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A "READER'S THEATER" INTERVENTION TO MANAGING GRIEF: POSTTHERAPY REFLECTIONS BY A FAMILY AND CLINICAL TEAM

Anne Marie C. Levac
Children's Hospital of Eastern Ontario

Sue McLean
Foothills Hospital

Lorraine M. Wright Janice M. Bell
University of Calgary

"Anne" and "Fred"*

The sudden and accidental death of a child can be one of the most devastating events in the life of a family. This paper describes one couple's reflections of their grief and mourning following the death of their adolescent son as well as the clinical team's reflections of therapy. The uniqueness of this paper is that it offers a "reader's theater" intervention that enabled further change to occur. The clinical team used a belief model, emphasizing that altering constraining beliefs is at the heart of healing from such tragedies as sudden death (Wright, Watson, & Bell, 1996). This approach is operationalized through therapeutic conversations be-

Anne Marie Levac, RN, MN, is Director, Nursing Professional Development and Research, Children's Hospital of Eastern Ontario, 401 Smyth Rd., Ottawa, Ontario K1H 8L1. Phone (613)737-2533, e-mail amlevac@cheo.on.ca.

Sue McLean, RN, MN, is Nurse Clinician, Addiction Centre, Calgary Regional Health Authority, Foothills Hospital, Calgary, Alberta. Phone (403)286-6395, e-mail sjmclean@nucleus.com.

Lorraine M. Wright, RN, PhD, and Janice M. Bell, RN, PhD, are Faculty of Nursing, The University of Calgary, 2500 University Dr. NW, Calgary, Alberta T2N 1N4. Phone (403) 220-4647, fax (403) 284-4803, e-mail jmbell@acs.ucalgary.ca, lmwright@acs.ucalgary.ca.

*The couple who co-authored segments of this article wish to remain anonymous. Our clinical team would like to emphasize that the couple were major contributors to this paper. Without their participation, this paper could not have been written. Their willingness to participate in the co-authoring process has assisted us to better understand the experience of grief following the death of a child, to understand and acknowledge what was useful in therapy, and to consider the value of utilizing a reader's theater to reflect on the therapy process.

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tween family members, clinician, and clinical team. Interventions such as reflecting teams, therapeutic letters, and "homework tasks" were used to modify or challenge constraining beliefs of both the family members and the clinical team members. However, the intent to co-author a paper with this couple provided the serendipity intervention of a "reader's theater" that further served to identify, affirm, and solidify facilitating beliefs.

Most clinical articles are written by professionals about their work with individuals or families. The core of this paper, however, was co-written by the clinicians *and* the couple about their collaborative work together during 10 sessions over a 10-month period. The couple was referred to the Family Nursing Unit (FNU), an outpatient education and research clinic at The University of Calgary, by their family physician for assistance in coping with the death of their son, which had occurred approximately six weeks prior to the first session. During the ninth session, one of the clinical supervisors invited the couple to participate in co-writing this paper with members of our clinical team. The couple readily agreed but preferred not to have their actual names appear on the manuscript. Instead, the pseudonyms "Ann" and "Fred" were chosen.

During the second last session, it was agreed that the clinician, the graduate nursing student, and the husband and wife would each write about their experiences of the collaborative therapy process. This would serve as the rough draft and core of the paper. At that time, we, the clinicians, believed that co-writing the paper would provide therapeutic value to the family and, secondarily, a learning opportunity for the team. However, the profound experience of the husband, wife, clinician, and student was not *writing* the reflections but *reading* them to one another at the culmination of therapy. This profoundly dramatic and moving process became the most unique aspect of working with this family. This process, which can be likened to a "reader's theater," was serendipitous as the husband and wife, the clinician, and the student each wrote and subsequently read aloud their reflections on the family's story of grief and the therapy process. The couple reflected on their emotional and physical suffering and their responses to a practice approach that focuses on beliefs (Wright, Watson, & Bell, 1996). In actual theater, a reader's theater may be defined as the vocal dramatization of a script by a group of readers with minimal use of gesture, action, or stage props. In the therapy process described here, everyone sat together in the therapy room and one by one read his or her reflections aloud while others listened without interruption or comment. Each witnessed and affirmed the other's experiences and altered beliefs. The reader's theater illustrates the healing power of unconditional presence. A reader's theater is different from a recitation by one voice; it is multiple voices layered, each voice in the context of other voices. It is not a stringing together of posttherapy ideas but rather a reflective and deliberate authoring of family and clinicians' experiences shared in a respectful, nonjudgmental, and nonhierarchial manner.

Following this reader's theater, another meeting with the couple was arranged to work on the manuscript. In addition, the clinical supervisors involved with this family provided input into the final paper.

The Family

The family consisted of Ann, age 53, and Fred, age 56, who experienced the sudden and accidental death of their 17-year-old son, Jeremy. The couple were simultaneously experiencing the ongoing 10-year estrangement of their eldest daughter Jennifer, age 30.

Fred and Ann had been married for 33 years and had moved to a different city in Canada approximately one year prior to Jeremy's death. They had another daughter, Andrea, age 28, who was married. Andrea and her husband, Mike, had two children: Virginia, age 2, and Samuel Jeremy, who was born during the course of Ann and Fred's therapy. Both Ann's and Fred's fathers were deceased, and their mothers both lived in Europe.

Clinical Team

The senior author (A. M. L.) was the clinician who worked directly with this family. She provided demonstration interviews and clinical supervision to Master of Nursing students. The graduate student (S. M.) observed the therapy sessions from behind the one-way mirror as a member of the clinical team. She was responsible for conducting the presessions and the clinical documentation throughout the work with this family. Other clinical faculty (L. W. and J. B.) served as supervisors and team members during the clinical work. In addition, the clinical team included graduate nursing students (master's and doctoral level) specializing in family systems nursing, who participated from behind the one-way mirror.

Clinical Practice Approach: A Beliefs Model

The clinical practice approach practiced at the FNU was developed by Lorraine Wright, Wendy Watson, and Janice Bell (1996). The approach focuses on the intersection between the beliefs of the ill person, the beliefs of the family members, and the beliefs of the health care professionals. Through therapeutic conversations, the clinician brings forth facilitating beliefs and challenges constraining beliefs through a variety of interventions. Some of the interventions that were offered to this family included: interventive questions (Tomm, 1988), reflecting teams (Andersen, 1987), therapeutic letters (White & Epston, 1989), and White's (1988/89) "externalization of the problem." Core beliefs are those distinguished by the clinician or clinical team as most significantly influencing the family's responses to the presenting concern. Constraining beliefs restrict options for change and perpetuate problems. Conversely, facilitating beliefs assist families to increase options for change.

Interventive questions (Tomm, 1988; White, 1988a) may be considered one of the most powerful interventions used by clinicians who work with families. Interventive questions are posed by the clinician to elicit useful information about core family beliefs. Reciprocally, clinician and family responses give family members useful information. Some examples of these questions are: "If you were to believe that it is common for couples to be out of sync at times with each other in their grieving, what difference would that make to each of you?" "What might be the impact of closing the door (to your contact with Jennifer) but leaving it unlocked such that if she chooses, she can open it?"

During every session, family members were offered the opportunity to hear the clinical team's reflections in lieu of the clinicians meeting privately with the team. Reflecting teams (Andersen, 1987) provide a nonhierarchical forum in which commendations, speculations, and ideas are offered to the family in a spirit of wondering. Reflecting teams offer questions or comments that solidify facilitating beliefs and challenge or modify constraining ones. Multiple minds formulate multiple ideas, and family members are free to select those comments or questions that best fit them. There are no "right" or "wrong" ideas, and health professionals need not be overly concerned when families do not see their ideas as fitting. Rather, the family's responses to the interventions become information that feeds the team's eagerness to learn more about the family and to promote a collaborative relationship rather than one based on "expertship."

Therapeutic letters reflect the weight and value of the printed word in our society (White & Epston, 1989). They provide a potent therapeutic context in which nurses offer families their impressions, questions, and ideas. Within our approach, letters are designed to affirm facilitating beliefs and challenge constraining beliefs. Letters are sent to families between sessions so that they can revisit elements of the therapeutic conversation that stood out for the team.

FAMILIES, GRIEF, AND THERAPY

The death of a child can be one of the most devastating events in the life of a family. Of all losses endured by individuals, the death of a child is said to produce the highest intensities of bereavement and the widest range of grief reactions (DeVries, Dalla Lana, & Falck, 1994; Rando, 1985). These reactions are both physical and psychological in nature and each one bears its own validity; there is no right or wrong way to grieve. Many profound emotions may be connected to loss. For example, upon the sudden death of a child, parents experience an overwhelming sense of lost hopes, dreams, and expectations for the child while also experiencing the loss of a part of themselves and their future (Martinson, Davis, & McClowry, 1991; Rando, 1985). Guilt can be so overwhelming that parents can feel ruled and oppressed by it; their world is filled with extreme absence and loss (Miles & Demi, 1984; Miles & Perry, 1985).

The loss of a child often strains the marital relationship as each spouse struggles with his or her own grief while simultaneously dealing with the other, who also needs support. Contrary to popular belief, there are no studies that draw statistical conclusions that bereaved parents' divorce rates are higher than those of nonbereaved parents (Klass, 1986). What appears to be most crucial in the resolution process for these parents is the quality of their relationship communication patterns as they explore their beliefs about grieving and the role guilt plays in the death of their child (Gilbert, 1989; Rando, 1985; Valeriote & Fine, 1987).

Differences in grieving styles and grief experiences of parents can result in the spouses' having different expectations and coping strategies, and past conflicts may resurface during this time of crisis (Klass, 1986; Rando, 1985; Schwab, 1992). Gilbert (1989) explains that spouses' different beliefs about the "right" or "best" way of grieving often lead them to try to influence or even control each other's behavior. He surmises that this belief may come from a need to validate one's own way of grieving and is an attempt to help one's spouse grieve "correctly." This incongruent grieving pattern can occur at any point in the grieving process and can create misinterpretations, sometimes suggesting indifference in one spouse toward the other (Gilbert, 1989; Rando, 1985; Valeriote & Fine, 1987). Gilbert proposes that "the ability to engage in open and honest communication has often been seen as essential to recovery from loss" (1989, p. 616).

Although the family can never be the same following the death of a child, the availability of resources to help bereaved families with their grieving can make a considerable difference in their healing process. Clinicians are frequently involved with families during times of grief (Sedney, Baker, & Gross, 1994; Walsh & McGoldrick, 1991; Wright & Nagy, 1993) and therefore have unique opportunities to make a difference in a family's experience of grief. One approach is to bring forth facilitating beliefs and modify or challenge constraining beliefs to diminish the suffering associated with grief.

REFLECTIONS OF A COUPLE, CLINICIAN, AND CLINICAL TEAM MEMBER

Several sessions paved the way prior to the session in which the couple was invited to co-author a paper with the clinical team. The couple was well engaged in the therapy process, had a trusting relationship with the therapist and clinical team, and had previously consented to a team approach that they knew might involve publication of clinical case material. This section contains the actual verbatim texts that were read aloud in the clinical room by Ann, Fred, Sue McLean, and Anne Marie Levac. This process became a powerful intervention that we have named the reader's theater intervention. The supervisors and other members of the clinical team observed from behind a one-way mirror.

The Couple's Reflections: Ann and Fred

We are glad to participate in writing this article because of all the help sought and offered since our son's death. We both have found the FNU team the most useful. Because we have each experienced our family traumas so differently, we have responded separately at first with our thoughts on our son's death and our daughter's estrangement.

Ann's reflections. My son's death is physical and emotional pain and grief to me. My daughter's estrangement is terrifying and ego-destructive. The two combined have led to my experience of myself as an unworthy mother who put my career ahead of my family and has been punished. Sometimes I feel that it is hard to go on with my life.

I wish that I had a strong religious conviction. I have sought desperately for it but cannot just *choose* faith. I need to find an existence and meaning in life that gives me purpose now. I no longer feel I am a functioning mother. My grandchildren are a joy but live some distance away. I hope to return to my career shortly in an effort to regain equilibrium.

I read a book recently that talked of the primary loss, that of your child, and secondary losses, like loss of role and loss of seeing your child graduate, marry, and have children. Until I read this book I had felt strange that as well as grieving the absence of my son, I had all these other griefs.

My grief for my son has been compounded by concerns around the avoidable nature of his accident and the unknowns that will never be answered—my distress over the concept of brain death and the transplant of our son's heart from his still-breathing body. At the time it seemed right to donate his organs, but I have had so many worries since.

It is my custom to study as much as I can in an effort to understand things and the death of our son has been no different. Things I was told or read that have helped include:

"Why want him back when he would then have to die again?"

"There may have been something worse in his future."

"Grief is only thought. Your brain has to adjust to his loss."

"The world is governed by chance, not purpose."

"You haven't lost the past but the future. He would never have been 3, 7, 11, 14 again, and you still have your memories of those times."

"Every 'what if' is of equal value. Millions of decisions led to that point in time. Moving to Calgary made no more difference to his death than his being late for tennis with his father."

Things I was told that were not helpful include:

"It's six weeks now; you should be over it."

"I believe your son was going to hell because he was not raised a Christian, so I prayed for him."

"I think they rushed declaring him brain-dead."

"As you sow so shall you reap."

"He would always have been a burden to you. Start doing things for yourself. You've suffered enough."

"There are no accidents."

Fred's reflections. The loss of our son is a tragedy and lies heavy on my heart. It's like being smothered by a pillow and struggling to breathe. I feel that it is very sad that he cannot realize any of his ambitions. He was really looking forward to being an adult and fending for himself. So much of our lives were centred on him. He was part of every decision. I miss his sense of humor, his naiveté, his companionship, and his love. It is strangely like losing a limb. You can still sense it.

My mother's response to the news of our son's death was "Well you can't do anything about it, can you?" Philosophically I agree with her. I do not believe in any mystic afterlife or heaven or in a creator. I suppose that if I did, it might ease the pain. Possibly though, the pain might be greater if I believed that he was somewhere else fretting about those he left behind. He was a very sensitive person who hated to see anybody upset. There is, however, some easing of the pain from my belief that his "awareness" ceased in August 1994 and so therefore did his existence. He "isn't," so cannot feel pain or regret. We can only feel it for him. Therein lies the problem. Those of us still existing suffer from our thoughts and feelings. I feel guilty that I was not able to protect or save our son. Those thoughts are not directly constructive. They may prime us for our own and others' protection, but they cannot do anything for the one we loved.

The loss of our eldest daughter doesn't lie particularly heavy on my heart. The estrangement started during a period when I was very ill and maybe that reduced the impact on me because I never really focused on her loss. The situation now is that our son's death is preeminent. Focusing on the loss of our daughter brings sadness to me, but it doesn't lie as heavy as the loss of our son.

My son occupies my thoughts several times a day. Mostly those thoughts are heavy with sadness. Fantasizing about solutions, like inventing a time machine to save him, help me get to sleep at nights. My thoughts ramble on to the sociological and economic implications of such an invention. During the day my thoughts can jump to him, but I am now able to push them back and concentrate on the task in hand. I couldn't do that for the first four to five months after his death.

Ann and Fred's reflections on therapy. The support we received from the FNU was what we would have hoped for from a caring family. From Fred's mother's refusal to talk about our son to Ann's mother's presentation to us of a very cruel letter she had received from our oldest daughter about our son's death, we were continually disappointed by our lack of family support in the early days of our loss. Our younger daughter and her husband were both loving and kind but did not share our grief in the same way. In our daughter's words, she "blocked" it. This, too, was painful for us.

The FNU gave us positive feedback from our first visit—on our relationship with each other, on how we were working to resolve some of our pain, and on us as people. They showed us love and caring. Looking for articles for us to read was the therapeutic equivalent of chicken soup. Their appreciation of meeting our younger daughter and granddaughter was soothing to the pain around our parenthood. When they looked at our family photos

willingly, it led to us feel that here were people who were sharing the burden of our grief as well as supporting us. Nothing was too hard to tell them, and all was received and responded to. Their most recent deed of sending our younger daughter a card on the birth of our second grandchild was, again, a loving, caring act. The detachment that some therapists engage in or the syrupy pity and condescension of others has played no part in this relationship, which feels clean, honest, and nurturing. Perhaps it helps to be behind a mirror when exposed to pain and frees the observers to "recollect in tranquillity" when providing feedback later.

Ann has been helped in dealing with her feelings of guilt by articles given her, by questions like "What amount of self-torture would atone for the loss of a much-loved son?", and by instruction to Fred not to rush in to deny her guilt but to encourage its expression.

Fred has been helped to understand that there are many different ways to experience grief and that it is to be expected that partners are "out of sync" with each other at times. He has found it easy in this setting to express himself and get some of his thoughts out, and also to get some beliefs tested. He has felt in one-on-one counseling that therapists were trying to get inside his head, and he is a private person who resents that. To both of us, the team approach is more effective than one-on-one grief counseling where there are no witnesses giving feedback. We also appreciated the intellectual component—referring to research, etc.—because this seemed to keep some of the work more clinical and objective.

The feedback received after each session was highly valued. Insights are gained when you don't have to keep talking and can be reflective. There therapists did not use secrets or "expert" positions to maintain power over the clients. The feedback was concrete and specific, so we could see more clearly what we had done or said. For example, we were praised for checking with each other after some statements and showing respect for the other's point of view. We were frequently reassured that what we were experiencing was not unusual—for example, our feelings of anger. We were often encouraged to notice what we were doing and to be aware of how we dealt with each other. This was helpful in getting us to be more conscious and therefore in control of our reactions.

When we did difficult things like visiting the accident site or dismantling our son's room, we received warm approval for our courage and our mutual support of each other. No one else did this for us. The letters that we received recapping what had occurred in each session were highly valued, like report cards. They were positive about us and our struggle, clarified and outlined important events and issues, and gave suggestions for next time. They helped us, at a time when our memories were poor, not to lose useful suggestions.

The positive nature of the feedback was a warm and tonic bath and a corrective for our tendency to see things negatively. Our son's funeral was described as a testimonial to our son *and* his parents. Our concerns that we knew too much about our son were translated into praise for our caring and into comparison with less-involved families.

Ann keeps a diary, and her reflections on the FNU are, from the beginning, positive. She wrote, "They suggest we put guilt into the light. This is a helpful idea. I see now that sensitivity is not a survival skill. No wonder my daughters didn't see me as a role model in this area."

The openness of the team included sharing their own feelings—for example, "It was difficult to hear you feeling you may have contributed to your son's death." Sometimes in the feedback sessions we could feel emotion generated on our behalf, and it helped when we felt so alone and unsupported in the real world. Practical ideas such as "Take a break from grief" were helpful and timely!

To be given homework to look for what thoughts fight guilt and to think about how Ann would help Fred if he had a similar problem took the focus off the negative and gave Ann positive tasks to undertake. A really helpful idea was to encourage both of us to remind ourselves that we had always made decisions with the best of intentions. The concept of balance was returned to many times. Suggestions that we practice saying "hello and goodbye" to both our children were ideas that we discuss and make use of still.

Toward the end of our time with the FNU, Ann wrote in her diary, "FNU was great as usual. I must stop pursuing our eldest daughter in my mind. 'Rejection is a powerful invitation to pursue.' They really care."

We felt empowered by the invitations to watch the team discussing us, as they had watched us during the interviews. We felt this at a time when we were feeling particularly powerless and of low status. We had lost two children—careless and bad of us. Again, we were in the driver's seat in deciding the number of sessions. It is very important to show this courtesy to people who feel so vulnerable. When our younger daughter attended a session with our granddaughter, she too was treated with respect, and her own copy of the usual letter was sent to her.

Ann's last entry in her diary about the FNU is as follows:

> Why do I like them so much? They build up, focus on the positive, do research to try to help; many minds help with good ideas. I feel they are strong, competent individuals and there is liking and trust between them. Their leader is a good role model. They are full of intentionality.

We are not fixed or cured. We continue to grieve our losses daily, and Ann still struggles with her sense of loss of purpose and value, but we feel that in our time with the FNU they held our heads above water when we were in danger of drowning, and gave us life-jackets to keep us afloat since the shore is not in sight and there are no rescuers.

Graduate Student's Reflections: Sue McLean

As a first-year Master of Nursing student specializing in family systems nursing, my role with this family was to lead presession discussions, participate in reflecting teams, and write therapeutic letters to the family. The presessions consisted of reviewing literature with the clinical team and developing hypotheses and questions for the clinician. I participated in the sessions with my student colleagues and a faculty supervisor. I reviewed the videotaped sessions and recorded them.

When I think of my experiences this past semester with the Family Nursing Unit, I feel full of enthusiasm and have a sense of awe and enormous respect for the family with whom I have been most closely connected. I have come to understand their strengths and commitment to one another, while watching their pain and anguish in trying to find a balance in their grieving.

As a participant observer from behind a one-way mirror, I was initially completely caught up in the human drama unfolding before my eyes. I cried when they cried, and I felt very affected by their obvious suffering and often thought of my relationship with my own adolescent children. I was very fortunate to meet this family on my first day of being behind the one-way mirror at the FNU because I have been able to reflect on the gradual changes I noticed in myself over the subsequent three and a half months. Although I am still very committed to this family, I am aware that I have a much broader perspective of the therapeutic conversations taking place. In the last four sessions of observing this family, I am now very conscious of the clinician's approach to the family members and her skill in

exploring their beliefs about the loss of their children. I was initially amazed at how persistent this exploration could be and now realize that I held a constraining belief that delving deeper may be invasive for the family. However, Anne and Fred have challenged this belief by their obvious receptivity to the interviewer's interventions and by sharing new perceptions of themselves as a direct response to a deeper exploration of their beliefs.

The skills used by the clinician invited the family members to explore possible solutions, validated their emotional responses, and provided information when they indicated a desire to know more. The clinician shared what she had learned and can pass on to other families, and she never "lost touch" with the family, thanks to an exquisite sense of timing in using her sense of humor and compassion. As I mentioned earlier, I was not able to appreciate subtle changes in the family members' beliefs initially and really started to become aware of a shift in their beliefs only after midterm.

The experience of writing the therapeutic letters to the family (White & Epston, 1989) was also very uplifting for me. I have always enjoyed writing but never really appreciated the power of the written word until I heard this family's positive responses to these letters. On reflection, I think that the value of the letters was a combination of increasing the impact of the therapeutic conversations, validating Ann and Fred as competent, loving, and caring parents, and embedding the facilitative beliefs that had been explored.

One facilitative belief I held, which was validated in working with this family, was that Anne and Fred exhibited an indomitable spirit in wanting to come to terms with the loss of their children. I realize that it is possible for family members to live alongside their grief, even in the face of such terrible losses. I think this belief is one that I will carry with me in my future work with other families, and I will endeavor to be always conscious of not underestimating the power and control that families possess.

The experience of being a member of the reflecting team (Andersen, 1987) seemed to be a huge responsibility initially, and I was quite fearful of saying something "inappropriate" that might offend the family, who viewed team sessions from behind the mirror. However, Ann and Fred frequently observed that they felt validated as parents by receiving commendations from the reflecting team, and they were able to share with the team that they had become used to feeling they were somehow to blame for the losses they had experienced. The discussion between the family and the interviewer following the reflecting team session allows further exploration as the family is invited to give feedback on the team's opinions and suggestions. I can think of many times that Ann and Fred's faces showed their pleasure and relief when they responded positively to the team's comments.

I am very aware how much this clinical practicum has affected my personal and student life in a positive way. I don't think I have ever really appreciated the potential that families possess to overcome adversity, and that the skill of the clinical team at the FNU can make an significant difference to the outcome in a family's journey to discover their own solutions.

Clinician's Reflections: Anne Marie Levac

As the clinician who facilitated the therapeutic conversations with this family, I would like to share my reflections about my work with them. In the sessions I asked the family many questions. Now I would like to turn the table and interview myself about my beliefs and experiences as a nurse and therapist who worked with this family.

Question. Many of the questions that you have posed to this family have focused on their beliefs about grief, beliefs about their progress, beliefs about themselves as individuals

and parents, and so on. Reflect on *your* beliefs as they relate to your work with this family. What beliefs did you or do you hold that may have facilitated your work with them?

Answer. A core facilitating belief for me was that families have tremendous strengths and resources that must be identified and emphasized. Grieving families can be plagued by guilt, which can convince them that they had control when they did not and which can force them to bury useful beliefs that they may have once held about themselves as parents and as people. My belief in their strengths helped me to explore and draw them forth and to encourage them to acknowledge these strengths with each other. It helped me to affirm and remind them of their abilities. Indeed, it was our comments about their strengths that stood out the most in their memory following our first session.

Another facilitating belief that I held was that grief is a process and each individual grieves in his or her own way. This helped me to explore their individual beliefs about styles of grieving and give them each permission to grieve differently while also encouraging shared grief experiences. I hoped that sharing this idea with them would enable them avoid the trap of believing that one person's style was better than another's. All of our beliefs about grieving were challenged when their daughter shared her grieving style as "blocking." We witnessed the upsetting impact of this style on her parents but were not inclined to try to convince her to change. Rather, we respected her choice and suggested to her that someday when she felt ready, it may be useful to confront grief more openly. We were also able to validate her parents' beliefs about the importance of open and shared grieving.

Question. What beliefs did you hold that may have constrained you in your work with them? How did these beliefs change?

Answer. I believe that I felt constrained initially about using the "D" word—death—with this family. The team and I discussed the importance of acknowledging Jeremy's death to his parents within the first five minutes of the first session. However, to continue to explore his death and its impact on them was difficult because I feared that it would evoke overwhelming pain and suffering in them and sadness in me. However, by opening the opportunity for death to be discussed (which did occur, despite my apprehension), emotional suffering entered into the light and thus could be made more manageable. Witnessing their step-by-step progress between sessions helped to challenge my earlier belief that exploring these painful issues would somehow lead to a negative outcome. I now believe that discussion about death needs to be brought into the open in a way and at a pace that fits the family. Families can help clinicians by providing feedback about pacing and intensity.

Question. What have you learned from this family that will be helpful to you in future work with other families?

Answer. I believe it is true that some families affect us more than others and, indeed, this family has had a tremendous impact on my continuously revised story of myself as a nurse and therapist. Here are some valuable insights that I have gained from my work with them:

- Grief is ever-changing and unpredictable. An important part of the grieving process is to allow families to explore their explanations for the loss. By exploring these explanations and challenging constraining ones that typically involve guilt, families are invited to live alongside grief rather than feel controlled by it.
- It takes time and effort for parents to find a balance in their grief, to share grief, and to open space that allows differences between styles of grieving. Parents' shared grief may bring comfort and lighten each of their burdens.
- Individuals who are grieving still need support months or perhaps even years after the death. It is unfair and disrespectful for friends, relatives, or others to assume

that these individuals no longer need or wish to talk about their pain or their happy memories.

- The death of a family member can intensify pain associated with other losses. It is important to ask the surviving family members how they would like to spend their time and to respect the need for discussion of these other losses that may surface.
- It may be useful to appeal to the altruistic nature of family members. When we respected Ann and Fred's daughter's decision not to discuss her brother's death but invited her to help us help her parents, she showed sensitivity to some of her mother's emotional suffering.
- Perhaps one of the most important things I learned from this family is that rituals are very therapeutic for grieving families. This couple's courage was demonstrated to us on a session-by-session basis as they would return to share a difficult step they had taken. For example, they told us that they returned to the accident scene; they spoke to the physicians who had cared for Jeremy; they met with the boy who had been with Jeremy at the accident scene; and they took a special time to burn Jeremy's clothes. They also read Jeremy's lovely poems and talked to one another and others about their happy memories of him. These "saying goodbye rituals" and these "saying hello rituals" (White, 1988b) are very significant ways to find balance in the grief experience, which was the couple's initial request of our nursing team.

Question. What particular interventions might you apply to work with other families in the future?

Answer. I hope to routinely offer families therapeutic letters capturing highlights from the session and my impressions of their strengths and progress. This is particularly significant because it is often difficult for families to remember session highlights when the session content may have involved high emotional intensity. Families value the opportunity to review such letters.

One question that I will continue to ask other families is: "What significant or newsworthy news has there been since our last session?" This is because many aspects of their progress were relayed to me when I asked this question and then we could continue to explore and build on those changes.

I will use a clinical team if one is available, so that multiple minds can offer multiple ideas. If this is not possible, I will consult with colleagues and share ideas from this consultation with the family at the next session.

I am grateful to this family for sharing their grief experience with our team and contributing an important chapter to my continual development as a nurse and therapist.

DISCUSSION AND IMPLICATIONS FOR PRACTICE

During the final meeting with the couple, which followed the reader's theater session, Ann and Fred took leadership as we prepared and reviewed the manuscript. They assisted us to clearly articulate our ideas and clarified their own in the process. Some of their earlier constraining beliefs about the future were erased. Ann replaced a self-negating statement with a more facilitating one. In reviewing Ann's segment of the text, the therapist asked Ann if she meant that "the shore was not *yet* in sight." Ann corrected her and stated, "No, the shore is not in sight." This brief interaction as she corrected the therapist demonstrated Ann's self-confidence and implicitly reminded the therapist to respect the family pace. We

believed that this was made possible by the previous reader's theater session, where each person shared his or her perceptions of the grief experience and therapy process.

Ann and Fred were active participants throughout the therapy process. They both found reading and writing to be useful tools for healing. Our invitation to them to co-write and then subsequently read their reflections was based on our experience with them, our experience with grieving families, and our collective informed clinical judgment that this couple could benefit from such an experience. Families who are invited to participate in these activities must, of course, be offered the options to decline or to withdraw their participation should they so desire. This avoids any potential for coercion or a sense that not participating would jeopardize their relationship with the therapists. Ideally, families should be informed early in the therapy process of the possibility of co-writing experiences. As with any intervention, the most important implication of this intervention is that the family, not the therapists, will most benefit from it. However, when both parties benefit, the notion of collaborative intervention is optimally realized.

CONCLUSION

The idea of co-writing articles with families is not new. However, the concept of a reader's theater provides an innovative opportunity for reflection on the therapy process while simultaneously solidifying change within the family system. The couple reported that "working on the article had become part of the therapeutic process itself." It provided a unique and therapeutic ritual, which assisted the couple to achieve closure to their work with the team. Our clinical team believes that it was the shared *reading* of each other's contributions to our article that provided the most profound opportunity for healing for this couple.

The reader's theater and the co-writing of this article have been greatly beneficial to our clinical team. It has invited us to review, reflect on, and evaluate the effectiveness of the beliefs model in dealing with loss through death. Ann and Fred have taught our clinical team that individuals, couples, and families can discover the strength to ride the waves of grief, to find balance, and to muster the necessary courage to look for the far shore.

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