Editorial
Therapeutic Failure: Exploring Uncharted Territory in Family Nursing

The need to examine the effectiveness of nursing interventions with families is a persuasive and persistent call for action in our oral and written conversations these days. Within the domain of clinical practice, I believe the nurse frequently has a sense of his or her own effectiveness with a family. Through internal dialogue, the questions are framed as: "Am I being helpful?" "Does this family seem to be responding to my ideas and suggestions?" The nurse's judgment about clinical effectiveness may be corroborated with family members, by others' observations, or through sophisticated clinical trials. However, at the heart of the interaction between a nurse and a family, each, I suspect, leaves with at least some beginning answers to the effectiveness question.

In an attempt to understand expert practice, my colleagues and I recently engaged in research using hermeneutic inquiry that examined therapeutic change with clinical families who showed exemplary change-families who showed dramatic physical, cognitive, behavioral, and/ or affective change during our clinical work with them. An analysis of videotaped clinical conversations between the nurse, clinical team, and family offered us an opportunity to focus not so much on the outcome of the interventions that were offered but to describe what happened inside the intervention. A description of practice emerged from this research which focused on beliefs about families, illness, change, and the role of the clinician (see Wright, Watson, & Bell, 1996). Specific clinical macromoves or interventions that seemed pivotal to the change process were identified.

The experience of examining therapeutic change was exhilarating. As we reviewed the videotaped conversations between the clinician, clinical team, and the family, new understanding about expert practice emerged and we were excited about what we learned and uncovered (see Gail, Chenail, Watson, Wright, & Bell, 1996). Using Maturana and Varela's (1992) ideas about structural determinism, we have advanced the idea that interventions offered by the nurse will be taken up by the family only to the degree that they "fit" with the family members' structures (Wright et al., 1996), rendering the idea of "noncompliance" a biological impossibility (Wright & Levac, 1992).

The next step we have chosen in this process of understanding clinical practice has been to examine therapeutic failure-families who reported no change in their presenting concerns, who terminated their involvement with us prematurely, and/or who reported dissatisfaction with the services they received in a follow-up survey. This is uncharted territory; there has been little research about therapeutic failure. We believe that the comparison of therapeutic change and failure will be useful to refine our understanding of what happens inside and during the intervention in actual family nursing practice.

Along with my colleagues at the University of Calgary, Doctors Lorraine Wright and Dianne Tapp, we have begun an intensive analysis of exemplars of therapeutic failure. Even though we are only in the beginning stages of our analysis, it has been the most disturbing research experience we have encountered in our program of research. It has been painful to watch errors of omission-when interventions which are characteristic of our clinical practice with families were not offered-and errors of

commission-when interventions were offered but were not useful given the data available.

Imagine a clinical conversation in which you had a memory or some post hoc evidence that the clinical work with a family did not go well. With the actual videotapes of the clinical conversation with a family readily available for analysis, your sense that there was not a "fit" between the family and the interventions the nurse and clinical team were offering becomes more clear. In one exemplar we examined, a clinical team seems to be convinced of the rightness of its conceptualization of the family's presenting concern: that the difficult behavior the parents reported of their son diagnosed with ADHD has more to do with the father's parenting than with other factors. This blinded both the student clinician and the faculty supervisor from asking for a systemic description of reciprocal impact of the son's behavior on all family members and instead invited a linear, judgmental conversation almost solely with the father about his parenting skills. It also blinded us from asking for the family's ideas about the problem, or about the solution. The mother's frequently voiced concern, "But what can we do about the fighting between the children?" was virtually ignored. The family attended two clinical sessions and then terminated their contact with us. In the follow-up interview, the mother reported that the family's difficulty was "not understood" by the clinical team.

Our research about therapeutic failure has invited questions about our present responsibility to these families and to the clinicians who worked with these families. Should we share what we have learned now, several years after the clinical work has been completed, about therapeutic failure with the family? With the student clinicians? It has also renewed our appreciation for the very complex task of trying to find a fit between the unique structures of both the clinician and the family members. In the unique structures of the clinician and clinical team, where are the potential blind spots? What are the practices that would sensitize the nurse to be continually curious about fit? Wright and Leahey (1999) offer useful, practical questions to inquire about therapeutic success or failure. In the meantime we are trying to take comfort from the adage, "An error is only a mistake if you haven't learned from it."

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