about their anger at the delays in the system.

**Helpfulness of offering alternative explanations/beliefs.** Another aspect of the clinical work which Jeanie described as being most helpful was hearing “other angles” to understand the behavior of other family members. The example that she used in the research interview was her concern that her mother was doing too much physical activity around the house, and that she had been frustrated with her brother’s willingness to have Alice iron his shirts. The reflecting team had offered another explanation for this which made sense to Jeanie. Her brother, Stuart, was perhaps not being lazy and unhelpful to Alice. Perhaps he was helping her to feel useful and productive as she contended with time on her hands and the frustration of being unable to return to her employment. The activity of ironing Stuart’s shirts might not have been something that added to her mother’s frustration, but could have helped her to cope with the waiting. This explanation offered Jeanie an alternate belief which helped to reduce her worry and distress about her mother overdoing household activities. It also helped her to reduce conflict and anger between herself and her brother.

**Listening, Hearing and Understanding**

These interpretations of the clinical work continue to uncover aspects of how the nurse and the family conduct themselves to address the concerns or experiences related to living with heart disease. Again, there was something significant about “who in the world?” might have these conversations together. The nurse acted differently than other
nurses that the family had encountered in the hospital setting. She was less directive and specified fewer boundaries to their conversations. She asked different kinds of questions, some of which were very difficult to answer. How these conversations were conducted was experienced as different by the family. The conversations between mother and daughter were less censored by mother’s preference against discussion of worries about the waiting and the uncertainty of the future than their usual conversations at home. Between friends, the nurse facilitated a different kind of conversation: Grace’s desire to offer Alice assistance was legitimated, and the possibility that Alice’s pride might have been a liability in this circumstance was questioned. Even as pride and self-reliance were questioned, these beliefs were valued and acknowledged as beliefs which had courageously conserved her existence in the past. Where these conversations occurred was important in this situation. The distance between the context of the FNU and the acute care hospital may have freed the family up to have more open conversations about their anger and their frustration with the health care system. The family may have felt less vulnerable to repercussions from disclosure of anger and mistrust at the FNU.

What the nurse and the family discussed was also different. The nurse heard and understood their concerns about the unfairness of waiting and the confusing messages about risk and urgency. Alice learned what her daughter thought about her, and what her daughter worried about related to the illness and her future. The nurse offered ideas about the waiting that questioned the appropriateness of waiting patiently. She questioned the complicity of not only the family, but also of other health care providers in quietly accepting political agendas and health care changes that were not serving the people who need access to health care.

At the end of the research interview with Alice and Jeanie, Alice described yet again the comment by the graduate student during the reflecting team of the second session. She was hopeful that he really heard and understood her situation, that he listened and heard
how it was for the patient, not just for the health care worker. She eloquently offered the metaphor of listening and hearing for the experience of being understood. She offered advice to nurses about the need to listen for meanings below the surface in order to really understand what people go through during illness.

Alice: You can read a book, like when I read a book I’m in that story. Or if I see a show, I’m in there. Or I hear a song. Other people can do the same thing and don’t get anything. They hear the music, they don’t hear what the words are, cause they mean something. They read a book and they don’t get anything out of it. So you can listen, and you can listen. Or you can hear, and you can hear, but you’re not hearing it. And he heard.
III. Choosing to Live at Risk:

Dodging Bullets, Enjoying Life More,

and “living by the seat of your pants with your hair on fire”

A conflict is always a mutual negation. It can never be solved in the domain where it takes place if the disputants are “certain.” A conflict can go away only if we move to another domain where coexistence takes place. This arises through a novel experience brought forth through reasoning, through the encounter with a stranger, or, more directly through the expression of a biological interpersonal congruence that lets us see the other person and open up for him room for existence beside us. This act is called love, or, if we prefer a milder expression, the acceptance of the other person beside us in our daily living....we have only the world that we bring forth with others, and only love helps us bring it forth. (Maturana & Varela, 1992, p. 246, 248)

When Cecile initiated contact with the Family Nursing Unit, she and her family had already been living with ischemic heart disease for twelve years. Her husband, Mark, had his first heart attack in 1983 when he was only 40 years old. Their three children ranged in age from about 13 to 19 years at that time. The experiences of this family and the clinical work with them reveal some of the ways in which cardiac illness may cause suffering for family members other than the person experiencing heart disease, even after living alongside the illness for many years. Differing beliefs about the prognosis in the future and about the ability to influence the illness were beliefs at the heart of matter (Wright et al., 1996). The experiences of this family also uncover many effects of the ever-present demand for lifestyle modification on family relationships.

Mark was a 51 year old man who owned and operated a very successful manufacturing business. His wife, Cecile (aged 49) had occasionally been involved in the business over the years, but had committed her energies to raising three children and maintaining a large home. Their daughters, Cheryl (aged 31) and Josie (aged 30), had both attended university, were employed, and were busy establishing homes of their own. Cheryl and her husband recently married and had a child, and Josie had a common-law partner. Both were very physically active and health conscious. Mark said that Cheryl had “muscles on her muscles”. Their son, Jonathan (aged 25), had spent several years as a
professional athlete, and was currently a university student planning to study medicine. He had a strong sense of discipline regarding diet, exercise, and lifestyle through his active interest in athletics.

Mark had a very strong family history of heart disease. A maternal uncle died of a heart attack at age 32. When Mark was 28, lipid studies showed that he had a hereditary form of hypercholesterolemia. His mother had cardiac bypass surgery in 1983, from which she had recovered uneventfully and was managing well more than a decade later. Mark had a heart attack in 1983, and he believed that it was inevitable that he would need heart surgery. He eventually did have triple bypass surgery in 1992. During the three years preceding his heart surgery, his symptoms of deteriorating health had become increasingly noticeable: fatigue, shortness of breath, poor tolerance for walking, and frequent angina pains in his arms.

At the time of his bypass surgery, he was told that he was not an ideal candidate for the surgery due to pre-existing damage to his heart from the heart attack. He was told he had a 10% risk of not surviving the surgery. Two months following the surgery, Mark thought he felt better, but a follow-up angiogram showed that the vascularization of his heart was not improved compared to pre-operative tests. Following two failed exercise stress tests over the next two years, an angioplasty was done with good results. Mark returned to a full and active role in his business life.

From Cecile’s perspective, the angioplasty was an example of Mark being able to “dodge another bullet”. Ever since the hypercholesterolemia was diagnosed, Cecile had read extensively about diet and heart disease. She was determined to exert as much influence as possible over the illness by incorporating changes to the family diet. She lived her own life as an example of healthy diet and exercise, and their children had learned these lessons masterfully. Although Mark had been feeling very well in recent years, she described his lifestyle as “excess in everything except exercise”. She was concerned that
his lack of attention to exercise, eating, smoking, and alcohol consumption would contribute to future health problems. She was also troubled by the demands of his busy work commitments on his health.

A couple of months before coming to the FNU, Cecile had accompanied Mark to the airport for his departure on a two week business trip to Europe. Cecile suspected that Mark had been smoking covertly outside the home for some time, but he consistently denied that he had resumed this habit. At the airport, he went to the duty-free shop and bought two cartons of cigarettes. Cecile confronted him, and he replied that he had bought the cigarettes as gifts for business contacts and relatives during his trip. She did not believe him. Cecile was shaken by this open effrontery. She sat down as she was overwhelmed by utter disbelief that Mark would play with this loaded gun. She despaired for her husband’s future.

A week later, Cecile responded to an advertisement in a city newspaper for the research project at the FNU. The ad offered a series of four sessions to assist families to address any issues that the family was experiencing as a result of living with heart disease. Cecile knew of another family who had attended family sessions when the mother was dying with liver cancer, and who had found the sessions to be very helpful. Cecile’s family was seen for a total of five sessions over the following ten months. Cecile came alone to the first session; the couple came with the son, Jonathan to the second session; Mark came with Jonathan and younger daughter, Josie, to the third session; Mark came to the fourth session; and the couple came to the fifth and final session.

**Session 1**

The presenting problem which had been identified by Cecile on the referral form was that Mark “doesn’t take [the] illness seriously and family [members] are very worried about it”. Hypotheses discussed during the presession were based on two articles selected from current cardiac literature (Bises, 1990; Miller, Wikoff, McMahon, Garrett, & Ringel,
1990). The clinical team wondered whether Mark might be carrying on with home life and business as usual, while Cecile might be worrying about a recurrent heart attack and lobbying for lifestyle changes. The team was curious whether the couple agreed or disagreed about sharing responsibility for lifestyle changes. They hypothesized that Cecile might be taking on a lot of responsibility for lifestyle changes, and might believe that lifestyle changes would prevent another heart attack. If Mark believed that another heart attack was inevitable, and that changing lifestyle would not affect the long term outcome, he might be less likely to accept responsibility for lifestyle changes. As the team discovered through the clinical work, these possibilities were connected to the family beliefs at the heart of their concerns.

The Worry Club

Cecile came alone to the first session. She became teary within minutes of the early conversation with the nurse. When the nurse inquired about the cognition behind this affective arousal, Cecile commented that the whole situation about her "husband's health and the way he doesn't look after himself" seemed so hopeless. Cecile explained that her husband's health was causing the most stress in her own life at present. She described her concern for her husband's lifestyle of excesses, and revealed her worry that her husband would die prematurely.

Cecile explained that Mark was optimistic about the future, did not seem to worry about making lifestyle changes, and believed that he could control his health. She believed that all three of their adult children shared the worry that Mark did not take care of himself, that he should change his lifestyle, and that he would die prematurely if he did not attend to his risk factors more responsibly. Cecile thought that their son, Jonathan, probably worried the most, and showed his worry through anger and frustration with his father. The nurse was intrigued by the way that all of the family except the father had united in their worry.

LMW: So is Mark aware that you all, the family members have this "worry club" going? If I could call it that?
Cecile: Yes, yes he is. Yes he can’t miss.
LMW: And Jonathan’s sort of president it sounds like, of the worry club, is he? That he’s the best worryer in the family? Your husband is aware that everybody’s worrying their hearts out?
Cecile: Very much so. He can’t miss it.

The language of the “worry club” was a useful metaphor in talking about the influence of worry within the family. Part of Cecile’s frustration was that Mark knew of everyone’s concern for him, but he still had not been motivated to change.

LMW: You’re saying that you’re not totally sure, but you think that he perhaps is not worrying. And that the big worry for all family members, it seems, that if father doesn’t quotes ‘look after’ himself, that he will kill himself in other words. Because you believe that the thing that would influence the risk of further heart problems the most is that he change his lifestyle? Is that what you’re thinking like?
Cecile: Oh, I, I think it would prolong his life.

With the exception of Mark, it seemed that all family members shared the belief that lifestyle changes would prolong Mark’s life and prevent his premature death.

Meanings Behind Beliefs - Why Won’t He Take Responsibility for His Own Health?

As the nature of the worries about father’s health became clearer, the nurse became curious about the meanings behind the beliefs which might be contributing to the suffering of family members. The belief that lifestyle changes would prolong father’s life, and that father might die a premature death encouraged family members to commit significant effort to conveying their concern and desire for lifestyle changes to Mark. However, this had not helped him to develop the kind of lifestyle changes they hoped for him.

LMW: Now if Mark continues along this path and doesn’t change his lifestyle, I’m going to ask you a really tough question now. If he didn’t change his lifestyle, and he went along this path,... and the worst [thing] that you’re worrying about happened, that he died. Would you feel that...you should have taken even more responsibility, done something differently? Or would you feel at this point, no, I gave it my best shot to try and help Mark change it? Like how much responsibility would you take in that situation Cecile, or how much do you think that Mark should have assumed, if the worst happened?
Cecile: I believe that myself and our children have done everything we can.
LMW: ... What do you anticipate the children would then say to you? Would they say, “Mom, we should have tried harder” or would they say “No Mom, that was his responsibility, he should have done more’?”
Cecile: They would have thought we gave it our best shot.
It was understandable that the worry that Mark might die prematurely could be painful in itself, but the nurse wondered whether other ideas about his death might also contribute to suffering. The nurse explored what Mark's death might mean to this family. In the transcript above, she explored the hypothesis that when father died, family members might blame themselves for not having tried hard enough to help him. Another possibility could be that family members might be angry with Mark after he died for not trying harder to take care of himself and to live longer.

LMW: Because what does it mean to you that he doesn’t take more responsibility for his health? What, what message is he giving you?

Cecile: (pause) That he doesn’t care enough? About himself or his family to want to stay with us?

LMW: I see. So if he cared more for you, he'd want to be around you longer, therefore he'd look after himself?

Cecile: Yes

LMW: Okay. And so, you think this is a bit of a selfish thing then, that he’s doing, that he’s only thinking of himself in the situation? That he’s not caring about, you folks think he’s not caring for himself either?

Cecile: Both. He definitely doesn’t care about himself. But as far as, I can’t really call him selfish, I don’t think he’s doing it with selfish motives, no. I don’t think he thinks that much of it to tell you the truth.

It was hurtful to Cecile that Mark’s lack of caring for himself might mean that he did not care about the family, and did not care about how much life or time he had to spend with his family. Even if Mark did not intend to convey this message, his lack of action on the concerns of others was interpreted by other family members as lack of caring.

Cecile had reached a point where she thought she had done everything she possibly could, but she was still wanting to find out whether there was anything else they could be doing. She said that one question that hoped might be answered in the clinical work at the FNU was “How do you get someone to look after themself healthwise?” She accepted an invitation to observe a reflecting team conversation from behind the one way mirror.

The Reflecting Team - Backing off from Showing Worry

The reflecting team commended Cecile for being such a responsible woman and a responsible wife who really wanted to do the right thing for her husband. They noticed that
while she was unhappy with her husband's lifestyle excesses, she was not furious with him, but rather seemed to show caring for him through her worry. The team commented on the worry about Mark's premature death, and the disappointment in the belief that if Mark cared more for the family, he would commit to lifestyle changes and want to be around them longer. The team wondered about whether there was an inadvertent power struggle occurring in which father might be reacting to others' efforts to control or influence his behavior. They wondered whether father might do something differently if he was given all the power and responsibility back to influence the illness.

A faculty member offered a description of a study (Hoebel, 1976) which intervened with wives of men who were having difficulty complying with lifestyle changes recommended by their physicians. As he worked with these women, the researcher noticed that they were all terrific naggers. Instead of helping the wives to encourage and support their husbands more effectively, the researcher worked with the women to reduce nagging behaviors. The study found that the husbands were even more successful in shifting toward adopting the recommended lifestyle changes. The team offered the suggestion that Cecile might try to back off showing her worry.

LMW: And that's why I'm wondering, if Cecile when she says "How do you get someone to look after themselves healthwise?", I'm wondering, if she backed off, if she could back off. Although I'm not saying not to worry, but if she backed off showing her worry.

Faculty: Ahhhh! There's an interesting distinction.

LMW: Not that she doesn't have to worry, she can have her own private worry, but not to make it known to Mark. Would it make any difference? I don't know, I think she'd have to experiment with that cause it might not make any difference at all. But on the other hand, it might. Maybe she could observe to see if it makes any difference.

The idea was offered as a tentative possibility: how might Cecile experiment with backing off showing her worry? They invited Cecile to trust that she would best know what nuances of her own behavior she might change to shift her usual reaction and to catch her husband's attention.
Responses to Reflecting Team - I'm a Nagger

Even as Cecile was walking back into the interview room, she began responding to the team's discussion: she immediately confessed to nagging!

Cecile: I'm a nagger, but I try to control it.
LMW: You're a nagger. But you try to control it. Okay.
Cecile: Where does nagging stop and suggesting or caring start? I mean, it annoys me. I don't like naggers. I don't want to be a nagger.

Prior to the reflecting team, the conversation had not connected the experience of worrying to nagging. The notion of nagging fit for Cecile. She raised the cutting edge of nagging so succinctly: where does nagging stop and suggesting or caring start? The reverse of this question could be similarly troublesome: where does caring stop and nagging start? Cecile was interested in the idea of taking a step back from showing worry, following up on some ideas she had already tried, and watching her own and her husband's behaviors to notice if there were any differences.

The second idea that had perturbed Cecile was that worrying was part of a power struggle. She believed that both she and her husband were powerful personalities, and neither liked to give up easily. She wondered about the ways that trying to influence Mark's behavior might be controlling the rest of the family by giving them less time to pursue other interests.

At the conclusion of the session, the nurse invited Cecile to consider whether she might bring other family members to a second session during an externship program which the nursing faculty were teaching a few weeks later. A group of health care professionals from all over North America and Japan would be attending a week long seminar. A live family session was usually conducted during the externship to illustrate the clinical work conducted at the FNU. Although 40 people would be observing the session by video television linkages, the family's experience of the session would be similar to what Cecile had already experienced. Cecile agreed to participate in the externship, and hoped that the rest of the family would be able to attend the next session.
Session 2

The second meeting with the family was three weeks later. The presession extensively reviewed the family information and brief videotape segments from the first session to introduce the family to the participants of the externship program. Although neither of the daughters were able to attend, the clinical team was excited to hear that Cecile, Mark, and Jonathan were present to participate in the session.

Engagement - The Wife Who Does Not Take Advice from her Husband

Cecile offered that she had attempted the experiment proposed at the end of the first session. Without explaining any details, she indicated that it had not seemed to matter what approach she took. The nurse invited the family to briefly tell about the exciting news of the eldest daughter’s recent wedding. She also inquired about Cecile’s recent efforts to reconcile a longstanding dispute with her own parents over the time period of the wedding celebrations. The reconciliation was not as successful as Cecile had hoped, but Mark commented that he was proud that Cecile had stood up to her family. He would have preferred that she had taken action to attempt a reconciliation sooner, as she had not been speaking with her family over the past two or three years.

The nurse anticipated that conversations about father’s health and his lack of effort in the creation of lifestyle changes were going to be a significant focus of much of the session. She noticed subtle parallels between the peripheral topic of Cecile’s dispute with her own family, and the dilemmas facing the family around father’s lifestyle changes. Mark had different ideas about what could or should have happened so that Cecile might have reconciled sooner with her parents. The nurse introduced a conversation with Mark about the dilemmas of offering suggestions and encouragement to his wife!

LMW: So when your wife doesn’t follow your suggestions, then what happens? Do you just let it be, or do you wait a while and let’s try again or, what happens in your family?....Cause it’s curious isn’t it, sometimes, we usually keep going back to people and giving more advice when we’re fairly convinced that we’re right about this particular idea, eh? We’re really kind of in love with our idea, but we want to offer it, and so we keep going back and saying, “I think it
would be a good idea. Don’t you think you should call?” So I’m just curious whether you’ve tried that over a number of times, and she didn’t listen to you, then what do you do?

Mark said that he would perhaps try offering the suggestion again at another time.

Sometimes he would get upset at the moment, but he did not think that he carried a grudge.

The nurse asked Cecile whether she preferred Mark to continue coming back from time to time to suggest ideas, or whether she thought he should just give it up. Cecile replied that she appreciated his input and interest, and that she knew he was making the comments for her own benefit. After this extensive exploration of suggestions around Cecile’s family dispute, the nurse finally approached the topic of offering suggestions to Mark about lifestyle practices. The nurse asked Cecile about her own experience of offering suggestions to Mark.

LMW: Okay, now what about, what about the other way? Are there things that are there a lot of the time that you try to make suggestions to your husband about?
Cecile: Most definitely.
LMW: Most definitely! And what is that Cecile?
Cecile: How he treats his personal health.
LMW: How he treats his personal health?
Cecile: Or he doesn’t treat it.
LMW: Or he doesn’t treat it. Okay. So that was one of the things that we talked about, I’m sure, your wife told you last time. And we want to explore that.

The nurse finally approached the topic that everyone had known was going to be discussed, but she prepared for this discussion by demonstrating how understandable it was that sometimes it is difficult both to offer and accept suggestions from other people. The nurse’s pacing and patience in approaching this topic may also have heightened the family’s curiosity about what was going to happen in the session.

The nurse kept the family in suspense even a little longer. She asked Cecile what she had thought about the first session. Cecile said that she had thought a lot about “the worry club”, and that she thought it should be dissolved or eliminated. She thought that worry took up time for all family members that could be spent more productively. The nurse asked for Mark and Jonathan’s opinions about who was worrying the most, and how
worry influenced other family members. Jonathan agreed that the worry club should be disbanded, and that Mark should take the responsibility for it himself to relieve the rest of the family from worry.

Finally, they reached the topic of Mark’s lack of willingness to take responsibility for lifestyle changes. The nurse remained attentive to engagement issues which might influence Mark’s participation in the session, and she sought his permission to discuss this issue.

LMW: Well this is really the thing, I guess, that brought your wife here, wasn’t it? And, is it okay if we move into this area now?
Mark: I guess we are.
LMW: I guess we are aren’t we, drifting into it. So, let’s talk about that if that’s okay for a few minutes eh?
Mark: Sure.
LMW: I’d really love to get your perceptions cause I was able to talk to Cecile, so if you don’t mind (to Cecile), I’m going to ask them some questions for a while Cecile, just about all this. Cause I got Cecile’s perceptions on it last time, and I’d be real curious to get yours.

The conversation shifted from what could have been a debate about who might be right or wrong about the need for lifestyle changes, to a discussion of perceptions, perspectives, or points of view which might be different, but each of which had merit.

**Enjoying Life More Versus Enjoying More Life**

The nurse asked Mark about his past and present experiences with heart disease. Mark was feeling much better since his bypass surgery three years previously. He was having no episodes of angina and had resumed his previous level of activity and work commitments. He described his early efforts to change his eating habits as efforts to regiment and discipline himself and his bad habits. The efforts were stronger at the time of his first heart attack and his heart surgery when he had a “real scare”. He described his embarrassment at not having the willpower to sustain efforts not to smoke, and to be more concerned about his diet, exercise and weight.

The nurse asked whether or not Mark believed that these efforts would make a difference for his heart condition. Although Mark believed that the research suggested
statistically that lifestyle changes influence heart disease, he was less convinced that this was necessarily true for himself. He believed that he had been successful at reducing his stress at both the office and at home, and that this was a significant accomplishment. Mark thought that this would reduce the possibility of further heart disease, but he was unsure how much the impact might be. The nurse persisted in exploring this success, inquiring about how he and other family members accounted for this accomplishment. Her questions reflected her curiosity about what change in his thinking was necessary for him to do this, what he had learned to do differently, and whether other family members thought that this was a significant accomplishment. Although both Cecile and Jonathan agreed that Mark had indeed reduced his stress, Jonathan was less able to give his father credit for this success.

LMW: How do you think he was able to change his thinking?
Jonathan: I think he just wants to enjoy life more.

LMW: I see. So you think that was the change in his thinking?
Jonathan: He went through his surgery, and he was scared big time before. And I don’t blame him. I don’t blame him one bit. And then he came out and he felt better, and I just think he wants to enjoy life, and not be bitter or be uptight. And he has realized through running my parents’ business that he can’t deal with everything.

Jonathan may have believed that if he gave his father more credit for reducing cardiac risk through better stress management, that his father would commit even less effort to other lifestyle changes. A clash of beliefs between father and son began to become more understandable. Mark may have been able to reduce stress out of his efforts to enjoy life more after his life threatening episodes of a heart attack and heart surgery. Jonathan and other family members had become frustrated with Mark because they really wanted him to enjoy more life.

**Nagging and Nasty Confrontations**

The conversation helped the clinical team to understand the ways in which worry and nagging influenced the relationship between father and the 25 year old son. Jonathan suggested that worry had not decreased, but that he was learning how to handle worry better.
Jonathan: Maybe a year ago or two years ago before that, I'd always say to my Dad, I'd 
bitch at him, say "Dad, you got to do this. You can't eat that. Don't have this. 
You're overweight. You can't do that! What are you doing?" And if people kept 
saying that to me I'd probably get pissed as well. And he'd bite back at me. Deep down, I know, he knows I'm not out to get him, but at the time he feels like I'm out to get him, and it is, I just care about him. I want him to be around forever.

LMW: Okay. So how have you been able to hold back on your nagging or bitching at him like you were saying?
Jonathan: I believe a lot in self-help. And you have to help yourself, and I see my Mom try, and my Dad gets bitter at my Mom for trying. [It] may come across as her just griping, but it's just that she truly cares about him. But a lot of times it might not come across as all sweet and everything? Cause it can't be.

Jonathan's efforts to support his father were initiated out of caring and concern. When his suggestions were unheeded by his father, anger and resentment accompanied worry and crept into their relationship. Encouraging and supporting increasingly felt like nagging and bitching, and led to nasty confrontations and disagreements between father and son.

Jonathan said that he and his father "had major, major fights" mostly about lifestyle.

Jonathan appreciated what it might be like for his father to be the recipient of nagging and bitching. For both father and son it may have felt like caring stopped when nagging started.

Unheeded and unappreciated advice was getting in the way of their relationship.

The Helpfulness of Nagging

Mark indicated that he did not want his family members to worry so much that it was hurting them. But, he suggested that as much as these reminders were sometimes annoying, he also experienced the nagging as helpful!

Mark: I mentioned earlier that I didn't want them worrying as you just said. But, by them mentioning these things to me, they do help. They do help, to me.
Jonathan: Nagging helps?
(Mark and Jonathan chuckle)
Mark: It does.
LMW: The nagging does help, yes?
Mark: I hate to say that. I hate to hear it, but I think about it then, and fine, and I'm fine for a while, you see. (chuckles) That's tough to admit, but that's the truth (laughs)
LMW: Well that's a bit of a dilemma for them then, isn't it? Because on the one hand, if they nag you, you're saying it reminds you of your weaknesses. But does it really make any difference one way or the other, whether they nag you, don't nag you? In terms of what you do differently?
Mark: Yeah, probably not.
LMW: Probably not, yeah.
Cecile: Short term.

The paradox of nagging was that sometimes it helped. Perhaps it was comforting to Mark to hear that they were concerned. Sometimes it even worked! Sometimes Mark actually followed through on a suggestion. The idea that nagging sometimes did result in desired behaviors might have been reinforcement enough for family members to persist in their efforts. If these desired behaviors never happened in response to nagging, perhaps family members would have given up this strategy.

**Jonathan’s Tribute to Father**

The frustration about the fighting in the relationship and sadness about not having a closer relationship with his father were evident in Jonathan’s description of the influence of worry and nagging. The nurse became curious about Jonathan’s beliefs which might sustain worry, and which might motivate the expressions of encouragement, nagging, and disagreement.

LMW: Well in terms of the situation with your Dad with his health problem, what is your biggest worry?
Jonathan: I just want him to be around forever.
LMW: So your biggest worry is?
Cecile: (softly) Say it, sweetheart, say it (Cecile was teary throughout this conversation)
Jonathan: I just want him to treat himself better. (Jonathan became teary, wiping his eyes, voice cracking.)

(Mark gasped occasionally and wiped away tears)
LMW: Because (long pause)
Jonathan: Because I want him to be around till he’s 70 or 80.
LMW: Sure, so your biggest worry is that he’ll die prematurely is it?
Jonathan: Yeah
LMW: Yes. Well that’s an awful worry isn’t it?
Jonathan: And he’s a great person. And he has a lot to show me still.
LMW: Yes. Well that’s really a tough one.
Jonathan: And I have a lot to learn from him, in terms of business, and getting my career on line and so on. And I don’t want my Mom to be by herself, cause she loves him dearly and she’s been with him since she was 17 and my dad was 19. And it’s like I said, I want him to be around forever.

If this son did not care for his father, his suffering would likely be very different. The father, mother, clinical team, and externship participants witnessed a powerfully moving
tribute of love from the son for the father. Unfortunately this kind of tribute is often
witnessed as a eulogy, after the death of the beloved. Tears were shed not only in the
interview room, but also behind the mirror and in the classroom. The belief that father
might die prematurely was a formidable influence on worry, concern and the relationship
between father and son. The nurse asked Mark what impact his son’s words of love and
concern had on him. Mark replied that he knew of his son’s worry and caring before, but
that he had not appreciated the depth of his son’s caring. He was very proud of his son and
admired his son’s ability to show his feelings.

Differences in Beliefs about Prognosis and the Future

The nurse had begun to more fully appreciate the belief about father’s risk of
premature death as a menacing influence on worry for both Cecile and Jonathan. The
magnitude of the differences in family beliefs about the future was dramatically
demonstrated when the nurse inquired about how long Mark thought he would live. Mark
suggested that, considering his heart disease, he would be pleased to live to age 65 or 70.

LMW: Just let me ask your family, this is very interesting. You have an interesting
belief that you’re going to live for at least another 14 perhaps, 19, 20 years?
Mark: Yes.
LMW: Now. (To Cecile) Do you believe that? Do you think that the prognosis is good?
Would you be pleased if he were around till he’s 65, 70?
Cecile: Of course I would.
LMW: Of course you’d be pleased?
Cecile: I would like more.
LMW: You would like even more?...But let me ask you this, Cecile. If he went on,
didn’t make any other changes right now, smoked sometimes, not sometimes,
drank sometimes, not sometimes, exercise, sometimes not, is that sort of how it
goes?
Cecile: Yes, exactly.
LMW: Okay. Would you agree that his chances would be good that he would live then
till 65, 70? If he didn’t do anything different? If he just were to keep on with,
sometimes he’s got a grip on it sometimes he doesn’t? And he just went on sort
of like that? What do you think?
(Cecile is teary during this, Mark’s eyes swell)
Cecile: Okay. This is where I have a dilemma, because to encourage him, I say, he can
live as long as he wants to. But, inside (softens) I don’t think it’s going to be
very long at all.
LMW: You don’t?
Cecile: No
LMW: How long would that be? Less than 65 to 70?
Cecile: *Definitely!*
LMW: Definitely.

(Mark gasps)

LMW: A year? 5 years?
Cecile: Perhaps, perhaps. *Any day.*
LMW: *Any day? Any day?*
Cecile: Yes, because I can see the, the *changes.* I sleep beside him and listen to *breathing.* I know how sick he is (softly)...And I really hate to *admit* that because I think he’s losing a *support* system by my admitting that? (voice shaky)
LMW: That he’s losing?
Cecile: *My support.*
LMW: *Your support?*
Cecile: Encouragement, *positive* outlook, and I think it shows too much negativity in *admitting* this.
LMW: So you think somehow you could inadvertently influence?
Cecile: I don’t like to *tell* him that he could die any day.

This 51 year old man would be happy to live until age 65 or 70. Cecile’s suffering was magnified by her belief that he could die any day, and that his expectations of the future were unrealistic. In her efforts to encourage Mark, she had supported his positive outlook about the future while privately concealing her own doubts and apprehension. Mark then wondered whether he took all of this too lightly because he currently felt well. He said that if he were having more symptoms, he would “*probably* be a little more scared about *dying* and *do* something”.

**Reflecting Team - Staring Death in the Face**

The family accepted an offer to go behind the one way mirror to observe a reflecting team conversation. Four of the externship participants introduced themselves to the family, and offered commendations for the family’s *respectfulness* for each other and the comments and gestures of love between them which were witnessed in the session. The team commented on the challenge of giving up worry when they cared so much, and the bind of nagging which reminded of weakness but also helped Mark. They wondered about disbanding the worry club and having a family support meeting once a week to offer ideas, suggestions, and expressions of caring and worry.
Another team member offered a different view of what a family meeting might be like. She wondered about the differences in their beliefs about when death might happen, and whether conversations addressing these particular worries might make a difference.

Faculty: Maybe the secret, if there's a secret in this family is this secret of death. That both Jonathan and Mother, are like, death is like right here (puts both hands close in front of her face), up in the face, immediate. And for Father, it looks like it's, you know, way off there in the distance, and the...showing of caring through the nagging and everything has been their attempt to put some distance between them and this thing called death... Maybe it's not so much worry, maybe it's the loss, or the threat of loss. And I'm just wondering, if, what if they were to get on to the business of really talking about the loss...staring death in the face, big time. I mean, this is tough, tough work, this is not anything easy, but I'm wondering what would happen if they were to have a discussion about so what will happen when Dad dies, not if....I don't know, if that would make a difference in terms of relieving some of the suffering about, rather than having to fight against it constantly...stare it in the face! Go with it, and perhaps that might reduce some of the intensity around it.  

The team comments encouraged family members to consider many topics in these meetings, from the impact of Mark's death on the family business to funeral plans.  

Responses to the Reflecting Team.

Cecile and Jonathan were skeptical that family meetings to offer suggestions to Mark would be helpful. However Cecile was interested in the idea about staring death in the face. She commented that the prospect of being alone was very scary, and that preparation of their personal and business affairs might help in this regard. They wondered about whether they might be able to get family members together for some kind of a family meeting on their own over the summer months.

Mark was influenced by the team's comments about this exceptionally caring family. Even more so, he was moved by the affirmation and love expressed by his son.  

Mark: I think it's helpful, like I learned something today from my son.  
LMW: Yes. What did you learn about your son today?  
Mark: Well that he loves me a lot more than I thought he did. That he wants to learn a lot more from myself. I didn't think he was interested (voice cracks). So I'm happy I came today....So I was looking for something, so what did help me today was listening to my son today, which I gained out of this.
The son's tribute to his father was a conversation of "affirmation and affection" which was a sharp contrast to the conversations of "accusations and recriminations" (Wright et al., 1996, p. 115) which had characterized the conflicts between father and son. During the final session with the family, it became clearer that these conversations of love were far from inconsequential in this clinical work.

**Session 3**

The third session occurred in the fall, almost 5 months later. The team had understood that the couple would be attending the session. They were surprised to discover that Mark had arrived for the session with Jonathan and Josie, the youngest daughter.

**Dad is The Problem - The Litany of Complaints**

As the nurse met Josie and re-engaged the family, Mark explained that he and Cecile had a "bit of a spat" the previous night, and that she had refused to drive four or five hours in the car with Mark to attend the session. Although Mark reported that nothing had changed since that session, he reported that Cecile had become less controlling in her efforts to influence his health. He explained that in the past, she would remind or nag him about once a day, whereas he now estimated that she would nag him once every three days. Jonathan agreed that nothing had changed, and that his father was "still miss[ing] out on the big picture". Jonathan was sullen and quiet during the session, clearly frustrated with this lack of change. The family meeting had not happened over the summer. Josie and Jonathan were skeptical that this would make a difference.

**Josie:** I think a lot of the problems though are stemming from people wanting to help you to change, people committed to somehow support you whether it be through emotional support, talking to you.... But I think it's just painful for us just to sit down and have 5 people talk about it when the fundamental problem is, Dad you've got to be committed to change to help yourself out....And he's been lucky, because he's had close calls with his health, on many different things, many different occasions, and until he's committed to change, I don't think any meeting at Christmas time to help Mom have a better understanding of what's going to happen, financially or whatever if something happens to my father.
This conversation located the problem exclusively in the realm of father’s behavior. It was his problem. He was the problem. His inability to commit to change was the problem. The litany of complaints was elaborated with Mark’s own non-defensive participation: he had gained twenty pounds over the past eighteen months; he was a closet smoker; he was walking irregularly; he did not look well; he always looked tired and had not been getting enough rest; he said that he felt well, but he was worried about going for a follow-up appointment with the doctor. Mark was embarrassed about his lack of effort. Throughout this conversation, although both children offered criticisms of Mark, he listened patiently. As Jonathan had offered a tribute to Mark in the second session, Josie offered another testimonial of love for Mark. Her caring and concern for her father were present throughout this critique: “we’re not giving up on him”; “I want him around for a very long time”. Simultaneously though, their frustration with their father was also palpable.

**Beliefs about Death - Who Will Die First?**

The nurse was curious to learn whether Josie shared the belief that Mark would die prematurely, and to explore other beliefs about what Mark’s death might mean. The nurse asked Josie how she might react if her father had another heart attack or died. Josie tearfully replied that a few years ago she would have felt guilty for not trying to help her father, but now, she thought that she would be angry with her father. She thought that he had a chance to take better care of himself and that he knew what needed to be done, but that he did not respect himself enough to take action. She admitted to losing respect for her father. This conversation explored possible meanings that influenced present relationships. These anticipations of the future are rarely probed easily or by choice in family conversations. It was difficult for Josie to tell her father that she was losing respect for him, and it was difficult for Mark to hear these comments.

The presence of a life-threatening illness in the family can coach anticipations of certainty about death: that the ill person is marked for death, and that the time of death for
the ill person is more known than the time of death for other family members (Bolen 1990). The nurse challenged the fear of Mark’s premature death by doubting that Mark would die first.

LMW: None of us like to think about our parents ever dying. But when we do allow that idea to come to our minds, do you always think it’ll be your father dying first? Do you ever wonder about what your mother might die of or, would she die before your father or?

Josie: (pause) Since I believe my Mom is in better health than my father, (teary and broken voice) I think of something happening to my Dad first. But the thing that I worry about is if my Mom goes, I worry about her just giving up on her marriage and her family, and either just going out and driving and not being aware of what she’s doing, and being in a car accident because she’s carrying a lot of stress around. I don’t believe she is suicidal, don’t get me wrong. But I often think that if she’s going to go it’s going to be something like that. And I’d feel very angry at my father then because I would think that if something like that happened to her, it’s because of the stress and anxiety that she’s carrying around, and carrying the baggage for my Dad. And my Mom’s always been there for everybody in the family.

In addition to Josie’s prediction of anger toward her father in the event of her mother’s death, she also predicted that Mark would cope poorly without Cecile. She speculated that he would start drinking, involve himself totally in his work, and take even less care of himself. Josie would be angry with Mark whether he or Cecile died! Josie had considered the possibility that their mother would die first, but this idea was more stunning to Jonathan. He wondered if his mother would have as much support from Mark if she became terminally ill. It is unclear whether this new idea was perturbing in a helpful way, or whether it invited more worry about mother. Both Mark and Josie were seemingly aligned against their father as they considered this possibility.

Reflecting Team - Shifting Goals

The family accepted an offer to observe a reflecting team conversation, and the nurse invited each family member to ask a question of the team. Josie wondered whether the family needed to get together to discuss the situation, or whether Mark needed some form of an outside program or individual counseling. Mark wanted advice from the team for a pointed question.
Mark: How far out in left field am I?....Why am I taking all this for granted?...Is it just my character, my upbringing, my arrogance, my stubbornness?...my independence?....is it my nature?

Mark was trying to make sense of his own behavior. Jonathan appeared stoic and harsh. His discouragement and frustration were conveyed in his question: “Where do you begin? Plain and simple.”

The team responded to Josie’s question by saying that they thought the problem was a problem for both father and the family. The nurse explained her understanding of the situation by saying that Mark had a problem with procrastination which made very good sense. Because he felt well, he believed that he was going to live a long time. He was optimistic about his future, and he could put off taking responsibility and making the changes desired by his family. The belief of other family members was that the future was grim without these changes. This belief invited them to take more responsibility for repetitive encouragement or nagging because they cared deeply about his future. The nurse explicitly suggested that perhaps the family goals needed to be shifted from “How can we get Dad to commit to lifestyle changes?” to “How could family members turn personal responsibility over to Mark?” How could they do this without feeling guilty or responsible if he still did not change? How could they find other ways to show their caring to Mark? Could they back off without feeling like they were giving up on Mark? What would help the family to challenge the belief that the future was grim without change?

Team members offered Mark the idea that as nurses, they had encountered many people who struggled with lifestyle changes, and that he was not “out in left field”. They suggested that Mark’s pattern was to be regularly irregular in attending to his lifestyle, and that this might be “Mark at his best”. They wondered whether this pattern was better than consistently not doing anything to take care of his health.
Responses to the Reflecting Team

Josie responded to the team’s wonderings about whether all family members might be able to back off and hand responsibility for lifestyle change totally over to Mark with a concern that this solution would not help her mother. She worried that her mother would have difficulty “watching my dad on the slippery slope”. Jonathan suggested that if they all backed off, his father would not do anything and would self-destruct. Jonathan agreed with a team member’s comment that he was very angry with his father.

Jonathan: The support I’ve tried to give to him hasn’t helped. Well I’m not going to give the support, because he’s not trying. But if he tries and he wants to try and he says to everyone “Look I want to try and I want to do well” hey, the gates will open. And we’ll pull him in and we’ll help him, but if he doesn’t want to do it himself and he isn’t going to make an honest effort, then forget it.

This young man desperately wanted to help his father. Perhaps he even felt rejected as he angrily accepted that his father did not want his help. Jonathan specified the terms of his relationship with his father. Their relationship was conditional on the father’s willingness to change.

Mark said that the team’s comments helped him by hearing that he was not abnormal. The team’s comments enabled him to give himself credit for the changes he had been able to create.

Mark: So I guess I’ve changed somewhat, not as well as people would like, or what you read, or what your doctor would say, but I have changed. Maybe I didn’t change a 100%, maybe 20 or 30, in my mind, I have cut out a lot of things.

As at the conclusion of the second session, Mark commented on how helpful it was for him to hear different expressions of the depth of his family’s caring for him, and to understand his family differently. Although the sessions were not changing Mark’s behaviors in the direction that his family desired, he reported another significant change: “Mentally I feel better”. He chose to return by himself for the next session, which he booked for a month later.
The team’s postsession discussion of this decision to return for an individual session was enthusiastic. They wondered how Mark’s willingness to come alone for a session might be an intervention on the family. One team member commented that she did not think that Josie and Jonathan liked the reflecting team comments which had acknowledged and validated their father’s efforts. Others thought that the family wanted the team to “take on” the father, and support their position about lifestyle changes. The team agreed that all of the other family members were very health conscious, and that Mark was expected to live up to extremely high standards. One team member wondered if Mark was in the “wrong” family. Was that grating tension part of the suffering in this family? Did Mark experience himself as living in the wrong family?

**Session 4**

Mark attended the next session alone. He continued to notice that Cecile was backing off, and that she was not as demanding or domineering about reminders or nagging. The nurse asked how Mark thought his family might understand his willingness to attend a session individually.

Mark: Well they’re probably saying “At least I think he cares. He wants to do something about it, or understand the situation.” I would assume that. I’m sure that’s what they’re thinking. So it’s maybe a plus that at least Dad is showing, or I am showing that I’m interested at least to better communicate, better understand. Possibly “He may do something” about my physical condition.

Mark thought that this effort might convey to his family that he cared about the situation, but he remained fully aware of his family’s hopes that this clinical work might somehow change his efforts to improve his lifestyle.

**I Believe in Fate**

The nurse revisited the topic of the family’s differing beliefs about prognosis to explore a private conversation with Mark about his own thoughts on this dilemma.

LMW: Well, it seems that at least from what we learned here, that your children and your wife, the reason they’re on your case so much is that they have a different belief about you, about your future, don’t they?

Mark: Yes they do, there’s no question yeah.
That they’re concerned if you don’t do these things you’re going to die prematurely.

They’re thinking I’m taking my condition way too lightly. And I probably am. I’m not fully convinced. Cause I think I believe that I’ve got to be happy with myself. Whether life is short or long, to me, it’s irrelevant. I better enjoy life every day, okay? And I enjoy life, I really do!

In the second session, Jonathan had explained an understanding of his father which was affirmed here: his father would prefer to enjoy life more than to enjoy more life. This explanation became even more coherent when Mark explained his belief in fate.

If you were to believe that you would die prematurely if you don’t do these things, would it make any difference? Would you lose weight more quickly, or not. Or would you exercise more or not?

I don’t know, I probably wouldn’t... I think it would be as tough as ever, cause I look at it, I guess I believe a little bit in fate?

Ah do you?

I really do. I think that there’s a number there somewhere. You see, because I have some friends of mine, a doctor for an example, like a personal friend. Fifty-three years old, perfect physical condition. Died of a heart attack! While he’s pumping iron, that’s an example.

A belief in fate may have been reinforced by knowing others who had devoted themselves to healthy lifestyle, and died prematurely in spite of these efforts. Mark explained that investigations at the lipid clinic had demonstrated that his cholesterol level was unaffected by changes in his diet because of the way that his body produced and metabolized cholesterol. Mark questioned whether efforts to change his lifestyle would have any influence whatsoever on how long he lived. He accepted in a different way than the rest of his family that there may be limits to one’s ability to control or influence illness.

Mark also understood in a different manner that there might be limits to one’s ability to forestall death. He consistently spoke of the possibility of his own premature death without affective arousal, in a very practical and accepting manner.

I would like to please them, but I guess not enough. I’m sitting here saying, “Well I guess I’m kind of winning now, they’re easing off.” Bad attitude but it’s probably what I’m thinking. Right? At least they’re easing off Dad here, okay? Right or wrong?

I think it is good that they’re easing off regardless of what you do, because it was causing conflict between you folks. Because they are so concerned that you might die prematurely.

Oh sure it was. And I may well.
And you might, eh? They might be right, Mark, eh?
Mark: Oh sure
LMW: They might be right, if you don’t do these things. On the other hand, you might be right. That despite what you do, you might live another, who knows how many years.

Mark accepted that his family might be right about the possibility of his premature death.

Throughout this conversation, the nurse was exquisitely nonjudgmental. She made no attempt to predict who was “right”, nor to take sides with either the family’s stance or Mark’s stance. There was no effort made to prognosticate or predict whether death would come prematurely. She did not in any way imply that she agreed or disagreed with his belief in fate, or with Mark’s choices about his lifestyle. She did acknowledge the many ways that Mark’s explanations of his experiences helped her to understand him. Neither Mark nor the nurse were kidding themselves: Mark might die prematurely.

Reflecting Team - Is Tempting Fate Irresponsible?

As in the previous session, Mark again requested an opinion and advice from the nurses during the reflecting team: “Do you think I’m abnormal? Because I don’t know.” As the team responded to his question, they described one of the research articles which had been reviewed by the clinical team during the presession (McSweeney, 1993). The study identified factors that participants believed contributed to their ability to initiate and maintain behavior changes after a heart attack. The review of the literature had examined barriers to behavior change and suggested that sustained behavior changes were difficult for up to 80% of people even after participating in a self-help group or cardiac rehabilitation program. The team offered the idea that many other people experience the same struggle with lifestyle changes that Mark was encountering.

The nurse asked the team for their professional opinions about Mark’s future if he continued not to make changes. One team member offered that not making more lifestyle changes was “tempting fate” more than if he did make more lifestyle changes. They agreed that he was increasing his risk by tempting fate, and that one would have to be able to say
that they could live with the increased risk. The nurse then asked the team members whether they believed that it was irresponsible for Mark to tempt fate in this manner. They responded that irresponsible seemed to be too harsh a description.

LMW: He’s tempting fate because the risk is higher, by not doing some of the things he’s doing. But he may, he may get away with it. He may get away with it...And he may not. But that’s fate, eh, you don’t know.

Student 1: It’s a gamble right?
Student 2: But it’s not being irresponsible.
LMW: It’s not being irresponsible. I don’t think it’s being irresponsible. Do you think it’s being irresponsible?
Student 3: I think, as you said, I think his children think it’s irresponsible.
Student 1: But they would probably think that all of our lifestyles are irresponsible too, because (laughter)
LMW: Yes, I’m sure if they learned how the rest of us lived behind the mirror here, and what we’ve eaten today, and those kinds of things, they would, yes, they would probably.

How could these nurses be so forgiving about Mark’s lack of attention to lifestyle changes?
How can Mark’s behavior seem reasonable and understandable to these nurses?

These nurses may have encountered people in their own clinical work who had struggled with making lifestyle changes around a variety of health problems. For this family, lifestyle changes represented a possibility which may prevent premature death. The nurses appreciated the difficulties of making lifestyle changes, for people experiencing illnesses and for themselves. The clinical team had a ritual of partaking in sustenance together at some point on each clinical day. Sometimes, team members brought simple, health-conscious, nutritious snacks. On other occasions, the food was calorie or cholesterol laden. Team members may have been guiltily reflecting on their own eating practices on this particular day, and wondering whether Mark’s family members would also view these practices as irresponsible. If knowledge was all that was needed to live healthy lifestyles, how could it be that nurses, doctors, and other health care providers might be overweight, eat fatty foods, smoke cigarettes, be burdened by stress, or unable to obtain sufficient exercise?
Responses to the Reflecting Team

Mark was relieved by the team’s comments that they did not believe him to be irresponsible. He noticed the research statistic cited by the team which suggested that sustained lifestyle changes were difficult for 80% of people following a cardiac event. This idea was comforting and helped to challenge the idea that he was somehow abnormal. He wanted to assure the team that this did not mean that he was going to “ease right off” because of this. He agreed that he was indeed tempting fate, but also that he was happy with his life.

The session concluded with an unexpected and very direct question which Mark asked the nurse. She offered a direct response, and the clinical team phoned in another possible explanation.

Mark: Do you think Cecile by saying that “You’re not looking after yourself and you’re going to die prematurely, and it’s not fair to me being alone”, is she showing concern for me? Probably is. Or is it selfishness?

LMW: Let me tell you what I think it is. I think it is real concern for you. And I think it’s fear on her part about being alone. I would say fear more than selfishness....I think it’s very scary for her, as it is for many women to think about being alone without their spouse.

.... (Phone-in comment from team)

LMW: Another idea that the team has, that she might also have some sadness about that. Because she might have some ideas of how the next few years are going to go for you as a couple, have some dreams and hopes of how she’d like to spend it with you, and gets sad about the fact that maybe you won’t be able to do that if you die prematurely.

Mark: That’s right, so, her hopes and

LMW: Her hopes and dreams could be aborted.

Mark raised a provocative wondering. Although most of the conversation in this session had focused on differences in family beliefs about the influence of lifestyle modifications on Mark’s prognosis in the future, this question was in a different realm. Somehow, he had moved from not only attempting to make sense of his own beliefs about fate and the future, but he was also attempting to make sense of his own beliefs about his relationship with his wife. He knew of her concern for his health, but his question implied a possible belief that her concern was in some way self-motivated, a selfish concern. His direct asking
of the question spoke to his readiness to entertain other possible explanations which could help him to make sense of his wife’s behaviors and their relationship together. He was creating space for the possibility that her perspective and concern was in some way understandable and legitimate. He was reflecting on the circumstances of their coexistence together (Maturana, 1992). The final session uncovered Cecile’s explanations of the ways in which his own manner of existence had been legitimated by family members’ expressions of caring within the clinical work.

Session 5

Cecile and Mark attended the final family session at the FNU three months later. It was anticipated that this would likely be the final session with the family. This was the first session in which the couple was seen together without adult children present.

**Stepping Back in Love**

As Cecile had not attended a session for almost nine months, the nurse initially spent a few minutes asking her about what she was doing for herself these days. Cecile commented that she had a lot of time on her hands over the winter. The nurse asked whether she thought about her husband’s condition more or less as she had this time on her hands. Cecile said that the “step back approach” had been really helpful to think less about these worries.

LMW: Tell me more, I’m real curious, how were you able to do that and? How did you accomplish that?
Cecile: I don’t know, if it’s becoming, I don’t like to say it but, less interested?
LMW: Less interested in (pause), how he’s managing it or how?
Cecile: The whole health issue? His health issue?
LMW: So less interested
Cecile: Or is it trying to be less interested, trying to be less controlling, since it didn’t do any good.

....

Cecile: I’m not sure if it’s a change in me, or a change in him? (pause) That you’re on your own buddy. Sink or swim. We’ve shown you how we all feel...And this is yours, and actually, I think he’s realized it.

The nurse asked what she thought the outcome of this had been for herself and Mark.

Cecile said that things were more relaxing at home, that she had more peace of mind, and
that her sense of humor had grown. She said that she thought that Mark seemed really happy.

The nurse also asked Cecile whether she was as concerned about Mark dying prematurely from the heart disease. Cecile said that at the beginning of the sessions, that worry was overwhelming, and occupied her 75 to 80% of her thoughts. Although this was still a big concern, she estimated that this was reduced to about 50%, because of the change in Mark’s outlook and her own ability to be less pessimistic about the future. She continued to worry about the future impact of the demanding family business on Mark’s health. She worried that Mark’s health would not be able to withstand the financial and business stresses if there were another drastic downturn in economy in the future. However, she had decided that this 50% worry was something that was manageable and “part of the lifestyle that I ask for and enjoy”.

Mark had noticed Cecile’s efforts to step back. He said that Cecile had eased off on her reminders, that instead of reminding ten times a day, she might now say something once or twice a day. He thought that his own attitude was better because of this, and that he was friendlier as a result. Mark described feeling less stressed by nagging and more contented. Mark offered that he believed that Cecile still cared about him, but that she probably understood that he was going to “do his own thing”. He believed that the children were also backing off.

Cecile: I think that’s what these sessions have brought to Mark is how much we do care. And before when we’d ignore the situation...we were giving him the cold shoulder. We didn’t care, it was this attitude that he took on, “Nobody cares about me because they got on my case?” And I think that through these sessions, it’s just not so.

Mark: They probably, I’m sure they’re still on my case, they just don’t say anything to make things worse I guess.

Cecile: But we’re not being quiet for spite or punishment.

Mark: No it’s less said now. They still say “No it’s not good for you”, but they say it now once a week instead of once a day, once a month instead of once a week.

Cecile may have been freer to step back from reminding and nagging when she believed that Mark really did know how much the whole family cared about him. It may have been
safer to back off when she could be more convinced that lack of encouraging, reminding repetitively or nagging would not be misconstrued by Mark as lack of caring. Perhaps a new shared belief was that nagging did not mean that there was no caring, and that nagging was not the only way to show caring.

The nurse persisted with this conversation about the changes the family had noticed, distinguishing, amplifying and embellishing these descriptions of change (Wright et al., 1996). She carefully and repeatedly gave credit to the family for their efforts and successes as ideas about the impact on the entire family were discussed.

Mark: I never thought my kids cared that much. So I think they were very helpful to me because I think our family is a little more open, and we communicate a little better now than we ever have had before these sessions....You know, I think, anyways, we say what we think lately.

LMW: (To Cecile) What's your perception?

Cecile: I see it as the four of us, leaving Mark on the outside before? It was the four of us against him? We always communicated, the children and I. It's been an open line there....ever since they were born, in every aspect. He was absent a lot of the time, and I think he felt like an outsider much of the time. And when he didn't do things according to the rest of the family's wishes, the four of us, he felt like he was fighting a losing battle, he was alone?

Even though the family's wishes were intended to keep father with them, to prolong his life, to sustain their connection to their father, somehow the loving intent had been derailed.

Cecile's determination to encourage her family to live a healthy lifestyle by her own example was a success for all family members except Mark. Cecile wisely sensed the ways in which this desire to influence father's lifestyle inadvertently over time had become misconstrued as punitive. The more desperate and coercive the efforts of family members' became, the more Mark experienced their condemnation for what he perceived as his weaknesses. Cecile understood the ways that this experience as an outsider had become a constant battle. Her example of stepping back from reminding and nagging may have been an invitation for other family members also to step back. She could do this in a different manner knowing that Mark knew that they loved him.

Mark: So it's something that maybe I took for granted. Maybe it's something I didn't realize that the children are a lot closer to their parents than we think they are. At
least ours are, and I really saw that emotion. Maybe it was always there but I was blind to it for 20 years at home? And I saw it kind of here.

A previous postsession conversation of the clinical team had wondered about the idea of Mark being in the wrong family. Perhaps it was these expressions of caring by family members' persuasively convinced Mark that they did not want to exclude him, and that they wanted him back in this family.

The session concluded with a conversation about their clinical work together: the family's experiences of the session; their ideas about what was most useful to them; their advice to the nurse regarding suggestions for working with other families in the future; and the nurses' sharing of her learnings from the family.

The postsession discussion revealed the nurse's beliefs about the powerful influence of caring and love on illness and healing. The team discussed the impact of Mark's realization of the depth of his family's caring for him, and wondered whether this would invite him to commit effort to other lifestyle changes in the future.

LMW: Yes, but he'd have more of a reason to embrace life then, eh? If you really believe that people care for you, then there's more of a reason to try to be around longer. But he also has this very powerful belief that he's going to live! That this is not a big worry, I mean he's been saying that to us. I mean it became the clearest when I saw him individually. He really believes in fate. That if it's your time, fine, and it's not, and I'm going to live... You saw me asking him today about being optimistic and he still is. But I think there's that other important twist to it all now, eh? Yes, he's optimistic, and he believes in fate, but he also believes that his family cares for him more than he realized.... The thing that you'll read about that I've come to believe so strongly, that if we could see what's happened to his cells with all of this, eh? If you really believe that somebody else cares for you and loves you, it does something to your cells.... My influence by Maturana and other people you can read about, that clearly, that love has a lot to do with healing. So I'm not saying that just as long as you love each other you will cure your heart disease, no. But at least it has a major contributing factor to how well he's going to do and how well he's going to cope.

The bringing forth of love and caring in this clinical work was not only an accidental happening. It was influenced by a powerful belief of the nurse that healing and suffering are influenced by the physiological effects of love.
Another Layer of Reflection - The Research Interviews

The clinical work with this family extended over a period of ten months. At the end of the fifth session, the nurse concluded the clinical work with a ritualized discussion about the clinical work: Did helpful changes happen here? How did the family and the nurse contribute to these changes? What advice would the family offer the nurse? What could the nurse have done differently? What did the nurse learn from the family? Many of the questions about the character of the therapeutic relationship typically addressed in the research interviews were included in the conversation of this final interview. Additionally, a research interview was conducted about one year after the completion of the clinical work with both of the adult children who attended the sessions.

Reciprocal Engagement - The Family-Nurse Relationship

One of the impressive findings in the research interviews with both the family and the nurse who worked with them was that all had a very strong sense of “liking” each other. During the first session, the nurse was accepting of Cecile’s preference to “check out” the FNU alone on behalf of her family. There was a strong possibility in this situation that the father might not have wanted to participate in sessions knowing that his habits, behaviors and weaknesses were likely going to be a significant topic of discussion. This could have presented a very significant obstacle to engagement with the family and to creating a context for change (Wright et al., 1996). The conversations with Mark in the second session could easily have been dominated by complaints about father’s lifestyle and defensive responses and justifications. The nurse skillfully avoided these potential pitfalls, and the family identified many of the particular practices of the nurses which influenced the experience of being comfortable in the sessions.

When asked what the nurse had done that was helpful to them at the time of the sessions, the two adult children commented succinctly about their recollections of the nurses’ practices. These responses reflect not only that the family was well engaged, but
speak to the specific practices which have been described previously in other research
which has explored nursing practices at the FNU (Robinson, 1994a, 1996; Wright et al.,
1996).

Josie: She was very direct with my Dad.
Jonathan: I like how she put him at ease too.
Josie: I like how she dealt with him, and he likes her. Like she asked him some very
direct questions, and she was direct, but she just had this sort of kind of kid
glove approach. So she could be direct but not, not offensive? Or putting
anybody on the defensive?
Jonathan: That’s definitely true.
DT: So you liked that she was direct with your Dad?
Josie: Yeah, she was direct, but not rude. She put him on the spot, but without him
feeling like he was on the spot? Like he had to answer her questions .
DT: And did you think that she put him on the spot enough? Like was it the right
amount? or what needed to be said?
Josie: I think so.
Jonathan: I thought she was great really. She’s direct, but she puts you at ease too where
you don’t, like if she would ask you the question “Were you ever”, let’s say
“done something really bad?” or whatever. And you answer, and she didn’t
look at you like you had 3 heads. You know what I mean? She’s like, okay
Josie: Not judgmental
Jonathan: Not judgmental, she made you open up? Or she, I mean you feel comfortable to
allow yourself to open up. She’d say “Do you have a drinking problem?” and if
you thought you did, you could just sure enough and tell her.

Jonathan: There was equal time to everyone. It wasn’t like focus on my mother or focus
on my father. She went around comfortably, not turning one person off and the
other one on, but kind of just blended across. Her approach was just really
comfortable.

These family members described not only liking the nurse, but also not feeling judged by
the nurse in a way that might have constrained the discussion. They were sensitive to the
possibility that father might have been uncomfortable in the session, and they noticed the
nurse’s way of asking questions which enabled him to answer questions yet to be on the
hot seat in the sessions. The 25 year old son had tearfully opened up and poured his heart
out to his family and 40 externship participants during the second session, and described
himself as comfortable.

Cecile and Mark made similar comments directly to the nurse which suggested that
they also felt comfortable, and that they noticed the manner in which the nurse’s questions
made a difference.
Cecile: I think you put people at so much ease, and before you know it, you have us thinking and talking about things that
Mark: That we normally don't talk about, that's your talent.
Cecile: I'm just amazed at your ability to, to reach in and pull all these feelings

Mark: And you have a tendency, you have a knack for getting certain things out of people that normally would not be said. And it's the way you phrase your questions and so on.

(Session 5)

These comments from the family provides support for a belief that a relational stance which emphasizes engagement, a nonjudgmental attitude toward people and ideas, and the intent to offer questions as invitation to reflections (Robinson, 1996; Wright & Leahey, 1994; Wright et al., 1996) makes an impact on family members. The family members distinctly remembered these aspects of the conversation.

The nurse also commented in the research interview about liking this particular family, and about the ways in which she feels much freer to connect with families when she does not judge them. She explained, for example, that although she had no tolerance for violence, understanding the beliefs connected to episodes of fighting in a family helped to understand and make sense of the family in a way that did not require judgmental labels.

LMW: I've also come to realize there's very few families that I don't like any more, or very few individuals. It's rare compared to 10 years ago, 15 years ago....[with less] judgmentalness about people, when I understand, they can behave in an awful way.... But when I understood his beliefs about it, it made sense to me.

The nurse did not have to agree with their beliefs or choose the same beliefs for herself. However, understanding their beliefs as clues to the ways that their experiences made sense, were coherent and legitimate for them helped her to constrain judgmentalness.

Family Suggestions for the Clinical Work

When Josie and Jonathan were asked what they might suggest could have been done differently, or what would have been helpful to do more, they offered four suggestions. They thought that the sessions might have been more helpful if they were closer together. The five sessions were done over a period of about ten months, with different family members attending each session. They believed that there might have been
more momentum if the frequency of the sessions was increased. The scheduling of the sessions was influenced by the closure of the clinic over the summer months, by the five hour drive from the primary residence of Mark and Cecile to the FNU, and by family preference.

Secondly, while they acknowledged the difficulties of coordinating schedules for the family and the nurse, both Josie and Jonathan thought it would have been helpful to have more sessions with the entire family present. They thought that their eldest sister, Cheryl, who was unable to attend any of the sessions, would have benefited from coming to the FNU. They described Cheryl as very strong, but very burdened by worry for Mark, and less likely to discuss it. They thought it would have been helpful for her to have a chance to participate in these discussions.

Thirdly, Josie and Jonathan would have appreciated more direct advice from the nurse at the end of the session. They wondered whether it would have been helpful for the nurse to summarize three hot tips or silver bullets of advice at the end of the session that would help the family decide what to do.

The fourth suggestion that the young adults made was to continue with the reflecting teams, which they experienced as very helpful. They liked hearing the opinions and suggestions of various team members, but did not equate this with "advice". The language of reflecting teams as wonderings, possibilities, other explanations or curious understandings is intended to be tentative and to avoid instructive advice giving (Andersen, 1991; White, 1995; Wright et al., 1996). A distinction possibly could be that advice leaves the family with more of an impression of what the professional might believe to be the "right" thing to do. The preference of the professional could be a powerful lobby vote in swaying the perspectives of family members. The possible ideas, explanations and solutions offered tentatively by reflecting teams might not help family members to pick particular solutions, though the family suggested that these conversations helped to see,
hear and understand other possible perspectives, and other interpretations of family members’ perspectives. They noticed that when a team member discussed an issue that had been addressed by another family member, hearing the idea from someone else outside the family would help other family members to think about it in a different way.

Expectations of the Clinical Work

In the research interview, both Josie and Jonathan clearly described their hope that the clinical work would finally convince their father to commit to lifestyle changes.

Jonathan: I hoped that my father would see the light and change his ways. That’s probably the biggest thing.

DT: In terms of changing some lifestyle issues?

Jonathan: Lifestyle issues for sure....And I was thinking that this would be like, the savior kind of thing.

Josie agreed with Jonathan and was teary as she described her sadness related to the troublesome belief that persisted: Dad will die prematurely.

DT: And so how much frustration is left in terms of having that hope unfulfilled?....

Josie: Personally, I’ve given up. I was thinking, well we’ll just let him do what he wants to do, and the unfortunate thing is that he will probably die younger than (voice breaks) he should. There’s nothing I can do about that (teary).

These young adults may have come to accept that they might not be able to change their father, and that Mark would have to be responsible for making these changes in his own way, but they still strongly believed that the likelihood of father dying prematurely was greater because of his choices. The disappointment, sadness and frustration was still present.

At the end of the fifth session, the nurse asked Cecile and Mark whether what had happened in the clinical work had met their expectations.

Cecile: Oh, it fulfilled everything that I hoped for and then some. I was at a very low point, desperate to change the pattern of things, because it just seemed like everything was just going right down.

Mark: But the pattern hasn’t really, I mean, just the (muffled) for a moment, okay? You, correct me now, you probably expected me to lose weight, eat less or something, do more exercise, and all this. Which I really haven’t done!

Cecile: No. No. I know this won’t happen overnight.

Mark: Okay. You know what I’m saying?

Cecile: No, I didn’t expect you to.
LMW: So what do you think she’s most pleased about? That’s happened here?
Mark: Well I think she’s most pleased about what she’s learned, that she can’t change other people unless the people are willing to change. I, that’s what I think. And she found that out.
Cecile: Right. I had exhausted all avenues. (Session 5)

Mark responded to Cecile’s comment that her expectations had been surpassed with great surprise. He also believed that the goal of coming to the FNU was to change his behavior and encourage him to change his lifestyle.

Many postsession discussions during the clinical work reflected the nurse’s deliberate efforts to avoid joining family members and other health care providers in lobbying for lifestyle changes. The nurse had not framed “the problem” as how to convince father to commit to lifestyle changes. Her conceptualization of the problem was more related to understanding the ways that the dynamics of the family’s efforts to entice lifestyle changes was contributing to suffering in the family. The nurse understood from the first session that Cecile was hoping to change family relationships as much as she had hopes for Mark to embrace lifestyle changes.

The nurse was clear throughout the clinical work that her emphasis was on alleviating suffering within the family rather than lobbying for lifestyle changes. During the research interview, the nurse explained that at the first session, she had been aware that Cecile was checking out the FNU before inviting other family members to the sessions.
She also understood that Cecile experienced significant suffering as a result of the heart disease.

LMW: We have to be open to this in our practice of not expecting the person who is suffering the illness to have to be there when family members are checking you out...I think if we go with who is experiencing the illness, that sometimes we can miss out on who is suffering the most. So he was experiencing the illness but when I met the whole family, he was not suffering the most in the family if you had to rank order them. I would say it was mother suffering the most. I mean of the people that I met, the son and the daughter were probably somewhat equal of the children I did meet, between the three. And the father was the least, he wasn’t suffering. So I think we have to be very careful that if the person that’s experiencing the illness isn’t here, that...the person who makes the contact nine times out of ten is the person who is suffering the most. And that may or may not be the person who is experiencing the illness.
There can be a difficulty in rank ordering or gauging the depth of the suffering of various family members, because their experiences of suffering may be very different even in relation to the same illness experience. The suffering of the mother and children was related to the belief that father was going to die prematurely through his own negligence and lack of effort. The father may have been suffering in a more sinister and subversive manner. The father’s suffering was more related to the many ways that the expectations for lifestyle changes negated his personhood and undermined his legitimacy in his preferences about enjoying life. These expectations were continuously present and monitored in family conversations and relationships, and were reinforced by all of the other family members. His suffering was more in the realm of the experience of being shunned as an outsider in the family. He could not exert his own preferences for daily living as legitimate choices. The person who was perhaps most attuned to Mark’s suffering was probably the person who knew him best. Cecile sought assistance with her own worry and perhaps understood most intimately the impact of the tyranny of lifestyle modification on all family members. In session five, she explicitly told the nurse that she did not want Mark to experience himself as an outsider in his own family.

**The Different Character of the Illness Conversations**

Family members described the conversations at the FNU as different than the kinds of conversations they had on these issues at home. The difference in context between the FNU and home was significant, and resounds echoes of previous wonderings in this research about “where in the world can these conversations occur?” and also, what is this “news of a difference?” (Bateson, 1972, p. 454). Josie and Jonathan explained many of the ways that these were different conversations that they had at home: everyone had to stick to the conversation and could not physically leave (for example to defuse anger); the objective third party helped to referee and defuse jabs and defensiveness, and to avoid rehashing past issues; and this was a calmer place to discuss intense emotional reactions.
Cecile and Mark offered another idea about how these conversations were different in the fifth session, when the nurse asked for advice about the clinical work. The family had offered the idea that the nurse’s questions had enabled people to say different things. They acknowledged the nurse’s way of phrasing questions helped to discuss topics that normally would not be discussed. But both Cecile and Mark suggested that getting families to communicate about the ways that the health problem was related to other aspects of family life was important.

LMW: To get them to communicate. Okay. To get them talking about the health problem amongst themselves, is that what you mean Cecile?
Cecile: That’s right. About everything.
LMW: About everything?
Cecile: Because as I said before, I think they’re all related. All related.
Mark: Their feelings for each other, with the health problem.
LMW: So they’re all inter-related you’re saying? That’s what you found in your experience, how they’re related to other aspects of what’s going on within the family.
Cecile: Right, right. (Session 5)

Perhaps the illness conversations in this clinical work were not only different than the illness conversations that the family had at home, but perhaps they are conversations that had not occurred at home. Perhaps the character of these conversations elicited new and different kinds of family understandings of the influence of the illness that had been operating outside the awareness of family members.

The nurse offered the possibility that one of the reasons why the family might experience conversations in this context differently was because the nurse was more attentive to the ways that the illness was influencing each of the family members.

LMW: I would say that I was more, I would hope they would say that I was more interested in how all of them were doing around this experience of a serious (tape skips) illness. I would hope they would.

In most health care contexts, the experiences of adult children often would not even be considered in understanding “coping” with health maintenance issues. In this instance, the ongoing involvements and connections amongst all family members were intimately inherent to the experience of the illness.
The nurse had a sense that some of these conversations were news of a difference for the family because they were new conversations. In the sessions with the adult children, she described seeing “a therapeutic conversation changing right in front of your eyes”. The intensity of the affective arousal was one of the obvious ways that this difference was apparent to the nurse. As Mark responded to Jonathan’s tribute of his love for his father, it became very clear that this was a conversation they had not had with each other before. This shift in conversations from “accusations and recriminations” (Wright et al., 1996, p. 113) to “affirmation and affection” (p. 115) are “interactions that trigger in us reflections upon our circumstances of coexistence with other human beings” (Maturana, 1988, p. 70). These dramatic shifts in the conversations do not occur in every session, but across the course of the work, these are significant conversations that were recalled by both nurse and family as conversations that were different.

Outcomes - What Happened Here?

In contrast to the clinical work with the previous two families described in this research, this family had very clear expectations, hopes and preferred outcomes for the clinical sessions. Cecile was hoping to influence the worry that family members were experiencing related to Mark’s lack of efforts to maintain his health, and related to the possibility of Mark’s premature death due to heart disease. Josie and Jonathan were hoping that the sessions would convince their father to change his neglect of his health. Mark’s attendance at the sessions was, at least initially, a gesture of his willingness to address Cecile’s concerns. If the outcomes to be measured had been traditional measures of cardiac rehabilitation and health maintenance (i.e. reduced weight, increased exercise, decreased serum cholesterol, smoking cessation), this work could be viewed as a failure. Josie and Jonathan might have been most inclined to term it a failure in this regard.

Reducing emotional suffering. The nurse did not share the view that lifestyle changes would be the preferred development of this clinical work. In the final postsession
discussion with the clinical team at the completion of the clinical work, she offered the following perspective:

LMW: Fifteen years ago, I would have been very disappointed that I hadn’t made a difference in terms of him losing weight, or that he hadn’t quit smoking. I would’ve been very disappointed in myself and in this family. I feel terrific today about what happened with them! I feel very good about our work with them. Cause I see changes that they’ve done. And we just tried to facilitate that, get them some ideas, throw out some ideas, see what they select as a perturbation, and there’s some very nice changes in this family. But no, he still smokes, eh? And no he still has, he still has some weight to lose. But their general well-being, they are not suffering emotionally. That’s the biggest difference I’d say today in them. That she was really suffering when she came, and she’s not now. And neither is he. He’s a happy guy. He’s got a sense of humor, I’m happy...I feel I’m going to live for many more years. He has this wonderful belief about his lifespan.

Student 1: And he might be right too.
LMW: And he might be right. He might be right. (Postsession 5)

Even at the completion of the clinical work, the nurse was not compelled to take sides or make predictions regarding who was “right” in the family about whether Mark would live a long or short time if he continued not to change, or about whether or not Mark should commit more energies to changing his lifestyle.

As described previously, in the fifth session conversations between the nurse, Mark, and Cecile, it appeared that the couple agreed with the significance of these outcomes. Cecile described herself as being able to step back from worry, reducing worry significantly from consuming 75 to 80% of her thoughts to 50%. She believed that Mark understood the depth of his family’s caring, and that although they were reminding or nagging him less, they were not caring for him less. She suggested that he felt like more of an insider, that he probably knew more than ever that his family loved him. She said that humor was more present for them. Mark said that his family’s ability to back off had reduced his stress, that he felt more contented, and could be more honest with Cecile when having an occasional cigarette.
Mark: And I’m glad I did come, and I’m glad it turned out this way because, it’s a little easier at home now. We understand each other a little better. I think that she’s seeing that no matter what she says or raises, or what terminology you use, that hey I’ll do some things, but not all of it right? (to Cecile)

Cecile: Right (Session 5)

This was the first time in the conversations at the FNU that Mark pointedly asserted his position: he was willing to make some efforts, but did not intend to do everything that his family hoped he would do.

**Mom benefited more than Dad.** Although Mark and Cecile were at least somewhat satisfied with these developments, their children clearly were not. In the research interview almost a year after the final session with their parents, Josie and Jonathan believed that Cecile had perhaps been helped the most by the sessions, and both remained very frustrated with their father. Both of these young adults suggested that perhaps their parents had come to a different understanding of the situation. They thought that although their mother remained somewhat frustrated with Mark, that she had accepted that she could not change her husband’s living habits. From Jonathan’s perspective, his father realized that he does have some “faults” that caused problems for the rest of the family, and that his father had more appreciation of the impact of the concern for his health on the rest of the family. Josie thought that Mark had been thinking about it more, and could be more convinced that his family supported him.

There were still hints though that this support still focused primarily on support to make lifestyle changes. Josie and Jonathan’s frustration with lack of lifestyle changes persisted, perhaps even as strongly as previously.

Jonathan: He’s changed minimally...what I think and what my siblings and my mother think, I don’t think he’s changed the way that a heart patient should change.

Josie: I would say so too. I agree with that.

Jonathan: Severely

Josie: I think the change has been very, it’s very minimal.

DT: In terms of lifestyle changes that he has done?
Josie: That’s right. I think it caused him maybe to think about it a little bit more. But to be motivated to really change? Nothing very dramatic. I think, I agree with you Jonathan, it’s helped my Mom deal with it better, in terms of realizing that it’s not Mom having a nagging issue, that there are some genuine concerns for my Dad. That he doesn’t change his habits and isn’t committed to leading a healthier life. And it’s not just her being paranoid, or overly concerned.

From these perspectives, their father was still the problem, or his lack of ability or desire to change was still the problem.

Was the worry club disbanded? During the fifth clinical session, Cecile had told the nurse that her worry about the possibility that Mark would die prematurely was significantly reduced, and that she felt more able to manage the remaining worry. In the research interview, Josie and Jonathan were asked about their impressions of the worry club a year later. Both of these young adults offered the explanation that they were busy with their own lives and had less time or opportunity to worry as much as they had previously. Perhaps this was an appropriate development in the family, that these young adults were moving on to other preoccupations in their own lives (i.e. their own partners, their own commitments in their work and university studies). This possibility is offered from a view which is respectful of the ongoing connections and involvements within this family rather than viewing this caring concern as “over-involvement” or “enmeshment” or “fusion” between these parents and their children. Worry was still present for Jonathan, but less so. He described a reduction of nightmares about the conflict about lifestyle issues with his father, making the emotional intensity of his distress about these disagreements even more understandable.

In the research interview, the emotional intensity was further appreciated as Jonathan expressed his sadness for his hopes to have a closer relationship with his father as an adult.

Jonathan: I thought we had a good relationship when I was growing up and that, but the relationship we have now is just average. Which is disappointing.

DT: You had hoped for more, more closeness, more connection with your Dad?
Jonathan Yeah, just a closer relationship, but his lifestyle really bothers me.

...
Jonathan: His lifestyle and his attitude towards it. And then other things build on that. I mean you trace the problems because of how he lives. If he was in better shape and took care of himself in his eating and smoking and drinking....I can live with people's difference, or live with peoples' differences I guess. Or faults if you think they're faults?

Jonathan was saddened by the ways that his father's inability to respect himself and to create desired lifestyle changes interfered in their relationship. The ongoing tension seems to reflect continuing disapproval of his father. This healthy young athlete son was reflecting on the circumstances of his coexistence with his father. The clinical work had invited him to express his caring for his father differently, but he had not yet discovered a way to see or understand his father differently, or understand the coherence or legitimacy of his father's choices about his lifestyle. This difficulty is not a fault of the son. It reflects a pervasive and repetitively reinforced cultural message about the right way to live.

Choosing to Live at Risk

Mark chose to live at risk. At one point, Cecile had described this sense of living at risk as "dodging bullets", having close calls or brushes with acute illness and death on an episodic basis. When a bullet is successfully dodged, the immediate crisis passes for the short run, but in the long run, the future may remain uncertain. Another bullet could come along at any time. Living at risk was Mark's way of accepting a future that he believed to be inevitable and his way of making the most of whatever time he had left. This was his way of enjoying life more without tempting fate in an irresponsible manner. For Josie and Jonathan, living at risk was negligent. At the end of the research interview, Jonathan wondered about whether other families have similar struggles around the impact of lifestyle changes within the family.

Jonathan: Are there other families that have fathers that are just negligent about their health, and just live by the seat of their pants with their hair on fire kind of thing?
Living by the seat of your pants with your hair on fire sounds like a dangerous lifestyle. In a culture which values control, this description sounds like a lifestyle viewed as very much out of control. These are three very different descriptions of living at risk.

One of the outstanding aspects of the clinical work with this family was the nurse’s ability to accept the coherence of Mark’s choice to “tempt fate” or to increase his cardiac risk by attempting to exert his own lifestyle preferences in contradiction to the preferences of others. The right to live at risk is often taken for granted (McIntyre, 1997). When healthy lifestyle practices are prescribed as treatment for heart disease, a choice to exert one’s right to live at risk can be interpreted as negligent. When confronted by the many levels of normalizing judgment about healthy lifestyles extending from culture and the media, to the family, and to self, one may distinctly feel different or abnormal. When the desire to enforce healthy lifestyles becomes a norm which can not be questioned or challenged, we are invited to forget that we are all living at risk: at risk of illness, at risk of accident, and at risk of death.
CHAPTER FOUR:

THE CHARACTER OF THE FAMILY-NURSE RELATIONSHIP

If we know that our world is necessarily the world we bring forth with others, every time we are in conflict with another human being with whom we want to remain in coexistence, we cannot affirm what for us is certain (an absolute truth) because that would negate the other person. If we want to coexist with the other person, we must see that his certainty - however undesirable it may seem to us - is as legitimate and valid as our own because, like our own, that certainty expresses his conservation of structural coupling in a domain of existence - however undesirable it may seem to us. (Maturana, 1992, p. 246)

In the previous chapter, the particular circumstances of the clinical work with each family were explored in detail. The clinical conversations of each session and the research conversations were traced and highlighted in order to contextualize the clinical work, and to delve into the complexities and contingencies addressed with each family. In spite of the differences depicted within each family situation, there are resemblances and familiarities which echo across the clinical work as a whole. Throughout this chapter, these resonating understandings from the clinical work and the research interviews continue to be explored: “What happens here?”, “What is different about these conversations?”, or “What is helpful to these families?” These questions are important to understanding of the ways of living and nursing in the midst of lives complicated by heart disease.

In particular, this chapter will attempt to uncover the character of the family-nurse relationship which contributes to therapeutic conversations. In what manner might this relationship be distinctive, or make a difference that matters? Although interested in the reciprocities between nurse and family, there is heightened attention to the nurse’s manner of situating herself, in order to delve into understandings of how it is that the nurse may conduct herself well in these relational practices. Just as the family members may be called in this clinical work to reflect on the circumstances of their coexistence with others, the nurse may also called upon to reflect on the circumstances of her coexistence with the family, or her relationship with the family. The nurse’s manner of situating herself in the
relationship contributed to the family’s experience of a different kind of conversation with the nurse.

In the original research question, the contributions of the family members and the nurse were conceptualized as the “concerns, beliefs, skills, and practices” of both the family and the nurse as they coevolved understandings of the problems encountered in the experience of living with ischemic heart disease, and as they coevolved interventions to address concerns of family members. Of course, in the interpretations of the clinical conversations and the research interviews, the contributions of participants did not fall neatly into these four categories. The manner in which the nurse and the family conducted themselves well in the co-creation of a therapeutic conversation would be trivialized by reducing their conversations and their relationships to the concepts of concerns, beliefs, skills and practices. This would undermine the desire of a hermeneutic understanding to “restore life to its original difficulty” (Caputo, 1987, p. 1). The complexity and difficulty that characterizes this clinical work

will not be remedied if we read the right books, believe the right things, or practice the right techniques. Rather, this unfinishedness, contingency and difficulty signify that the living character of education [and nursing] is a deeply human enterprise that is not surpassable and encompassable by simply having the right theory or framework or method in hand. (Jardine & Field, 1996a, p. 256)

To limit understandings of these conversations to concerns, beliefs, skills and practices would be an attempt to specify variables of human social behaviors which are characterized by complexity, interactivity, participation, and eventful invention and creativity. The manners in which nurses and family members conducted themselves well will never be a closed matter. These understandings are always “on the way” (Gadamer, 1981, p. 105)
with each unfinished conversation about the clinical work, and with each recollection of the work with these families as they inform our experiences, understandings and practices with other families in the future.

I. Ischemic Heart Disease: A Call to Reflect on the Circumstances of our Co-existence with Others

The family participants in this study shared a common experience: each of them was living with ischemic heart disease. While family members may not have had the disease process occurring within their own bodies, the therapeutic conversations revealed the many ways that family members indeed experienced a form of a “collective heart attack” (Siebert, 1990). The lives, emotions and bodyhoods of all family members were irrevocably touched by this experience. This understanding of a collective heart attack runs counter to common understandings of a heart attack as a thoroughly individual matter of the body. The popular metaphor of the human body as a machine, and in particular the metaphor of the heart as a pump in both the professional and lay literature (Nuland, 1995; Siebert, 1990) reinforces the view of heart attack as an individual affair.

The metaphor of heart-as-pump ignores and forgets the enduring traditions of the heart as a deeply felt embodiment of emotions and human spirit (Moore, 1992). Our language is rich with descriptions linking the heart with emotion. One's heart can leap with delight, race with excitement or panic, ache with sadness or grief, and break with love lost. One can be faint-hearted with cowardice, brave-hearted with courage, cold-hearted with callous insensitivity, and stone-hearted with malice. The language of love and social practices linking the heart and love are present in poetry, music, literature, courtship and marriage. This is a language of connection and inter-relatedness that is betrayed by the metaphor of heart-as-pump.
Ischemic heart disease is not only a chronic illness, but also a life-threatening illness, the leading cause of death in North America. It is a "common form of heartbreak...where the continuum of body and mind is broken" (Seibert, 1990, p. 56). It is an illness that "cuts close to the bone" and "takes us out of our minds and into our bodies" (Bolen, 1996, p. 70). It is a loss of the "hidden character of health" (Gadamer, 1996, p. 126), the capacity to forget ourselves, to forget our embodiment in our taken for granted ability to be involved in the world. For many people, ischemic heart disease brings with it the revival of a relation with the body that is often denied or that we would prefer to forget: that we are frail, fleshy beings, and that our existence in this form is time and space limited.

This reminder of our finitude and mortality is oft addressed as the cardiac patient's willingness to embrace a "second chance" (Bramwell, 1986; Johnson & Morse, 1990). To have survived a heart attack is to have had a brush with death that can open new possibilities for living differently. The second chance is often described in terms of a chance to live a healthier lifestyle, to take better care of one's body, to live life more fully, to take time to enjoy more leisure activities, or to refuse the stressful demands of an oppressive job. This understanding of the second chance still implies that the opportunity is primarily enacted within the realm of the individual person experiencing the illness, yet the emotional impact on family members (Hilbert, 1993; Hilgenberg et al., 1992; Yates & Booton-Hiser, 1992) reflects the toll of the collective heart attack. The clinical work in this study describes practices which address second chances in the lives and relationships of family members experiencing the collective heart attack. Several studies have mentioned the impact of an acute cardiac event on a marriage as bringing the couple closer together (Meddin & Brelje, 1983; Gilliss & Belza, 1992; Hilgenberg et al., 1992; Schott & Badura, 1988; Thompson, Ersser, & Webster, 1995), the recovery as a time of "grappling with the presence of another" (Coyne & Smith, 1991; Coyne, Ellard, & Smith, 1990), and a time of discovering those who care and relating to these others in a different way (Ford, 1989).
The call to address family relationships when this life-threatening illness occurs may be a call to address the sense of disconnection not only between mind and body, but also between self and other.

All of the family members who participated in the sessions demonstrated a readiness and an openness to reflect on the circumstances of their coexistence with the ill family member and with other family members. Alex and Georgina were embracing a chance to restore a sense of balance to their lives. As a couple, they still had hopes and goals for their future that they wanted to realize together. They were weathering a transition to improved health within their own relationship, and within their relationships with their adult children. As Alice confronted the uncertainty of heart surgery and the possibility that she might not survive the wait for surgery, she wondered about what her children thought about her. Her daughter, Jeanie, wanted her mother to know of her concerns, that she cared about her and did worry about her mother, but Jeanie was constrained from voicing her concerns by her respect for her mother’s self-reliance. Cecile was concerned about the influence of worry on her relationship with her husband, and with their adult children. She wanted to challenge the effects of attempts to influence Mark’s choices about maintaining a healthy lifestyle. She wanted to reduce the conflict between Mark and Jonathan, and to reduce the effects of worrying within the entire family. Each of these family situations required that the family and the nurse respond to the influence of ischemic heart disease on the circumstances of the coexistence of all family members.

The language of the therapeutic conversations was very different than the traditional diagnostic, technical and instructive medical and nursing language of the cardiac patient and ischemic heart disease. To sustain the connections between the heart as body and the heart as emotion, it might seem even more plausible to speak of these conversations as a language of “love”. Maturana (1996) offered a biological explanation of love as “a domain of those relational behaviors through which another arises as a legitimate other in
coexistence with you”. To speak in this manner about the inherence of emotion, relationships and heart disease is not meant to imply that this embodiment of experience is unique to persons experiencing the illness of heart disease. The call to retrieve and strengthen a sense of connectedness between self and other may be similarly experienced in other illness experiences.

In this clinical work, the nurse responded with each family to reflect on the circumstances of their coexistence. The nurse was also called upon to reflect on the circumstances of her coexistence with the family, or her relationship with the family. The relational nursing practices which are described below uncover the character of conducting oneself well in the family-nurse relationship. These practices include accepting the legitimate ways that family members have conserved their existence, offering and accepting invitations to reflections, and offering invitations to emotional shifts within the conversation.

II. The Legitimacy of the Other

When Maturana speaks of the “legitimate other”, he is not invoking the traditions of the “Other” as in Western metaphysical philosophy, epistemology, ethics, politics or religion (Bernstein, 1992). Maturana offered a biological explanation of the other as another living being. In this instance, the other is a human being with whom we wish to coexist. The other person is legitimate not only or simply because of their humanity. Their explanations of their experiences are warranted and legitimate because they have arisen through the course of their existence. Their explanations reflect the ways that they have conserved their existence.

Maturana (1988) offered a definition of reality as an explanation for the world that we live with others. From this perspective, one can not make a claim about an objective reality that exists independently of oneself. One can only make distinctions in language and
offer an explanation of coherences of experiences, an explanation of the ways that experiences make sense. In contrast, when a claim is staked for objective knowledge of persons and their experiences, there is a demand for obedience, for mutual or self-negation, to accept certain questions, explanations and truths. All other explanations are deficient, illegitimate, and the other is intrinsically wrong.

When it is accepted that there are structurally determined differences between persons, it is more understandable that different persons will offer different explanations for the same situation. Persons operate in different, yet equally legitimate domains of reality or explanations of reality. The emotioning which accompanies the view of other as legitimate is that of acceptance. When the other is viewed as legitimate and coherent, “explanatory disagreement is an invitation to a responsible reflection of coexistence, and not an irresponsible negation of the other” (Maturana, 1988, p. 31).

By accepting the legitimacy of each of the others present in the family-nurse relationship, the nurse can operate within a different domain of emotioning than when one is searching for certain truths. When the experience of the other is accepted and respected as legitimate, there is an invitation to curiosity as one attempts to understand what that experience is, and how the experience of the other makes sense. Accepting the legitimacy of the other invites a manner of relating based on respect and collaboration.

SS: These postmodern ideas around multiple realities invite us to be tentative...like not to know. Like Anderson and Goolishian’s (1992) not knowing. We don’t know! We have some knowledges, and we believe we know some things because of our experiences, and in theory, but we don’t know for you. And that is so collaborative....believing in multiple realities or...having that idea that everybody’s reality is equally real, although maybe not equally as desirable.

(Nurse Interview)

The clinical approach of Wright et al. (1996) invites this kind of tentative language to reflect upon, explain and describe the legitimate differences which arise in explanations of the beliefs, or the “truths” of subjective realities without negating the other.
Throughout the therapeutic conversations, there was an explicit valuing and honoring of the beliefs, ideas, perspectives, and opinions of each of the family members. There was no effort to assert an overarching professional belief or truth that would “fix” the family’s problem.

LMW: When we feel you have to have the right answer, you feel you have to have the answers, it’s part of falling into objectivity-without-parentheses, eh? That you know the best way that this person should function, and the way they should be. And when you give that notion up, no, together we will coevolve something, hopefully, that will reduce any emotional or physical suffering, then, you don’t have to assume all that responsibility. I mean you still assume responsibility for change, I mean that is our responsibility. People come here suffering. Your responsibility is to create a context for change, and that you can help them to alleviate some of that suffering. And when families ask me “What would you do about this, or do you have an idea?” I mean, I will give them my best clinical judgment on it. But I always either end it or preface it by saying “But I don’t know if this will fit for you”, and “I don’t know if this works for you”, and “I don’t know, but you might want to try that on”...It’s so much more respectful. I have to say it’s just really freed me up, and I find it more respectful and much less judgmental. Because if you have a certain notion in your mind of how this couple should be or how this family should be, and then they don’t measure up, eh, they don’t behave, and they don’t follow your wonderful suggestions, then you’re very judgmental aren’t you? “Well if they’d only listen to my good advice their life could be beautiful!” But they don’t do that so therefore, “No wonder they’re suffering because they don’t listen to me”.

(Postsession 5 after session with Cecile & Mark)

There was also overt exploration of the ways that different family members held their own beliefs to be true based on their experiences. There was much discussion of the ways that family members’ beliefs and explanations differed.

LMW: Okay. Could it be though that because your beliefs are so different about the future for yourself, that this is where you really run into difficulties? I mean, it’s very understandable to me, that if Jonathan and Cecile feel that you’re not going to live as optimistically as you feel, till 65 or 70, that they’re on your case, about wanting you to [change], because they care and

Mark: I feel I’m going to make that for sure, if not longer.

LMW: Yeah, but you see their belief is different. So therefore they suffer more and worry more for you, and on your case more. But, your belief is quite different. You’re very optimistic, 65, 70, eh? That you feel that you’re

Mark: I hope that’s not optimism

LMW: Well, I’m just saying you’re more optimistic than they are.

(Session 4 with Mark)

As family members were invited by the nurse to appreciate each others’ perspectives as legitimate, there were very few attempts by family members to offer counter arguments of
privately held certainties. Family members consistently commented on how helpful it was to hear other angles, to understand other perspectives or viewpoints of family members. Through the clinical work, family members also become curious about the perspectives of others in the family, and begin to wonder for themselves about the ways in which other perspectives might be legitimate. A poignant example of this occurred at the end of the fourth session when Mark met with the nurse individually.

Mark: Do you think Cecile [his wife] by saying that "You're not looking after yourself and you're going to die prematurely, and it's not fair to me, being alone", is she showing concern for me? Probably is. Or is it selfishness? (Session 4 with Mark)

As Mark reflected on the circumstances of his coexistence with his wife, he considered the ways in which her explanation might be legitimate. He was open to other explanations, and solicited them directly from the nurse and the clinical team. When they offered two possible explanations, Mark entertained some of the possible ways that he might be implicated in conversations which could have prevented him from understanding his wife's perspective. Family members often become more open to the possibility that the other person might be "right", or at least as right as their own opinion or perspective.

The nurse conducted herself in a manner which was nonjudgmental toward family members and their differing beliefs and perspectives. This does not mean that the nurse held no perspectives or values of her own which influenced her understanding of the explanations of different family members. This does not mean that the nurse held no preferences about the ways that family members might chose to change. It does mean that she respected these beliefs and explanations as "multiverse", as "equally legitimate, but not equally desirable, explanatory realities" (Maturana, 1988, p. 31). The difference from many other clinical practice contexts and models is that the nurse did not impose her preferences on the family, or even believe that her own preferences were necessarily correct or right for the family.
As both the family and the nurse attempted to “make sense” of the family members’ explanations of their experiences, the legitimacy of their explanations became more understandable. The nurse did not try to find out what was real or true about the explanations, but tried to understand how the explanation was coherent, how it contributed to the ways that family members had conserved their existence.

LMW: So I want to tell you what I learned from you today. And what I learned today was that if people are optimistic like you are, that you have a health problem, but if you are optimistic, and you have a belief that “Gee, I, I’m quite convinced that I’ve got another few years”,

Mark: I am! I believe that.

LMW: Then it makes sense then, to me, why you wouldn’t be... getting a grip on the willpower. When you think “Gee I’ve got a lot of years that I’m going to be doing this”...

Mark: I may be fooling myself though.

LMW: You may be fooling yourself. You may be right, and you may be wrong, eh?

Mark: That’s right. That’s the gamble I’m taking.  

(Session 5 with Cecile & Mark)

As the nurse attempted to understand and make sense of the situation without judging the family, they were also able to become less invested in defending their own position.

The nurse attempted to understand the situation for herself, but this was not enough. The challenge for the nurse was to “make sense” of the legitimacy of these explanations for herself, and to understand patterns and relationships in the ways that each of the family members explained and understood the situation, and to create space or a context where family members might be able to entertain different ideas and explanations. The active participation of the nurse in the conversation was a catalyst to the release of new or different understandings within the conversation. The questions asked helped to reveal new nuances of understanding, to reveal shadings of difference amongst family explanations, and to approximate gulfs in family perspectives to reveal similarities. Family members consistently mentioned the nurse’s questions and her presence as a third party referee or witness to these conversations as important contributions to the difference experienced within the sessions.
Alice and Jeanie pointed to the importance of also feeling “heard” within the conversations. While the intent here is not to minimize the importance of listening as essential to understanding, the point is that there is no guarantee that a nurse’s passive listening to a family story will constitute understanding. The story of the illness experience which is told by the ill person or family is often colored by their expectation of what the health care professional wishes to hear. When the family’s expectation is that the professional wishes to hear the medical story of the illness, about the onset and trajectory of symptoms, the list of medications, and the efforts to reduce cardiac risk, a very different story is told and heard (Frank, 1995). The nurse’s questions elicited a telling of the story which bore a different character than the medical history. The nurse’s questions created opportunities for the experiences of all family members to be heard. For Alice and Jeanie, having the opportunity to have their experience validated in a telling which received their explanations as legitimate and coherent could have been a different experience and a different conversation than they might have experienced previously with nurses or other health care providers. For some persons, listening to their story might be enough. In this clinical work, there were times of thoughtful listening by the nurse, but the questions asked of family members were an important introduction of difference within the conversations.

This notion of making sense of family members’ explanations is related to many of the ways that participants in McIntyre’s (1994) exploration of “constituting understanding” described the experience of being understood in illness. The willingness to address issues related to death, the acknowledgment and affirmation of strength in the face of difficulty, the acceptance of a preference to live at risk, respect for the ability to judge risk for oneself, and the avoidance of blaming language are all examples of influences within these conversations which McIntyre described as constituting the experience of being understood in illness. Her research suggested that “being comforted in the experience of suffering aligned closely with being understood” (p. 144). The experience of healing and comfort
reported by family members following these therapeutic conversations may have been related to the opportunity to be understood, and to have their explanations heard and accepted as legitimate by the nurse.

**Non-pathologizing Discourse as Respect for Legitimacy of the Other**

*Whenever there is an underlying foundational theory of truth, there must be an expert to interpret it. When the area of supposed expertise is another person's experiences, the expert is, ironically, taking that person's voice away from her/him* (Parry & Doan, 1994, p. 8).

*Blame, the source of misunderstanding, is inscribed in the everyday language we use to talk about illness.* (McIntyre, 1994, p. 143)

Health care professionals have a long history of participation in the creation and maintenance of pathologizing discourse. Foucault (1965, 1973) traced the rise of Western medicine in Europe in the eighteenth century, including the traditions of the medical “gaze”, and the medical location, specification, and classification of diseases of both mind and body. The traditions of the language of nursing diagnosis have mimicked, perpetuated, and extended the value-laden classification and categorization project of medical diagnosis (Lutzen & Tishelman, 1996; Mitchell, 1991; Muller & Cox-Dzurec, 1993; NANDA, 1989). Pathologizing is a practice of naming problems, and of identifying what is wrong with persons (Freedman & Combs, 1996). The converse of this can be the imposition of conceptions of the right way to be. O’Hanlon (1993) offered further distinctions within the realm of pathologizing language. He described blaming as the attribution of bad, sick or evil intentions or character traits. This can be different from invalidating, which is the “minimizing, denying or undercutting a person’s felt experience, sense of self or point of view in a way that devalues them” (p. 14). The nurse’s manner of language and participating in this discourse is a deeply ethical act with implicit assumptions related to beliefs about preferred views of oneself, views of nursing as a discipline, and views of the legitimacy of other persons and families.
What does it Mean to Engage in Non-pathologizing Discourse?

Families consistently commented in both the sessions and the research interviews on their surprise at hearing positive descriptions of themselves, their family members, and their experiences from both the nurse and the reflecting team members. Drawing forth of family strengths through commendations is a practice which occurs at every clinical session at the FNU. Family reactions to commendations suggest that this practice contributes to the experience of difference in the conversation with the nurse.

In addition to explicit acknowledgment of family strengths, non-pathologizing discourse within the clinical work was also noticeable by the nurses’ reluctance to apply labels in terms outside the family’s descriptions and understandings of their experience. The story of Alex and Georgina demonstrated some of the ways that the practice of pathologizing can accompany even the well-intentioned practices of purposefully seeking and commenting on family strengths. Even though this couple preferred not to present themselves as having “problems” or as “needing assistance”, the post-session conversations of the clinical team revealed many hypotheses and hunches about possible problems that the family might be experiencing. Many of the postsession discussions were working out the tensions of persisting in problem-focused language when this was not the family’s preferred view of themselves.

With all families, there was concerted effort to hold nursing and family theories and explanations in humility, recognizing that preconstructed understandings of families and illness may be of limited assistance in this particular circumstance. Alex and Georgina’s experience could have been framed as uncertainty about the future, or denial of a chronic illness. Mark and Cecile’s situation could have been interpreted as a wife’s nagging problem related to her husband’s non-compliant lifestyle. Instead, the descriptions of family experience which were co-evolved had an intent to give “value and dignity to the current behavior of those involved” (Cecchin, Lane, & Ray, 1994, p. 19). The family
experiences are legitimate when they are understood as the ways in which they have conserved the family’s existence.

The character of these conversations is often noticeably tentative: “I wonder about....I was thinking about....I am curious about....If you were to believe that...”. This language invites openness to multiple views of the situation, many explanations of the problem, many different beliefs about the possible cause of the problem and the potential solutions. This language challenges the closure of statements of certainty, and encourages questioning, doubting, and reflection. It encourages the broadening of possibilities of many different views of the “right” way to be in this particular circumstance. This tentativeness constrains enthusiasm for offering of direct advice, certain instructive directions, and probabilistic prognostications. This tentative language created opportunities for other explanations to be raised. The “what do you think?” type of questioning to families supports the notion that what they think does matter.

To attempt to adopt a non-pathologizing stance does not mean that one only discusses strengths and competencies, or that one does not discuss problems. This work would be misunderstood if one were to think that embellishing facilitative beliefs, drawing forth descriptions of strengths and competencies, and attempting to engage in non-pathologizing conversation meant that problems were not addressed. Most families coming to the FNU have a dilemma, a concern, a problem, or a difficult life situation that motivated them to seek assistance. To fail to struggle through this dilemma with them would be a failure to respond to the obligation (Caputo, 1993) which our role and position as nurses compels us.

The Myth of the Expert

A belief in the merit of expert talk or problem talk is not only held by health care providers, but often also by the people who seek their assistance. Some of this labeling is connected to the implicit social expectations enacted in the nurse-patient roles. Often
families present with problems which they have identified. They have already developed a way of talking about their experience that languages about their experience as a problem. In seeking assistance with a problem, there is reciprocity in the helper/helpee relationship, implicit agreement that the health professional is a knower of a different kind than the people living out the experience. There is often an expectation to hear criticisms from the nurses, and to have “the wrong things” pointed out to them, and to receive information and advice.

People may prefer the nurse to assume the position of the knowledgeable expert. This was characterized by the comments of Jeanie and Alice during the research interview when they suggested that they would have preferred more direct questions and advice from the nurse. Similarly, Josie and Jonathan suggested that it would have been helpful for the nurse to offer three hot tips or silver bullets to summarize the session, or to offer advice to families at the end of the session. Families usually expect experts to tell them what the expert thinks the family should do regarding their concern. The family may not appreciate a nurse’s preferred stance as “non-expert”.

But the history and traditions of the evolution of expert knowledges and skills extend much farther back through histories of knowing. Implicit in the notion of expert is the intimation of knowledge for the purpose of mastery and control. These are traditions that extend to the time of Descartes and Kant, to a time when European culture took up the belief that “the human subject lives in a world of its own making” (Jardine, 1992, p. 30), and that “the Earth is there for us” (p. 35). The belief that the Earth belonged to man were present in religious traditions prior to the sixteenth and seventeenth century (Spretnak, 1991), but the birth of modern scientific consciousness provided a method for using knowledge to exert human domination over nature (Berman, 1981). Knowledge became an instrument of control, and nature became the object of control and mastery.
So the expert became "a person who has special skill or knowledge in a particular field" (Costello, 1991). In the domain of nursing practice, the notion of expert has taken on new meanings over the past three decades with the impact of technological advances in medical sciences, particularly within hospital settings, but increasingly in home care settings as well. Nursing knowledges have mushroomed alongside medical advances, resulting in specialty certifications which parallel those of the biomedical sciences. For example the Canadian Nurses' Association offers specialty certification in critical care, emergency, nephrology, occupational health, oncology, perioperative, neuroscience, and psychiatric nursing. As in other health care professions, the notion of the expert in nursing often becomes tied up with the notion of the progressive conquest of disease and illness. Perhaps there is a myth of the expert which is upheld by social practices within a health care system inadvertently conspiring to cover up the inability to completely eliminate disease and the impossibility of eradicating suffering due to illness.

Perhaps this is the hope for which the public continues to invest in the expert. The attribution of expertise and the accompanying potential for the abuse of power and knowledge is not simply a self-aggrandizing activity on the part of nurses and other health care professionals. The proliferation of experts in the domain of health care is not necessarily caused by power-hungry individuals who wish to exert influence over others. Nor is the role and function of experts simply specified by the institutions and health care systems that have evolved to provide for society's health care needs. The existence of experts may be a reciprocally sustained and mutually reinforced desire for the availability of experts to assist with resolution of difficult problems within our culture. The voice of the expert is valued, sanctioned and respected in North American culture.

Pathologizing discourse is sanctioned, and in most contexts, expected within health care systems. This discourse is part of problem identification and treatment of health problems. Health care professionals continue to receive educational experiences in which
theories, models and conceptual frameworks are taught as foundational “truths”. We are “indoctrinated to listen with a diagnostic pathologizing ear”, and educational systems continue to place “emphasis on knowing the right answer” (Freedman & Combs, 1996, p. 43). Motives in pathologizing discourses can be subtly subversive: pathologizing of another can invite caretaking. For health care providers to justify their own existence as “caretakers”, the practice of pathologizing language must be sustained. These pathologized problems operate as knowledge and power, and can be abused when the effect of the problem description is to objectify the person, and to diminish the person’s view of their own competencies and capabilities.

The Myth of the Non-expert

If then, a nurse prefers to position herself within the stance of a non-expert, what is at stake? Is it likely that persons and families will easily give up efforts to obtain expert opinions to assist them? Does the nurse have no knowledge and understandings from her work with other persons and families that might be helpful to others in similar circumstances? Do theories and frameworks hold no merit for assisting us in efforts to conduct ourselves well in our nursing practices? Freedman and Combs (1996) offer the distinction between situating oneself in a “not-knowing” position as different than situating oneself in an “I don’t know anything” position (p. 44). A not-knowing position can invite the nurse to explicitly recognize and acknowledge that she does not know about this particular family’s experiences with ischemic heart disease and the unique beliefs, meanings, explanations, and conversations which inform their particular experiences. This need not minimize what she does know about family experiences of ischemic heart disease from her encounters with other families, from her own experiences with heart disease in her own family, from nursing and medical research, from literature, or from other media. A not-knowing position can invite her to be respectful and curious about the family’s legitimate explanations and knowledges of their own experiences.
It could be argued that when the non-expert gives up mastery and control, the result is that the person’s or family’s own sense of agency is restored. However, is this a false sense of agency? Does this perpetuate the hope that there is a certain, demonstrable and true answer to be discovered that will enable the person or family to master the suffering inherent in living alongside chronic illness? Does this expectation of an answer again deny the “original difficulty” (Caputo, 1987) of living in chronic illness?

Michael White (1995) proposed that therapeutic relationships can never be truly egalitarian. Firstly, the power differential between the professional and the client can not simply be ignored. The respective knowledges of family and nurse are different. The power and knowledge of the professional may limit or facilitate access to other diagnostic or supportive services within the health care system. Discourses of expertise, power and knowledge operate not only in language, but are embedded in social practices and coevolve with social practices. These social practices are contextual influences which impinge upon the ways that families and nurses situate themselves in their conversations together and impinge upon the possibilities for addressing concerns and problems related to living with illness. Secondly, the professional has moral and ethical responsibilities which accompany their position. In this clinical work, the efforts to adopt a non-pathologizing stance does not mean that the nurse’s expertise, knowledge and obligations are diminished or forfeited. There is an intent to respect the person or family’s legitimate and meritorious knowledges of their own experiences.

**Meritous Understandings of Illness**

Perhaps there is an understanding of “expert” which need to be reclaimed from etymological sources of the word: trained by experience. Both the nurse and the family have understandings of the illness that are credible and warrantable, coached by their respective experiences in the nursing of persons experiencing illness, and in the living out of illness. If there is no voice for family understandings of living well alongside chronic
illness to be heard by nurses and other health care providers, what is lost? Thorne’s (1993) research spans a decade of inquiry about health care relationships and chronic illness. She suggested that experts and health care systems are geared to treat and conquer acute illness, but generally do a less than adequate job of understanding and supporting persons experiencing chronic illness. What do we have yet to learn?

Confronted by the medical technology of health care experts, persons lose the right to have privileged knowledges of their own experiences. Alex’s son, David, wanted to know about his father’s polycystic kidney disease.

David: what he felt like, and what he felt like before he went on dialysis, maybe warnings for me...And then I try to remember what he was like before he went on dialysis, in the years through his life when I was growing up, to look for warnings and look for signs like that. (Session 3)

David recognized the merit of his father’s illness experiences. He wanted to know how it felt, how to read the changing signs of his body in the possibility that he too might develop this hereditary disease.

Was Jonathan so passionate in his efforts to recruit his father, Mark, to commit to lifestyle changes in order to bolster his own belief that this would make a difference if he, too, should develop heart disease at some time in his own life? His father’s heart disease was the result of a hereditary cholesterol disorder. Did Jonathan worry about his own health in the future? Alternatively, what could Jonathan learn from his father’s ability to enjoy life? Art Frank (1995) offered powerful reminders of the ways that illness stories implicate the witness or the listener: “in listening for the other, we listen for ourselves” (p. 25) and illness stories “invite others to recognize themselves in it” (p. 50). By denying the merit of family expertise and experiences in living with ischemic heart disease, we may be losing knowledges of ourselves as frail human beings subject to similar circumstances and fates.

To learn to accept illness for what it is - this is perhaps one of the great changes brought about in our modern civilization by the progress of
medicine. This presents us with new challenges. It is surely not without significance that today doctors seem to be able almost to conjure away so many illnesses, so that for the patient they simply disappear without anything having been learnt from them. Significantly, it is now the chronic illnesses which stand at the forefront of medical interest, precisely because they cannot simply be taken ‘away’. In fact the most chronic of all illnesses is the path which leads us towards death. To learn to accept this is the highest task of humankind. (Gadamer, 1996, p. 90)

These understandings which inform expert practices of nurses and families are important understandings. These understandings open possibilities for conducting ourselves well as nurses with families experiencing heart disease. Perhaps what remains available in a non-pathologizing stance is a different form of expertise. This is an expertise that knows of theories about families and illness, but does not expect them to be true in this particular circumstance. This is an expertise that knows of many possible ways of naming problems, but respects that none of these ways may fit with the family’s understandings. This is an expertise of patience, of time well spent listening carefully to family members’ explanations and respecting the ways that they have conserved their existence. This is an expertise as a form of openness that makes you more sensitive to the particularity of what comes to meet you (Jardine, 1995) in the family’s explanations of their situation.

In this clinical work, the nurses’ view of the other as legitimate lends a distinctive character to the family-nurse relationship. The ability to reflect on many different legitimate explanations of the family’s circumstances, to accept multiple views as plausible, and yet to offer other possible explanations that might be helpful to the family is a hallmark of these practices. The nurse’s ability to conduct herself well includes practices which are non-pathologizing; which elicit descriptions of family competencies and strengths; which do not
label, blame, or invalidate; which acknowledge the merit of family understandings of illness; and which respect the expertise of both family members and the nurse.

III. Offering and Accepting Invitations to Reflections

Another practice consistently noticed within the clinical conversations of these participant families and nurses was that the nurse’s contributions to the conversation were primarily in the form of questions rather than answers. The questioning practices of the nurse were very different than the data-seeking or information/advice-giving interactions which are more often the norm in health assessment and health education interviews. In these therapeutic conversations, the nurses asked many questions, and would respond to family members’ answers with more questions. The nurses made few declarative statements of opinion, unless directly asked for advice or an opinion by the family. The content of the questions was different. The nurses were more interested in understanding the reciprocal influences between the illness and family relationships, and more interested in understanding the ways that the illness was connected to other events, meanings, and understandings within the day to day life of the family. The questions were sometimes described by family members as difficult to answer, perhaps because there was often no “correct” answer, but many possible answers. The “emotional posture” (Griffith & Griffith, 1994, p. 66) from which the nurse offered questions was one of curiosity and reflection rather than interrogation and examination. These conversations bore the character of “invitations to reflections” (Wright et al., 1996, p. 116), in which both family and nurse were invited to reflect upon the circumstances of the concerns presented by the family, and upon the circumstances of their clinical work together.

Invitations to Reflection

Wright et al. (1996) described their belief that the clinician offers invitations to reflection as a practice which underpins their descriptions of offering questions, ideas,
opinions and advice to families. Maturana and Varela (1992) described the moment of reflection as "the moment when we become aware of that part of ourselves which we cannot see in any other way...Reflection is a process of knowing how we know. It is an act of turning back upon ourselves" (p. 23). This is a reflection in which the family member is invited to consider the possible ways in which they are implicated along with other family members in the maintenance and dissolution of the concern or problem which confronts them. Family members were invited to reflect upon the circumstances of their co-existence, the manner in which each of them had a legitimate stake in being in the world in the circumstance of a family member’s illness. The family members were invited to retrieve or recreate their own coherences of experiences which helped them to make sense of their illness experiences. Family members noticed many examples of the ways in which they were invited to consider other possibilities, and to appreciate other perspectives. The two major practices in this clinical work which families noticed and described in the research interviews were the nurses’ questioning practices, and the reflecting team practices.

**Questioning Practices and the Language of Beliefs**

Invitations to reflections were most often embedded in the questions asked by the nurse. These questioning practices at the FNU (Loos & Bell, 1990; Wright, 1989; Wright & Leahey, 1994a) have evolved through the incorporation of ideas of family therapists over the past twenty years, beginning with the work of the Milan team (Cecchin, 1987; Selvini et al., 1980); Karl Tomm’s extension of the Milan team ideas with his descriptions of circular and reflexive questioning (1985, 1987, 1988); and Michael White’s contributions on relative influence questioning (White, 1988; White & Epston, 1990). When questions invite reflection by family members, the person comes to understand something about him/herself, or about other family members, that they would not have known if they had not reflected in this manner (Freedman & Combs, 1996). These questions were generative, as family members and the nurse co-evolved descriptions of experiences and preferred
realities rather than simply gathering data or facts. These questions were transformative, as family members changed perspectives by listening to each others’ answers and becoming curious about other family members’ experiences and explanations.

Many of the questioning practices of the nurse were invitations to family members to reflect on their beliefs or “truths”, their subjective realities that seemed certain and true to them. They were efforts to help make sense of family members’ experiences through the explanations that they offered about the illness, and about their relationships. Family members were invited to consider the legitimacy of the beliefs, truths, and certainties of other family members. The conversations between family members and the nurse reflected possibilities of other ways of remaining in relation, of co-existing with others in preferred views of the future.

Conversations about beliefs were a way of languaging about perspectives, opinions, and understandings. Conversations about beliefs helped the nurse to understand family members’ meanings and explanations for their experiences. Through the language of beliefs, the nurse made distinctions about the explanations offered by various family members for their subjective realities, and about her own explanations of their experiences. What was real or true for each participant in a conversation on the same topic could be very different. The language of beliefs is less certain and more respectfully tentative than the language of truths, knowing, correctness, and reality. Beliefs can be passionately held with great conviction, and yet be held with more openness, being understandably more true for the beholder than for another observer.

I came to realize that there were important differences between the work of the two clinicians around the use of the language of beliefs. The work of LMW, who was the clinician with Cecile and Mark’s family, was rich with exemplars of the use of the language of beliefs: “What is your belief about that...? What if you were to believe that ...? It makes
sense to me because your beliefs are so different..." However, this was not the case with the work of SS, who was the clinician working with the other three families.

Although there were many congruencies between the clinical approaches of the two nurses, there were differences between their preferred conceptual and explanatory frameworks and practices based respectively on an approach focusing on beliefs and an approach based on narrative therapy. The family comments about the relational stance of the nurse across the clinical work with all three of the families bore striking resemblances. The families all commented on the respectful curiosity of the nurse in her asking of questions, the ability to ask particular questions that elicited news of difference, the accepting atmosphere devoid of blame, and the third party presence to witness responses to questions and to mediate differences in the family. It became increasingly apparent, though, that each of the nurses had their own style of inviting family members to reflect on the circumstances of their co-existence.

To illustrate these differences in clinician styles below, firstly several transcript segments from the second session with Mark, Cecile, Jonathan and the nurse (LMW) highlight the language of beliefs embedded throughout these examples of questions asked of the family. Notice in the first example (and others) the way that family members also took up the language of beliefs (i.e. "I think that’s his belief").

LMW: Is this sort of the manly thing to do?... Are you a more traditional family? He sort of feels like he’s more the head of the house and head of the family, and he shouldn’t be showing those kinds of weaknesses?
Cecile: I think that’s his belief yes.
LMW: Okay.
Mark: (laughs) I don’t believe it.
Cecile: And I, I like to think a little further than that. Thinking this is the 90’s and you can’t be everything to everybody.

LMW: Okay. What do you think about that? Where do you think that idea comes from of yours Mark, that this belief that you have that if your family points out something? Cause your wife is making the distinction here. She’s saying “Gee in his business he takes advice”. But it’s like in the family around a health problem, you have the belief that if they encourage you or nag you or point that out, that it’s a sign of weakness on your part?
Mark: No, they’re pointing out my weaknesses.
LMW: Oh, they're pointing out your weaknesses. So you believe it's a weakness?
Mark: Well sure.

LMW: No, you're quite an exceptional family, you do have one dilemma though it seems. Your family cares about you a whole bunch, eh?
Mark: Right
LMW: They'd like you to behave differently, and you have different ideas about that because you have different beliefs about that.

LMW: They're worrying to the point that they really suffer because their worst fear is that you're going to die prematurely. You have a different belief about that, that you're going to live much longer, regardless. Do you believe that regardless of whether you smoke or not smoke, or just if you pretty much carried on the way you do now?

Cecile: She observed our differences, beliefs, I mean, we're miles apart.
LMW: yes
Cecile: One thinks he's going to go on perhaps forever, the other half, [think that he might die] daily.

LMW: Yes, so do you believe then that if you felt worse right now, if you were back having some of those symptoms like you were before?
Mark: Then I would probably be a little more scared about dying and do something. You know, maybe I'm saying that gee I feel good anyway, why should I bother?

Throughout the transcript segments above, the use of language which explores beliefs is evident. This language provided leverage for exploration of family members' explanations of relationships with each other, reciprocal influences between illness and various family members, and predictions about the future.

In the following segments of transcripts, the other clinician, SS, was meeting with Alice and Jeanie during the first session of their clinical work together. In these transcript exemplars, the language of beliefs is noticeably absent. Yet the questions are difficult to answer because they require thoughtful pensive reflection. Without using the language of beliefs, the nurse inquired about the influence of frustration on waiting for heart surgery:

Alice: But the reaction surprised me.
SS: Did it?
Alice: Yeah cause I got chest pain, and I usually don't react to anything like that. Not unless it's something big.
SS: So do you think that was...a big warning signal to your Mom, that something, that this frustration and anger was really starting to get quite big?
Jeanie: Oh I think so, yeah. Yeah because, like she says, she never does that. Never does that, you know.
SS: Did you see it coming, or did you see frustration and anger building or getting more of a grip on your Mom?
Jeanie: Oh yeah, a little bit, because you know she started going out more and trying to do more things and, you can't! I mean at the beginning, you're probably cautious, you know, you're a little more cautious and you're thinking "Well it's only going to be a couple months, so I can live with that". But once it starts going over a certain time, then you want to start going back and doing what you did before.

SS: Have you and your husband or you and Stuart or other people in the family, have you been kind of thinking that she's just denying that something could go wrong? Like that word "denial", that she's denying it?
Jeanie: I think she's denying that it's an illness, that it's something she's going to have.
SS: But when you hear her talk today about, she looks at both sides of it. Does it sound less like denial to you?...Can you tell me, like the difference it might make today talking about some of these things that haven't been talked about with you?
Jeanie: I don't know, maybe she's not cause she looks at it both ways obviously, and she's got all her stuff ready and being positive about it. But being always like, she's always so frustrated that she can't do what she wants to do and, when she wants to do it and, not acknowledging that yeah , she's ill, like this is a big thing holding her back!
SS: It's your feeling that she's acknowledging it.

A comparison of these examples of questions from the session transcripts of the clinical work demonstrates that the nurses had very different styles of asking questions. In both sets of transcripts, the reflections differ from an interrogative, fact finding format of question and answer. Both styles of questioning invited deep reflections upon the circumstances of family members' relationships with each other and with the illness. As Jeanie and Alice described in the research interview, these questions can be difficult to answer. When there is not an expectation on the part of either nurse or family to come to a correct or true answer, there is an invitation to curiosity on the part of all participants. This is a major shift for thinking about questioning practices in nursing: “Our questions don’t access experience. They generate it.” (Freedman & Combs, 1996, p. 117). These questioning practices attempt to generate descriptions and explanations of preferred realities rather than to gather data about the family.

In the midst of these questions, the nurse was also invited to reflections by the responses of family members. She reflected on the family members’ explanations of their
experiences, and hypothesized about possible implications of those understandings, and how they might be interpreted by other family members. As in the second session of the clinical work with Alice and Jeanie, the nurse reflected upon the ways that she, too, had been lulled into being patient with the changes of the health care system in accepting the circumstances of Alice's delayed heart surgery. The nurse was invited to reflect on the ways that she was implicated in the conversation by acceptance or complicity with other discourses, and by the kinds of questions that she asked.

As the nurses attempted to understand the beliefs, truths, subjective realities or stories of the family, the languaging of questions, the acceptance of particular explanations, and the reflective posture in offering questions underpin an ethical stance. The emotional posture from which questions were asked was consistently a posture of respect, curiosity, generativity, and openness, which is very different from reported postures of health care providers as scorning, pathologizing, paternalizing, belittling, or condescending (Bolen, 1996; Burton, 1993; Frank, 1991; Thorne, 1993).

In the offering of an invitation to a reflection, there is always a possibility that the family will decline the invitation. They may disagree with the question, answer a different question, or be unable to respond to the question at that particular time. A question is only an invitation if it can be declined without blame, or it is actually a demand for obedience (Maturana, 1992; Robinson, 1994). As the nurse reflected on the circumstances of her co-existence with a particular family, she was open to having her own beliefs challenged, and to avoid imposing her own certainties on another person. During a postsession conversation with the clinical team following the final session with Cecile and Mark, the nurse explained her thinking about offering reflections to families and using tentative language to avoid imposing ideas on families.

LMW: Well I didn't want to propose it that that is the truth. I mean that's we're always trying to work against eh, is imposing that these statements are, are true and that this is the way it is. But it's always a nice little addendum like you said, to add on to that, if you want to throw out an idea, and then say, "I don't know if
that's useful for you”. But you *throw* it out and say “I don’t know if this will *fit* for you”. You *throw* it out and say “I don’t know if this is useful for you or not, or it’s a curious thing, gee isn’t it, how people sometimes behave that way?” Because *all* the while, what are we trying to do? It’s to invite people to a reflection. You’re *continuously* trying to look at what will they feed back on *themselves*, looking in the *mirror*? ...What can you *say* or do that might get them to open space to *reflect* on that particular idea.

(Postsession 5 after session with Cecile & Mark)

**Reflecting Teams Offer Invitations to Reflections**

The reflecting team is an invitation to shift from an emotional posture of responding and reacting to one of listening and reflecting (Griffith & Griffith, 1994). It is “a place in conversation where one can listen to others talk without feeling compelled to respond to what is heard” (p. 160). The team members addressed their impressions of the conversations which they observed from behind the one-way mirror, and offered other possible descriptions and explanations. They offered other ideas about the problem, the people, the future, or other conversations that might be helpful (Andersen, 1991; Wright et al., 1996).

Family members consistently reported in the research interviews that the experience of listening to a reflecting team helped them to appreciate other perspectives, opinions, and ideas from the clinical team. Family members were very curious to hear how other people, “objective third parties” outside the family, viewed their situation. They also heard other family member perspectives differently when they heard the perspective embellished, described or offered through the team discussion. Sometimes, they reported feeling that their own ideas were validated by the comments of reflecting team members.

Across the clinical work with the families, the reflecting team was a source of helpful ideas, perturbations, and invitations to reflection which were different than the nurses’ contributions, or which complemented the nurses’ contributions. In the first session with Alex and Georgina, the reflecting team experience was described as “shocking”! They had not expected health care professionals to comment on the positives and what the family was doing well, but had expected to hear about the negatives and what
they should change. The reflecting team reinforced and supported the nurse’s invitation to the family to reflect on their transition to health and autonomy as a couple from a view of competency and respect for the family’s capabilities. For this couple, the presence of several health care providers as witnesses to this transition may have also supported the widening of the audience to this view of themselves. The reflecting team supported the invitation.

For Alice, the comment from a graduate student during the second session reflecting team had a profound impact on Alice’s view of her situation which persisted several months later during the research interview. The student suggested that he had realized as he listened to Alice and Jeanie during the session that when he and his friends who worked in the health care system discussed the cutbacks to the health care system, that “I don’t think we ever really once talk about how it affects the people we look after.” Alice mentioned this comment in the conversation with the nurse immediately following the reflecting team, and at the beginning of the next session. The student’s comment enabled Alice to feel heard understood by the deaf system, and invited her to reflect on the possibility that others might also be able to hear. She became more hopeful that there was a possibility that other doctors, nurses, and booking clerks working in the system might similarly be able to understand a situation like hers.

For the clinical work with Cecile and Mark, the first session reflecting team offered the suggestion or idea which Cecile later described as being most helpful to her. Although the session conversation focused extensively on the influence of worry and beliefs about Mark’s premature death, the reflecting team invited Cecile to reflect on the ways that worry might be overtaken by nagging. Cecile responded to this idea immediately following the reflecting team by enthusiastically confessing that she was a “nagger”, and wondering about the influence of power struggles in her relationship with her husband regarding his lifestyle habits. From this idea, she experimented with what she later called the “stepping
back” approach, where she showed her worry less through nagging or repetitive encouragement. In later sessions, Mark commented on the ways that he was freed up and feeling mentally better by not having as many reminders from Cecile, and the couple reported in the final session that there was more room in their relationship for humor and relaxation as a result of Cecile’s shift in her approach. Again, this is a powerful example of an invitation to reflection through the discussion of the reflecting team. Cecile was invited to consider the circumstances of her co-existence with her husband, and to account for the ways in which she was implicated. Although Mark’s preferences about lifestyle practices were undesirable to her, she shifted from negating him through criticisms or suggestions for change in order to remain in co-existence with him in a preferred manner.

Reflecting teams are not a technique. They could be undertaken in a posture of pathologizing, instructive interaction, and criticism, and would likely contribute to very different results. The posture engaged in this clinical work acknowledged the legitimacy of the other person, and accepted that there are many possible explanations of problems, and many possible solutions. The invitations to reflection were offered to the family with no expectation that any of the suggestions or ideas would necessarily be pursued by family members unless there were selected as useful or desirable by family members.

Family members were invited to reflect on the circumstances of their co-existence through invitations to reflection offered by the questioning practices of the nurses, and by the comments and conversations of the reflecting teams. These questions and conversations helped family members to understand their experiences differently, or to entertain other perspectives and viewpoints which could be as legitimate as their own. Another distinctive aspect of the character of the family-nurse relationship was the manner in which family members were invited to emotional shifts during the therapeutic conversations, to engage in different kinds of conversations than they had previously related to the illness and their relationships with each other.
IV. Inviting Emotional Shifts in Therapeutic Conversations

Human social systems can only change if their members have experiences that trigger in them changes in bodyhood that result in them no longer participating in its constitutive network of conversations. (Maturana, 1988, p. 70)

In several of the therapeutic conversations, a shift in the emotioning of family members was noticeable as a palpable visceral response. This observation of intense affect accompanying conversations of difference is not inconsequential. Maturana (1988) suggested that one cannot be invited to change their mind or to appreciate another’s explanation on purely rational grounds. He offered the idea that people must be invited to change their rational premises by a shift in their emotioning. Our conversations have consequences for our bodyhood: they are constitutive of who we are. If this is so, our bodies may tell us how we are implicated in patterns of conversations and explanations, and when the potential for change is present.

Emotions as Bodily Predispositions for Actions

Maturana (1988) offered an explanation for emotioning based on the premises of biology, that is, that emotions are “dynamic body predispositions for actions” (p. 49). Griffith and Griffith (1994) attempt to bridge understandings of mind-body problems (i.e. treatment of psychosomatic disorders) by applying Maturana’s explanation for emotioning to what they call an “emotional posture” or “the overall configuration or patterning of body components that, during a specific emotion, participate in readying the body for a specific path of action.” (p. 46). They make distinctions in therapy between emotional postures of tranquility and emotional postures of mobilization. Emotional postures of tranquility could include reflecting, listening, musing, understanding, trusting, affirming, and loving. Tranquil postures direct minimal attention to controlling one’s environment, and low vigilance to threat. In contrast, emotional postures of mobilization could include justifying, shaming, controlling, distancing, protesting, defending and walling off. Mobilizing
postures prepare for bodily readiness to defend or attack, with attention focused outward and primed to control the environment, and toward high vigilance for potential threat.

Across the clinical work with the research families, many different emotional postures could be described. Predominant postures in the clinical work with Alice and Jeanie could be described as protesting the unfairness of the waiting list, or distancing from the system to defend oneself from humiliation or to preserve self-reliance, or Jeanie’s desire to control her mother’s activity by eliminating the need for Alice to iron her son’s shirts. Jonathan’s anger with his father’s lack of effort to change his lifestyle was characterized by postures of walling off, shaming his father’s lack of willpower, and the entire family’s efforts to exert influence or control over the father’s eating and exercise behaviors.

However, if one considered the dichotomy of emotional postures of tranquility and emotional postures of mobilization across the sessions, postures of tranquility predominated. The postures of reflecting, listening, affirming, and loving were noticeably present. Some of the most dramatic moments in the sessions were those characterized by shifts of intense emotions and affective arousal that differed from mobilizing postures—these were moments of intense affirmation, reflection, love or understanding. These were moments of news of a difference for family members and for the nurse. These were moments when family members seemed to be more open to new understandings about themselves, about other family members, and about the circumstances of their coexistence in lives that included illness.

Both nurses commented on the impact of affective arousal on themselves. Strong affect invited them to reflect on the significance of the conversation at particular points in the session. In the postsession following their first meeting with Alex and Georgina, the clinical team had difficulty identifying a focus for the clinical work and for understanding what might have been helpful to the family in the session. However, the nurse who worked
with the couple commented on the presence of strong affect as a cue to her that there was something important about the conversations. During the session, Alex had become weepy during the description of the hospital experience with the acute myocardial infarct, during the conversation about beliefs about the future and their hopefulness to have more of a life following the kidney transplant, and behind the mirror as he listened to the reflecting team conversation. During the postsession conversation, the nurse commented on this shift in Alex's emotioning that was palpable to her in the session. This was convincing evidence to the nurse that something had been useful or important to Alex, even if the team could not explain what it was that motivated the family's desire to return for another session.

During the first session with Alice and Jeanie, overt affective arousal within the session was minimal, but there were many verbal descriptions of frustration and anger accompanying the wait for heart surgery, and subtle suggestions of worry about what might happen during the surgery. During the postsession discussion, the team members described their various understandings of the family and how the nurse might have been helpful to the family.

Faculty: No I don't think we were unhelpful to the family. Absolutely not, but... I just never felt like we really had a context for change that was created. It wasn't clear really what the issue was that they thought that was important to deal with, totally, I didn't think we totally understood. I think we had a nice, a much better understanding of their situation, the horrendousness of waiting, the fact that all that piece was tough for them. But, I would say it's a wonderful example of getting to the end of the first interview without a context for change being yet created.

SS: See I wouldn't even have called it that, I would have said there's a context for change cause I saw change happening. We didn't have a contract or a frame for therapy, is how I would have put it. But there's not "We are now working on this", but the whole facilitative conversation that was new and different.

There was something palpable, a bodily sensation, of change happening in the room.

This description of something happening echoed loudly in the affectively charged conversations with Mark and Cecile's family. During their second session, five nurses participating in an externship program observed the session from behind the mirror, and another 35 observed by television link-up to a nearby classroom. Jonathan described his
worry about his father’s premature death, his sadness that he believed that he had a lot to
learn yet from Mark, and his wish to have his father around forever. Not only were family
members moved by this tribute, but the impact on the externship participants was electric.
There were many tear-filled eyes and quiet gasps of recognition behind the mirror and
within the classroom. Participants were moved physically by both the emotions and
language, moved by the impact of this event for this particular family, and perhaps moved
by the implications on their own bodyhood, as kinships, ties, recollections, possibilities
and regrets within their own family connections were stirred.

The nurse also had a profound sense that this conversation was news of a
difference for the family. In the research interview, she was asked how she might explain
her own contribution to these conversations of difference, or how she knew in this clinical
work when she was conducting herself well.

LMW: How would I conceptualize this to you? It was when you can see a therapeutic
corversation changing right in front of your eyes. That you saw that there was
dramatic change, and that was when I was able to go from conversations of
accusations and recriminations...about what he wasn’t doing. And even these
avful ones from the son, so much so that they’d even become violent with each
other. And the reason they’d become violent was because, when you
understand the son also believed that his dad was going to die prematurely if he
didn’t change his ways. And that you can change that conversation to one of
conversations of affirmation and affection. You know, right in front of your
eyes! And to see this young man shift from being so critical of his father to
expressing his fears in a different way. It wasn’t that fears perhaps were any
less, but he expressed them in a different way. Instead of being violent with his
father, he wept with his father. He told him how much he cared for him, that he
wanted him around. I forget all those wonderful things that he said, but he
wanted his father around for a long time, and “that there was a lot I could learn
from him”. And the daughter came in and did the same thing! From being
furious with him, to changing it... And to see this family come together, and to
see this father then, what difference did it make in him? Suddenly, somehow he
had missed that they cared about him this much. He knew they cared, but he
didn’t know they worried this much about him....It was a conversation that
they had not had with each other before.

DT: Right then and there, just, there’s something about that dramatic, the
noticeableness of the shift right in the room?
LMW: Yes, and the intensity of the affect. I mean, when you have that kind of intense
affect, those are the things, when I feel, I feel like you’re really doing your
work well when you can see in front of you.
This shift in conversations from “accusations and recriminations” (Wright et al., 1996, p. 113) to “affirmation and affection” (p. 115) is an example of “interactions that trigger in us reflections upon our circumstances of coexistence with other human beings” (Maturana, 1988, p. 70). These dramatic shifts in the conversations do not occur in every session, but across the course of the work, these are significant conversations that were recalled by both nurse and family as conversations that were different.

**Inviting Family Members to a Different Domain of Emotioning**

Maturana’s (1988) description of emotions as “dynamic body dispositions for actions” that underpin our rational premises and explanations is useful in this attempt to explain the noticeable shift in languaging and emotioning occurring in some of these conversations. Both emotioning and languaging influenced the understandings that were coevolved within conversation. Change was possible when the network of conversations which constituted the experience of a particular sort of interactions was shifted. Within Mark and Cecile’s family, there was a dynamic of emotioning (anger, frustration, disappointment) which constituted the network of conversations around the actions of repetitive encouragement, offering advice and support, or nagging. The nursing practices with this family were distinctive in the ways in which the nurse invited family members to reconsider or to change their rational premises (i.e. the belief that the future is grim if father does not change, or that father must submit to the expectations of other family members) by inviting them to shift their emotioning.

Perhaps this is a partial explanation of the “power” of commendations. Commendations invite family members into a network of conversations of affirmation of their capabilities, strengths, resourcefulness, and the legitimacy of their experiences. In the first session reflecting team, Cecile heard many commendations from the team regarding her willing responsibility to do the right thing for her husband, her deep caring for her husband, and acknowledgment of her dreadful worry for his future. This validation of the
legitimacy of her experience may have enabled her to consider the circumstances of her coexistence with her husband. She then reflected on the possible influences of her own behavior in offering reminders and nagging, and her attempts to control her husband’s behavior. Consideration of these possibilities would seem to be more likely under the influence of the emotions of validation and affirmation than defensiveness or self-blame.

The nurse also invited family members to a different domain of emotioning by intercepting potentially incendiary conversations of “accusation and recrimination” (Wright et al., p. 113). As the nurse engaged Mark and Jonathan at the beginning of the second session, she was sensitive to the difficulties of a possible conversation which could put Mark on the hot seat by focusing on family perceptions of his weaknesses and unmet expectations. She launched on an exploration of the story of the wife who did not take advice from her husband. Through this discussion, primarily with Mark, the nurse invited family members to consider the ways that both offering advice and receiving advice could be difficult. This helped family members to appreciate the possible differing perspectives of others in the family, and defused a conversation which could have potentially been laden with anger, offensiveness, and defensiveness.

There were also several very touching examples in this clinical work where family members were invited into a different domain of emotioning by conversations which facilitated expression of different emotions directly to each other. In the second and third sessions with Mark and his adult children, both Jonathan and Josie spoke about their caring and love for their father with tearfully intense affect. Their conversations previously had been primarily “conversations of complaint for unfulfilled expectations”, which operate in an “emotional background of frustration” (Maturana, 1988, p. 53). The network of conversations which constituted the repetitive encouragement was interrupted, and the father was deeply moved by understanding the depth of his children’s concerns. Although even this did not compel him to fulfill their expectations, perhaps this experience of
difference in emotioning in these conversations helped family members to move from positions of rigid mutual negation. Mark understood better that his children and wife were not offering criticisms with punitive intent or for their own selfish interests. He understood the depth of their caring for him. Cecile stepped back from repetitive encouragement, was more convinced that her husband understood the family’s caring for him. She could absolve herself from self-negation for not being able to change her husband. Although the adult children continued to report frustration with father’s lack of lifestyle change, they also reported themselves as stepping back from repetitive encouragement.

These conversations of difference with the family were distinguished by the many ways that the nurse invited family members to a different domain of emotioning than that of frustration, disappointment, and disapproval which had previously characterized conversations of repetitive encouragement. The commendations, interceptions of conversations of mutual negation, and invitations to expression of love and caring are examples of the ways in which the nursing practices contributed to these conversations of difference. These conversations do not just happen in language, or in relationship. These are sensuous, embodied experiences which help us to “bring forth a world with others” (Maturana, 1992, p. 246) which sustain our mutual co-existence.

Synopsis

Ischemic heart disease is a call to revive a relation between the self and the body that can not be totally forgotten: we are frail humans. This is a reminder of the sensuous, embodied connections between mind and body, and between self and other. Ischemic heart disease is an invitation to reflect not only on the circumstances of one’s own existence, but on the circumstances of one’s co-existence with others. This chapter has explored the ways that therapeutic conversations between the nurses and families in this research illustrate the ways that they responded to this call: by exploring the many legitimate ways that family members were influenced by the illness, responded to the illness, and attempted to make
sense of the illness; by offering and accepting invitations to reflect on the circumstances of
their co-existence; and by shifting patterns of emotioning which contributed to suffering.
These aspects of their conversations reflect some of the ways that the family-nurse
relationship is distinctive in this clinical work. In the final chapter, particular topics of the
therapeutic conversations will be explored.
CHAPTER FIVE:
FAMILY-NURSE CONVERSATIONS ABOUT ISCHEMIC HEART DISEASE

We say that we “conduct” a conversation, but the more genuine a conversation is, the less its conduct lies within the will of either partner. Thus a genuine conversation is never the one that we wanted to conduct...No one knows in advance what will “come out” of a conversation. Understanding or its failure is an event that happens to us. Thus we can say that something was a good conversation or that it was ill fated. All this shows that a conversation has a spirit of its own, and that the language in which it is conducted bears its own truth within it - i.e., that allows something to “emerge” which henceforth exists. (Gadamer, 1989, p. 383)

The therapeutic conversations between the family and the nurse were influenced by the ways that they responded to the call to reflect on the circumstances of their co-existence within the family. How they conducted themselves in these conversations were important contributions to the understandings of the illness and of each other that emerged within these conversations. What they discussed, the topic of these conversations, was also an influential difference in the character of these emerging understandings about themselves. These were conversations of the many ways that lives, emotions and bodyhoods of all family members were irretrievably touched by the experience of the collective heart attack. Family members were structurally changed by this event, and there was seemingly no way of simply going back to the way things were before this event, as much as they could attempt to re-cover the illness. These were conversations of entertaining ideas about how to go forward in these extraordinary circumstances.

There were echoes of three motifs which ran across the clinical work with each of the families in this research. These echoes may have been heard more loudly in the work with one family when compared to others, but the strains were noticeably present in each circumstance. These are strains which are distinctly related to the family experiences of chronic illness, and of living with ischemic heart disease in particular. Firstly, there were conversations with each of the families about the impact of lifestyle changes and health
maintenance challenges in living alongside heart disease. Secondly, there were many conversations of family dilemmas and preferences about efforts to be helpful and supportive to one another in responding to the influence of the illness. Thirdly, there were conversations with each of these families about the uncertainty of the future and the possibility of death. Each of these topics (i.e. lifestyle modification, family support, and uncertainty) have been extensively described in the cardiac research literature. The family-nurse conversations uncover examples of the ways in which the families and nurses in this research “conducted” these conversations in manners which were non-directive, non-instructive, generative and transformative. “What in the world” was discussed by the family and the nurse, and was intricately woven with “How in the world” these conversations occurred.

As the nurse offered families invitations to reflect on the circumstances of their co-existence together, there were striking examples of the reciprocal impact of the family on the nurse. Something in the conversation would invite the nurse to reflect on the ways that she, too, was implicated in the conversation. As she attempted to understand the coherence of family members’ explanations and to understand the legitimacy of their beliefs, truths, and perspectives, she was called to question and challenge her own beliefs and truths. I became curious about the imagination and creativity of nurses in their efforts to offer family members other possible ideas that might help make sense of the family’s explanations. The ideas offered were often related to other social, cultural and medical explanations. The interplay and allusions to these other discourses were a source of invention, imagination, contradiction, ambiguity and possibility in the conversations.

These other discourses included discourses of economics and health care policies and systems; discourses of control, independence and autonomy; and professional discourses of social support and health promotion. These are not all of the discourses at play in the family-nurse relationship and the illness conversations of the research
participants, but they do reflect instances of the social and cultural influences which impinge on living well with heart disease. In the realm of postmodern thought, the writings of Michel Foucault have had a significant impact, certainly within the family therapy community, on the use of the word “discourse” (Rabinow, 1984; White 1991, 1995; White & Epston, 1990). Discourses are socially invented systems of perception, meaning, and knowledge which are embedded in local practices and coevolve with social practices. “The modes of circulation, valorization, attribution, and appropriation of discourses vary with each culture and are modified within each” (Foucault, 1984a, p. 117). Dominant discourses are those knowledges which are accorded truth status, which construct norms around which persons are expected to shape their lives, and which establish a field of power and knowledge which disqualify and subjugate other knowledges (White & Epston, 1990).

These discourses are not entities existing “out there” somewhere in society. They are enacted in local discursive practices, such as illness conversations within families, with nurses, with other health care providers, and with friends. They are enacted in the structures and role expectations within the social institutions of the health care system. They are enacted in the funding decisions and political debates about health care within provincial and federal politics. The intent in pointing to these discursive influences is not in the mode of a deconstructive postmodern view “aimed at unmasking the pretense of our beliefs, conventions, precedents, disciplines, traditions, and the like” (Jardine & Field, 1996b). The intent here is to understand some of the ways that discourses may offer authoritative and ambiguous messages to persons about how to live with illness, and about how to behave in the health care system. These discourses are embedded in traditions and precedents which are often unrecognized. Unquestioned beliefs and discourses may be authoritative impositions of power, and they may also be generative and sustaining. They may have “compelling moral force” (Jardine & Field, 1996b) in our practices, that provide openings and understandings for conducting ourselves well. The nurses’ questioning and
doubting of these discourses often helped to understand and make sense of the family’s explanations. The nurses’ openness to other discourses enabled the offering of alternative perspectives and other explanations which introduced different possibilities for addressing the family’s concerns.

I. Conversations about Healthy Lifestyles

When expectations for healthy lifestyle practices are prescribed as treatment for disease, taken for granted ways of being are called into question. These expectations are intimately connected to basic aspects of living: eating, exercising, relaxing, resting. These ways of being are relational, embedded in a context of family and social relationships. Prescriptions for lifestyle maintenance often neglect consideration of the context in which behavior changes are expected to occur. The family members who are affected by the heart attack may also have preferences about whether to join the quest to improve lifestyle habits, to encourage the ill family member to take up these changes for themselves, or perhaps to urge the ill family member to completely take responsibility for these issues themselves.

Nursing practices in the realm of conversations about healthy lifestyles tend to rely heavily on health education and instruction about cardiovascular risk factors. The expectation that persons receiving treatment following an acute cardiac event will take up these lifestyle practices is reflected in the extensive literature which examines barriers and enhancers to lifestyle change or wellness motivation (Biggs & Fleury, 1994; Fleury, 1991a, 1991b, 1996; Frenn, Borgeson, Lee, & Simandl, 1989; McSweeney, 1993) and compliance with cardiac rehabilitation regimes (Comoss, 1988; Hilbert, 1985; Miller et al., 1988; Miller, Wikoff, Garrett, McMahon, & Smith, 1990). Covert beliefs often underpin the discourse of cardiac rehabilitation and compliance with lifestyle recommendations: that the person in the sick role should cooperate with the health care professional by accepting their advice or recommendations; that compliance results in cure while noncompliance
results in morbidity and mortality; that the health care professional knows the best outcome; and that the effects of medical and nursing intervention are beyond question (Hess, 1996).

The nursing discourse of health education could be viewed as a form of conversation that circulates within a cultural discourse of lifestyle modification and healthy lifestyles. During the clinical work with Mark and Cecile’s family, the postsession discussions with the clinical team often addressed possible dilemmas of the nurse as she attempted to situate herself without aligning with various family members’ perspectives regarding the need for lifestyle changes. There was a risk that the nurse could fall into the same trap as the family, and that she could become isomorphic to the problem by supplanting the family’s repetitive encouragement (or nagging) with repetitive health education.

Just as it was not intended to imply that family members purposely choose to oppress other family members through repetitive encouragement, this perspective is not intended to imply that nurses purposely choose to exercise power by educative and health promotive efforts to sustain health and prevent illness. Family members may genuinely desire to express their caring concern and love by offering suggestions, repetitive encouragement and nagging. Nurses may genuinely wish to provide persons with information that empowers them, and that enables them to make the best decisions possible about how to live well with ischemic heart disease. However, these benevolent intentions are betrayed when these social practices mutually reinforce each other in a manner that diminishes possibilities to exercise one’s own judgment about preferences in living out one’s existence. This occurs when the nurse behaves as if the lifestyle imperative is the “truth”, and that other possibilities are wrong.

LMW: To get along in life, you have to have strong beliefs about things, but you also have to have the wisdom to be able to give them up when they are no longer useful....I have to be open...that some of my beliefs have to be changed and challenged, as families [do], to allow that to happen to me. And they have to do the same. (Research Interview)
This clinical work is distinguished by the determined efforts on the part of the nurse to stay open to having her own beliefs challenged, to attempt to hold open the possibility that the other might be right. This effort is different than being neutral to various observer perspectives or being nonjudgmental about ideas, beliefs and explanations that differ from one’s own. This stance invites the nurse to constantly question her own beliefs and the ways that her nursing practices with families are influenced by these beliefs. The persistent effort to understand beliefs is an attempt to understand the ways that the other person’s explanations of their experience are legitimate for them.

LMW: I’m just trying to draw forth who’s on the side of him changing and who isn’t, and where he’s at, and his belief is different. But I don’t feel an impulse to align with either side of that.

Faculty: But you’re right, that could be a trap eh? Cause LMW (Nurse) could have spent a great deal of time saying, “Well right, okay, now I understand why you’re not doing those things. So let’s see if we can remove some of the barriers so you can get on with doing that”. But did you hear her say toward the end “So it may help, and then again it may not”? (Postsession 2)

....

LMW: What I always find...for so many reasons, why we don’t call families resistant or dysfunctional, or non-compliant is because once you understand their beliefs, their behavior usually makes very good sense. And that’s what I tried to say to him was “Now that I understand your belief about your prognosis, why you don’t keep up with your diet and all these things, makes very good sense now. Because you’re not worried about dying today or tomorrow”....I would like to ask him that question. Does he think that I’m on the side that he should get a grip on these things too? Cause I want to be real clear...that I’m not on that side that he should, or he shouldn’t. I can offer the professional belief that yes, I share the same belief as your family that from the literature and from my own knowledge that those things, eh, reduce the risk. But I’m not really trying to figure out ways that you must do that. (Postsession 2)

When the nurse understood how family member beliefs and perspectives made sense for them, she was able to understand their suffering differently, and she had different leverage for attempting to influence the suffering.

The Healthy Lifestyle Imperative

Discourses of healthy lifestyles and lifestyle modification following illness episodes of acute cardiac events play a role in preventative public health measures and health promotion techniques. The imperative for normative behaviors for healthy lifestyles for
persons experiencing ischemic heart disease is based on the authority of an extensive body of scientific research which links ischemic heart disease to behavioral and psychological influences of diet, exercise, stress management, and nicotine addiction. The clinical work with Mark, Cecile, Josie and Jonathan revealed some of the ways that this imperative can operate through worries about premature death, and through the belief that life can be prolonged through healthy lifestyles.

There is much research to support the effectiveness of healthy lifestyle practices in reducing mortality and improving indicators of health following acute cardiac events (Dawber, 1980; Reeder et al., 1993; Wielgosz, 1995). Healthy lifestyles and preventative medicine are effective, and people still get sick. There are limits to the control that individuals can exercise over their health. Some people live extremely healthy lifestyles and still develop ischemic heart disease. The expectation that persons experiencing ischemic heart disease will adopt healthy lifestyle practices is an intensification of an imperative which is reinforced medically, culturally, and politically (Epp, 1986; Lalonde, 1974).

Healthy lifestyle practices have become normative expectations in our culture. There is a difference, however, when these expectations for healthy lifestyle practices are prescribed as treatment for disease. The prescription of lifestyle changes as part of a treatment program for a chronic and life-threatening illness can become an imperative for expected and required action. When a person with ischemic heart disease fails to fulfill these expectations, this “failure” may be viewed as a weakness or a fault. In professional discourses, this may be viewed as non-compliance or non-adherence with the recommended treatment (Comoss, 1988; Hess, 1996; Hilbert, 1985; Miller et al., 1990). The imperative to live a healthy lifestyle comes under the surveillance of not only the physician, but also the family and the self. This surveillance can take on the punitive tone of a normalizing judgment which becomes an instrument of power and coercion (Foucault 1984b) which can include the anticipated harassment of the physician; the humiliating
disapproval and critique of both family and physician; the conditional love of family members; and the negation of self.

**Normalizing Judgment Outside the Family**

The discourse of healthy lifestyles can become oppressive as a normalizing judgment when it negates the legitimacy of differences in preferences about how to live one's life. Hence Mark's repeated question to the nurse and the reflecting team was "Am I abnormal?" The message that a lack of lifestyle changes meant that he was not normal could be subtly reinforced in social practices at multiple levels.

The results of scientific research are increasingly accessible to the lay public in North American culture in the media of newsprint, television, and the Internet. Interpretation of the significance of research findings is hampered by scientific and statistical jargon, and by abbreviated reports which usually do not allow ‘laypersons’ to adequately weigh the merit of the study, or to make informed comparisons to other studies. Research findings may be accepted as truths or facts, even though the findings are often contradictory and ambiguous.

**LMW:** Do you believe that would make any difference in terms of your heart condition...?

**Mark:** Well *statistically*, yes it does. I guess *statistically* it does, when you *read* all this, of *course*, these are things you should be *doing*. (Session 2)

**LMW:** Do you think that reducing your stress is...decreasing...the possibility of further heart problems? Do you think that helps you?

**Mark:** I believe that ...because it's written everywhere, and that's what I've been told. Now I don't know what percentage is greater. Is the stress better than the, shall we say the one or two cigarettes occasionally, or the overweight? I don't know. (Session 2)

**Mark:** There's no real true stats saying how much does the stress part weigh? And the type A is part of the stress factor right? How much does that outweigh the weight and the smoking? I don't know what the stats are okay? (Session 4)

**LMW:** And how much do you believe, or what has been explained to you about how stress relates to heart disease?

**Mark:** Well the articles I used to read, like you're a type A personality, like apparently I am or was, is worse than anything else. And then you read lately some
articles, it’s not as bad as other things. So I’m confused... it depends on what article you read. (Session 5)

If a person believes in the merit of research, the power of statistics and numbers can be a powerful influence on beliefs about the effectiveness of lifestyle modification to treat heart disease. This information becomes accepted as truths, and is integrated into popular literature, self-help books, and instructional materials developed by health professionals.

In her conversations with Mark, the nurse did not impose her own view of the truths or facts about cardiac risk factors. Her questioning invited Mark’s reflection about his own ideas about risk factors in a tentative way that acknowledged that statistics are ambiguous and are not always truths. His beliefs about the importance of various influences on cardiac risk were accorded as much status and truth as these statistics.

The normalizing judgment of health care providers can result in blaming and labeling, efforts to coerce lifestyle changes, and perhaps even unintended experiences of harassment and humiliation which influence follow-up and monitoring.

Mark: I know it’s a weakness...I had a bypass, what am I doing still overweight? 3 years ago! I’m embarrassed to go back to the doctor’s office for a check up. First thing he’s going to say “You didn’t lose the weight like I asked you to!”...I don’t want to hear that! (Session 2)

Mark: No I’m way overdue for stress test, so and I guess like, it’s back to, I don’t want to hear this guy giving me the third degree for half an hour, okay. You know in terms of the weight.. I’m sure I can pass it. I want to go for the stress test cause that’s kind of a confidence builder, saying you know, the stress test for half an hour, 25 minutes, under full load okay, and the old heart’s pumping at 150, 170, and there’s 2 doctors ready to, in case something happens, and you pass that it gives me some confidence. So I want to go for that portion to find out how the system is working....And that does bother me cause if there is something wrong, I don’t know that right? Until I’ve gone through it.

LMW: So your biggest, your biggest constraint from not going is you think they’re going to hassle you, is that right?....Cause has that happened before that you’ve gone and they hassled you?

Mark: Oh have they ever. (Session 4)

The unfortunate side effect of these past experiences in this instance was that Mark postponed follow-up which might prevent future acute events in order to avoid subjection to comments and critiques which reinforced his sense of abnormalcy. Again, the nurse did
not attempt to convince Mark that he should go for this check-up. She invited Mark to explore the consequences of his choices, and invited him to reflect on his beliefs about the constraints to going for the check-up. His choice not to go was respected as legitimate, and making sense in view of past experiences of “hassling” during these check-ups. The conversation also revealed the benefits of going for the check-up, that he might have more confidence in his health as a result of passing an exercise stress test. Mark reflected on both the benefits and constraints of his choices.

**Lifestyle Surveillance by Family Members**

During the fourth session, Mark revealed that although he remained optimistic about the future, he was quite concerned about his weight gain over the previous year and a half, as he felt more tired recently. The weight gain was a visible indicator to his family of his lack of attention to lifestyle changes, and contrasted other family members’ pride in their own fitness and physical appearance. Mark explained that he continue to smoke occasionally, but that he had come ‘out of the closet’ with his smoking in recent weeks. In the past, he had denied smoking when confronted by Cecile, or he would have said he had one cigarette when he actually had two. He expressed relief that he was now able to be open about this and was not longer lying to Cecile about smoking.

The surveillance of lifestyle habits is commonly taken up by family members after heart attacks and coronary bypass surgery (Artinian, 1991; Gilliss, 1984; Gilliss & Belza, 1992; Stanley & Frantz, 1988). This vigilance often begins out of their concern to protect the health of the ill family member and their desire to prevent a recurrent heart attack in the future. Concern and disapproval, reminders and nagging, frustration and condemnation are all possible developments as family members are inadvertently recruited to enforce the lifestyle imperative.

Jonathan: The support I’ve tried to give to him hasn’t helped. Well I’m not going to give the support, because he’s not trying. But if he tries and he wants to try and he says to everyone “Look I want to try and I want to do well”, hey, the gates will open, and we’ll pull him in and we’ll help him. But if he doesn’t want to do it
himself and he isn’t going to make an honest effort, then forget it. He won’t get the help. And I’m not going to try to give it unless he wants to, unless he comes to me and says “Look I want you to help me with this”. (Session 3)

The annoyance and frustration on this issue was a longstanding interference in this father-son relationship. The son’s acceptance of his father and desire to show support for his father became constrained by the lifestyle imperative: his father had to want to do very specific actions to help himself in order to receive the conditional approval of the son.

In the third session, a reflecting team conversation challenged these beliefs about who was responsible for lifestyle change. What did it mean that Mark had not followed through more with lifestyle changes? How did this influence his relationships with his adult children? In this conversation, the reflecting team was responding to questions that had been asked by each of the three family members present.

LMW: You see, I don’t think that’s fair to them to have to be on his case sometimes and not [other times]. I mean, when it comes to this issue of personal responsibility, how can they turn personal responsibility over to him? If he wants it, he seems to give the message that he would prefer that. So in terms of Josie’s question, “Is this an individual problem or a family problem?” I mean it’s really both isn’t it?... And in terms of father’s question...”Is he really far out in left field?” Well no, we’ve met lots of people with cardiac problems, that have a very hard time changing their lifestyle, changing their patterns.

Faculty: And in terms of Jonathan’s question, “Where do we begin?”

Student 1: Changing the approach.

LMW: Changing the approach, I mean, they’ve tried this, and it hasn’t worked, eh?

Student 2: And they’ve really done a really good job.

LMW: They’ve really done a good job of trying to encourage him, showing their caring for him. They’ve got mad, they’ve got frustrated...they’ve wept in front of him, they’ve told him how much they cared. I mean that was a very moving session last time, they can weep, they can get mad, they can get pissed off, but it doesn’t change. So, the only thing that I’ve seen that they haven’t completely tried, and, and I suggest when I say tried, that it may or may not make a difference. But it just might make them feel better and get along with their dad better, is turn it all over to him.

(Mark, Jonathan & Josie, Session 3)

The frustrations incurred by hoping that Mark would change were explicitly acknowledged. Mark’s difficulties in changing lifestyle were also acknowledged as understandable and similar to difficulties encountered by other persons with heart disease. The adult children were invited to reconsider the effects of their efforts to remind and encourage Mark: these
efforts were admirable, but were not creating a difference. Jonathan and Josie were invited to entertain the idea that Mark might prefer to take on more responsibility for his lifestyle himself.

Although the sessions may have helped all family members to back off on their efforts to remind and encourage father about lifestyle changes, for the adult children, the frustration and sadness about their efforts to help father to change were still very present during the research interview. There was more acceptance from all family members to let Mark make his own choices, even if they disagreed with his choices. What was remarkable about this family was Cecile’s wise desire to break out of the intolerable influence of the inadvertent role of the family as the lifestyle police unit. Cecile was the first family member to experiment with stepping back from showing worry, and with handing more responsibility to Mark to manage his health. Perhaps her ability to back off showing her worry through repetitive encouragement also helped their adult children to attempt a similar approach.

**Self-Surveillance**

From Foucault’s view, the effects of surveillance and normalizing judgment are perfected when it is no longer necessary for another to be present for the critique to be in force. When the person allows self-surveillance to augment the critique of others, the subjection of the discourse is fully enforced (Foucault, 1984c). Mark had come to think of himself as ab-normal. When a reflecting team had commented that he was not irresponsible in tempting fate, he commented on his relief.

Mark: It’s good to hear that you don’t think I’m irresponsible, that was a real lift. The whole group said that, because I question myself. I say “Gee maybe you’re really crazy or something”, right?...You know cause you kind of second guess yourself after a while? (Session 4)

Mark offered a fascinating glimpse of the self talk he experienced around surveillance of healthy lifestyle behaviors. In this passage, it becomes understandable that Mark did not
need reminders and objections from others. The probable objections of anonymous others had become counter voices to his own.

Mark: I guess I feel bad that I do disappoint my children. Again you would say, “Not bad enough because you’re not doing enough”. I think I’m doing something, in my opinion.

LMW: Yes. Well especially if you believe that you’ve changed this 20 to 30% or whatever

Mark: and it sounds like your children are already way up there at 90 or 100%, that they would like for you.

Mark: And they could say well “Gee you were aware of this for the last 6 or 8 years, that’s not much progress for 6 to 8 years”. If I was doing a grading here, if I was your employer at an interview for the year, “What have you done in the last year? Well I’ll give you a D minus or something”. And I think that’s what they’re looking at. Well I would give myself maybe a C+.

LMW: Okay. So where do you think we should go from here in terms of who should be seen. Who should we have our next session with, should it be you by yourself, should it be trying to get all the family in, should it be you and your wife.

Mark: I would come in, I think I gain something out of these. And what it is I don’t know, I just, I guess I, before the last meeting in May, I didn’t know my family cared. So maybe we don’t, well I think they care but I didn’t know they cared that much. And I think by communicating it helps me. Now, you would say well, “What’ve you done the last 6 months?”, and I admit not much. But mentally I feel better.

....

Josie: But does that encourage you to, to do, to

Mark: Well I think it does, but you’d say, “but I don’t believe you Dad”.

(Session 3)

Mark had ongoing self-inflicted, critical and nagging conversations with himself. The nurse acknowledged that even 20 or 30% effort to address lifestyle management was an accomplishment, even though it was understandable that other family members might not be as able to appreciate this effort. The nurse’s conversations with Mark about lifestyle changes were different conversations at least partly because of her willingness to acknowledge his efforts in this regard.

These practices of normalizing judgment and lifestyle surveillance were at play in the beliefs and the conversations of this clinical work. Of course, the nurse was not immune to these practices, but she was aware of the possibility of being conscripted into these practices, particularly in her role as a health professional. To have attempted to figure out ways of inviting Mark to change his lifestyle would have been more of the same kinds
of conversation that he had experienced with the family members. Her ability to remain aware of and cautious about the ways in which she could also be coerced to participate in the enforcement of the lifestyle imperative is one of the nursing practices which made these 

different conversations with this family. Family and nursing initiatives relating to health maintenance are often motivated by a benevolent intent to sustain health and prolong life. These initiatives are intricately connected to beliefs about ability to influence health and illness.

**Discourses of Autonomy, Independence, and Control over Illness and Health**

Georgina: Well, if you feel ill, and keep on making yourself believe all of this, and worry about this, and this is going to happen to you and whatever, I think it really would. I really think that it would happen to you. If you did that day after day after day. But hey, the sun is shining, it's beautiful out, and you can breathe, and you can walk, and you can use your hands and feet.

Alex: The Premier said two nights ago in the news, "The doctors tell me that 75% of all the patients who are sick are there because of choice. They *tell* themselves they're sick. It's a matter of attitude." (Research Interview)

Both of these comments address the same topic from different directions. Georgina offered the belief that what you think, what you believe, and one's approach to appreciating the world around oneself influences illness. There are partial truths in this statement that are matters of great interest in both popular media and preventative health care movements: what are the connections between beliefs, attitudes, mind, emotions and health (Cousins, 1989; Sternberg & Gold, 1997). Her husband, Alex, offered the antithesis of this perspective, the biting flipside that can sting, blame and hurt people who experience illness whether or not they have had a positive attitude. The implication is that if you can will yourself to be well, when you become ill, you must have also chosen that option. Wright et al. (1996) suggested that interference with emotional dynamics can influence illness, but they challenged the idea that disease is a sign of ethical, moral, or spiritual weakness. Surely illness is not solely a matter of attitude, willpower, or emotioning.
Control, autonomy and independence are a trio of ideas with a shared history. They are traits that are highly valued in North American culture. They are part of a heritage of mastery and domination over nature that has been the product of three centuries of faith in the progress of science (Borgmann, 1992; Berman, 1981). When applied to health and illness, efforts to control nature take the shape of attempts to influence and control the body. Modern medicine has developed many means by which technology can influence, heal and cure the body. The belief that the mind can control the body rather than influence the body invites responsibility for determining the outcomes of encounters with illness. It can justify blaming for ill health: “It’s a matter of attitude.” This belief can shift the burden of responsibility for health squarely on the shoulders of the individual. For example, from this perspective environmental influences on health may become secondary, unnoticed features. The influence of valued employee traits such as competitive drive or ability to withstand work stressors (Helgeson, 1995), and the discounting of explanations related to social class and poverty (Kringlen, 1986) are ignored. Less complex models of accounting for cardiac risk factors focusing on individual biology and psychology are favored. This blaming can be taken up subtly in discourse, and was noted repeatedly throughout the transcripts.

Grace: But it may be the reason why she doesn’t seek help from other people and is so independent in that she will handle it herself, and she does.

Alice: Well you can! Like we said on the way up here. You can make yourself sick if you want to

Grace: That’s right

Alice: Or you can make, what was the other thing we were saying?

Grace: You can make, well, you can make yourself well, you can really make life worthwhile or you can enjoy poor health!

Alice: Yeah we were talking about people that enjoy poor health. How can you do that?

Grace: And Alice never has. You know, although she has had some tremendous health problems, and, and I tell her quite bluntly, you know you’ve brought a lot of this on yourself with your smoking! (Family 5, Session 3)

Frank (1995) countered this notion with the idea that “The sick role is no longer understood as a release from normal obligations; instead it becomes a vulnerability to extended
institutional colonization" (p. 172). He suggested that it is much more difficult these days to enjoy poor health.

In health care, valuing of self-control and independence is compounded by health promotion and maintenance messages which emphasize personal responsibility for health. In some ways, these messages are a welcome restoration of the belief that persons have credible understandings of their own capabilities in the management of their health concerns. In Thorne's (1993) research on relationships between health care systems and persons and families experiencing chronic illness, a shift toward personal responsibility for health maintenance was viewed as a necessary and valuable counterpoint to the blind belief that doctors know what is best for patients.

Regaining control required that those with chronic illness become confident that their own understanding about general well-being was as valid as any clinical or technical expertise for making chronic illness decisions...It gave them strength in the knowledge that they were avoiding harm and promoting health by taking actions consistent with an informed interpretation of health and well-being. (Thorne, 1993, p. 190)

A grounded theory study by Johnson and Morse (1990) identified the major process in the adjustment after an MI as the struggle to regain control. The dimensions of this core variable of regaining control following a heart attack included "predictability (the ability of the person to predict the outcome of an action), self-determination (the ability of the person to make informed decisions), and independence (the ability of the person to act on decisions)" (p. 128). This is an example of the language of control and independence at play in discourses about recovery and learning about how to influence the illness. This language can be helpful in understanding the possibilities of influencing the illness. This
language can also make a belief in fate extremely difficult for health care professionals to fathom. Is a belief in fate deeply counter to a belief in mastery and self-control?

Taken to an extreme, the message of personal responsibility for health can become warped to a message of self-blame for illness. To expect an individual to control their health is asking them to be able to control nature, or to control their body, in a manner which may not be humanly possible. Blaming for occurrences of illness could influence willingness to seek professional help in the event of illness, and may invite persons to feel less entitled to access required assistance. This kind of blaming and negative labeling occurs in professional discourses, in the media, and in self help literature.

SS: And it keeps, it brings me back again to our role as health care professionals. That we be aware that sometimes that dynamic happens. People are not going to tell you how bad things are, what they’re really like because of all the beliefs around, ‘if you show weakness, or you complain, or you’re a wimp or’, you know all kinds of things.

... DT: Well I think it’s, it’s kind of two pronged. One of it, one part of it might be, “What are they going to think about me?” and another part of it is “Does it make me more vulnerable in getting services from them too, what they think about me?”

SS: Yes because the same operating, beliefs they operate under, around if you complain too much you’re whiny or you’re a wimp or you’re neurotic or, like it has all kinds of negative connotations. If you say too much about how bad it is right? Well the professionals have that same sort of belief as well, “Oh you’re just a wimp or you’re exaggerating or you’re somaticizing or you’re, or it’s your emotional state. It’s not really that bad”, right? (Research Interview)

These discourses result in blaming not only for being ill, but when combined with funding issues, results in blaming for “abusing” health care services. One who is in need of health care services can inadvertently be condemned for needing access to services.

Mark: Well I also think there’s a lot of people that we know, they think they’re sick, they run to doctors weekly or monthly. There’s nothing wrong with them, you know it’s more mental than anything else. (Session 5)

This message can be one which makes it more difficult to ask for assistance. If needing help is a weakness, to ask for help is admitting one’s weakness, and can open one up to unwanted critique and labeling as a malingerer, a complainer, a neurotic, somaticizer,
or attention seeker. This discourse may underpin some of the beliefs which constrained
Alice from making her escalation of symptoms and deterioration of activity more of an
issue with a cardiologist who might be able to influence the wait for surgery. The belief that
she perhaps should not need help, or that she could depend on her own self-reliance to
manage on her own could belie a core belief that asking for help is a sign of weakness.

Beliefs and discourses about control or influence over the illness are often
connected to conversations about lifestyle changes. The messages within these discourses
are ambiguous and can result in blaming and disparaging views of individuals and families
experiencing heart disease. The nurses’ ability to question these discourses and be aware of
these possible influences on the family had significant consequences. The nurse was freer
to decline participation in these discourses in a manner which could contribute to negation
of persons in their experiences with the illness. She could decline participation in a manner
which could diminish possibilities for the persons to exercise legitimate preferences for
conserving their own existence or their mutual co-existence with other family members.

II. Conversations about Family Support and Sustaining Mutual Co-Existence

The clinical work of the sessions described in this research were very much
communations of family support, of the ways that all family members were carried along by
the illness experience, and of the ways that they helped each other to endure and persist
through the illness experience. Within these conversations there was discussion of the
obvious and subtle ways that the illness was influencing each family member, and the ways
that family members believed that they could influence the illness. These were also
conversations of complex relational dilemmas of offering and receiving help: of desiring
assistance and asking for help yet wanting to be viewed as capable; of offering help,
encouragement and reminders yet being frustrated when advice is unheeded or assistance is
declined; and of receiving help and advice even though it is not desired.
What is family support?

How do family members help each other through recovery from a life-threatening illness? In the cardiac literature, the family has often been viewed as a resource, or a source of support which assists the ill family member through recovery from acute cardiac events. Social support theory and stress and coping theory have been popular frameworks for exploring the nature of family coping and family support following myocardial infarction and cardiac bypass surgery (Beach et al., 1992; Bramwell, 1990; Fleury, 1993; King, Reis, Porter, & Norsen, 1993; Markle-Reid, 1989; Moser, 1994; Rankin & Monahan, 1991; Redeker, 1992; Riegel, 1989; Waltz, 1986; Yates, Skaggs, & Parker, 1994). Social support theory attempts to address the contribution of social relationships to individuals coping with stress. However, from this perspective primary emphasis continues to be placed on the coping of the individual experiencing the illness. Social support becomes another psychosocial risk factor: a flat, linear, dichotomous concept which is either present or absent. Family support is often reduced to a perception of the adequacy of support available to the person experiencing the illness or to the caregiver. Interpretation of the social support research is complicated by the many different attempts to operationalize definitions of social support including marital status and living alone; size of social network within and outside the family; perceptions of availability of needed support; emotional support, tangible support, informational support; affect, affirmation and aid; and appraisal, esteem, belonging, closeness, and tangible support.

The current conceptual view of social support invokes a tendency either to ignore the effects of the illness on family members other than the person with the disease, or to focus exclusively on the caregiver needs for social support. For families experiencing ischemic heart disease, there have been numerous reports suggesting that spouses of cardiac patients experience as much or more stress as their ill partners (Allen et al., 1991; Artinian, 1991; Moser et al., 1993; Nyamathi, 1988; Orzech & Staniloff, 1987; Stanley &
Frantz, 1988; Thompson & Cordle, 1988; Yates & Booton-Hiser, 1992). These reports have called for the inclusion of spouses in inpatient cardiac teaching programs and cardiac rehabilitation programs. However, there has been minimal attention to the ways that spouses of cardiac patients are also vulnerable in ways that can not be addressed simply by adding other sources of support from outside the family. The possibility that the vigilance and surveillance of activity, health maintenance and other caretaking activities of spouses of cardiac patients may also be related to their efforts to manage their own distress has been significantly overlooked (Coyne et al., 1990; Coyne & Smith, 1991). The impact of cardiac illness on the children (school-aged, teenaged, or adult children) of persons experiencing heart disease has not been addressed in the research literature.

Family and marital relationships are complex and vary in degrees of closeness, intimacy, and conflict, all of which influence perceptions of the availability of social support. The family can be a resource to the ill family member, but the family can also be a source of stress resulting in problematic or non-supportive environments (Ben-Sira & Eliezer, 1990; Moser, 1994; Waltz et al., 1988). When family situations are depicted as providing low support (i.e. conflictual, demanding, or otherwise problematic) interventions may be based on the assumption that what is needed is *more* family support. Instead, the situation may require resolution of difficulties posed by relationships or perhaps insulation from non-supportive relationships “rather than instigating more involvement” (Coyne et al., 1990, p. 131).

In addition to proposing that understandings of family responses to heart disease requires an interactional perspective of recovery following acute cardiac events, Fiske, Coyne and Smith (1991) also suggested that the stress and coping literature has diminished the experiences of family members (particularly wives and mothers). They questioned the gendered manner in which “overprotective” mothers have been cited as the cause of numerous psychological and medical problems in children. They extended this critique to
include the possibility that the literature on cardiac invalidism and overprotectiveness may
have pathologized women’s relational responses to family illness by depicting
overprotectiveness as “an almost exclusively female failing” (p. 7). They questioned the
causal punctuation of overprotection as a cause of rather than a response to difficulties of
the ill family member. “It [overprotection] has been viewed as a motivated, destructive
influence on the recipient, instead of as an adaptive response or miscarried coping strategy
for the overprotector” (Fiske et al., p. 16).

Contrary to the prevailing beliefs of many health care professionals, a study by
Riegel and Dracup (1992) concluded that overprotection may prevent cardiac invalidism.
They found that post-MI patients who described themselves as receiving more social
support from family and friends than desired reported less emotional distress, higher self-
esteem, and less emotional reliance on others when compared to those describing
themselves as receiving less support than desired. Coyne and colleagues make distinctions
in their research (Coyne et al., 1990; Coyne & Smith, 1991) between protective buffering
(i.e. hiding concerns, denying worries, and yielding to the partner in order to avoid
disagreements), and overprotectiveness which involved intrusion (i.e. interfering too much
in their partner’s life in activities which they could be doing for themselves). They
suggested that neither protective buffering nor overprotectiveness were necessarily related
to the pre-existing quality of the marriage.

This review of professional discourses of social support is offered as a caution to
the tendency to oversimplify the complexity of the conversations of family support which is
implied in much of the cardiac research related to family support. The character of the
conversations with the participants in this research project was distinctively different than
Teaching interventions which would instruct families how to be more supportive to each
other, or identification of resources within the community to expand social networks
outside the family. The nurses and families engaged each other in conversations of the full
complexity of the reciprocities and relationships within the family: consideration of the
suffering of all family members in their experience of the illness, and consideration of the
dilemmas of asking for help, offering help, and accepting help. The conversations were
invitations to family members to reflect on their preferences related to offering and
receiving help, and reconsideration of preferences which resulted in negation of themselves
or other family members. These conversations invited reflection on the ways that family
members were nurturing and sustaining their own individual existence and their mutual co-
existence in the face of life-threatening illness.

Conversations about Asking for Help During Shifting Times of Need

The dilemmas which were raised during clinical conversations about the influence
of all family members on the illness and the expression of concern and desire to help each
other were complicated matters. How do you get the help that you need as an ill person or a
family member of an ill person? How do other people know what you need? What do you
expect that other family members should know about your needs? Should you have to ask
for help? How do you ask for help and yet maintain a sense of competency about your
ability to recover? These are questions that are often difficult to answer. These are
questions about negotiating relationships in the face of a life-threatening illness, and in the
face of constraints related to beliefs and discourses about autonomy and independence.

This conversation was explicitly raised in the conversations with Alex and Georgina
about their preferences for involvement of their adult children in their lives during their
transition following the heart attack and kidney transplantation. During the fourth session
with the nurse, the couple was regretful that they had been unable to coordinate schedules
with all of their adult children to bring them to the final session. Even though the adult
children were not present, the nurse was curious about what the couple was hoping their
children might hear or learn by coming to a session. This couple addressed some of the
dilemmas around pacing of help offered. In their circumstance, the couple believed that it
took a while for their adult children to realize that they needed more help. Later in the recovery, the couple was wanting their children to appreciate their capabilities, and that less help or involvement was required. The nurse explored understandings about this difficulty in pacing, and offered another possible explanation for the difficulty in pacing of help.

SS: Well let me ask you this... do you think that at this stage, that they’re *regretting* or something, that they *weren’t* involved as much as they should have been or and that makes them want to say well “Maybe now, I should do it?”

Georgina: *They might* be, I don’t know.
Alex: Yeah

(Session 4)

Throughout these conversations, the nurse appreciated that Alex and Georgina might have different views and preferences about the involvements of their children, and inquired about each of their perspectives. Georgina offered a reminder that asking for help and being privileged in being able to provide help within the family can be a source of connection that enriches and nurtures relationships.

Part of the tension in dilemmas of asking for help is a pull between a desire to be independent and to be viewed as capable, and yet wanting to have assistance when you need it, and wanting to sustain connections in the family that allow for reciprocal helping and interdependence. For this couple, asking for help was easier when they had a sense of reciprocity, when they could offer something back to their children. Alex described an example where he asked his son David for some help with some small repairs to the electric windows on his car. In return, Alex and Georgina babysat the grandchildren for David and his wife for the evening.

Alex: So David said "Dad, *this* is the way I *want* it. When you *need* help *ask*. We’re not going to *force* ourselves on you, but *ask!*" So David has got the *message*, you see.

SS: And do you think that your children *trust* you that you *will* ask?
Alex: I think so.
SS: Like do they *know* that you will ask for help when you need it?
Alex: I think so, yeah.
SS: Or do they know that you are *reluctant*? Some parents are *reluctant* to ask, so their children may feel like, "Well I know they're not going to *ask* me, so I have to always kind of *guess* and try and do it, *without* their asking”.

Georgina & Alex: Yeah
Or are you the kind of people that would say, "I want help", "I don't want help" or more clear?

Georgina: We never have been

SS: No, so you'd be more likely to be not so clear and you'd hope they'd kind of guess a bit?

Alex: Yeah, yes

Georgina: Yes. Or use their own brain... (laughs)

SS: But peoples' needs are so different. What you think somebody else needs, you think usually what somebody else needs is what you need and you have different needs than other people.

In the above transcript, the nurse invited the couple to reflect on their ways of asking for help in the past. She invited them to wonder about how their children would know if they needed or wanted help, and how it could make sense that their children might be less certain about how much to be helpful in the present in view of past ways of not asking directly for help. The nurse persisted with this idea, inviting the couple to reflect on the circumstances of their co-existence with their children, and to explore the possibility of helping their children in another manner.

SS: But, so again I, but how will they know what you need? Because it's changed so much now...I imagine you are getting to know what it is, how it is at this stage in your life. You are more healthy but you're also older.

Georgina & Alex: Yes, yes

SS: So do you think that, to help your kids out, (and maybe yourselves as well I'm not sure) in figuring out this new transition, do you think it would be a good idea to try and sort through in your own minds what it is you want from them?

Alex: Ah

SS: Like how much you want them to help and how much you want them to stay out? Like would that something you could do for them? To sort it out in your own minds?

This negotiation of helping and assistance is far more complex than understandings conveyed by measures of social support as a perception of more or less assistance than desired. Through this conversation about pacing and timing of help, and about explicit or covert expectations for help, the nurse invited the couple to consider the ways that they might influence their children's ability to gauge their needs and preferences, and to coach their children as they accompanied the parents through their transition.
Conversations about Reluctance to Ask for Help

Through the interpretive account of the clinical conversations with Alice, her daughter Jeanie, and her friend Grace, we heard of Alice’s fierce determination to maintain her pride and self-reliance in her relationships with health care providers. Alice’s determination and self-reliance also extended to protecting her children from knowing of her financial difficulties while awaiting heart surgery. Her children were unaware that she had halved her heart medications during the last few months of the wait in order to be able to pay for her utilities. Alice revealed this situation to the nurse during their final session which her friend, Grace, attended with her. In this conversation, the nurse invited Alice to reflect on the consequences of not asking for help by asking for the perspective of her trusted friend on this matter. This was a conversation about understandings of dis-allowing others to help.

Grace: Her son is living at home, and I believe if my son was living at home with me, and I don't know Stuart’s financial health, but I know Stuart also doesn’t know Alice’s. And I think he should. He’s a grown man of 37 years old, he should be there helping his mother financially. I would love to be able to take this stress away from her in any way I could. Financially, I would come and work for her, I would do whatever needed to be done, if she would allow it. But I really feel with Stuart being there, he should be doing more for her.

SS: Do you believe from your knowledge of Stuart, Grace, that he would like to know? That if he knew what he doesn’t know, what am I trying to say?

Grace: That’s a very, very good question, I know exactly what you’re asking.

SS: Do you think it’s more hurtful that he doesn’t know it? If he was to find, like when he finds out?

Grace: Except that, again, Alice has always protected her kids. So they maybe aren’t emotionally prepared for that.

Alice: Yeah they are. But you don’t tell em what I haven’t told them...

Grace: I would never do that, I would never ever go behind your back, and that’s the reason I never have. But it is a big concern to me.

Alice: Well, like I say. Stuart helps me financially, he helps me around the house, and he’s only going to be there until he’s got his stuff cleared [i.e. his own debt following bankruptcy].

SS: But is there something that you’re noticing in your son, Alice, that tells you that he wouldn’t be able to handle it, or that he wouldn’t be there for you if you let him know?

Alice: Oh definitely, he’d be there. He is there as much as he can be.

SS: He’s the kind of man that would?
Alice: They both are!
SS: They're the kind of kids that would really want to help you?
Alice: Oh yeah (Alice and Grace, Session 3)

In this conversation, the nurse wondered aloud whether Alice might believe that her
children did not want to help, whether her children would feel hurt if they discovered that
she had not asked them for help, and whether Jeanie and Stuart were capable of helping
their mother. Through this invitation, Alice spoke of her conviction that her children were
both capable and willing to help if she had asked. There was a subtle suggestion in this
conversation that her refusal to ask them for help might indeed be a instance of depriving
her children of the privilege of helping.

The nurse invited Alice to reflect on what it might be like for her children not to be
allowed to help their mother by posing the dilemma to Grace, as a friend who also wanted
to be helpful to Alice.

SS: Could you say, like Grace for you, what’s the impact for you when Alice
doesn’t maybe allow you to help her? How is that for you as a friend?
Grace: Well, it it hurts, it hurts. Because I have so much. See when we, our roles are
completely reversed from kids. I had nothing as a child...Alice had a working
mother, a more stable home than I did. But she never ever changed her
friendship for me. So now I am able to help her ....(Alice & Grace, Session 3)

This was a difficult conversation for Alice to hear because her belief in her own self-
reliance had been her “survival unit” as a single working mother raising two children. Her
preference not to ask for help was not only in relation to her illness experiences, but had
been a mainstay throughout her life. Not only did Alice prefer not to ask the insurance
company for more help to sort out her disability insurance, she also preferred not to ask her
children for financial assistance.

Alice: But I was raised that way, you don’t ask for help.
Grace: It wasn’t asking for help, you deserved this financial help. And this is what I
kept saying to her “You’ve paid for this, you deserve this financial help”. But
my, I would say, my assessment of this is the fact that Alice had reached a
blank wall where she didn’t know what to do next. So she put up pride front,
because she didn’t have the knowledge to go anywhere further. And no one in
her family offered to help her go any further with it...
SS: Well had they not offered? I suspect it sounds like Stuart and Jeanie would have
liked, would like to have.
In this conversation, the nurse directly challenged the idea that Stuart and Jeanie might not have wanted to help their mother. The conversation explicitly considered the ways that protecting her children from her financial worries could have constrained their ability to be helpful to their mother.

**Dilemmas of Offering Suggestions and Encouragement**

The offering of suggestions and encouragement is a very particular kind of assistance. Coyne and colleagues (Coyne & Smith, 1991; Coyne et al., 1990; Fiske et al., 1991) have drawn attention to the possibility that offering support and encouragement may be undertaken as much to deal with one’s own distress as to assist and alleviate the distress of another family member. The tricky dilemmas of offering suggestions was most explicitly raised in the conversation with Cecile, Mark, and Jonathan at the beginning of the second session. In this family where everyone was so intent to offer suggestions and encouragement to Mark, the nurse raised these dilemmas in a conversation with Mark about his experiences of offering advice to his wife.

LMW: **Then** what happens? Do you just let it **be**, or do you wait a while and let’s try **again**? Or what happens in your family? You make a suggestion, eh? It sounds like a **good** suggestion, you know of trying to encourage her to

Mark: Well you **work** on it...you attempt again a few months **later**.

LMW: Try again a few months later? Yes?

Mark: Then you shut down and you leave it **alone**.
Okay, so what do you say to yourself though? When you make these, what you think is a good suggestion, and she doesn’t follow through with it? What do you say to yourself?

Mark: (chuckles) What do I say to myself?

LMW: Yeah?

Mark: Well I guess at the moment I’m probably, I’m sure I’m upset.

LMW: You’re upset with her at the moment. So “Why doesn’t she listen to my good advice?” or

Mark: That’s right, you know and a while later, fine. I mean, I don’t carry grudges ... Like I think she carries a grudge for days or weeks in my opinion. Where I think I can get over things in an hour or two, I think, but I could be wrong.

Jonathan: I think that’s pretty accurate

LMW: Would you agree with that perception of your Dad’s? Yes?

Jonathan: Yes

LMW: Okay, cause it’s curious isn’t it, sometimes, we usually keep going back to people and giving more advice when we’re fairly convinced that we’re right, eh? About this particular idea, eh? You know, we’re really kind of in love with our idea, eh? But we want to offer it, and so we keep going back and saying, “I think it would be good idea, don’t you think you should call?” It sounds like, so I’m just curious whether you’ve tried that over a number of times, and she didn’t listen to you, then what do you do?

LMW: I guess I’m real curious too, from you Cecile, when he keeps suggesting things to you that you don’t agree with, what do you do? Like, I gather you say to him, no you don’t agree. But do you like him keep coming back and suggesting ideas or would you prefer that he just you know, give it up?

Cecile: No, no, I appreciate the interest, the input.

LMW: You appreciate the interest?

Cecile: and I knew that he was doing it not for anyone’s benefit but for myself.

(Session 2)

This conversation is so fascinating because family members were invited to consider the experiences of other family members in the dilemma of offering encouragement and suggestions. Mark was invited to reflect on his own experience of offering suggestions to his wife, and in the process was enabled to consider the legitimacy of other family members’ benevolent efforts to support him and assist him.

Suggestions and encouragement can be on the fine edge of nagging, repetitive encouragement, or overprotectiveness, especially when the support or help takes on an intrusive feeling, or a feeling of unwanted assistance. Ford (1989) suggested that vigilance of activity and the offering of suggestions may interfere with recovery by drawing attention to the illness just as one is attempting to resume a taken-for-granted manner of being well
once again, or just as one is regaining the ability to become forgetful about one’s body in
the return to health (Gadamer, 1996). With Mark and Cecile, the suggestions to both Cecile
and the adult children to step back or to back off enabled Mark’s own preferences for
lifestyle maintenance to regain some credibility. The nurse questioned whether the family
might be more able to back off if they believed that Mark was up to the challenge of making
lifestyle changes when he was under less pressure. However, the nurse also explicitly
raised the possibility that backing off might not make a difference.

LMW: So you’d be okay at this point about backing away?...Because on the other
hand he says when you do [offer suggestions], it reminds him of his
weaknesses, when you point it out to him. And I’m just wondering if the family
backed away, and didn’t offer all this advice, would it make any difference to
you or not?...
Mark: I mentioned earlier that I didn’t want them worrying as you just said, but I
don’t, by them mentioning these things to me, they do help. They do help to
me.
Jonathan: Nagging helps?
(Mark and Jonathan chuckle)
Mark: It does!
LMW: The nagging does help, yes?
Mark: I hate to say that, I hate to hear it. But I think about it then, and fine, and I’m
fine for a while, you see...Hey, that’s tough to admit, but that’s the truth
(laughs)
LMW: Well that’s a, a bit of a dilemma for them then, isn’t it? Because on the one
hand, if they nag you, you’re saying it reminds you of your weaknesses. But
does it really make any difference one way or the other, whether they nag you,
or don’t nag you? In terms of what you do differently?
Mark: Yeah, probably not.
LMW: Probably not, yeah.
Cecile: Short term.
Mark: In the long term probably not, no, because it hasn’t. (Session 2)

Mark was invited to consider the difficulty that nagging poses for other family members:
Mark resented nagging and repetitive encouragement, and found it to be frustrating because
it reminded him of his weaknesses, and yet his family members also knew that sometimes
it made a difference. The intrusiveness of nagging was as frustrating for Mark as the
effectiveness of nagging was frustrating for everyone else.
Conversations of Preferences

The conversations which weighed dilemmas of offering encouragement versus nagging were laden with the language of preferences. Family members were often asked about preferences for the ways that they could be helpful to each other. This kind of conversation invites consideration of the impact of the illness on all family members, and invites consideration of the legitimacy of many possible ways of responding. Preferences about the helpfulness of others seem to be implicit in family relationships: family members often believe that others should know what is helpful with little explicit negotiation or discussion of these matters. This dilemma was raised in the conversation with Alice and Jeanie during their first session. One of the worries that Jeanie described was a worry about her mother doing too much activity. Jeanie commented that her mother’s friend, Grace, was very different and much more direct about offering advice to her mother.

Jeanie: She's [Grace] always asking her, you know, “Stop doing this!” and “Don't do that!” and “You’re not doing this” and whereas I don’t really do that. (laughs)

SS: So which is more useful to you Alice? Is Grace’s approach more useful to you or your daughter’s approach, or somebody else’s?

Alice: These, they’re backing me in what I want to do. You know.

SS: You like that.

Alice: Yeah, I like more that they’re there.

SS: That they’re there? Yeah.

Alice: I know they’ve always been there.

Jeanie: But do you want us to, do you want me to bug you about (laughs) not smoking? [Jeanie’s husband] gets mad, my husband gets mad at me all the time...before she stopped smoking, that I wasn’t going over there and telling her to stop smoking... I thought I might do that, but then I thought, “It’s not going to do any good anyways. It’s just going to make her mad!” If I keep going and saying “Why don’t you stop smoking (in a whiny voice).” Don’t you know what this is going to do and blah, blah, blah”. So now, finally, after not bugging her, she did it any ways and she’s not smoking.

Alice: I had every intention of doing that.

Jeanie: But is that the best thing or should I be nagging? (laughs)

SS: Yeah, what do you prefer Alice? You have these people in your life trying to help you in certain ways.

Alice: Mention it.

Jeanie: Mention it?

Alice: Like I try to deal with them. Like if they come over and then give me a “Oh here’s what we’re going to do, what do you think?”. I’ll say “Well, there’s this, this, or this you can think of”. To do it. Now whether they do it or not makes no difference. The suggestion is there if they want to take it, and if it helps them, fine. If they don’t that’s fine too. (Session 1)
This example illustrates some of the ways that nagging and suggesting can also be experienced as intrusive by the person offering the suggestions. Jeanie explained that she thought nagging would simply make her mother mad, but in some way felt guilty about not nagging. In this instance, the nurse facilitated a different kind of a conversation by explicitly asking about Alice’s preferences: “How do you like to be treated?” Alice also suggested that in some way, nagging helped. Alice’s explanation of how she would offer suggestions to her children also helped to make sense of how advice and suggestions could be helpful. Again, there is something different about offering suggestions as invitations rather than expectations or commands for obedience. When the person offering the suggestion or advice respects that the other person’s choice to either follow the advice or to ignore the advice is legitimate, the nagging or encouraging is experienced as less intrusive.

In the clinical work with these families, conversations of family attempts to offer support and encouragement to each other, and to support lifestyle changes are seemingly common. In some form or another, they are conversations that families have often encountered at home. This contrasts significantly with the last topic of conversations to be addressed in this chapter. Family conversations about the uncertainty of the future and the possibility of death are understandably more difficult and seemingly much more uncommon.

III. Conversations About Uncertainty and Death

*Until the Second World War...Death was as great a mystery as it is now, but dying was not. How people died, and how they faced death, was a common experience - an experience in which a large spectrum of behavior was possible. Which is to say: dying was alive.* (Ventura, 1996, p. 26)

Ischemic heart disease is both a life-threatening and, potentially, a life-shortening illness. With each family, there were conversations of uncertainty about a recurrent heart attack in the future, and conversations about the possibility of death or a shortened future. The belief that the future would be shortened and that death would be premature was
common. As the meaning of the "collective heart attack" was lived out by each of the family members, there was often a sense that they were living in the face of death. Family members were living in the face of a new understanding of finitude, of knowing in a different way that the embodied existence of humans is time limited. These were conversations of both worry and courage, acceptance and despair, as family members considered possibilities for living well with these new understandings of dying, of their "second chance" in this regard. These were conversations of how to keep dying "alive", and how not to let the spectre of death in the future interfere with living well in the present. These were conversations of difference, usually because this topic was one that family members had not discussed together previously.

The nursing research literature has consistently suggested that both the person experiencing ischemic heart disease and their partner have great concerns about uncertainty related to the possibility of a recurrent heart attack, and the possibility of premature death due to heart disease (Artinian, 1991; Bennett, 1992; Gilliss & Belza, 1992; Hilgenberg et al., 1992; Thompson et al., 1995; Yates & Booton-Hiser, 1992). It is often disconcerting to the ill person and their family members that there are no guarantees that lifestyle changes will reduce risk of future cardiac events or death (Christman et al., 1988; Lovey, 1990; Preston, 1997), and that attempts to influence the future through lifestyle changes are strife with probabilities rather than certain results. Much of this research depicts these uncertainties as stressors, and attempts to identify coping strategies for lessening the impact of these stressors from the perspective of stress and coping theory. When nursing interventions are suggested in this literature, descriptions usually include hollow platitudes: offering support, offering encouragement, listening attentively, providing information, and encouraging verbalization of feelings. These descriptions offer little substance to clinicians attempting to conduct themselves well in this most tender realm of conversation, which is usually laden with emotion, existential wonderings, and questions in the spiritual domain.
of life. The concluding section of this chapter will explore the particular ways that these conversations attempted to speak to the mystery of these eventful concerns and wonderings.

**Conversations about Near Death Experiences**

During the clinical sessions, each of these families had an important story to tell about their experience of an acute cardiac event, either a dramatic time of an unexpected heart attack, or during the risky time of cardiac bypass surgery. In the interpretive accounts of the clinical work, these stories were sometimes told in the beginning introduction to the family, such as the story of Alex's shocking heart attack and being rushed to the cardiac catheterization lab. Cecile told the story from the perspective of a partner suffering and worrying through the time of her husband's surgery. Alice told the story of realizing that she might not survive the wait for surgery following a conversation with a booking clerk, and the visceral response it evoked through violent nausea and chest pain.

These stories were usually told by family members during the first session and were often laden with emotion. These are important stories which mark turning points or shifting ground on the path of the illness experience. Bolen (1996) described these events:

> The shift that occurs has the force of a natural disaster, a personal earthquake that disturbs the ground under us. Before the operation, before the accident, before the discovery that there is something wrong, we live in innocence or denial. Then everything changes, and we feel that nothing may ever be the same again (p. 23).

The nurses invited the telling of these stories by asking questions about the illness experience. These are stories that may not be easy to tell, and that may take time to tell. Perhaps they are stories that health care providers are often not privileged to hear in the context of “history taking” conversations constrained by time, or when storytelling is curtailed if it is not viewed as contributing to a diagnosis (Frank, 1995). These are
important stories, but they are not necessarily problems. They are significant life experiences. One of the nurses commented on this Alex’s telling of his story during the first session:

SS: I don’t know that they had a fear of dying or a fear of the future but they experienced his nearly dying as very powerful anyway. I guess that’s why it was like, I was like looking for a problem like fear of dying or fear of the future! And how did that influence the family, or not talking, but that didn’t seem to be there. But they still seemed to need to talk about that experience. (Research Interview)

These powerful experiences often shape and color the family members’ expectations of the future. When catastrophic fears of the future are discussed in the first session, even when the nurse and the family do not know each other well, it is often through these stories of past encounters with death that openings for these difficult conversations about the future arise.

**Possible Constraints to Conversations of Uncertainty and Death**

There are many reasons why conversations of uncertainty and death may be difficult for both family members and for nurses. Nurses may believe that there is little that can be done about uncertainty, or may hold themselves responsible for providing answers to difficult questions or issues that arise during conversations of death and uncertain futures. Nurses and family members may respect preferences of others not to discuss this topic if they believe that it would make them uncomfortable.

As in other therapeutic conversations in this study, the nurses typically attempted to understand families and to offer ideas about uncertainty and death through the asking of questions. The asking of questions about death and uncertainty is very different than trying to provide answers to the family’s questions. When the nurses invited family members to reflect on their anticipations of the future and the meanings that they hold about these expectations, these are difficult questions to answer. They are questions that the nurse can not possibly answer for the family, or even for herself. If the nurse had believed that she
must fix the family's distress about uncertainties, she could be constrained from even attempting to engage in such conversations when openings arise.

**Asking Permission to Speak about Death**

One way of tentatively inviting the family to explore their concerns about the possibility of death was to directly ask for their permission to discuss the topic. In the first session with Alice and Jeanie, both had intimated that they had worries, or thought that the other family member had worries that they had not spoken about previously. Alice had hinted at the worry about having another heart attack while she waited for surgery, but had been reluctant to say that she worried about dying during the wait. As the nurse later described in the postsession conversation, she was aware of this hesitancy and slowed the conversation down to seek her permission to discuss this worry more explicitly by describing it as a conversation about "the unexpected".

SS: Is it okay to talk about that? I mean, you know, you expect one thing, but is it okay to talk about what might happen if it's the unexpected?
Jeanie: Is it? (giggles nervously looking at Mom)
Alice: I never looked at that end of it cause it won't happen.
SS: Is it okay though to talk about it now? As even just a possibility or? Are you okay about that?
Alice: Possible, but I'm just
Jeanie: Or if the outcome isn't great ...[and] you do have a stroke, or, but I mean, that's what I don't understand, what are the risks?

(Alice & Jeanie, Session 1)

Although Alice was curious about what her children thought of her and wondered what they worried about, this kind of conversation about worries was very different. She was cautious as the nurse posed questions asking for permission to move in this direction, and may have been swayed to go with it by Jeanie's interest, as she asked her mother "Is it?" okay to discuss this.

**Uncovering Constraints to Conversations about Death and Uncertainty**

As the above conversation with Alice and Jeanie continued, the tension continued: should we or should we not be discussing this? Again, the nurse was aware of this tension
and inquired about the family’s discomfort in discussing the risk of death either while awaiting heart surgery or during the surgery.

SS: So has your family talked at all about your dying or about their worries? You say you never talk much about your worries, or you people have been trying to keep a real, stiff upper lip?

Jeanie: Not that it doesn’t happen, it’s just that it hasn’t happened. You know I mean the only person that’s died in our family has been grandma, and I mean that’s, she was older, that happens. You know.

SS: So is that something that, worrying about whether or not you’ll die? Or does that sort of simmer under the surface do you think?...

Jeanie: Sure, sure cause it’s, like I said, it’s possible.

Alice: I don’t know where they’re all thinking (Alice & Jeanie, Session 1)

The nurse remained curious about what might have been constraining Alice and Jeanie from having more open conversations about their worries in general, and about risk of dying in particular. She was also curious about how this might influence their responses to waiting for the surgery.

SS: Do you think that not talking about some of these things that you kind of are suspecting, or that it’s kind of sneaking around underground, or things unsaid, do you think that they contribute to some of the worry right now, or the distress that you feel at this point?

Alice: It could be I suppose, I just never really

SS: I don’t know. Just wondering.

Jeanie: Cause I know we’ve never sat down and said “Well gee Mom, if you die tomorrow and”

Alice: No, you just don’t want to do that.

SS: Is that kind of painful do you think? ...

Jeanie: You could get hit by a truck tomorrow. That’s the way I look at it you know.

Alice: Sure. It’s all on the wall somewhere. So that’s why I never worry about it.

SS: Right, but if you think you’d jinx it then you might not talk about things that need to be talked about do you think?

Both: No

SS: Well, I just think, sometimes you just have these kind of ideas that just kind of linger around in the back of your head. Like “If I really talk about it, it’s going to happen?” It’s a kind of a little belief that kind of, makes you act in a certain way you don’t even feel, or you don’t even think you really believe that, but somehow it still gets in the way?

Jeanie: Um hmm

Alice: Yeah but I do.

SS: You do?

Alice: It’s going to be fine.

The nurse invited the family to consider the possibility that discussing the risk of death or the unexpected could inadvertently jinx or jeopardize the outcome might hold them back
from having conversations about might help to reduce their worries during the wait for the surgery.

In the sessions with Cecile and Mark and their two adult children, the influence of worry for all family members was strongly related to their beliefs about the possibility of Mark’s premature death. Although Mark was fully aware of their worry and their desire for him to change his lifestyle, he did not realize the depth of their concern for his future. The conversations in the second session with Cecile, Mark and Jonathan revealed how different their beliefs were about the future. Mark believed that if he did nothing further regarding lifestyle changes, that he had a good chance of living another 15 to 20 years. This was in stark contrast to the belief that Cecile revealed in the conversation: she believed that he could die any day. Again, this was a different conversation than they had previously at home, because of Cecile’s desire to encourage and support her husband.

Cecile: I don’t have much faith in his future.
LMW: You don’t have. You’re not as optimistic, by any means, it sounds like he is, about 65 to 70?
Cecile: No, no, and I really hate to admit that because I think he’s losing a support system by my admitting that? (voice shaky)
LMW: That he’s losing?
Cecile: My support.
LMW: Your support?
Cecile: Encouragement, positive outlook, and I think it shows too much negativity in admitting this.
LMW: So you think somehow you could inadvertently, um, influence?
Cecile: I don’t like to tell him that he could die any day.

(Cecile, Mark & Jonathan, Session 2)

This conversation uncovered some of the ways that conversations about the future may be constrained by a desire to sustain optimism and hope for the future. Cecile may not have expressed her concern that her husband might die in the near future out of a concern to nurture Mark’s positive outlook for the future.

Some family members may believe that to talk about death and uncertainty would somehow jinx or influence the possibility of the unexpected actually occurring. Some family members may prefer not discuss death and future illness in their effort to stay
positive and to offer support and encouragement for the ill family member. Others may prefer not to discuss these difficult issues out of a desire to conceal their own despair and sadness over the possibility of the loss of a loved one.

**Exploring Meanings of Beliefs and Offering Possibilities for the Future**

In the conversations with each of the families, concerns about the possibility of a recurrent heart attack or death were discussed. However, the nurses did not simply accept that these concerns contributed to anxiety or worry. They were also curious about what meanings these worries had for various family members. Understanding the family’s meanings behind the beliefs helped the nurses to offer other possibilities for keeping dying “alive”, and for living well in the present in spite of knowledge of death.

During the first session with Alex and Georgina, conversations about the future raised both sadness and hopefulness. The shock of the experience of a heart attack so soon after receiving a kidney transplant threatened to shatter their hopes and anticipations for a healthy future unencumbered by hemodialysis. One of the reflecting team comments at the end of the first session spoke eloquently to the possibility that facing up to uncertainty might free the couple to enjoy and celebrate their lives in the present.

Faculty: If they were to believe that the future does look very promising and it does look very rosy, but there is a piece of uncertainty about how long that would last, what would they be doing differently? What would they be saying or doing differently with their children? What would they be saying or doing differently together as a couple that would maybe deal with some of that uncertainty in a little different manner, rather than just saying “The future is 100% rosy and we have no concerns”. I’m wondering if that might in fact free them up, having dealt with of some of that, perhaps, things that need to be said or done. If that would free them up to really get on with the celebration and enjoying whatever they have left?  

(Georgina & Alex, Session 1 Reflecting Team)

This suggestion acknowledged that the future may be unpredictable, but raised wonderings about what could happen in the present to challenge the influence of uncertainty. There was an explicit intent in this conversation to speak to possibilities even in the face of uncertainty about the future. The use of tentative language and lead-ins (e.g. “If they were to believe...would maybe...I’m wondering...”) softened what might be experienced as a
harsh or cruel conversation. Offering these ideas in a spirit of wondering and tentativeness also runs counter to the typical advice-giving, certain directives, and probabilistic prognostications that may be offered by health care professionals. For Alex and Georgina, the belief that the future might be shortened raised sadness because of their hopes to enjoy time together in their retirement years. The reflecting team comments attempted to offer suggestions for acknowledging uncertainty and facing up to it.

In the clinical work with Cecile and Mark, the distressing worry and belief that Mark would die prematurely if he did not change his lifestyle was very understandable. However, Cecile believed that not only would Mark die prematurely, but that his lack of effort to forestall death by attending more to lifestyle changes could mean that he did not want to live longer, to be with her longer, was terribly hurtful. Somehow his actions could mean that he did not care for her, and this added to her distress. The concerns of other family members also made even more sense when the nurse asked Josie and Jonathan what it would mean to them if Mark died prematurely. Notice the use of gentle and tentative languaging by the nurse to elicit this conversation.

LMW: And so if your father, I mean, let’s just play out this worst case scenario, and I know this is not fun to think about, but this, this is why your family gets so concerned okay? So if the worst case scenario happened, he either had another coronary or worse yet he died what would be your reaction to that? Do you think you’d be sad or furious with him or would you say well “We tried to help him. We did our best, but he didn’t respond”? Would you feel guilty, what do you think your reaction might be?
Josie: Had it been a few years ago, I probably would have felt guilty (voice starts to quiver)
LMW: You would have felt guilty. For not trying to?
Josie: For not trying.
LMW: Trying to encourage him more or have more influence on him?
Josie: That’s right.
LMW: But if it happened now?
Josie: But now if it happened, I’d be, I’d be very angry.
LMW: You’d be angry.
Josie: I’d be very angry with him (with quivering voice)
LMW: Because, you would believe that?
Josie: He had a chance to start, respect himself more, to take better care of himself. I mean all the literature is before him. He has a family who’s supports him, but he just, he doesn’t act. He doesn’t, I don’t think he respects himself enough.
This conversation has the character of "speaking the unspeakable" (Wright et al., 1996, p. 177). These are conversations that are close to the heart of the matter, related to core beliefs held by family members, that may be painful or difficult for family members to articulate, and where the nurse deliberately goes against social convention by raising the topic in the therapeutic conversation. In this conversation, Mark heard Josie voice not only her love for her father, but the belief that she would have angry and perhaps even disrespectful memories of him in the event of his death. The tenacity of the catastrophic fear of the future was fuelled by anger which had not been voiced directly to Mark. This could have been an acrimonious and destructive disclosure. Mark was visibly shaken by the idea that he was losing his children’s respect. The disclosure had the effect of shifting Mark’s understanding of the influence of his behavior on his adult children and perhaps defusing some of the anger by exposing its secret.

Mark had very different understandings of the possibility of his premature death. He accepted it with a pragmatic and fatalistic air. He was less troubled by the prospect of his own death because of his belief in fate. There were conversations of both the advantages and disadvantages of “tempting fate”, and the differences of opinion within the family about the effectiveness of lifestyle changes in reducing cardiac risk.

**LMW:** They [your family] might be right, if you don't do these things, you might [die prematurely]. On the other hand, you might be right. That despite what you do, you might live another, who knows how many years. How many years would you like to live?

**Mark:** I’d like to live as long as, as long as I’m feeling good.

**LMW:** As long as you’re feeling good.

**Mark:** I don’t want to be in a wheelchair. I’m the type pull the plug please, you know.

**LMW:** Okay.

**Mark:** Hopefully 20 years.

**LMW:** Hopefully 20. So if you could live another 20 years, you’d be pleased.

**Mark:** I’d be well satisfied.

**LMW:** And that would take you up to?

**Mark:** 70, I’d be 71.
LMW: 70, 71. And you'd be happy then if you had seven score and ten?
Mark: I would. You betcha. I don't want to be 78 without a mind.

(Mark, Session 4)

Although the nurse persistently raised questions about the hazards of trusting in fate, she also accepted that Mark's belief in fate was consistent with his behavior, and made sense of his willingness to attempt some lifestyle changes, but also to enjoy life more. Perhaps this belief was the most facilitative belief possible for him to live well knowing that he had heart disease.

Conversations of uncertainty and death are not conversations to be avoided. They are very often affectively charged conversations which are connected to family suffering. The belief that death will come prematurely because of heart disease is not one to be "challenged". There is no certainty to be offered in this regard, except that each of us eventually dies. However conversations about the meanings behind this belief can offer families different understandings of possibilities for continuing to live well in spite of knowing that time is limited.

**Synopsis**

The character of the family-nurse relationship which was described in chapter 4 was palpable throughout these conversations of heart disease: through efforts to accept the legitimacy of the other by engaging in non-pathologizing discourse and by acknowledging the limitations of expert practices; by offering questions which invited family members to consider the circumstances of their co-existence; and by inviting emotional shifts in the conversations within the family. *How* the nurses conducted themselves in these conversations was woven through and through with *what* was discussed, the many topics of these conversations. These were conversations of possibilities for families to live well with heart disease by understanding different perspectives of the influence of lifestyle changes, and by challenging lifestyle imperatives which could limit options for legitimate preferences for living well. These were conversations which explored family dilemmas and
preferences about how to be helpful and supportive to each other as they learned about living with heart disease. Finally, these were conversations which explored possibilities for continuing to live well in the present in spite of knowledge that heart disease may shorten the future.
EPILOGUE

To explain is not to present a set of finished reasons, but to tell a story... a story must be judged according to whether it makes sense... to make sense is to enliven the senses... to rejuvenate one's felt awareness of the world. (Abrams, 1996, p. 255)

Throughout the interpretive accounts of the clinical work described in this research, there has been purposeful attention to the particulars at play in the therapeutic conversations. Family members and nurses addressed their eventful concerns in very unique ways dependent on their circumstances, though there were echoes and resemblances which resounded across the work with all of the families. Similarly, although these particular encounters are unlikely to be duplicated in other contexts or even the same context, there may be resemblances between the circumstances of the participant families and encounters with persons and families experiencing ischemic heart disease in other health care contexts. The intent of this research was to bring the nursing practices at the FNU alive in a manner which could allow aspects of this clinical work to be taken up in other contexts.

What has the Inquiry Uncovered?

This research has explored understandings of therapeutic conversations between nurses and families experiencing ischemic heart disease in the context of the Family Nursing Unit. The manner in which the nurses conducted themselves well suggests a purposeful ethical and relational stance which views the other as legitimate. The skillful nursing practices of questioning and inviting family members to reflect on their own experiences and the experiences of other family members distinguish this clinical work. The recognition of embodied cues of shifts in emotioning which influence possibilities for shifting conversations was also uncovered as an expert practice within this clinical work. These practices influenced conversations which addressed family suffering related to living with ischemic heart disease, including conversations about healthy lifestyles, conversations
about family support and efforts to sustain mutual co-existence, and conversations about uncertainty and death.

**With Whom in the World can one have Illness Conversations?**

The interpretive accounts revealed many examples of the ways that family members felt constrained from having illness conversations with each other, with their adult children and grandchildren, with friends, with other health care providers, and even with their pastors. Of course it is not impossible for these others to understand illness conversations, but family members implicitly expected that the nurse *should* understand the illness experiences uncovered in these conversations. One family member said that the nurse saw people living with illness every day in her work, and that even if the nurse could not do anything about their suffering or their experience, she should know what the experience was like. These illness conversations were sometimes described as healing, and the presence of the nurse as a third party witness, mediator, and participant in the healing effects of the conversation was recognized by family members.

Nurses must be able to speak the language of illness conversations. These conversations were clearly in the realm of nursing practice. These were conversations about family responses to health and illness, and conversations about living with heart disease. As nurses, our choice to situate ourselves within this realm of human experience (i.e. within the realm of human health and illness) obligates us to engage in illness conversations in a manner that will hopefully facilitate healing and alleviate suffering. It is this intent which makes these conversations “therapeutic”. In therapeutic conversations, our obligations have proper names (Caputo, 1993) and particular circumstances which challenge our creativity and compassion.

In our complicit participation in these conversations, we recognize ourselves, we recognize our own families, and we recognize our own loved ones. If we listen carefully, we hear ourselves and our own lives read back to us in these conversations of illness and
suffering. We hear possibilities for our own future, and we would be wise to listen well and to learn from these experiences. We will need the courage and meritorious knowledges of these families to face our own futures. A passion for clinical nursing practice may be compelled by recognition of the implications of these meritorious understandings for living out one's own life.

However, it is our obligation to others in these nursing practices that compels attention to the ways that persons and families seeking our assistance heal themselves, and that compels attention to the ways that we can assist them to sustain their existence by healing their relationships. While there may be comfort from suffering when illness is witnessed and understood by the nurse, this comfort can be sustained and nurtured when family members are enabled to witness and give testimony to each others' experiences. Therapeutic conversations are healing when understandings are shared amongst family members who know each other well and who wish to understand each other better, and when the conversations support possibilities for family members to sustain each other's existence.

What in the World are Illness Conversations about?

Illness conversations are about the contingencies that greet families as they live out lives touched by knowledge of illness, suffering and the possibility of death. The conversations with families in this study were about lives touched by ischemic heart disease, though the topics encountered may share similarities with conversations about other forms of life-threatening, chronic, or life-shortening illnesses. Each of the three instances or topics of conversations which were uncovered in this clinical work is related to issues of relationship and sustaining mutual co-existence. Family efforts to conserve health through lifestyle changes reflect concerns to preserve the life of the ill family member, to sustain the physical existence of the other person. Family conversations which offer support and encouragement are attempts to assist each other with the impact of the illness,
to understand preferences about how to be helpful to one another and how to co-exist in the face of the illness. Family conversations of uncertainty and death reflect concerns about the possible loss of the existence of a family member. These were often respectful but brave forays into conversations in the realm of the unspeakable (Wright et al., 1996), tender topics that family members may have been hesitant to raise together for many different reasons: respect for each other, desire to stay positive and to offer encouragement, or possible discomfort with broaching a particular topic.

These family responses to ischemic heart disease were intensely relational and interactional. One of the distinguishing marks of these conversations was the persistent effort of the nurse to acknowledge and explore the impact of the illness on all family members. The therapeutic conversations sought understandings of the impact of the illness on the individual experiencing heart disease and their partner, and their adult children, and the reciprocal influences between the illness and all family relationships. The conversations helped family members to appreciate the subtle and blatant ways that heart disease was related to everything else that was going on in their lives.

These conversations were affairs of the heart in a domain related to but different than the ways we typically think about healing heart disease in North America. This domain speaks loudly of the sensuous embodiment of the heart with irreducible affiliations between mind, emotion, body and spirit, and the sensuous embodiment of the heart in relation to others with whom one wishes to remain in co-existence. These were conversations of the many ways that human beings are situated in the world, in vulnerable physical bodies susceptible to illness, in complicated lives, and in relationships with others.

Where in the World can Illness Conversations Occur?

The therapeutic conversations described in this study occurred at the Family Nursing Unit, which is a very particular context. The FNU offers a health care service in an educational setting. The nursing practices are very autonomous in comparison to many
traditional nursing practice contexts. The nurses engaging in the clinical work both had significant experience in clinical practice with families.

The most significant limitation of this study is the unique context of the FNU. Throughout the descriptions of the clinical practices at the FNU, the intent was not to imply that this is the only way of conducting oneself well with families, or even that this is the best way of engaging in advanced family systems nursing practices. Nor was it meant to imply that these practices are better than nursing practices in other cardiovascular nursing contexts. However, it is my assertion that these practices are different than common practices in many other practice contexts. This research has been a concerted effort to explore these differences. The reader must decide for themselves which aspects of the therapeutic conversations described in this research resonate, sound true or plausible, or could be applied to other practice contexts where nurses encounter families experiencing ischemic heart disease or other illnesses.

A second major limitation of the study is also related to the practice context. Throughout this research, there has been persistent effort to understand the ways that the nurses working with these families at the FNU conducted themselves well. The practices of the nurses have definitely been in the foreground of the interpretations offered. However, it would be unfortunate to fail to acknowledge ways that family members also conducted themselves well in this clinical work. These families were remarkable in their openness to working with nurses in different roles and in a different context than they had previously encountered nurses. Even more remarkable was their willingness and ability to address the impact of ischemic heart disease on their relationships. These families were open to healing relationships in their lives as part of the healing of heart disease. These family members understood that healing heart disease involved more than mending a scarred cardiac muscle, or relieving a blocked coronary artery. These family members were willing to attend to their co-existence with each other as part of the healing, as part of the language of the heart and
the poetry of the heart. It is very possible that the notion of coming to a Family Nursing Unit may have fit for these families because of their readiness to attend to the impact of ischemic heart disease on family relationships. Perhaps other family members who read the same newspaper advertisement, posters and brochures about the FNU and this study and chose not to participate would have participated differently in these conversations. In this manner, there may have been a subtle selection bias in the recruitment of research participants.

Families commented on the helpfulness of having these conversations in a different context than their homes, where familiar ways of engaging or avoiding particular conversations could be more easily sustained. Therapeutic conversations often addressed possible ways of continuing the conversations after leaving the FNU, or ways of publicizing and widening the audience for the conversations between the family and the nurse. Families often contrasted their experiences at the FNU with other encounters within the health care system, particularly with nurses in acute care hospitals and physicians in office settings. They often described the perceived constraint of time to be a major barrier which limited possibilities for having similar conversations in other health care contexts. This raises questions about whether nurses value time spent conversing with patients. It also raises questions about whether health care systems are organized to disallow time for conversations which do not contribute to assessment or diagnosis, which are not related to completion of technical tasks, or which may be viewed as non-essential. The possibilities for taking up aspects of the therapeutic conversations described in this study will be significantly influenced by responses to these questions.

Conducting Oneself Well—How in the World can Therapeutic Conversations Occur?

This question is closely related to the major impetus of this study--what can be learned from these nursing practices which could have bearing on how one conducts oneself well in therapeutic conversations with families experiencing ischemic heart disease?
The distinctive character of the family-nurse relationship and the practices described in chapters four and five point in the direction of these understandings. The explanations which have been offered here and which describe these practices suggest that conducting oneself well involves knowledge of illness and families, and also requires judgment, discretion, tact, and experience. The nurse's contributions to the character of the family-nurse relationship were distinctive, moral and ethical choices which made a difference in this clinical work. A major contribution of this study has been the offering of an explanation for the distinctive character of these choices.

When the nurse accepts the legitimacy of the other person, many observer perspectives become equally plausible: differing explanations of experiences are warranted and legitimate because they reflect the ways that persons have conserved their existence. The ability to reflect on many different legitimate explanations of the family's circumstances, to accept multiple views as plausible, and yet to offer other possible explanations that might be helpful to the family is a hallmark of these nursing practices.

When the nurse engages others from an emotional posture of acceptance rather than negation, she can be invited to curiosity rather than judgment about the explanations offered by various participants. The emotional posture of acceptance engages the nurse's ability to conduct herself in a manner which is non-pathologizing; which elicits descriptions of family competencies and strengths; which does not label, blame, or invalidate; which acknowledges the merit of family understandings of illness; and which respects the expertise of both family members and the nurse.

When the others' explanations are accepted as legitimate, one is potentially invited to view one's own explanations with humility. One can no longer operate in a domain of self-righteous unquestioned "truth". One's own beliefs, theories, explanations and truths become more open to questioning. One can become obligated to account for complicity in the use of languaging which can be interpreted as blaming, diminishing, or pathologizing.
One can become more respectful of other knowledges of health and illness that are meritorious. One can become obligated to account for the ways that one is complicit in power structures sustained by taken-for-granted discourses (i.e. preferred professional expert discourses, uncontestable discourses of faith in science and technology, and cultural discourses of control and manipulation of illness and the body).

Family members were invited to consider legitimate, plausible, coherent perspectives of other family members and of the nurse through the skillful questioning practices of the nurse. The nurses' questions invited family members to reflect on the circumstances of their existence as individuals, and the circumstances of their mutual co-existence as a family. The questions were generative, as family members and the nurse co-evolved descriptions of experiences and preferred realities rather than simply gathering data or facts. The questions were also transformative, as family members changed perspectives by listening to each others' answers and becoming curious about other family members' experiences and explanations.

The nurse attended to emotional shifts during the therapeutic conversation as palpable indicators of embodied shifts accompanying openings for new understandings or important news of a difference in the conversation. Family members were invited to emotional postures which sustained the possibility of thoughtful reflection through acceptance, respect, and love. The nurse invited family members to shift patterns of emotioning in the conversation by offering commendations, and by inviting conversations of affirmation and affection amongst family members.

Throughout these conversations, the prevailing view of ischemic heart disease as an individual illness characterized by a failed pump or a blocked artery was challenged. These conversations offered repeated reminders of the embodied, sensuous connections between individuals afflicted with ischemic heart disease and others in their world. The therapeutic conversations repeatedly invited family members to reflect on the circumstances of their
mutual co-existence. The eventful family responses to the illness revealed their efforts to conserve their existence as a family.

**Emerging Areas for Further Inquiry**

This research offers detailed descriptions and interpretations of the clinical practices at the Family Nursing Unit. In this manner, the study offers an extensive description of therapeutic conversation as "nursing intervention", or as a nursing explanation of what we think we do that makes a difference in the clinical work. The clinical practices reflect the nurses’ efforts to alleviate the suffering of families in particular instances of living with ischemic heart disease. The interpretations offer openings for understanding these practices, and attempt to explain the offering of interventions through therapeutic conversation, and to account for both family and nursing explanations for the merit of the clinical work. The interpretations describe shifts, changes, or outcomes occurring throughout the clinical work from session to session. The research interview following the completion of the clinical work also described outcomes which were apparent at a later point in time. The outcomes or changes desired and reported by the family members were considered relevant in this account of the clinical practices. These explanations of nursing practices and possible outcomes could provide beginnings for further explorations of nursing interventions during cardiac recovery.

An area of inquiry which emerged from these conversations and which should be addressed in future research is the significant impact of ischemic heart disease on adult children. In the cardiac research literature, the extensive focus on cardiac spouses has neglected the importance of family relationships between ill parents and not only school-aged or teenaged children, but also between parents and adult children no longer living in the home. In the professional literature, other adult family members have usually been viewed as resources for offering the patient or spouse additional family support, and for offering relief for caregiving burden. Each of the families in this study chose to include
their children in the sessions. These families reminded us of the ongoing involvements between parents and children which extend across their lifetimes. These are kinships and reciprocities which have received minimal interest in current research inquiry.

The clinical work with these families also points to the possible helpfulness of this clinical work during both the acute phases and long term recovery process, and extending to many years following the onset of ischemic heart disease. The clinical sessions with Alex and Georgina began two months following Alex’s heart attack and angioplasty. The sessions with Alice and Jeanie occurred in a time frame which covered the acute surgical period. The therapeutic conversations addressed issues pertinent to the acute and early recovery period for these two families. The sessions with Cecile and Mark were more than a dozen years following his first heart attack, and four years following bypass surgery. This family offered a reminder that in chronic illness, issues confronting families may have long histories. This long-standing suffering has been unrecognized and discounted in health care systems which accord great status to technology in the acute treatment and management of ischemic heart disease. The potential benefit of therapeutic conversations which attempt to alleviate suffering during both acute episodes and long term recovery could be another useful point of exploration.

**Unanswered Questions about Therapeutic Conversations**

The therapeutic conversations described in this research are not only socially constructed explanations, narratives, or stories of family relationships and illness experiences. Wright et al. (1996) offered that “beliefs occur not only in the domain of meaning, but also in the domain of emotion and behavior. We have also come to appreciate that beliefs influence even cellular functioning” (p. 25). In the nursing practices described in this research, there is an assumption that language can alleviate suffering. If we believe that mind and body cannot be separated, and that the healing effects of language influence the person as a complex embodied living being, perhaps we could believe with more
conviction that therapeutic conversations have physiological consequences. Conversations and languaging are embodied experiences, not only ways of knowing and constructing explanations of ourselves, but ways of being.

Conversations are embodied experiences. What if understanding, languaging about, and making sense of illness experiences has implications for our bodyhood? How would we understand this work with families differently if we were to believe that these interventions in language are embodied experiences that are intricately connected to our body’s sensory and perceptual capabilities, intimately a part of emotions as embodied physical events? What if these sensuous perceptions and emotions are related to the functioning of immune systems and endocrine systems? How could we demonstrate that therapeutic conversations are healing practices? Would this help to create explanations and justification for believing that what we say as nurses in our conversations has as much merit as what we do in our technical and physical interventions? How would we treat people differently in health care institutions if we believed that our conversations and relationships had implications for their bodyhood, for healing and recovery? How could we continue to operate health care systems as if organizational economics were the primary guiding principles if we believed that lack of attention to healing relational contexts could actually harm people who are accessing health care services? These are questions that are connected to the understandings uncovered in this study, but clearly beyond the scope of this research. These questions are suggestive of meanings and possibilities which may lead to other avenues for understanding the influence of therapeutic nursing conversations with families.
References


Alex, Georgina, and David

Appendix A - Family Genogram

Kidney transplant 1995
MI 1995

M 1950
Family Genogram

Alice, Jeanie, and Grace

Joyce 58
MI 1989
Awaiting CABG surgery
Long time childhood friend

Stuart 36
Living with Joyce
Family Genogram

Cecile, Mark, Jonathan, and Josie
This is to certify that the Committee on the Ethics of Human Studies at The University of Calgary has examined and approved the research proposal:

Applicant: Dianne Tapp

Department: Faculty of Nursing

Project Title: Exploring the Experience of Coevolving Therapeutic Change with Families Experiencing Ischemic Heart Disease

Sponsor (if applicable): Heart & Stroke Foundation of Canada (possible)

(the above information to be completed by the applicant)

Chair, Committee on the Ethics of Human Studies

Date

Appendix C - Participant Consent Forms

Family Participant Consent Form for Participation in Research Project
Faculty of Nursing, University of Calgary

PROJECT PURPOSE: To explore the experience of change through nursing consultations with families experiencing heart disease

PROJECT DESCRIPTION:
You are being asked to participate in a study of the experience of the nurse-family relationship during sessions conducted at the Family Nursing Unit, University of Calgary.

This study will assist the clinical work of nurses by increasing understanding the meaning of the concerns, practices and skills of both the family members and the nurse as they work together to understand the problems presented by the family and to identify options to address the family problems.

By agreeing to participate in this study, you and other family members consent to take part in one or more interviews with Dianne Tapp, R.N., which will be conducted either in your home or a place of your choice. The interviews will be arranged at a time that is convenient for you. This consent includes your agreement to audiotaping of the research interviews.

Questions posed during the family interviews will focus on your contacts with the nurse during the family sessions attended at the Family Nursing Unit, University of Calgary. It is possible that the questions may raise emotional topics. If desired, information will be available regarding resources and support available in this event.

All interviews will remain confidential. The identity of all participants will remain anonymous. The interview information will be transcribed from the tapes to a wordprocessor, and participants will be assigned fictitious names. With anonymity thus preserved, study results may be shared in publications and presentations. In accordance with University of Calgary policy, audiotapes and transcriptions will be retained for 3 years following completion of the research. The codebook which links actual names to fictitious names will be destroyed upon completion of the research (estimated mid-1997). You may withdraw from the study at any time. There is no compensation for your participation in the study.

Further information about this study may be obtained by calling Dianne Tapp at 220-4647. We will let you know the results of the study if you are interested. Please feel free to ask questions now or at any time. A copy of this consent form will be left with you.

Authorization:
We have read the above and understand the inconveniences and risks of the study which are described above. We consent to the participation of ourselves and we understand that we can refuse to participate or withdraw at any time.

Signed: ___________________________ Witness: ___________________________

______________________________ Date: ___________________________
PROJECT TITLE: Exploring the Experience of Coevolving Therapeutic Change with Families Experiencing Ischemic Heart Disease

PROJECT DESCRIPTION:
You are being asked to participate in a study of the experience of the nurse-family relationship during sessions conducted at the Family Nursing Unit, University of Calgary.

This study will assist the clinical work of nurses by increasing understanding the meaning of the concerns, practices and skills of both the family members and the nurse as they work together to understand the problems presented by the family and to identify options to address the family problems.

By your consent (below) to participate in this study, you agree to:

a) ___ Participate in one or more interviews with Dianne Tapp, R.N., which explore your experience of your clinical work as the interviewer working with a family seeking consultations at the Family Nursing Unit, University of Calgary. The interviews will be arranged at a time that is convenient for you. The interviews will be audiotaped with your consent.

b) ___ Videotaping of your participation in presessions, intersessions, and postsessions in which you share your ideas about the clinical work with families seeking consultations at the Family Nursing Unit, University of Calgary.

There will be no risks to you by participating in this study. A possible inconvenience to you could be the time commitment for research interviews (a). All interviews will remain confidential. The identity of all participants will remain anonymous. The interview information will be transcribed from the tapes to a wordprocessor, and participants will be assigned fictitious names. With anonymity thus preserved, study results may be shared in publications and presentations. In accordance with University of Calgary policy, audiotapes and transcriptions will be retained for 3 years following completion of the research. The codebook which links actual names to fictitious names will be destroyed upon completion of the research (estimated mid-1997). You may withdraw from the study at any time. There is no compensation for your participation in the study.

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Authorization:
I have read the above and understand the inconveniences and risks of the study. I consent to the participation and I understand that I can refuse to participate or withdraw at any time.

Signed: ___________________________ Witness: ___________________________

Date: ___________________________