**Final Draft**

# Going "Inside" the Intervention: Research About What Works in Family Nursing Practice

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## Abstract

The future of family nursing research needs to reflect the essence of family nursing practice, i.e., to heal emotional, physical, and/or spiritual suffering within families. The authors challenge the predominant belief within "good science" that before intervention research can be designed and conducted, there first must be a thorough understanding of the phenomenon, (i.e., an in-depth knowledge of the variables that mediate families' response to health and illness). In this model, only after the variables are understood and the relationships between the variables are known, can interventions be designed to alter these variables in an effective manner. This may be a useful model for theory building that hopefully, after many years of systematic study, improves nursing practice. But in daily nursing practice, nurses encounter family suffering in a variety of practice settings that require immediate care and intervention. Therefore, family nursing practice as it occurs in the daily life of nurses needs to be described, explored, and evaluated to gain an understanding of what ***is*** working in the moment. What are nurses actually doing and saying that is helpful to families in their experience of illness? This chapter offers ideas for conducting research about nursing practice with families that goes "inside the intervention" to find answers to the question, "How do we make sense of what nursing actions helped the family to diminish or alleviate suffering?" This kind of research enables immediate reflections, changes and makes improvements to practice, and thereby increases possibilities for diminishing suffering.


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# Introduction

Nurses are altering and/or modifying their usual patterns of clinical practice as they shift from caring for only the "individual patient" to seeing the "family as the patient" and increasingly including families in health care (Schober & Affara, 2001; Wright & Leahey, 2005a). Involving families requires a conceptual shift, even a paradigm shift, i.e., nurses need to think about the interaction and reciprocity between health/illness and family functioning, the interaction between nurses and the families in their care, and also consider the larger systems within which families and nurses exist. The ability of the nurse to assess and intervene within and across multiple systems levels in order to diminish suffering requires theory and skills that range across a continuum from generalist family nursing on one end to advanced practice in family systems nursing on the other end (Wright & Leahey, 2005a). A vogue term for this increasing ability to think systemically and interactionally is *relational* practice. (Doane & Varcoe, 2005; Hartrick, 1997; Robinson, 1996; Tapp, 2000).

As a practice profession, nursing has an obligation not just to remain curious about richly exploring and describing the impact of illness on families obtained through skillful interviews and useful questions. Listening and witnessing stories of suffering in the context of illness is paramount to being able to fully acknowledge their suffering. However, the most crucial aspect of encounters with suffering families is how to assist them with the challenges of illness, which is how to ***intervene***. Having the knowledge and skill to diminish illness suffering within the family, rather than only providing education and support to individual family members is definitely within the scope of nursing practice. We need to think interactionally to lift the delivery of health care from a linear, individual focus to a family, relational level. We need to conduct research about health/illness, suffering, families, and nurses in combination rather than

as separate entities (Wright & Leahey, 2005a). Nursing research that seeks to improve practice with families must reflect this conceptual shift.

## The Landscape of Family Nursing Research

Since the hallmark contributions of Suzanne Feetham (1984, 1990, 1991) and Catherine Gilliss (Gilliss, 1983, 1989, 1991; Gilliss & Davis, 1992;) who provided a conceptual map for shifting nursing research from individual family members to the family unit, nurses have contributed extensively to the development of knowledge about the family experience in health and illness as evidenced in the most recent integrative reviews of the family nursing literature (Gilliss & Knafl, 1999; Knafl & Gilliss, 2002; McCubbin, 1999). Chesla (2005) has highlighted the potential that narrative approaches have for "opening up families' everyday suffering" (p. 372) making it possible to more fully understand what nurses might do to diminish or alleviate illness suffering through clinical practice and research. Efforts to extend knowledge about families and illness by targeting key family protective and risk factors amenable to family intervention have been occurring across other disciplines as well (Weihs, Fisher, & Baird, 2002). Parallel to these efforts to more fully understand family suffering in the illness experience, a growing body of literature has focused on conceptual and methodological advances for the design, measurement, and analysis of research with the family unit (Bell, 2000; Deal, 1995; Fisher, Kokes, Ransom, Phillips, & Rudd, 1985; Fisher, Terry, & Ransom, 1990; Ganong, 1995, 2003; Greenstein, 2001; Larsen & Olson, 1991; Sabatelli & Bartle, 1995; Touliatos, Perlmutter, & Holden, 2001). However, most family health and family nursing researchers conclude their writing about these ideas with a plea for more family ***intervention*** research (Bell, 1995).

## The Landscape of Family Intervention Research

Craft and Willadsen (1992) were the first to identify and define nine family nursing interventions using a two-round Delphi method with a sample of 54 nurse academics and clinicians. A small but increasing number of studies have examined interventions that target specific health concerns of families.

An early integrative review of family intervention research was offered by Gilliss and Davis (1993). They found 59 family health intervention studies in their review of the literature from 1985-1989 (this excluded mental health intervention or therapy). Interventions were most frequently directed to individual members or subsets of members within families (patient and caregiver) rather than whole family units. The type of intervention provided in these studies was either education (cognitive) or a mix of education and support (cognitive and affective) that was frequently provided in family groups. Behavioral interventions were not described in any of the studies. Outcome measures included patient's and/or family caregiver's self-reports of stress, coping, family functioning, or social support. Despite the limitations in capturing family as unit data, meta-analysis across five studies, for which there were adequate data, demonstrated that family health interventions had a positive effect on family outcomes.

The effectiveness of family interventions in the treatment of physical illness has been examined in two integrative reviews conducted by Campbell & Patterson (1995) and Campbell (2003). These reviews included only studies that used a control group. Support was found for the effectiveness of interventions directed to the family rather than just the individual diagnosed with the illness. Campbell's (2003) recommendations for future intervention research included:

> Intervention studies need to describe family interventions in more detail so that they can be replicated, and to determine what the most effective ingredients of the

> intervention are. This will help researchers determine why one intervention is effective and another is not. (p. 276)

Weihs and colleagues (2002) reported the efforts of a multidisciplinary group who reviewed and collated existing literature about family interventions in chronic illness. Three general goals for family-focused interventions were identified that included helping families cope with the challenges of chronic illness management, mobilizing family support, and reducing intrafamilial hostility and suffering.

Matire, Lustig, Schulz, Miller, and Helgeson (2004) conducted a meta-analysis of randomized designs that compared usual medical care with psychosocial interventions targeted to the patient's closest family member or both the patient and the family member. While they found statistically significant aggregate effects, supporting the usefulness of family interventions, the effect was small. One of the recommendations they offered for future research is the need to identify the theoretical and conceptual models used to develop the interventions and outcome measures and the importance of linking the findings back to theory.

Researchers in Utah chose a novel examination of family interventions in physical health. They examined the number of health care visits made by randomly chosen individuals who had received individual therapy, marital therapy, or family therapy. Those individuals who had received marital and family therapy showed significant reduction in their subsequent use of health care services. (Law & Crane, 2000; Law, Crane, & Berge, 2003).

Whittemore and Grey (2002) recently offered a fascinating description and phase model for the systematic conduct of intervention research currently used by the U.S. National Institutes of Health. Similar to a pharmacological model of knowledge development, a sequential model of knowledge building across four phases is outlined. Beginning with the need to establish the

content, strength, and timing of the intervention within a small group, the four phases proceed to determining efficacy (under ideal conditions) and eventually monitoring effectiveness of the intervention within the general population. The randomized clinical trial is seen as an essential design for intervention research.

In the most recent integrative review of the family nursing literature (family response to non-normative events such as illness), Gilliss and Knafl (1999) found only a small number of nursing studies that focused on examining interventions. Data from the National Institutes for Nursing Research suggest that only 25% of all funded nursing research is focused on family and even fewer studies are focused on family intervention (K. A. Knafl, personal communication, July 25, 2005). Why is this so? Several reasons are hypothesized.

One reason is that, following the norms of "good science", we are still accumulating evidence to identify particular aspects of the family's illness experience that are amenable to change. Leading the way in this important area of investigation within nursing include Knafl and Deatrick with their program of research about family management styles (2003); Chesla's exploration of family processes in chronic illness (Chesla, 1991; Chesla et al., 2004; Chesla & Chun, 2005; Chesla, Martinson, & Muswaswes, 1995; Chun & Chesla, 2004); and Kendall's program of research about ADHD and the family (Kendall & Shelton, 2003; Kendall, Leo, Perrin, & Hatton, 2005).

Another reason for the limited amount of family intervention research is that our profession is at a very neophyte stage of identifying and describing family interventions (Craft & Willadsen, 1992; Wright & Leahey, 2005a). Chesla (1996) found that family nursing interventions were especially deficient within hospital settings, particularly in critical care units (CCUs). She reported that CCU nurses are "less caring and helpful in order to focus on

technological biomedical care" (p. 202). Stories of family care were more evident when the patients were infants or children and when death was imminent; however, family care was less evident in acute phases of patient illness or when patients were slower to recover. Chesla recommended that educators or consultants who are skilled in family care be introduced into CCU's to reduce the tremendous gap between the daily practice of the nurse at the bedside and the need for more family interventions. These recommendations were made in response to the nurses' startling comments that they learned most of their family nursing practice by trial and error. Perhaps feelings of incompetence or inadequacy about family nursing care can trigger nurses to distance themselves from families and maintain a focus on technological care (Chesla, 1996; Chesla & Stannard, 1997; Hupcey, 1998). More intervention research will hopefully close the gap between the theory, articulation, and testing of nursing interventions with families.

Even when family interventions are proposed, studying interventions offered to families is a complex and often messy process (Kazak, 2002). Examining the ***outcome*** of the family intervention is often the focus of this work because there are "rules" from science to deal with the messiness. In its long and productive history of examining "talking cures", psychotherapy research has developed methods ranging from sophisticated and expensive randomized clinical trials to single case designs. The typical form of these outcome studies is to quantitatively gather baseline data, administer the standardized family intervention, and collect follow-up data while controlling for extraneous variables and comparing the results to no treatment or to other "talking cures". The intent is to demonstrate causality, i.e., that the intervention changed some aspect of client/family behavior to the extent that a significant difference is found between the experimental and control groups on the outcome measure.

Recent distinctions between outcome and ***process*** intervention research (Greenberg, 1986, 1991; Johnson & Greenberg, 1988; Lebow, 1996; Pinsof , 1989; Pinsof & Wynne, 2001) have offered many other methods for examining family interventions (Sprenkle & Piercy, 2005). Nursing researchers are joining the call for more qualitative studies that examine the efficacy of interventions and uncover the process of the interventions, thereby extending knowledge about clinical interventions and outcomes (Morse, Penrod, & Hupcey, 2000; Sandlelowski, 1996).

## The Need for a Particular Kind of Family Intervention Research

Family nurse clinicians are grounded in the everyday complexities and uniqueness of each family they serve. While clinicians may benefit from the research literature that offers a description of family responses in health and illness, they are intimately involved in ***doing*** intervention and consequently are intrigued with questions about the intervention process itself and about the specific practice offered to families. Nurse researchers who wish to extend knowledge about family nursing interventions have the intention to describe the practice, name the interventions, and ask questions about their usefulness (efficacy) while not specifying the outcome in advance. This is complicated research to design and implement because it is discovery oriented, strives to account for a relational process which involves both the nurse and family members, and focuses data collection on more than one individual.

The models and methods for conducting exploratory family intervention process research are frequently considered inferior to the randomized clinical trial, which is held as the gold standard of biomedical intervention research. It would be much easier, and likely more rewarded within our present academic structures, to join the majority of nurses who conduct descriptive research about family phenomena with the intent of eventually accumulating enough evidence to attempt intervention research. However, nursing is a practice discipline and our practice with

families must be articulated, distinguished, and named. Any clinician/researcher who attempts family intervention research is to be commended for their risk-taking, innovation, and creativity.

Those studies that have begun to uncover family interventions with families experiencing illness are small but growing in number. Nurses ***are*** desirous and anxious to learn more about the usefulness of family interventions that target family interactions and examine the influence of each family member's illness experiences on other family members (Duhamel & Talbot, 2004; Goudreau & Duhamel, 2003; Duhamel & Noiseux, 2003; O'Farrell, Murray, & Hotz, 2000). As we will illustrate, this is risky, exciting, and pioneering work! We begin by introducing some important conceptual distinctions to guide family intervention research.

*Conceptual issues in examining family nursing interventions*

How nurses define an intervention has implications for the research nurses conduct. The most rigorous effort to contribute to a standardized language for nursing interventions is the work of Gloria McCloskey and Joanne Bulechek and their colleagues at the University of Iowa. (McCloskey & Bulechek, 1996). They, along with the contributors to their books, have extended nursing knowledge through classifying nursing diagnoses and defining and labeling nursing interventions (Bulechek & McCloskey, 1999).

The most widely accepted definition of a nursing intervention offered by McCloskey and Bulechek (1996) is "Any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance patient/client outcomes. Nursing interventions include both direct and indirect care; both nurse-initiated, physician-initiated, and other provider-initiated treatments" (p. xvii). We have offered an alternate definition of a nursing intervention. Our definition is "any action or response of the clinician which includes the clinician's overt therapeutic actions and internal cognitive-affective responses, that occur in the context of a clinician-client relationship

offered to effect individual, family, or community functioning for which the clinician is accountable" (Wright, Watson, & Bell, 1996, p. 120). We expand on our definition of intervention by suggesting that an intervention "usually implies a one-time act with clear boundaries, frequently offering something or doing something to someone else" (p. 154). Interventions are normally purposeful and conscious and usually involve observable behaviors of the nurse. We believe that nursing interventions are ***only*** actualized in a relationship. That is, ***all*** nursing interventions are interactional: the responses of a nurse (interventions) are invited by the responses of the client/family (outcome) that in turn are invited by the responses of a nurse (Wright & Leahey, 2005a; Wright et al., 1996). Therefore, intervention studies that only focus on family behaviors or nurse behaviors do not take into account the relationship between nurses *and* families.

How nurses conceptualize change in families' influences whether research focuses on the results or outcome of change, the process of change, or both. Every nursing intervention is intended to effect change. Not all interventions accomplish this goal. We consider effective interventions are those where a *"**fit**"*, or meshing exists between the intervention offered by the nurse and biopsychosocial-spiritual structure of the client/families (Wright & Leahey, 2005a; Wright & Levac, 1992; Wright et al., 1996). The Calgary Family Intervention Model (CFIM) is one family nursing model that attends to the ideas of fit (Wright & Leahey, 2005a). The elements of the CFIM are interventions, domains of family functioning, and "fit" (effectiveness). It is heartening to learn of intervention studies that are examining the "fit" of the interventions with particular families utilizing this conceptualization (Duhamel & Talbot, 2004).

Nurse researchers or clinicians who predict the outcome in advance of the intervention fall into the trap of being invested in a particular direction of change, without regard to the

structure of the client (Maturana & Varela, 1992). But how do nurses know when change has occurred? We have found the American anthropologist Gregory Bateson's (1972) notions about change very useful. He suggested that with regard to the perception of change, the mind can only receive news of difference. In other words, difference is information and information is a difference. Therefore, Bateson (1972) states that change is "difference which occurs across time" (p. 452). These ideas also concur with Chilean biologists Maturana and Varela (1992) who offer the idea that structural change is occurring in humans from moment to moment. From our own clinical work with families, we concur with Bateson, Maturana and Varela that change is constantly occurring in families.

We also believe that major changes within individuals and within the entire family system can occur and can be precipitated by major life events such as a serious illness or loss and/or by interventions offered by nurses. However, nurses need to be cognizant that we are not change agents; we cannot and do not change anyone (Wright & Levac, 1992). Changes in family members are determined by their own biopsychosocial-spiritual structures, not by others (Maturana, 1988; Maturana & Varela, 1992). Conceptualizing change in this manner suggests that intervention research needs to account for change across time and give language to the ways that nurses invite this structural change.

## Going Inside the Intervention: Research about Therapeutic Conversations with Families Experiencing Illness

Going inside the intervention invites nurses to reflect on their notions of reality when conceptualizing nursing interventions. Maturana (1988) offers some useful thoughts on the critical notion of reality by submitting that individuals (living systems) bring forth reality--they do not construct it and it does not exist independent of them. This concept has profound

implications for nurses' clinical work with families; specifically, what nurses perceive about particular situations with families is influenced by how they behave (interventions) and how they behave depends on what they perceive.

Therefore, one way to change the "reality" that family members have that may be enhancing their suffering is to develop new ways of interacting ***in*** the family and ***with*** the family. The most useful way to research this kind of process is to examine the therapeutic conversations that families and nurses engage in with one another. This focus on going inside the intervention has tremendous promise for addressing three critical needs: 1) create a common language for family nursing interventions; 2) offer a rich description about the interventions themselves; 3) identify the mechanisms of change; and 4) describe the usefulness of the interventions identified from the perspective of the nurses and families. We now offer examples of this kind of research from research programs at the University of Montreal and the University of Calgary.

*Going Inside the Intervention: Research from the University of Montreal*

Duhamel and Talbot (2004) conducted an ambitious study to evaluate the usefulness of a family systems nursing approach utilizing the Calgary Family Assessment (CFAM) and Intervention Models (CFIM) (Wright & Leahey, 2005a) with families experiencing cardiovascular and cerebrovascular diseases. This study used participatory action research (PAR) that allowed for continuous feedback and improvement of the interventions throughout the study. Family members described "the humanistic attitude of the nurse, constructing a genogram, interventive questioning, offering educational information, normalization, and exploring the illness experience in the presence of other family members" (Duhamel & Talbot, 2004, p. 21) as the most useful interventions. The study also had a positive impact on the nurses involved as co-investigators, a revealing finding. The nurses reported that not only did they gain

a better understanding of the impact of the illness on the family members' relationships, but they immediately integrated new family systems nursing interventions into their practice! (For other reports of family nursing intervention research conducted at the University of Montreal see: Duhamel & Dupuis, 2004, 2005; Goudreau & Duhamel. 2003;Noiseux & Duhamel, 2003).

*Going Inside the Intervention: Research from the Family Nursing Unit, University of Calgary*

At the Family Nursing Unit, University of Calgary we developed a program of research that focuses on what happens inside the intervention during a particular therapeutic conversation in a particular nurse/family relationship. The emphasis moves from the ***result*** of the intervention on the family to include the process ***during the intervention***, and requires capturing the nurse-family interaction on videotape so that both language and behavior might be analyzed.

The Family Nursing Unit is a unique outpatient clinic focused on clinical scholarship and advanced nursing practice with families suffering with serious illness (Bell, 2002; Wright, Watson, & Bell, 1990). It was established within the Faculty of Nursing in 1982 under the direction of Dr. Lorraine M. Wright. Families referred are experiencing difficulties with serious illness. Faculty and graduate students collaborate and consult with families to alleviate emotional, physical, and/or spiritual suffering (for more information see: www.ucalgary.ca/NU/fnu). The primary purpose of each therapeutic conversation with a family is not for research alone but rather to diminish or alleviate family suffering in their illness experience. Direct involvement with nursing care of families enables a focus of inquiry on examining the practice, offering descriptions of the practice, and continuously learning from families resulting in the discovery, organization, analysis, synthesis, and transmission of knowledge about caring practices with families experiencing illness. This knowledge has been

called advanced practice in Family Systems Nursing and uses the Illness Beliefs Model (Wright, 1997; Wright & Bell, 1997; Wright, Watson, & Bell, 1996) and The Trinity Model (Wright, 2005) as theoretical foundations.

The unique approach to intervention research in the Family Nursing Unit represents the postmodernist view of "both/and" thinking, rather "either/or". It honors the idea that the nurse ***and*** family co-evolve and change together through the process of their interaction. Recognizing that the nurse is a significant element in whether an intervention is effective or not necessitates a description of nurse behaviors, language, and cognitive processes ***in concert*** with those of the client family. Process and outcome and the family-nurse relationship become inextricably linked together with the aim of creating knowledge about interventions that will inform future clinical decisions.

The complexity of accounting for what is happening inside the intervention is overwhelming. Rather than trying to simplify the phenomena, we have risen to the challenge of its complexity and have primarily utilized interpretive inquiry (Benner, 1994; Chesla, 1995; Gadamer1960/1989, 1976; Packer & Addison, 1989) to account for what is happening inside the therapeutic conversation. We routinely ask families for permission to videotape each therapeutic conversation for research purposes. Over the past 24 years we have developed a rich data set of videotaped therapeutic conversations and extensive clinical documentation about each therapeutic conversation with families who are suffering in their experience of serious illness.

*Therapeutic change.* Because the purpose of family nursing intervention is change, a beginning step in our program of research was to focus on significant change events (Wright et al., 1996). In our clinical work with families at the Family Nursing Unit, Faculty of Nursing, the University of Calgary, we have experienced many incredible changes within families that have

invited healing and a return to health. To understand these changes, we embarked on a funded research project that helped us learn about what accounted for this therapeutic change. Specifically, our research project was entitled “Exploring the process of therapeutic change in family systems nursing practice: An analysis of five exemplary cases”. The investigators were Janice Bell, Lorraine Wright, and Wendy Watson. Our research question was: “How does therapeutic change occur?” Our clinical research team reviewed all the families we had worked with from 1988-1992 and chose 5 exemplary cases. All family sessions with these selected families were conducted by two expert family clinicians/nurse educators, one of whom is a co-author of this paper. In each of these cases, the family showed dramatic cognitive, affective or behavioral change during the family systems nursing interviews which ranged from 2 to 5 sessions. The families also reported improvement in the presenting problem when they were interviewed six months after the completion of the clinical sessions for our outcome study.

Direct observation of the previously videotaped clinical sessions constituted our data set. We first viewed the videotape to get an understanding of the whole of the clinical work with the family. Next, each member of the research team selected segments of the interview she considered salient to the process of therapeutic change. (Gale, Chenail, Watson, Wright, & Bell, 1996). Each interview was examined to see how the nurse clinician responded to the family and how the family responded to the nurse. The members of the research team then convened to discuss their choice of change segments to see if consensus among team members could be reached. The change segments were then transcribed and interpretive analysis was done on the text of the change segments. Questions were asked of the data such as: What is happening here from the nurse’s perspective and from the family’s perspective? Is this move or intervention unique or is it similar to another? Has it happened before? Do we have a usual name for this

move? What else could we call it? This process uncovered the personal, contextual, and cognitive processes that form the clinician's formulation of any given case and the overall model of intervention. We have come to name this approach the Illness Beliefs Model (Wright et al., 1996).

One of our clinical research families was a 34 years old man and his parents. The young man was disabled with multiple sclerosis (MS) and his parents had moved across the country to help care for their son in his home. The parents described much tension in the home that they attributed to being burdened by their care giving and lack of respite. They believed they needed their son's permission to take a break and felt they could not ask him. One of the interventions the nurse used was to encourage the family to explore the illness experience. She did this through the asking of perturbing questions such as: "Has there been any good come out of this illness?", "Do you have the most influence over your illness or does your illness have more influence over you?", "What has been the biggest surprise of this illness?" In this manner, the nurse explored the illness experience and highlighted the interactional relationship between illness and family, that is, the effect of the illness on the family and the effect of the family on the illness. The son also made the distinction between not having influence over the illness but "doing things in spite of it".

The analysis of this change segment enabled us to label and describe a family intervention that we now name Uncovering and Distinguishing Illness Beliefs. This intervention of distinguishing particular illness beliefs within the illness narrative paved the way for a heart to heart conversation between the nurse and son about his emotional suffering of having MS. The nurse drew distinctions between his sadness versus anger, and between crying on the inside versus crying on the outside. This young man offered that he was more sad than angry and cried

on the inside when with others and on the outside when alone.

In a later session, we learned that the family had never discussed the emotional suffering of this young man. By listening, witnessing, and acknowledging the emotional suffering of both parents and son, a context for change was created whereby all family members were now able to talk openly about their need for family members to have a vacation from each other. The outcome was respite for the parents, reduced tension and improved health for all family members. This conversation provided tremendous healing opportunities for the family to offer support to one another and for the first time to be able to talk and acknowledge each other's suffering.

The impact of conducting this research on our practice has been substantial. The study helped us uncover new understandings about our clinical practice approach and gave us a language with which to describe the therapeutic process that evolved into the advanced practice Illness Beliefs Model (Wright et al., 1996). The research influenced our practice by inviting a shift in focus in our clinical work to recognize that:

1. beliefs are at the heart of healing; certain beliefs are facilitating for creating options for change and healing, and others are constraining and can contribute to increased suffering;
2. the control paradigm of illness limits healing i.e. options for managing illness, such as making a place for illness, living alongside illness, and putting illness its place, increase possibilities for healing;
3. a clinician's worldview that facilitates therapeutic conversations is one that acknowledges another person as a legitimate other, even though one may not embrace or agree with the other's opinions; cellular and "soulular" changes occur through

conversations, i.e. changes in beliefs involve changes in the biopsychosocial-spiritual structures of family members and clinicians;

4. one key to therapeutic change is a respectful, curious, non-oppressive, and compassionate relationship between a nurse and family members that facilitates discussion of even the most difficult topics and invites the consideration of alternative or modified beliefs;
5. therapeutic change involves the synergism and collaboration between the expertise of family members about the experience of illness and the expertise of the clinician about managing illness;
6. that distinguishing therapeutic change sustains and maintains change. (Wright et al., 1996, p. 288-289)

*Therapeutic failure.* Unfortunately, not all relationships and interventions with families result in therapeutic change and consequently do not diminish or alleviate suffering. To understand more about what happens in the therapeutic conversations when healing does not occur, we embarked on a study to explore the process of therapeutic failure (Bell, 1999; Wright & Leahey, 2005b). The investigators were Lorraine Wright and Janice Bell. The focus of this study was to analyze the clinical practice with three families who reported negative responses. These families suffered from serious illnesses and were seen in our Family Nursing Unit by a clinical nursing team of faculty and graduate nursing students. Results of this study provided helpful feedback that immediately was used to improve our family nursing practice. The most helpful learning was that creating a context for change was either ignored or neglected among families that were dissatisfied with our nursing team's clinical work. Curiosity was absent on the part of the nurse clinician. For example, the nurse interviewer did not seek clarification of the presenting problem

or concern. Also, the nurse interviewer paid no attention to how the intervention "fit" the family's functioning. The nurse interviewer did not ascertain from the family if the intervention ideas offered were useful. Another example of not creating a context for change was the error of commission of our nursing team becoming too "married" to a particular way of conceptualizing the family's problems or dynamics that was not in harmony with the family's conceptualization.

These findings (Bell, 1999; Wright & Leahey, 2005b) have influenced our practice by inviting:

1. reinforcement of the careful attention that needs to be paid in creating a context for change;
2. a sensitivity to the temptation to abandon neutrality and take sides; and
3. an avoidance of the tendency to offer solutions prematurely before understanding the problem or concern.

*Family interventions in chronic illness.* Following the examination of our clinical practice overall, two further studies were conducted with particular populations to examine the practice of the FNU. The first one was a qualitative grounded theory study conducted by Carole Robinson (1994; 1998) with supervision by Lorraine Wright that explored the processes and outcomes of nursing interventions offered families experiencing difficulties with chronic illness. The families reported the clinical nursing teams' "orientation to strengths, resources, and possibilities to be an extremely important facet of the process" (Robinson, 1994, p. 284). Another learning of this study was that 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). Robinson (1998) also uncovered that even though illness affects all family members, it

does not affect all family members equally. It was the women in this study who were suffering the most regardless if they were the one with the diagnosis, or their spouse or child.

These findings (Robinson 1994, 1998; Robinson & Wright, 1995) have influenced our practice by inviting us to recognize that:

1. gender differences exist in illness experiences and in particular with respect to the burden of illness work which is most often borne by women;
2. the act of bringing the family together ***is*** in itself a significant therapeutic intervention; and
3. the commending of strengths, resources, and competencies has the potential for healing.

*Family interventions in cardiac illness.* Another qualitative study conducted in the FNU with a specific clinical population was conducted by Dianne Tapp (1997; 2000; 2001, 2004) with supervision by Janice Bell. Gadamer's hermeneutic philosophy (1960/1989, 1976) was used to examine what occurs in therapeutic conversations between nurses and families when one family member is experiencing ischemic heart disease. Family members who initially reported feeling constrained from having illness conversations with each other or with other health care providers were able to engage in particular therapeutic conversations with the nurse clinician and the clinical team in the FNU. Tapp's (1997) reflections about the distinctive nature of these therapeutic conversations led her to ask, "where in the world can illness conversations occur? (p. 262); what in the world are illness conversations about? (p. 263); with whom in the world can one have illness conversations?" (p. 262). Openness to particular family systems nursing interventions was profoundly influenced by the relationship between the nurse and the family (Tapp, 1997, 2001). Through therapeutic conversations, the family and the nurse collaborated

and co-evolved to discover the most useful interventions that reduced family suffering (Tapp, 1997, 2001).

The findings from Tapp's research (1997, 2000, 2001, 2004) have influenced our practice by inviting a shift in focus to recognize that:

1. there are distinctive conversational practices involving skillful questions and invitations to family members to reflect on their own experiences and the experiences of other family members. These frequently invite emotional shifts in conversation;
2. these practices allow a unique space and place of distinctive conversation characterized by the acceptance of the legitimacy of the other by engaging in non-pathologizing discourse and by acknowledging the limitations of expert practices; and
3. there is a need for distinctive conversations with the cardiac population that address the often unspeakable topic of death.

More recently, the research conducted in the FNU has begun to "unpack" specific family interventions, particularly, the use of therapeutic letters and commendations. These studies also utilized hermenutic inquiry based on the philosophical hermeneutics of Hans-Georg Gadamer (1960/1989, 1976).

*Examining specific family interventions: Therapeutic letters*. A qualitative study, by Nancy Moules (2000, 2002, 2003), with supervision by Janice Bell, was the first of its kind to examine therapeutic letters written to families by nurses in the course of the clinical work of the FNU. It appears from this research that the specific intervention of therapeutic letters served as a healing balm for suffering and was reapplied when suffering re-emerged. Families reported that they offer went back to these letters and reread them when they felt the need. Letter writing also

provided an opportunity for clinicians to reflect and then offer the family another perspective on their suffering in order to bring forth hope.

The influence of this research by Moules (2000, 2002, 2003) on our practice invited a shift in focus in our clinical work to:

1. recognize the "cries of the wounded" in the letters to acknowledge that the family's suffering has been heard;
2. write therapeutic letters that are attuned to the relationship, in tone and context with the relationship of the writer and reader;
3. offer enough news of difference to make a difference but not so much that the letter cannot be heard;
4. ask enough questions to invite reflections but not so many that they are intrusive or are overwhelming and close off reflection; and
5. leave enough room in any letter for the legitimization of all beliefs and write tentatively in ways that open room for other ideas.

*Examining specific family interventions: Commendations.* Another aspect of therapeutic letters and therapeutic conversation is the opportunity to offer commendations (Bohn, Wright, & Moules, 2003; Limacher & Wright, 2003; Wright, 2005; Wright & Leahey, 2005a; Wright et al, 1996). Commendations highlight individual and family members' strengths, competencies, and resources. A research study conducted by Lori Limacher (2003), with supervision by Lorraine Wright, focused on unpacking the intervention of commendations as offered in the clinical practice at the FNU. A key discovery was that both families and nurses reported and reiterated the value and power of commendations that brought forth "goodness" and helped alleviate their suffering (Limacher, 2003).

This bringing forth of goodness becomes a relational phenomenon in the context of nurse-patient and nurse-family relationship. The routine practice by nurses of commending family and individual strengths is a particular way of being in clinical practice. This particular kind of nurse and way of being in clinical practice are best represented by a person who looks for strengths amid suffering, hope amid despair, and meaning amid confusion.

The influence of this particular research by Limacher (2003) on our clinical practice has been to:

1. recognize that families and nurse value the power of commendations that bring forth goodness, and help diminish or alleviate suffering;
2. recognize that there are gender differences (e.g., often women tend to respond to external validation while men respond more to concrete strategies to alleviate problems; and
3. challenge the seduction of pedagogical practices towards routinizing and ritualizing such delicate contextual conversational events, and the labeling of these practices as "interventions" and instead to remember the importance of contextual elements and the nature of the relationship where commendations emerge.

*Examining specific family intervention processes: Spirituality.* Three recent studies have focused on family nursing intervention processes, namely, spirituality, grief, and suffering. Debbie McLeod's (2003) hermeneutic inquiry study, with supervision by Lorraine Wright, explored the meaning of spirituality and spiritual care practices in Family Systems Nursing as practiced in the FNU. She concluded from this study that spiritual care practices must include conversations about beliefs and the meaning of illness in families' lives and relationships, conversations about suffering, plus mentoring and life experiences. The influence of McLeod's research (2003) has had on our current practice includes:

1. recognize that suffering embodies an obligation to respond to the spiritual; and

2. recognize that practices to create space for spiritual conversations include creating a sanctuary for stories of suffering to be hear and the use of rituals in acknowledging the sacred.

*Examining specific family intervention processes: Grief and beliefs*. Another study which examined specific family intervention processes related to grief and family beliefs was conducted by Nancy Moules (Moules, 1998; Moules, Prins, Angus, & Bell, 2004). This study was conducted in two phases: examining videotapes of clinical work at the FNU with families experiencing grief to uncover constraining and facilitating beliefs that are held around the experience of grief; and secondly, interviewing clinicians and families who delivered and received bereavement care at a local hospital support group with a focus on intervention with families to diminish the suffering that accompanies grief.

The influence of this research study (Moules et al., 2004) on our clinical practice has been to:

1. recognize that grief is a lifelong experience that does not result in resolution as measured by the absence of feelings of grief;
2. recognize that grief involves both saying goodbye to the lost person and greeting a new and changed relationship with the loved one who is no longer present, but still fundamentally a part of the family.

*Examining specific family intervention processes: Illnesss suffering*

Our current research project, funded by the Social Sciences and Humanities Research Council of Canada, involves the examination of conversations of illness suffering between nurses and families in the FNU. Members of the research team are Lorraine Wright, Janice Bell, and Nancy Moules. More specifically, we are examining the nature of illness conversations that

bring forth experiences of suffering and healing. The study uses interpretive inquiry based on the philosophical hermeneutics of Hans-Georg Gadamer (1960/1989; 1976). Our initial emerging findings and interpretations are: there is a loneliness that lies in illness suffering; that listening to the voices of illness suffering are calls of moral obligation; and the dilemma of the clinician in conversations of illness suffering of whether to be willing or willful. This research has already influenced our practice by inviting us to:

1. routinely ask questions about suffering within our therapeutic conversations;
2. fully witness and acknowledge suffering; and
3. be prepared to hear and enter into difficult conversations of suffering and avoid the pitfalls of trying to rescue, cheer up, or ignore suffering (Wright, 2005).

## Conclusion

In conclusion, nursing has paid its dues through the numerous exploratory, descriptive and correlational studies on the impact of health and illness on the family. As a practice profession concerned with ameliorating human suffering, it is time nurse researchers shift their focus to family interventions. If nurses invest their energies in family nursing intervention research, they create a much-needed bridge between research, theory, and clinical practice. But we encourage a kind of research that has immediate application for improving practice and reducing suffering and thus, hopefully, reducing the tremendous lag time that normally exists between publication of research findings and implementation of the findings in practice. By going “inside the therapeutic conversations” between nurses and families, we simultaneously go “inside the interventions” to identify and flush out the obvious and the not-so-obvious mechanism of therapeutic change, examine the fit between the clinician, the intervention, and the family, and uncover new understandings of what are the most useful interventions to assist

families who are suffering in their experience of illness. This kind of research provides a much-needed language to describe the interventions that will enable our clinical work with families to be more easily articulated and understood. When we have a language to describe these useful interventions, they can also be documented--making this vital and important nursing practice with families even more real and visible. The interventions can also be replicated by others and tested in future research. Most importantly, family nursing intervention research becomes more congruent with the honorable nursing goal of reducing the emotional, physical, and spiritual suffering of patients and their families. This alternative model of family nursing intervention research brings us closer to answering important intervention questions that direct all intervention studies: what intervention is most effective, for what family, for what illness or problem, delivered by what clinician, as measured by what and by whom?

References

Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine Books.

Bell, J.M. (1995). Wanted: Family nursing interventions [Editorial]. *Journal of Family Nursing, 1*(4), 355-358.

Bell, J.M. (1999). Therapeutic failure: Exploring uncharted territory in family nursing [Editorial]. *Journal of Family Nursing, 5*(4), 371-373.

Bell, J.M. (2000). Editor's choice: Selected bibliography on research with families. *Journal of Family Nursing, 6*(4), 400-404.

Bell, J.M. (2002). 20th Anniversary of the Family Nursing Unit [Editorial]. *Journal of Family Nursing, 8*(3), 175-177.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 99-127). Thousand Oaks, CA: Sage.

Bulechek, G.M., & McCloskey, J.C. (1999). *Nursing interventions. Effective nursing treatments* (3rd ed.). Philadelphia: W.B. Saunders.

Campbell, T.L. (2003). The effectiveness of family interventions for physical disorders. *Journal of Marital and Family Therapy, 29*(2), 263-281.

Campbell, T.L., & Patterson, J.M. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy, 21*(4), 545-583.

Chesla, C. A. (1991). Parents' caring practices with schizophrenic offspring. *Qualitative Health Research, 1*(4), 446-468.

Chesla, C. A. (1995). Hermeneutic phenomenology, an approach to understanding families. *Journal of Family Nursing, 1*(1), 63-78.

Chesla, C.A. (1996). Reconciling technologic and family care in critical-care nursing. *Image: Journal of Nursing Scholarship*, 28(3), 199-203.

Chesla, C.A. (2005). Highlights from the 7th International Family Nursing Conference. Plenary Address: Nursing science and chronic illness: Articulating suffering and possibility in family life. *Journal of Family Nursing, 11*(4), 371-387.

Chesla, C. A. & Chun, K. (2005). Accommodating type 2 diabetes in the Chinese American family. *Qualitative Health Research, 15*(2), 240-255.

Chesla, C. A., Fisher, L., Mullan, J., Skaff, M. Gardiner, P., Chun, K. & Kanter, R. (2004). The

family and disease management in African American patients with Type 2 diabetes. *Diabetes Care, 27*(12), 2850-2855.

Chesla, C. A., Martinson, I., & Muswaswes, M. (1995). Caregiving: Continuities and discontinuities in family member's relationships with Alzheimer's patients. In K. R. Gilbert (Ed.), *Annual editions: Marriage and family* (pp. 184-190). Guilford, CT: Brown & Benchmark.

Chesla, C.A., & Stannard, D. (1997). Breakdown in the nursing care of families in the ICU. *American Journal of Critical Care*, 6(1), 64-71.

Chun, K., & Chesla, C. A. (2004). Challenges to Chinese American beliefs and health practices from type 2 diabetes. *Psychology and Health, 19*(6), 767-785.

Craft, M.J., & Willadsen, J.A. (1992). Interventions related to family. *Nursing Clinics of North America, 27*(2), 517-540.

Deal, J.E. (1995). Utilizing data from multiple family members: A within-family approach. *Journal of Marriage and the Family, 57*, 1109-1121.

Doane, G.H., & Varcoe, C. (2005). *Family nursing as relational inquiry*. Philadelphia: Lippincott, Williams, and Wilkins.

Duhamel, F., & Dupuis, F. (2005, June). *Where does the "one question question" lead us in family nursing?* Paper presented at the 7th International Family Nursing Conference, Victoria, British Columbia, Canada.

Duhamel, F., & Talbot, L. (2004). A constructivist evaluation of family interventions in cardiovascular nursing practice. *Journal of Family Nursing, 10*(1), 12-32.

Feetham, S.L. (1984). Family research: Issues and directions for nursing. In H.H. Werley & J.J. Fitzpatrick (Eds.), *Annual review of nursing research,* vol. 2 (pp. 3-27). New York: Springer.

Feetham, S.L., (1990). Conceptual and methodological issues in research of families. In J.M. Bell, W.W. Watson, & L.M. Wright (Eds.), *The cutting edge of family nursing* (pp. 35-49). Calgary, Alberta, Canada: Family Nursing Unit Publications.

Feetham, S.L. (1991). Conceptual and methodological issues in research of families. In A. Whall & J. Fawcett (Eds.), *Family theory development in nursing: State of the science and art* (pp. 55-68). Philadelphia: F.A. Davis.

Fisher, L., Kokes, R., Ransom, D., Phillips, S. & Rudd, P. (1985). Alternative strategies for

creating relational family data. *Family Process, 24*, 213-224.

Fisher, L., Terry, H.E., & Ransom, D. (1990). Advancing a family perspective in health research: Models and methods. *Family Process, 29*, 177-189.

Gadamer, H.G. (1960/1989). *Truth and method* (2nd rev. ed.) (J. Weinsheimer & D.G. Marshall, Trans.). New York: Continuum.

Gadamer, H.G. (1976). *Philosophical hermeneutics* (D.E. Linge, Ed. & Trans.). Berkeley, CA: University of California Press.

Gale, J., Chenail, R.J., Watson, W.L., Wright, L.M., & Bell, J.M. (1996). Research and practice: A reflexive and recursive relationship. Three narratives and five voices. *Marriage and Family Review, 24*(3/4), 275-295. [Special issue: Methods and Methodologies of Qualitative Family Research.]

Ganong, L. (1995). Current trends and issues in family research. *Journal of Family Nursing, 1*(2), 171-206.

Ganong, L. (2003). Selecting family measurements. *Journal of Family Nursing, 9*(2), 184-206.

Gilliss, C.L. (1983). The family as a unit of analysis. Strategies for the nurse researcher. *Advances in Nursing Science, 5*(3), 50-59.

Gilliss, C.L. (1989). Family research in nursing. In C.L. Gilliss, B.L. Highley, B.M. Roberts, & I.M. Martinson (Eds.), *Toward a science of family nursing* (pp. 37-63). Menlo Park, CA: Addison-Wesley.

Gilliss, C.L. (1991). Family nursing research, theory and practice. *Image: Journal of Nursing Scholarship, 23*, 19-22.

Gilliss, C.L., & Davis, L.L. (1992). Family nursing research: Precepts from paragons and peccadilloes. *Journal of Advanced Nursing, 17*(1), 28-33

Gilliss, C.L., & Davis, L.L. (1993). Does family intervention make a difference? An integrative review and meta-analysis. In S.L. Feetham, S.B. Meister, J.M. Bell, & C.L. Gilliss (Eds.), *The nursing of families. Theory/research/education/practice* (pp. 259-265). Newbury Park, CA: Sage.

Gilliss, C.L., & Knafl, K.A. (1999). Nursing care of families in non-normative transitions. The state of science and practice. In A.S. Hinshaw, S.L. Feetham, & J.L. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 231-249). Thousand Oaks, CA: Sage.

Goudreau, J., & Duhamel, F. (2003). Interventions in perinatal family care: A participatory study. *Families, Systems & Health, 21*(2), 165-180.

Greenberg, L.S. (1991). Research on the process of change. *Psychotherapy Research, 1*, 3–16.

Greenberg, L.S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

Greenstein, T.N. (2001). *Methods of family research.* Thousand Oaks, CA: Sage.

Hartrick G. (1997). Relational capacity: The foundation for interpersonal nursing practice. *Journal of Advanced Nursing, 26*(3), 523-528.

Limacher, L. H. (2003). *Commendations: The healing potential of one family systems nursing intervention.* Unpublished doctoral thesis. University of Calgary, Alberta, Canada.

Limacher, L. H., & Wright, L.M. (2003). Commendations: Listening to the silent side of a family intervention. *Journal of Family Nursing*, 9(2), 130-135.

Hupcey, J.E. (1998). Establishing the nurse-family relationship in the intensive care unit. *Western Journal of Nursing Research*, 20(2), 180-194.

Kazak, A.E. (2002). Challenges in family health intervention research. *Families, Systems & Health, 20*(1), 51-59.

Kendall, J., Leo, M.C., Perrin, N., & Hatton, D. (2005). Service needs of families with children with ADHD. *Journal of Family Nursing, 11*(3), 264-288.

Kendall, J., & Shelton, K. (2003). A typology of management styles in families with children with ADHD. *Journal of Family Nursing, 9*(3), 257-280.

Knafl. K.A., & Deatrick, J.A. (2003). Further refinement of the Family Management Style Framework. *Journal of Family Nursing*, *9*(3), 232-256.

Knafl, K.A., & Gilliss, C.L. (2002). Families and chronic illness: A synthesis of current research. *Journal of Family Nursing*, 8(3), 178-198.

Larsen, A., & Olson, D.H. (1990). Capturing the complexity of family systems: Integrating family theory, family scores, and family analysis. In T.W. Draper & A.C. Marcos (Eds.), *Family variables. Conceptualization, measurement and use* (pp. 19-47). Newbury Park, CA: Sage.

Law, D.D., Crane, D.R., & Berge, J.M. (2003). The influence of individual, marital and family therapy on high utilizers of health care. *Journal of Marital and Family Therapy, 29*(3), 353-363.

Lebow, J. (1996). Do-it-yourself research. The practical advantages of studying your own practice. *The Family Therapy Networker, 20*(6), 61-63.

Matire, L.M., Lustig, A.P., Schulz, R., Miller, G.E., & Helgeson, V.S. (2004). Is it beneficial to involved a family member? A meta-analysis of psychosocial interventions for chronic illness. *Health Psychology, 23*(6), 599-611.

Maturana, H. (1988). Reality: The search for objectivity or the quest for a compelling argument. *The Irish Journal of Psychology, 9*(1), 25-83.

Maturana, H., & Varela, F.J. (1992). *The tree of knowledge: The biological roots of human understanding* (rev. ed.). Boston: Shambhala.

McLeod, D.L. (2003). *Opening space for the spiritual: Therapeutic conversations with families living with serious illness*. Unpublished doctoral thesis. University of Calgary, Alberta, Canada.

McCloskey, J.C., & Bulechek, G.M. (Eds.). (1996). *Nursing interventions classification (NIC)* (2nd ed.). St. Louis, MO: Mosby-Year Book.

McCubbin, M. (1999). Normative family transitions and health outcomes. In A.S. Hinshaw, S.L. Feetham, & J.L.F. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 201-230). Thousand Oaks, CA: Sage.

Morse, J.M., Penrod, J., & Hupcey, J.E. (2000). Qualitative outcome analysis: Evaluating nursing interventions for complex clinical phenomena. *Journal of Nursing Scholarship, 32*(2), 125-130.

Moules, N.J. (1998). Legitimizing grief: Challenging beliefs that constrain. *Journal of Family Nursing, 4*(2), 138-162.

Moules, N.J. (2000). *Nursing on paper: The art and mystery of therapeutic letters in clinical work with families experiencing illness*. Unpublished doctoral thesis, University of Calgary, Alberta, Canada.

Moules, N.J. (2002). Nursing on paper: Therapeutic letters in nursing practice. *Nursing Inquiry, 9*(2), 104-113.

Moules, N.J. (2003). Therapy on paper: Therapeutic letters and the tone of relationship. *Journal of Systemic Therapies*, 22(1), 33-49.

Moules, N.J., Simonson, K., Prins, M., Angus, P., & Bell, J.M. (2004). Making room for grief: Walking backward and living forward. *Nursing Inquiry, 11*(2), 99-107.

Noiseux, S. & Duhamel, F. (2003). La greffe de moelle osseuse chez l'enfant. Évaluation constructiviste de l'intervention auprès des parents.( Bone marrow transplant in children: A constructivist evaluation of interventions for the parents). *Perspective infirmière*, 1 (1), 12-24.

O'Farrell, P., Murray, J., & Hotz, S.B. (2000). Psychological distress among spouses of patients undergoing cardiac rehabilitation. *Heart and Lung*, 29(2), 97-104.

Packer, M.J., & Addison, R.B. (Eds.). (1989). *Entering the circle: Hermeneutic investigation in psychology*. Albany, NY: State University of New York Press.

Pinsof, W.M. (1989). A conceptual framework and methodological critique for family therapy process research. *Journal of Consulting and Clinical Psychology, 57,* 53-59.

Pinsof, W.M., & Wynne, L.C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy, 26*, 1-8.

Robinson, C.A. (1994). *Women, families, chronic illness and nursing interventions: From burden to balance*. Unpublished doctoral dissertation, University of Calgary, Alberta, Canada.

Robinson, C.A. (1996). Health care relationships revisited. *Journal of Family Nursing, 2*(2), 152-173.

Robinson, C.A. (1998). Women, families, chronic illness, and nursing interventions: From burden to balance. *Journal of Family Nursing, 4*(3), 271-290.

Robinson, C.A., & Wright, L.M. (1995). Family nursing interventions: What families say makes a difference. *Journal of Family Nursing, 1*(3), 327-345.

Sabatelli, R., & Bartle, S. (1995). Survey approaches to the assessment of family functioning: Conceptual, operational, and analytical issues. *Journal of Marriage and the Family, 57*, 1025-1039.

Sandelowski, M. (1996). Focus on qualitative methods. Using qualitative methods in intervention studies. *Research in Nursing & Health, 19*, 359-364.

Schober, M., & Affara, F. (2001). *The family nurse: Frameworks for practice*. Geneva, Switzerland: International Council of Nurses.

Sprenkle, D.H., & Piercy, F.P. (Eds.). (2005). *Research methods in family therapy* (2nd ed.). New York: Guilford.

Tapp, D.M. (1997). *Exploring therapeutic conversations between nurses and families experiencing ischemic heart disease*. Unpublished doctoral dissertation, University of Calgary, Alberta, Canada.

Tapp, D.M. (2000). The ethics of relational stance in family nursing: Resisting the view of "nurse as expert". *Journal of Family Nursing, 6*(1), 69-91.

Tapp, D.M. (2001). Conserving the vitality of suffering: Addressing family constraints to illness conversations. *Nursing Inquiry, 8*(4), 254-263.

Tapp, D.M. (2004). Dilemmas of family support during cardiac recovery: Nagging as a gesture of support. *Western Journal of Nursing Research, 26,* 561-580.

Touliatos, J., Perlmutter, B.F., & Holden, G.W. (2001). *Handbook of family measurement* Volumes 1-3 (2nd ed.). Thousand Oaks, CA: Sage.

Weihs, K., Fisher, L., & Baird, M. (2002). Families, health, and behavior. *Families, Systems & Health, 20*(1), 7-46.

Whittemore, R., & Grey, M. (2002). The systematic development of nursing interventions. *Journal of Nursing Scholarship, 34*(2), 115-120.

Wright, L.M. (1997). Beliefs, illness, and healing: A dynamic threesome. *AFTA Newsletter,* Summer (68), 15-18.

Wright, L.M. (2005). *Spirituality, suffering, and illness: Ideas for healing.* Philadelphia: F.A. Davis.

Wright, L.M., & Bell, J.M. (1997). Beliefs, families and illness: The evolution of a clinical practice approach. *AARN Newsletter, 53*(1), 11-12.

Wright, L.M., & Leahey, M. (2005a). *Nurses and families. A guide to assessment and intervention* (4th ed.). Philadelphia: F.A. Davis.

Wright, L.M., & Leahey, M. (2005b). The three most common errors in family nursing: How to avoid or sidestep. *Journal of Family Nursing, 11*(2), 90-101.

Wright, L.M., & Levac, A.M. (1992). The non-existence of non-compliant families: The influence of Humberto Maturana. *Journal of Advanced Nursing, 17*, 913-917.

Wright, L.M., Watson, W.L., & Bell, J.M. (1990). The Family Nursing Unit: A unique integration of research, education and clinical practice. In J.M. Bell, W.L. Watson & L.M. Wright (Eds.), *The cutting edge of family nursing* (pp. 95-109). Calgary, Alberta, Canada: Family Nursing Unit Publications.

Wright, L.M., Watson, W.L., & Bell, J.M. (1996). *Beliefs: The heart of healing in families and illness.* New York: Basic Books.