Homecare Nurses’ Perceptions of the Impact of Nursing Behaviors on Family Communication in Families with an Adult Palliative Member: A Pilot Study

By

Rona Miller

B.S.N., University of British Columbia, 1990

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

In

THE FACULTY OF GRADUATE STUDIES

(School of Nursing)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

December 2003

© Rona Miller, 2003
Library Authorization

In presenting this thesis in partial fulfillment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Rona Miller
Name of Author (please print)

Dec 15, 2003
Date

Title of Thesis: Homemae Nurses’ Perceptions of the Impact of Nursing Behaviors on Family Communication in Families with an Adult Palliative Member: A Pilot Study

Degree: Master of Science in Nursing

Year: 2003
Abstract

An interpretative descriptive approach was used in this pilot study to lay the foundations for a full-scale study to explore how homecare nurses influence family communication and their perception of the impact of their nursing strategies on family communication in families with an adult palliative member. A convenience sample of eight experienced, diploma-prepared homecare nurses was recruited following the presentation of the study at a staff meeting and the distribution of information letters that detailed the study and invited homecare nurses to participate in the study. In-depth participant interviews were the primary method of data collection. Data analysis involved constant comparative analysis of the interview transcripts to identify emerging data themes. While the findings mainly related to limitations in the research process, such as participant recruitment and a single data collection method, some preliminary codes identified from the data were: "creating a family circle," "speaking for," "bringing it out into the open," "family rules," and "taking the time." These preliminary codes reflected strategies that the homecare nurses used to influence family communication and while some, such as creating a family circle and bringing it out into the open, are strategies that are supported in the communication and family literature, others such as, speaking for, are not supported in this literature. Creating a family circle referred to how the homecare nurses interacted with families by creating a circle around the palliative individual, and this strategy perhaps reflected the focus on the individual rather than family-focused nursing care. Speaking for referred to the situations in which the nurses spoke on behalf of individuals in the family. The nurses tended to speak for individuals when they perceived a benefit to the palliative individual's care. Bringing it out into the open reflected the strategies used by the nurses to ensure open family communication. The data for the code taking the time referred to how the nurses structured their workload to make time for the palliative individual and family, to workplace support, and to the nurses' knowledge, skills, and energy in assessing and intervening in family communication. Recommendations for a future study include more active recruitment strategies, the triangulation of data collection methods, such as nonparticipant and videotaped observations, a focus group, and the inclusion of
methods, such as nonparticipant and videotaped observations, a focus group, and the inclusion of family interviews to provide data on the families’ perspectives of nurses’ interventions in family communication. The findings from this study have implications for nursing practice and education. The palliative tenet of family-focused care was not clearly reflected in the data suggesting that nurses may benefit from education and supportive work environments to shift from the individual to family-focused nursing care.
TABLE OF CONTENTS

Abstract ........................................................................................................... ii
List of Tables .................................................................................................. ix
Acknowledgements ....................................................................................... x

CHAPTER ONE: INTRODUCTION .................................................................. 1
  Background to the Problem ........................................................................ 1
  Problem Statement ....................................................................................... 4
  Purpose of the Study .................................................................................... 5
  Research Questions ...................................................................................... 5
  Significance of the Study ............................................................................ 5
  Assumptions ................................................................................................ 6
  Theoretical Framework ............................................................................... 6
    Family Systems Theory ............................................................................. 6
    Communication Theory ............................................................................ 7
  Definition of Terms ..................................................................................... 8
    Homecare Nursing ................................................................................... 8
    Homecare Nurses .................................................................................... 8
    Palliative Care ......................................................................................... 9
    Family ....................................................................................................... 9
  Summary and Overview of Thesis ............................................................. 9

CHAPTER TWO: LITERATURE REVIEW ....................................................... 10
  Family Tasks and Supportive Nursing Strategies in Terminal Care ........ 11
  Family Communication .............................................................................. 15
    Factors that Influence Open Family Communication ......................... 15
    Relationship of Communication Patterns to Adjustment and Coping ..... 18
  Nurse-Patient Relationship ...................................................................... 22
    Homecare and Palliative Nurses’ Behaviors and Competencies ............ 23
<table>
<thead>
<tr>
<th>Strategies Used by Nurses in Family Communication with Palliative Patients</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequacy of Nurse Communication Skills</td>
<td>27</td>
</tr>
<tr>
<td>Nurses’ Knowledge and Skills, Attitudes and Verbal Communication Behaviors</td>
<td>27</td>
</tr>
<tr>
<td>Nurses’ Communication Skills of Empathy, Touch and Therapeutic Use of Social Conversation</td>
<td>32</td>
</tr>
<tr>
<td>Summary</td>
<td>33</td>
</tr>
</tbody>
</table>

**CHAPTER THREE: RESEARCH METHOD** | 38 |
| The Research Design | 38 |
| Selection of Participants | 39 |
| Sampling Procedures | 39 |
| Selection Criteria | 40 |
| Sample Selection | 40 |
| Data Collection | 43 |
| Interviews | 43 |
| Field Notes | 45 |
| Reflective Journal | 45 |
| Data Analysis | 45 |
| Evaluation of the Pilot Study Process | 47 |
| Rigor | 49 |
| Credibility | 49 |
| Transferability | 49 |
| Auditability | 50 |
| Confirmability | 51 |
| Ethical Considerations | 51 |
| Limitations of the Study | 52 |
Summary ................................................................................................................. 53

CHAPTER FOUR: FINDINGS .................................................................................... 54

Challenges Faced in the Selection of Participants .................................................. 55

Challenges Faced in Data Collection .................................................................... 56

Development and Use of an Interview Guide ....................................................... 57

First Revision of the Interview Guide .................................................................. 58

Second Revision of the Interview Guide ................................................................ 59

Third Revision of the Interview Guide .................................................................. 64

Challenges of the Interviews ............................................................................... 68

Participants .......................................................................................................... 68

Researcher Characteristics and Skills .................................................................. 69

Structuring the Interview ..................................................................................... 69

Asking Clearer Questions ..................................................................................... 70

Guiding the Interview .......................................................................................... 71

Recalling and Interpreting What Was Said in the Interview ............................. 71

Preliminary Data-Coding Schema ....................................................................... 72

Creating a Family Circle ...................................................................................... 73

Speaking For ......................................................................................................... 75

Bringing It Out Into the Open ................................................................................ 76

Taking the Time ..................................................................................................... 78

Family Rules .......................................................................................................... 81

Summary ............................................................................................................... 82

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS ............................... 84

Recruitment of Participants ............................................................................... 84

Data Collection ..................................................................................................... 88

Discussion of Preliminary Data Coding Schema ............................................... 92

Strategies Used by Homecare Nurses ................................................................. 99
Creating a Family Circle ................................................... 99
Speaking For ........................................................................ 94
Bringing It Out Into The Open ........................................... 95
Family Rules ........................................................................ 96
Taking the Time .................................................................... 96
Summary ............................................................................ 98

CHAPTER SIX: SUMMARY, PRELIMINARY CONCLUSIONS,
IMPLICATIONS, AND CONCLUDING COMMENTS .................. 102
Preliminary Conclusions ....................................................... 104
Implications for Nursing Research, Practice and Education ...... 105
Implications for Nursing Research ........................................ 105
Support for the Continued Use of a Qualitative Research
Approach ............................................................................ 105
Participant Sampling and Recruitment Procedures ............... 106
Data Collection ..................................................................... 108
Nonparticipant Observation ................................................ 109
Homecare Nurse Interviews ............................................... 111
Family Interviews .................................................................. 112
Focus Group ........................................................................ 112
Field Notes .......................................................................... 113
Data Analysis ....................................................................... 113
Implications for Nursing Practice ....................................... 114
Implications for Nursing Education .................................... 115
Concluding Comments ....................................................... 116
REFERENCES ..................................................................... 117
APPENDIX A ..................................................................... 135
APPENDIX B ..................................................................... 136
LIST OF TABLES

Table 1. Demographic Characteristics of Study Participants .......................... 42
Acknowledgements

This thesis would not be possible without the support and encouragement of many people.

I would like to thank my thesis committee for their ongoing and continued support throughout this process. I would like to acknowledge and thank Ann Hilton, Clarissa Green and Joan Bottorff for their feedback, support, enthusiasm, and expertise with this project. I would also like to thank Ann Hilton for making the time to meet with me, usually after "regular office hours."

I would also like to thank all of the participants who gave unselfishly of their time to answer my questions and who assisted me in this research process. I would also like to acknowledge my friends and colleagues who have wished me well, as well as, encouraged and supported me in this endeavor.

I would also like to acknowledge and thank my family who throughout this process have continued to believe in me and my ability to complete this thesis, and have continued to offer me encouragement, especially at those times I doubted myself. Thank you for putting up with me and my moods and my obsession with this thesis.

Thank you to everyone. Without your support and encouragement this thesis would not have been completed.
CHAPTER ONE

INTRODUCTION

Background to the Problem

Most patients with a terminal illness will spend the majority of their last year of life at home. In fact, approximately 5000 British Columbians choose to die at home each year (British Columbia Government, 2001). In the Abbotsford Palliative Care Program, 30 percent of the patients die at home (Katherine Ross, personal communication, March 4, 2002). Research has shown that when possible and with adequate support, patients prefer to remain at home to die (Haylock, 1993; Higginson, Wade & McCarthy, 1990; Jarrett, Payne & Wiles, 1999; Llamas, Pickhaver & Piller, 2001; Skorupka & Bohnet, 1982; Tolle, Tilden, Rosenfeld & Hickman, 2000; Wright & Dyck, 1984). Although many terminally ill individuals do remain at home, this is not always possible because of a lack of social, emotional, physical and financial support, the lack of ability of a family to provide care in the home, and perhaps the desire of the person or family not to die at home. The move away from hospital-based care to community-based care has influenced the context in which patients with terminal illnesses are nursed (Hileman & Lackey, 1990; Kilpatrick, Kristjanson, Tataryn & Fraser, 1998). With the trend toward shorter acute hospital stays and the development of technology and government initiatives, individuals can receive end-of-life care in their own homes through such programs as the Palliative Benefits Program (British Columbia Government; Smith, 1992; Wearing, 1991). Additionally, the move to community-based care has been reflected in health policy since the late 1980’s and has been driven by the premise that home care is less expensive than hospital care (Hunt, 2001).

Since the inception of palliative care by Dame Cicely Saunders with the creation of St. Christopher’s Hospice in 1967, there has been an increased interest to improve the quality of care
for the terminally ill (especially those with cancer) and their families (Nebauer, Prior, Berggren, Haberecht, Ku, Mitchell et al., 1996; Willard, 1999). Public and political awareness and research allocation related to end-of-life care and increased emphasis on personal choice have all contributed to this increased interest in palliative care (Head, 2000; Thorne, 1999).

The 1990 World Health Organization’s (WHO) definition of palliative care forms the basis from which palliative care has been defined in the literature (Dunne & Sullivan, 2000; Ronaldson & Devery, 2001; Willard, 1999; Williams & Wheeler, 2001). Palliative care has been defined as the active, holistic care of individuals whose illness is no longer responsive to curative treatment and the primary goals are the control of pain and other symptoms, and the support of psychological, social and spiritual issues (Dunne & Sullivan; Ronaldson & Devery; Willard; Williams & Wheeler). The goal of palliative care is to promote the best quality of life for the patients and their families (WHO). Two core tenets of palliative care are family-focused care and effective communication. Effective communication refers not only to communication between the health care professional and client/family but also between patient and family members.

Research in the cancer experience has demonstrated the powerful impact cancer has on not only the individual but also the family (Compton, McDonald & Stetz, 1996; Kristjanson & Ashcroft, 1994; Sales, Schulz & Biegel, 1992; Thorne, 1999). As Thorne said, “social discourse within which cancer is lived powerfully shapes the way people cope with cancer, the meaning that it has in their lives, and the way they account for the positive and negative outcomes it produces” (p. 370).

Family communication is a means by which family members can share concerns and feelings about the disease and its impact on the family. Many researchers have concluded that family communication in the terminal stage seeks to complete unfinished family business and to
provide closure (Czerwiec, 1996; Hall & Kirschling, 1990; Hayslip & Leon, 1992; Kristjanson & Ashcroft, 1994; Menard & Saucier, 2000; Vachon, Kristjanson & Higginson, 1995). Communicating with a dying family member, however, can be extremely difficult and stressful for family members (Beach, 1995; Davies, Reimer & Martens, 1994; Hull, 1991; Kristjanson, Sloan, Dudgoen & Adaskin, 1996; Sales et al., 1992; Seale, 1991; Walsh-Burke, 1992; Zahlis & Shands, 1991). How family members interact with each other and with the ill individual is influenced by many factors, such as, family communication patterns, family roles and responsibilities, and the gender and age of the ill individual (Thorne, 1985). Family members may also assume that being optimistic and cheerful rather than thinking or talking about the actual reality of the individual having a terminal illness is more beneficial to the ill individual and the family (Kristjanson & Ashcroft; Zahlis & Shands). Hinton (1998) states that this avoidance of any open discussion of the illness is used to protect the patient and family from negative emotions, a viewpoint that is supported by other researchers (Cooper, 1984; Northouse & Northouse, 1987). Although no direct link has been made between effective family communication in the terminal phase with decreased stress during the bereavement phase some researchers have implied such a relationship (McCorkle, Robinson, Nuamah, Lev & Benoliel, 1998; Northouse, 1984; Vachon, Freedman, Formo, Rogers, Llyall & Freeman, 1977).

The nurse-patient relationship is an essential component of the delivery of effective nursing care. In the homecare setting, the entire family becomes the recipient of care (dela Cruz 1994; Keyes, 1999; Mignor, 1995). In contrast to the hospital setting, family issues become very visible in the home where behaviors are more natural and offer a clearer insight into individual and family dynamics and ways of coping. Much has been written about the nurse-client relationship and the benefits to both the client and nurse are well described (Bottorff, 1993;
Bottorff, Gogag & Engelberg-Lotzkar, 1995; Bottorff & Morse, 1995; Estabrooks, 1989; Williams, 2001). Additionally, research on communication of families experiencing a life-threatening or terminal illness indicates the need for communication to occur among family members in order to complete unfinished business and to support each other. Unfortunately, there is a paucity of research on how homecare nurses can enhance family communication in families with an adult palliative member. As well, there are no published studies that articulate what it means to enhance family communication from the perspective of homecare nurses. A description of homecare nurses' practices in relation to family communication in families with an adult palliative member as described from the perspective of homecare nurses could be useful in the identification of skills and interventions required by these nurses to meet the needs of these families.

Problem Statement

Major health care changes have occurred that have influenced the delivery of health care in the community by homecare nurses. Supported by family members and homecare nurses, and influenced by the shortage of hospital beds, some individuals with terminal illnesses are choosing to remain at home to die. Family communication in terminal illness is receiving more and more attention in the literature, with the conclusion that family members need to be able to communicate with each other about the terminal illness often enough and in enough depth to complete unfinished business. No studies were found that clearly articulated what homecare nurses do to ensure that communication between palliative care patients and family members effectively meets the needs of all members. Consequently, there is a lack of knowledge about how homecare nurses intervene in family communication patterns in families with an adult
palliative member and also what changes in family coping strategies result from these interventions.

Purpose of the Study

The purpose of this pilot study was to lay the foundation for a full-scale study to describe the nature of homecare nurses’ experiences of supporting family communication in families with an adult palliative member and also to describe nurses’ perceptions of the influence of nursing behaviors on family communication patterns. It is anticipated that the understanding gained from the articulated experiences of these nurses will provide information on strategies to assist family members in communicating with each other during the terminal illness experience. In addition, the pilot study would provide a means to test the research process, such as participant selection, data collection methods and data analysis, as well as, provide the researcher with an opportunity to learn about the research process.

Research Questions

The following questions guided this study:

1. What is the nature of homecare nurses’ experiences of influencing family communication in adult palliative patients and their families?

2. What are homecare nurses’ perceptions of the influence of nursing behaviors on adult palliative patients and their families’ communication patterns?

Significance of the Study

There is a need for further research to identify strategies for assisting families to communicate about the terminal illness experience in ways that are beneficial to all family members (Vachon et al., 1995). Additionally, in an attempt to support palliative patients and their families, nurses need to determine what the experience for these palliative patients and
families is like and how nurses can influence family communication. Research directed at understanding the palliative patient’s and family’s communication and the homecare nurses’ behaviors that influence this communication would provide valuable information to the very limited body of knowledge on the nature of homecare nurses’ experiences of influencing family communication in families with an adult palliative member. Qualitative research about the experience of homecare nurses would be valuable to increase nurses’ perspectives on family communication in a terminal illness and improve nursing strategies with family communication in palliative care situations. Findings could also be used to articulate communication knowledge and skills required by homecare nurses to provide quality family palliative care services in the home.

Assumptions

It was assumed that the homecare nurses who participated in this pilot study were skilled and knowledgeable in homecare nursing practice as well as palliative care practice. This included knowledge and skills related to family assessment and family communication theory. Additionally, it was assumed that homecare nurses involved in palliative care were committed to the enhancement of family interaction in terminal illness. It was also assumed that homecare nurses would be able to clearly and candidly articulate their perceptions and experiences.

Theoretical Framework

This study was guided by the theory of family systems and communication theory. These two theories will now be presented.

Family Systems Theory

As evidenced by the increasing body of nursing literature, nurses have long been interested in the family as a focus of nursing care. Palliative care nurses in particular strive to
include the family as the unit of care (Nebauer et al., 1996; Willard, 1999). There is much disagreement in the literature about what constitutes a family (Ferzt & Houck, 1986; Friedman, 1998; Hall & Kirschling, 1990; Hanson & Boyd, 1996; Hayes, 1997; Jassak, 1992; Wright & Leahey, 1994). For the purpose of this study, therefore, family will be broadly defined as two or more individuals who share a past and experience some degree of emotional bond to each other and who identify themselves as being part of the family (Friedman). Since the family consists of individuals interacting as a unit, the theory of family systems provides a framework for the conceptualization of the impact of a terminal illness and the provision of palliative care to a family. Family systems theory directs nurses to attend to the family as a unit, in addition to individual family members and this is in congruence with the holistic care orientation of nursing (Wright & Leahey). A frequently identified advantage to systems theory is that it focuses nurses' attention on family members' interactions (Clements, 1983; Fawcett, 1975; Wright & Leahey). A number of studies that investigated the impact of cancer on family needs have utilized the family systems theory (Jassak; Kilpatrick et al., 1998; Northouse, 1989; 1994; 1995). The theory emphasizes the interrelatedness of each family member. The manner in which an individual responds to illness can, therefore, affect the needs and responses of other family members (Friedman; Kilpatrick et al.).

**Communication Theory**

Family systems theory is comprised of four structural dimensions: role, power, value system and communication (Friedman, 1998). Family communication is, therefore, one of the four structural dimensions of family systems theory, and as such, is viewed as a key aspect of family process (Friedman). As previously stated, these dimensions are interrelated and a change in one will impact the other structural dimensions. Communication involves the reciprocal
process of sending and receiving messages between two or more individuals. Communication has been referred to in the literature as both a process and an experience (Bohnet, 1986; Friedman; Northouse & Northouse, 1985). As a process, communication occurs through both verbal and nonverbal means. As an experience, it is the essence of everything we do (Balzer Riley, 2000; Bohnet). Verbal communication involves cognitive and affective messages sent through words, voice inflection and rate of speech. Nonverbal communication conveys messages via methods such as eye movement, facial expressions, body language, and the use of silence. Communication can create shared meaning and understanding of selves and others (Bohnet; Galvin & Brommel, 1991). Communication is a complex process involving a sender, a receiver, a message, a channel and an interaction (Balzer Riley; Bohnet; Friedman; Northouse & Northouse; Wallace, 2001). The complex process of communication can be influenced at any point by multiple factors that affect how messages are sent and received (Balzer Riley; Bohnet; Northouse & Northouse).

Definition of Terms

Homecare Nursing: A field of nursing practice requiring the synthesis of community health principles with theory and skills of medical-surgical, maternal-child, oncology and mental health nursing and the delivery of nursing care within the context of clients’ homes (Humphrey & Milone-Nuzzo, 1996; Rice, 1996).

Homecare Nurses: Homecare nurses are registered nurses who deliver nursing care to clients in the home setting, including palliative nursing care. For the purpose of this study, the homecare nurses worked at the staff level and had a minimum of two years experience in homecare nursing.
Palliative Care: Palliative care is both a philosophy and a care delivery that values the active, holistic comfort care of the dying individual and family.

Family: For the purpose of this study, family is broadly defined as two or more individuals who share a past and experience some degree of emotional bond to each other and who identify themselves as being part of the family.

Summary and Overview of Thesis

This thesis is organized into six chapters. In the first chapter, the rationale for a study of homecare nurses’ perceptions of influencing family communication in families with an adult palliative member was outlined. The problem and purpose were clarified, as were the research questions and the underlying assumptions. The significance of the study was described related to its potential to increase our understanding of family communication in families with an adult palliative member, and how homecare nurses might influence family communication. Such an increased awareness could result in more effective nursing care for palliative patients and their families. In Chapter Two, a review of the literature will be presented and in Chapter Three, the methods will be described in terms of design, participant selection procedure, data collection procedures, relevant ethical considerations and processes for data analysis and ensuring rigor. In Chapter Four, the findings will be described. In Chapter Five, the findings will be discussed. In Chapter Six, a summary of the study, preliminary conclusions, implications for nursing research, practice, and education will be presented.
CHAPTER TWO

LITERATURE REVIEW

In this chapter a review of the literature will be presented to provide a framework for this study of the nature of homecare nurses' experiences of supporting family communication in families with an adult palliative member and their perceptions of the influence of their nursing behaviors on family communication. The methodology of interpretative description requires that the research question be based within existing knowledge including formal research, clinical knowledge and the researcher's own personal experience (Thorne, Reimer Kirkham & MacDonald-Emes, 1997).

The research questions directed the researcher to examine literature related to nurses' experiences of family communication in adult palliative patients and their families, and nurses' perceptions of the influence of nursing behaviors on family communication patterns. Communication is influenced by a variety of factors, such as, characteristics of the interactants, relationship of interactants, both within the family and between the nurse and family, cultural and family roles, rules, and responsibilities. Because of these influencing factors, as well as, the research approach, literature related to terminal care, palliative care, nursing care of palliative patients and families, communication (both family and nurse-client), and palliative and homecare nurses' attributes were reviewed. While it is recognized that palliative patients can have various terminal illnesses, the majority of palliative patients are those with terminal cancer; this focus was reflected in the literature.

The literature reviewed is presented in four main sections: family tasks and supportive nursing strategies in terminal care, family communication, nurse-patient relationship, and
adequacy of nurse communication skills. In each of these sections a review of relevant research and literature is presented.

Family Tasks and Supportive Nursing Strategies in Terminal Care

A terminal illness affects not only the individual but also all family members and therefore, the family is the focus of palliative care (Hall & Kirschling, 1990; Hayslip & Leon, 1992). Terminal illness and death may disrupt all family processes including, communication patterns (Lewis, 1986; Woods, Lewis & Ellison, 1989). A main family task in terminal care has been described as being the resolution of loss. The resolution of loss involves being able to share feelings and emotions with each other. Nurses have a role in assisting family members to be supportive of each other and to facilitate effective family communication in this terminal phase.

In this section, a review of the literature in relation to family tasks that are associated with the terminal phase of the illness will be presented. Next, nursing literature describing nursing strategies to support the patient and family through the terminal phase will be presented.

The centrality of the stage of illness in relation to family tasks and needs is prominent in the terminal care literature (Feldstein & Rait, 1992; Hilton, 1994; Hinton, 1973; 1981; 1998; Kristjanson & Ashcroft, 1994; Lewandowski & Jones, 1988; Thorne, 1999; Walsh-Burke, 1992). Researchers have identified and described typical issues and stressors within distinct phases of the cancer trajectory (Kristjanson & Ashcroft; Lewandowski & Jones). These phases, although not identical in the literature, have many similarities and typically include an initial, adaptation and terminal phase. Although these phases are defined primarily in the cancer literature, it is conceivable that these phases could be used with any illness and that the end stage of cardiac disease could also be termed the terminal phase. The terminal phase is described as the stage in which there is physical deterioration of the individual and the aim of treatment becomes
palliative versus curative (Kristjanson & Ashcroft; Lewandowski & Jones). An essential family
task at this time is the resolution of loss and separation, and primary family needs include
information and support (Hall & Kirschling, 1990; Hayslip & Leon, 1992; Hull, 1989;

Researchers have investigated nursing approaches believed to be helpful during terminal
care. Nursing strategies used by LPNs and RNs caring for terminally ill patients were described
by Reisetter and Thomas (1986). Results of their survey of 210 licensed practical nurses and
registered nurses indicated that nursing approaches in terminal care include: providing
opportunities for families to be together, providing family members with information about the
patient’s condition and impending death, and providing family members the opportunity and
support to share emotions as indicative of quality terminal care. Lewandowski and Jones (1988)
identified the most and least helpful nursing behaviors with adult family members of cancer
patients in each of the phases of the cancer trajectory. One hundred and fifty households,
randomly selected from a telephone directory were mailed one of three vignettes that described a
cancer patient in one of the three phases of living with cancer. The households did not
necessarily have members who were ill or dying. To obtain information on what the family
perceived were the most and least helpful nursing behaviors, participants were requested to read
the vignette, imagine that they were the family in the vignette and then complete the
accompanying questionnaire. The 62 completed and returned questionnaires were then analyzed
and the results were reported as ranked interventions according to the phase of living with
cancer. The findings indicated that in the terminal phase, nursing interventions that encouraged
and allowed family members to express emotions were rated as high by the participants in
comparison to the other phases of the cancer trajectory. The researchers concluded that these
findings supported the need for family members to complete unfinished business with the dying family member and to talk openly about dying. These results, however, need to be viewed in relation to several limitations of the study. First, the sample was randomly selected through the telephone book and the researchers assumed that participants would be able to relate to the vignette and then respond accurately to the questionnaire. Second, the number of respondents in subgroups representing the phases of living with cancer was small (initial phase, n = 13, adaptation phase, n = 16, and terminal phase, n = 11). Third, the vignettes depicted cancer patients in hospital, and consequently, the results cannot be generalized to other settings. Fourth, the investigators did not include any data about the validity and reliability of the questionnaire used in the study.

Another researcher explored what families perceived to be indicators of quality nursing care for terminal patients (Kristjanson, 1989). Quality of care was not defined in this study. Kristjanson studied 210 family members of terminally ill patients across acute care, palliative care and homecare settings and used a Q-sort methodology to identify what family members perceived as the most important health care behaviors in the care of the patient and family. Families in all three settings prioritized having clear, honest information about the patient’s progress. Families in the homecare settings also identified the need for the patient to be viewed holistically and that nursing care be directed at meeting the patient’s physical, social, emotional, and spiritual needs. This need for the recognition of psychosocial and interpersonal aspects of care, in addition to the physical care, is supported by other palliative care researchers (Dunne & Sullivan, 2000; Ronaldson & Devery, 2001; Willard, 1999; Williams & Wheeler, 2001).

Essential nursing behaviors required to provide care to the terminally ill were investigated in a qualitative study using a purposive sample of ten experienced nurse educators.
and ten experienced palliative care nurses (Degner, Gow & Thompson, 1991). Seven essential nursing behaviors were identified: responding to the death, providing comfort, responding to anger, enhancing personal growth, responding to colleagues, enhancing the quality of life, and responding to the family. Responding to the family included the use of strategies to reduce family regret and being supportive to family care. The investigators did not provide a thorough description of specific strategies other than to state activities that promoted the patient’s quality of life also had a positive effect on other family members as did the involvement of the family in the patient’s physical care. While providing some important insights about the strategies that nurses utilized in the care of terminally ill patients and their family members, the small sample of experienced nurses and educators limited generalizability. Degner et al.’s findings nevertheless were supported by Heslin and Bramwell’s (1989) descriptions of family care as related to the expression of emotions, conflict resolution and teaching effective family communication strategies.

Much of the literature that has focused on nursing behaviors in terminal care has identified effective nursing behaviors as those that address family issues and concerns and that holistically support the patient and family members. The findings of several studies point to the importance of nursing strategies that encourage family members to be together and to share emotions during the terminal phase of the family member’s illness. These studies, however, lacked specificity in relation to how to accomplish these goals given the complexity of family dynamics and communication processes.
Family Communication

In this section, literature related to family communication in a life-threatening illness or terminal illness is presented. The myriad of factors that influence family communication have been described, including past family communication patterns, family members roles and responsibilities. With the added stressor of having a palliative member, family communication could be significantly affected. Knowledge of family communication patterns has been posited to be critical to gaining a comprehensive understanding of family functioning (Friedman, 1998). Furthermore, others have concluded that allowing the sharing of information and emotions is essential to the continued coping of family members (Cohen, Disenhus & Winget, 1971; Pister, 1997; Vess, Moreland & Schwebel, 1985). Open communication has been defined as the free expression of feelings and thoughts between individuals. Clinical reports, however, often indicate that open communication does not occur in many families (Chekryn, 1984; Hilton, 1993; 1994; Hinton, 1973; 1981; 1998; Northouse, Cracchiolo-Caraway & Appel, 1991; Northouse & Northouse, 1987; Thorne, 1985; Walsh-Burke, 1992). In the following sections the literature focusing on factors that influence open family communication and the relationship between family communication patterns and adjustment, and coping to a terminal illness will be presented.

Factors that Influence Open Family Communication

Several themes that have appeared in the family communication literature to explain the variations in degree of open family communication in a life-threatening illness or terminal illness will now be presented. These main themes relate to such factors as preference, deliberate intent, maintenance of previous communication patterns, avoidance, and shared meaning of the experience.
An analysis of interviews with sixty-two married couples found that about one third openly shared with each other, one third partially shared, and another third did not share anything with each other about their awareness of dying (Hinton, 1981). Hinton described these findings as not a failure in communication but more as a preference for couples not to speak to each other of dying. This preference for not discussing dying appeared to: 1) communicate hope and the will to keep “fighting” the disease, 2) protect the partner and self by preventing distress that resulted in kindly meant lies or statements of reassurance, and 3) reflect a continuation of previous communication patterns of not talking about feelings or beliefs.

Similarly, the findings from Chekryn’s (1984) descriptive correlational study of marital couples in which the women were experiencing cancer recurrence indicated that 40 percent of the patients and 30 percent of the spouses deliberately did not talk to each other about the cancer recurrence or the potential impact on the family unit. Even the dyads that did talk about the recurrence did so only to a limited degree. Chekryn suggested that some dyads were simply following previous approved communication patterns about sensitive issues and that there was an important difference between talking about cancer and talking about feelings in relation to cancer. This finding was further supported by conclusions by Walsh-Burke (1992) that families felt more comfortable talking about information about cancer rather than emotions related to cancer, especially when it came to feelings related to death. Chekryn also noted that the marital dyads did not necessarily share the same meaning about the cancer recurrence. She related this to factors influencing the communication process including not only understanding of the message but also interpreting the importance of the message.

Thorne (1985) suggested that families use communication strategies that have both been previously effective and are consistent with the family philosophy. Some families may use open
communication and other families may value selective communication or very limited communication of emotional and sensitive issues. An essential precept to the selected strategy of family communication is the congruence and acceptance of the style by all family members.

A further theme present in the family communication literature was avoidance. Beach (1995) explored the communication experiences of adult family caregivers of terminally ill patients and found most caregivers in the study avoided direct illness-related discussions. Participants stated that direct and open discussion was useless because the course of the disease was unchangeable. Communication mainly consisted of small talk with complete avoidance of discussions of the illness, prognosis or any psychosocial concerns between caregivers and patients. There was also very limited discussion or disclosure to other family members. Caregivers in this study indicated significant stress associated with family interactions and tended not to rely on family members for emotional support.

In a quantitative study that explored communication between terminal cancer patients and their relatives and a hospice care team, Hinton (1998) concluded that for patients there was a precarious balance between the need to share their fears and concerns and the relief obtained from doing so. There was no predictable outcome of relief due to many variables, which included the degree of open communication. He suggested that two of these influencing variables to open communication included: family members' stage of acceptance and adaptation to the terminal illness, and the meaning of family communication during a terminal illness. For example, family members may want to reminisce and share memories, whereas, the patient who faces death may prefer to escape into the comfort of avoidance or denial of the situation and not talk. Hinton posited that open communication between patients and relatives resulted in increased illness awareness and the likelihood of patients dying at home because patients and
family members were more likely to make their wishes regarding the care context known to each other.

An important theme in Dunne and Sullivan’s (2000) phenomenological study of family members who had been involved in the care of a palliative individual was the difficulty family members had in communicating with their loved ones. Family members expressed an inability to talk about death and what life would be like for remaining family members. Many other researchers have also noted that communication with a dying family member was extremely stressful (Beach, 1995; Davies, Reimer & Martens, 1994; Hull, 1990; Kristjanson et al., 1996; Seale, 1991; Walsh-Burke, 1992; Zahlis & Shands, 1991). Maddison (cited in Krant & Johnson, 1978) coined the term “conspiracy of silence” to describe the restrictive family communication in the area of death and dying, and argues this pattern of communication is linked to inability of family members to realistically plan for the future. Although Hull and Thorne (1984) suggested that family members needed to be given time to talk openly, no suggestions were given as to what amount of time was required.

Relationship of Communication Patterns to Adjustment and Coping

Another prominent theme found in the cancer and terminal care literature was the relation of communication patterns to adjustment and coping with a life threatening or terminal disease. The degree of open communication and the degree of shared meaning of communication has been linked to positive coping and adjustment to a life-threatening illness. Research related to this theme will now be presented.

In a study that explored the awareness of dying between husband and wife dyads, Hinton (1981) found the ability of couples to talk openly about the patient’s death appeared to give them
greater closeness in the terminal phase of the disease. Open communication has also been found to result in fewer bereavement issues (Northouse, 1984; Vachon et al., 1977).

Walsh-Burke (1992) explored the role of family communication in family coping and assessed the impact of a weekend intervention program that was designed to improve communication in families living with cancer. She collected qualitative and quantitative data from 14 families participating in the “We Can Weekend.” The qualitative data were collected through open-ended questionnaires and in-depth interviews with five couples. Quantitative data were collected through pre- and posttest questionnaires constructed by the researcher to measure the relationship of family communication with family coping. The pretests were administered a week prior to the We Can Weekend and posttest data were collected at one week post weekend to measure the short-term influence of the weekend intervention program and then at three months to measure the longer term impact of the weekend intervention. Walsh-Burke concluded that families who communicated frequently and used several coping strategies reported fewer difficulties in coping with cancer than those who used fewer coping strategies; however, the findings must be cautiously viewed due to the limitations of the study. The study sample was a convenience sample of families participating in an intervention weekend offered by oncology professionals. Although the participants were quite heterogeneous related to types of cancer and time since diagnosis, they were quite homogenous related to ethnicity (Caucasian) and age (mean age of 44). The researcher sought to measure very complex concepts and relationships and did not offer any information relating to validity or reliability of the instruments. In addition, the researcher did not discuss how the interview data were analyzed and no participant quotes were given to substantiate the findings. Walsh-Burke stated the interviews with the five couples indicated that although participants identified that they rated their overall communication as
good and reported no communication difficulties, communication about the cancer experience sometimes did not occur. The researcher also reported that several participants indicated concern about death or the recurrence of cancer.

In a study of communication patterns in 41 partnered women with breast cancer, Hilton (1994) found that the couples' degree of adjustment and coping to the illness were correlated with their beliefs regarding the importance of communicating their fears and concerns. Both qualitative and quantitative methods were used in this study. Qualitative data were obtained through interviews at five different intervals: at diagnosis, three weeks, three months, eight months and twelve months post-diagnosis. Family members also completed a set of standardized instruments. Couples completed the Couple Communication Scale. All family members completed the Spielberger’s State Trait Anxiety Inventory or the How I Feel Scale (for children 6-12 years). Three main couple communication patterns were identified: those with similar views regarding the importance of talking about issues and concerns and who openly communicated; those with similar views concerning communication who were not open communicators; and those with dissimilar views concerning communication. The couples with the discrepant views of communication experienced the most communication problems. Hilton suggested that a combination of open and selective disclosure was the most satisfactory communication pattern and further suggested that providing couples with the opportunities to share could improve family communication, even in families that preferred not to talk and share the cancer experience with each other.

Chalmers, Thomson and Degner’s (1996) study resulted in similar findings to Hilton (1994). They examined the information, support and communication needs of women with a family history of breast cancer. Communication was identified as being restricted or non-
restricted among family members. In restricted communication, discussions focused mainly on treatment issues and there was very little discussion about the meaning of the experience or fears. Although there was no direct relationship to previous communication patterns, Chalmers et al. noted that if previous communication patterns had not included discussions of emotions, then subsequent discussions about the breast cancer experience were severely restricted. In contrast, unrestricted communication patterns involved discussions of both the physiological and psychological aspects of the breast cancer experience. They further noted that communication patterns involved a degree of positivity which related to degrees of optimism seen in communication patterns. Communication was therefore classified as: restricted with unrealistic positivity, restricted with realistic positivity, unrestricted with unrealistic positivity, and unrestricted with realistic positivity. In this study restricted communication with unrealistic positivity was the most common and most problematic type of communication pattern that hindered the family’s ability to come to terms with the breast cancer experience. Outcomes of this type of communication resulted in fear and anxiety about the breast cancer experience, lack of family preparation for the death of the ill family member, and family remorse regarding interactions with the ill individual.

Kilpatrick et al. (1998) assessed the information needs of husbands whose wives were newly diagnosed with breast cancer. They concluded that husbands of women newly diagnosed with breast cancer did not have their information needs satisfactorily met. This finding may be in part due to spouses not wanting to worry each other with their concerns and, therefore, not discussing any concerns relating to the diagnosis or treatment. Husbands in Kilpatrick et al.’s study also reported that communication was not always open or truthful. Two way information flow was associated with an increase in open communication about the cancer and, conversely if
there was not open communication within the family, husbands were reluctant to discuss the cancer with their wives.

There is evidence that many families have difficulty discussing the impact of life-threatening illness with children (Walsh-Burke, 1992; Zahlis & Shands, 1991). In Walsh-Burke’s study, one-fourth of the participants stated that they did not talk openly with their children about the cancer or prognosis and one-third never talked with their children. Further research is needed to explore difficulties in communicating about the cancer experience with children in the family and to explore communication patterns of children when a parent or grandparent has cancer.

Although there is a growing body of literature regarding families and communication patterns throughout the cancer trajectory most of the research has focused on the marital dyad or individual family members and not the family as an entire unit. As stated by Lewis (1986) the family must be assessed in terms of individual members and as an entirety. Most of the research has focused on women with cancer and further research is needed as to whether family communication patterns are affected in similar ways when an adult male family member has cancer.

Nurse-Patient Relationship

The ability of homecare or palliative nurses to connect with the patient and family is important to assist the palliative individual and family in the palliative process. Nurse-patient relationships, therefore, are an essential element of nursing in palliative care. There is a wealth of literature relating to nurse-patient interaction, focusing on not only communication techniques but also the meaning and significance of the relationship to both the nurse and patient (Kruijver, Kerkstra, Bensing & van de Wiel, 2000; Lotzkar & Bottorff, 2001; Morse, 1991; Rittman, Paige,
Rivera, Sutphin & Godown, 1996). In addition, the added factor of the psychological impact of having a terminal illness may also influence the nurse-patient relationship. This added factor might result in the initial withdrawal and inhibition of sharing thoughts and feelings by the patient and family and, consequently, increase the difficulty of communication between not only the patient and family but also between patients and families and health care professionals (Hinton, 1998). Families of both homecare and palliative patients perceived effective communication skills, caring, nonjudgmental attitudes, and competence in practice as the most caring of behaviors of nurses (Hull, 1990; 1991; Rice, 1996). In the following section, literature related to homecare and palliative nurses' behaviors and competencies is presented. This will be followed by a review of the literature that illustrates the strategies used by nurses in family communication with palliative patients.

**Homecare and Palliative Nurses' Behaviors and Competencies**

Quality of life of cancer patients is an area of increasing research interest. Healthcare professionals play an important role in the quality of life of cancer patients (Kennedy, 1998; Kristjanson & Ashcroft, 1994). Literature related to the attributes and competencies of palliative and homecare nurses was, therefore, reviewed in order to identify key characteristics and competencies that nurses need to deliver quality terminal care to patients and families.

Zerwekh’s (1995) qualitative study of 32 expert home hospice nurses in Washington State supported and further expanded Dobratz’s (1990) categories of hospice nurse functions and resulted in a description of home hospice nurses’ competencies and a hospice nursing practice model. Zerwekh’s model includes 10 nursing competencies one of which focuses on “strengthening the family.” Four dimensions included in this competency were assessing the family, developing the family’s ability, going between [family members], and facing limitations.
Assessing the family included observing and determining the impact of death not only on the patient but also on the family as a unit. Developing ability included teaching to foster caregiver capability. Going between was identified as a unique dimension of the home hospice nurses’ role to strengthen family communication. Home hospice nurses frequently reported advising family members how to communicate with each other, interpreting family members’ behaviors to each other, and assisting family members to talk with one other. The fourth dimension, facing limitations, included the identification and acknowledgement of circumstances that limit family ability and the need for nurses to work within these restrictive parameters. For example, if the family was dysfunctional, home hospice nurses needed to develop achievable practice goals for this situation.

A grounded theory study by Knill (2000) and an ethnographic study by Wright (2001) provide further support for Zerwekh’s (1995) model of nursing competencies. Knill’s study findings conceptualized the work of palliative shift nurses as a process of nurturing the dying. This process consisted of four dimensions, including connecting with the client and family. Similar to Zerwekh, Knill and Wright also noted the need for palliative care nurses to acknowledge the dynamics of the family and to have effective communication skills. It appears that hospice nurses need to acquire the skills and knowledge to assess family structure and processes and to incorporate skillful, individualized interventions to support and provide an environment conducive to strengthening the client’s and family’s quality of life as the client faces death.

**Strategies Used by Nurses in Family Communication With Palliative Patients**

Many studies in family communication in terminal care have identified the need for health professionals to assist families in talking to the dying patient. Keyes (1999) reported the
nurse’s role as being the “thread of continuity” between family members as the nurse promoted continuous interactions among family members during the client’s terminal illness and facilitated the client’s and family’s need to complete unfinished business. In a study by Pierce (1999), the need for families to be assisted to have the opportunity and permission to touch a loved one was expressed. One individual stated “They let me help to turn him and hold him—that was important to me—I was helping keep him comfortable.” (p. 10). A second excerpt from Pierce’s study emphasized the need for family members to share the dying individual’s story... “touching, music, listening...it was important to my mother to tell her life story...it was important to my father to relate that, to others...” (p. 10).

The terminal phase has also been conceptualized as a transition of ‘fading away’ (Reimer, Davies & Martens, 1991). Nursing approaches during this transition included the creation of an environment conducive to the sharing of family concerns and feelings. The sharing of family concerns was important to the process of coming to terms with the situation, so nurses need to facilitate situations and environments in which family members are able to share feelings, beliefs and concerns. Similar to other research, Reimer et al. acknowledged that not all families would be able to openly communicate and that the role of the nurse was to facilitate as much open communication as the family was able to manage. In order to facilitate effective, individualized family communication, the nurse must be competent and comfortable in family assessment and communication strategies. If not, nurses tend to avoid or block discussions of topics in which they feel uncomfortable or unknowledgeable (Frost, Brueggen & Mangan 1997; Reimer et al.).

The nurse-patient relationship is further complicated in community nursing as the interaction takes place in the patient’s home (Hunt, 2001; Luker, Austin, Caress & Hallett, 2000; Stulginsky, 1993; Williams, 2001; Zerwekh, 1992). Community nurses reported the importance
of ‘getting to know’ the patient and family as central to quality community palliative care.

Getting to know the patient has been identified in previous studies (Bottorff, Steele, Davies, Porterfield, Garrossino & Shaw, 2000; Compton, McDonald & Stetz, 1996; Keyes, 1999; May, 1995; Raudonis, 1995; Rittman et al., 1996); however, little attention has been focused on getting to know the family.

Zerwekh (1992) discussed the necessity of expert homecare nurses “getting through the door” (p.18) and the need to gain entry into the family system. Entrance into the home and family is granted, not assumed as in the hospital setting, and homecare nurses need to quickly establish trust and rapport with the family (Stulginsky, 1993; Zerwekh). Luker et al. (2000) further postulated that getting to know the patient and family in the home context is different and more demanding than in a hospital setting. In the home setting the patient and relatives have control over the environment. Control belongs to the client and family and, consequently, the homecare nurse has a different power base than nurses in hospitals.

To gain knowledge of the patient and family, community nurses used several strategies including establishing early contact with the family, spending time with the patient and family to address psychosocial needs and physical needs, and determining who knows what in the family (Keyes, 1999; Knill, 2000; Luker et al., 2000). Community nurses have reported preferring to work in an environment of open awareness (Luker et al.). Luker et al. linked nurses need to discover who knows what about the patient and diagnosis to Glaser and Strauss’ (1965) work on awareness contexts of terminal illness. Glaser and Strauss identified the following four awareness contexts: open awareness, in which the patient and caregiver are aware and openly acknowledge the patient’s prognosis; mutual pretense, in which patient and caregiver are aware the patient is dying but pretend each does not know this; suspicious awareness, in which the
patient does not know but suspects others know and attempts to discover what they know; and closed awareness, in which everyone other than the patient know about the patient’s impending death. Community nurses in Luker et al.’s study preferred working in a home environment where there was open awareness in which the patient and family members were aware of the prognosis. Nurses found open awareness environments to be less stressful than other awareness contexts as there was no need for untruths or deceptions to hide the prognosis from either the patient or caregivers.

Adequacy of Nurse Communication Skills

As evident from the findings in the previously reviewed literature, nurses need to have knowledge and skills to effectively communicate with patients, as well as assess and intervene in family communication. In this section, a review of the literature pertaining to the communication skills of nurses will be presented. First, literature related to the adequacy of nurses’ verbal communication skills will be presented. This will include both research and literature that describes nurses’ knowledge and skills, nurses’ attitudes and beliefs about communication, and communication behaviors used by nurses in communicating with patients. Second, literature related to communicative strategies of empathy, touch, and therapeutic use of social conversation will be presented.

Nurses’ Knowledge and Skills, Attitudes and Verbal Communication Behaviors

While communication skills are seen as essential in caring for patients and families and in the development of the nurse-patient relationship (Wallace, 2001), concern has been expressed in the nursing literature about the poor quality of nursing communication skills in eliciting patient and family concerns (Heaven & Maguire, 1996; 1997; Maguire & Faulkner, 1988). Three themes were found in the literature that impact nurses’ communication with cancer patients: nurses’
knowledge and skills, nurses' attitudes and beliefs about communication, and the role of workplace support in facilitating nurse communication skills (Heaven & Maguire, 1996; 1997; Hitch & Murgatroyd, 1983; Maguire & Heaven, 1997; Parle). The majority of the research, however, has focused on nurses' knowledge and skills. Research related to nurses' knowledge and skills, namely, blocking and facilitating behaviors will be presented. Following this, research related to nurses' attitudes and beliefs about communication will be presented. This will be followed by the presentation of research related to the role of workplace support in influencing nurse communication skills.

Some nurses lack the knowledge and skills to effectively communicate with cancer patients (Wilkinson, Bailey, Aldridge & Roberts, 1999). It has been suggested that some nurses tend to have poor knowledge and application of skills to effectively deal with complex communication tasks, such as, eliciting psychosocial concerns or validating patients' nonverbal behaviors (Booth, Maguire, Buttersworth & Hillier, 1996; Booth, Maguire & Hillier, 1999; Maguire, Booth, Elliott & Jones, 1996; Wilkinson, 1991; Wilkinson et al., 1999; Wilkinson, Roberts & Aldridge, 1998). For example, in a study of 44 hospice nurses by Heaven and Maguire (1996) hospice nurses were found to fail to document a patient's main concern in more than fifty percent of the cases. Heaven and Maguire explained this finding by stating that nurses tended to interpret or guess patient nonverbal cues as concerns and did not validate their interpretation with patients who were reticent to discuss psychological, social, and spiritual concerns. The findings of this study need to be considered cautiously due to several limitations. First, this study was a single group pre-post test design that measured nurses' assessment skills using audio taped interviews. Second, a rating system was used to measure nurses' skills in eliciting and responding to patient concerns. Third, no information was provided about the
validity or reliability of the coding scale. Fourth, the researchers studied only nurses’ verbal communication skills, with no attention given to how nonverbal or contextual factors influenced the interaction.

The literature on nursing communication skills with cancer patients provides some evidence that nurses use both blocking and facilitating behaviors. Blocking behaviors are behaviors used by nurses that ignore patient’s cues or change the topic. Facilitating behaviors are nursing behaviors that encourage and facilitate in-depth discussion of patient concerns. Researchers have concluded that some nurses tend to use a variety of blocking behaviors to prevent patients from sharing emotional issues and, thus, interactions were at a very superficial level with very little attendance to psychosocial issues (Booth et al., 1999; Fallowfield & Jenkins, 1999; Heaven & Maguire, 1996; Kruijver et al., 2000; Maguire, 1999; Maguire et al., 1996; Webster, 1981; Wilkinson et al., 1999). Some nurses also tended to focus primarily on physical needs (Wilkinson et al.). In contrast, the nurses who facilitated patient discourse appeared to attain a more comprehensive assessment of patient issues.

In a study of 54 registered nurses who provided care to cancer patients, four nursing styles of communication were identified by Wilkinson (1991): facilitator, ignorer, informer and mixer. Facilitators utilized verbal strategies such as open and focused questions, reflection and empathy to elicit and clarify concerns with patients at all stages of illness in order to achieve an in-depth, comprehensive assessment. Ignorers were nurses who did not pay attention to patient cues and constantly changed the focus of discussion throughout the interview. Informers provided inappropriate information and opinions to maintain control of the interview and to prevent discussion of emotional issues. Mixers tended to use a mixture of blocking and facilitating behaviors. Wilkinson concluded that the identification of communication styles
increased understanding of blocking behaviors since informers were aware that they were
avoiding discussion of potentially distressful topics, whereas, ignorers and mixers were not.
Communication education programs, therefore, need to identify nurses’ communication styles in
order for nurses to develop more effective communication strategies (Wilkinson).

There remains, however, much debate in the literature about the type of education
programs needed to develop lifelong effective communication skills and as yet studies have
resulted in inconclusive findings (Booth et al., 1999; Maguire, 1999; Maguire et al., 1996;
Razvai, Delvaux, Farvacques & Robaye, 1988; Wilkinson et al., 1998; 1999). In a follow-up
study that sought to determine the long-term effects of a communication skills training program
on 110 palliative and cancer nurses, Wilkinson et al. (1999) found that the participants overall
maintained their level of competence when interacting with palliative patients and that in the area
of psychological assessment the majority of the nurses demonstrated an improvement over time.
This result is contrary to the study by Heaven and Maguire (1996) in which hospice nurses
continued to have difficulty eliciting palliative patients’ concerns.

Nurses’ attitudes and beliefs about cancer communication have received less research
than nurses’ communication knowledge and skills. Wilkinson (1991) assessed nursing attitudes
that may impact interviewing behavior and concluded that a healthcare professional’s “fear of
death” was a strong predictor of the use of blocking behaviors. Nurses who were uncertain about
their abilities to openly communicate with patients tended not to use communication strategies
that would encourage open disclosure. Parle et al. (1997) related this finding to self-efficacy
theory in which individuals with strong beliefs in their ability to successfully perform a behavior
tended to initiate and continue with the behavior even through difficult situations, while those
with poor self-efficacy tended to avoid the behavior.
There is emerging evidence that workplace support for communication may also be related to the use of communication skills (Wilkinson, 1991; Parle et al., 1997). Nurses who perceived they had administrative support to spend time interacting with patients in order to elicit patient concerns as well as to have the opportunity to debrief with colleagues, tended to use more effective communication skills in their interactions with patients. Conversely, nurses who perceived that administrative support was not present tended to keep interactions superficial and used more blocking communication behaviors (Parle; Wilkinson).

The previously mentioned studies that examined nurses' communication skills were quantitative studies that did not address nurses' nonverbal communication with patients and family members. Researchers rated the responses of nurses to simulated patient situations or used a timed nurse-patient interview in which the nurse had a limited time span to elicit patient concerns. These researchers did not consider any contextual factors that influenced the ability of the nurse to elicit patient concerns. These contextual factors could include such aspects as the quality of the nurse-patient relationship, the degree of trust the patient had in the nurse to disclose concerns, time, and setting of the interaction. All of the previously mentioned studies explored the ability of the nurse to verbally elicit patient concerns in the hospital setting. The studies also used audio taped interviews as the method of data collection and none used observational methods to gain data related to the influence nonverbal behaviors had on the interaction. All of these studies focused on eliciting patient concerns and none explored how nurses identified family concerns. In future studies, there should be increased attention on exploring skills that optimize nurse-patient relationships and on exploring nurse-family interactions. Moreover, future studies should focus more on exploring nonverbal communication
and the influence this type of communication has on establishing rapport, conveying respect and empathy in the nurse-patient (family) relationship.

Nurses' Communication Skills of Empathy, Touch, and Therapeutic Use of Social Conversation

In contrast to studies of nurses' verbal communication skills, some qualitative nursing studies have described several effective communication strategies used by nurses. Effective communication behaviors are those that seek to gain information to understand the individual's experience and to convey that the individual is understood and respected (Kruijver et al., 2000). These studies were not based on communication frameworks and have identified communication skills used by nurses that have been effective in clinical situations. These communication skills include such skills as empathy, attending, comforting behaviors, and social conversation, and researchers have continued to provide conclusive support for their continued use as an effective means of communicating. Raudonis' (1995) study examined the meaning and impact of the empathetic relationship between 14 terminally ill patients and hospice nurses. From Raudonis' study two categories of empathy were found: affirmation and friendship. Affirmation was the acknowledgement of the individual as a person and friendship was the reciprocal meaningful relationship between patient and nurse. In terms of a family focus these categories could be further elaborated to mean the family unit was unique and individual, and that friendship was the reciprocal meaningful relationship between the family and nurse. Raudonis concluded an empathetic relationship positively affected the patient's (and family's) physical and emotional well being. Several studies have examined the types of touch and attending nurses use in interactions with cancer patients that have positive effects on nurse-patient relationships (Bottorff, 1993; Bottorff et al., 1995; Bottorff & Morse, 1994; Estabrooks, 1989). Bottorff and Bottorff & Morse's qualitative studies explored nurses' patterns of touch and attending when
caring for oncology patients. The researchers found that the nurses used five types of touch: comforting, connecting, working, orienting, and social. The nurses used touch as a means to provide comfort and to show acceptance of individuals. Sometimes touch was the only available means of communication (Bertero, 1999). Touch as a communication behavior is shaped by the intentions of the nurse and by the interpretation of the patient (Fredriksson, 1999). Touch was also used as a means to protect the nurse from emotional pain (Estabrooks). In addition to these qualitative studies, nurses have also explored the use and effect of other communication techniques, such as social conversation. Several researchers have either directly or indirectly studied social conversation to explore the effect of informal conversation on the establishment of nurse-patient interactions and the elicitation of patient concerns (Bottorff et al.; Langley-Evans & Payne, 1997; May, 1995). The outcomes of this research indicated that nurses used social conversation to establish a nurse-patient relationship, to create transitions from one nursing activity to another, and to prefix patient disclosures of sensitive, emotional issues. Nurses also used social conversation as a mechanism to elicit patient information (Donnelly, 2001). Social conversation, however, needs to be further examined in order to determine the effectiveness of this communication strategy in the nurse-patient relationship as well as its overall effect on patients’ outcomes.

Summary

As the focus of this research was how nurses influence family communication in families with a palliative family member and their perceptions of the impact of their nursing behaviors on family communication, literature related to family communication in a terminal or life-threatening illness was reviewed. This review specifically examined literature related to family
tasks in a terminal illness, family communication, homecare and palliative nurse attributes and competencies, nurse-patient relationship, and adequacy of nurse communication skills.

Research on family tasks in a terminal illness is not a current focus in the literature as evidenced by the older studies reviewed in this chapter. This research, however, was included as it provided a framework for the effects a terminal illness has on family members and the role that nurses have in supporting families through this experience. As the findings from the reviewed literature illustrate, a terminal illness can alter family roles, responsibilities and communication patterns, and therefore, nurses have an important role in assisting families to effectively adapt and cope with this event. While researchers have identified general nursing behaviors that families perceived as being helpful to them and viewed as being indicative of quality nursing care, specific nursing strategies were not described. In addition, the studies that explored family needs and supportive nursing behaviors during terminal care did not address the dynamic nature of family perspectives and needs during the terminal period. As stated by Hull (1989), family needs and perspectives change as the terminal phase progresses and are further influenced by environment, social and personal variables, and therefore, future research needs to include these influencing factors.

Much of the literature on family communication in a life-threatening or terminal illness focused on the degree of open family communication and the relationship of communication patterns to adjustment and coping with a terminal illness. This literature revealed that family communication could be influenced by several factors. Open family communication could be influenced by such factors as, preference, deliberate intent, avoidance, previous communication patterns, and shared meaning of the experience. Some families deliberately did not speak about any issues, concerns or feelings about the terminal illness. Previous family communication
patterns influenced how open families were to discussing thoughts and feelings about the terminal illness. Families tend to maintain previous communication patterns. Shared meaning related to whether family members had a common understanding of the experience and a desire to share with each other about the experience, as well as, whether family members and palliative individuals were at the same stage of acceptance and adaptation to cancer.

Researchers have begun to explore the relationship of family communication patterns to adjustment and coping to a terminal illness. Although labeled differently by the researchers, the findings from this research have identified several patterns of family communication that allowed the open sharing of thoughts and feelings and that were viewed as supporting adjustment and coping with cancer. The most problematic communication pattern was the one in which thoughts and feelings were not shared among family members. As stated by Thorne (1985), however, perhaps maladaptive communication patterns do not exist if families are able to share what needs to be shared. As a result, it appears that nursing strategies to support family communication need to be individualized to acknowledge and support the degree of openness each family is able to achieve.

Nurses, therefore, have an important role in assisting families to cope with a terminal illness. Nurses need to have the knowledge and skill to effectively interact and intervene in family communication in order to assist families through the palliative stage of the illness. Much has been documented about the communication skills of nurses in relation to the elicitation of patient concerns. As evident from the literature review, nurses' abilities to elicit patient concerns has being linked to such factors as nurses' knowledge and skills, attitudes and beliefs, and workplace support. Researchers who explored nurse communication skills identified two main categories of communication behaviors. These communication behaviors were facilitating and
blocking. Facilitating behaviors were communication behaviors that nurses used to effectively elicit patient concerns. In contrast, blocking behaviors were those that nurses used to ignore or change the focus of patient concerns or conversation. Studies that have researched nurses' communication skills have been mainly quantitative and have examined only the verbal skills that nurses used to elicit patient concerns in the hospital setting. In addition, these quantitative studies have not explored how other factors such as, nurse-patient characteristics, age, ethnicity and culture, and stage of terminal illness may have influenced the nurse-patient interaction. These studies also used mainly audio taped nurse-patient interviews and did not include any direct observation of the interaction. Moreover, the majority of these studies focused on nurses working in hospitals and very little research has been done to examine how homecare nurses communicate with patients or how homecare nurses influence family communication. As stated in the homecare nursing literature, homecare nurses face the additional factors of gaining access to the family and establishing a therapeutic relationship because the patient and family have control over the environment. There has been some qualitative research on nurse communication skills such as empathy, attending, touch and the role of social conversation in nurse-patient interactions. Literature related to these was reviewed in order to provide some insight into the benefit of such communication strategies in nurse-patient interactions. There was no research or literature found that addressed how homecare nurses influence family communication in families with an adult palliative member.

In summary, the literature review provided a perspective of the literature relating to the role of family communication in a terminal illness, the role of the nurse in family communication, and behaviors that may impact on either of these. Communication patterns in families with a family member with cancer may be changed resulting in a decreased ability for
families to exchange information and be supportive to each other (Lewis, 1983). The findings from the reviewed literature illustrates that nurses can have a pivotal role in facilitating family communication.

There is an increased pressure on health care professionals to demonstrate an evidence-base for the care and service provided to patients and families. The ongoing development of research-based practice, therefore, is a key aspect of quality service and consequently, there is a need for nurses to develop researched-based practice to continuously improve care (Daniels & Exley, 2001; Dodd, 1992). Because several limitations and suggestions for further research were presented in this review of the literature, as well as, the fact that no studies were found that specifically addressed nurses’ roles in family communication in families with an adult palliative member this is an area requiring further study. By using a qualitative research approach, to explore how homecare nurses support family communication in families with an adult palliative member new insights may be revealed about nurses’ interventions.
CHAPTER THREE
RESEARCH METHODS

In this chapter the research methods are presented. The methods include a description of the research design, the sampling procedures and setting, a description of participants in this study, the data collection and data analysis procedures, the approaches used to address rigor, and information about the ethical considerations for this study.

The Research Design

The main research question for this study focused on describing the nature of homecare nurses' experiences in influencing family communication in families with an adult palliative member and nurses' perceptions of the influence of their nursing behaviors on family communication in families with an adult palliative member. Because the design for a study should be determined by the nature of the research question(s) (Strauss & Corbin, 1990), a qualitative research method was chosen for this study. This approach is appropriate because little is known in relation to the homecare nurses’ experiences of influencing family communication in families with an adult palliative member and there is a need to develop nursing practice knowledge about this area. Qualitative research methodology is used to gain knowledge and develop theory from an emic perspective and from an inductive approach (Morse & Field, 1995). Qualitative methods are also suitable for research questions that seek to explore the lived world of individuals through the insights and meanings they find in their own experiences. Through this approach, researchers attempt to examine and explore the experiences, feelings and perceptions of the individuals they study.

The interpretive descriptive was the specific approach used. Thorne, Reimer Kirkham and McDonald-Emes (1997) described interpretive description as a research method that met the
needs of nursing. It “is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of much of the health-illness experience, yet allows for shared realities” (Thorne et al., p. 172). Interpretative description, hence, allows for the exploration of previously unexplored areas and can contribute to the nursing profession’s understanding of not only how individuals experience their health and illness but also to how and what nurses can do to make a difference.

A pilot study design was selected due to the planned small sample size and constraints of time. A major advantage to conducting a pilot test is to help identify limitations or the need for refinement of the research methods prior to undertaking a larger scale study (van Teijlingen & Hundley, 2002). Pilot studies are also useful as a way of training novice researchers in many aspects of the research process (van Teijlingen & Hundley; Burns & Groves, 1997).

**Selection of Participants**

In this section, the sampling procedures including selection criteria will be presented. Then, a description of the study sample will be presented.

**Sampling Procedures**

To recruit participants, the researcher contacted the Director of Home Health Care, Fraser Health Authority, Fraser Valley Area, to explain the study and gain permission to invite homecare nurses to participate in the study. The details of the study were presented at a general staff meeting. The researcher also explained the study details to some of the homecare nurses in one of the homecare offices who had been unable to attend the general staff meeting due to workload issues. A letter explaining the study and inviting participation was also distributed to each of the nurses attending the meeting and additional letters were left in the homecare offices for the nurses who were unable to attend the meetings (Appendix A). The letter also explained
the process by which nurses could contact the researcher to ask questions or to indicate interest in participating in the study. Participants interested in participating in the study initiated contact with the researcher. The researcher used this opportunity to provide any additional information about the study and issues of informed consent and to clarify participants’ expectations. With the agreement of the Director of Home Health Care, application for approval of the research was made to the Behavioral Research Ethics Board of the University of British Columbia where the researcher was enrolled in the graduate nursing program.

Selection Criteria

The designated population, in which the homecare nurses’ experiences of influencing family communication in families with an adult palliative member were studied, was homecare nurses working in the Fraser Health Authority. Selection of participants in qualitative research is based on the established criteria of the researcher and on what is already known (Morse, 1986). Participants in this study, therefore, were selected based on the following criteria:

1. Currently working in homecare nursing with a minimum of two years experience in homecare nursing.
2. Responsibilities included providing nursing care to palliative patients and families.
3. Willing to articulate and share their experiences.
4. Interested in being interviewed and living within the Fraser Valley.

Sample Selection

The participants in this study were eight registered nurses who provided palliative nursing care in the home setting. Seven of the participants were homecare nurses in the Fraser Health Authority. The eighth nurse, who provided home-based palliative care through a private Fraser Valley nursing agency, pilot tested the initial interview guide, and data from that
interview were included in the analysis. Six of the participants worked on a full time-basis and two participants worked part-time.

Generally to facilitate maximal theme variation, researchers use theoretical or purposive sampling in interpretive description (Thorne et al., 1997). The sampling in this study constituted purposive sampling, because the researcher consciously targeted specific respondents. Purposive sampling is a non-probability sampling technique used to select participants who can illustrate the phenomenon being studied (Burns & Groves, 1997; Clark, 1997; Coyne, 1997; Morse & Field, 1995; Sandelowski, Davis & Harris, 1989; Thorne et al.). As the researcher was interested in developing an interpretation of how homecare nurses influence family communication in families with an adult palliative member and how nurses perceive the effect of their behaviors on the family, participants were selected on the basis of their ability to articulate and elucidate their interpretations of this phenomenon (Morse, 1986; Morse & Field; Thorne et al.).

Demographic data to describe the sample included: age, years in nursing, prior nursing positions, prior nursing experience, years in homecare nursing, nursing education, number of palliative patients in caseload, length of time with palliative patients, and courses and other educational events taken in the last three years (Table 1). All of the participants were female with a mean age of 52. All were experienced nurses with a mean of 22 years nursing experience, and a mean of 14 years experience in homecare. All of the participants were diploma-prepared and none had baccalaureate preparation. The most frequent range of number of palliative patients per caseload was two to four and generally the nurses had time in which to get to know the patient and family as the patient was on the homecare caseload for several weeks. All of the participants had attended various workshops/inservices related to palliative care that included bereavement and symptom management. The participants also reviewed palliative care articles to keep current
Table 1: Demographic Characteristics of Study Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of Age in Years</td>
<td></td>
</tr>
<tr>
<td>35-55</td>
<td>7</td>
</tr>
<tr>
<td>&gt; 55</td>
<td>1</td>
</tr>
<tr>
<td>Years in Nursing</td>
<td></td>
</tr>
<tr>
<td>10-25</td>
<td>5</td>
</tr>
<tr>
<td>&gt; 25</td>
<td>3</td>
</tr>
<tr>
<td>Homecare Nursing Experience (years)</td>
<td></td>
</tr>
<tr>
<td>&lt; 5</td>
<td>1</td>
</tr>
<tr>
<td>5-10</td>
<td>3</td>
</tr>
<tr>
<td>10-15</td>
<td>1</td>
</tr>
<tr>
<td>15-25</td>
<td>3</td>
</tr>
<tr>
<td>Number of palliative patients per caseload</td>
<td></td>
</tr>
<tr>
<td>2-3</td>
<td>3</td>
</tr>
<tr>
<td>4-5</td>
<td>4</td>
</tr>
<tr>
<td>&gt; 5</td>
<td>1</td>
</tr>
<tr>
<td>Average length of time palliative patient on caseload</td>
<td></td>
</tr>
<tr>
<td>3-7 days</td>
<td>1</td>
</tr>
<tr>
<td>weeks</td>
<td>6</td>
</tr>
<tr>
<td>months</td>
<td>1</td>
</tr>
</tbody>
</table>
in palliative care issues and trends. None of the participants had received any formal education/training in family theory or counseling.

Data Collection

The researcher used multiple data collection approaches including interviews, field notes and a reflective journal.

Interviews

Prior to the initiation of the interviews, the researcher ensured that each participant understood the purpose and process of the study, and an informed consent was obtained (Appendix B). Data collection involved semi-structured interviews that were audiotape recorded and later transcribed verbatim. Each interview was approximately 60 to 90 minutes long with two of the participants being involved in one interview each, three of the participants being involved with two interviews each, and three of the participants being involved in three interviews each. The researcher constructed an interview guide based on the study purpose, the literature and the researcher’s experience. The guide was pretested in one interview with a nurse, who was actively involved in palliative care in the home context to ensure that the questions were clear and useful (Appendix C). Based on the experience of conducting the initial interviews, the trigger questions were revised (Appendix E). Following interviews with six participants the interview guide was again revised (Appendix F). The revised interview guide was then piloted in four additional interviews. With these revisions, participants were able to explore and describe their experiences in sufficient detail to allow for the emergence of common themes as well as those themes that are unique to individual experience.

Interviews took place at each participant’s place of choice and at a time mutually convenient to both participant and researcher. The location was mainly the homecare nurses’
offices, with one interview taking place at the researcher's place of work. In all locations, privacy was ensured in order to facilitate open conversation as well as to maintain confidentiality.

As the intent of the interview was to gain a rich description and interpretation of the experience of each participant, the researcher needed to create an environment that was comfortable, safe and trusting (Kvale, 1996); therefore, each initial interview began with an informal conversation and an explanation of the researcher's interest in the topic in an attempt to "break the ice" and relax both parties. The interviews were semi-structured to allow participants to describe their experiences from their own perspectives and in their own language. The researcher also used reflection, requested examples and description of events, and used open-ended questions in the attempt to fully understand the participant's experience.

During the follow-up interviews, the emerging themes were shared with the participants and they were asked to comment on whether the themes captured their experiences. Further clarification and understanding of the homecare nurses' experiences were also sought at this time. Due to time constraints and work schedules the researcher interviewed two of the participants together. This created an interesting dialogue in which the two participants shared and elaborated on their experiences. Overall, the follow-up interviews allowed the participants the opportunity to share their interpretations of the findings and thereby refine and validate the interpretations.

Setting aside the researcher's own judgment and preconceptions of homecare nursing behaviors assisted the researcher to focus on the participants' experiences (May, 1989). The setting aside of the researcher's judgment and preconceptions was accomplished by bracketing (Munhall & Oiler Boyd, 1993; Sandelowski et al., 1989). Bracketing occurred prior to and after
data collection and data analysis with anecdotal documentation in the researcher’s reflective journal and ongoing discussion and consultation with the thesis committee. This assisted the researcher to reflect on each participant’s experience with openness and without preconceptions and judgments as the researcher’s own personal assumptions and beliefs were identified (Morse & Field, 1995).

Field Notes

Field notes were completed as soon as possible after each interview in order to supplement the data obtained from the tape-recorded interview. Field notes were used to describe the setting, impressions, and the nonverbal communication in the interview process, and any discussion that occurred after the interview was completed. The field notes were useful in recording the researcher’s thoughts and feelings about the interview, and provided opportunities to critique and modify the interview style. Additionally, field notes were used to note any behaviors that may have influenced the interaction and assisted the researcher to remain open to participants’ experiences as described in the interviews.

Reflective Journal

As recommended by Thorne et al. (1997), a reflective journal was kept in which any personal insights, issues, and subjective biases were recorded. The researcher also used the reflective journal to record ongoing thoughts regarding the data collection and analysis of the findings.

Data Analysis

As is usual with qualitative approaches, data analysis occurred concurrently with data collection. This approach to data analysis is in keeping with inductive analysis (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Thorne et al., 1997), and is a “process of conjecture and
verification, of correction and modification, of suggestions and defense. It is a creative process…” (Morse, 1994, p. 25). Glaser and Strauss’ constant comparative analysis guided data analysis for this study. The interview tapes were transcribed verbatim. To acquire familiarity with the data and an overall sense of the interviews, transcripts were read several times (Corbin & Strauss, 1990; Sandelowski, 1995). This was followed by the researcher again reading the transcripts in order to begin to identify and label units of information. Content analysis involved line-by-line analysis in which the researcher constantly asked questions of the data. Questions such as “What is happening here?” and “What am I learning about this?” were asked by the researcher in order to comprehend the participants’ experiences. The researcher became aware of persistent themes and recurrent issues raised within the interviews. Codes were then developed to represent the meaning of themes. Codes that were both “in vivo” and terms constructed by the researcher were used to represent the essence of what the participants said, observed, or did. Codes were then compared and similar codes were clustered and assigned to broad categories. With successive interviews and data analysis, codes and categories across transcripts were compared with the intent of identifying similarities and differences and accurately recording them. When several broad categories had emerged from the data, the researcher began identifying the properties of each of the categories. The identification of the emerging categories was based on the researcher’s understanding of the categories. Data analysis continued with the researcher comparing codes within each category with the properties of the category. This analytic process allowed for the emergence of relationships between categories and in keeping with the purpose of interpretative description, the researcher focused on understanding the homecare nurses’ experiences in detail while also recognizing emerging shared themes across the experiences.
The data analysis and the subsequent understanding of the homecare nurses’ experiences were supported by several procedures. Concurrent data collection and data analysis, a method that is well supported in the qualitative research literature, in order to continually refine and develop the emerging understanding of the phenomenon under study was done by the researcher (Burns & Groves, 1997; Glaser & Strauss, 1967; Lincoln & Guba, 1985; Morse, 1994; Morse & Field, 1995). Additionally, the researcher read and reread each transcript to gain an overall understanding and sense of the interview, and as stated by Thorne et al. (1997), “repeated immersion in the data prior to beginning coding, classifying, or creating linkages” (p.175) is essential to accurately and comprehensively comprehend, synthesize, theorize and recontextualize the data. Furthermore, throughout the data analysis, the researcher wrote journal entries in order to describe and clarify emerging categories and the relationship between categories. These journal entries assisted in the identification, clarification and questioning of emerging themes and relationships, in the identification of missing or incomplete categories, and the posing of questions for further clarification with the participants.

Evaluation of the Pilot Study Process

The primary aim of this pilot study was to provide a means for testing the research process prior to a full-scale study. Essential to the determination of the feasibility of conducting a full-scale study was the ongoing evaluation and critique of the recruitment strategies and data collection methods. The recruitment strategy of obtaining participants was evaluated based on the characteristics of the participants, as well as, their ability to articulate their experiences in influencing family communication in families with an adult palliative member. As the participants were interviewed what became apparent was their similar educational preparation and difficulty in articulating what strategies they used to influence family communication. A
more purposive recruitment of experienced homecare nurses who also had theory and clinical practice in family assessment and intervention was carried out, but due to time constraints this strategy did not result in any additional participants. The use of interviews as the primary data collection method was also evaluated. In conducting the interviews and in analyzing the data from the interviews the researcher constantly asked, “Does the interview provide a description of how the nurse supported family communication?” “What is missing from the nurses’ narratives of their experiences?” “What am I learning about this experience?” The interview questions were continuously evaluated based on the ability of participants to respond to the questions with data that met the purpose of the study. The researcher also evaluated the questions based on the ease or difficulty that participants had in responding to them. This resulted in the revision of the interview guide several times. As the interviews progressed, the opportunity was taken to clarify themes and ideas generated from previous interviews. The researcher also sought feedback from the participants on how they perceived the interview questions and the interview process. This feedback was incorporated into the ongoing revision of the interview guide.

Initially, the interviews were semi-structured and the interview tool was used only as a guide to facilitate the interviews, hence, the questions posed to the participants were not necessarily the same for each participant as the questions depended on the process of the individual interview and what the participants said. The third interviews were more structured in the researcher’s attempt to evaluate the quality and ability of the questions in eliciting information about the strategies nurses used in supporting family communication and their perceptions of the impact of these strategies on family communication.
Rigor

Lincoln and Guba (1985) described four essential criteria of trustworthiness necessary for the evaluation of qualitative research. These criteria of credibility, transferability, auditability and confirmability were used to address the issues of rigor in this study.

Credibility

The validity of a qualitative study relies on the credibility or truth-value of the findings to the study participants (Sandelowski, 1986). Credibility was ensured by the accurate interpretation of the participants’ experiences and continuous validation of these interpretations by the researcher with participants and thesis committee members. Each of the participants was able to speak to the experience because they lived that experience daily in their work. Researcher bias, both individual and substantive can be a threat to the credibility of the study findings. The researcher has a background in palliative care nursing, albeit not in the homecare context, which could have influenced the study. In this study, the researcher attempted to counter bias within the research through the use of several measures. The researcher had discussions with her thesis committee about the data collection and analytical processes. A reflective journal was also used in which the researcher recorded thoughts, feelings and questions regarding the research processes. The researcher also interviewed six of the participants either twice or three times with the aim of the second and third interviews being to provide opportunities for participants to validate the interpretation of the experience being studied and to offer further ideas or clarification of the interpretation of the experience.

Transferability

Transferability refers to how well the research findings fit into another context (Sandelowski, 1986). Generally transferability is addressed through theoretical sampling,
however, in this pilot study purposive sampling was used and therefore, the researcher cannot guarantee theoretical saturation of data due to the small size and homogeneity of the sample. Additionally, for the transferability criterion to be met, a rich description of the findings must be presented in order that the establishment of typical and atypical behaviors or responses allow for the accounting of similar and dissimilar cases.

A number of issues related to rigor may have affected the transferability of the study findings. The participants volunteered for the study and, therefore, may represent nurses who placed a greater emphasis on family communication in families with an adult palliative member than nurses who did not volunteer. The transferability of the study cannot be established as the sample represented one rural health region and the services offered within this region. The majority of the participants were experienced nurses with many having fifteen years or greater nursing experience with five or more years in homecare nursing and all were diploma-prepared nurses. The participants provided home nursing care to clients with a variety of health issues, not just specifically to palliative patients.

**Auditability**

The auditability of findings is evidenced through the consistent documentation of the researcher’s “decision trail.” The decision trail is the researcher’s detailed notes of all steps taken from the initial interest in the topic through to the interpretative conceptualizations (Sandelowski, 1986). Auditability is, therefore, accomplished when the researcher’s decisions can be clearly and logically followed and similar conclusions made by other researchers (Sandelowski). In this study, the literature review provided the context for the study. Additionally, the explication of data collection and analysis procedures, validation of themes and interpretations with participants, ongoing use of field notes and a reflective journal to describe
the researcher’s thoughts, reflections and possible biases provided information about the researcher’s audit trail. The critical analysis and documentation of the difficulties encountered in this pilot study also provided the context and rationale for the suggested recommendations for a full-scale study. The links between the data collected and the reported findings were demonstrated by the inclusion of data in the thesis and this further supported the criterion of auditability.

**Confirmability**

Confirmability or neutrality refers to the absence of bias in the research procedure and results (Morse & Field, 1995); however, Thorne et al. (1997) stated that the absence of bias in research is impossible, and that the researcher therefore, needs to take measures to account for the influence of bias upon the research. In this study, the researcher attempted to control bias through prolonged contact with participants and through the use of reflective journaling to record researcher biases. In this pilot study, however, confirmability was not established due to the following factors. One, there was only one method of data collection. Credibility could be enhanced with the triangulation of data sources (different participants, different location), and multiple methods of data collection. Triangulation provides an increased trustworthiness of data by enabling the researcher to explore for similar and dissimilar experiences. Two, the transferability of the findings is questionable due to both the characteristics of the participants and the context of the study. Three, the accuracy and plausibility of the preliminary themes needs to be further evaluated in the full-scale study.

**Ethical Considerations**

It was not anticipated that participation in this study would harm the participants in any way, nevertheless, the participants were sharing personal and professional and confidential
information with the researcher. Several procedures were used to protect the rights of the participants in this study. Ethical approval was obtained from the University of British Columbia Behavioral Research Ethics Board. Prior to the start of the study, permission to recruit participants was obtained from the Director of Home Health Care, Fraser Valley Health Authority, Fraser Valley Area. To ensure the participants’ rights to informed consent, each participant received a written and verbal explanation of the study’s purpose and was also provided with opportunities to discuss any concerns about the study.

A written consent to participate in the study was obtained from each participant prior to the initial interview. To ensure informed consent, both the Participant Information Letter and Participant Consent Form clearly outlined the purpose of the study, the interview process, the confidentiality measures and the potential benefits to the participants (Appendices A & B). Participants were also informed that they were free to withdraw from the study at any time or to refuse to answer any question without consequence to them.

Confidentiality of participants was assured by the use of a code number on all audiotapes, transcripts and in the research report. The researcher was the only one who knew both the code numbers and participants’ identities and these were kept secure in a locked drawer in the researcher’s home. Access to the tapes, disks, and transcriptions was limited to the researcher and thesis committee members. Documents, tapes, disks and transcripts were locked in a filing cabinet when not in use and data stored on computer hard drive was accessible only be password.

Limitations of the Study

The limitations of this study will now be discussed. A major limitation was the fact that this was a pilot study with a small and fairly homogenous sample. The findings can, therefore, only be viewed within the context of this study (Burns & Groves, 1997; Morse & Field, 1995;
Thorne et al., 1997; van Teijlingen & Hundley, 2002). The credibility of the study was enhanced as participant validation was used to check the findings through discussion of the researcher’s interpretation of the data. A limitation to using interviews as a data collection method is that disparity can exist between what the participants say they do and what they actually do. Additionally, the data was anecdotal in nature.

This was the researcher’s first experience with a formal research study. The researcher’s skills for data collection and analysis were limited. The time frame of the research was another limitation because the research process was conducted within the confines of a graduate program.

Summary

In this chapter the research methods were presented. This included the nature of the interpretative descriptive approach as well as the processes of sampling, participant recruitment and sample selection criteria. A description of the sample was included. The procedures for data collection and data analysis were described. The criteria for rigor in qualitative research was examined in relation to this study. The ethical considerations of this study were outlined. Finally, the limitations of this study were discussed. In Chapter Four, the results of the study will be presented.
CHAPTER FOUR

FINDINGS

The aim of this pilot study was to lay the foundations for a full-scale study to describe the nature of homecare nurses' experiences of supporting family communication in families with an adult palliative member and their perceptions of the impact of their nursing strategies on family communication. Although the researcher had hoped to provide some preliminary findings about the nature of strategies that homecare nurses used to address family communication issues it became apparent while conducting the study that there were major limitations in the research process. As a result, the focus of this chapter will be the presentation of the findings in relation to these limitations. Preliminary codes were identified in the data collected for this pilot study. These codes are presented in this chapter with the caution that they are preliminary and need to be further explored in future studies to determine their suitability for supporting an analysis of the strategies that homecare nurses use to address family communication patterns.

In this chapter the findings of the pilot study are organized into two main sections. First, the challenges faced with the research process will be discussed. In this section the challenges related to the selection of participants and the data collection method will be presented. The findings of the data collection method related to the design and use of an interview guide, and the challenges the researcher experienced in conducting the interviews will be presented. Although these areas of the pilot study will be discussed separately, it is recognized that these processes are interrelated. In the second section of the chapter, selected codes from the preliminary data coding scheme derived from analysis of the interviews will be presented. Although only preliminary codes, they provide implications for future research.
Challenges Faced in the Selection of Participants

The selection of participants is an essential process of any study. In order to provide meaningful data, participants need to be able to articulate their experiences in relation to the research study questions. In addition, participants need to be representative of the larger population (in this case homecare nurses) and, therefore, provide experiences that are reflective of this population.

Participant recruitment was a major influencing factor in this pilot study. Due to the time frame inherent in completing this study as part of a degree requirement, the researcher chose to recruit participants from her local region. The method of recruitment was mainly through an announcement at a staff meeting and an invitation to the homecare nurses to participate in the study, as well as, posting of an information letter explaining the study in one of the homecare offices. Some of the participants were also obtained using snowball sampling. All participants who volunteered to be participants and met the eligibility requirements outlined in Chapter Three were included in the study. Six participants initially volunteered, the seventh was obtained in the latter stages of the pilot study. These methods of recruitment, while providing the number of requested participants, also resulted in a very homogenous sample for the study. All of the participants were female, Caucasian, diploma-prepared nurses with more than 10 years nursing experience and 5-25 years of homecare nursing experience. All of the participants had previously nursed in the hospital setting prior to their work in the homecare setting. Family theory and family nursing did not become part of nursing education until the early 1980s and then usually only in nursing degree programs (Wright & Leahey, 2000) and, therefore, none of the participants had received any formal education in family nursing theory. In addition, none of the
participants had received any post diploma training/education in counseling or working with families.

When the researcher observed that the participants had difficulty sharing their ideas and perceptions of their experiences with family communication in families with an adult palliative member, efforts were made to recruit nurses who may be more likely to describe their family intervention patterns, for example, nurses whose undergraduate degree programs where counseling skill intervention was included, or nurses who had education in working with families. An additional recruitment strategy used was asking participants if there were any degree-prepared homecare nurses, and on learning that there were two in the region, asking the participant if she would contact these homecare nurses and inform them of the study and if interested in participating to contact the researcher. In addition, a contact community nurse was obtained with the assistance of one of the researcher’s committee members and while this nurse was not a homecare nurse she also sought to recruit participants for the study. Unfortunately, neither of these strategies resulted in additional participants with differing educational and experiential characteristics who may have offered different perspectives on the study questions, and due to time constraints no additional recruitment strategies were attempted. It is important to note that participants’ difficulties in articulating and sharing their experiences may have also been related to the data collection process which will be discussed later in this chapter.

Challenges Faced in Data Collection

The data collection method of a study should have the capability to produce the data that will provide descriptions of the experience being studied. The main method of data collection for this pilot study was in-depth interviews. The researcher developed an initial interview guide from the literature and the research questions. Both the interview guide and the interview process
posed challenges in gaining data about homecare nurses' experiences of intervening in family communication. The challenges with the interview guide will be discussed initially and then the challenges of conducting the interviews will be presented.

**Development and Use of an Interview Guide**

The questions in the interview guide were initially intended to be used to facilitate the interview and not to necessarily structure the interview because the researcher wanted to learn about the experience from the participants' perspectives by allowing the participants to "tell their stories." The interview guide, however, was also intended to help keep the researcher focused on the research topic by providing examples of questions to ask the participants regarding their experiences with family communication in families with an adult palliative member. What became apparent as the data collection was initiated and the interview transcripts were reviewed was that the interview questions were not well developed and did not always meet the needs of the study. For example, in each of the initial interviews and the first follow-up interviews, participants provided rich descriptions of their experiences with families with palliative members but these descriptions did not generally provide specific data related to the research questions.

The development and testing of the interview guide resulted in the interview guide being revised three times. It is important to note that while the revision of the interview guide was an ongoing learning process for the researcher, it was also, therefore, an ongoing challenge to the study. A discussion of the interview guide revision process will now be presented and examples of participants' responses to selected questions will be provided to illustrate both the ongoing development of the interview guide and to provide examples of the type of responses to the questions. It is important to note that the interview guide was not consistently utilized in interviews following the first revision for two reasons. First, the researcher had planned to use a
mainly unstructured format with the intent to allow participants to tell their stories and second, the researcher found the interview guide distracting to use in the interviews. The researcher used the interview guide more consistently in the follow-up interviews.

**First Revision of the Interview Guide**

The researcher designed the initial interview guide with some recommendations from her committee (see Appendix C). This initial interview guide was further revised with input from the thesis committee (see Appendix D) in an attempt to make the questions more focused on family communication in families with an adult palliative member. In the pilot interview, the researcher had both interview guides present due to her lack of confidence in her abilities to facilitate the interview to obtain data to meet the purpose of the research. Questions from both these interview guides (Appendix C & D) were used because the researcher thought some of the questions were similar, as well as, the researcher wanted examples of questions that offered alternative ways of asking the participant for information. In reflecting back, although some of the questions were similar in both these interview guides, the order in which they were organized was different and the questions still did not address the homecare nurses’ perceptions of the influence of their nursing behaviors on family communication. Some of the questions from the interview guides (Appendix C & D) were piloted in an initial interview. This preliminary interview allowed the researcher to identify several issues with the nature of the questions, the wording and the sequencing of the questions. The initial questions in both these interview guides, “What would you describe as the purpose of family communication?” and “Based on your background and experience in homecare and palliative nursing, what does family communication mean to you?” were not related to the research question and were very difficult for the participant to answer. These questions did not provide a positive way in which to start the
interview because it increased the participant's anxiety about her ability to participate in the interview and research process. Although questions 3 and 4 in the interview guide (Appendix D) attempted to obtain data to answer the research questions, the other questions did not. For example, question 5 asked, "Can you tell me about an experience in which you believe an adult palliative patient and his/her family communication has a positive effect/outcome on the patient and/or family members?" did not address any of the research questions. Although the intent of questions, such as "Please share a story with me about an experience or incident that you believe is an example of family communication in an adult palliative patient and his/her family?" was to gain an understanding of what the nurse observed family communication to be and from this observation then explore under what circumstances she would intervene and how, the question was nonspecific and did not result in any data that met the needs of the study. The sequence of questions was also not logical and revisions were made to more closely reflect the purpose of the study. As a result the following revisions were made and subsequent revisions to this guide will be labeled second and third drafts.

Second Revision of the Interview Guide

The second revision of the interview guide included several changes (see Appendix E). The opening question was revised to "Tell me about the most recent experience you had with a family with an adult palliative member" (see Appendix E). While this open-ended question allowed the participants to relate their most recent experience with a family with an adult palliative member, the data did not generally relate to family communication but more to a description of their involvement with a specific family. An example of a participant's response to this question was the following:

I. If you could tell me about the most recent experience you had with a palliative care patient. I'm looking at adult palliative care, not children or adolescents, but adults. If
you could just tell me about a situation of what that family was like, and what your involvement was with that family.

P We have a lady, just at the moment, she's seventy and she has rectal cancer. She had an abdominal-perineal resection two years ago. She's from Mennonite background and had a very tough growing up. She has very stringent ideas about control issues. I think in the last several months she has reappeared at the doctor with obvious symptoms of encroachment of the tumour.

Another participant responded in a similar manner to this initial question with a description of the palliative individual and family. In addition, this participant also alluded to some of the family dynamics:

I would say an elderly woman; I think she was approximately late seventies, maybe early eighties. It started with ca [cancer] in her breasts 10 years ago and she had a radical mastectomy. And then it went to ca of the bowel that meant within the last five years she has had an ileostomy, radiation and chemo. At that time, she progressively deteriorated and then moved in with her son and daughter-in-law. As her condition deteriorated the daughter-in-law became the primary caregiver, left her job and became the primary caregiver. The son was involved but not extremely active. He helped within the home but the primary caregiver was the daughter-in-law. And there was a very close relationship between mother-in-law and daughter-in-law, but a lot of the family dynamics was through the rest of the children. They would question a lot of the things that the daughter-in-law would make about the decisions in the care. They wouldn't come and help that much, but they would question how she would do things. That's the most recent one that I've been doing.

Another question in this interview guide referred to asking for a description of an experience that was different from the previous experience. The intent of asking this question was to prompt recall of a full range of experiences and to encourage participants to explain the strategies they used in different situations. While participants did relate situations with families with palliative individuals that were diverse, once again the descriptions lacked specificity in relation to family communication. When asked the question, “Can you tell me about an experience that was different from the one you have just described?” participants generally described an experience that was the exact opposite of the experience they had previously described. For example, one participant described an experience with a family in which the
family members came together to talk about a conflict in the care of the palliative member and were able through this to resolve the issue and work together to support the palliative individual. When asked to describe an experience that was different from that one, the following situation was described:

A client, I think he was approximately in his sixties and a very dysfunctional family. And he was quite a dysfunctional man in his entire approach to life, period. He was estranged from most of his siblings and lived with his elderly mother and basically expected her to be the primary caregiver. He ended up with ca of the bowel and had a colostomy done. And he had a wound that never healed and [therefore] about three years later or two years later he was brought back onto our program in the last stages. The cancer had now spread and invaded into his bladder and he had quite a progressive tumour growth. Very quickly he became confined to bed. This man's lifestyle, he was from a gay lifestyle and his mother was angry regarding that. His siblings were not pleased with that and he basically had alienated them. He was not a very pleasant person. Very aggressive, verbally and had been physically aggressive in the past. So not a pleasant environment to be in, period. A lot of people had backed off [from him], you know, saying I'm not dealing with you. He would be quite abusive with his mother, verbally abusive, with his elderly mother who was doing the bulk of his care. She was ninety. It just was not a good situation. Very verbally abusive to anybody that came in. It was not pleasant at all.

Another participant described a situation such as:

When they are more and more ill, again families tend to be just exhausted. And so then sometimes emotions are really raw and so suddenly the sisters can't stand one another or the brother says what do you think you can do. Suddenly there will be one caregiver for someone who's been at it for a long time and has done a fairly good job with or without mistakes, then the out-of-towner comes along and decides how they're supposed to be doing things and suddenly there's a lot of friction there. Because they see the end coming and you know it's just natural that their emotions run raw.

As demonstrated by these responses to the interview questions, participants did recount their experiences with palliative care individuals and their families but the data obtained from these interviews once again did not provide a rich description of the homecare nurses' experiences in influencing family communication. In an attempt to obtain a more comprehensive description of the participants' experiences, follow-up questions were posed to participants to clarify and facilitate a recounting of the experiences. At times the follow-up questions were directly related
to the experience being described, whereas, at other times the questions were used as a probe to elicit further information. An example of a question used as a probe to elicit further information was “If I were to ask you what would you see in a family that was communicating, what would see, what would you hear, what would you feel? One participant responded by describing how the family ensured the palliative individual was included in the family day-to-day activities:

They'd even go so far as, you know, take the hospital bed and turn it so he would have different views to look at in the room. He wasn't the type, he didn't like to read, he didn't like anyone to read to him. He would watch a little bit of T.V. more towards the beginning but lost interest in that later. They had the music playing in the background to make it more soothing. She [daughter-in-law] was able, because they were both in the corrections service, she was able to bring files home and work at the table right there. So she would do that a lot of times. So she would do her sewing in the same room, because he was in the family room. She was able to sit there and be in the background if he needed anything. So they made a real commitment to do that for him.

Another participant responded to this question with the following response:

I think you have go with your instincts, and you have to listen to the feelings that you get in the home and you can feel a sensitive person can feel a vibe from people, and sometimes you just know that because Don has brought Janice a drink of water with a smile on his face that you achieved what you wanted. Even though he's never said, you know Janice, I'm really sorry and, you know, you just know that you achieved it by the non-verbal expression and sometimes it's difficult, a physical act. Some families are only going to show just tactile physical skills. You may never achieve that hug or that open feeling from them.”

The following question was used to clarify the participants’ experiences and to describe differences and similarities in the experiences in relation to communication within the family:

“So given those two situations, I mean, there's some obvious differences between the families. So in terms of communication, do you think it was quite different also?” This question was posed to a participant who had just described two experiences with two different families with an adult palliative member and in each situation the family was coping differently with having a family member who was dying. The participant responded with the following response:
Yes I do, because one family was willing to see there was a problem, when it was brought to their attention. They didn't realize there was a problem. It was perceived as wanting the best for Mom and questioning whether this was the best. It wasn't perceived as a problem. Um, when it was brought about that there’s tension here, things aren't going right, what can we do about it? Suddenly it was, oh dear, that's not what we wanted, and they were willing to work with that and work through and discuss it. The second family, um, I feel we did make some strides in communicating with mom to bring her to see that she is not as guilty and to work through some of those feelings of guilt, but as far as actually being successful at bringing the family together, no.

While probes and follow-up questions were used, at times the participant responded with an answer that did not further clarify the experience and repeated attempts only served to make the participant anxious because she felt she was not “doing well” in the interview and requested reassurances from the researcher. Other times, the researcher did not use follow-up questions because the participant was in the middle of describing a situation and it did not seem appropriate at that time to interrupt, and although the researcher later sought clarification by redirecting the participant back to the situation with a prompt such as “I would like to go back to the experience you have just described and can you tell me more about...,” at other times follow-up questions were not asked and, therefore, limited the richness of the data. Follow-up questions were at times not asked because the participant had proceeded to a description of another situation, as well as, the researcher at times was caught up in the type of experiences being described. In addition, the researcher did not have a clear understanding of the type of questions to ask to elicit the data to answer the research questions and did not have a clear understanding of the type of data necessary to answer the research questions.

Although all of the homecare nurses provided some data in relation to family communication, the data lacked specificity in how and when they influenced family communication and what they perceived to be the influence of their interventions on family communication. One participant described an experience she had with a family in which the
woman was palliative and the primary caregiver for her husband who had Alzheimer’s. There were two daughters in the family who were visiting from out of town and as the woman was becoming more ill, the nurse felt the need to open the discussion with the family about the future care of the woman’s husband:

Her husband, for example has Alzheimer’s. So when she goes, Papa has to go somewhere. So you have to start talking that way as well. What’s going to happen to Papa? Who’s going to look after him? Where is he going to go?

Nurses attempted to describe the roles they perceived they had in family communication but these descriptions lacked detail or represented a limited range of responsibilities. One of the roles the nurses perceived they had was that of a facilitator to bring family members together:

Sometimes one of our roles is to actually say, it wouldn't be bad to have a little consult, including the person and whomever.

Another role the nurses described was one of acting as a resource. For example:

If there's a lot of family communication problems, we only have so much time in our day that [we] can deal with that. So at that point in time, I would do a referral to a social worker with their permission.

In the interviews, nurses focused more on supportive nursing strategies and comfort measures provided to the palliative individual rather than their actions to influence family communication. The interview guide was therefore revised and used in four additional interviews.

**Third Revision of the Interview Guide**

The revision to the interview guide included the redesign of the trigger questions in an attempt to obtain data that related specifically to family communication and to provide specifics of when, how and with what intent homecare nurses intervened in family communication in families with adult palliative individuals. The questions were, therefore, more specific to family communication and what and how the nurse intervened. In addition, questions were revised to
obtain specific data about how the nurse interpreted these interventions as influencing family communication (see Appendix F). Again, the interview guide was used as a means to facilitate and clarify the participants’ discussions. In contrast to the previous interviews, in these four interviews conducted with the revised interview guide, participants were able to articulate responses to the initial question that also provided data to some of the other questions. This may also be related to the fact that this was a third interview for three of the participants and they may have become more adept at responding to the questions and in determining what the researcher was interested in hearing about. To illustrate the increased efficacy of the questions in providing data that was relevant to the research questions, some examples of participant responses to selected questions from this revised interview guide will now be presented.

The first question asked participants to “Tell me about a situation in which you interacted with family members in a family with an adult palliative member.” If the interview guide was being used in a follow-up interview, the participant was reminded by the researcher of an experience they had previously described and then asked “In relation to that situation can you tell me how you tried to influence the family’s communication? What did you do/not do to try to influence their communication? Walk me through the situation.” A response by one participant was as follows:

That was one visit in which I walked into the home and I felt coldness. It felt like I was walking into the freezer at Save-on-Foods and so I went and saw the patient, the mother-in-law. While I was doing some care for the mother-in-law, I asked her what's happening, and the mother-in-law said nothing. I said, well I feel there's coldness in this house and that's not normal, it's actually usually a very warm, very welcome visit. It's not how I've been experiencing it. So the mom then said there was some issue with her daughter-in-law because mom had talked to another son who was from out-of-town and had complained about the care that the daughter-in-law had been giving. Not complaining so much, as I'd describe it as just trying to assert some control over the situation. Control that she felt she was losing through the palliative care disease process. And she had just said that you know there are small things that she had asked for to be changed. Like to
have the medication at a different time, but the daughter-in-law had felt that the mom was questioning her and she had felt that she wasn't being appreciated.

As a probe to follow-up this example, the question “How did you know whom in the family to start with?” was used to elicit information about family dynamics and communication patterns. The following quote illustrates the effectiveness of this probe in eliciting the nurse’s perception of the family’s communication patterns:

So after talking with the mom and getting an idea I shared with the mom how the daughter-in-law was feeling and then brought them together to talk about it. I usually do start with the patient because that's whom we have gone into the house to see. But then certainly, I will address some of those other issues that I feel are happening. I usually try to seek out either the patient or the caregiver just to see how they're dealing with the situation and get their feedback on it or their concerns about the situation. And then I may also just start with any of the other family members that I feel have some concerns or I feel that they are not comfortable with what's happening. I'll seek them out also.

When the participants were asked, “How did you get the family together?” most of the nurses provided examples in which they invited the family members or asked the patient or caregiver to invite family members to be present for a family meeting. This is exemplified in the following quote:

Other family members were coming into town later that week and so I arranged to meet with them all at a visit. I asked the mother-in-law to make sure that the family knew that I would be there and for them to bring any of their concerns to this meeting.

The questions that three out of the four participants had difficulty responding to were the questions that asked for a description of the nonverbal communication and of the feelings that were being expressed or not expressed by the family members. The questions that were asked to elicit information about the family’s nonverbal communication and the nurse’s interventions were “What were some of the nonverbal communications that were occurring?” and “How did you assess and intervene with this?” Three of the participants had difficulty recalling specific examples of the nonverbal and the emotions of the family members. In addition, when asked to
describe how they responded to family members' nonverbal behavior, they provided very
general examples of how they might respond if they noted that a family member was upset or
angry. In responding to a family member's nonverbal behavior, some of the nurses stated it
would depend on the situation and on how they interpreted the situation, whether they would
comment on the nonverbal behavior or not. This is exemplified in the following example when a
nurse described a situation in which a family member was sitting at a distance from the other
family members and not interacting with them, and when asked how she had intervened in this
situation the nurse stated:

For my own self, I think you have to, sort of, intuit when you look at the person. I just felt
from the depth of what I saw and her non-verbal. Like it just seemed she was holding all
her pain in. I just felt from that it wasn't a good time to try to have her come into the
group.

The nurse in this example did not clarify her perception with the individual and chose to not
explore how that individual was feeling. Similarly, when another nurse was recalling a visit with
a family and was asked, "What were some of the nonverbal communications that were
occurring?" and "How did you assess and intervene with this?" the nurse described a situation in
which she felt some tension in the home in particular between the patient's wife and mother but
due to her interpretation that they did not want to talk about it, she chose not to intervene:

It was difficult to try and somehow penetrate or enter into what was perhaps going on.
That's it, and I think it was that they didn't really want me to suggest that we sit down.
That was their way of coping.

In contrast, the fourth participant responded to the questions about what were some of the
nonverbal communications that were occurring and how she intervened with a specific example
of how she intervened and how she perceived this to have influenced the family communication:

I noticed the son had said something that the sister was reacting to non-verbally. I let the
son finish and then I said to the sister, Susan [name changed] I see, I may be wrong and
maybe you can clarify this for me, but just by looking at the way you are sitting in the
chair with your arms crossed, you look kind of closed in, you look a little upset with what Jim [name changed] is saying. I then left it up to the family member to either share what she was feeling with the rest of the group or not. But I certainly would comment on what I was seeing within the family group because I want things to be open, to share.

In the four interviews in which the revised interview guide was used, the participants were able to provide some important data related to family communication. This revision of the interview guide was, therefore, more successful in obtaining data that addressed the research questions of this pilot study. In relating their experiences, however, the participants still had difficulty in articulating the nonverbal communications of the family members. Responses to the interview questions also did not provide any description of how the nurses’ nonverbal or behaviors may have influenced their interventions with family communication. There was also no description of the context in which these interactions took place and whether the nurses’ behaviors, both verbal and nonverbal, were influenced by the context of the home and the family.

Challenges of the Interviews

The quality of the interview process was dependent on several factors. These factors included participants, interviewer characteristics and skills, and the interview questions. The ability of the interview questions to elicit data meaningful to the study has been discussed. The challenges associated with conducting an in-depth interview as a means of data collection will now be presented. These challenges related to 1) the ability of the participants to articulate rich descriptions of their experiences in intervening in family communication, and 2) the researcher’s skills in conducting in-depth interviews.

Participants

Participant selection is critical to obtaining data that addresses the research questions. Participants must have the ability to provide rich, accounts of their experiences in order to provide useful and adequate data. Some of the participants were not able to describe their
interventions in family communication other than in generalities. Many digressed frequently from the research topic. The majority of these interviews took place at the end of the participants’ workday and this may also have influenced their ability to concentrate on providing descriptions of their experiences. Although it is recognized that some people may be more difficult to interview than others, an essential task of the researcher is to motivate and facilitate the participants’ experiences and to obtain interview data that is rich in detail in relation to the research topic.

**Researcher Characteristics and Skills**

The researcher needs to have the abilities to facilitate and obtain rich data. The researcher must, therefore, have the skills to make choices about what to ask and how to ask. The researcher’s skills in composing questions, sequencing questions and knowing when to follow-up the participant’s stories appropriately to gain a comprehensive and descriptive account of experiences that related to the research questions was an influencing factor in this study. What became apparent through the analysis of the interview transcripts was that this was a skill that the researcher needed to develop. Ongoing learning of these skills occurred throughout the course of this pilot study. Skills that were improved on throughout these interviews were the ability to structure the interview, ask clearer questions, guide the interview, and recall and interpret what the participant stated. These skills will now be presented in relation to the interview process and their influence on the findings.

**Structuring the Interview**

The need for the researcher to structure the interviews became apparent as the interview transcripts revealed large amounts of data that were not pertinent to the research topic. This also related to the design and use of the interview guide. The second revision of the interview guide
resulted in data that addressed the research questions. By the third follow-up interviews the researcher also reviewed the trigger questions with each participant prior to starting the interview in order to provide the participants with information about the direction and focus of the interview. These interviews were also concluded with a summary of what had been discussed and whether the participant had any questions or anything else to add. This technique often resulted in further clarification or the relating of other experiences.

**Asking Clearer Questions**

Asking clearer questions related to both the interview guide and the researcher’s ability to pose clear, simple and short questions. At times the researcher’s questions were long, awkwardly worded and directed the participant to answer with a very limited response. An example of this was:

“What do you see as the homecare nurse role in the family interaction or helping people towards closure? What do you think?”

Another example of this was:

Is it sometimes hard for people to actually say things to a family member? If I was a patient and I wanted to say something to a family member. Such as, to resolve some issues. Sometimes, do you just help that person find the words or role play with them to help them approach the family if they are not ready to hear or talk about it?

The use of reflective and evaluative statements also limited the participants’ responses. For example:

I've certainly heard, from your experiences that everyone is so different and what works with one may not work for the other one. So you go with what you know of the family and how they are working together, or not. But what I've certainly heard from you is sometimes you are really up front in saying, you know, you really need to talk about that. Like with the first example. There are things you have to talk about, or otherwise it's going to be done and you won't have said those things.
As the interviews progressed and the skill of the researcher in guiding a qualitative interview improved, the frequency of these types of statements decreased and more use of prompts such as “mmh” were used to encourage the participant to continue.

Guiding the Interview

Guiding the interview referred to the researcher’s abilities to direct the course of the interview and to know what she wanted to find out about and what was important for the research. In this study, the researcher at times lost track of the focus of the research, due in part to the type of responses and experiences the participants were recounting, as well as, the amount of data that in-depth interviews provide. An example of this was in the second follow-up interviews when the researcher sought clarification of situations from the initial interviews with the result that the focus shifted to the process of homecare nurses’ interaction with families and their roles with family communication rather than the nature of the intervention they used to intervene in family communication.

Recalling and Interpreting What was Said in the Interview

The ability to retain and recall what a participant has said throughout an interview, as well as, the ability to continue to interpret and clarify the meanings of the participants’ descriptions in interviews was difficult, especially at the end of a work day and with many interruptions in the interview setting. Other than three interviews, the interviews all took place in the homecare office, generally in the staff coffee room. Although the interviews were scheduled at the end of the workday, the interviews were often interrupted when others came into the coffee room to speak to the participant, or to obtain coffee. These interruptions were disrupting, so interviews were usually stopped until those who were interrupting left the coffee room.
In the third interviews, a revised interview guide (Appendix F) was used. In addition, prior to each of these interviews the researcher reviewed with the participants the nature of the questions in the interview with the intention of providing the participant with the direction of the interview and to allow them to tailor their responses to these areas of discussion. In the third interviews, with the use of the revised interview guide and with the increased skill of the researcher, the analysis of the interview transcripts revealed some preliminary data that related to the research questions.

Preliminary Data Coding Schema

In this section of the chapter, some examples of the preliminary data codes are presented and described in relation to the nature of the data that the codes represented. These preliminary data-coding schema were obtained from the four 3rd follow-up interviews as well as from the analysis of interview transcripts from previous interviews. These codes were developed to represent the emerging concepts. The coding captures some of the ways in which nurses intervened in family communication and their perceptions of the impact of their interventions on family communication. It must be emphasized that this is only a tentative working code schema and must be viewed as such and that some of the data fit more than one code. The selected codes are described in order to provide some direction for future studies. Future studies will need to explore and interpret whether these codes do in fact represent homecare experiences of influencing family communication and the nurses’ perceptions in relation to the impact of their interventions on family communication. The following preliminary codes will be presented: creating a family circle, speaking for, bringing it out into the open, taking the time, and family rules.
Creating a Family Circle

Data related to this code was apparent throughout the interviews and reflected how the nurses and the family members positioned themselves for family discussion. For example one nurse stated:

It was a family circle around the bed and it was a big enough room to sit because some of the furniture had been removed. There was a hospital bed in the room and so they brought in chairs for everybody and it was a semi-circle around the bed.

Family circles generally occurred wherever the palliative individual was and, therefore, could take place in the bedroom, family room or kitchen. One nurse stated that if the palliative individual was not able to cognitively participate in the meeting then she did not always have the family discussion where the patient was. All of the nurses stated that they allowed the family to seat themselves in the circle because this allowed the family members control over the process.

As one nurse stated:

I tend to let people take their own seats in the circle. I don't try to seat the people or do anything like that, because, people pick where they are most comfortable and if they are comfortable where they are sitting then that opens up the communication because people feel safe and comfortable and secure in being able to share. Otherwise if you tend to seat people, they're so uncomfortable, maybe where you put them, they are not able to participate as much as they would normally be able to or want to in the situation.

Where the nurse seated herself in this family circle varied among the participants. One of the nurses talked about allowing the family to determine where she would sit and this was usually determined by the family either verbally indicating to the nurse where to sit or was implied by leaving a chair for the nurse:

I tend to just sit where the family has left a chair for me to sit. I don’t select a seat in the circle. I just wait to see what chair is left empty or what the family feel is my place to sit. This gives the family control over the situation and gives them comfort in that I am not dictating how that process is going to be, because it's their issues that need to be shared.
The other three nurses described how they positioned themselves next to the palliative individual. This tended to occur if the family was meeting to discuss issues involving the palliative member. One nurse described a situation in which a family meeting was arranged to discuss the treatment of the patient and, therefore, she arranged herself next to the patient in order that the focus would be on the patient and the plan of care:

The meeting itself was around the patient in the family room. It was actually a large, long room and there were many chairs and we were just in varying circles around her. The family was grouped and sort of semi-circled around. I was standing by the patient's head. I wanted everybody to see my face and to see her and for her to be the focal point and so that we could all have eye contact.

Another nurse described positioning herself so that she was not in between family members, because she did not want the family to feel as if she was dividing them, as well as, she did not want to feel as if she was refereeing the discussion:

I usually feel more comfortable, personally, if in fact, they are together or maybe they're opposite each other and you're not directly in between them then I feel I'm not trying to divide them. If I find that, in fact, I'm bang in the middle and they're on either side of me, I feel like I'm sort of a referee and I mean it happens and you can't really change that but I try to do it that way now, and also it allows, if someone else comes by, I can just go to one side and someone else can fill in. It's like I, if I foster a sense of togetherness.

What has been described in this code relates to power and control of the interaction and poses questions that need to be explored in a future study. What would the family communication be like if the nurse positioned family members? Would there be a change in the power and control of the interaction? Would there be a change in the power and control of the interaction if the nurse positioned herself? What makes family members chose where they position themselves? What if the nurse did not position herself next to the palliative family member, would this influence the family communication? What effect does the nurse’s position have on the organization and sequence of the interaction, and how is this influenced by the focus/purpose of the interaction?
Some of the nurses described experiences in which they spoke on behalf of a family member or the palliative member when they believed this person was unable to speak for herself/himself. Reasons why they felt an individual was unable to speak for herself/himself related to the individual’s past communication patterns, family dynamics, and assumed roles within the family. All of the nurses stated they spoke on behalf of a family member as a means to ensure that family communication was open and correctly interpreted by themselves and other family members. For example, one nurse described a situation in which a family member had returned home because her father was dying, and on her return she did not feel she was able to participate in her father’s care. The daughter felt because she was from out of town and had just arrived and because her mother and sister seemed organized with her father’s care that she had no right to assist with any of the care. As a consequence she felt alienated from both the experience and her family and did not feel comfortable sharing these feelings with her family. The daughter had voiced this concern to the homecare nurse and the nurse spoke to the other family members on behalf of the daughter. The nurse explained her actions:

Sometimes I feel I have to speak for an individual who is not able to speak for themselves to other members and to support them and then try and open up the communications that way. For example, if someone is feeling left out of providing care and they don't feel comfortable saying that to the caregiver. Sometimes I have talked to the caregiver on behalf of that individual and then brought them together to share those issues. Sometimes having that first discussion with each individual just makes it a little bit clearer, a little less defensive and brings them together so they are able to open up and share their feelings.

In a similar situation, a daughter had arrived from out of town when her mother was dying. The mother and father lived with the son, and after a homecare visit the daughter walked the homecare nurse out to the car and told the nurse that she felt her mother’s time was short and that she did not know how to tell her father and brother that she felt excluded from the experience. The nurse recalled the daughter’s disclosure:
[She told me,] “I’m feeling excluded and I feel without power in the family circle that’s happening right there [at the bedside], and I need to be able to experience this time as a gift while mom’s alive, and I want her to know the things that are in my heart before she dies.”

The nurse stated the daughter was not comfortable saying this herself to her father and brother and, therefore, she agreed to share these feelings with other family members in the daughter’s presence. The nurse recollected the way she presented this information to the woman’s father and brother:

[I told them] It would be wonderful for your daughter/sister to be able to help with this because she’s feeling kind of a bit alienated and doesn’t really know how to go about helping you because you all seem so organized and so comfortable.

This code also raises questions to be further explored in a future study. Questions such as, What would be the effect on family communication if the nurse did not speak on behalf of the family member? Does speaking on behalf of a family member alter family communication patterns or facilitate further communication about important issues? Or does speaking on behalf of others maintain communication patterns that are not open? What is the effect on other family members when the nurse speaks for a family member? Do other family members view this strategy as helpful, or unhelpful? What factors make it difficult for a family member to speak for her/himself? What strategies could the nurse utilize to empower the family member to speak for her/himself?

**Bringing It Out Into The Open**

This tentative code relates to situations in which the homecare nurses described how they helped families communicate by ensuring that everyone knew what the other was feeling or thinking. The nurses stated that family members sometimes do not clarify with each other how they are feeling and, therefore, they sometimes need to make family members aware of the thoughts and feelings of each family member. To do this the nurse directed attention to the nonverbal behavior of a family member by commenting on the nonverbal behavior:
Bring it out into the open and for that I’d just ask, “I noticed that you were awfully quiet when we were talking about this, do you have any questions or concerns?” Or “I noticed that you are standing quite far apart.” That sometimes just breaks the ice and lets families talk with each other.

In another situation, a nurse was visiting a palliative patient who was living with a son and daughter-in-law and they and another son were providing care to the father. In this situation when the father had been diagnosed as being terminal, the mother could not care for him at home and he, therefore, was placed in a long-term care facility. He was in the long-term care facility for about a month and then his son and the son’s wife had brought him to their home to die, because they did not want him to be in the nursing home and did not think he was getting the care that he needed in his last two weeks of life. On one of the nurse’s visits, the mother arrived and told the sons that they were not going to be able to take care of their father and that they should have left him in the nursing home. The nurse noted that this upset the sons and, therefore, asked everyone to sit down and discuss the situation. During this discussion she thought it important to comment on the nonverbal behavior of the son:

I made a comment to the mom that the sons were doing the best that they could and that they were doing well with the care for their father and that this is where they would like him to be. The mother replied, “Just don’t expect me to be able to participate because I’m just not able to and I don’t want to.” Then I noticed that the younger son looked very upset about this. He was kind of fidgeting in the chair with a look of disbelief on his face. So I asked the son, how did he feel about what the mom had just said. He said, “I just have a hard time with that because that isn’t my view of family, I think family should stay together and should support each other and I just find it very hard that she doesn’t want to be part of this experience for Dad.”

All of the homecare nurses commented that by bringing things out into the open family communication is more honest and open because everyone knows what the other is thinking and feeling. Issues and feelings are not hidden; they are shared and are resolved. Another nurse described a situation where was conflict with what the daughters wanted and what their palliative
mother wanted. In a family conference the nurse asked the daughters to share with each other and the mother how they were feeling when their mother refused to take any analgesia for the severe pain she was experiencing:

I think that may have helped the daughters communicate more directly with the mother. That these things are brought out into the open and the words are said.

This code also raises questions that need to be further explored in a future study. What would the impact be if the nurse did not share her observations to stimulate open communication? Are there strategies that nurses use to assist family members to voice their own concerns and feelings to each other? How can the nurses empower family members to speak for themselves? What would be the impact on family communication if the nurses stated that a family member had an issue to discuss with the family and then facilitated the family member to relate the issue? Are there times when bringing it out into the open can unnecessarily increase conflict? How do nurses manage conflict when it arises? Are there times when they should not be brought out into the open (for example when the strategy is not used)?

Taking the Time

Taking the time refers to the nurses needing to take the time to ensure that they assess how the family is coping and how family members are communicating with each other. Taking the time was related to the nurses having the expertise to assess and intervene, having enough time in their workload to assess and intervene, having the support of their colleagues and supervisors, and having the energy to intervene. In addition, several of the homecare nurses commented that there were some families that they related to more than others and at times were more willing to take the time and assist the family.

Having time in their workload to assess and intervene in family issues was a factor for some of the nurses. Some days their workload did not permit them to take the time to intervene
with family issues and all they could do was ensure the palliative individual was comfortable and the family had the technical information to care for the palliative family member. Other nurses stated their workload did not impact the time they took with each palliative individual and their family. As one nurse stated:

But I know if I have palliatives, I very often leave them until a little bit later in the day, um, for different reasons. One is, except for a bad night, then sometimes they'll lie in for that little bit in the morning so I let them do that. But one of the other things is, I can zip through dressings and what have you, and then I can put as much time as they [palliative] need and I never ever, I mean I might run in and say to a patient, “Oh, it's busy this morning, you know, I'm just going to,” and I might rush a dressing or a drain or whatever, but I never, ever rush a palliative. I would never in a million years say to a palliative, “You know, it's been an absolute zoo, I'll have to go.” If they need an hour, they'll get an hour, if they need three hours, then they'll get three hours.

Having the support of their colleagues and supervisors was important to the nurses. It was important because the support enabled and encouraged the nurses to continue to deliver nursing care to palliative individuals and their families and provided a means for the nurses to brainstorm with each other strategies of dealing with issues and to use each other as sounding boards. Through this support and assistance, the nurses stated that they were able to continue to take time to assess and intervene with families with palliative individuals even when faced with major family crises. As one nurse stated:

Sometimes we talk back at the office and, sort of say, “What have you seen?” So actually that's helpful because somebody might have seen another person reacting in a different way. So we brainstorm.

Having the energy also influenced the amount of time a nurse may take with each family. Many of the nurses described experiences that were very difficult for them due to the family dynamics that were occurring in some of the families, the complexity of the care the palliative individuals required, or to the number of palliative individuals they had on their caseload at one
time. As one nurse stated, if the nurse did not have the energy she may not take the time to assess and intervene with a family:

We need to just take the time to do that, to have the energy because it can be very, very draining dealing with some of the family dynamics and family issues. But we have to have a commitment to look at the family holistically not just the individual. To look at the family members and how they are doing and what they are saying and what they are not saying because sometimes that's the clue when these families aren't saying anything or they're not answering questions.

Another nurse described an experience in which she found she did not have the energy to assist the family. This was a situation in which there was much anger and arguing between family members:

Sometimes with your own life you're busy, and you know sometimes these families can just overwhelm you. Every time you walk in the door all the questions and the anger and then, you know, I find sometimes that I back away, just because I can't keep up with it all.

Many of the nurses recounted experiences in which they related more closely to some families than others. In describing these experiences, the nurses also related the extent to which they intervened with these families. For example, one nurse recalled how she had personally contacted an estranged daughter of a palliative patient to ensure that the daughter visited her mother before she died. The nurse stated she knew it was important for this palliative individual to be able to talk in person with this daughter and, therefore, she did what she could to ensure that this happened. In contrast, if a nurse did not have a good working relationship with the palliative individual and family, she did not always take the time to assess and intervene in the family issues other than to ensure the palliative family member's symptoms were being adequately managed.

These data also raise areas to be explored in a future study. For example, how much time do nurses perceive they need in order to assess and intervene in family communication? What is
the 'ideal' amount of time to establish a therapeutic relationship with a family with a palliative member? What workplace support is necessary or ideal for homecare nurses to have the time to intervene in family communication? Do regular debriefing sessions enable the nurses to have the energy to continue to support families, particularly those with major issues or crises? What are some strategies that nurses could utilize in their interactions with families perceived as being 'difficult' or 'challenging'? Do nurses use different strategies in intervening in families that are perceived as difficult? How do nurses view their roles and responsibilities in interacting and intervening in families perceived as difficult?

**Family Rules**

Several of the nurses alluded to family “rules” or norms of family interaction and that sometimes families are not willing to change family communication patterns. The nurses thought families were reluctant or unwilling to change communication patterns because of past family history and the roles and responsibilities individuals had within the family. For example, when one nurse was asked, “What influence do you think your nursing strategies have on family communication?” the nurse responded by stating that she did not think she could always influence family communication. She believed that sometimes all she could influence was what was currently happening with the family communication, and that the long-term family communication patterns would not be changed due to family dynamics and an unwillingness to change behaviors. As this nurse stated:

*Family members tend to stay with the roles that they are comfortable with or their responsibilities or with the pattern of communication that they have been using and are usually quite comfortable to do that and so I don’t see that I am always going to change how families communicate, their overall pattern of their communication of who can say what to so and so, and visa versa within the family. Those are those family rules that sometimes are laid. Sometimes with the length of time that we have with the palliative family, we are not going to change the long-term pattern of the communication. But what I am trying to do is make this experience very open.*
These data raise questions as to what strategies the homecare nurse could use to elicit a change in the family communication patterns. How does the nurse assess family communication patterns? What role does the nurse have in influencing family communication and what role does the family perceive the nurse to have?

These selected codes are presented as preliminary codes derived from the interviews in this pilot study. Whether they are accurate representations of the data or are only representative of this set of data will be determined in future studies that describe how homecare nurses support family communication in families with an adult palliative member.

Summary

In this chapter the findings related to the challenges encountered in conducting this research plan were presented. Challenges related to the research process included limitations in the method of participant recruitment and selection, as well as, limitations to the data collection method of the use of an interview guide and the challenges of conducting in-depth interviews.

Participants were recruited for this study through the request for volunteers from homecare nurses in the Fraser Valley. This limited setting and method of recruitment resulted in a homogenous sample of participants who were all female, Caucasian, experienced, diploma-prepared homecare nurses. Most of the participants had difficulty describing their experiences in relation to the research questions. The interview guide and the quality and sequencing of the questions were also a significant finding in relation to the research process. The interview guide required several revisions and testing before the questions were successful in eliciting data relating to the study’s purpose. The challenges associated with conducting an in-depth interview as a means of data collection related to 1) the ability of the participants to articulate rich descriptions of their experiences in intervening in family communication, 2) the ability of the
interview questions to elicit data meaningful to the study and 3) the researcher's skills in conducting in-depth interviews. What became clear was the need for the researcher to be focused on family communication and that the interview guide needed to be composed of questions that were focused on the domain of family communication. Finally, some preliminary data codes were provided from analysis of interview transcripts, primarily from the last four interviews in which the last draft of the interview guide was used. The preliminary codes of "creating a family circle," "speaking for," "bringing it out into the open," "family rules," and "taking the time" were presented to illustrate some of the themes found in the data collected from these interviews and to provide some direction for future research in this area.

In Chapter Five, a discussion of the findings in relation to sample recruitment and selection and the use of in-depth interviews as the main data collection method will be discussed. The preliminary codes will also be discussed in relation to the communication and family literature.
CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

As stated in Chapter Two, the purpose of this research study was to lay the foundation for a full-scale study to describe the nature of homecare nurses' experiences in supporting family communication in families with an adult palliative member. This pilot study provided the researcher with the opportunity to gain an understanding of the research process, and to test and refine the research methods. The selection of participants and the method of data collection were challenges in this pilot study. A discussion of these challenges will be presented in this chapter. This discussion will then be followed by a discussion of the preliminary codes in relation to the literature.

Recruitment of Participants

Recruitment of participants proved to be one of the main challenges experienced during this study. The nature of the challenges included a limited number of participants, their homogeneity and the ability of participants to articulate their experiences in relation to the research questions.

There were several reasons why the recruitment of participants was challenging. These reasons related to the education and experience of the homecare nurses, hiring practices of homecare nurses in this region, the homecare nurses' beliefs about palliative care, as well as, the actual recruitment strategies used to obtain participants. A brief discussion of each of these factors will now be presented.

The area of the Fraser Valley, where the pilot study was conducted, is a fairly small region in terms of the number of homecare nurses. An inclusion criterion for the study was that the homecare nurses have a minimum of two years homecare nursing experience. Although this
inclusion criterion resulted in obtaining a sample of experienced homecare nurses, it also resulted in a sample wherein all of the nurses in the study were diploma-prepared. The majority of homecare nurses in this region are diploma-prepared nurses with only a few nurses prepared at the baccalaureate level. Although the career advertisements for homecare nurses in this area of the Fraser Valley state that the nurse must be a RN with a BSN or equivalent, with at least two years of medical/surgical experience, due to the limited number of nurses that meet all these qualifications, nurses who are diploma-prepared and have medical/surgical experience are hired into the available positions. This area of the Fraser Valley has also had a very stable homecare nurse population, and as evident from the demographics of the study's participants, many of these nurses have been in homecare for many years. In addition, although the Fraser Valley is experiencing a population growth, there has been no concurrent increase in the number of full-time or part-time homecare nurses. There are only career opportunities for casual positions in homecare nursing in this area of the Fraser Valley (Fraser Health Authority, 2003).

Nursing education has an impact on the ability of the nurse to effectively assess and implement family interventions. Family nursing theory has been traditionally taught in undergraduate and graduate university programs and not in diploma-nursing programs (Wright & Bell, 1989; Wright & Leahey, 1990). The clinical application of family theory, however, is an area of concern that is apparent in the family nursing literature (Hall & Kirschling, 1990; Laforet-Fliesser & Ford-Gilboe, 1996; Meiers & Tomlinson, 2003; Wright & Bell, Wright & Leahey, 1990; 2000). As previously stated, many of the homecare nurses in this area of the Fraser Valley are diploma-prepared nurses who have not received any formal education in family theory or family counseling skills. As stated by Wright and Leahey (1990; 2000), nurses tend to conceptualize family in two general ways. One way is with the focus on the individual in the
context of the family. The second way is with the focus on the family with the individual as the context. When nurses use the former conceptualization they focus on the individual’s experiences with a specific illness in his/her family. For example, homecare nurses would ask the palliative individual what his/her experience has been like coping with a terminal disease. In the latter conceptualization, homecare nurses would question the palliative individual’s family about what this experience has been like for them. A further example of these two conceptualizations would be for the homecare nurses to question the palliative individual about any issues he/she had in communicating with the family, or to ask the family about any concerns they had about communicating with the individual. Wright and Leahey further state that there is a third conceptualization of family that nurses could utilize. This conceptualization entails viewing the family as the unit of care. They label this conceptualization as family systems nursing. In family systems nursing, the focus is on the simultaneous observation of both the individual and the family, and the reciprocity of the interaction of the individual and family. Wright and Leahey further state that at the undergraduate level of nursing, the family is viewed as context, whereas, at the graduate level the family is viewed as client.

In this study, the participants appeared to base their practice on conceptualizations of the family as the context of care because all of the nurses stated the needs of the palliative individual came before the needs of the family. Several nurses also stated that at times the focus of care changed. Sometimes the palliative individual was the primary focus of their nursing care; whereas at other times, specific family members were the focus of nursing care. The palliative individual, however, was most often the primary focus and the homecare nurses stated that this was due to the fact that the referral they received was for the palliative individual. This approach to palliative care may be reflective of the North American culture that places a high value on
individualism (Wright & Leahey, 1990), and of the fact that many models of care focus on the patient as the recipient of care (Frost et al., 1997). In this study, family members became the focus of care for the homecare nurses only if the palliative individual was comfortable and symptoms were well controlled. Seldom did the entire family become the focus of care for several reasons. One, the homecare nurses did not always have contact with the entire family at any given time. Two, the homecare nurses stated they did not have time in their workload to assist and work through multiple and/or complex family needs, and often referred these families to other resources, such as, the social worker and chaplain. Three, the homecare nurses did not ask the family to gather as a group for an interview.

Despite the nurses’ focus on the patient as the recipient of care, analysis of the data provided by the homecare nurses did provide some preliminary findings that indicated that they were able to intervene with families of palliative individuals. One could postulate that the homecare nurses had difficulty in articulating what they actually did to intervene in family communication and how these strategies influenced family communication because of the lack of formal education in family theory. All of the nurses who participated in this study were perceived by colleagues to have both experience and expertise in the provision of palliative nursing care. Experience in nursing has most often been related to the number of years in practice, and at times has been linked to expertise and competency. However, research on nursing knowledge and levels of expertise has provided information that nursing expertise is more accurately related to knowledge gained from experience and the application of this knowledge to patient care situations. Experience aids nurses to establish their knowledge of the possible range of patient responses to specific situations (Jenny & Logan, 1992; Tanner, Benner,
Chesla, & Gordon, 1993). Personal growth and life experience have also been identified as fundamental to the provision of palliative care (Rasmussen, Norberg & Sandman, 1995).

The method of participant recruitment also had an impact on the study sample. The researcher discussed the study at a staff meeting, but due to workload demands, few homecare nurses attended this meeting. As a consequence, the method of recruitment was the posting of an information letter in the homecare office with the request for nurses interested in participating in the study to contact the researcher. This type of passive recruitment resulted in a sample that consisted of volunteers and of participants who may not have been reflective of the larger population of homecare nurses. This type of recruitment also did not enable the researcher to evaluate the ability of the participants to articulate their practice experiences in relation to the study’s purpose. In contrast, if a more active recruitment strategy had been used perhaps participants could have been identified who could recall their experiences and explain how they intervened in family communication with ease. For example, the researcher could have used key individuals, such as the manager of continuing care within the organization to recommend nurses who not only provided palliative nursing care, but also family-focused care. In addition, the researcher could have sought input from the palliative care nurse specialist as to who she would recommend for the study. This type of active recruitment would have perhaps resulted in a sample of nurses with varying expertise and the ability to recall and reflect on their experiences with families of adult palliative patients.

Data Collection

As discussed in Chapter Four, the use of in-depth interviews as the main data collection method was problematic. Several revisions of the interview guide were required before effective questions were identified. Furthermore, in-depth interviews require participants to articulate their
experiences, and this can be a challenge to the study if participants are not able to do so in a manner that provides comprehensive and accurate descriptions of their experiences. In addition to the ability of participants to articulate their experiences, the effect of co-construction by the interviewer and interviewee also needs to be considered. These two factors will now be discussed in relation to this pilot study and the literature.

It is recognized by the researcher that although participants may in actual clinical practice be utilizing effective nursing strategies that impact family communication, these interactions may be too complex to recall accurately or in sufficient detail for the purpose of this study. This complexity of the interactions is perhaps best described in the health communication and family literature. In this literature, communication has been described as an interactive, relational process that shapes and forms the ongoing relationship between not only family members but also between the healthcare provider and family (Meiers & Tomlinson, 2003; Rogers, 2001; Tapp, 2000; Wright & Leahey, 2000). This view of interpersonal communication is founded on the perspective that communication is composed of both content and relational components (Cecil, 1998; Rimal, 2001; Rogers; von Friedrichs-Fitzwater, Callahan, Flynn & Williams, 1991; Watson & Gallois, 1998). The content component involves the verbal expression of the subject matter, whereas, the relational component indicates how participants in the communication process regard each other and their relationship (Gallagher, Hartung & Gregory, 2003). The relational component, therefore, provides the framework for the interpretation of the content.

When interacting with families, nurses are involved in assessing both the verbal and the nonverbal communication behaviors exhibited by all members, as well as, being aware of their own behaviors and the influence these may have on the interaction. Each family also needs to be considered and understood within the roles that each family member has within the family (Hall
& Kirschling, 1990; Wright & Leahey, 1990; 2000). Each family has rules (spoken and unspoken) that govern family functioning, such as, who speaks to whom and who makes decisions within the family. In addition, families have secrets that are known to certain family members or that are only shared within the family. Family rules that permit the hiding of these family secrets can both influence and reflect family communication (Hayslip & Leon, 1992).

Families dealing with the fact that a member has a terminal illness are generally vulnerable to the stresses associated with this. For example, these stressors could include; coping with the awareness that a family member is dying, providing caregiver services, including the performing of skills that may be completely new to them, and facing unresolved family issues. These added stressors can negatively affect the family’s ability to cope with this illness and place the family into a crisis situation. The homecare nurse, therefore, is not only attempting to initiate family dialogue about what this palliative experience means to the family, but is also simultaneously assessing and intervening with the day-to-day functioning of the family. As a result, the ability to recall detailed information about what precipitated a family discussion, where individuals are situated during this discussion, what family members’ nonverbal and verbal behavior was, and how the nurse reacted to the family, are likely impossible to recall in detail sufficient to meet the needs of this study. Furthermore, by only interviewing nurses, the family perspectives of the nurses’ interventions are not obtained.

In addition to being able to recall specific details of family interactions and what the nurse did to address the family’s communication processes, the issue of co-construction needs to be considered. Co-construction refers to the idea that the narrative, whether a healthcare provider interaction with a patient (Eggley; McLeod, 1999; Sundin & Jansson), or a qualitative research interview (Manias & Street, 2001; Rapley, 2001), is created or constructed by the interaction of
all the participants in the interaction. In other words, narratives of experiences evolve through the interaction of the participants in the interview. The interviewee may narrate an experience in a random fashion and the interviewer facilitates the chronological ordering of the events of the experience by posing questions to elicit the chronological relations between these events (Eggley; McLeod). In this study, the researcher together with the participants sought to develop a chronological accounting of the strategies that the nurses used in influencing family communication in families with an adult palliative member. The researcher posed questions to elicit a more detailed and comprehensive understanding of not only the nursing interventions, but also the antecedent factors that influenced the intervention and the outcome to the intervention. This co-construction of the events may have also been influenced by the researcher’s professional background as a clinical nurse educator for a palliative-medical unit, and more recently as a nursing instructor for a local nursing program. Through these roles, the researcher had professional knowledge of three of the participants, as well as, an interest in the research topic. This may have influenced the interviews, because the researcher and the participants at times co-constructed events based on the participants’ and the researcher’s knowledge and practice base.

The difficulties encountered in collecting data via interviews with nurses points to the need to have several methods of data collection to ensure that the obtained data is comprehensive, rich, and reflective of the actual experiences. The triangulation of data collection methods is particularly important in examining complex and relational subjects such as, family communication and nursing interventions that influence family communication. By incorporating several methods to obtain data the rigor of a qualitative study can be enhanced (Morse & Field, 1995; Streubert & Carpenter, 1999).
Changes to the participant selection and recruitment procedures and data collection methods are necessary to ensure comprehensive and adequate data about the homecare nurses' experiences with communication in families with an adult palliative member. A larger study would be very feasible and important in terms of increasing nursing knowledge about family communication and identifying nursing strategies that could assist family communication in families with an adult palliative member. As was evident from the pilot study, detailed descriptions of nursing care enrich nursing knowledge and share experiences and expertise with other health professionals and the public; the outcome being a high quality of patient care.

Discussion of Preliminary Data Coding Schema

In this section of the chapter, a discussion of the preliminary coding schema presented in Chapter Four will be provided. The preliminary data codes of “creating a family circle,” “speaking for,” “bringing it out into the open,” and “family rules” relate to strategies that nurses utilized in assessing and intervening with family communication, and will be discussed in relation to the literature on family communication and communication theory. Next, the code of “taking the time” will be discussed. This preliminary code, while being a strategy used in intervening with families, also relates to external contextual factors, such as, workplace support, workload, and nurse-family relationship.

Strategies Used by Homecare Nurses

Creating a Family Circle

The data related to this code illustrated that the homecare nurses generally interacted with families by creating a family circle wherever the palliative individual was reflecting their belief that they were there first and foremost for the patient and then for the family, particularly the caregiver.
The creation of the family circle is reflective of communication theory since individuals involved in the interaction need to be able to both see and hear each other. The nurses allowed the family to seat themselves within the family circle to establish an environment of trust, comfort, and collaboration. In allowing the family to position themselves, the nurses also were able to observe and assess not only the family’s interaction patterns but also the manner in which family members aligned themselves with other family members (Wright & Leahey, 2000). This strategy provided the nurses with important insight and knowledge about family functioning.

Nurses’ decisions about where to place themselves in this family circle are interesting. The homecare nurses viewed themselves as “guests” in homes where families were vested with control and power in the relationship (Luker et al., 2000). One of the nurses, therefore, described how she allowed the family to either implicitly or explicitly determine where she sat. Others described situations in which they positioned themselves next to the palliative individual and one nurse described how she tended not to be seated between family members. The majority of the family nursing literature alludes to the establishment of a collaborative non-hierarchical nurse-family relationship (Lang et al., 2002; Tapp, 2000; Wright & Leahey, 2000), and therefore, the choice of where the nurse positions herself within the family circle may have an important influence on nurse-family interactions. For example, when the nurse aligns herself with the patient this could indicate, to both the family and the patient, that the nurse views the patient’s needs as the most important, and the ones she will be most concerned about. When the nurse allows the family to determine where she will sit, this communicates that the family are “in charge” and will determine how the interaction will be developed. In contrast, when the nurse does not sit between family members this could indicate to both the family and the nurse, that she is involved but still apart from the family.
Speaking For

The data related to the code, "speaking for," reflected the nurses' beliefs that at times they had to speak on behalf of an individual to other family members. This strategy was typically utilized when the nurses observed that a family member was unable to participate in the care of the palliative individual, or when a family member voiced this concern to the nurses. The nurses believed that they had a professional responsibility to speak on behalf of individuals in order to ensure that all family members were able to participate, as much as they wanted to and were able to, in the care of the palliative individual. The literature addressing family nursing does not ascribe to this strategy. In fact, family nursing theorists support nursing strategies that empower the individual to speak for him/herself (Friedman, 1998; Meiers & Tomlinson, 2003; Tapp, 2000; Wright & Leahey, 2000). This strategy of speaking for an individual is perhaps indicative of the nurses' beliefs about palliative care, family nursing, and the role of the nurse in the nurse-family relationship. As previously stated, all of these nurses viewed the palliative individual as the primary focus of care and they endeavored to ensure that the individual received the care they required, from the nurses themselves, and from the family. If speaking for an individual had benefit for the palliative individual and enabled the family members to share and participate in the care, the nurses believed this to be an effective family intervention. The use of this strategy is also perhaps indicative of the nurses' views of the role they had in family communication. Many of the nurses did not believe they had any long-term impact on family communication due to the nature of their involvement with the family, long-standing family communication issues, and that the time they had with the palliative individual and family did not allow for interventions that had long-term impact on family communication patterns.
The data for the code, “bringing it out into the open” reflected the nurses’ beliefs in open family communication and that families need to openly communicate in order to understand and acknowledge what family members are experiencing during their palliative journey. The nurses attempted to initiate open communication by commenting on family members’ nonverbal and verbal messages, and by asking family members to clarify how they were feeling. This type of intervention is certainly found in the family literature, in which many family specialists espouse the encouragement of open communication in families (Lang et al., 2002; Meiers & Tomlinson, 2003; Tapp, 2000; Wright & Leahey, 2000). Other family experts and researchers state that open communication should only be facilitated to the extent that individual families can openly communicate and that the degree of open communication will vary from family to family for several reasons. The degree of open communication has been linked to the themes of preference, deliberate intent, maintenance of previous communication patterns, avoidance, and shared meaning of the experience (Chekryn, 1984; Cohen et al., 1971; Hilton, 1993; 1994; Hinton, 1973; 1981; 1993; Pister, 1997; Vess et al., 1985; Walsh-Burke, 1992). Thorne (1985) suggests that families use communication strategies that have both been previously effective and are consistent with the family philosophy. Some families, therefore, may use open communication and other families may value selective communication, or very limited communication of emotional and sensitive issues. Hinton (1998) concludes that for patients there is a precarious balance between the need to share their fears and concerns and the relief obtained from doing so. Patients and relatives might be at different stages of acceptance and adaptation during the terminal illness experience, and therefore, this may influence the degree of open family communication. In addition, not all families will be able to openly communicate and the role of
the nurse is to facilitate as much open communication as the family is able to manage (Reimer et al., 1991).

Family Rules

Family rules refer to the spoken and unspoken rules that govern family behaviors, responsibilities, values, and beliefs (Friedman, 1998; Hayslip & Leon, 1992; Wright & Leahey, 2000). In this study, the structure and roles and responsibilities within the family determined how the family interacted and related with not only each other but also with the homecare nurses. The family’s communication patterns influenced to who and how the nurses intervened, and each family was perceived by the homecare nurses to be different and unique. Nurses stated that the family structure influenced not only the family communication patterns, but also their nursing role with that family. Family structure influenced who the primary caregiver was, as well as, the number of family members who were involved and needed to be included in any interactions. As stated by one of the nurses, she did not think that she could always permanently impact family communication due to the unwillingness of the family to change. Wright and Leahey also state that in order for interventions to be successful, the family has to want and be committed to changing behaviors. In addition, nurses can only offer interventions. It is up to the family whether they act on the intervention or not. The family’s openness to intervention is also influenced by the nurse-family relationship and the nurse’s ability to facilitate the family’s reflection on their issues (Meiers & Tomlinson, 2003; Tapp, 2000; Wright & Leahey).

Taking the Time

Data for the code, “taking the time” represented the nurse’s knowledge and skill in assessing family communication, and in taking the time necessary to assess the family and intervene as required. Taking the time to assess the family was related to workload, workplace
support for assessing and intervening in family communication issues, and having the personal energy to intervene, particularly when there were challenging and difficult family issues.

The nurses reported that poorly controlled or uncontrolled symptoms in the palliative individual also resulted in an increased intensity of the situation. When the palliative individual’s symptoms were not well controlled, the family and the palliative individual were less likely to engage in any meaningful conversations about the palliative process with each other, or the homecare nurses. Usually, this lack of meaningful conversation was because all of the family’s emotional energy was focused on resolving the symptom crisis, and the family and palliative individual looked to the homecare nurses as being the experts to assist them in this task. Poorly controlled symptoms in the palliative individual also resulted in increased stress in the homecare nurses and most of their expertise and skills were predominantly focused on the comfort of the palliative individual and therefore, at these times, the palliative individual became the primary focus of care, and the family, and the family needs became secondary. In these situations, the nurses stated that they were so overwhelmed with meeting the family’s immediate needs that they could not, and did not intervene in any other family issues.

The need to have workplace support for taking the time to intervene in family communication is supported in the health communication literature (Chalmers, 1993; Parle et al., 1997; Wilkinson, 1991). Workplace support encompasses the administrative support in allowing nurses sufficient time with families, allowing nurses opportunities to debrief with colleagues, and in the recognition of nurses’ contributions to family interventions. Most of the nurses in this study stated that at times they made time in their workload to spend time with the palliative individual, and that this usually involved rearranging their appointments to make the time, and conducting other home visits as quickly as possible. When the nurses had to rearrange their
workload in such a manner, they felt unsupported by administrators. Findings in the literature indicate that when workload is modified to enable the nurse to take the time to interact with patients (families) there is an increased level of therapeutic interactions (Paxton, Porter & Heaney, 1996). These endeavours to make the time resulted in the nurses feeling ‘burned-out’ at times and, as a consequence, unable to provide the same level of care to every palliative individual and family. The nurses also shared that they did not have any regular, formal debriefing opportunities and usually debriefed with each other at the end of the shift. This method of debriefing and supporting each other has been identified in the literature as a supportive strategy often used by hospice nurses (Cohen, Haberman, Steeves & Deatrick, 1994; McNamara, Waddell & Colvin, 1995), although at times this strategy can also result in nurses not feeling totally supported in the work they do with palliative patients and families (Bram & Katz, 1989). The quality of the nurse-family relationship also impacted the amount of time that the nurse spent with each palliative individual and family, as well as, the amount of time and personal energy that she took to intervene in family communication issues. These findings are supported in the literature of nurse-patient relationship in which taking the time to get to know the individual was a prominent theme (Chalmers, 1993; Lotzkar & Bottorff, 2001; Luker et al., 2000).

Summary

In this chapter a discussion of the findings in relation to the challenges of participant selection and recruitment and the use of interviews as the primary method of data collection was presented. The preliminary data codes were also discussed in relation to the communication and family literature.
The recruitment of the study’s convenience sample was a challenge to this pilot study. Several reasons for this related to the education and experience of the homecare nurses, hiring practices within this region of the Fraser Valley, homecare nurses’ beliefs about palliative care, and the use of passive recruitment strategies. All of the homecare nurses in this study were diploma-prepared nurses with extensive nursing and homecare nursing experience. The nurses did not have any formal education in family theory and their practices were based on experiential knowledge. As a result, many of the nurses had difficulty articulating the strategies that they used in intervening in family communication, as well as, the rationale of why they used these strategies. The hiring practices of this region of the Fraser Valley contributed to the obtainment of a sample of diploma-prepared nurses. Although career advertisements for casual positions in homecare nursing list the requirement of a baccalaureate degree in addition to medical/surgical nursing experience, the limited pool of applicants necessitates the hiring of nurses who have the nursing experience but not the educational requirement. In addition, in this region the homecare nurse population has been very stable and many of the nurses have been in homecare for many years. In this study, the nurses appeared to base their practice on the conceptualization of the family as the context of care, and this may be reflective of traditional models of care and of the North American culture. The recruitment method of information letters resulted in a volunteer sample that may not have been reflective of the larger population of homecare nurses. In addition, this type of passive recruitment did not allow the researcher to evaluate the appropriateness of the participants for the study.

The use of interviews as the primary method of data collection also posed difficulties for this study. Several revisions of the interview guide were required before effective questions were identified. Furthermore, the ability of participants to recall and articulate their experiences and
the effect of co-construction can influence the quality of data obtained from interviews. Participants may in actual clinical practice be using strategies that influence family communication but these interactions may be too complex to recall in comprehensive detail. In addition, by only interviewing nurses, the family perspectives of the nurses’ interventions are not obtained. The influence of co-construction also needs to be considered when using only interviews as the data collection method. Narratives of experiences can evolve through the co-construction of the chronology of events, the co-construction of key themes through repetition, and the co-constructed interpretation of events by the participants in the interview.

The preliminary data codes of “creating a family circle,” “speaking for,” “bringing it out into the open,” “family rules,” and “taking the time” refer to strategies used by these nurses in intervening in family communication in families with an adult palliative member. “Creating a family circle” referred to experiences in which the nurses created a family circle around the palliative individual, reflecting the nurses’ belief that the palliative individual was the focus of their care. The family circle provided the nurses with insight and knowledge about family functioning and of who had power and control of the interaction. The choice of where the nurse positioned herself within the family circle may have significance on nurse-family interactions. All of the nurses described situations in which they felt the need to “speak for” individual family members. Although the nurses in this study perceived this to be an effective strategy in influencing family communication, this strategy is not supported by the findings in the family literature. Instead, family theorists cite the strategy of empowering individuals to speak for themselves. The data for the code “bringing it out into the open” reflected the nurses’ beliefs in open family communication and the nurses attempted to initiate open family communication by such strategies as commenting on family members’ verbal and nonverbal behaviors and by
clarifying family members' feelings and thoughts. Many family theorists support strategies that encourage open family communication; however, caution needs to be made as to the degree of open communication that a family may be comfortable with. Many of the homecare nurses described situations in which “family rules” influenced how they intervened in family communication. The implicit and explicit family rules influenced the type of strategies used by the nurses, as well as, the receptiveness of the family to the interventions. Family theorists also state that in order for interventions to be successful, the family has to want and be committed to changing behaviors. Data for the code “taking the time” related to the nurses’ knowledge and skills and in taking the time to intervene as required in family communication. Taking the time was also influenced by the nurses’ workloads, workplace support for intervening in family communication, and having the personal energy to intervene, especially when there were difficult and challenging family issues.

In Chapter Six, a summary of the study will be presented followed by the preliminary conclusions derived from this pilot study. Implications for nursing research, practice and education will then be described, followed by concluding comments from the researcher.
CHAPTER SIX
SUMMARY, PRELIMINARY CONCLUSIONS, IMPLICATIONS, AND CONCLUDING COMMENTS

The purpose of this study was to lay the foundations for a full-scale study to describe the nature of homecare nurses' experiences of supporting family communication in families with an adult palliative member. To the researcher, as both a practicing palliative nurse and an instructor in nursing, the practice of family assessment, and in particular family communication in relation to palliative nursing care, is an area of interest.

The researcher chose interpretive description as the methodology for this study as it allowed the researcher to explore and interpret the data from a nursing practice perspective. A convenience sample of eight homecare nurses in the Fraser Valley participated in this pilot study. The participants were obtained through passive recruitment strategies such as an information letter. This method of recruitment resulted in a sample of participants that were all diploma-prepared nurses with extensive nursing experience but with no formal education in family theory. In addition, this type of recruitment strategy did not enable the researcher to evaluate the ability of the participants to articulate their experiences in intervening in family communication in families with an adult palliative member.

In conducting the pilot study several challenges were identified. First, several revisions of the interview guide were required before the participants' responses resulted in data that addressed the research questions. Second, the participants had difficulty in articulating the rationale of how and why (or why not) they intervened in family communication. Third, the use of a single data collection method, namely interviews with nurses did not allow for the collection of rich data. Fourth, the limited abilities of the researcher in conducting qualitative research
interviews and interpreting the data were limitations to the study. Despite all these challenges, some preliminary data codes were identified from the data.

The findings of this pilot study related to the previously identified challenges of the study and also to the preliminary codes that were identified from the data. The preliminary codes of “creating a family circle,” “speaking for,” “bringing it out into the open,” “family rules,” and “taking the time,” were identified as strategies that the homecare nurses in this study used in intervening in family communication in families with an adult palliative member. In “creating a family circle” nurses described situations in which they interacted with families by creating a circle around the palliative individual. In the family circle, the nurses allowed the family members to position themselves, but the nurses varied in whether they positioned themselves or allowed the family to determine where they would sit, as well as, where in the circle they sat. The position of the family members in the family circle provided the nurses with important insight about family functioning; whereas, the position of the nurse may have an important influence on nurse-family interaction. “Speaking for” referred to situations in which the homecare nurses spoke on behalf of individuals to other family members. While this was a strategy that the nurses used, family theorists support nursing interventions that empower individuals to speak for themselves. All of the nurses believed in the importance of open family communication and this was reflected in the data for the code “bringing it out into the open.” The nurses articulated that “family rules” determined how they intervened in family communication as well as the type of relationship they had with families. The ability of the nurses to intervene in family communication in families with an adult palliative member was reflective of their knowledge and skills, workload, workplace support, personal energy, and
quality of the nurse-family relationship and these data are captured with the code “taking the
time.” These preliminary codes provide direction for a future study.

Preliminary Conclusions

The following preliminary conclusions were drawn from the findings of this pilot study:

1. The importance of developing an interview guide that covers the domain of the
research topic cannot be understated. In this pilot study, several revisions to the
interview guide were required before the questions elicited participant responses
that addressed the research questions.

2. A skilled qualitative researcher requires skills in composing and asking questions,
as well as, in conducting participant interviews. The quality of the interviewer and
the quality of the interview guide have significant impact on the quality of the
study data.

3. The selection of participants needs to be based on the theoretical needs of the
study and the participant’s knowledge. As was evident from this study, a
convenience sample does not always meet the purposes of a study.

4. In this study, although none of the nurses had in-depth knowledge of theory in
relation to family communication and had difficulty in articulating their
experiences, some preliminary data codes were identified that suggest potentially
useful strategies in supporting family communication that need to be explored in a
full-scale study.

5. The homecare nurses in this study viewed the individual within the context of the
family and not the family as the unit of care. The palliative individual was the
primary focus of care, despite the palliative care tenet that palliative care be family-focused.

6. A fuller understanding of family communication could be obtained with the use of multiple data collection methods.

7. Pilot studies are a useful strategy in testing and evaluating the research process and can provide valuable information for changes to the research design.

Implications for Research, Practice and Education

The findings and preliminary conclusions from this study have implications for research, practice, and education. The implications for future research will be discussed, followed by the implications for practice and then for education.

Implications for Nursing Research

The challenges associated to participant selection and recruitment, the use of interviews as the sole data collection method, and a brief discussion of the preliminary codes were presented in Chapters Four and Five. From these discussions, recommendations for changes for a future full-scale study will be presented. A primary purpose of this pilot study was to determine if a full-scale study was feasible, and therefore, a detailed discussion of the recommendations for future research will be presented. First, support for the continued use of a qualitative research approach for a full-scale study will be presented. Second, recommendations for future participant sampling and recruitment will be discussed. Third, recommendations for the future triangulation of data collection will be presented. Fourth, recommendations for data analysis in a future study will be discussed.

Support for the Continued Use of a Qualitative Research Approach

A qualitative research approach is very suitable for studying communication, whether it
is communication between a healthcare provider and patient, healthcare provider and family, or between family members (Ballard-Reisch, 1990; Cecil, 1998; Lambert, Street, Cegala, Smith, Kurtz & Schofield, 1997; Watson & Gallois, 1998). A qualitative approach is appropriate to explore how nurse-patient interactions are related to individual characteristics, and whether these interactions change over time (Lambert et al.). This type of research would allow for the viewing of nurse-patient interactions as an ongoing narrative, and one in which health issues are discussed in relation to the individuals' lives, personalities, and other contextual factors (Cecil; Rimal, 2001; Tardy & Hale, 1998; Vanderford, Jenks & Sharf, 1997; von Friedrichs-Fitzwater et al., 1991; Watson & Gallois). Vanderford et al. also state that appropriate research methods need to be used, such as, patient narratives, gaining access to patients' experiences through the use of in-depth interviews, participant observations, ethnographic fieldwork, and textual analysis.

A qualitative research approach would allow for the observation and interpretation of how a family with a palliative member communicates (Bensing, van Dulmen & Tates, 2003, Lang et al., 2002), how cultural and ethnic characteristics may impact the nurse-family communication (Ramirez, 2003; Ulrey & Amason, 2001), and how power and control of the interaction is negotiated (McNeilis, 2001; Rimal, 2001; Shaikh, Knobloch & Stiles, 2001; Street & Millay, 2001; von Friedrichs-Fitzwater & Gilgun, 2001; von Friedrichs-Fitzwater et al., 1991; Walker, Arnold, Miller-Day & Webb, 2001). Power and control have been linked to not only the verbal exchange between participants but also to how participants position themselves, such as sitting, standing, and turning away from each other (Walker et al.).

Participant Sampling and Recruitment Procedures

In a future study, the selection of participants should be based on purposive sampling. The intent of purposive sampling is to allow for the exploration of maximal theme variation of
interactions to allow for the greatest range of variations (Morse & Field, 1995; Lincoln & Guba, 1985; Sandelowski, 1995; Spiers, 2002), and therefore, provide a rich account of how nurses influence family communication in families with an adult palliative member. In addition, purposive sampling would allow the collection of accounts that disclose not only the particular but also the general experience (Thorne et al., 1997). As a result, participant selection would be aimed at understanding the particulars and the general both within and across themes. In a future full-scale study, additional participants should be sought to confirm the emerging themes of the inductive analysis of data and achieve maximal theme variation (Morse & Field, 1995; Thorne et al.).

Recruitment strategies for the full-scale study need to include a variety of strategies, such as seeking out nurses who are considered by unit administrators, nurse specialists, and other homecare nurses as “experts” in the delivery of family-based palliative care. Participants should also be sought from home healthcare agencies in the Greater Vancouver area based on the assumption that the potential to recruit nurses of different ages, cultural and ethnic backgrounds, with varying education and experience in nursing is enhanced. An additional eligibility requirement to those used in the pilot study would be that participants must be degree-prepared and/or have received advanced education in family nursing or family counseling. The homecare agency directors would be contacted regarding the study and permission to circulate information about the research study using posters and email would be sought.

The researcher should also seek permission to recruit nurses attending university undergraduate and graduate classes. This recruitment strategy could include attending selected classes, such as a class on family theory, and briefly speaking to the class about the study, as well as, posting advertisements for the study in the nursing student lounges.
Several health communication researchers have stated that in any interaction whether it is between a physician and patient, nurse and patient, or a healthcare provider and family, each participant influences the interaction. Although this pilot study sought to explore the strategies that homecare nurses used to influence family communication and to obtain the nurses’ perceptions of the impact of these strategies on family communication, a recommendation for a future study would be the inclusion of families receiving homecare palliative care in order to include data of how the family influences the strategies that the homecare nurses use.

In a future study, the homecare nurses who agree to participate should be asked to recruit families with an adult palliative member. As with the selection of nurse participants, purposive sampling should be used for selecting families in an attempt to allow for maximum theoretical variations of interactions. As a result, families with palliative members at various stages of the palliative trajectory, various family dynamics and varying contact with the homecare nurses would be sought.

Data Collection

Based on the review of the pilot study and of the health communication literature, the necessity of studying the various contextual factors that may influence a communication interaction was identified. Through the use of a variety of methods to obtain data related to the research questions, a more comprehensive and accurate interpretation of the experience can be obtained. In addition, the ability to analyze the verbal and nonverbal interaction as it occurs and impacts the organization and structure of the interaction is essential. As a result, the recommended means of data collection for further study of the nature of homecare nurses’ experiences in influencing family communication in families with an adult palliative members should include: nonparticipant observations, videotaped observations, separate interviews with
the homecare nurse and family, a focus group with the homecare nurses, extensive field notes and a reflective journal.

**Nonparticipant Observation.** Participant observation has been used in health communication research and has been demonstrated to be an effective method for studying communication (Caris-Verhallen et al., 1998; 1999; duPre, 2001; Ellingson & Buzzanell, 1999; Kettunen, Poskiparta and Gerlander, 2002; Spiers, 2002; Walker et al., 2001). In a future study, the researcher should accompany participating homecare nurses to the homes of families with an adult palliative member who have agreed to participate in the study. The researcher by being a nonparticipating observer would only observe the interactions between the nurse and family and would not take part in any of the interactions, thereby, not influencing the nurse-family interaction. A limitation to this type of observation is that the researcher cannot ask questions to clarify or interpret the interactions as they occur. Other data collection methods, however, should be used to clarify interpretations, including interviews with the homecare nurses, family, and a homecare nurse focus group interview.

A further recommendation for a future study would be that the researcher should also selectively videotape homecare nurse-family interactions. The interactions that would be videotaped are those in which there is a planned meeting with a family, such as a family circle discussion. These discussions could be videotaped in order to accurately gather data about the interactional process and of how individuals verbally and nonverbally communicated. In the qualitative study by Spiers (2002), the researcher demonstrated the feasibility of conducting videotaped observations in the home setting. A portable videotape recorder should be used in order to allow for flexibility within the home. For example, a portable videotape recorder would allow the researcher to move with the participants in the home without requiring time to set up
The use of videotaping to record interactions provides a comprehensive record of verbal and nonverbal behaviors and the sequences and processes involved in these interactions (Bottorff, 1994; Morse & Proctor, 1998). Videotaping minimizes the selective bias and memory limitations frequently noted in human observation and self reports (Heacock, Souder & Chastain, 1996). Videotaping allows for the simultaneous awareness of the process and context of the observed discussion or behavior (Bottorff; Haggman-Laitila, Pietila, Friis & Vehvilainen-Julkunen. 2003; Latvala, Vuokila-Oikkonen & Janhonen, 2000.). The use of videotaping has been a method of data collection that has been gaining in popularity due to improving technology in video cameras (Bottorff; Latvala et al.; Morse & Proctor; Spiers, 2002).

Another advantage to videotaping is that it allows for events to be reviewed as many times as necessary and in a variety of ways, such as, real time, slow motion, forward or backward, therefore, allowing a thorough analysis of the data (Bottorff, 1994; Heacock et al., 1996). Videotaped data can also be analyzed in a variety of ways. For example, in the initial review of the videotape the researcher may concentrate on the verbal behavior at the individual level, and with each subsequent review of the tape may focus on other aspects of the data (Heacock et al.). The literature on the use of videotaping as a data collection method also describes the ability of the researcher to develop and use multiple coding systems to analyze the complexities of the phenomenon of interest (Beverly, Sroour & Winkelman, 1996; Bottorff; Heacock et al; Haggman-Laitila et al., 2003; Latvala et al., 2000; Morse & Proctor, 1998).

Limitations to the use of videotaping are also well described in the literature. The limitations relate to mechanical and technical challenges in using video cameras and the
reactivity of participants. Mechanical and technical difficulties relate to the researcher's lack of expertise and familiarity with the equipment and to the control of external environmental influences such as lighting and noise level (Beverly et al., 1996; Latvala et al., 1996; Morse & Proctor, 1998). The use of a video camera also has the potential to influence participant behavior (Bottorff, 1994; Latvala et al.). Participants may act in a manner that they think the researcher is expecting rather than how they would normally react.

There are also benefits and limitations to the use of participant observation supplemented with videotaped observations (Paterson, Bottorff & Hewat, 2003). The use of these two observational methods can allow for the collection of data that could not be obtained with only participant observation, the evaluation of the research process and any possible researcher biases and to increase the validity of the researcher's observations (Paterson et al.). In terms of limitations, the use of two observational methods requires an experienced researcher, can be time-consuming and costly, and may result in a reactive effect from participants. In the future full-scale study, videotaped observations should be used to validate the researcher's observations and to evaluate the research process.

Homecare Nurse Interviews. Immediately following each observational homecare nurse-family visit, the researcher should interview the nurse to elicit data about her/his perception of the visit, nursing goals, conversation topics, and any communication challenges (Spiers, 2002). It would be important to conduct the interviews with the homecare nurse immediately post family visit, as immediate recall of events is generally more accurate than having to recall the events at a later date. Questions from the interview guide (See Appendix F) could be used to gain an understanding of the strategies used by the homecare nurse, as well as, the nurse's perception of the visit. This interview should be audio taped and transcribed verbatim and would be used to
confirm and challenge the ongoing description and interpretation of the experience. This would allow for a richer interpretation of the experience (Bottorff, 1994; Sundin & Jansson, 2003; Sundin, Jansson & Norberg, 2000).

**Family Interviews.** Family interviews post nurse-family interactions should also be conducted in a future study. A family interview should be done to identify, review, explore, and obtain the family’s perception of the visit, conversation topics, communication challenges, and the family’s perception of the impact of the nurse’s strategies on family communication. Interviewing the families would provide information on their perception of the impact of the homecare nurse’s strategies and would also provide data related to the impact of interpersonal characteristics on the nurse-family interaction.

**Focus Group.** In a future study, a focus group with the homecare nurses should also be conducted. A focus group is “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment” (Krueger, 1994, p. 6). Focus groups have been used in qualitative research as both a primary and secondary source of data (Brown, 2000). A focus group could be conducted to verify and refine emerging findings with participants. As a result the focus group could provide greater depth and comprehensiveness to the results (Brown). Focus groups have the potential to stimulate and enrich the discussion by participants. As new ideas and perspectives are introduced, other members in the group are often inspired to share their ideas and thoughts. To facilitate an open, honest discussion at the focus group the researcher should establish an environment in which the participants feel safe to express their ideas and feelings. The researcher should also inform participants that there are no right or wrong answers, rather each participant’s ideas, opinions and experiences are important to hear. As a result participants would be encouraged to have an opportunity to contribute, would
be listened to respectively by all other participants and that all contributions to the discussion would be valued equally.

During the focus group, the researcher should outline the preliminary findings. Discussion would be stimulated by inviting the participants to comment on the accuracy and completeness of the description and by responding to questions that arise from the analysis. A further recommendation would be for the focus group to be audio taped and transcribed verbatim to ensure accuracy of the analysis of the group discussions. As a means to encourage attendance at the focus group, the researcher should contact participants prior to the date of the focus group as a reminder of the time and place of the meeting.

Field Notes. In a future full-scale study, detailed field notes should be kept of each interaction with individual nurses, families, each participant observation of nurse-family interaction and focus group. Field notes would not be completed for any videotaped observations because the video would provide the required data. Field notes would be completed to record observations and would include descriptions of the setting, participants and nurse-family interactions. These notes would include the stimulus of the conversation, the individuals engaged in the communication, and verbal and nonverbal behaviors of each participant. Field notes would also include the researcher’s thoughts and feelings. In addition, any behaviors that may have affected the interaction should be documented.

Data Analysis

In a future study, the recommended method for data analysis would be the categorization and determination of emerging themes. All data should be analyzed on an ongoing basis using constant comparative analysis in conjunction with the researcher’s immersion in the data. Ongoing data analysis would involve the description and interpretation of the communication
strategies used by the nurse. After the initial identification of themes and categories, all subsequent data would be compared to determine similarity or difference, to expand, to limit, or to refine initial and ongoing themes and categories. In a future study, a further recommendation would be for the researcher to review the videotaped recordings of the interactions and to note verbal and non-verbal nursing behaviors of interest. As the videotape is being reviewed, the researcher should continuously ask questions about the data. Question such as “What is happening here?” “What am I learning about the experience here?” What was the nurse’s intent by doing this?” When the nurse did this what was the effect on family communication?” What are the characteristics of this interaction?” The use of the videotape would allow for the observation and analysis of when behaviors were initiated and in what sequence and, therefore, allow for the observation and analysis of the organization and structure of the interaction. Through this ongoing description and interpretation of the interactions, video clips of nursing behaviors in influencing family communication would be delineated. Each clip would then be compared and contrasted with other clips from the same interaction, from other interactions with the same nurse and family, from the same nurse and other families, or with other combinations of nurses and family interactions to identify evolving themes (Spiers). Videotaped observations would, therefore, be used to confirm and challenge the interpretation of the observation field notes, interview and focus group data.

**Implications for Nursing Practice**

A tenet of palliative care is that the family is the focus of care, however, in this study, the homecare nurses stated that the palliative individual was their primary focus of care. As evidenced by the participants’ experiences, without adequate communication and comprehension of family theory and family nursing interventions, nurses might be limited in their ability to
provide effective family care. The findings of this study illustrated the need for all practicing nurses to have knowledge of family and communication theory and to be aware of the process and context of family communication and the influence that nurses can have on family communication. All nurses, therefore, need to have the opportunity to seek out or be offered experiences related to family. The findings also highlighted the need for nurses to be able to describe communication-focused interventions. An additional challenge for nursing practice is the reorganization of the healthcare system and workplace, time and financial constraints that impact nurses' abilities to take the time to learn about and conduct family interventions. In addition to the impact on having the time to learn, chart, and conduct family interventions, healthcare constraints also influence the amount of time that nurses have to assess and intervene in family communication. This challenges the homecare palliative care nurse to be innovative in creating opportunities and strategies to assess and support family communication in families with an adult palliative member.

**Implications for Nursing Education**

The findings of this pilot study serve as a challenge to nurse educators to ensure that nurses have knowledge of family theory and intervene with families. Family theory should not only be taught in nursing schools but should also be offered in continuing education workshops and workplace nursing inservices. All nurses, regardless of their area of practice, whether emergency room or homecare, should have at the very least, knowledge of how to assess family functioning. Numerous examples of strategies to teach family theory and instill in nurses a belief in the value of family nursing can be found in the literature (Bell, 1997; Green, 1997; Laforet-Fliesser & Ford-Gilboe, 1996; Wright & Leahey, 1999; 2000). As stated by Wright and Leahey (1990), regardless of time constraints and workload issues, family nursing knowledge can be
effectively applied, even in brief family meetings. They also state in order to involve families in health care, every nurse should have “sound knowledge of family assessment and intervention models, interviewing skills, and questions” (p. 260).

Concluding Comments

Communication is not a static process but is instead a dynamic and ever changing process. In hindsight, although the intent was to design a study that was suitable and feasible for a master’s thesis, it was perhaps naïve of the researcher to think this complex topic could be studied using interviews as the primary data collection method. As a learning experience, however, this project was very valuable as it provided the researcher with the opportunity to design and conduct a pilot study and, through the challenges of doing this, identify areas for improvement. In addition, this research provided the researcher with the opportunity to critically reflect on her abilities, as well as, the outcomes of the research and propose changes for a full-scale study.

In concluding this thesis, the researcher would also like to comment on the importance of conducting and reporting the findings from pilot studies. There are few detailed reports of pilot studies in the literature (van Teijlingen, Rennie, Hundley & Graham, 2001). Pilot studies can provide valuable insights for other researchers, but are generally only reported in the justification of the research methods and/or a specific research tool. When reported in the literature, researchers generally state that they had learned from the pilot study and made the necessary changes to the research design without making mention of any details of the changes. Some of these processes and outcomes could be beneficial for other researchers embarking on projects using similar methods and/or instruments and, therefore, the researcher hopes that this research can be beneficial to others interested in conducting research on this topic.
REFERENCES


Clark, D. (1997). What is qualitative research and what can it contribute to palliative care? Palliative Medicine, 11(2), 159-166.


APPENDIX A

Participant Information Letter

Project: "Homecare Nurses’ Perceptions of the Impact of Nursing Behaviors on Family Communication in Families with an Adult Palliative Member."

My name is Rona Miller. I am a student in the Master of Science in Nursing Program at the University of British Columbia. From my work in palliative care and through my professional and personal experiences of working with families with an adult palliative member, I am interested in how homecare nurses regard their experiences of helping these families to communicate during this difficult time. For my Master's thesis, I am studying these perceptions of homecare nurses in order that other nurses and healthcare professionals will understand what homecare nurses experience when providing nursing care to families with an adult palliative member.

Homecare nurses who are currently practicing and have a minimum of two years homecare experience and who provide nursing care to families with an adult palliative member are invited to participate in this study. As a participant you will be interviewed about the nature of your experiences of influencing family communication in adult palliative patients and their families, and your perceptions in relation to the influence of nursing behaviors on adult palliative patients and their families’ communication patterns. Participation in the study will involve two interviews, each approximately one hour in length, at a time and place convenient to you. The interviews will be audiotape recorded and transcribed so that information collected from you is accurate for analysis. These tapes and transcriptions will be stored safely in my home in a locked filing cabinet and will be destroyed upon completion of the study.

Any information that you provide will be kept strictly confidential. Any names or identifying information will be omitted from all the transcripts and research report. You are under no obligation to participate and you may withdraw from the study at any time. Withdrawal or nonparticipation will pose no personal or professional consequences.

There are no anticipated risks to participation in this study. Benefits to participation in this study may include personal understanding and clarification of family communication patterns in families with an adult palliative member and how nurses can influence and be influenced by family communication.

If you are interested in obtaining more information about this study, please contact me. I will answer any questions that you have about the study and if you are interested in participating in this study, we will arrange a mutually convenient time to meet. At that time, I will obtain written consent from you prior to the interview. I appreciate your interest and participation in this study.

Thank you for your consideration.

Rona Miller BSN
Graduate Student
UBC School of Nursing
Telephone: xxx-xxxx

Dr. Ann Hilton RN PhD
Professor
UBC School of Nursing
Telephone: xxx-xxxx
APPENDIX B

Participant Consent Form for Interviews

Project: Homecare Nurses’ Perceptions of the Impact of Nursing Behaviors on Family Communication in Families with an Adult Palliative Member

Principal Investigator       Dr. Ann Hilton
                             Professor School of Nursing,
                             University of British Columbia
                             Telephone: xxx-xxxx

Co-Investigator             Rona Miller
                             Graduate Student
                             School of Nursing
                             University of British Columbia
                             xxx-xxxx
                             (This study is for a Master’s of Science in Nursing graduate thesis)

Purpose:

The purpose of this study is to explore and describe the nature of homecare nurses’ experiences of influencing family communication in adult palliative patients and their families as well as homecare nurses’ perceptions of the influence of nursing behaviors on adult palliative patients and their families’ communication patterns.

Study Procedures:

Participants (homecare nurses) who consent to participate in this research project will be interviewed by the co-investigator at two intervals. Each interview will take approximately one hour. The initial interview will consist of questions seeking to gain an understanding of the nature of the homecare nurse’s experiences of influencing family communication in adult palliative patients and their families and participants’ perceptions of the influence of nursing behaviors on family communication of adult palliative patients and their families. Questions such as, ‘what role(s) do you believe nurses have in family communication in families with an adult palliative member?’ and ‘how would you describe your role as a homecare nurse in intervening/facilitating the process of family communication with an adult palliative member?’ will be asked. A follow up interview will be conducted with each participant to clarify interpretations of the data. All interviews will be tape recorded and analyzed by the researcher.
Confidentiality:

All information obtained for this study will be kept strictly confidential. All documents will be identified by a code number and kept in a locked filing cabinet in the co-investigator’s home. Data entered on the computer will be entered in a password protected computer file by the co-investigator. Participants will not be identified by name in any reports of the completed study and only the principal investigator, co-investigator and thesis committee members will have access to the coded data.

Contact:

If I have any questions or require any further information with respect to this project I can contact Rona Miller at xxx-xxxx I may also contact Rona Miller’s thesis advisor Dr. Ann Hilton of the School of Nursing at the University of British Columbia at xxx-xxxx. If I have any concerns about my treatment or rights as a research subject I can contact the Director of Research Services at the University of British Columbia at xxx-xxxx.

Risks and Benefits:

There are no expected risks to participants. I understand that while I may not receive any immediate benefit by participating, this study is being done to provide information about homecare nurses’ perceptions of the impact of nursing behaviors on family communication with an adult palliative member.

Consent:

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without any jeopardy to my employment.

I have received a copy of this consent form and the Participant Information Letter for my own records.

I consent to participate in this study.

Subject Signature ___________________________ Date __________

Signature of Witness ___________________________ Date __________

CF Version: May 10, 2002
APPENDIX C

Initial Draft of the Interview Guide

1. What would you describe as the purpose(s) of family communication?
2. Is this different or similar in palliative families? How so?
3. What do you think family communication means to the palliative individual and his/her family members? palliative families?
4. Can you share with me some of your experiences with palliative families that you have been professionally involved with?
5. What are some of the ways you have noticed these palliative family members communicating with each other?
6. What was similar in how members of the families communicated with each other?
7. What was different in how members of the families communicated with each other?
8. How would you explain the similarities and differences?
9. What role(s) do you believe nurses have in palliative family communication?
10. How would you describe your role as a homecare nurse in intervening/facilitating the process of family communication?
   a) What are some of the barriers?
   b) What are some of the incentives?
11. What are some of the reasons you intervene in family communication?
12. Are there circumstances when you do not intervene? What are they?
13. Can you share with me a few experiences of helping family members to communicate with each other?
   a. What were some of the strategies you used?
   b. How did you know when to use these?
   c. How did you feel about this experience?
   d. What was your understanding of the outcome(s) for the family members?
12. How do you feel when you influence family communication?
APPENDIX D

Trigger Questions

1. Based on your background and experience in homecare and palliative care, what does family communication mean to you?

2. Please share a story with me about an experience or incident that you believe is an example of family communication in an adult palliative patient and his/her family.

3. What role(s) do you believe nurses have in adult palliative family communication?

4. Can you share with me an experience of helping family members to communicate with each other?
   a. What were some of the strategies you used?
   b. How did you know when to use them?
   c. How did you feel about the experience?
   d. What was the outcome(s) for the family members?

5. Can you tell me about an experience in which you believe an adult palliative patient and his/her family communication had a positive effect/outcome on the patient and/or family members.

6. Can you share an experience in which you felt an adult palliative patient and his/her family did not have a positive effect/outcome on the patient and/or family members.

7. What has stayed the same in your care of the adult palliative patient and his/her family in relation to communication?

8. What has changed in your care of the adult palliative patient and his/her family in relation to communication?
APPENDIX E
Second Draft of the Interview Guide

I will precede the interview with the following introduction:

From my experience as a nurse in palliative care I know that many patients and families have difficulty communicating with each other. I have also found from the literature about palliative care and family communication that there have been studies done with nurses who work with palliative patients and their families but none of them have specifically asked homecare nurses about their experience. As a result of my reading I had a number of questions about the work that homecare nurses do when they care for patients who are dying as well as for their families and specifically more about the experiences/situations in which homecare nurses intervene in family communication. For example when do homecare nurses intervene, who do they interact with in the family, how do they intervene and why? In addition, I would like to learn more about what homecare nurses think is the result or impact of their interventions on family communication. I think that the information you share with me will increase the understanding of family communication in families with an adult palliative member as well as the role that homecare nurses have in this process and will contribute to more effective care for people who are dying.

I will begin the interview with the question:

Tell me about the most recent experience you had with an adult palliative patient and their family

I have prepared the following questions as guidelines to which I will be able to refer if there is a need for clarification, more specific direction to facilitate the participant in providing information.

Can you tell me more about.....
In what way...

What were some of the ways in which you noticed family members communicating with each other?

What was similar in how family members communicated with each other?

What was different in how family members communicated with each other?

How would you describe your role as a homecare nurse in intervening/facilitating the process of family communication?

a) What are some of the barriers?

b) What are some of the incentives?

What are some of the reasons you intervene in family communication?
Can you share with me a few experiences of helping family members to communicate with each other?

a. What were some of the strategies you used?

b. How did you know when to use these?

c. What was your understanding of the outcome(s) for the family members?

What were you thinking when you did that?

So it is helpful when ....?
APPENDIX F
Third Draft of the Interview Guide

1. Tell me about a situation in which you interacted with family members in a family with an adult palliative individual. How did you know whom in the family to start with?

2. How did you know who in the family to start with? How did that influence the family’s communication? What was your hope in starting with ____________?

3. How did you get the family together? How did this affect their communication?

4. Where in the home did this take place? Describe the room set up for me? How did this influence the family’s communication?

5. Did you do anything to change the room? If so what was your intent in doing this? How did this influence the family’s communication?

6. What were some of the nonverbal communications that were occurring? How did you assess and intervene with this? (i.e. tone of voice, facial expressions, body position etc). How did this influence the family’s communication/behavior?

7. What were some of the feelings/emotions? How were they being expressed/not expressed by the family (members)? How did you address this? How did this act of your part influence the family’s communication/feelings/emotions?

8. Can you tell me about a case/situation that really stands out for you where you felt that you really made a difference to the way the family communicated? What did you do in this situation to affect their communication?

9. What’s another example of a time when you ______? Another?
10. Tell me about a case/situation that you remember because it was unusually challenging to influence the family’s’ communication? How did you manage that case/situation? What specifically did you do? When? Why?

11. What’s another example of a time when you _____? Another?

Examples may be helping families to talk about DNR order, helping families to talk about an approaching death or deterioration in the palliative individual’s condition, helping families to talk about what is happening, or helping families in crisis to talk through and resolve the crisis. Another situation may be when a family member arrives from out of town and has issues/concerns about what the palliative individual has decided in terms of treatment/or has issues with other family members’ care of the palliative.
APPENDIX G

Demographic Data Form

This information is being obtained in order to gain a description of the participants in the study.

Please circle the appropriate answer.

1. Age group
   a). 20-25
   b). 25-35
   c). 35-45
   d). 45-55
   e). >55

2. Years in Nursing
   a). < 5
   b). 5-10
   c). 10-15
   d). 15-25
   e). >25

3. Prior Nursing Positions
   a). Staff nurse
   b). Charge nurse (HN, assistant HN)
   c). Nurse Clinician
   d). Other-please specify

4. Prior Nursing Experience
   a). Medical-Surgical
   b). Pediatrics
   c). Specialty

5. Years in Homecare Nursing
   a). < 5
   b). 5-10
   c). 10-15
   d). 15-25
   e). >25

6. Nursing Education
   a). Diploma
   b). Bachelor
   c). Master
   d). Other-please specify
7. Number of palliative patients you usually have in your caseload.
   a). 1
   b). 2-3
   c). 4-5
   d). >5

8. Average length of time you work with a palliative patient
   a). < 3 days
   b). 3-7 days
   c). Weeks
   d). Months

7. Please list any courses/education that you have taken in the last 3 years that pertain to palliative care.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. Please list any other courses/education that you have taken in the last 3 years.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________