**A Christmas Without Memories:**

**Beliefs About Grief and Mothering-A Clinical Case Analysis**

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In clinical work using the Illness Beliefs Model, therapeutic leverage is focused on challenging constraining beliefs of family members that are contributing to their suffering. This challenge occurs in many ways, including offering alternative facilitating beliefs that may lead to healing rather than suffering. This article describes an exemplar of clinical work with a family who sought services in the Family Nursing Unit at the University of Calgary, with the presenting concern of unresolved grief. This analysis describes the therapeutic conversation that occurred between the family and a team of nurse clinicians, where the young woman's beliefs about grief and mothering were distinguished as beliefs that were contributing to her emotional pain and her belief in her mothering capabilities. The nursing team offered alternative beliefs of which the family rapidly embraced and, subsequently, experienced diminishment of the suffering previously experienced.

Grief, in itself, is a powerful and profound human life experience. Grief compounded by echoes of expectation, pathology, and prescription can become a consuming experience of failure in one's life, not the least of which is a belief in one's personal failure to navigate experiences of grief well. In the following description and analysis of a clinical exemplar, we explore the use of a particular practice framework, named the Illness Beliefs Model (IBM; Wright, Watson, & Bell, 1996), in clinical work aimed at addressing the presenting issue of grief.

In this work, the clinical team held a foundational belief that grief is best understood as a lifelong, ongoing experience that is not resolvable, as measured by its absence, but is a mutable and malleable experience of learning to make space for its presence, while simultaneously creating and sustaining a continued yet changed relationship with the deceased (Moules 1998; Moules, Simonson, Prins, Angus, & Bell, 2004; Silverman & Klass, 1996; White, 1989). In this case analysis, however, it becomes apparent that a dominant societal belief that grief needs to be resolved, and gotten over, had invited this young woman into experiences of increased suffering in her loss that were both directly and inadvertently fueled by conscription to this discourse. In particular, the influence of these beliefs about loss and grief invited this young woman to insidious and influencing beliefs about her own inability to mother well in the face of the loss of her own mother.

**The Setting and Context: The Family Nursing Unit (FNU)**

Nursing has long been interested in family health and healing. The nursing of families has been conceptualized as dealing with family as context and family as unit (Gilliss, 1991; Wright & Leahey, 2005), with the need for advanced practice skills for assessing

and intervening with family as a unit (Bell, 1996). The FNU at the University of Calgary is an outpatient educational and research clinic within the Faculty of Nursing that was created by Dr. Lorraine M. Wright in 1982. It provides opportunity for families who are suffering from illness, loss, or other struggles to participate in therapeutic conversations of suffering and healing. Constructed as both a research unit and an educational opportunity for graduate students to learn advanced practice knowledge and skills for working with families, the clinical work in the FNU provides the unique opportunity for a clinical team, videotaping, and live supervision for every session. Sixteen years of this teaching and clinical research focus on families, illness, suffering, and intervention has resulted in the evolution and development of an advanced practice model called the IBM (Wright et al., 1996). The basic tenet of this model is that rather than the presenting problems per se, it is the beliefs held about problems that are the problem and can cause suffering in families, lives, and relationships. Specifically, both family members and health care professionals, as well as larger cultural and societal beliefs, may intersect in ways that create dilemmas for living well in health and illness. These constraining beliefs often lead to an inability to solve problems and increased suffering. At the intersection of family beliefs, health care professionals' beliefs, and societal beliefs, there also may be facilitating beliefs that increase solution options and offer possibilities for healing (Wright et al., 1996).

In developing the IBM, Wright et al. (1996) identified the significance of multiple levels of beliefs as the lenses through which we view the world and as the heart of health and healing. Wright et al. (1996) argued that therapeutic work is better termed and understood as moves, rather than interventions, suggesting that the artfulness of therapeutic conversations lies not only in the one time, even impositional, offering of something, but also in the delicate and carefully crafted movement that happens in the therapeutic relationship, a movement that is at once intentional and often seamless, but rarely discrete from other pieces that shape the relationship, context, and integrity of the conversation. The IBM (Wright et al., 1996) is conceptualized into four categories, or macromoves, that guide clinical practice with families. These macromoves are *creating a context for changing beliefs; uncovering and distinguishing illness beliefs; challenging, altering, and modifying constraining beliefs;* and *identifying, affirming, and solidifying facilitating beliefs.* These larger moves are operationalized by several therapeutic micromoves. Within the medium of a therapeutic conversation, the opportunity is created to identify, challenge, or affirm the beliefs that are at the heart of suffering for each family (Wright et al., 1996) and specifically with the bereaved to assist people in "finding a way to develop a relationship with their grief that is cooperative and resourceful" (Moules & Amundson, 1997, p. 385). Therapeutic change is believed to occur when there is a fit between the move offered by the clinician or clinical team, and the biopsychosocial-spiritual structure of the family member (Maturana & Varela, 1992; Wright et al., 1996).

There have been several recent research initiatives related to the IBM. Moules (2002, 2003) studied therapeutic letters as used in the FNU, whereas Hougher Limacher and Wright (2003) explored the use of commendations. McLeod (2003) explored the role of spirituality in therapeutic conversations between nurses and families who are suffering. In researching specific populations, Tapp (1997) studied families experiencing cardiac disease. Robinson (1994) researched the impact of chronic illness on the family and

also sought to identify the nature of the interventions that were helpful to families in the context of conversations that occurred in the FNU. Ongoing research projects in the FNU include outcome studies and the study of the use of reflecting teams, therapeutic failure in clinical work, and conversations of illness and suffering. This research helps to further our understandings of therapeutic conversations between nurses and families with the hoped for outcome of alleviating suffering.

The focus of the clinical work described in this article is therefore contextualized as the attempt to challenge constraining beliefs and offer alternative more helpful beliefs to this family. Although several micromoves were offered to the family with the earlier described intent, specifically therapeutic letters (Epston, 1994; Moules, 2002, 2003; Wright et al., 1996) and reflecting teams (Andersen, 1987, 1991) were the mediums for conveying commendations (Hougher Limacher, & Wright, 2003; Wright et al., 1996) and interventive questions (Cecchin, 1987; Selvini, Palazzoli Boscolo, Cecchin, & Prata, 1980; Tomm, 1987, 1988) to challenge constraining beliefs and to offer alternative, more facilitating beliefs. These were selected for analysis in this article, as they represent what the family stated were the most useful or beneficial ideas offered by the clinical team, and to which the client attributed her changed beliefs.

The clinical work that is described here represents that of a team of graduate nursing students, at both masters and doctoral levels, and the faculty supervisors at the FNU. The second author is the nurse clinician who worked with the family and was a second year master's student, completing a second clinical practicum in the FNU.

## The Family: Missing a Mother in the Face of Mothering Well

Julie, 25 years old, at the time of the session was married to Scott for 5 years, and they had two daughters, age 3 years and 6 months old. Julie's mother died in a tragic accident 18 years earlier, when Julie was a young girl. The family was referred by a community family worker, who recognized that Julie was struggling anew with the long ago loss of her own mother, and that this issue was resurfacing in Julie's role as a new mother. Julie's presenting concern at the time of referral was the lack of resolution of the loss of her mother. The family was seen during two sessions; Julie attended the first session by herself, and her husband Scott joined Julie for the second session.

## Session One: The Constraining Belief Shows Up

In the first session, Julie stated that she was stressed in her parenting and experiencing postpartum depression. Somehow, in her conversation with her community worker, she made a connection between her current feelings and her long ago loss of her mother. Julie believed that she needed to "deal with this [the loss of her mother], or I'm not going to be a good mom." In exploring her beliefs of how the clinical team in the FNU could be most helpful to her, she stated,

> I know in my mind how I should be dealing with my mom's death, but can't emotionally connect that with my life, I'm worried that I'm going to leave my girls, I get so uptight. . . I think if dealt with my Mom's death and came to terms with it, it would make my life easier; so I can be better not just for my kids' sake, but for my own sake. . . you have to deal with it, you have to go through it to get it over with.

In the invitation to discuss the loss of her mother, Julie described herself as an impressionable, innocent 7-year-old who watched her parents fight on a camping trip and her mother angrily drive away in the car, only to be killed in an accident. Julie recalled hearing police cars and ambulances and shortly thereafter being informed that her mother had been killed in the accident. Integral to this memory is that her mother nearly took her along in the car. In a short period of time, her father remarried a woman who never connected emotionally or relationally with Julie, and Julie experienced an emotional withdrawal from her father. In her mind, she was left parentless.

In this first session, the student clinician explored what dealing with her mother's death would look like, and how she might be different if she were to complete the work of dealing with it. Julie explained that although she felt she knew what grieving should be, she struggled with connecting this to her experience of loss.

> *I know that it's okay, that I'm going to be fine, that life goes on, I know what you go   through with grief, but I can't connect that emotionally. I know I need to deal with it, I need to get past it and get to the emotional end of it . . . I   know, you have to deal with  it, you have to go through it to get it over with.*

Julie explained her conviction that if she could do this, a huge weight would be lifted from her, and she could relax and be a better mother and person. She expressed consuming worry about leaving her daughters, either by physically not being present or by being emotionally vacant and of them not having a mother who could provide them with good memories of her own childhood. In her mind, the ability to share her own childhood memories inherently constituted a good mother. Presently, she did not believe that she was providing her children with an environment in which they felt loved and secure. She attributed this stress in her mothering role to not having a mother herself when she was growing up and subsequently not having dealt with the loss appropriately. Julie described needing to pack everything that she could into daily interactions with her daughters, in case she was not around in the future. This led her to feel stressed, exhausted, and generally self-critical.

Julie further explained that she believed that her emotions were caged up, and that she believed she needed to let them out to heal. This would enable her to "close that chapter in [her] life." There were feelings of sadness and anger related to not having her mother around for important life events.

> *I know what you go through with grief. . . I know I feel a lot of anger because I missed out on things, and a lot of sadness, I just feel angry and sad all at the same time. . . and I don't have time to deal with that pain.*

She described feeling a physical pain at certain times in her life when, for example, she was around her friends and sister-in-law and their mothers, and she was faced with the evidence of what she was missing in her life, in particular a mother who was present and loving. In exploring further these caged in feelings, the clinician inquired what her worst fear would be if they were released. Julie stated that her worst fear in releasing these emotions is that she would change as a person and that Scott would not love her anymore: "I know he would never leave me, but I'm worried that I would not be the same person."

**Grief and Mothering Through a Different Lens: The Alternative Beliefs**

From the team's perspective, a core constraining belief was uncovered in this first session: Julie believed that grief needed to be resolved, or dealt with, so that painful emotions would no longer be present. Julie believed that her unresolved grief was inviting stress and depression into her life and inhibiting her from being the good mother, wife, and person that she wanted to be. The leverage in clinical work in the FNU lies in challenging these constraining beliefs and offering more facilitating and healing beliefs. In the work with this young woman, the clinical team offered commendations (Hougher Limacher & Wright, 2003; Wright & Leahey, 2005), interventive questions (Tomm, 1987, 1988), and alternative beliefs (Wright et al., 1996) throughout the session, as well as through the use of a reflecting team (Andersen, 1987, 1991) and a therapeutic letter (Epston, 1994; Moules, 2002, 2003). All of these micromoves were at the service of challenging Julie's beliefs in herself, her mothering, and how to live with the loss of her mother.

*The belief* is *challenged.* After the careful uncovering of the beliefs that the clinical team discerned as the most constraining ones, Julie was offered the opportunity to hear from the clinical team as she observed and listened to the team's discussion behind the one-way mirror. The use of a reflecting team as a micromove is for the purpose of offering various ideas and opinions, offered respectfully and tentatively (Andersen, 1987, 1991; Wright et al., 1996). From this variety of ideas offered to the family, family members may find a fit between the ideas and their own thinking. The conversation in reflecting teams at the FNU generally includes acknowledgment of the family's suffering, commendations, reflections, ideas, suggestions, and questions to the family in the effort to challenging constraining beliefs and offering more facilitating beliefs.

During the first session, the reflecting team was composed of two faculty members as the clinical supervisors of the session, and three graduate students, including the student clinician. Initial comments were offered that included commendations and acknowledgment of Julie's suffering.

> *This was a powerful conversation; I would like to acknowledge her suffering and the continued sadness and anger over missing these experiences.*
>
> *This is a tragic story, but how responsible she is to recognize that. . . she wants to do well by these kids. . . she may not have had a mother to learn from, but has learned a lot about mothering and the particular ways that she would like to mother responsibly in a committed way.*

The team also offered commendations (Wright & Leahey, 2000; Wright et al., 1996) around her courage to seek help when she realized something was blocking her from being the mother and person she wanted to be in this world; she was wise to recognize that there is no such thing as a perfect mother.

This was followed by several questions and comments that served to normalize and legitimize her emotions and experiences.

> *Emotions in a cage are a really powerful influence now in her life, in a negative kind of way. . . there are a lot of changes, transitions, and challenges [as a new mother] . . . and she's interpreting it as it would have been different if she hadn't been abandoned.*
> *The 'it would have been different' contributes to her sense that she needs to do something about it . . . I had the same worries with my child, and other mothers too, who haven't had losses, maybe a part of loving a child is that worry. . . if she could believe that is a part of what mothers go through and that it's*

*not a symptom of her not dealing with the loss. . . I wonder if she could be more accepting of it, rather than thinking that something's wrong.*

The intent in this idea was to offer that her worry of leaving her children, and of wanting to create good memories and be a good mother, were perhaps normal responses to mothering and not an indication that she had dealt poorly with the loss of her own mother.

Embedded throughout this conversation were ideas of different ways of thinking about her experience or alternative beliefs about her situation. The team spoke about differing beliefs about grief and emotions and the ways in which one deals with grief.

*It makes sense that she would have these feelings at this time, when there are frequent reminders. . . It makes sense that [her loss] feels so acute at this time, but may not be an indication that there's something wrong with the way she dealt with it [her mother's death], but more of an indication that it's absolutely normal that it would show up at this point [when she herself is a mother].*

*She has a belief that feelings of sadness and anger of not having her mom. . . have become toxic, ugly, painful. . . A lot of people think of emotions that way. It sounds like since age 7 that she has been living alongside and dealing with feelings in some very mature ways. . . She has had experience dealing with these emotions in the very best way possible and they're not toxic; they're a normal response to an awful situation.*

The team offered further beliefs around how one lives alongside the emotions that often accompany grief and that perhaps people learn to make a place for grief in their lives and let it inform them. The team also described research findings about grief that one can learn to live alongside it in a sophisticated and healthy way, which they believed Julie to be doing. The question was posed to Julie of what if she were to imagine that her feelings would always be with her in some way, sometimes more discrete, sometimes more present, but as a reminder of her love for her mother.

In response to the reflecting team, Julie stated that she agreed that it was okay to feel pain around her loss at certain moments, to live alongside it, that those feelings do not have to go away. Perhaps, she reflected, she was not as abnormal or out of control as she thought she was, considering what she had experienced. She was eager and agreeable to return to a second session. In the interim, a therapeutic letter was sent.

*Mailing the belief back home.* Clinical work in the FNU has incorporated the use of therapeutic letters for more than 20 years. Letters to families include content of recognizing suffering, offering commendations, asking questions, offering ideas that stood out from the session, highlighting the work with the family and what has been learned, and giving any further ideas that might extend the therapeutic conversation (Wright et al., 1996). Research about the practice of therapeutic letters used in the FNU has shown letters to be a significant micromove in the therapeutic work with families (Moules, 2002, 2003). This specific micromove proved to fit very well with Julie, as will be described in her response during the second session. The following letter, sent to Julie, served as an extension of the ideas offered in the session and in the reflecting team.

*Dear Julie,*
*Greetings from the Family Nursing Unit. Our team was pleased to meet with you on November 2 and we would like to share some thoughts and impressions.*

*Julie, as a young woman, you have experienced some very painful and even tragic life events. The loss of your mother at such a young age, and the seeming abandonment that you felt with your father are not life events that all people must endure. These terribly sad experiences have, you taught us, invited a painful sense of loss and at times even feelings of anger. We heard that it is especially at this time in your life as a young mother yourself, when you find yourself revisiting the pain around growing up without your mother or your father's presence in your life.*

*But, apart from your honest and heartfelt expression of your sadness and loss, we heard and saw something else that was quite remarkable. Somehow, without role models, without having been the recipient of the physical presence of a mother in your life, you have embraced some important beliefs about mothering, about being a good, loving, and responsible mother. We believe it takes considerable wisdom and remarkable maturity to recognize that some things may be inhibiting you in living up to your beliefs of what a good mother would be. Yet, along with this recognition and sensitivity, your wisdom seems to extend to the acceptance that it's not realistic to expect to be a perfect mother-that such a thing does not exist! Still, you know when you need to call someone for support, when you need time with yourself, and when you need help. Realizing that it's okay to not be this "perfect mother" is something that a lot of mothers struggle with and never quite figure out.*

*We were interested to hear about some of the connections that you have made between feelings that you are having now and how you attribute these feelings to losing your mother at such a young age; and how these seem to be influencing you in ways that you are not happy with. It seems as if you have interpreted these feelings around changes, transitions, and challenges in your life as a sign that you have not "dealt with" the loss of your mother. Although we were interested in your beliefs around how things should be "dealt with," we have to repeat our comments to you, that we saw no indication that you were not dealing with this loss. In fact, we were impressed with how you, in our eyes, are dealing with this in a much more aware way than many people are able to do.*

*We have learned from our work with other women that having children of one's own evokes a myriad of feelings-of fear, of love, of loneliness, of incompetence, of inadequacy, and of responsibility. If you were to believe that the presence of these feelings are evidence of deep feelings of mothering, rather than of an indication that you have some unresolved work to do around past losses, how might you be able to understand and live with these feelings differently? There is some indication in the research that the biological need to protect our young is deeply and fiercely embedded. What might change if you were to believe that your fear of not being there for your daughters is not indicative of your lack of "dealing with" the death of your mother, but rather is a very common, maybe even a biological experience of motherhood?*

*In our one meeting with you, we saw evidence of you living alongside your feelings of anger and sadness and dealing with your loss with a mature awareness. For example, your ability to witness your sister-in-law interacting with your mother-in-law and know that the pain you felt with that was around you not having your mother. And, furthermore, that it is normal to feel that pain! Not all people would have this kind of degree of self-reflection to both recognize and accept these natural responses. In some regards, it makes sense to us that it is at this time in your life when these feelings would arise. We wonder if perhaps you have being dealing with these emotions in your life in the very best way possible, and that your reactions have been a normal, appropriate response to a sad and tragically unfair situation.*

*We are wondering if perhaps these feelings of pain, anger, and sadness are not things that need to be let go of. We believe that part of grief is learning to live alongside these emotions; sometimes they may take over, but sometimes they also inform us, educate us, and remind us that we have loved. How might things be different if you were to believe that these feelings would always be with you in some way, sometimes they'll be more discrete, and sometimes they'll be more apparent, but they're an ever-present reminder that you loved and were loved by your mother?*

*We were impressed to hear that you have the support of your husband. It has been found that support of this significant person during any challenging*
*life events, such as postpartum depression, is significant to promote healing.*
*We also wonder how you may utilize his support in other ways. We look forward to meeting with you, and hopefully Scott as well, in our next session.*

*With warm regards,*
*Lorraine Thirsk, RN, 2nd year Masters Student*
*Nancy Moules, RN, PhD, Faculty, Family Nursing Unit*
*Janice Bell, RN, PhD, Director, Family Nursing Unit*

*and members of the clinical team*

## A Shift in Beliefs

Julie returned to a second session at the FNU a few weeks later with her husband. When reviewing the last session and what had stood out from the letter, Julie replied, "I know I'm going to be okay. . . It is okay to live with it [grief], I didn't realize I was." Further discussion revealed a shift in her belief-that, despite her original self-critical belief, she had actually been dealing with and living with her grief over the loss of her mother. Julie spoke about the change she felt as a mother herself, that she was not as abnormal a mother as she thought, and that perhaps she was better able to step back from a stressful situation and realize that some things were not worth getting upset over. She further described that believing that she was dealing with the loss of her mother in a way that is acceptable and normal had allowed her to let some things go and not be so angry about the same things: "I guess I hadn't realized that I was living with the pain… and I am dealing with it. I realize that I'm not wrong, I'm actually doing okay with it."

In exploring the change that had occurred in Julie, the clinician asked Scott about his observations of changes in his wife. He replied that he saw her self-esteem increasing and improving. Julie then responded to the question of what changes she has noticed in her beliefs. She replied "I'm okay, that things are going to be okay, that the girls are going to be fine, that I'm going to be fine." In some further exploration of this change, it was uncovered that Scott had been trying to tell Julie that she was going to be okay and that she was a good mother, but they agreed that now Julie had found the capacity for this reassurance within herself. After exploring more of the effects and potential effects of this new belief about herself, mothering, and her grief, the clinician inquired as to the family's hopes for the current session. Julie replied that there was not anything pressing that she wanted to discuss, but explained that the upcoming holiday season was going to be difficult. Although Christmas was her favorite time of year, it was also the most difficult, as she was reminded of not having memories of Christmases with her mother and not being able to share any of her childhood memories with her own children.

The clinician offered some beginning ideas of how research around grief addresses holidays as difficult times to navigate when there has been a loss. Following this, the clinical team offered another reflecting team. In the team, there was a focus on punctuating and celebrating Julie's changed beliefs. The team members offered commendations around the commitment that both Scott and Julie had to their family. Further comments drew attention to Julie's shift in beliefs from her question in the first session "Am I going to be okay?" to a current sense of believing that "I am going to be okay." The team openly attributed this shift in beliefs about herself as further evidence of her commitment to mothering well. The team offered some findings from research (Vickio, 1999) about ways that perhaps Julie could incorporate a tribute to her mother at Christmas, in a way to acknowledge her loss and perhaps the pain she might feel but also to signify the importance of mothers. It was suggested that rather than recounting her own childhood memories of Christmas, perhaps it was her job to create good memories of Christmas for her own children.

Following the reflecting team, Julie and Scott had several ideas of their own about traditions or symbols that they could start at Christmas, including finding Julie's mother's nativity set, finding a picture of her mother to make into a Christmas ornament, or

lighting a candle in memoriam. Julie explained that she now saw the light at the end of the tunnel, that in hearing the team's comments in the first session and reading the letter, she realized that she was going to be okay. Both Julie and Scott commented that the letter was both reminder and reassurance for them, and it had been read often since its receipt. In response to the clinician's inquiry regarding the family's sense of the direction or need for future work in the FNU, Julie replied that she did not feel that it would be necessary to come back at this time. A conversation of evaluation of the work elicited both Julie and Scott's perception that the most significant piece of the work for them had been the letter and the ideas offered by the team.

## Discussion: The Dominant Discourse and Primary Prevention

Julie explained throughout the initial session that although she knew what grieving was and what she needed to do to deal with it, this knowledge seemed in contradiction to her own emotional experience of the loss of her mother: "I know in my mind how I should be dealing with my mother's death, but I don't feel like I'm doing it." The dominant societal discourse around grief was apparent in this young woman's conversation. The belief that grief needs to be dealt with, and gotten over, is prevalent in everyday language and often held by helping professionals. Moules (1998) cautioned against this constraining societal belief: "If a person subscribes to the description of grief as a time-limited event, he or she might experience a disparity when grief continues to persist beyond the expected time boundary" (p. 153). This suffering is further apparent when Julie stated, "I know all the knows, I know how I should be dealing with my mother's death, but I can't emotionally connect that." In her experience with a tragic loss, she adopted and accepted the constraining belief that her emotions around the loss of her mother should eventually no longer be present. In the face of their continued presence, she was invited into the belief that there was something indeed wrong with her. Through the many ways of offering an alternate facilitating belief that perhaps these feelings would always be present in her relationship with her grief, Julie was able to have her experiences and emotions legitimized rather than thinking that she had to keep them locked in a cage.

The potential long-term effects of this new way of thinking may make a significant difference in this young woman's life. It is hypothesized that this new way of thinking may change the way in which she lives with, and interprets, her postpartum depression. This change may have significant future impact in her marital relationship, as she comes to see herself as more similar to the wife and mother she wants to be. The third significant way in which this work may positively influence this family is in the role of primary prevention for Julie and Scott's two young daughters. In the second session, Julie described how she could already begin to see significant changes in her mothering and the way that she viewed herself as a mother. Bond and Bums (1998) argued that we are more likely to achieve long-term enduring effects for healthy development and prevention of problems in children by ensuring they have enduring positive influences, ideally focused on parental skills, development, and health. These authors recognized that parents have wide-ranging influence in the environment in which the child develops and thus are important to any primary prevention strategy. Therefore, reducing the mental and emotional suffering that Julie was experiencing will hopefully empower her to continue to support and create a healthy environment for her children's development.

Of further significance to the clinical work was the way in which Julie so quickly embraced the offering of the alternative belief. In our clinical work, we often see this phenomenon of sudden change and have come to appreciate it as a possible response to the ways in which we work as a team. The observation of multiple minds, the offering of multiple perspectives, and the many seeds that are planted offer opportunities for family members to take up those that are the best fit for them. In Julie's case, we believe that the ability to hear alternative beliefs also lay in the many ways they were offered-in the clinical session, embedded in questions, in the reflecting team, in the therapeutic letter, and in the manner they were offered-not as a truth but as tentative possibilities of which she was invited to consider. Ultimately, despite the deliberate and careful offering of the ideas, the many hours of writing and rewriting the therapeutic letter, the fit of the ideas and opinions offered by the clinician and the clinical team lay within Julie's capacity to hear and recognize herself and her experience in the new belief. That she was able to do this so quickly-and that the adoption of this new belief was able to make significant shifts in her core beliefs about herself as a mother, wife, woman, and person-is, in our clinical judgment, an indication that the therapeutic change is more likely to be sustained over time.

**Possibilities for Future Research**

Despite the universal nature of grief, there is still a deficit in what we know about the ways in which we, as health care professionals, can be most helpful to those who are experiencing it. Possibilities for future research lie in understanding the nature of therapeutic interventions around grief and the ways in which interventions can be offered to increase the possibilities of grieving families to embrace their healing potentials. Furthermore, the curiosity about the nature of how therapeutic change, observed and reported in the clinical work, is sustained over time is a compelling call to understanding.

**Summary**

The belief that one is not living up to personal or societal expectations about how to be in the world can be profoundly debilitating and can lead to suffering in relationships and in health. Julie's belief about her own failure seemed to be manufactured from another belief that she had heard, embraced, and integrated-the belief that the loss of her mother had never been dealt with and her lingering grief stood in the way of her capacity to mother, love, and live well. In this advanced practice nursing model (the IBM), the careful and intentional uncovering of these constraining beliefs created the context for the offering of alternative beliefs of which Julie was able to both recognize as a truth and embrace as an internalized and lived shift in the ways she regarded grief and ultimately herself. We fully believe that there are many good memories in the making in Julie's home, and not just at Christmas.

**Note**
I. Names have been changed to protect confidentiality.

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