



Maximizing Time, Minimizing Suffering: The 15-Minute (or less) Family Interview

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Time is of the essence in nursing practice. Major changes in health care delivery, budgetary constraints, and staff cutbacks have required new ideas for involving families. Rather than excluding family members from health care, more efficient ways need to be determined of how to conduct brief family interviews. This article proposes that a 15-minute (or less) family interview with appropriate knowledge and skills can respond to this important aspect of nursing care. Suggestions are made for facilitating beliefs that need to be embraced for involving families in health care. Essential knowledge of sound family assessment and intervention models, interviewing skills, and questions are given. Identification and discussion of the five key ingredients for brief family interviews are offered. These are: manners, therapeutic conversation, family genogram, therapeutic questions, and commendations. This article cites two clinical examples that highlight the effectiveness and potential for healing in brief family interviews, whether in 15 minutes or in one sentence.

The statement "I don't have time to do family interviews" is the most common reason offered by nurses for not routinely involving families in their practice. In numerous undergraduate and graduate nursing courses, professional workshops, and presentations, we have encountered this statement as the resounding declaration for the exclusion of family members from health care. With major changes in the delivery of health care services through managed care, budgetary constraints, and staff cutbacks, time is of the essence in nursing practice. However, it is our belief that families need not be banned or marginalized in health care. To involve families, nurses need to possess sound knowledge of family assessment and intervention models, interviewing skills, and questions. We believe that family nursing knowledge can be applied effectively even in very brief family meetings. We also claim that a 15-minute, or even shorter, family interview can be purposeful, effective, informative, and even healing. Any involvement of family members, regardless of the length of time, is better than no involvement.

But what is time? And what exactly can be accomplished in 15 minutes or less with a family? Perhaps the best portrait offered about time, particularly therapeutic time, is Boscolo and Bertrando's (1993) comprehensive descriptions, explanations, and examples of clinical time. They offer three domains of time: individual, cultural, and social. Much of nursing practice time is socially and culturally coordinated, highly ritualized, and therefore honored. We propose that by ritualizing and coordinating meeting time with families, even 15 minutes, it too will become an honored part of nursing practice.

However, for nurses' behaviors to change, they must first alter or modify their beliefs about involving families in health care. We have discovered that when nurses do not include family members in their practice, some very constraining beliefs usually exist (Wright, Watson, & Bell, 1996). Some of these beliefs are:

- "If I talk to family members, I won't have time to complete my other nursing responsibilities";
- "If I talk to family members, I may open up a can of worms and I will have no time to deal with it";
- "It's not my job to talk with families, that's for social workers and psychologists";
- "I can't possibly help families in the brief time I will be caring for them";
- "What if the family becomes angry, then what would I do?"; and
- "What if they ask me a question and I don't have the answer, what would I do? It's better not to start a conversation."

Uncovering these constraining beliefs makes it more comprehensible why nurses may shy away from routinely involving families in nursing practice. We postulate that if nurses were to embrace only one belief, that "illness is a family affair" (Wright et al., 1996, p. 288), it would change the face of nursing practice. Nurses would then be more eager to know how to involve and assist family members in the care of their loved one. They would appreciate that everyone in a family experiences an illness and that no one family member "has" diabetes, multiple sclerosis, or cancer. By embracing this belief, they would realize that from initial symptoms, through diagnosis and treatment, all family members are influenced by and reciprocally influence the illness. They also would come to experience that our privileged conversations with patients and their families about their illness experiences can contribute dramatically to healing and the diminishing or alleviation of suffering (Frank, 1998; Wright et al., 1996).

Therefore, we would like to offer some very specific ideas for conducting a 15-minute (or less) family interview. The ideas honor the theoretical underpinnings of the Calgary Family Assessment and Intervention Models (CFAM and CFLM) (Wright & Leahey, 1994) and highlight some of the

most critical elements of these models.

KEY INGREDIENTS

What are the key ingredients to a 15-minute family interview? From our observations and experience, the key and essential ingredients to a successful, productive, and effective 15-minute family interview are manners, therapeutic conversation, family genogram (and in some situations an ecomap), therapeutic questions, and commendations. Of course, all of these ingredients can only take place within the context of a therapeutic relationship.

Key Ingredient 1: Manners

Manners form the core of common, everyday social behavior. However, in the last two decades in North America, our social behavior has dramatically shifted from more formal to more casual social interaction. Even our dress has been altered from "Sunday best" to "casual Fridays." But not all casualness in our society has been welcomed, and unfortunately much of it is experienced as rude, thoughtless, or uncaring. Martin's (1983) national bestseller on a "guide to excruciatingly correct behavior" offers more than 700 pages of her perspective and humor on manners. Miss Manners, as Martin (1983) is known, gives a thoughtful commentary on what is missing in the core of our interactions with one another and thus what is missing in our society. Manners are those simple but profound courteous acts of politeness, respectfulness, and kindness. Unfortunately, our culture as a whole seems to be undergoing an erosion of manners and thus civility. This erosion has sadly spilled over into our nursing profession.

Nursing has not been immune to the changes in social behavior. In some instances, we can argue that some formal nursing behaviors used in the past perhaps inhibited our relations with clients and families. Countless nurses still maintain respectful, polite, and thoughtful relations with their clients. However, we have witnessed and listened to far too many professional and personal encounters between nurses and patients where manners were pitifully absent.

One of the most glaring examples in nursing of the absence of manners is in the basic social act of an introduction. Numerous stories have been told of nurses who do not introduce themselves to their patients, let alone to family members. For example, a young 23-year-old man was seen in an outpatient clinic in a large metropolitan hospital following open heart surgery. He reported that the nurse did not introduce herself but began touching his body and adjusting his intravenous pic line without telling him what she was doing or why. He found this experience to be very invasive, frightening, and rude.

This clinical anecdote is consistent with a study that examined nurse-family relationships in the intensive care unit. Hupcey (1998) found that one of the nursing strategies that inhibits the establishment of therapeutic relationships is the depersonalizing of the patient and family. Examples given were "not referring to the patient by name, labeling the patient or family difficult, providing care without encouraging participation by the patient or family, and not talking or making eye contact" (Hupcey, 1998, p. 187).

So, an essential ingredient to a successful family interview is obvious. Nurses need to introduce themselves to patients and families, always. Introductions by nurses have certainly changed from overly formal to overly casual. Just a few years ago, nurses would introduce themselves as "Miss Sanchez," whereas now a more typical introduction is "Hello, my name is Sasha, and I'm your nurse today." Any introduction is better than no introduction, but as one client exclaimed to us, "Nurses don't introduce themselves any differently than a waiter who says, 'Hi, my name is Josh, and I'm your waiter tonight.'" We would encourage nurses to introduce themselves by their full names except in unique circumstances when there might be concerns of safety.

Sadly, the most serious sin of omission is the lack of introduction by nurses to their patients' family members. What inhibits or prevents nurses in hospitals, community health clinics, and home care from introducing themselves to those persons at a patient's bedside? What prevents nurses from inquiring about those persons' relationships to the patient? Worse yet, what precludes nurses from giving eye contact to family members or friends, one of the most expected social norms in our culture? We have discussed this phenomenon with our nursing students and professional nurses. It has been revealed to us that the belief of lack of time constrains many nurses from talking with anyone but their patients for fear that visitors may ask questions or "require time from me that I just don't have." We would like to counter this belief by offering the suggestion that, in the end, nurses would save time if they would engage in a few manners with family members or friends. Nurses who did this would likely not be pursued at even more inopportune times by relatives wanting to inquire about their family member. Nurses who have involved family members in their practice have reported that they have enjoyed increased job satisfaction rather than less (Leahey, Harper-Jaques, Stout, & Levac, 1995).

Good manners also have the effect of instilling trust in family members. Richardson (1987) described seven ways that a nurse can build trust with a patient. These seven points could really be described as good manners that invite a trusting relationship. They are the following: Always call a patient by name, tell the patient your name, check your attitude, explain your role for that shift, explain a procedure before coming into the room with the equipment to do it, if you tell the patient that you will be back at a certain time keep that appointment, and be honest with the

patient.

Key Ingredient 2: Therapeutic Conversations

All human life takes place in conversations, and nursing is one of the networks of conversations. Nurses are always engaged in therapeutic conversations with their clients without perhaps thinking of them as such. No conversation that a nurse has with a patient or family member is trivial. Each conversation in which we participate influences change in our own and in family members' biopsychosocial-spiritual structures (Wright et al, 1996).

The conversation in a brief family interview is therapeutic because from the start it is purposeful and time limited, as are the relationships. Therapeutic conversations, between a nurse and a family, can be as short as one sentence or as long as time allows. All conversations between nurses and families, regardless of time, have the potential for healing through the very act of bringing the family together (Robinson & Wright, 1995; Tapp, 1997). However, it is not the length of the conversation or time that makes the most difference; rather, it is the opportunity for patients and family members to be acknowledged and affirmed that has tremendous healing potential (Tapp, 1997). Nurses are socially empowered and privileged to bring forth either health or pathology in the conversations in which they engage with families.

The art of listening is also paramount. The need to communicate what it is like to live in our individual, separate worlds of experience, particularly within the world of illness, is a powerful need in human relationships (Nichols, 1995). Frank (1998) suggests that the listening by health professionals to illness stories is not only art but an ethical practice. Frequently, nurses believe when they listen that it also entails an obligation of doing something to fix whatever concerns or problems are raised. More often, however, the most therapeutic move, intervention, or doing can be the nurse listening, showing compassion, and offering commendations.

It is the integration of task-oriented patient care with interactive, purposeful conversation that distinguishes a time-effective 15minute (or less) interview. The nurse makes information-giving and patient involvement in decision making an integral part of the delivery process. She uses opportunities and searches for opportunities to engage in purposeful conversations with families. These differ from social conversations and can include such basic ideas as the following:

- Families are routinely invited to accompany the patient to the unit/ clinic/hospital.
- Families are routinely included in the admission procedure.
- Families are routinely invited to ask questions during the patient orientation.
- Nurses acknowledge the patient's and family's expertise in managing health problems by asking about routines at home.
- Nurses encourage patients to practice how they will handle different interactions in the future, such as telling family members and others that they cannot eat certain foods.
- Nurses routinely consult families and patients about their ideas for treatment and discharge.

Key Ingredient 3: Family Genograms and Ecomaps

Nurses need to make it a priority to draw a quick genogram (and sometimes, if indicated, an ecomap) for all families but particularly for those families who will likely be part of their care for more than 3 days. Details for the collecting of genogram and ecomap information are offered extensively in the discussion about the Structural Assessment category of the CFAM (Wright & Leahey, 1994, see pp. 39-56). In a brief interview, the collection of genogram and ecomap information needs also to be brief. This information can be gleaned in about 2 minutes from family members.

The most essential information to obtain is data about ages, occupation/school grade, religion, ethnic background, migration date, and current health status of each family member. Begin by asking easy questions (ages, current health) of the household family members. It is not necessary, or time efficient, to draw out information relating to, for example, siblings' divorces or grandchildren, unless it is immediately relevant to the family and health problem. Once this genogram information is obtained, then, if indicated, expand the data collection to obtain external family structure information in the form of an ecomap. It may be useful to ask such questions as "Who outside of your immediate family is an important resource to you? Or is a stress?"; "How many professionals are involved in treating your husband's current heart problems?" The obtaining of this structural assessment data through the genogram and ecomap also serves as a quick engagement strategy because families are usually very pleased that a nurse is asking about their entire family rather than just the person experiencing the illness. It quickly acknowledges for the family the nurse's core underlying belief that illness is a family affair.

Hopefully, the genogram becomes part of the documentation about the family/patient. In one cardiac unit, the genogram information is collected on admission and the genogram is hung at the patient's bedside. Emergency telephone numbers for family members are listed on the genogram. In this way, the genogram acts as a continuous visual reminder for all health care professionals involved with the patient to "think family."

Key Ingredient 4: Therapeutic Questions

Therapeutic questions are a key, defining element in a therapeutic conversation. Many ideas and examples of circular and interventive questions are given in *Nurses and Families: A Guide to Family Assessment and Intervention* (Wright & Leahey, 1994, see pp. 101-104, 166-167). When a nurse is attempting to have a very brief family meeting, there are key questions that the nurse could ask family members to involve them in family health care. We encourage nurses to think of at least three key questions that they would routinely ask all family members. These questions need to fit the context in which the nurse encounters families. For example, the questions a nurse may ask family members in an emergency or oncology unit in a hospital might differ from those a nurse might routinely ask family members in an outpatient diabetic clinic for children. However, there are some basic themes that need to be addressed, such as the sharing of information; expectations of hospitalization, clinic, or home care visits; and challenges, sufferings, and most pressing concerns/problems. Below are some examples of questions that address these particular topics:

- 1 Who of your family or friends would you like us to share information with and who not? (Indicates alliances, resources, and possible conflictual relationships.)
- 2 How can we be most helpful to you and your family or friends during your hospitalization? (Clarifies expectations, increased collaboration.)
- 3 What has been most/least helpful to you in past hospitalizations or clinic visits? (Identifies past strengths, problems to avoid, and successes to repeat.)
- 4 What is the greatest challenge facing your family during this hospitalization/discharge/clinic visit? (Indicates actual/potential suffering, roles, and beliefs.)
- 5 What do you need to best prepare you/your family member for discharge? (Assists with discharge planning early.)
- 6 Who do you believe is suffering the most in your family during this hospitalization/clinic visit/home care visit? (Identifies which family member is in the greatest need for support and intervention.)
- 7 What is the one question you would most like to have answered during our meeting right now? (Wright, 1989). I may not be able to answer this question at the moment but I will do my best or will try and find the answer for you. (Identifies most pressing issue or concern.)
8. How have I been most helpful to you in this family meeting? How could we improve? (Shows a willingness to learn from families and to work collaboratively.)

Key Ingredient 5: Commending Family and Individual Strengths

We routinely commend families in each session on the strengths observed during the interview. Even in a brief family interview of 15 minutes or less, we still endorse the practice of offering at least two commendations to family members of individual or family strengths, resources, or competencies that the nurse observed or were reported to her. Remember that commendations are observations of behavior that occur across time. Therefore, the nurse is looking for patterns rather than a one-time occurrence that is more likely to be the offering of a compliment. An example of a commendation is: "Your family is showing much courage in living alongside of your wife's cancer for 5 years." A compliment would be: "Your son is so gentle despite feeling so ill." Families coping with chronic, life-threatening, and/or psychosocial problems frequently feel defeated, hopeless, and/or like failures in their efforts to overcome their illnesses or live alongside of them. Therefore, one can never offer too many commendations. We believe that frequently there is a commendation-deficit disorder with most families who are experiencing illness, disability, or trauma.

The immediate and long-term positive reactions to such commendations indicate that they are powerful, effective, and enduring therapeutic interventions. Robinson (1998) explored the process and outcomes of nursing interventions with families experiencing difficulties with chronic illness. The families reported that the clinical nursing team's "orientation to strengths, resources, and possibilities to be an extremely important facet of the [therapeutic] process" (Robinson, 1998, p. 284). Families who internalize commendations offered by nurses appear more receptive and trusting of the nurse-family relationship and tend to more readily take up ideas, opinions, and advice that is offered.

By commending families' resources, competencies, and strengths, nurses offer family members a new view of themselves. By changing the view they have of themselves, families are frequently able to look at their health problem differently and thus move toward more effective solutions to reduce potential or actual suffering.

PERSONAL EXAMPLE OF INVOLVING FAMILY IN NURSING PRACTICE

To poignantly illustrate how involving family members in health care can be both effective and healing, or ineffective and result in needless increased suffering, Lorraine M. Wright (LMW) offers a personal story to illustrate the best and worst of family nursing. These experiences occurred during two very brief interactions with nurses in an emergency unit of a large city hospital while

accompanying her mother for a possible admission.

Over the last 4 years, my 77-year-old mother has experienced several major exacerbations from Multiple Sclerosis (MS) with frequent hospitalizations. Each exacerbation has left my mother more physically disabled. The extreme exacerbations of this last year have now left my mother a quadriplegic. With each exacerbation, my mother has never returned to the level of either physical or cognitive functioning that she previously enjoyed. Currently, one of the most demoralizing aspects of this disease is the chronic pain my mother suffers in her hands. Despite all of these setbacks, there is tremendous courage on the part of both my mother and father. My mother's moments of complaining, sadness, or grief have been amazingly minimal, which of course buffers other family members' suffering. I have witnessed my father become a very caring caregiver and "nurse" while his own life has become very constrained.

On one of my mother's recent admissions to the hospital I encountered two very brief but powerful conversations with nurses in an emergency unit of a large city hospital. One nurse I prefer to call "naughty nurse" and the other "angel nurse." Both of these nurses had a profound impact on my emotional suffering. Both of these nurses interacted with me for a very brief period of time, not more than 5 minutes each.

Prior to the arrival at the hospital emergency department, a very exhausting few hours had been spent with my mother. My father, mother, and I were enjoying a day at our cottage about an hour out of the city. But as the afternoon unfolded, it became apparent that my mother was becoming more wobbly when walking (at that time she was still able to walk a few steps with assistance). As we were packing to leave, my mother was unable to bear weight. With great difficulty, my father and I lifted her into her wheelchair and we headed down the ramp of our cottage to the car. But now the greater challenge lay ahead of us: to get my mother from the wheelchair into the car. It took all of our strength and ingenuity to accomplish the task, with my mother of course frightened that we would drop her. After some 30 minutes and lots of perspiring, we realized our goal, and my mother was safely in the car. On the way into the city, a mutual decision was made to take my mother to the hospital, where she had been admitted on previous occasions, to have her assessed for possible admission. We all believed that my mother was having another severe exacerbation.

Upon arriving at the emergency department, I was very relieved. It had been a very worrisome and arduous few hours. I now looked forward to my mother receiving nursing and medical assessment and treatment to assist her and us. My father waited with my mother in the car at the curb of the emergency department while I entered to seek assistance to lift my mother out of the car. Upon arriving at the nursing station, I encountered "naughty nurse." I explained the current situation to her and requested assistance to lift my mother out of the car and into the emergency department. "Naughty nurse" responded in a curt, distrustful tone by saying, "How did you get her into the car?" This initial brief interaction was shocking to me. Our initial and brief conversation was accusatory, blaming, and distrustful of one another. No therapeutic relationship was being developed here. This nurse's response invited me to counter with an equally rude, impolite response. I said, "with great difficulty—so we will need help to lift her out of the car." Our conversation now escalated in terms of accusations and recriminations; "naughty nurse" retorted, "Well, I can't lift her out of the car." I suggested that perhaps one of her male colleagues could assist us. As they approached the car to assist my mother, neither introduced themselves to my mother nor did they discontinue the social conversation that they were having with each other. This was the worst of a nonfamily nursing experience. By now, I was very distressed and upset by the treatment offered by this particular nurse. The sad irony is that this nurse was completely unaware that in my professional life, I teach about, practice, research, and write about family nursing.

But all was not lost. Within a short while, we were placed in a room in the emergency unit and after a brief wait, "angel nurse" appeared. First, she introduced herself to my mother and then explained that she would be taking her blood pressure, temperature, and that blood work had been ordered. This "angel nurse" competently and kindly attended to my mother, inquiring both about her medical history and her illness experiences about MS. In a very impressive manner, she reassured my mother that she would probably be admitted for another round of intravenous steroids and that all would be done to keep her comfortable. At that moment, she came to me, reached out her hand to shake mine, introduced herself, and warmly inquired about the nature of my relationship to my mother. I was softened by this nurse's kind and competent approach. I offered the information that I was the daughter and that I was visiting from another city. Then this nurse offered a possible hypothesis in the form of a statement and said, "This must be very upsetting for you." In that one sentence, this nurse assessed and acknowledged my suffering. "Angel nurse" provided comfort and understanding through her very brief interaction with me in probably less than 2 minutes. However, in just 2 minutes this nurse had involved me in her practice and in just 2 minutes my emotional suffering had been acknowledged.

Later, upon reflection, my reaction to this nurse's encounter with me was to make every effort to assist this nurse in the caring of my mother because I could see that she was overloaded with many patients in the emergency room. "Angel nurse's" particular nursing approach with me had invited me to want to be more helpful to her. Kindness invites kindness; accusations invite accusations. Perhaps not all of the key ingredients that we have suggested for a brief family interview are evident in this interaction with "angel nurse," but it exemplifies how the context and

the appropriateness of the situation determine how much family members can be involved. This nurse beautifully demonstrated that family nursing can be done even in busy emergency units, even in 2 minutes, and effect healing.

PROFESSIONAL EXAMPLE OF A BRIEF FAMILY INTERVIEW

A 32-year-old woman, Greta, was admitted to a medical unit with the diagnosis of questionable influenza. Her weight had dropped to 82 pounds, a loss of 10 pounds in the week prior to admission. Greta also had a genetic disease involving weakness and wasting of skeletal muscles. The nursing staff experienced her as angry and abrupt, and they wondered what the problem was. They felt sorry for Greta and thought of her as "very dependent." The purpose of the brief interview was to explore Greta's expectations, beliefs, and resources. Her family was invited to the meeting, held on the unit, but they did not come.

In a 15-minute interview with Greta alone, the nurse initially drew a quick genogram. She noted that Greta lived with her two younger brothers and mother, all of whom had what Greta called "The Disease" (wasting of the muscles). The patient was the only family member able to drive, and this was the reason the others did not attend the meeting.

The nurse then asked Greta about her expectations for the hospitalization and how the nurses could be most helpful. Greta responded to the therapeutic questions by saying that she would know that the staff would care for her "by how they talk with her and other patients, show her respect, and trust and treat her independently." She stated that, she needed to be strong so as to care for her brothers and mother "who depend on me."

The nurse asked Greta what hopes and expectations the other family members had for Greta's hospitalization. She replied that when her mother had previously been hospitalized, the staff had "pushed her to eat." Greta found this very disrespectful. The nurse inquired how the current staff were treating Greta's reluctance to eat. Greta described how they offered her food choices and found this quite satisfactory.

The interview concluded with the nurse inviting Greta to talk more with her if Greta had any concerns about her care.

From this interview, the nurse revised her opinion of Greta being "very dependent" to thinking of her as someone who needs to be commended for her independence and caregiving. She now saw Greta as a "strong person" and passed this message on to her nursing colleagues.

A few days after the very brief interview, Greta commented during morning care, "Remember when you told me to tell you if something wasn't going right?" Greta then shared that the evening staff were "pushing her to eat and not respecting her choices." She had lost one pound. The nurse listened and remembered the morning report in which Greta was talked about as being "manipulative." The staff were concerned with her weight loss and therefore "pushed her" to eat more. In turn, Greta ate less.

The nurse conceptualized the problem as an unhelpful circular interaction (Wright & Leahey, 1994) between the patient and the evening staff. She decided to intervene by doing the following:

- inviting the dietician to talk with the staff regarding food groups and choices,
- putting a note in the record system that Greta could "eat on demand," and
- encouraging individual members of the nursing staff to give Greta options about various types of food.

The outcome of this brief family-oriented interview and the interventions was that Greta gained some weight over the course of hospitalization. The other staff nurses said they felt "less responsible for making Greta eat" and more responsible for offering her choices and promoting her independence. Most significant to the primary nurse was the intervention used in the unit documentation system in which she identified the problem, proved a rationale, and recommended direction for other staff. From our perspective, an important outcome was that Greta's skills and competencies to manage and live alongside her chronic illness were reinforced. She went home stronger both physically and emotionally and was able to assist herself and other family members with ongoing health issues. This brief interview also indicates how nurses can include other family members in the therapeutic conversation, even if they are not present. Involving family members in nursing practice means inquiring about them whether they are present or not.

CONCLUSION

In conclusion, an overall framework for a brief family interview is as follows:

- 1 Use manners to engage or reengage; introduce yourself by offering name, role, and orienting family members to the purpose of a brief family interview.
- 2 Assess key areas of internal and external structure and function; obtain genogram information and key external support data.
- 3 Ask three key questions to family members.
- 4 Commend the family on two strengths.

We generally find this to be a useful guide when conducting a brief family interview. However, these key ingredients to a brief family interview need to be adapted according to the competence of the nurse, the context in which nurses and families encounter one another, and the appropriateness and purpose of the family meeting. We are confident that if suitably implemented, nurses and families will both be satisfied with the usefulness of a brief family interview. Nurses can and do reduce families' physical, emotional, and/or spiritual suffering by engaging in therapeutic conversations with family members, if only for 15 minutes or even in one sentence!

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