UNIVERSITY OF CALGARY

"Right There, in the Midst of it with Them":

Impacts of the Therapeutic Relationship on Nurses

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

CALGARY, ALBERTA

JULY, 2009

UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "'Right There, in the Midst of it with Them': Impacts of the Therapeutic Relationship on Nurses" submitted by Angela Charene Morck in partial fulfilment of the requirements for the degree of Master of Nursing.

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June 29 /2009
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ABSTRACT

Mental health nurses are frequently confronted by intense emotions within the therapeutic relationship. In this philosophical hermeneutic inquiry, five mental health nurses were interviewed to uncover new understandings of how nurses are impacted by the interplay with the often emotion-laden narratives of their patients. Findings revealed the nurses' journey between a fluctuating need to separate and protect their private from their work lives. In order to be open to this fluctuation, they developed a sense of the world as requiring a sanctuary. This ontological place of true home is the extent to which they felt safe and sheltered in order for this process of awareness of self as person and self as nurse to unfold. This inquiry brings to the forefront the ways in which mental health nursing practice, education, and research are reciprocally moved by the practical day-to-day activities of being in therapeutic relationship.

ACKNOWLEDGEMENTS

I first and foremost need to gratefully acknowledge the support and supervision of Dr. Nancy Moules. Her kindred love of words and her gracious wisdom nurtured and sustained my abilities to bring this work to fruition.

I also would like to extend my utmost gratitude to the five mental health nurses in this study who openly shared their time, nursing experiences and multi storied lives. A debt also needs to be acknowledged to my colleagues at the "Rock". They were the impetus for this work and it is to them that I return it.

I would like to acknowledge the time and contributions of the entire supervisory committee: Dr. N. J. Moules, Dr. D. Jardine, Dr. A. Lane, Dr. A. Estefan, and Dr. S. Wilde. Their generosity and thoughtful participation in this work challenged me to go beyond the taken for granted and explore new possibilities.

Thank you also to my family and friends who have all supported me in more ways than mere words can express. Much of who they are and what I have learned from them are found here. Lastly, to Rich, for keeping my compass always directed towards home.

DEDICATION

For my father Paul A. Morck

always

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CHAPTER ONE

Introduction

> *I am a trained professional and I am drowning. Nobody else appears to be drowning, and maybe from the outside I don't either, so I certainly try to portray that I'm not... I don't know how you work with people who have a mental illness and not end up taking some of it on; because even as a human being you do that, let alone someone sharing their most intimate insecurities and behaviors and thoughts. But nobody tells you it will be this hard, nobody ever tells you that. Who would go into mental health if they did that. (Pat)*

Drowning - - an evocative word and image from one of the five mental health nurses who shared with me their experiences of the therapeutic relationship. Mental health nurses frequently confront situations in their work that elicit intense emotions in both their patients and themselves. Like Pat, nurses can unexpectedly find themselves in perilous territory. Warne and McAndrew (2005) reminded us that it is the nurse's responsibility to "acknowledge the complexity of the human experience and to navigate the therapeutic relationship" (p. 683). What happens, however, if the navigators find themselves in uncertain waters, in danger of being pulled under, or in peril of drowning? These are some of the hidden territories of the therapeutic relationship that I have long pondered. In this research inquiry, I explored the understandings, meanings, and processes by which mental health nurses take up and navigate the illness and life narratives of their patients. I was interested in discovering the impact this position as

listener of often emotion-laden narratives has on the nurse, his/her ability to be present within the therapeutic session, and ultimately what the impacts are on the nurse-patient relationship.

CHAPTER TWO

A Call to the Topic

Gadamer (1989) wrote that understanding begins when something addresses us. Its arrival disrupts us out of the lassitude of our everyday existence and demands something of us. This topic of narrative impact arose from a conversation with my mental health colleagues. In mulling over a decision to switch from a course-based masters to a thesis, I did, as we so often find ourselves doing, talking out the choices. In this instance, it was in the charting room of the inpatient mental health unit on which I worked, and those of whom I was seeking counsel were my fellow nurses. In the discussion of possible research areas, I shared my belief that whatever the topic, it needed to not only resonate with me, but mental health nurses. The research needed to uncover the often hidden nature of our work, to speak of us and to us. Again, as so often happens within conversation, the threads lead down paths connected, yet distant, from their starting point. We began to speak of our work, of our patients and those who haunt us, of their worlds and their impact on our own. One colleague, in sharing why she continued to find fulfillment in her work, stated that the difficult times and the joys of her work resided in the relationship with her patients. For her, it is that, we are, "right there, in the midst of it with them, the good, the bad, we are there for all of it." I looked around the room at that moment to find all my colleagues nodding in agreement, acknowledgement, and resonance. With a return to the original threads of the conversation, another colleague caught my eye, winked and exclaimed, "Well, Angela, I think we have your topic." In this way, the topic called and one story awoke another.

Landscape of the Topic

> It is easier for us to shut our eyes than close our ears. It is easier for us to remain untouched and unmoved by what we see than what we hear; what we see is kept at a distance, but what we hear penetrates our entire body. (Levin, 1989, p. 32)

Nursing, as a profession, necessitates a unique way of observing and listening to the patients for whom we care. These means of being with our patients requires consideration of individual experiences and situations and an attention to the particular. Our involvement in their lives as listeners creates a supportive space within which healing can begin. Listening in nursing "is more than a biological function between the ears and the brain. Therapeutic listening hears the sigh developed over a lifetime or the anxiety in the tone of voice or despair in a facial expression" (Stickley & Freshwater, 2006, p.17).

Mental health nursing, as a specialty, involves a unique way of listening and being present with the narratives of our patients. Mental illness, as with many chronic conditions, challenges a person's sense of identity. Relationships with others are disrupted and the meaning of experiences and life itself are altered. The affected person will often use narrative in an attempt to re-establish order and equilibrium (Cameron, Kapur, & Campbell, 2005). In keeping with such, a question often asked of patients upon arrival to our inpatient psychiatry unit is "Please help me to understand a little of what has brought you to us today." We are asking for entrance to their lives, to their stories. Patients bring with them the narratives of their lives; in essence, they are exposing how

they came to be, as they are, in this place and time. These narratives are shared and opened with the hope that we, as nurses, will be able to assist them in interpreting and making sense of what is happening.

This involvement in the lives of others means that we, as nurses, not only listen to but also continually tell stories (Stickley & Freshwater, 2006). In this creation of an oral tradition, we hold, share, and reflect upon the intertwining of our experience with the pain, joy, hope, and suffering of our patients. I am curious about what happens in the quiet still hours after listening to these stories. How are the nurses affected and where do the words go?

Henderson (2001), in her pivotal work on the theory of emotional labour, asserted that the self of the private person and the self of a nurse are constantly interacting and changing one another. It is a circular, interdependent relationship. Implicit in this interconnectedness is the premise that there is both a personal reward and a cost to the undertaking of a profession of care. How, as nurses, do we belong to the stories of our patients? How can we live a practice of care, possibility, and hope without being overwhelmed? How do we bring light to darkened spaces, and spirits without darkening our own?

Purpose of the Inquiry

My purpose in this research inquiry was to speak with mental health nurses in an attempt to extend the understandings, meanings, and processes by which these nurses take up the illness and life narratives of their patients. This research was timely considering the lack of research found in the literature examining the impact of the

therapeutic relationship on the mental health nurse. The therapeutic relationship is considered to be the "crux" (Peplau, 1962, p. 53), and the "heart" (Perraud et. al, 2006, p. 224) of the discipline. It is thus forwarded that we not only need to know what a therapeutic relationship is and how it progresses, but it is imperative that we uncover what it means to the person responsible for navigating the relationship, the nurse.

CHAPTER THREE

Review of the Literature

Theoretical Background of the Therapeutic Relationship

The relationship between nurse and patient is central to the practice of mental health nursing. This therapeutic relationship has been deemed the "essence" (Forchuk, 2002, p. 93); "crux" (Peplau, 1962, p. 53); "core" (College of Nurses of Ontario, 2006); and the "heart" (Perraud et. al, 2006, p. 224) of the discipline. It is regarded as a "trusting relationship where values are respected as the nurse listens to the patient's concerns, provides information and advice, relieves distress by encouraging the expression of emotion, improves morale through review of established outcomes and encourages the patient to practice self help" (Moyle, 2003, p. 103). The newly published code of ethics for Canadian nurses stresses that therapeutic relationships are critical to understanding patient and family's needs and concerns (Canadian Nurses Association, 2008).

To delineate this professional relationship from a social one, numerous names have been used to describe it including interpersonal relationship in nursing, therapeutic use of self, one-to-one relationship, therapeutic alliance, therapeutic bond, nurse-patient relationship, and nurse-client relationship (Lego, 1999; Perraud et al., 2006). Regardless of the term used to describe it, the relationship has received much attention in nursing literature and research since 1952 with the publication of Hildegard Peplau's book *Interpersonal Relations in Nursing*.

The complexities and understandings of therapeutic relationship have been inherited through the language and culture of mental health nursing, which in part

remains situated in the larger context of psychotherapy. In an examination of the therapeutic relationship in mental health nursing, it is essential to trace the ancestors of counseling and psychotherapy as viewed across multi-healthcare disciplines.

The Therapeutic Relationship in Psychotherapy

Etymologically, psychotherapy comes from the Greek *psyche* meaning spirit, soul, life or mind, and *therapeia* meaning to heal or nurse (Oxford English Dictionary, 1971). The theoretical ancestors of counseling and psychotherapy can be traced to eighth century Persia. Current theoretical foundations are rooted in the development of moral therapy in the eighteenth century. In the twentieth century, orientations within the discipline started to become established with traces back to Freud's conception of psychoanalytic theory (Haugh & Paul, 2008). In an examination of the immense literature on therapeutic relationship, broad groupings of theoretical perspectives become helpful. While not allowing differentiation of subtleties and differences within the groupings, one is afforded a view of the various perspectives on therapeutic relationships. These groupings have been referred to as the "four forces" (Haugh & Paul, 2008, p. 10) of psychotherapy - - psychodynamic, behavioral, humanism, and transpersonal. In the past thirty years, a new force has arisen in the form of relational theories (Berkery, 1997).

Psychodynamic theory. In this form of therapy, the analysis of the relationship between the therapist and patient is central to treatment. The therapist focuses on the relationship, known as transference, to draw parallels between the therapy sessions and occurrences in the patient's current and past life situations. The therapist maintains a more or less neutral stance but may often be viewed by the client as a parent figure. The

working therapeutic relationship is believed to be the healthy part of the client who joins with the therapist to work jointly on the unhealthy part of the patient (Berkery, 1997; Shattel, Starr, & Thomas, 2007).

The archetypical version of psychodynamic theory is Freudian analysis. Freud maintained an authoritarian stance within the therapeutic relationship. Improvement in the patient was attributed to the therapist's hypnotic suggestions or wise interpretations of dreams and symptoms. A rejection of these interpretations was viewed as resistance. Other versions of psychodynamic theory attempted to depart from the biological focus of Freud. Jung adopted a more egalitarian approach to working with his patients (Gallop & O'Brien, 2003). In his clinical theory, Jung rejected the word patient, preferring to speak instead of "persons working with him" (van der Post, 1977, p. 59). Jung viewed the therapeutic relationship as a dialectic process, which transforms both therapist and patient. He used the metaphor of temenos as the residence of the therapeutic relationship. From ancient Greek, temenos refers to a sacred protected space (New York Association for Analytical Psychology, 2008). Other forms of psychodynamic therapy, from Sullivan, Horney, Fromm, and Fromm-Reichmann, included a focus on interpersonal, cultural, ethical, and social considerations. The work of Adler, Sullivan, and Alexander saw the choice to make to make the therapist a more flexible, active participant. Davanloo, Luborsky, and Strupp focused on the development of parameters for short-term therapy (Haugh & Paul, 2008). While these theories departed from Freudian analysis, the therapeutic relationship is maintained as an important aspect of the therapy. The focus of therapy mains centered on how the current relationship is affected by prior relationships

(Haugh & Paul, 2008; Hubble, Duncan, & Miller, 1999).

Behavioral/learning theory. In behavioral and learning therapies the emphasis is on intervention, not on the therapeutic relationship. Traditionally, behavioral and learning theories tended to be action oriented with an emphasis on teaching versus open-ended self-exploration. However, while these theories position less emphasis on the therapeutic relationship, the working relationship and the patients' real relationships are central components (Berkery, 1997; Derlega, Hendrick, Winstead, & Berg, 1991). An important focus of the therapy is the working relationship that focuses on mutually agreed upon goals. The relationship is viewed as a facilitative factor in producing change. The better the relationship between therapist and patient, the more likely it will that the therapist will be persuasive, believable, and able to effect change in the patient's behavior. In this stance, the relationship is asymmetrical with the therapist considered an expert. Within current therapy practice, perhaps the most prevalent perspective is the work of Beck on cognition and depression that formed the foundations for cognitive behavioral therapy (Hubble et al., 1999; Perraud et al., 2006).

Humanistic theory. The therapeutic relationship in humanistic therapies is less authoritarian and expert driven. Therapists are viewed as authentic, not neutral and their role is more like that of a friend than an authority figure. Carl Rogers is perhaps the most well known theorist with his client-centred, non-directive, humanistic therapy. In Roger's belief, it is imperative the therapist is authentic, genuine, and able to be empathic and compassionate. The therapeutic relationship then becomes a healing medium through the "experience of an intensely human interaction within the context of an emotionally 'real'

relationship" (Gelso & Carter, 1985, p. 213). This broad category of humanistic theories consists of a range of approaches including Gestalt therapy and existential therapy. Central to humanistic therapies is the focus on patient self-disclosure and self-exploration with the view that the therapist's job is to provide the proper setting for these to occur (Haugh & Paul, 2008; Rennie, 2007).

Transpersonal theory. Transpersonal theorists consider humanism to be missing the spiritual and transcendent portion of the human experience. Therapy is deemed holistic, with the therapist's role in the therapeutic relationship as that of a guide to a higher transcendent state of development. Transpersonal psychotherapy consists of moving between this transcendent state, and learning techniques for restructuring situations of altered reality for the purpose of healing (Haugh & Paul, 2008).

Relational theory. It is difficult to separate psychotherapy theories from the particular time and culture in which they arose. The past thirty years has seen the development of a range of interpersonal and relational theories. Perhaps, as our world becomes increasingly viewed as a fast paced global marketplace, awareness has arisen of how we are all interconnected. These new theories have moved away from the four traditional schools of thought and focus on human relations and the therapeutic relationship. This movement has seen the development of integrative approaches that cross disciplines in the application of patient interventions (Haugh & Paul, 2008; Shattel et al., 2007).

Relational theory emphasizes that the therapist and the patient co-create and co-interpret intersubjective realities as the therapeutic relationship unfolds. Thus, while

homage is paid to the foundation of Freud and Sullivan, relational theorists also embrace postmodern, social constructionist, and feminist perspectives (Barker, 2003). In attempts to establish the science of psychotherapy, the therapeutic relationship has been somewhat abstracted and lifted out of its context. While it was acknowledged the therapist was a participant observer in the relationship, the focus was on the observer therapist. Relational theories place greater emphasis on the reciprocity of the relationship. In this stance, the therapist is viewed as a participant therapist (Berkery, 1997; Haugh & Paul, 2008).

Current estimates suggest that over 400 varieties of counseling and psychotherapy are practiced, each with their own nuances and differentiations. In addition, the last thirty years has seen blending of schools of thought. It is of interest that research and meta-analyses reflect this blending of modalities, with no clear evidence that any one approach is better than another. Recent research has further indicated that the therapeutic relationship itself may be more instrumental in the process of change in the patient than the theory of psychotherapy used (Haugh & Paul, 2008; Hubble et al., 1999). Regardless of the theoretical or clinical practice model used, the relationship between the therapist and patient remains central. While this therapeutic interaction is conceptualized in different ways, it remains the central dimension of virtually all therapy modalities (Shattell et al., 2007).

The Therapeutic Relationship in Mental Health Nursing

Within nursing literature, theory on the therapeutic relationship is dominated by Hildegard Peplau. Peplau has been credited as the "mother" of modern mental health

nursing and bringing the nurse-patient relationship forward and central to practice (Forchuk, 1994; Tomey, 2006). Peplau was influenced by Freud, Maslow, and specifically built on the interpersonal theory of Harry Stack Sullivan. Her work centred on the nature of the relationship between nurse and patient (Tomey, 2006). Peplau viewed this interaction as a helping relationship and "the process by which the nurse can facilitate personal growth in another by helping the person to identify felt difficulties, experience emotions, and understand his or her own behavior" (Lego, 1999, p. 9). The interpersonal focus of her theory required the nurse, as participant observer, to pay attention to the processes that occur between nurse and patient. According to Peplau (1992), the exploration of the patient's feelings and concerns leads to personal growth in both patient and nurse.

Peplau stressed the difference between professional relationships and social relationships. For her, the differentiation resided in the therapeutic relationship's exclusive focus on the patient. While the nurse remains aware of her own needs, there is a detachment of self-interest such as to become an agent of change for the patient (Peplau, 1988). Peplau asserted it was the responsibility of mental health nurses to know themselves in practice in order to be able to help others. In discussing the therapist's role in the collaborative phase of the therapeutic relationship, Peplau asserted that one needed to remain aware to "struggle with the problem and not with the patient" (Peplau, 1997, p. 164).

Peplau believed the therapeutic relationship developed in predictable stages. The patient's behavior changes thus corresponded to progression through the relationship

stages. Peplau identified four phases of the nurse-patient relationship: orientation, identification, exploitation, and resolution, covering stages of patient care from admission, treatment period, convalescence, rehabilitation, and discharge (Peplau, 1992; Tomey, 2006).

Peplau viewed her theory as relevant to all nursing practice, not just to the specialty of mental health nursing. This belief is also reflected in the work of Orlando (1961) who developed a psychodynamic theory of nursing. While Peplau's work focused on a long-term relationship between nurse and patient, Orlando focused on the immediate needs of the patient (Forchuk, 1994b). Orlando stressed the reciprocity of the therapeutic relationship and believed the "nurse-patient situation is a dynamic whole" (Orlando, 1961, p. 15), each affecting the other.

While not as well known as Peplau or Orlando, another nurse scholar, Joyce Travelbee, focused her work on the therapeutic relationship. Travelbee's theory extended and synthesized the interpersonal relationship theories of Peplau and Orlando (Tomey, 2006). Travelbee introduced her theory of human-to-human relationship in her book *Interpersonal Aspects of Nursing* in 1966. She announced her work as an admonishment to the premise of remaining emotionally uninvolved with patients (Shattel et al., 2007). To Travelbee, therapeutic use of self is a fundamental characteristic of a nurse and incorporates the other dimension, that of a "disciplined intellectual approach to problems to create the educated heart and the educated mind" (O'Brien, 2001, p. 132). Travelbee asserted that a therapeutic relationship is deliberately and consciously planned by the nurse. She also believed that emotional involvement is necessary to establish a

relationship; and that complete objectivity is neither possible nor desirable. Rather than being helpful, objectivity hinders a meaningful relationship (Tomey, 2006).

As in the broader psychotherapy stream, current nursing theory on the therapeutic relationship has become increasingly focused on integrative relational approaches situated in postmodern, social constructionist, and feminist perspectives. The therapeutic relationship has come to be viewed with a collaborative nonhierarchical stance that involves a weaving of the nurse's expertise with those of the patient (Bell, 1996). Barker (2001) asserted that mental health nurses journey with, and learn from, people experiencing mental distress. In this process, there is a continual involvement in the narrative of others who are attempting to make meaning of their mental illness. Hartrick Doane and Varcoe (2007) have written on the interconnectedness of the relational commitment and acknowledgement of self and other. Bergum (2004) focused her work on the moral space of the therapeutic relationship. For Bergum, the relational space between self and other, patient and nurse is "where personal meaning is awakened and where inherent knowledge is developed" (2004, p. 125). It is an appreciation that all relationships are moral obligations and direct the nurse to continually question what is the right thing to do for self and other. This stance of the moral obligation of the therapeutic relationship is also reflected in the work of MacDonald (2006) who purported "we can only live well autonomously if we live well together" (p. 123). Nurse scholars Wright, Watson, and Bell (1996) articulated that the work of therapeutic relationship is situated in the junctured space between the individual, family, nurse, and larger system beliefs. It is

in this therapeutic juncture that beliefs can be uncovered, understood, and challenged and so too where suffering may be diminished and healing begun.

The Context of Narrative and Story

The therapeutic relationship does not occur without context. It is woven into and emerges out of the fabric of the everyday existence of both participants. Maturana and Varela (1992) stated, "the world everyone sees is not *the* world but a world which we bring forth with others" (p. 245). We bring this world forward through dialogue, through relationships, and through narrative. Narratives or stories are the means by which we create meaning and make sense of our world. We tell them to ourselves through our thoughts and we share them outwardly with others in an attempt to connect and make sense of what is happening. Narratives offer an opportunity to explain, to review actions or inactions, to consider what has happened to us, and what we have done to others and perhaps simply to open up something that has been held in. Personal narratives, told to self and other, give meaning to experiences and position life in a historical context. They link present to past, affect to cognition, and express self (France & Uhlin, 2006).

Storytelling appears to be a natural reaction to illness as a means to make sense and find personal meaning within a condition that is foreign and different than a previous way of living, the-taken-for-grantedness of health. "Unlike the careful factual description of history, narrative asserts the human meaning of events, creating, often metaphorically, the categories for interpreting those events. So, one may review past events through narration and say, 'Oh now I see,' as if it were the first time" (Churchill & Churchill, 1982, p. 73).

Frank (2000) postulated that the storytelling relationship fosters people's sense of togetherness. It offers those who do not share their form of life a glimpse of what it means to live informed by such values, meanings, relationships, and commitments. "Those who accept an invitation into the storytelling relationship open themselves to seeing (and feeling and hearing) life differently than they normally do. Listening is not so much a willing suspension of disbelief as a willing acceptance of different beliefs and of lives in which these beliefs make sense" (Frank, 2000, p. 361). The listener may choose to not remain in the world of the story but their world will be changed as a result.

Foster, McAllister, and O'Brien (2006) shared their belief that it is this process of connection, in hearing the personal and emotion filled stories of our patients, as witness to their suffering, that brings the richness of nursing to fruition, and serves to make nursing practice visible. "The use of story in nursing may then reflect the intersubjective nature of the nurse-patient relationship, where neither individual is separated as object or subject, but rather exists in connection with each other" (Foster et al., 2006, p. 45).

In this connection of story, nurse and patient emerge changed. It is interesting to note that etymologically the word story is connected to *histoire*, history (Oxford English Dictionary, 1971). In nursing, as in life, "we are surrounded by stories, and we can trace these stories back to other stories and from there back to the beginning of language. For these are our stories, the cornerstones of our culture" (King, 2003, p. 95). In essence, our history, our culture, our context, is our story.

Therapeutic Relationship in Mental Health Nursing Research

While seemingly central to mental health nursing practice, the therapeutic relationship has remained elusive. Nurse scholars have long attempted to portray and illuminate its complexity. Barker (2003), Peplau (1952), and Travelbee (1966) have all held that the therapeutic relationship is the rock on which mental health nursing is built. Welch (2005) has intimated that an explicit understanding of what constitutes the relationship is vital to performing the role of a mental health nurse.

What is a Therapeutic Relationship?

In 1999, a classic review of literature by Suzanne Lego was republished. This review of the nurse patient relationship examined 166 published articles from 1946 to 1974 and explored history, trends and research on what she claimed was the foundation of mental health nursing. In conclusion, Lego (1999) punctuated the staggering number of unanswered questions regarding the therapeutic relationship. For Lego, the most perturbing question remained: "What exactly does or should take place in the one-to-one relationship?" (Lego, 1999, p. 17).

Three recent studies have attempted to tackle this question. While often proclaimed that the therapeutic relationship is distinctive to mental health nursing (Forchuk, 1995; Peplau, 1997; Walsh, 1999), the tenets of this claim remain elusive. In an attempt to delineate the unique practice based knowledge of therapeutic relationship in mental health nursing, Geanellos (2002), conducted a hermeneutic inquiry into the nature and specific knowledge held within the mental health nursing practice of therapeutic relationship. Working from both the nurse and patient perspective, she hoped to uncover

and make explicit the practice knowledge of the therapeutic relationship in the context of adolescent mental health nursing. Her findings suggested the unique contribution of mental health nursing resided in the nurse's ability to foster a "transformative change of self" in patients (Geanellos, 2002, p. 1). This was accomplished through guiding the potential for change, and facilitating positive outcomes while engaged in the therapeutic relationship.

Welch (2005) continued to probe the issue in an interpretive phenomenological study that explored nurses' perspectives of pivotal moments in the therapeutic relationship. Welch, like Geanellos (2002), hoped to identify what a therapeutic relationship is, and how it is practiced. Welch uncovered key qualities demonstrated in therapeutic moments including trust, power, mutuality, self-revelation, congruence, authenticity, and conscious action. The defining, or pivotal crux, of the relationship was deemed to be "a reflective, open and chosen act to bring out and model empathy in action" (Welch, 2005, p. 165).

Scanlon (2006) returned again to Lego's question in a grounded theory study of psychiatric nurses' perceptions of what constitutes the therapeutic relationship. Scanlon discovered, like those researchers before her, that a therapeutic relationship is therapeutic, but the degree of positive change remains difficult to measure. For Scanlon, the life experience of the nurse was the culminating factor of the therapeutic moment that acted in combination with learned interpersonal skills (Scanlon, 2006).

In each of these three studies, a complete answer to what is a therapeutic relationship remained elusive. While each scholar attempted to uncover and understand

its unique core in mental health nursing, there was an inevitable return to a description of concepts that left each researcher suggesting further research was needed into this complex relationship. Forchuk (1995) claimed the therapeutic relationship was a "unique combination of each dyad" of nurse and patient and created a "unique situation" each time (p. 36). If one accepts this definition of the relationship, one contributes to its complexity.

Development, Characteristics, and Concepts of the Therapeutic Relationship

In an attempt to delineate its hidden nature, research has often focused on some concept or component of the relationship. Canadian nurse scholar, Cheryl Forchuk, and her colleagues have long undertaken research into the development, progress, and phases of the therapeutic relationship, according to Peplau. Their work has seen the development of the Relationship Form instrument (Forchuk & Brown, 1989), which outlined the phases of the nurse patient relationship. The instrument was designed to allow the nurse to ascertain appropriate nursing interventions based on the findings of the phase and progress of the relationship.

Subsequent studies utilized the Relationship Form instrument to evaluate the relationship progress with patients who had severe and persistent mental illness to determine length of time needed for treatment (Forchuk, 1992, 1994a, 1995). Forchuk et al. (1998) examined factors influencing progression through the phases, utilizing 10 nurse-patient dyads, the hypothesis being that movement through the phases is sequential, with orientation needing to be complete before patient problems are worked on. Patients perceived nurse attitude and the nature of the nurse-client interactions as being the most

influential on relationship progress. In a follow-up study, nurses described the importance of providing consistent care with appropriate patient based timing as essential to movement through the relationship phases (Forchuk et al., 2000).

Beyond the phases and progress of the therapeutic relationship, what happens in the relationship has been explored in attempts to understand how it is helpful to the patient (Forchuk & Reynolds, 2001; Hagerty & Patusky, 2003; Walsh, 1999). Hagerty and Patusky (2003) challenged Forchuk and colleagues' focus on the linearity and temporality of the therapeutic relationship with a reconceptualization on human relatedness. For Hagerty and Patusky, connection, not time, within the therapeutic relationship attributed to an increased sense of wellbeing and comfort. In deference, disconnection resulted from lack of active involvement and concomitant anxiety, distress, or lack of wellbeing. Connection promoted health and recovery; disconnection contributed to illness and 'stuckness' (Hagerty & Patusky, 2003).

In alternate attempts to delineate components of the therapeutic relationship, other concepts studied have included empathy (Hardin & Haralis, 1983); connection (Miner-Williams, 2007; Wiebe, 2001); commitment and involvement (Morse, 1991); transference (Evans, 2007); nurturance (Raingruber, 2003); and boundaries of the relationship (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2006; Milton, 2008). Therapeutic relationships have also been explored in the context of a variety of patient populations, clinically depressed (Beeber, 1989), and with suicidal individuals (Sun, Long, Boore, & Tsao, 2006). These studies, while emphasizing the importance of therapeutic use of self and the development of relationships with patients as the core of

mental health work, do not address the meanings of the relationship for the participants, nor do they identify the skills that the nurses used to develop and maintain the relationships. Morse (1991) wrote "maintaining a therapeutic relationship in psychiatry appears to be one of the most difficult aspects of caring for patients in this specialty" (p. 466). From these studies, the needed fundamentals of an effective therapeutic relationship appear to comprise of reciprocity, an investment of time and emotion by both parties.

Patients' Perceptions of the Therapeutic Relationship

If the maintenance of a therapeutic relationship is one of the most difficult aspects of caring for patients in mental health (Morse, 1991) and requires the commitment of time and emotion from both parties, there is a need to explore the patients' wishes and perceptions. Moyle (2003), in a phenomenological study of individuals hospitalized with depression, found a dichotomy between the close relationship expected by patients and the distant relationship provided by the nurse. Her findings challenged the assumption that nurses readily encourage a therapeutic relationship. The patients in her study revealed the perceived distant relationship negatively impacted their wellness trajectory. Similarly, Coatsworth-Puspoky, Forchuk, and Ward-Griffin (2006) found when patients held a negative perception of the relationship with the nurse the therapeutic components of the relationship deteriorated.

Horberg, Brunt, and Axelsson (2007) found patients required security, trust, genuineness, companionship, confirmation, and development within the therapeutic relationship to move forward in healing. Conversely, in a phenomenological exploration of the therapeutic milieu, it was nurses who yearned for the therapeutic relationship while

patients derived support from interactions with other patients (Shattell, Andes, & Thomas, 2008).

Patients' perceptions have also been addressed in regards to desired attributes of the nurse within the therapeutic relationship (Bedi, 2006; Bedi, Davis, & Williams, 2005; Littauer, Sexton, & Wynn, 2005; Lowenberg, 2003). These studies indicated patients wished nurses to be warm, calm, responsive, empathetic, and compassionate. They wanted nurses to be non- judgmental, honest, to listen attentively, show acceptance, confidence, understanding, and to balance questions and comments with listening. In addition, Hostick and McClelland (2002) found patients wanted validation of their experiences, emotional support, care, appropriate education, and referrals.

Understanding the patients' perspective on the therapeutic relationship is vital if appropriate interventions are to be developed and implemented. However, equally important is a need to explore the other side of the relationship from the nurses' perspective.

Nurses' Perceptions of the Therapeutic Relationship

Horberg et al. (2004), Hostick and McClelland (2002), and Lowenberg (2003) also explored the therapeutic relationship from the nurses' perspective. Their studies reported that nurses believed trust, being comfortable with the patient, being sensitive to 'vibes', and respect were important components of the relationship. O'Brien (2000), in a hermeneutic phenomenology inquiry of nurses' experiences in the context of community psychiatric nursing, found similar perceptions. Nurses in her study believed 'being there',

establishing trust, and facilitating transition were fundamental to the therapeutic relationship.

These studies focused on the therapeutic relationship and how the nurse facilitated it. Their central focus remained on uncovering the structure of the relationship as viewed by the nurse, not on the impact or meaning per se of the experience. They remained patient focused and did not attempt to uncover the impact and meaning of this relationship on the nurse, and how that in turn affects the therapeutic relationship.

Lego's (1999) classic review of literature concluded the meaning of the therapeutic relationship remained largely unexplored. This gap in the literature has been attributed to the difficulty in separating tasks from their meaning in the practice of mental health nursing (Lego, 1999). Three studies in the 1990s attempted to close this gap of meaning. All three studies were completed as part of doctoral dissertations; one focused on outpatient addiction work, the remaining two focused on masters prepared advanced practice mental health nurses. Conti-O'Hare (1995) conducted a phenomenological study of therapeutic use of self with addicted clients in early recovery for her doctoral dissertation. Findings indicated nurses were able to relate, in some way, to the patients' experiences. The nurses believed both parties invested time and energy and in turn both benefited from, and felt valued within the relationship. McElroy (1990) used Heideggerian hermeneutics to explore the experiences of mental health therapists. Berkery (1997) continued this exploration, again using Heideggerian hermeneutics. Berkery (1997) described the therapeutic relationship as a double helix, in which both nurse and patient are actively committed on a healing journey. Both studies revealed the

need for nurse therapists to dialogue with each other about the therapeutic relationship. McElroy (1990) shared her belief that it is only within these conversations that the excellence, expertise, and meaning of the profession could be uncovered.

The therapeutic relationship between the nurse and patient is considered to be healing and growth promoting for both participants (Peplau, 1952, 1988). While we know a great deal about what patients want and what nurses are supposed to do within in a therapeutic relationship, we continue to know very little about the meaning of this everyday experience for mental health nurses. The majority of current research has been conducted on the concepts held within the relationship. While these investigations have been vital in revealing the complexity of the relationship, they have failed to explore its meaning to, and impact on, mental health nurses. This gap is knowledge that opens space for an interpretive look into these phenomena through conversations with nurses who live within the everyday experience of the therapeutic relationship.

CHAPTER FOUR

Research Design

Method

Description

My research was guided by the philosophical hermeneutics of Hans-Georg Gadamer (1900-2002). In this context, Gadamerian hermeneutics was chosen because it specifically looks to understand and interpret language and experience. Since the focus of this research is to uncover the meaning of listening to illness narratives, hermeneutics allows a portal to uncovering deep meanings and understandings; hermeneutics is attuned to what is spoken and unspoken, hidden and exposed, part and whole (Gadamer, 1989). According to Gadamer (1989), understanding always occurs through dialogue and the dialectic of question and answer, a dialectic that is not unlike the dialectic that occurs in conversation between nurse and patient.

Gadamerian philosophical hermeneutics has no methodological script for correct interpretation or research. "Hermeneutic philosophy is essentially unconcerned with method and offers little direction regarding its use in research" (Geanellos, 1999, p. 39). The aim of hermeneutics is to value experiences of truth, of understanding and how they are situated in history, dialogue, and linguistics (Jardine, 1992). This is in contrast to the entrenched stance of method that is classic within the scientific paradigm. Rather than a concern for strict methodological procedure, one should become concerned with "methodos, meta-odos, which is the way in which we pursue matter" (Caputo, 1987, p. 213).

A Conversation of Fit

The ability to listen and attend to another human is the "universal dimension of hermeneutics" (Gadamer, 1996, p. 166). Gadamer (1996) contended this universality extends into the heart of philosophy, beyond the pursuit of logical thinking into a "pursuit of the logic of dialogue itself" (p. 166). The heart of mental health nursing, the therapeutic relationship, is situated in dialogue in the uncovering and rediscovering of a person's narrative. It is the work of mental health nursing to listen, to interpret, re-contextualize, and re-offer alternatives, with the building of new narratives through the intertwining of the nurse with the patient creating a new narrative for both. This work dwells in the realm of the unknown, in the tenuous borderland beyond what the natural sciences can know, predict, and explain (Gadamer, 1996). The workings of the human mind, heart, and soul are nebulous and elusive and often exist beyond our knowing and doing (Gadamer, 1989).

It is in this position, in the borderland beyond the natural sciences realm, that the connection between psychiatry and hermeneutics is revealed (Gadamer, 1996). The "attempt to grasp the unpredictable character of the spiritual and mental life of human beings is the task of the art of understanding which we call hermeneutics" (Gadamer, 1996, p. 165). I would further that so too is this the task of mental health nursing and psychiatry. Mental health nurses are situated in the midst of stories, of lives lived in shifting contexts, histories, and relationships. The given task is to navigate situational particulars, and through interpretation place these particulars into an understood whole (Moules, 2000, 2002). In this way, both interpretive researchers and nurses can be viewed

as "brokers of understanding" (Moules, 2000, p. 18). Hermeneutics and psychiatry endeavor to bring forward through language that which has been dormant, hidden or forgotten, to enter the unexplainable and incomprehensible and bring back new possible selves (Gadamer, 1996). This interplay between two individuals engaged in the humanist of deep conversation leads towards self and shared understanding. Listening and attending to one another then becomes the outward expression of hearing, thinking, and understanding of the topic at hand (Hovey & Paul, 2007).

Data Generation

Hermeneutic inquiry generates data through engaging in dialogue with participants. The aim of such dialogue is to bring the topic forward, to enliven it and extend our understanding of it (Moules, Simonson, Prins, Angus, & Bell, 2004). With this as the intent, hermeneutic inquiry is less concerned with numbers of participants and interviews than with selection of those who are able to speak to the topic and enrich our understanding of it (Jardine, 1992). Thus, I chose participants who, as mental health nurses, were knowledgeable and able to speak to the experience of listening to patients' narratives.

The purpose of conversation, in the context of dialogue between nurse and patient or in a hermeneutic inquiry, is to ask questions in such a way as to open space for the topic to emerge. This interplay in dialogue of question and answer, probing further into some areas and not into others, is negotiated in a responsive recursive manner to allow meaning to be co-understood (Gadamer, 1989). "To reach an understanding in dialogue is not merely a matter of putting oneself forward and successfully asserting one's point of

view, but being transformed into a communion in which we do not remain what we were" (Gadamer, 1989, p. 379). In this regard, it is not my point of view as researcher or as a mental health nurse, as an expert, that brings to bear but rather an awareness of my pre-understandings and what is at "play" in the conversation such that I begin to "know" my "way around" in the language of it (Gadamer, 1989, p. 260).

Participants

Number and Criteria

Hermeneutic inquiry cannot be measured or predicted by a number, therefore there is no appropriate sample size calculation. Five participants were interviewed to provide the needed richness of data required for this particular topic at this level of masters' study and analysis.

The participants for this research inquiry were garnered through a purposive selection to provide a detailed rich encounter of their experience as a listener of patients' stories. Inclusion extended to any nurse registered with the College and Association of Registered Nurses of Alberta (CARNA) and presently working in the Calgary Health Region in a mental health clinical practice area.

Recruitment

Recruitment occurred by email and direct presentation. The study was introduced, and participation invited, by first sending out an email with a poster attachment, introducing and outlining the details of the study and providing contact information to patient care managers of mental health facilities within the Calgary Health Region. This

email also requested their permission to place the study recruitment poster in staff areas of the units. The recruitment poster is included as Appendix A.

Presenting the Participants

Five mental health health nurses agreed to participate in this research study, met the inclusion criteria, and were interviewed. The field of mental health is a small community, and to heighten anonymity only a brief snapshot of the participant group is offered. All five were registered baccalaureate prepared nurses who received their training in Canada. The length of their nursing practice varied from two to eight years. Two of the participants, Lana and Dianne came from other specialty areas prior to working in mental health; the remainder have worked in mental health since the completion of their undergraduate degrees. All five participants have worked on in-patient hospital units with one participant now working in a community based out patient program. All five are women, in their late twenties to mid-thirties, with varied cultural, spiritual backgrounds, and beliefs. For purposes of this research, the pseudonyms Dianne, Lana, Meg, Kaylee, and Pat were used.

Ethics

Overview

This research project was submitted to the University of Calgary Conjoint Health Research Ethics Board for approval. Principles of ethical research were addressed through an ethics review examining informed consent of participants, privacy and confidentiality, conflict of interest and inclusion in research.

The consent form (Appendix C) and consent process included an overview of the inquiry, a statement of commitment to participate in a research interview, an explanation of the voluntary nature of participation and ability to withdraw consent at any time, and a description of how confidentiality is addressed throughout the research process.

Consent and Confidentiality

At the time of meeting with the participants, informed consent was obtained. This included consent for audiotaping the interviews, as well as for publication and presentation of the research findings (Appendix C). I transcribed all the interviews myself, and thus did not use a transcriptionist. The only other person who had access to the complete data was the study supervisor; members of the supervisory team had access to select aspects of data analysis. Consent forms were kept in a locked drawer in the office of the study supervisor, and were the only items containing participant names or study ID numbers. Transcripts, documentation, and field notes related to the research were kept in a locked filing cabinet in the study supervisor's office. Any electronic versions of the data were maintained on a password-protected computer.

In the transcripts, participants' names were replaced with pseudonyms. The use of pseudonyms will be maintained for any future writing or publications regarding the research. In addition, any direct quotes from transcripts that are used for publication will be further screened to limit identifying information that could lend to the participants identification. It is possible that despite every effort, the participants and other nurses may recognize the participant's story if they were to read it. Participants were made aware of this risk.

If during the interview, a participant decided to withdraw from the study, the interview would not have been transcribed, and thus citations would not be used in the research. This did not happen and thus all interviews were transcribed and formed textual data.

Potential Harm

While no harm was expected from this research study, measures were taken to prepare for the eventuality should it arise. As I was speaking with mental health practitioners, particular attention to protecting anonymity was taken while assuring safety and mitigation of harm. Should a potential for harm to self or others have been revealed, the participants were informed in the consent form, that legal authorities would need to be informed. If a participant indicated the topic was causing personal distress, and they did not have a personal counselor, I would have sought assistance from Dr. Moules, who is an experienced counselor. In this manner, I would not be referring them to a service or counselor, who may be a colleague.

The Interview Experience

The research interviews occurred one-on-one with individual participants and myself in a mutually agreed upon time and location. The individual interviews took between 1 to 1 ½ hours to allow for adequate time to establish an environment conducive to the sharing of stories and experiences. The interviews were audio-recorded and then transcribed verbatim into written text. The written text allowed for a revisiting of the interviews on repeated occasions.

Through the use of an unstructured interview, I explored what it meant for the participants to take up, process, and experience the narratives of their patients. What did it mean for them to listen? How were they able to do this? Does the stance of being a mental health nurse and a listener of stories disrupt their previous held version of themselves? How does it manifest, influence, or affect them? I chose to open up the research interview with the question, "I am curious about a time when a patient's story has stayed with you, come home with you; what has been its biggest impact?" Probing, clarifying, and uncovering further utilized difference or behavioral effect questions to delineate meaning and deeper understandings (Wright & Leahey, 2005). A list of guiding questions, for the interviews, is included in Appendix B.

Data Analysis

The process of data analysis, and interpretation began with the research interviews. My task in this analysis was to uncover alternate or extend new understandings from within the experience of illness narratives (Gadamer, 1989). Further, it is about revealing the story, the significance, meanings, and influences that the topic at hand renders in the process of coming to a place of truth (Jardine, 1992). In this way, the research process was guided not by methodological procedures but rather by thoughtful systematic attention to the topic (Moules, 2000).

Dialogue, language, and conversation are inherently human modes of understanding (Binding & Tapp, 2008). They constitute the fabric of everyday life, and are the means by which we express and experience the world. It is language that provides both understanding and knowledge and is regarded as the art of interpretation (Dowling,

2004). In order for interpretation to occur, there must exist something, some 'text' (Ricouer, 1998). In this inquiry, text was derived from the participants and my words and provided the ground of the interpretation. The profound implication of dialogue in interpretive work is the awareness that we alone are incapable of understanding the "contours of the story" we are living out (Jardine, 1992, p. 59). The fusion of horizons provides a description of how understanding comes together: "the hermeneutical has to do with bridging the gap between the familiar world in which we stand and the strange meaning that resists assimilation into the horizons of our world" (Linge, 2004, p.xii). Hermeneutics thus provides an opening into the understanding of an experience of, something, by being present, and aware of the pre-understandings brought into a topic. The hermeneutic process becomes a dialogical fusing wherein the horizons of interpreter and the thing being studied are combined (Laverty, 2003; Moules, 2002).

The metaphor of the hermeneutic circle originated in the work of Heidegger and was taken up by Gadamer as a descriptor of movements between the part and the whole (Koch, 1996). This movement from the specific to the general, from the general to the specific is an attempt to understand the whole in terms of the detail, and the detail in terms of the whole. It becomes a circular process of movement back and forth that leads to understanding. In order to understand the meaning of something held by another, we must not attach blindly to our pre-understandings. Rather, we need to remain 'open' to, and embrace the meaning held by the other person (or text). We must be aware of our biases for the text to portray its uniqueness against our own pre-understandings (Gadamer, 1989; Laverty, 2003). It was my hope that the text would open up and

illuminate a way forward as it could be read, reread, and interpreted. Reading and re-reading formulate an understanding of the parts and creativity is emergent with the reconstruction of the whole in a meaningful, purposeful, insightful way that offered understanding about the topic (Jardine, 1992).

In the analysis phase, I also returned to the literature. Literature was used to explore, understand, and find meaning in history, context, and language of what the participants were saying about the topic. In this sense, it was not used as validation or confirmation that the interpretation is the 'right' one, but rather as a landmark of resonance with the topic (Jardine, 2006).

Writing Myself In

This research inquiry consists of the interwoven experiences of five mental health nurses and me of being in relationship with our patients. I believe that I am the sixth participant in this research. As a mental health nurse of five years, I am not able to position myself outside of the context and history of this topic area. As Jardine (2008) denoted, I am of it, immersed in the landscape of mental health nursing, and situated in the topic of impact of therapeutic relationship. It is for this reason I have chosen to write using the pronouns 'our' and 'us' rather than 'they' or 'theirs'. This is a story of the impacts of the therapeutic relationship on mental health nurses; it is also my story and my history.

I grew up as a Lutheran minister's daughter. I was accustomed to the late night telephone calls from parishioners often heralding a situation filled with pain and suffering. Spending time with my father often meant accompanying him while he visited

parishioners. I would sit at his knee while he listened to, spent time being with, and comforted those in need. I was not sheltered from these stories or the emotions they evoked; loss and suffering were commonplace and somehow normalized in my household. Horrible things happen to people. Loss and suffering permeate life.

These times with my father sustained within me a curiosity about people, their lives, and stories. I was drawn into nursing, not because I believed I could make a difference in people's lives or because I entertained myself as a good listener, but rather due to this curiosity and predilection in wishing to hear about the lives of others. Who do they love? Where are they going? Where have they been? Who are they? I believe I am able to take up this work, as a mental health nurse and as a researcher, because of my personal experiences with loss, suffering, and from the importance of being in relationship with others taught to me by my father. In this sense, I am suggesting that my experiences, my history, and traditions have opened up a receptivity or sensitivity to others who share a different yet similar predilection to narrative, story, and relationship. To me, this use of self-knowledge and application is one of the 'fits' of hermeneutic inquiry to my research topic. A research topic, which embraces patients' narratives in the context of the therapeutic relationship, is known to me as a mental health nurse who has listened to and taken in similar narratives. In this, there is an inherent sense of obligation and responsibility to the topic as it presents itself.

Trustworthiness of the Research

There exists a great weight of responsibility in an interpretive inquiry in the process of drawing meaning from the text. Articulating understanding, through

interpretive writing, fixates, as it were, the spoken word in a time and space distanced from its original conception. The narratives from the participants were honored, yet detached for new relationships to emerge, with the intent of having the "interpretation disappear and the meaning of the text remain" (Binding & Tapp, 2008, p. 127).

In hermeneutic research, there will never be a finitude or scientific reproducible truth. The goal, rather, is to uncover, to go beneath, and beyond in a way that resonates a common understanding of a perhaps forgotten truth (Gadamer, 1989). In this work, there is a pursuit to jar us awake from the stupor of forgetfulness that us lulled us in our day-to-day existence. This work requires the researcher to proceed with caution, maturity, and experience in order to reveal a 'fitting' truth (Jardine, 2006, 2008). The work is deemed valid and to hold merit when the reader acknowledges with a nod, and assent of "ah, yes this is right", when there is, for them, resonance with the topic (Gadamer, 1989).

The rigor of interpretive research should be judged on its coherence, comprehensiveness, appropriateness, and potential (Madison, 1988). In this regard, I detailed the 'how' of my work, in the form of an audit trail, journaling, and interpretive memos. My supervisor, who is experienced with the topic of therapeutic relationships and hermeneutics, reviewed my research. There was also a need for me as the researcher, to look up from the work to remember where I was in regards to the topic. There was a call to become experienced, to search the literature, to familiarize myself with the landscape, history, and ancestors of the topic (Jardine, 2006). Finally, those who read my research work will ultimately speak to whether or not it is coherent, useful, and provides potential new understandings of the topic.

CHAPTER FIVE

Wondrous Dangerous Stories

I came to nursing and the area of mental health later in life. I had progressed through many vocations, had traveled, and lived throughout the world. I believed I had experienced many things, and there remained nothing that could shock or disturb me. While in Africa, I worked and spent time with people dying of AIDS. Emaciated skeletons, they were, dwarfed by huge eyes and empty rooms smelling of unclean bodies and lingering death. I nursed my father, too, as pancreatic cancer ravaged his once massive frame and shriveled his presence away piece by agonizing piece. I held these experiences close, and many more, and yet somehow I was not prepared for what I would encounter within the space of the therapeutic relationship.

These are not stories that I tell often, or ever. I prefer to keep them locked away, firmly sequestered in the far reaches of my mind. I tell you these stories, of my experiences in the therapeutic relationship, not out of a voyeuristic intent to traumatize you the reader(s), or exploit the patients' stories, or the impacts on the nurses. Rather, it is to bring us to a particular landscape and place of story in mental health nursing to begin a discussion. "Storytelling is the recursive elaboration of the relationship between those sharing the story" (Frank, 2000, p. 354). In this way, those who tell and those who hear stories are changed in the process. We become part of a life that is thus lived and felt differently then before (Frank, 1998). We, collectively become changed by our involvement with stories, and this is my intent. I believe, as Thomas King (2003) said, "the truth about stories is that that's all we are" (p. 2).

These are the stories that haunt and stay with me, spilling out of the recesses of my mind where I had neatly and purposefully tucked them away. There is the encounter with a woman who shared with me she wished each night to not awaken the next morning. The eyes of her children, murdered in a post partum psychosis, haunted her and were too much to bear. I recall also the Chilean student activist who sobbed as he shared with me his wish to hug his young daughter. His arms scarred and battered from being tortured, he could not bring his arms outward enough to do so. He spoke of hearing the sound of his friend's screams from adjoining cells. He wondered aloud to me, how do you live when you are the last one left of your friends. There is one story however that among all others often returns when I lie awake at night with the voice and face of a young man.

We shared a connection this young man and me. Our fathers were both church ministers. We would talk as he played his guitar and over time he began to speak of what brought him to hospital. He asked about my father, I shared with him my father had died. "I have no father too" he sighed. "They killed him in front of me, with my brothers and I watching. They shot him and tore his body apart". He spoke of how he was forced to watch, held back by men with guns and then thrown aside. He was eight years old. His father's crime was being a church minister and leader of his village. I sat and stared at his hands playing his guitar. An aching sound came forth as if the chords played his sorrow. We sat side-by-side playing and listening, while I struggled to find words worthy of being spoken aloud. "There flowed a river of blood", he said. "I lay on the ground and my father's blood trickled warm around me. That is why I go to the river. I want to

cleanse myself, purify. They think I'm crazy, that I will harm someone just as my brother did. Do you think I am crazy?" My response, all I could think to speak, was "Do you think you are?" He turned from me, no longer willing to look at me, and continued to play the woeful tones. Our connection broken, I left him in the room. I intended to return but the busyness of the unit prevented it. I did not see him again. I never got the chance to give him another answer, yet he remains with me still.

There is a need to voice caution as we proceed: These stories while "wondrous" are also "dangerous" (King, 2003, p. 9). The stories we share in mental health nursing exact a toll, they may be painful, disturbing, and even traumatizing. They hold the power to haunt us. Once spoken, a story "cannot be called back. Once told it is loose in the world" (King, 2003, p. 9). These stories become part of us. King (2003) warned that we must "be careful with the stories [we] tell. And [we] have to be watch out for the stories that [we] are told" (King, 2003, p. 10).

As I reflect on the stories I have opened and shared, my hope is that they hold the potential to be seen and heard in new and different ways. "This is one aim of the stories that haunt us. They do not allow us to be misled by the surface of things. They invite us to embrace struggle" (Rashotte, 2005, p. 42). If stories speak us, they also allow us to reflect on our world (Frank, 2000; King, 2003). They invite us to join together to explore our deeply held questions of life and embrace the intimate answers returned (Frank, 2000; Rashotte, 2005).

Ben Okri, the Nigerian storyteller, spoke of why he has shared the often-dark stories, of his childhood. "We live by stories, we also live in them. One way or another

we are living the stories planted - knowingly or unknowingly- in ourselves. We live stories that either give our lives meaning or negate it with meaninglessness. If we change the stories we live by, quite possibly we change our lives" (1997, p. 46).

CHAPTER SIX

Home as Shelter

> Human beings would lose themselves were they not to remain on the way, in search of home (Harries, 1978, p. 27).

Mental health nurses journey with, and learn from, people suffering mental distress. In this process, there is a continual involvement and immersion in the narrative of others who are attempting to make meaning of what is happening to them (Barker, 2003). These journeys, and the therapeutic relationships in which they dwell, are complex, dynamic, contextual, and full of impact. For Dianne, there existed no topographic map or perfect formula that can be taught and reproduced; it is rather about joint discoveries with patients and finding our own way as nurses.

> *D: I think ...it is very important for nurses to be able to have these relationships with our patients and that it isn't necessarily something that can be taught. I think it is one of those things that you learn in the fundamentals of what a nurse-patient relationship should look like and you find your own way from there.*

Finding our own way evoked, to me, a discovery journey of self and our place as mental health nurses in the world. It is also a journey of language, conversation, and uncovering new, or perhaps different, understandings of dwelling in the place of our patients' narratives. Ultimately, this journey as mental health nurses of the therapeutic relationship has been about finding a way home.

Our home as human beings is fundamentally and essentially brought forward by language. We thus live in language, are housed in it, in the same way we live in the

world. It is within language that our Being dwells, and through language that our Being is either disclosed or concealed (Dreyfus, 1991; Hayes, 2007; Heidegger, 1962). In this way, I refer to Being as the sum total of whom someone is at any moment in time given their history, culture, education, future, and how they are situated in their ontological stance. Being is a fluid, changing awareness of living and dwelling authentically (Heidigger, 1962). This dwelling, to me, evokes the paradoxical web that is representative of home.

What, however, is the connection between the concept of home and mental health nurses speaking about the impacts of the therapeutic relationship? I heard in their words the subtle, yet clear, call of wounded-ness. Wound is related to the Latin *orificium* meaning an opening or portal to a new way of understanding (Oxford English Dictionary, 1971). It was through this portal that the voices spoke of a struggle to find shelter from the onslaught of emotive narratives and of an impulse to return to a place of safety. To me, home is this haven in the turbulent seas of postmodern chaotic life. Home embodies safety, the familiar, the comfortable, and ease. It anchors place, identity, and self by providing a locale perceived as ours (Reinders & Van Der Land, 2008).

Being at home is a most cherished experience. It is where we come from and to where we return at the evenings end. Home is a refuge, a shelter, a haven that protects and shields us from outside forces and public scrutiny (Reinders & Van Der Land, 2008). The word, home, has been venerated as the most universal and frequently referred to noun in all languages (Hulse, 1992). The conceptualization of home brings forward more than its physical structure; it is a functional, relational, virtual, mystic, sacred, and verbal

environment (Hayes, 2007). Carl Jung (1975) likened the psyche to an old house with many rooms. Stored in every corner and closet are the psychic artifacts of all human experience. While the idea of home is universally understood and sought after, this lived meaning of the psyche is complicated by a home's private interior nature. By virtue of its sheltering and concealing nature, the everyday psychological interior is difficult to access.

Disruptions to Home

Feeling at home is to be caught up in day-to-day activities; it is to be focused on the rituals of employment, socializing, family, and events of living in a world with expectations, rules, and traditions. It means comfort and being lost in the everydayness of normal life. In this living of day-to-day events, people actively avoid thinking about, or engaging in, events that create anxiety, stress, and discomfort (Svenaeus, 2001). What happens, however, if your chosen vocation is to listen to the painful, evocative, and often disruptive narrative of others? How is this being in the world as a mental health nurse played out as this disruptive force evades an at home way of living?

The disruptive effect of the relationship with her patients took Pat by surprise:

P: There is no way coming into mental health I ever felt, I mean and maybe it wasn't realistic, may be it was the idealizing of a brand new student, but did I ever think it would impact my home life this much? Even knowing I was the kind of person to take stuff home, I never thought it would impact my life this much.

This stepping into the life of another and the opening of your home, your being, to another is the working realm of a mental health nurse. People are constantly being

confronted by life situations that cause disruptions to their comfortable, familiar, at home way of living (Svenaeus, 2001). Life's stressors, large and small, positive and negative, have the potential to create unrest, concern, and distress. When we feel not at home because of disruptions to our known world we are thrown, according to Heidegger (1962), into a new way of being. This thrownness, in the form of specific challenges to our life, causes us to question why these events are happening and to search for answers. These are answers to our questions, not of why and how this is troubling to me; rather, they are directed toward the immediate relief found through a return to a pre-thrown state that was without our sense of disrupted-ness.

The disruption to Pat's world became evidenced, in its fullest intensity, when listening to a patient's narrative, directly and profoundly affected her. The arousal of fear and anxiety disrupted her at home way of being, and she sought to adjust to the thrownness this created. The personal impact of this stressful event was also intertwined with how she perceived the stressor, its closeness to her, and how she interpreted its delivery and message (Dreyfus, 1991). The self as nurse, was being brought home into her awareness as self as person. While she recognized she was the type of person to bring work home, she continued to be surprised by how much it affected and impacted her home life. Pat had begun to search for reasons why work had so deeply impacted her. In her search for understanding, one is afforded a glimpse of a shifting and realignment of Pat's perceptions of self. As she contemplated the disruptive influence, a shifting of the idealization of a brand new nurse with an impenetrable shield, has been altered to reveal itself anew as typically worn, battered, and scarred. In this adjustment of history, Pat now

claimed she was not realistic in her prior belief of how much work would infiltrate her home life. Along with this, is the premise that she should have been able to separate the two, the work and home life, and that this was possible and ideal.

This separation of personal and private life was evident as well in Meg. She appeared to hold a strong belief that she too could, and should, be able to separate the two.

> *M: I guess I just feel like it's not my, it's not my job to be affected by the stories. I'm really empathetic at work. I focus on being there and listening to whatever the story is even if it is hard to listen to. But whatever the story is, at work..., I'm able to realize that letting it bother me is not going to do any good.*

The affective and the effective components of Meg's work are divided. She delineated that it was not her job to be affected by the relationships with her patients and to do so would not benefit anyone. Henderson (2001) outlined this separation in her description of the successful navigation of the emotional demands of nursing work. Henderson (2001) viewed this as a continuum between the fluctuating dynamics of engagement and detachment. Engagement is viewed as an emotional attachment and connection to one's patient. Detachment is seen as a distancing objectivity required to effectively function in certain aspects of nursing work. From this viewpoint too much emotional attachment renders the nurse ineffective and incapable of doing their job, whereas, if a nurse is too detached, there is no point of connection with patients and care suffers. To be successful in this endeavor a nurse can be described as needing to continually shift between these two polarized dimensions (Henderson, 2001).

M: I think so, yeah. But I need to separate it right, the work from home and let that go. I just trust that the other nurses take it up and so it will be okay. Otherwise I couldn't do this.

A: Couldn't do this work?

M: Yeah. I trust the nurses I work with and so I can go to sleep at night and say okay, okay and turn it off you know.

Meg believed that, in order to sleep at night, she needed to separate work from home, turn off thoughts of work and detach these two portions of her life from one another. This form of separation is akin to pulling apart, as in to cut off, shear or tear (Oxford English Dictionary, 1971). By placing the worries of her day with her colleagues, she was able to partition her mind and rest. To me this evokes a divide or wall placed for a particular purpose.

On a shelf, in my office sits a graffiti covered lump of concrete chiseled from history. This piece of the Berlin wall, which overnight, divided families, friends, and communities, echoes to me the divide Meg built. The Berlin wall arbitrarily wove its way through homes, train lines, and buildings and perpetuated the divergence of two German states. What began as a border protection defense by the East German state quickly developed from an imaginary line into an entangled wall of wire, steel, and concrete. While the physical wall has been gone for over twenty years, remnants remain. The cultural differences propagated over the years, between East and West Germans, have been described as *mauer im kopf*, the wall in the head (Fischer, Maes, & Schmitt, 2007). Peter Schneider, a West Berlin author wrote "it will take us longer to tear down mauer in

kopf than any wrecking company will need for the wall we can see" (Schneider, 1981, p. 8). To me, this speaks to the power of the mind to divide and section itself and the power of social systems and constructs to form and shape thought. While the seen wall is demolished and gone, the foundational tensions and beliefs have become an invisible fault line. For some, the Berlin wall was a protective mechanism against the fear of western advancement, to others it was a prison barricade. The perspectives and remembrances of the wall are as varied and complex as those attributed to the walls original formation (Fischer et al., 2007).

For Meg, and the other participants in this inquiry, the wall in the head reveals the complexity of the mind, the power of perspectives and beliefs, and the frayed edges the separation of work-home, nurse-human can evoke. There is in Germany a continued discussion of the meanings and necessity of the wall (Fischer et al., 2007); necessity is a singular word, with much hidden depth. Meg viewed the separation between work and home as a protective mechanism. It allowed her to not only be able to be in relationship with her patients, but to return home at shift's end, sleep, and rejuvenate her being. In this sense, the wall was necessary, a defense of protection, not isolated imprisonment. Erected partitions can be viewed for their physical divides, of home and work as shown by both Meg and Pat. They can also be viewed temporally separating past, present, and future. This is evidenced in Pat's attempts to realign herself in the past as a brand new student, which repositions not only her present viewpoint but also how she sees her self moving forward. Finally partitions can be seen as perceptual, in that which defines and distorts

our conceptions of self and other. These components of separation collectively serve to either enhance or diminish as they shape, mirror, and challenge our identity of self.

In the instances of both Pat and Meg, the at-home feeling of being has been disrupted from relationships at work. They have been lost in the everyday-ness of nursing until their relationship with a patient throws them into anxiety. Thrownness is the condition of people being in situations that are unpleasant, disruptive, and unfamiliar. When we feel not at home because of disruptions in our world, with no causative explanations, anxiety arises (Svenaeus, 2001). Anxiety individualizes us, exposes us to a sense of aloneness, separateness, or displacement from our previous at-home way of being. It is a disquieting abruptness that calls us to reexamine our life (Dreyfus, 1991; Svenaeus, 2001). Anxiety's oft companion is fear. Anxiety assails us from within, with its resolute determinism and purposefulness. While fear assails us from outside ourselves, freezes us in its indecisiveness. We become rooted in a lost present our past forgotten. So, the two are irrevocably joined, with anxiety calling forth the anticipation of fear's next arrival. Anxiety may thus be calmed, and be quelled but its arousal is unknown, yet ever anticipated, because fear lurks around the next corner (Dreyfus, 1991; Gadamer, 1996).

We are ceaselessly intertwined with narrative, immersed in the telling and hearing of our own and others' stories. We understand our lives and our place in the world by interpreting our lives through narratives (Frank, 1998). Humans are beings who care about our lives, about what we are becoming and what we will be. In this sense, we are moving in two different directions. We fall into the day-to-day affairs of what we are expected to do according to norms and customs. Simultaneously we are continually in the

process of composing stories of what we are in the midst of doing and the life happening around us (Dreyfus, 1991; Heidegger, 1962; Svenaeus, 2001). As self-mediating beings, we are thus always ahead of ourselves, projecting forward while looking backwards. This is not a simplistic mode of one or the other, but rather a continual shifting between the two both situationally and contextually. We process a new experience through our past experiences, which thus continually changes both past and future (Gadamer, 1989).

Risks of Bringing Work Home

Henderson (2001) spoke of the recursive nature of the nurse-patient relationship, and of the inherent risks and rewards to both professional and personal self of this occupation of care. The therapeutic relationship was described as containing intrinsic tensions and pitfalls of emotionality that were left to the individual nurse to mediate.

> *L: I think in this work you kind of need to - for self preservation, you kind of need to be able to turn off or otherwise there is the risk of bringing it, all of that, information, or whatever it, whatever the word is for it, home with you. I can see how people would become overwhelmed and burdened if you can't if you can't leave that at work.*

Preservation is the act or process of keeping something safe, or from injury, destruction or decay. Self-preservation is part of an animal's instinct that perpetuates survival. It is also a condition of being human. As humans we are subject to typical biological responses to threats such as stress reactions, fight and flight, adaptation and renewed homeostasis. Pain and fear are parts of this mechanism. Pain causes discomfort so we endeavor to stop the pain; while fear acts as a warning to seek safety and protection

from difficulties and danger (Donatelle, Munroe, Munroe, & Thompson, 2008).

Humans think; we can consciously perceive and react to stimuli, plan ahead, and decide how to respond to actual or perceived physical, mental or emotional threats by flight through fleeing or fight in defending one's self (Donatelle et al., 2008). In this reaction to fear and its appeal on self, we are required to be convinced of our own mortality (Heidegger, 1962). To not believe would be to not save self in the presence of imminent danger. For "among all things, the conscious mind fears the unknown, and death endures as the greatest unknown of all" (Anonymous, accessed 2009). The perception of our death addresses the lived tension of considering death as an actual event, and death as a possibility of our own being. In this awareness of our own mortality, the possibility of our not being is brought home. This shift of perception is fraught with a disquieting realization that death is in actuality a part of living and living is finite (Dreyfus, 1991; Svenaeus, 2001).

For Lana, there was a need to keep safe and to seek shelter and a place of refuge from work. In this sense, preservation also afforded a sense of self-observation, watchfulness, and guardedness. There is also an element of covering, concealment, or camouflage in an attempt to diminish detection and the perceived threat to self. To not move or seek shelter would have been, for Lana, to find herself in the midst of another's tragic story, overwhelmed, motionless, and paralyzed by fear.

When we are forced to think and feel something of our patients' inner worlds, brought through our relationships, it has the capacity to penetrate our shelter of self-

preservation and arouse fear. Meg spoke of this in her attempts to conceal or hide herself away upon returning home.

M: I don't want to make small talk. I always need like a good twenty minutes, half an hour after arriving at home to just be by myself and get through the day.

As humans, we seek out elements that will enhance our chances for survival and avoid or evade those elements that might reduce it. In this Darwinian construct of survival of the fittest, we possess attributes that allow us to get the most out of our environment and to find a niche and adapt to it (Donatelle et al., 2008; Maturana & Varela, 1992).

For Lana and Meg, these attributes have come in the self-protective measure of separation of home and work. In order to adapt, Lana and Meg can be viewed as covering or protecting themselves in a quest to keep their home life clean, unsullied, and unsoiled.

M: It's a conscious effort I think. I feel like every day when I go home I'm reminding myself. When you go home you go over everything you do. If it's an evening shift, you'll be falling asleep and you remember something you didn't do. I kind of do that no matter what shift it is. I go over everything and say that's okay, that's okay, that's okay. And I think I did this, okay, but I think I could have done this better. Next time I'll do this and all that kind of stuff and then its left at work.

This review of her day was a conscious effort for Meg to push the worries of the day from her mind and keep her home clean. For Lana, there was a self-protective talk that attempted to leave the doors of work behind.

L: Sometimes I'll leave, I'll be walking out the doors, I'll say okay this shift, I'll actually tell myself, I'll be talking to myself okay... this shift is over, like yes this positive thing happened, this was a really good today or this happened, it wasn't so good but it is over with. The shift is over and tomorrow is kind of a new day.

In closing the doors of work behind them, the partition of self as nurse and self as person are separated and protected. With the shutting of the door a measure of self-protection is afforded in the holding of fears, anxieties, and worries of work at abeyance.

Retreating Homeward

Kaylee spoke of this need for separation and sheltering of her emotional self in her need to retreat homeward into her familiar way of being in the world (Dreyfus, 1991):

K: Maybe it is avoidance of, or maybe it's a way of retreating into your life, like okay, I need macaroni or whatever, right, because your life is a lot more safe than their life, because their life is scary.

In a situation that evoked fear and anxiety, Kaylee sought to mitigate the disruption and create distance from the cause. A disruption to our world is at its fullest potential when we perceive it is directly related to us or to someone important to us. Consequently, the distance of the disruptive event from us helps to determine its impact, and as long as it happens to another it does not impact our life specifically, directly or profoundly. The distance of the self to another disrupted person influences our capacity to empathize with his suffering (Dreyfus, 1991).

In this instance, Kaylee was retreating into the familiar, at home way of being, to create a safe distance from the arousal of fear the intertwining with another had created

(Dreyfus, 1991). It also calls forth other etymological roots of separate, those of crisis, from the Greek *krisis*, and judgment from Latin *krinein* (Oxford English Dictionary, 1971). In order to deal with a crisis, through a disruption to our world, we are required to think, make judgments, and then act to lessen harm and protect self.

In retreating homeward, Kaylee was also attempting to leave the outside world behind her and mitigate the crisis. When we retreat, we retreat somewhere. To Kaylee this was a retreat to a place and space of refuge and safety. For her, it was in the ability to retreat into the perceived safety of home. When we retreat however, we always leave something, a part of ourselves behind. In the word leave is found the threaded connection to remain or remnant. Just as the wall in the head, *mauer im kopf*, contains emotional remnants of a long gone visible barricade so too can we imagine the continued impact on Kaylee. It is often in the quiet shelter of home that the remnants of the day fall over the partitioned separations in our mind and reemerge with their call for review (Fischer et al., 2007).

This recognizes that we filter our sense of refuge and self-preservation through cultural norms and social constructs. Our sense of a niche of safety and respite, and how we can adapt ourselves to it, is formulated through our relationships with others and our community. To me this is reflected in a final etymological meaning of separate, that of to understand. In this sense separation is derived from Old English *understandan* meaning to comprehend, or more precisely, to stand in the midst (Oxford English Dictionary, 1971).

In retreating homeward and reviewing her life as safer than her patients', Kaylee was attempting to understand, to separate out her life in order to make sense of what was happening to her. As she reviewed the situation, she remained and stood in the midst of her relationship with her patient. This is a reminder that in order to contemplate a situation, or event, one is called to hold out, remove, and examine the particular in the context of the whole. There exists, within this process, recognition of the hermeneutic circle of understanding (Gadamer, 1989). Through this search of discovery, and preservation of the house of our being, we learn to care about our home, not just its content, but also its context (Svenaeus, 2001).

When you provide treatment to someone as a nurse, you are offering to them comfort, care, and connection. If this is turned on self, in terms of retreating to a place of refuge, one can be seen as needing to retreat into self, to 'lick one's wounds in private' before reentering the community. This speaks to the fundamentals of mental health nursing that one must know oneself, reflect in order to reach out and be an effective nurse (Peplau, 1988). Additionally, we are called to know explicitly that this work will be challenging, not only in a physical sense, but also in a guarding of one's house. Home is thus a metaphoric foundation that provides us, as mental health nurses, a safe place to reflect, process, and honor the work of that day.

CHAPTER SEVEN

Fragmented Images: Windows, Mirrors, and Reflections of Home

Altering Views of Self

> We live and dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate and love by narrative. In order to live we make up stories about ourselves and others, about the personal as well as the social, past and future. (Hardy, 1987, p.1)

Narratives are the means by which we create meaning and make sense of our world. We tell them to ourselves through our thoughts and we share them outwardly with others in an attempt to connect and make sense of what is happening. When our day-to-day narratives become threatened, they figure predominantly in the repair and restoration of the meaning created by the challenge presented. When confronted with uncertainty, trauma, or adversity, a previously held narrative about self may require reexamination, leading to a potential reconstruction of a new personal narrative that preserves and yet modifies a sense of identify (Dreyfus, 1991; Frank, 1998). Meg shared her reflection on how listening to particular narratives had altered her view of self:

> *M: I think I've just kind of accepted that this happens in people's lives and I'm lucky it didn't happen to me. Because we all have our own story, like, there are parts of my life that I think are horrible and I could feel sorry for myself, but I'm not going to feel sorry for myself and it's not going to help me if I feel sorry for somebody else all night.*

Narratives are heard and taken in by both the speaker and the listener. Through this activity of telling and hearing, understanding can occur (Hyden, 1997). In listening to the stories of others, Meg began to see herself as lucky despite having faced horrible situations in her life. She reformulated her view of herself to include a version that did not feel sorry for her, and who pushed through the horrible things in her life. There came then a certain level of acceptance that allowed her to place parts of her life in perspective with how she viewed the lives of others. In listening to others, accepting them in their irreducible difference, she also attended to the telling of her own body of experience, and has reconstructed herself into this new identity, in the context of being in the world as a listener of stories (Bauman, 1995; Levin, 1989).

For Kaylee, listening to the stories of others provoked an opening to examine particulars in her life she felt she needed to work on:

> *K: It's so fascinating for me to reflect on myself and what do I think about the world and what do I think about my life. This person has this depression going on and these are the things that they can change and maybe I should be working on some of that.*

Through her relationships with her patients, Lana had come to re-view her life and now saw her internal resources and capacities differently:

> *L: You look at something in your own life a little differently...I mean one of a big positive that I have gotten from working with patients is I've come to realize time and time again how resilient people really are. That is something I have used, that I have drawn upon and used in my personal life...Sometimes when you are going*

through something maybe terrible you might think back to that person or that situation and say ok, this is ok. There is a glimmer of hope or you know I can do this. It's not as bad as what that person is going through... It motivates me as well to be the best that I can be and to be resilient as well.

We, as humans, are natural philosophers and meaning makers (Barker, 2001). Storytelling appears to be a natural means to make sense and find personal meaning within a condition that is foreign and different than a previous way of living. "Unlike the careful factual description of history, narrative asserts the human meaning of events, creating, often metaphorically, the categories for interpreting those events. So, one may review past events through narration and say, 'Oh now I see,' as if it were the first time" (Churchill & Churchill, 1982, p. 73).

We devote much of our lives to examining and establishing meaning and value of our experiences. In doing so, we attempt to construct explanatory models of our world and our place in it. A re-valuation of life through the meaning they took from their relationships with their patients has occurred for Lana, Kaylee, and Meg. In learning about their patients, they also learned about themselves. This consciousness of self is formulated, according to Bahktin, when "I realize myself initially through others; from them I receive words, forms and tonalities for the initial idea of myself" (1984, p. 84). The roles we take on in life, as people and as nurses, are mitigated and formed in conjunction with those around us. They, in essence, reflect back to us who we are viewed as. This links understanding of the other with an understanding of the self. 'Who I am' is thus the response to the question 'Who is she' (Bahktin, 1984).

The Other Face in the Mirror

The work of a mental health nurse is situated in a face-to-face meeting with another through the medium of the therapeutic relationship. This immersion in dialogue requires a movement and opening of self. To me, this calls forth the notion of the face of the other from the philosopher Levinas (1996). He believed we are all responsible for one another. For Levinas, the face-to-face encounter with another person is an honored experience, in which the other person's closeness and distance are felt. There is a demand from the face before you to accept the call for help and care in that the other needs you.

> *L: Responsibility and (pause) I don't think there is a word for it. But I mean if somebody was upset or really teary, or sad about something I couldn't not be there.*
>
> *A: How did you come to that place?*
>
> *L: I kind of think I have always been that way. But I can be there, with that person because I see that they are upset. I want to offer them that support, even if I am not saying a word, just being present with them. I want to offer them that support.*

Lana heard this call of the face of the other in her acknowledgement of responsibility. For Lana, there was no choice or determination when the face presented itself, she responded with her presence and support. Through this interaction, Lana had the capacity to not only see the situations with her patients but to see herself from their viewpoints. There existed a constant requisition to ask what this situation looked like from the other's vantage point. How am I being represented in the mirrored refraction of the others consciousness? While it is an impossibility to know all of the collective refractions, all of the time, there

is an obligation to seek this perfection (Frank, 2004; Levinas, 1996). The pursuit was, for Lana, to come to know "all the possible refractions of his [her] image in those mirrors" (Bakhtin, 1984, p. 53). To see the face of the other, as Lana did, was to recognize the other needs you. This call to obligation, responsibility, and compassion was one that Dianne heard as well:

> *A: I hear another word in there, words really. I hear obligation and responsibility. Would either of those fit with how you see relationship?*
>
> *D: ... I think it is a professional responsibility*
>
> *A: Can you talk more about that?*
>
> *D: I think it is a responsibility in the sense that if you aren't able to...you shouldn't be in this position. If you can't, if you can not make those relationships... If you simply can not develop some sort of a working relationship with your patients then ...you are going to get more reward out of working somewhere else and your patients are going to receive better care.*

With this call, there is a need to open self and home to the other. The hospitality of the home of self is demanded and ruptures open our previous way of being. However, this exposure to the narratives of others must go beyond mere listening and attentive presence. There is a call to be aware of the interconnectedness of the relational commitment and acknowledgement of self and other (Hartrick Doane & Varcoe, 2007). Bergum (2004) contended this awareness of the relational space between self and other, patient and nurse, is "where personal meaning is awakened and where inherent knowledge is developed" (Bergum, 2004, p. 125). It is an appreciation that all

relationships are moral obligations and directs the nurse to continually question the right thing to do for self and other.

Ethical action requires an understanding of self as other and an ability to uncover another's situation and perspective. It is an acknowledgement that both parties enter the dialectic in an attempt towards genuine engagement. This occurs when the nurse is willing to see what the patient truly needs. Engagement with another uncovers abilities and traits previously unknown in self. Bergum (2004) intimated that we find ourselves, who we are, and what we are capable of through the engagement with others. In deference to Levinas's (1996) stance, I would assert that this is not a selfless act in relationship with a patient, but rather a recognition that each are whole beings directed toward the relational space. There is a realization that relationship happens when nurse and patient have "found a way to look at something together" (Bergum, 2004, p. 496). As Dianne asserted, this intimates connection in a relational and ethical sense. Placing emphasis on the telling and hearing of illness narratives, in true relational dialogue, implores us to remember that both nurse and patient contribute and share in the connection, but also sustain the process. There is an onus on us, as nurses, to come to see who we are, how we are mirrored and what the other requires of us in the therapeutic relationship for healing to occur (Bergum, 2004; Frank, 2000; Levinas, 1996).

Mirroring Images

See yourself in the mirror; you're separate from yourself.

See the world in the mirror; you're separate from the world.

I don't want that separation anymore.

(Nicholson, 1993)

The work of mental health nursing requires a movement and opening of self and yet simultaneously a reaction toward self-protection may occur. To mitigate the intensity and sense of dis-ease that ensues, there may be an impulse to avert one's gaze. This shielding of vision, as if peering through a mirror or window, assuages the images and creates a barrier (Levin, 1989). While a mirror or window is a reflective and representative image, by design, they also refract and distort. In choosing to mirror ones own life with the conflicted life of the other, a sense of protection is afforded in the distortion.

If we hold the premise that humans are self-mediating beings, we recognize that we shield ourselves as well. Pat recognized in her discomfort in dealing with a particular patient that she and her patient mirrored similarities.

P: I feel bad for her I guess. There is a part of me that could see can see myself in her if my life had gone differently I could have ended up where she is.

However, this practice of reflection is also a recognition that the foundation is vulnerable, and the home and its contents are open to the possibilities and repercussions that a significant disruption, thrownness, can create (Sveneaus, 2001). The aversion of gaze can also be seen as a retreat into the familiarity and sense of comfort created by one's own home and life situations.

P: Where there are children involved or there is some similar background circumstance...I just can't separate myself from that. My personal self, my self to

my kids, my self to my partner...I can't separate them out so I tend to bring those clients home a lot.

In this stance, it is less about the function of one's life, as the way the at home way of being expresses self; it is rather the way it mirrors the soul (Levin, 1989; Rybezynski, 1986). Pat recognized herself in her patient. While she acknowledged she was lucky to not be where her patient was, the comparison opened up a crack of vulnerability. She recognized this but was nevertheless unable to prevent the impact to her home life.

This comparison with another caused Kaylee to reevaluate how she should be as a nurse. She began to review her conceptualizations of what it meant to be strong and protected. She saw value in opening herself and revealing part of herself to her patients.

K: I think I used to feel like I don't want to be vulnerable around patients because I need to be strong and they need to get help from me...Now I feel like it's okay to let them know that you're a human being and that you have your vulnerabilities.

Vulnerability is often perceived in our western positivistic thinking as a frailty, a fatal flaw or weakness. It is related to the Latin *vulnerabilis*, meaning to wound or open (Oxford English Dictionary, 1971). To Levinas (1996), this opening of self, being susceptible to physical or emotional injury in being vulnerable, is the inescapable call revealed in the face of the other. This sense of vulnerability does not point to frailty, dependence, or loss of social autonomy. Rather, it is connected to recognition of the suffering of another. In this way, we are signifying an openness and nearness available for the other. This form of vulnerability is requisite to relational ethics. According to

Levinas (1996), it is the pivotal loci of responsibility for another human being. As nurses, we need to be able to listen to the otherness first in ourselves before we can truly be open to another. A call to ethics in relationship begins with this interruption of self by self (Levinas, 1996). Kaylee and Pat both became aware that the face of the other had impacted them affectively, emotionally. Protection can thus be reconceptualized as a repetition of the ethical conditions of vulnerability and an "apriori proof of vulnerability itself" (Frank, 2004, p. 48).

Intertwined in the therapeutic relationship, this vulnerability was evident in how Pat and her patients influenced each other.

> *P: I don't know how you work with people who have a mental illness and not end up taking some of it on, cause even as a human being you do that let alone someone sharing their most intimate insecurities and behaviors and thoughts.*

It can be said that, in their encounter with one another, they have structurally changed, each becoming less unfamiliar (Maturana & Varela, 1992). David Hilficker, an American physician who left his prominent Minnesota practice to work with the poor of Washington D.C., has often written of his experience of this shifting. In his attempts to respond to the wounded and chaotic lives of his patients, his own chaos was triggered. This has caused him to alter his perceptions of himself as a healer. "All of us who attempt to heal the wounds of others will ourselves be wounded. It is after all inherent in the relationship...In healing we ourselves take on the wounds of others" (Hilficker, 1994, p. 39). Hilficker perceived that we are all vulnerable beings, each harboring our own brokenness. While this brokenness inextricably binds and entangles us with one another,

it does not diminish the risk (Hilficker, 1994). Rather, it allows us to be open to the deserving values and responsibilities to the risks of being human (Frank, 2004).

Crumbling Foundations

Kaylee found that there came a time when openness exposed this inherent risk of being vulnerable. A particularly difficult experience with a psychotic patient left her questioning her choices.

> *K: Now I feel like I'm the prey in the game and now I don't want to be vulnerable. I need to be strong and it becomes scary.*

Rather then seeing the face of the other, as one who required care and need, she saw the eyes looking back at her with a predatory intent. She was interrupted by the fear it evoked in her.

> *K: I think my biggest fear was that it would happen again and I would keep taking stuff home and I would just crumble, like, I would just be unable to cope with my own stuff now, in my own life.*

Kaylee was troubled by the fear and that she may crumble in reaction to opening herself up. The foundation of who she was as a person and as a nurse was altered. In her words, she was in fear of crumbling and falling apart.

Foundations are basic building blocks. They form our base of knowledge and practice. They are the prepared ground on which our structure resides (Oxford English Dictionary, 1971). Kaylee's foundation included her beliefs about who she thought she was, and how she understood herself as a nurse and as a person. She believed herself to be a person able to withstand whatever she encountered in her relationships with patients.

This belief was embedded into her understanding of herself. It was solid, concrete, and a form of certainty that could be counted on. This certainty had been shifted and become riddled and crumbled with doubt. Anxiety appeared once again in the face of this new uncertainty and confusion.

> *K: Being on the floor is so different. There is nowhere to go. You're exposed the whole time... Your patients can see you. If they're angry with you they can follow you around...It's just like 8 hours of...hyper vigilance.*

The ensuing anxiety and fear left Kaylee feeling exposed, open, and unguarded without shelter or defense. She felt her confidence in herself disintegrate. Kaylee spoke of these fears in her search for an understanding of whether she was able to continue as a mental health nurse:

> *K: This is not what I signed up for. You want to help people, but I don't want to be a victim in the process, and so I was just thinking, maybe I'm not psychologically strong enough for this job, maybe I'm just not cut out for this area. I just, I remember driving home thinking this isn't for me; this isn't what I want to do.*

The maelstrom of doubt of whether or not she was cut out for work as a mental health nurse began to take hold in a stream of chaos about her abilities and resilience at work. To me, these shadows of doubt are played out as images in the rear view mirror of her vehicle as she drove home. She could be seen as attempting to lengthen the distance between herself and the prevailing doubts. It reflects an inner questioning tension of "Am I good enough, doing the right thing?" A mirror however, shows only fragmented shards

of reality. It is difficult for them to be viewed beyond their offered altered and shifting images. The shadows played out on these altered fragments have the capacity to become a singular voice of doubt that overrides the other narrations of competency. She began to only view herself as not fitting the social and cultural expectations of what a nurse is cut out, and templated, to be.

Kaylee could see the shadow in the rear view mirror. It formed a trail of what she was attempting to leave behind at work. Kaylee could also see her own eyes framed in the mirror, portals to her self and her increasing fear and doubt. Shadows play and lengthen, distorting off passing surfaces. They change throughout the day. Near sunset and sunrise they can be extremely long, calling out fears we had hoped to keep hidden and controlled. An unattended shadow, a shade, was thought by some cultures to be similar to that of a ghost, a flicker of life unable to move (Kearney, 2003). The shadows of driving are seen as a literal return to home and a metaphorical attempt to process the unsettling feelings. She was waiting to return home to safety to bring them out of the shadows and look at them. However they played with her, darting as images fleeting by her, unconscious and conscious as she attempted to focus on driving home safely. For Kaylee, there came a call to broaden, deepen, and rearrange her consciousness to attend to the shadows.

Shadows in the Mirror

Gadamer (1989) reminded us of our connection to our past, our inheritance and the traditions that collectively become us. We, in essence, "cannot step over our shadows" (Moules, 2002. p. 2). In substance, our shadow is devoid of detail and will

disappear with the right space and light. Nevertheless, it encircles us and "inadvertently and deliberately" follows us into both past and new ways of being in the present (Moules, 2002, p. 2). Humans bring the content of our lives as beings-in-time with an epistemological way of knowing the world around us, but we interact and live within and through our world ontologically, contextually (Gadamer, 1989). We are, by our very being, part of history, one which needs to be remembered, recollected, and interpreted as that which is most human (Moules, 2002). These interconnected recursive relationships of narrative, history, and tradition reflect our way of being but also how we have become such through our interactions with nursing's ancestors, ghosts, and inheritances (Jardine, 2006; Moules, 2002).

As nurses, we are en-cultured into a way of being that is beyond who we are as individuals. When we become a nurse, we are situated in a history of what it means to be a nurse, and what it means to be a good and competent nurse. This image is derived from our code of ethics and is instilled in us through our education. We learn what a nurse should be in how we are evaluated in school, how we interact with one another and our patients, and even how we dress becomes part of our professional identity. These threads form not only our personal identity as a nurse but our collective image. In saying, "I am a nurse", others immediately understand and identify with what "I am" as a profession. They know what they can count on a nurse to do, to know, and to understand. They hold the public's expectations of the role of nurse. In becoming a nurse, you become part of that long evolving history of the ghosts of those who have come before and paved the profession's way (Gordon & Nelson, 2005). We learn in nursing school that there is a

template of understanding of what a good nurse is. Peplau (1989) wrote that the word nursing is a symbol that stands for something more general and concrete than the seven letters that appear in it. There is a developed, socially constructed consensus, a template of understanding, of what a good nurse does and who she is (O'Brien, 2001).

Shadow of the Good Nurse

> The nurse who can enter most closely the mind of her patient, who can probe her feelings with instinctive readiness and adapt her circumstances to the varying moods presented, is, indeed a valuable auxiliary to the medical officer. (Lewis, 1899, cited in O'Brien, 2001, p. 132)

The above words, from the Medico Psychiatric Association of 1899, reflect some of the lengthy shadowed inheritances of mental health nursing. This use of self as a therapeutic agent has a sustained history. There is a continued belief that it is the nurse's responsibility to navigate, guide, and adapt to the situations encountered in the therapeutic relationship (Warne & McAndrew, 2005). Peplau (1952, 1992), in her work in mental health nursing, argued the importance of nurses knowing themselves. For Peplau (1952), "self insight operates as an essential tool and as a check in all nurse-patient relationships" (p. 11). It is thus the nurse's role to "unconditionally respond" to the patient, while making "no demands to protect or exert self" (Peplau, 1952, p. 11). The nurse is responsible for developing the patient experience in a way that promotes growth and change while not allowing anxiety to overwhelm (Peplau, 1952, 1992).

These shadows had begun to make Pat feel "inadequate", she had begun to question that "my toolbox isn't big enough or I don't have the right skills". The checks and balances, for Pat as a nurse, were no longer aligned.

> *P: I guess part of it was feeling like I wasn't doing a good enough job that she kept ending up in these crises or drinking again... I guess I just feel inadequate. I took it as, like it was personally my fault, so um (pause) so I guess that is why I took it home with me cause I just felt it didn't just impact me professionally, it impacted me personally as well.*

Pat felt inadequate. She had fallen short of her perceived way of Being as a nurse. In her view, she had not followed the template. She was thus not doing a good job and had allowed herself to be affected not only professionally, but also personally. Pat had integrated the inherited lesson: to her it was the nurse's responsibility to assist and guide the patient experience (Barker, 2001; Vandemark, 2006). When her patient chose what Pat thought to be poor choices, she blamed herself. This led her to believe it was all her fault. Pat was doubly affected, subjected to the varying pressures of home and work. Nevertheless her fault line remained invisible, held below the surface. While aware of the pressure our lives incur, we, as humans, have no internal seismograph that will tell us when the pressure of a situation is going to be too much and erupt open into a visible wound. Stress may build up as it did for Pat and when it reaches a level that exceeds the strain threshold, like rocks on two sides of a tectonic plate, energy will be released along the fault line. This strain is both accumulative and instantaneous. The accumulative strain

causes shearing and splitting of rock, the self. While, the instantaneous strain is seen as an earthquake of erupted anxiety and fears of inadequacy.

P: I don't have all the skills for this job and these clients prove that when they don't make any progress so I start to doubt myself as a clinician.

Pat believed she was lacking something and must make amends or correct the pressure. A shift in perception was noted in Pat. If it was her fault, then she did not match the template of a good mental health nurse and she doubts her skills. She faltered, folded in on herself along the fault line. There was a sense of deficiency, and a component of blame, culpability, and reproach. The distress and ache of doubt can be viewed as wavering between two minds of self. Doubt arrives from the Latin, *dubitare* of two minds (Oxford English Dictionary, 1971). She was torn by the continued need to separate home and work, nurse and person, affected and unaffected stances. In not being able to remain detached and impartial, there arose an impetus to divide and build a partition of self-blame. She began to have difficulty rectifying her experiences with the proper template of a nurse. When the fault line emerged, it became difficult to not question herself. When the two minds debated over the fault line, the voice spoke equally loud of "I am the nurse, it is my job to guide the client" or rather "If I am doing a good job navigating we should be able to get through this together".

Rogers (1995) claimed our language in mental health is laden with an us/them split. We, as nurses behind the desk, hold the pretense of having no difficulties, while imploring our patients to discuss whatever issue holds our attention at any given time. She argued that it is this entrenched belief of "well nurse, ill patient" that has continued

to foster the image of the self contained, unaffected nurse. Beyond this, it is the nurse's responsibility to not only navigate the therapeutic relationship but also, to save both parties from the vulnerabilities, hurt, and losses that may ensue. She likened this scenario as the nurse being responsible for "holding two stories, or two plays, together" (Rogers, 1995, p. 319).

The juggling of these two stories, of nurse and patient, became precarious and blurred for Pat. Meg as well, shared her struggles in holding her versions of listener and objective observer storied and together.

M: Yeah. And then I think, I don't ask the right questions. Like I have a hard time trying to do an assessment in my head and trying to engage her at the same time.

Like Pat, Meg began to question if she could have done a better job. We are encouraged as nurses to listen carefully to our patients to garner a full description of their history and situation. Reaching the details of their stories involves "getting to know a patient as a human" (Peplau, 1989, p. 218) and "talking with that person, in an investigative, purposive way, listening carefully, all the while being intellectually active and interested to know more" (Peplau, 1989, p. 218). Peplau (1962, 1989) viewed the therapeutic relationship through a scientific lens in encouraging us to be objective, impartial, and to step back from the situation (Gallop & O'Brien, 2003; Rogers, 1995). There exists a tensioned pressure of detachment yet demonstrative concern, interest, and care (Henderson, 2001; Vandermark, 2006).

While the stories and situations are often emotionally charged, nurses are required to be attentive, attuned to hear the story, and provide safety through containing the story

and the expressed personal suffering (Gallop & O'Brien, 2003; Warne & McAndrew, 2008). Pat echoed this tensioned position in her encounter with a patient that left her feeling vulnerable.

P: It was almost like a sense of weakness, if you get overwhelmed by the stories or what you see out there...There is some sort of weakness if you can't handle it.

Becoming emotionally overwhelmed by a relationship with a patient was a weakness or frailty in her professional identity. This prevailing view of a professional nurse as detached and self-aware perpetuated her own doubts about herself as competent (Dowling, 2006). The culture of mental health nursing has predicated a belief about the right amount of emotional involvement, with detached empathy and conscious rational detachment (Henderson, 2001; Warne & McAndrew, 2008).

While there exists an acknowledgment that the therapeutic relationship affects both parties, the ideal remains for the responsible nurse to use theoretical concepts to guide the patient to health. The nurse remains depicted as a detached removed expert. This has fostered the belief that one is able to grasp this theoretical construct and has perpetuated the reluctance to acknowledge when things in the relationship are not as they should be (Dowling, 2006; Gallop & O'Brien, 2003; Warne & McAndrew, 2008).

We live in and with the world, in which we find ourselves, as constructed in particular ways. Our professional identity as nurses thus may be an exposure of self in ways we had been unprepared for. Gordon and Nelson (2005) have argued that it has been with the best of intentions, in honoring our traditions and ancestors, that nurses and health care organizations have "perpetuated traditional images of nursing as self

sacrificing, devotional, altruistic, anonymous and silent workers" (p. 63). They maintained that we are clinging to a modern lens of the "virtue script of nursing" (Gordon & Nelson, p. 63) inherited from Nightingale. These shadowed remnants of compassionate, self-sacrificing, good woman were the borrowed template from religious sisters and meant to protect the virtuous image of those entering the profession of nursing. This image has remained, often running pervasively below our conscious awareness (Gordon & Nelson, 2005).

Educators and nurses are complicit in our perpetuation of, and belief in, our idealized version. Gordon and Nelson argued the virtue script is so enmeshed in our everyday lives that it has become a "social feedback loop" (2005, p. 64). While originated by nurses, it has been taken up and is now "projected back on its source – nurses who then have to 'live' the ideal" (Gordon & Nelson, p. 64). If the virtue script remains, we shall continue to perpetuate this dichotomy between theory and practice, between the content and context of nursing. We may continue to be divided, just as Pat, Meg, and Kaylee were, over the fault line between being a detached, self aware, and contained expert and doubt ourselves as doing good work and having the right answers.

Windows of Expectations

When we enter mental health nursing, it is not without expectations and an understanding of what the work will be. As she reflected back to her time as a new graduate nurse, Meg wondered if her expectations were beginning to shift.

M: I was still a new nurse and didn't realize how important it was not to take it home. But I kind of think that it was a shift between being a new grad and an RN

because I realize this is my job now. I'm done school and this is what I'm going to be doing for however many years and I have to learn to adjust to have it as a job and not take it home with me.

Meg appears to have the same window of expectation that I viewed as a new graduate nurse. As nursing students, we were taught the importance of therapeutic listening and the inherent emphasis on this aspect of building a therapeutic relationship. We learned to ask questions such to evoke a rich and textured recounting of an illness narrative. I do not recall learning how to deal with the answers. How do I hold the offered words with my patient? Where do I place them in my own repertoire of pain, loss, and experiences of suffering? What do I do with my own ghosts rumbling around in my head? How do they affect me as a nurse, as a person?

In learning how to adjust, how to make that shift from student to nurse, it was obvious to Meg and me that something changed. The elusiveness of this time as a new nurse remains hidden from me in the present. Relationships are different now; the stories are no less horrifying but the instinct to jam my fingers into my ears as if to stop the onslaught of pain has diminished. One would think I would be grateful for this diminishment. The ghosts have lessened their grip on my consciousness and their impact is quieter, less messy, and less intrusive. Yet, I cannot help wondering what has changed in me? Equally troubling is the thought that perhaps nothing has changed. Have I gained the requisite experience and needed detached perspective or have I become, as Barker (2003) asserted, a jaded mental health nurse, worn out by the demands of attending to listening and becoming more concerned with maintaining safety and a calm unit milieu

than 'joining' with my patients in their story? Perhaps the change has resulted from a shifting desensitization, or familiarity, or in becoming more accustomed to encountering the strong feelings brought with engagement. Pat spoke to this questioning of self and her difficulties in finding her way with certain relationships:

> *P: You just have those really tough relationships with clients it is really hard not to question what you could have done better... I have never seen anyone in mental health have a miraculous recovery and I never will, I know that. But I have seen them go to depths that you never thought they would be able to crawl out of again and some of them don't. So our job is to help them crawl out... I mean there is a level of acceptance there... but it is difficult.*

In working in relationships, in helping someone crawl out from the depths, we begin to adjust our expectations of ourselves as nurses. Pat was able to recognize that she was unable to assist all her patients from the depths but nagging questions persisted. While my sense of who I was as a person, as a new nurse was altered, I like Pat and Meg continued to wonder if I was doing a good enough job, and where the answers to the lingering questions could be found.

> *P: I've seen a lot of things, but every once in awhile I have a client that (pauses) I just I just don't feel like I am doing good work with...I try very hard to remind myself that it is not my responsibility...that it is their choice... But there is the other voice that says that they are only going to take up what fits with them so why can't I find what fits for them.*

Remnants of the virtue script template are echoed in Pat's words. Our expectations of what we should be as a nurse, and how we should be in relationship with our patients has a long tradition that continues to exert its influence and pressure, below our conscious awareness. In Gadamer's (1989) words, it extends "beyond our wanting and doing" (p. xxviii). Pat recognized she does not have the answers for her patients, recognized she could guide her patient in the right direction, that she could remain at a safe distance emotionally and yet appears to be trapped in a feedback loop of self doubt. As I wondered what had changed in me that the stories had lost their impact, so too was Pat wondering what was wrong with her. She asserted that she should be able to find solutions for her patients. The expectations that she should be capable of doing more are evident from Lana as well, as she questions herself and her arising frustrations.

A: What is that experience of feeling like "am I doing anything here"?

L: It can be frustrating...if you feel like, am I doing anything here, am I helping make change. Or what is happening here because sometimes a change can be quite slow... so yeah it can be I guess frustrating at times.

We appear to be caught in our expectations as nurses, singularly with our own doubts and struggles, yet collectively in comparison to the perceived idealized version of nurse. When these cannot be rectified or made sense of, frustration, difficulties, anxiety and confusion arise. Oddly enough, expectations are related to paradox, from the Latin *paradoxum*, to indicate a connection between two contrary statements (Oxford English Dictionary, 1971). In viewing these conflicted, contrary stances of how we are as nurses and how we believe we should be, a realization that our perspectives are framed arises.

When we look through a window, we receive a narrow viewpoint, for what is above, below, and to the sides remains shielded and out of our view. It thus becomes a framed perspective, a particular point of view on a situation, and we are afforded only the view that the window allows. There is no access to a full horizon or full perspectives on situations. To change our perspective, we need to step through and outside the frame into another view on the world. In this way, it becomes difficult to rectify the paradox we encounter in our work, for windows also separate us from the outside world. While protective, windows also distort and alter in their refractive projections. In entering mental health nursing, we look through a particular window that has wittingly and unwittingly become our lens on the world. Lens may provide protection or alter our perceptions without our being consciously aware of them doing so. We are always under this influence of history, and traditions of our chosen profession, situated in it and can not extricate ourselves from it (Gadamer, 1989). We can, however, become aware of its influence and expectations. The paradox of living with these expectations that in climbing through a particular window, we can become aware of different landscapes, views, and vistas.

Into the World of No Solutions

> *D: We are always talking about everybody else's problems and how they are supposed to fix them, right, when really none of us are experts in that. You know and the only way we know is from books we have read or from experiences we have had... I do experience a lot of the same things that they do, not just to the same extent, and the reason why is because I do this, this and this, these might*

help. So it is just not like you're taking your textbook and saying the textbook tells me that this is supposed to help for this you know it is coming from a real life example.

Dianne has climbed through a window of her own expectations as a nurse and has begun to examine a different landscape of being with her patients. She has come to the realization that her textbooks and educational preparation are valuable, however the ultimate point of connection with her patients is life experience. Dianne appears to have come to understand she has been viewed or was viewing herself through a window of expectations as an expert. In realizing that none of us are experts, she has managed to shift her expectations of herself as the sole navigator of the relationship and in doing so has relieved some of the pressure she has placed on herself. Kaylee, as well, spoke to the pressure of having the right answer and how she was able to alter and transform her nursing practice perspective.

K: I think, one of the big mistakes is thinking that you have a solution. You know what I mean? And that's what I've learned in the last couple of years is that I don't have any solutions for any of their problems...Whereas before I think I was thinking I have to do something, there's so much pressure right, because you're thinking what can we do about this, what can we do about this? And it's like nothing. You can think of the most awesome solution and the person, if it's not from within them, there's just going to be like...whatever.

Pressure refers to the act or fact of pressing on the mind or heart. It has lead to expressions in our current language such as 'gravity of the situation', and 'heavy heart' or

a 'heavy mind'. It can also refer to a metamorphosis, a transformation of something whose form has been altered, changed by the pressure it has been placed under (Oxford English Dictionary, 1971). The pressure of having the right answer has altered Kaylee and Dianne, and in response their nursing practice has been changed.

Problems, solutions, and answers appear to be irrevocably joined in the language of nursing. As nurses, we are taught that we need to assess for problems and then proceed with the appropriate and right solution. Solutions at their most basic chemical format are the building blocks of human life in the delicate balance of oxygen and carbon dioxide (Oxford English Dictionary, 1971). Nurses work with solutions. They exist in the oxygen given to ease gasping breaths, in the water that disperses, warms, and vaporizes a medication to slow an asthmatics breathing. They are in the ice chips touched to a dry mouth to provide cooling relief. In the right concentration, solutions become givers of life into veins rehydrating, and carriers of medication. They exist in dosage calculations, in the ampoules, tablets, suspensions, and injections.

Solutions are the tools of our profession. We learn to rely on the comfort of finding the solution, that there is one, or several, or a myriad of options. We learn to calculate, titrate, run, and mold solutions for our purposes and intent. How unsettling it must have been to come to the place of realization for Kaylee that she had no solutions. We, as nurses, involve ourselves in providing comfort and care for our patients. We suffer when this comfort and care is elusive or not there. For Kaylee, the realization that she had no solutions had the effect that, while freed from the pressure of having the right answer, it placed her in a new disquieting disrupted landscape far from how she thought

nursing care should progress and be. When we reach the place of having no solutions, we are entering the realm between the known and unknown. It has been described as working at the edge of the abyss. In can be seen as entering into the land of in-between, of gray (Warne & McAndrew, 2005, 2008).

CHAPTER EIGHT

Masked Messages: In the Wake of Hermes

K: I think it is our role to listen and just hear the story and guide the questioning for people to discover their own solutions...You're not saying a whole hell of a lot, but what you do say...guides, turns, turns. 'Turn left here and see what's down when you go left'. And it's like 'well I've never gone left before'. Okay fine, and then you look left and you think oh holy shit, there's all of this...And I don't know what's left either, as the person asking the question, I'm just saying what's down this road and there's well this, oh, surprising, because it could be nothing right. That's how I see what we do.

Mental health nursing is not a landscape of black and white, or diagnostic certainty. Rather, it is imbued with the rich vibrant colors that lie in-between, interlaced with infinite shades of gray. There is no map of the human psyche, no chart to follow to find one's way through and back home. It can be an easy day's wander, or as Pat voiced, a shared descent into black depths of human despair. It is a landscape filled with separation, and protection, where emotions and frailties of the human spirit, are positioned against societal norms and expectations. Can there be any wonder that those who wander this land, become momentarily or otherwise overwhelmed? This is a land of paradox: of the need to open oneself up, yet keep oneself safe and separate; to maintain professionalism yet be vulnerable. It is, as Warne and McAndrew (2005) articulated, working at the edge of the abyss. I question if, to be more precise, mental health nursing requires a jump into the midst of the abyss, in the space between realms.

Homesickness

In this opening to other, and the inherent vulnerability, there is a wish to retreat to a familiar way of being, a place, we trust to be safe. Homesickness is essentially the universal impulse to be home. In this premise, I am not referring to a physicality of home but rather the ontological search for a place in which Being can be (Dreyfus, 1991). The Germanic *heimlich*, or canny, means familiar, close, while the not-at-home, *unheimlich,* or uncanny, means that which is out of the ordinary, unhomely, strange, and frightening. True home requires an effort to both embrace and ultimately integrate the *heimlich* and the *unheimlich*, the familiar and the strange in order to become more authentically at home with ourselves and the world (Dreyfus, 1991; Harries, 1978; Woolley, 2007).

We feel at home in our day-to-day living, absorbed in our familiar roles, expectations, and relationships. It is only in the experience of anxiety, in the process of thrownness, that the world becomes unfamiliar, and we experience not being at home. Through anxiety we are disentangled from our absorptions in the world and enter this existential mode of not being at home. From this vantage point, we are able to view our ontological premises as humans and take responsibility for our life and the face of the other. This viewpoint would seem to equate the desire to be at home with a desire to evade responsibility, to deny our freedom and to refuse to face the ontological givens of uncertainty and individuality (Dreyfus, 1991; Harries, 1978; Hayes, 2007). However, home is a paradox. In this consideration, I depart from Heidegger's early stance of home and take-up his later writings. In his later writings, the concept of home is synonymous with authenticity (Dreyfus, 1991; Gadamer, 1994). This is where we, as humans, explore

our world; and home as dwelling and building is the ability to live in harmony with our physical and social environment. Being at home, living harmoniously, while not seeking to impose our will on others, is in a sense letting be. This understanding of home is not solely retreatist, exclusionary, or a nostalgic longing for the home of one's memory. Rather, it points to a way of being, through a new understanding of self, our place in the world and our relationship to others. In this way, home is no longer just a place of origin or departure but an expression of our becoming, our experience and our potential (Gadamer, 1989, 1994).

Passages of Home

Lang (1985) argued that the house is an extension of the body and its doorways, porches and yard serve to both "disclose and conceal human existence" (p. 201). The entry way acts as a threshold, or transition place, which helps to define one's identity and world. The doorway as both entrance and exit is where we realize we are coming home or leaving it. It is here that the meaning of home is highlighted. The metaphor of threshold as an in-between reveals the essence of home.

This recognition of the threshold reflects Victor Turner's (1969) realm of the liminal of "betwixt and between" (p. 15). The threshold is a place that is at once empty and full. It is on the margins, where one thing meets another, and in times of transition that environments bear most diversity and promise. "Life erupts at the boundaries" (Jardine, 1994, p. 9) it is where changes, merges, divisions of peoples and environments are evidenced. The liminal reverberates with the harmonious rhythmic dyads of life and death, hidden and revealed, light and dark, hope and despair, ill and well.

Turner (1969) described the liminal as a period of transition. During this time in the in-between, one abandons one's old identity and dwells in a threshold state of ambiguity, openness, and indeterminacy. Only after undergoing this process, does one enter into new forms of identity and relationship and rejoin the everyday life of the culture. In this way, the liminal can be viewed as a time of transition, transformation, and discovery. It is a passageway where one pushes the boundaries of possibilities, potentials, and limits. It is also where boundaries push back (Turner, 1969).

The liminal and a sense of participation in the community are integrally linked. The communitas, as Turner (1969) referred to it, is not about the disappearance of one into many. Rather it holds the recognition of each particular one as an equal part of the many, none to be called better or worse, hidden or excluded. This reflects the sensus communis of Gadamer (1989), and brings forward belonging to a place, a community, and a history.

In all communities, there are teachers and inheritances. Ghosts, strangers, tricksters, and monsters drift in the liminal. Their presence is at times to scare us, at times to impose and unsettle, calling our attention to the particularity of their presence and arrival. They speak to teach us something of ourselves (Jardine, 1994). According to Kearney (2003), "most strangers, gods and monsters, along with various ghosts, phantoms and doubles who bear a family resemblance are deep down tokens of fracture within the human psyche. They speak to us of how we are split between the conscious and unconscious, familiar and unfamiliar" (p. 4). Like the trickster Hermes, they appear

to startle us out of mediocrity, and challenge us to examine and understand beyond the taken for granted.

Hauntings of Home

The purpose...is to remind us

How difficult it is to remain just one person

For our house is open, there are no keys in the doors,

And invisible guests come in and out at will.

(Milosz, 1989, p. 3)

For Freud (1919, cited in Woolley, 2007), the not-at home experience of wandering in the liminal realm involved a perceived element of magic or supernatural. It is a return of the dead in spirit or ghostly forms to frequent ones home. It is a haunting. To haunt, can be traced back to its Old Norsk origins, from the word *heimta*, meaning to bring home, and the Old French word *hanter* to go often to, to frequent the company of, to claim, to recover, and to visit frequently, and lastly from the Latin word *habitare*, to dwell (Oxford English Dictionary, 1971). These inheritances linger in a sense of why hauntings often frequent places revealed as home, dwellings, and passages (Oxford English Dictionary, 1971; Rashotte, 2005) To Dianne, this represented a revisiting and bringing home of fear:

> *D: I think it is that fear of not necessarily rejection but the fear of, I guess, of just being told you are wrong, or not being viewed as competent. Because often that word of competency comes up in our lives as nurses I find. To be considered incompetent is a huge blow.*

Pat as well, was besieged by the fear of not wanting to appear inadequate to her colleagues:

> *P: We don't share these stories with each other about that client that made us want to leave mental health. There is this culture or code of silence around that sort of stuff. Some how you will be viewed as inadequate if there was a client that kind of got on top of you like that.*

In the boundary-laden space of the therapeutic relationship, Pat and Dianne had been impacted, and had wrestled with the inherent implications. According to Pat, a code of silence exists in mental health nursing. We do not speak about the negative impacts of the therapeutic relationship, and its marks and impressions. This code of silence is a strong social relationship that functions to internally sanction and control, while evoking support from its members, the nurses. The most renowned version of a code of silence is the Omerta of the Italian mafia. Omerta means manhood, and refers to the need for a man to resolve his own problems whilst maintaining a stoic silence (Oxford English Dictionary, 1971). The code of silence and the coinciding fear of being viewed as inadequate, incompetent, or lacking ability has marked Pat and Dianne.

A code of silence functions by controlling and internally policing its members. A deviation from expected norms heralds a consequence and punishment. Within mental health nursing, it has been shown that a key strategy for controlling nurses who deviate from socially acceptable norms has been to label them as over involved with their patients. Additionally, nurses have been described as vulnerable, weak, or having their

own psychiatric problems. These strategies, along with the maintenance of silence, have perpetuated the code upon the nursing profession (Dowling, 2006; Handy, 1991).

Dianne and Pat are besieged, haunted, by concerns of how they are being interpreted by their colleagues. According to Dianne, to be considered incompetent threatens professional identity and integrity of self. To position against the code places them in danger of being outside of the professional culture of mental health nursing (Handy, 1991). This sense of being positioned on the outside carries the etymological Old English *mearc* meaning boundary, limit, or mark. It also refers to any visible trace or impression and is the origin of the phrase a marked man, or one who is watched with hostile intent (Oxford English Dictionary, 1971). In the instance of Pat and Dianne, it was the fear of being marked as incompetent, deviant, or mentally ill (Handy, 1991).

Nurses may perceive other nurses' intimacy with patients as over involvement and thus deviant because of our socialization to believe so. There persists an inconsistency between theory and practice that may affect our identity and in turn impact those for whom we care. This may be evident in the rigid interpersonal behavior or in nurses distancing themselves. Fear of disclosure of self and affective responses have en-cultured a uniformity or sameness. We, as individuals, can find or lose identity in social groups such as nursing. As a defense mechanism, the individual may become part of the collective think and therefore complicit in a collusive agreement of silence albeit often running below one's level of consciousness (Dowling, 2006; Handy, 1991).

P: I think when you are doing this type of work with people you can't avoid being brought down a little...I think if you are trying to be caring and empathetic you

can't, you can't avoid it. There are times when you feel the weight heavy on you from all that you have been told or seen or experienced.

Pat felt weighed down, heavy from the experiences she encountered in her relationships with her patients. What she had seen and been told has burdened her and lingered with her. It was something she could not avoid if she was caring and empathetic toward her patients. This burden however, due to the nature of the code of silence, must be carried privately, individually, and stoically. Burden is related etymologically to the Old English *byroen*, which means a load and to the German *burde* that which is borne, or carried (Oxford English Dictionary, 1971). It typically refers to a heavy lot in life or fate, and has brought forth sayings such as 'to carry the weight of the world on one's shoulders'. This harkens back to the Greek god Atlas who was tricked by Hercules to eternally hold the heavens and earth asunder. In this endeavor, he became a symbol of strength and stoic endurance. Atlas, the bearer of the heavens, is often shown on one knee supporting an enormous round globe on his shoulders. Atlas can be traced to the Greek *atlao*, meaning to suffer, and *durus*, hard, and enduring, as well as from Proto-Indo-European, *tel*, meaning to uphold, support others (Theoi, 2009).

The weight carried by Atlas, Dianne, and Pat was both a mental and a moral burden. In his task of holding the heavens and earth apart, Atlas was afforded an advantageous view of both realms. He became familiar with the constellations and learned in the art of astronomy. He used this knowledge to craft navigational tools of the seas. Atlas could be likened to the navigational guide position of a mental health nurse. While privileged with an unrivaled vantage point or view of others lives, both are unable

to become over involved due to the parameters of the work. The myth prevails that Persus eventually turned Atlas to stone, forming the mountain range of North Africa that bear his name (Theoi, 2009). His metamorphosis into a mountain bespoke his hard, unmovable endurance. Worn under the pressure of his task, stoic in silence, his face became a mask of stone.

To Wear a Mask: Dark Cloud Before the Rain Comes

Struggling and worn under the pressure of maintaining appearances, Pat wore a mask of stoicism.

> *P: I mean you have to put on a mask around here that you're doing good work and you're not experiencing any ill side effects because of it. For me to be the one person on the team to say I am really struggling, I think my caseload is overwhelming me right now. It feels like you aren't pulling your weight.*
>
> *P: It could just be a mask that other people wear, because somehow I wear it. But there are clinicians with a lot more experience than me and it just seems to roll off their shoulders.*

Pat had learned that, in order to survive, she was required to repress her internal burden of feeling overwhelmed. She felt the need to mask, hide, disguise herself, and her internal fears that she was not doing good work. This was, at once, a protection of self - - to hide what she believed would place her on the outside of the boundary with her colleagues and place her in a vulnerable situation. She had become rote, mask-like, and hidden. Her emotional face was hidden behind a pretense of professional competence and sameness. The mask also brings forth a sense of haunting, other worldliness as in the presence of a

specter, ghost, or a nightmare (Kearney, 2003). In the Bezier dialect *masco,* mask, prevails in its meaning of a dark cloud before the rain comes (Oxford English Dictionary, 1971). Dark clouds are seen as ominous messengers of blackness and imminent storms. They hearken of troubles, sorrow, and suffering. Pat masked her suffering, kept it hidden away and private. Hidden beneath the mask, one is afforded a glimpse of enduring suffering.

The Language of Tears

Moules (2002) wrote that suffering brings us "closer to the mystery and prevents us from confusing what we find with idealized poetic notions and reveries. Suffering occurs in the heart of the flux and at the edge of the abyss" (p. 36). Suffering dwells in the liminal, in the in-betweens of relationship; it lives between words and images. For Hilficker (1994), it is this opening to our own and others' suffering that shatters the distance between us and exposes our humanity. "The face of suffering is a mask through which something deeper resonates, leaving its echo behind...the task...is not to decipher the speaker beneath the mask but to alert us to the distance which separates them – and then to preserve and keep it open" (Caputo, 1987, p. 290).

A: What are the tears about Pat?

P: (pause), I guess I am just feeling overwhelmed in my work lately (crying) so I guess it is just talking about it because we don't really talk about it around here that much. It is kind of you deal with it on your own I suppose (pause)... If you aren't doing well you just don't talk about it because somehow if you talk about it

then it makes you appear like you can't handle the work, because nobody else has to talk about it (crying).

The burden of wearing the mask had become too much. The protection it afforded her in keeping up her pretense of doing good work and being unaffected in her relationship with her patients had become in itself a burden. The mask, while offering protection, also isolated her. It kept the emotionally induced impacts hidden and perpetuated a sense of helplessness and aloneness. With the tears, came an openness to speak with me about the effects of her therapeutic relationships in a new way. Dianne shared this as well in her realization that she crossed the boundary of relationship with a patient.

D: When you get to the point of tears, in the room listening to what this person is telling you, when they are so scared that they just hug you because they don't know what else to do. And to also think that in our profession we are taught that hugging a patient is wrong. Yet in that situation, there was no way I was going to tell this patient no. You know, when that was the only thing that seemed okay, to be therapeutic for this patient.

She had broken the rules, yet for her it was the only thing she knew to do. The understanding of this situation broke through her mask and brought her suffering to the surface, visible as tears. She was torn asunder from her frozen stone-like state and with the tears a monster, a *monere*, brought a lesson that she was now ready to receive (Jardine, 1994; Oxford English Dictionary, 1971).

A *monere* is an omen or warning, just as the dark cloud of the mask foretold the coming rains (Jardine, 1994). Rain naturally cleans, refreshes, and provides life-giving moisture. It could suggest a period of renewal and fertility. However, dark clouds and a heavy downpour indicate feelings of isolation and helplessness. A heavy downpour could also represent unconscious thoughts and emotions attempting to enter the conscious mind (Linn, 1996). The rain can be viewed as that which falls as water from the eyes, as tears. It is the mask of the rainmaker, the specter of the gods foretelling of a change; perhaps it is a call by Hermes to look beneath the mask and to keep the space open. In this sense, the specter, ghosts, and tricksters arrive with tears and an opening to a new understanding. Even in the double entendre; the double take of the words tear, one can see this potential for openness. While one understanding of the word tear is rain from the eyes, wrought in sorrow and suffering, the alternate word tear means to pull apart, to burst asunder, and to open (Oxford English Dictionary, 1971). To tear can then be seen as a wound, a portal, or opening to a new lesson (Jardine, 1994).

The liminal is a rite of passage haunted by worldly masked figures to guide and teach one's way through the passage (Turner, 1969). While at once frightening, they are meant to provoke thought and challenge elements of the 'taken-for-granted' (Jardine, 2006). The language of tears, in its encounter with suffering emotion and promise to pull us apart, speaks us anew as a monstrous portal and tangible evidence of who we really are. "Like monsters in fairy tales, they wouldn't whisper to us or stop us in our tracks if they didn't have something to tell us" (Jardine, 2006, p. 271). Pat and Dianne's tears have

overrun the boundaries between home and work, nurse and self, and brought with them a new opportunity to discover potential and limits.

A Monster Came Calling

"Opportunities are not plain, clean gifts, they trail down dark and chaotic attachments to their unknown backgrounds, luring us further" (Jardine, 1998, p. 154). The monsters that bring these openings to understanding need not look monstrous to teach (Jardine, 2006). At times, monsters appear in the tear-rimmed eyes of a young girl. Yesterday, such a monster came calling and demanded I retrace my steps.

When I began my career as a mental health nurse, I felt totally inadequate in my ability to hear the stories of certain patients. I recall in my second week of work walking in to a room to find my patient huddled on the floor in the corner, a sharpened shard of glass running across her exposed wrist. She was silent, eerily so. I managed to convince her to hand me the glass and while I examined and bandaged her wrist she began to speak. She shared with me the image of her at five years old lying at the bottom of the stairs. Her father and his friend had just finished raping her and were urinating on her tiny body. It was raining that day she said and today the rain falling outside her window smelled of urine. She kept repeating: 'why can't the rain wash away the smell?' She did not expect an answer. I certainly did not have one to give. That was not what troubled me. I did, however, struggle with keeping my presence with her, with listening to what she was saying and to resist the urge to run terrified from the room with fists jammed in my ears to stop the flow of traumatized hearing and the evoked images.

Over the years, the struggle quieted. I no longer felt the visceral impact of emotion overtake me. I congratulated myself in being able to push it away, place it aside. This image of my patient became just another story in a repertoire of pain filled stories I had been part of. I did not realize that I too had donned a mask. I had become a complicit silent partner, maintaining and perpetuating the code. I wore this mask with unseeing eyes, not realizing its presence or its influence in my relationships with my patients. Yesterday, a trickster loosened the mask and it became visible. A young girl stared at me as she explained why "Daddy hurt me down there" and then she began to scream. The haunting primal sounds were echoed by the trail of blood dripping from her face, and pooling in her lap. It was an image best forgotten, yet it lingered, played with me as I walked home. It brought me back to the beginning, to the call of this topic area and to the feeling, the impact, of being in that first room. After two months and pages of analysis, it beckoned. I had not realized how I had turned from the face of emotion until it would not stop looking at me. So here, in the in-between of self, my analysis began anew, with a *monere*, a lesson from Hermes that broke open and shattered my pretense of skating the surface of relationship. Filled with a sense of repulsion, of wishing to distance myself from the task, it was time to follow the lure down into the powerful current of relationship and follow the tears (Jardine, 1994).

Drowning: Going Under the Mask

Masks hide us away, keep us separate but also hold in, hide, and perpetuate our suffering. With the opening of tears, we have discovered a portal to that which has remained hidden about our practice as mental health nurses. In this way, "dwelling with

the stories that haunt us" (Rashotte, 2005, p. 34) has the capacity to read us anew but also to bring us to places of untold danger. Such is the paradox of the in-between. Rather than accept the mask, we are called to interrupt our taken for granted experiences and to discover what lies beneath. This unmasking found Kaylee positioned in the replay of a patient's story:

> *K: Yeah, when you're hearing about it, it's like the movie of that story is playing in your head and this is the scariest movie. There is the struggle of, well this person's suffering and I'm supposed to be here to listen to you. But holy shit, I just, I'm going to be thinking about this later. I know I'm going to be thinking about this later, especially if, when you already kind of have the visual of the person cutting and stuff. It's like, oh God.*

Freud (1947) maintained suffering is exposed in the struggle between wishing for togetherness, *eros*, and a need for separation, *thanatos*. Kaylee was struggling to separate her wish to remain with her patient, to hear her, just as I had, but to shield herself from the provoked and sustained images that this union brought forth. Pat was being pulled under by her experiences in relationship.

> *P: I am a trained professional and I am drowning. Nobody else appears to be drowning, and maybe from the outside, I don't either, so I certainly try to portray that I'm not... I don't know how you work with people who have a mental illness and not end up taking some of it on.*

To suffer means to endure, to undergo an experience of something (Oxford English Dictionary, 1971). In the case of Pat, to undergo could be more appropriately

expressed as to go under. Pat was being swallowed up and drowning in the experience of being in relationship with her patients and her expectations of herself in those relationships. With her need to portray no ill affects and to wear the mask of indifference, she had found herself in a position of peril. Moules et al. (2004) wrote that when "grief [suffering] is uncovered, there might be times when the experience is too powerful to swim" (p. 104). These moments of drowning bring awareness of the boundaries of our humanness and reveal our finitude. Lana expressed this realization in sharing her experience of being in relationship:

L: There are sometimes where you have been talking to people all throughout your work, all throughout your shift where you are just emotional drained.

Lana understood that she had undergone an experience with her patients that altered and drained her emotionally. In the replay of the moving experience for Kaylee, Lana, Pat, and me, emotion is brought in as part of the experience but also part of the response. It became repositioned. Rather than a negative abyss, it was part of learning about self and others. In this reflection, there is recognition that we have been moved, altered, and changed by our experience with our patients. There is a need to acknowledge and mark this just as we too have been marked. "Self awareness entails a being placed in-between our past and future selves" (Davey, 2006, p. 17) and being positioned to "understand that the self resides in the differential space between what we understand ourselves to be and what others think us to be" (Davey, 2006, p. 17). At once vulnerable and available, by plying open the mask we become open to a new type of knowledge of relationship that alters our past and extends into our future relationships.

If we, as nurses, can be drained and in peril of drowning in relationship, conversely we are thus such beings that can be filled and become buoyant (Moules et al., 2004). While emotion can be uncomfortable and tumultuous, the awareness of it helps us discern, perceive, and live better (Nussbaum, 1990). It brings into view that the burden of wearing a mask and the border positioned between the cognitive and emotive is extracting a heavy toll on mental health nurses.

There appears to be a need to recover the Aristotelian understanding of emotion as not wanting a split between the cognitive and the emotive. Emotion can play a cognitive role and cognition, if it is to be properly informed, must draw on emotive elements (Nussbaum, 1990; Palmer, 1969). This is not a scientific type of knowledge through the application of general rules to "know better next time" (Palmer, 1969, p. 196). Rather, it is a practical wisdom (phronesis) that brings together the practice of rational, emotional, and social skills. In order to apply a general understanding to particular cases, we must acquire the ability to determine, for each particular occasion, which course of action is best supported. Therefore, practical wisdom cannot be acquired solely by learning general rules. Rather, through practice and self-application of these skills, including the emotive we are able to understand new ways of care, treatment, and healing (Svenaeus, 2003). It is a process of learning about ourselves in undergoing an experience that forwards who we are, and of what we are capable. Caputo (2000) wrote that we "learn by suffering, by running up against our limits, by the thunderstorm which is visited upon our plans and expectations" (p. 45).

"Stands in the Midst of it and is Silent"

> Were it possible for us to see further than our knowledge reaches, and yet a little way beyond the outworks of our divination, perhaps we would then endure our sorrows with greater confidence than our joys. For they are the moments when something new has entered into us, something unknown; our feelings grow mute in shy perplexity, everything in us withdraws, a stillness comes, and the new, which no one knows, stands in the midst of it and is silent.
>
> (Rilke, 1984, p. 82)

There all of types of losses, myriads of way to lose something, or someone. All losses come with a particular call to suffering that is universal in its subsistence. With each loss, a struggle arrives, beyond what we knew before or for which we could be prepared. Moules, Simonson, Fleiszer, Prins, and Glasgow (2007) articulated that "much of the language that surrounds" suffering is "dichotomous" (p. 122). In their belief, we have a tendency to wish to capture and "understand the mystery of this human condition" in "black and white terms" (Moules et al., 2007, p. 122). However, the true nature of loss and suffering evades our wishes and remains hidden in the realm of the in-between (Moules et al., 2007). It is in this liminal space, at the threshold of home where Lang (1985) contended that our words often falter. For Lana, there came a realization that her words were lost and had failed her:

> *L: I have talked and talked and talked about this for the past 6 days with so and so and I don't have anything new to say sometimes you are just talked out.*
>
> *A: What is it like to sit in that space and feel like you are talked out?*

L: It can be tiring. I mean it can be draining. Sometimes you are at sometimes you are literally at a loss of words.

Lana no longer knew what to say. She had entered the realm of the unknown, where her words failed, faltered, and were lost. As a mental health nurse, words are the hallmark of her trade. The space, in which she was in relationship with her patients exists, and was brought forward in language and words. To have them falter and fall away was to render her nursing practice invisible, yet to make her suffering and loss of her way forward visible. To lose one's words, as a practitioner of words, forwards a sense of disequilibrium and confusion. Lana began to not know how to move forward.

L: Hmm (long pause) I guess maybe you come to a point where you are questioning how do we move forward. I don't know if there is a word for that but you are kind of at a loss as to where do we go from here (long pause).

The inarticulate nature of this experience of loss was bounded by the fullness of emotion the lost words belie. She had become lost in the emotion of her relationship with her patients and was struggling to find her way back to a familiar place. The surfacing of silence is truth happening (Schweizer, 1995). It lays something bare, unmasks, and exposes a new understanding. In Lana's reticence or inability to find words and direction, I began to hear the silent spaces in her interview. With each successive question I asked, in an attempt to probe beneath the mask of her nursing practice, I was met with silence. Gadamer (1989) wrote that language is situated in a contextual world. A relationship exists between what is said and what is silenced. It is our task to venture with the words into the depths beneath.

In Lana's interview, silence had a story to tell me. The silent spaces questioned and stirred my imagination with their arrival. Silence perpetuates the in-between of reverie, contemplation, stillness, loss, fear, and emotion. It touches us with its call to the sacred and profane, light and shadow, calm and danger. Silence, in the centre of an experience such as Lana's, is a meeting with the ineffable. It is beyond words, perhaps too sacred to be spoken or too overwhelming to be expressed. In the silence, Lana and I have entered a profound human encounter with thought. Thinking requires silence and reflection. It is different to think while you are speaking (Schweizer, 1995). Gadamer (1989) contended that words, that language, can betray us, hold us at abeyance of understanding what is truly happening.

> *K: I think you see when we're talking to patients and somebody can be like, whoa, that person was pretty harsh with that patient, right? And it's almost like you become a robot and there needs to be silence right? I think sometimes it is easy to get desensitized, especially on Day 6 it's like I cannot hear anything you have to say to me right now. I'm totally wasted...I'm tired and I have trouble hearing and taking seriously what you're saying.*

For Kaylee, words had entered where silence should have prevailed. Language had lulled her colleagues and she into forgetting what might be happening in the situation. Upon reflection, she recognized that she had reached a space where she was no longer able to hear the offered words. In order to contribute and be present with her patients in dialogue, she needed time to be alone and silent. Rommetveit (1998) argued that solitary reflection could serve as a remedy against the prevalence of clanging

pluralistic reverie of ignorance. This could be viewed as a meditative retreat freed from the onslaught of constant voices, the duck speak or throat talk, as Jardine (2006) intimated, that speaks but says naught. We are "shareholders of language" (Rommetveit, 1998, p. 225), not owners. We need to be aware that the words we yield have the capacity to heal, but just as easily to harm. Words may speak to a truth or rather speak robotic-programmed nonsense.

When Nothing is Left

Thirty spokes meet in the hub,
but the empty space between them
is the essence of the wheel.
Pots are formed from clay,
but the empty space between it
is the essence of the pot.
Walls with windows and doors form the house,
but the empty space within it
is the essence of the house.
(Lao Tzu, 2004, p. 28)

There came a time for Pat when the inarticulate nature of emotion and suffering drained her until she had nothing left.

P: I sometimes feel like I have nothing to give and please don't make me talk today.

A: What is it like to sit in that space and feel like you have nothing to say anymore?

P: It's crappy (crying), to not enjoy it or to struggle to come into work. It is really distressing.

Pat believed she had nothing left to offer her patients. Language had failed her and her capacity for empathy wavered. She was struggling in the distress of trying to make sense of this uncomfortable scenario. Kaylee, as well, struggled with having nothing left.

K: You'll avoid one-one's and by Day 6, I'm just praying you don't come up and talk to me, don't come talk to me because I have nothing, I'm out, out of energy.

A: What is that like to have nothing?

K: That's tough... sometimes if I have nothing, my, my sensitivity or caring is less and I might be a little more harsh with somebody.

Both Kaylee and Pat struggled with a fleeting sense of caring or sensitivity and a growing wish to avoid interaction with their patients. We could be convinced to call this avoidance, apathy, or an indifference to the suffering of others. Relationally, it could be seen as a turning away from talking with our patients, a shutting down of the therapeutic stance in relationship and an uncaring distancing. However, apathy, from the Greek *apatheia*, freedom from suffering, originally held a positive denotation (Oxford English Dictionary, 1971). It indicated a reprieve or emptying of fear. The echo of the original intention can be heard in Kaylee's use of the word avoid, which means to clear out, or withdraw oneself from the Old French *esvuider*, to empty out (Oxford English Dictionary, 1971). It does not necessarily indicate that one is devoid or indifferent to the

emotion or feeling of others as is now held in our common vernacular. Rather, this sense of 'avoid' brings forward its connection to empty and nothing in the Buddhist concept of *sunyata*, or pregnant void. This concept of empty or nothing is paradoxical, at once pregnant or full with not yet realized unbounded potential. It can be said to be that nothingness contains everything (Vandusen, 1998). It is a position of leaving behind one's sense of perception and rationality and leaping into the unknown (Cohn-Sherbok & Cohn-Sherbok, 1994).

This sense of nothing does not demand an either/or position. Rather, it exists as a threshold, in the liminal space where neither self nor one's fears or desires are in control. It has been described as the moment at the apex of a pendulum's arc, when it is still, immediately preceding the beginning of its descent. Nothing is also that moment immediately after the exhalation of breath and preceding the inhalation. The culture of western society has predicated a tendency to fear the openness, avoid blankness, and rush to fill in the gaps with action, or objects, or words (Vandusen, 1998). If one accepts nothing as an indicator of the next sense of fullness to come, and view it rather as a fertile void, perhaps then, Kaylee and Pat could embrace rather than fear their need to withdraw and clear one self out for the pendulum's return arc.

Jung (1975) described nothingness in relation to the psyche as an indescribable field of possibilities out of which the world is constructed. It exists between the old ways of being and the not yet realized potential. There is recognition of the concept of *gellasenheit* from German, meaning a state of letting things be, letting them come and go

(Erikson, 1958). One is called to not only to relinquish, but also to yield or give up an old way of being such that a new one can be affected, opened and experienced.

Still a Human Being

In the realm of the liminal, in the in-between filled with monsters, ghosts, and shadowed teachers, the participants found themselves in new ways. They bumped up against themselves in an unmasking of emotional encounters within the therapeutic relationship. There had come a recognition that emotions stay close to home, exist in the being human, and in the ordinary day-to-dayness of being a nurse.

> *L: It brings it back to being human because you are able to see that yes ok somebody else had this reaction as well. It is human, it's ok or it is normal, yeah it does bring it back to being human because you are thinking ok maybe I'm over reacting to this and to hear that somebody else has had a similar reaction or emotion from that it does bring it back to being human.*

For Lana, recognition of emotion in her relationships allowed her to feel normalized and similar to her colleagues. Kaylee revealed that the emotion evoked while in relationship with her patients reflected back her humanness.

> *K: You're constantly you're still a human being so you're reacting to what they're saying or what they're doing. And so let's say, it's like this irritable manic who's unreasonably yelling at you and you're furious and then you think okay, hang on, I'm super furious right now, and this person is really ill; they're really ill. So what's going on? What's making you so furious?*

Abrams (1996) acknowledged that the humanity of self and emotion are intertwined. To neglect or deny this recursive relationship relegates our ordinary language incomprehensible and our sensory world mute. Imaginative possibilities exist in the opening of emotion and recognition of its potential impact to both self and nurse, meeting as a human being. Jardine (1999) reminded us that in "remaining open to the arrival of things (both in the life of the body and breath, and in the life of human understanding) – such "undergoing," such "suffering" – is where our humanity lies" (p. 125).

Dianne's words have begun to reveal a conscious awareness of the dialectic between home and not at home, the canny and uncanny (Woolley, 2007).

> *D: So for instance talking about anxiety, I'll share with my patients that journaling has always been something that I do and that I find it helpful... In the sense that I am human and I do experience a lot of the same things that they do not just to the same extent.*

In her words that she is also human, there is a growing awareness of the path required to form the essence of a healthy authentic self (Sveneaus, 2001). It reveals the inherent paradox of being a listener of narrative as a mental health nurse, exposing self to anxiety, and the need to simultaneously protect self from the induced fear. The extent or measure by which we are able to unify the paradox of existence is the extent to which we are authentically home, *gedankengang*, the process of consciousness becoming home with itself and its environment (Hayes, 2007). For the participants, this process of consciousness involved means of finding ways to cope with the anxiety and fear they faced in their ways of being in the world as mental health nurses. They were attempting

to find a balance, as well, between home and work, familiar and unfamiliar. To me, this represents a quest for a return to a state of homeostasis, and recognition of the passages, potentials, and possibilities of finding self along the way.

CHAPTER NINE

Homeostasis

Homeostasis originates from the Greek *homos* meaning equal and *histemi* to stand. In essence, it is to stand equally so as to maintain a stable, constant condition (Oxford English Dictionary, 1971). To stand equally and be afforded a sense of equilibrium requires a contemplation of the finitude of our existence and an awareness of the possibilities of life. We are able to discover our own individuality, authenticity, and conscience through accepting and moving through, or despite, fear and anxiety (Dreyfus, 1991). To Gadamer (1996), this "equilibrium which we call mental health is precisely a condition of the person as a whole being who is not simply a bundle of capacities; such equilibrium concerns the totality of a person's whole relation to the world" (p. 56).

Being Authentic

Lana believed the quality of being genuine was fundamental to her relationships with her patients. It defined her as a person, and carried with it a sense of presence within her own life as well as how she was able to be with those important to her.

> *L: Genuine means to me that you are a person who tries to be nonjudgmental. You have that openness where as even if you are saying something that I don't necessarily agree with I am going to listen to what you have to say. Genuineness in the sense that you are just there, that you make time for a person, that you are present, that you are focusing your attention.*

The word genuine is etymologically related to the word authentic in the Greek *authentikos,* meaning original or principal. Genuine implies that the presumed author or

speaker is the real one, while authentic implies the contents of the thing under consideration is factual and not fictitious (Oxford English Dictionary, 1971. Authenticity and inauthenticity are, according to Heidegger (1962), what gives us as humans our defining character. Authenticity involves taking responsibility for who we are and who we will become, recognizing that at every moment we are in the process of building a life, a life that is ours. To be inauthentic means to flee in the face of our Being and forget that we have a choice to live our life not merely follow the footprints laid out before us (Heidegger, 1962; Svenaeus, 2001).

We share a world and exist alongside others. Our being in the world is formed through our involvement in the world. Being in relation to others reveals that we are inescapably constituted by the world but also exist as constituting others. In this, there is a responsibility to one's self in relationship to others (Dreyfus, 1991; Gadamer, 1994). According to Gadamer (1989), we exist in language. It is through dialogue with one another that we fully come to realize our limitations and potentials. Through language and dialogue, we gain self-understanding that would not be possible to attain any other way. It is at this juncture where Gadamer (1989) departed from Heidegger's (1962) argument that only turning away from others and finding the one thing that will definitively individuate us attains authenticity. According to Gadamer (1989), authenticity requires turning toward others and engaging others in genuine dialogue.

Living Disrupted

We are always living disrupted as a being in the world. Each new episode of thrownness, that pulls us from our familiar and sets us to wander the in-between holds the

potential to teach us about our selves and offers to navigate our way through and back to a sense of familiar and homeness (Dreyfus, 1991; Svenaeus, 2001). Learning how we negotiate the leaving of home, the return, and the journey in the in-between speaks to us of our wish to be authentic and genuine. To Gadamer (1989), this is likened to becoming experienced, getting to know the landscape of mental health nursing, its hazards, joys, histories, and traditions. It also predicates that we are aware that we continually shift, live in the in-between of past and future. With each new situation, our past is redefined and our "future exists as a space in which the unfulfilled potentials of past understanding can be realized" (Davey, 2006, p. 61).

In this continual renewal of self, and becoming experienced comes a discernment of one's potentials as a nurse, but also an awareness of one's limits and need to protect self. For Kaylee, there came an understanding that her energy and giving of self was finite. She needed to be able to extricate herself from a particular situation before she was overcome.

> *K: He wanted me there and so I'll sit there. At some point you do draw the line though, there are some people who want you to sit in their misery forever and you've just kind of get out of there and say I'm done. I've given you what I can give you today.*
>
> *A: And what is that like to say I'm done?*
>
> *K: That's tough to say, because I'm here to help you but, I can't sit here with you anymore in this hopeless, miserable place, and so I'm going to leave you here. And you feel like you're kind of abandoning somebody in that place.*

A: So do you believe that that's part of that discernment we learn about the wading in or the skirting around, is learning how to walk out of that place of misery?

K: Yeah. And I guess I really didn't think about wading in as often. I was thinking about it more about wading into the past and wading into the traumas that have happened in the past, but sometimes you're wading right into the present and, yeah, you have to wade in and then you have to figure out to get out.

In Kaylee's words, it was a navigation of knowing how to get in, to develop a therapeutic relationship with her patients, and then an awareness of when the work was complete, how she could get herself out intact. There is a sense of balance here - - of knowing she was responsible for the therapeutic relationship but at the same time aware of her own needs as a nurse and as an authentic human being. In this sense of equilibrium, of potential and limits within the therapeutic relationship, her abilities as a nurse were sustained and she was able to offer her patients lessening of their suffering. Kaylee realized she needed to find a way to get out, and to get the impact of the narrative out of her to enable her to re-enter the relationship with renewed energy. This is not balance as is commonly understood within western culture or nursing literature. It does not predicate a need to separate work from home life, or afford equal amounts of time to leisure activities to clear ones mind. This is a sense of equilibrium closer to the one Gadamer (1996) brought forward as a sudden reversal of awareness. There is held within this view a connection to the Buddhist sense of nothingness containing everything (Vandusen, 1998).

Recovery of Equilibrium

And suddenly in this laborious Nowhere, suddenly
the unsayable place, where the pure Too-Little
incomprehensibly transforms itself -, springs over
into that empty Too-Much.
Where the great reckoning
balances without numbers.

(Rilke, 1997, p. 65)

The above writing from Rilke (1997) was used by Gadamer (1996) to illuminate his understandings of equilibrium and homeostasis. As in the experience of an acrobatic artist tumbling, "we experience the recovery of equilibrium in exactly the same way as we encounter the loss of it, as a kind of sudden reversal" (Gadamer, 1996, p. 36). Rather than a discernible transition from one state to another, there is a sudden awareness that something has changed. It is an encounter with our Being in a rhythmic spilling-over that brings forward that we have been disrupted from our previous state of living. When restoration of equilibrium is accomplished, we are once again teetering on the acrobatic tumbling line for the next sudden reversal. Balance is not merely than the maintenance of health and illness or work and home stability but is situated in a historical and social encounter with the "totality of being" in rhythm (Gadamer, 1996, p. 42). For Gadamer (1996), this is a recursive reciprocal state of equilibrium that sustains all of human life and, while at times it may "waver and flicker" (p. 42), it ultimately determines our "very state of being" (p. 42).

The Tumbling Movement of Equilibrium

In the maze of narratives that exist in therapeutic relationships, there also arises recognition of the delicate balance of truly being at home. As mental health nurses, we listen to, and are situated in, often-emotional evocative narratives with a patient. With each new arrival, our equilibrium is unexpectedly shifted and redefined as it tumbles over onto our at home way of being (Gadamer, 1996). In this struggle to realign balance, there is a need to accommodate this new weight. This requires holding the narrative long enough to acknowledge and witness its presence but not so long as to injure self by its absorption into one's being.

This living of equilibrium and the swinging pendulum divide of separation and protection predicated a need to get the narrative out. For all five participants, this need to get the narrative or emotion out was consistent. Each participant, however, had different means and forms of attending to this process and restoring a sense of equilibrium.

For Lana, there came a recognition that she needed to wipe the slate clean at the end of each shift to enable her to re-enter the next shift in a renewed manner.

> *A: It sounds like it is a really strong thing that you hold, that each day and each situation with a patient you enter is new. Do you have a word for it?*
>
> *L: Yeah, it is a bit of a blank slate. I don't think I always did that and I think that's maybe where there are roadblocks to some of your relationships with patients because if you are still hung up on what happened the evening before... if you are still carrying that with you that can definitely influence your interaction with them the next day.*

This idea of renewal and a clean slate was one to which Lana continued to return to in our interview; later on, she once again referred to this idea of starting each day anew.

L: ... Something will stick with you and you will need to let go of it and start a new day and start fresh with someone.

A: What are the ways in which you remind yourself to let that go?

L: Sometimes even some self talk, a reminder of ok you know this is a new day and I will actually say to myself this is a new day so start fresh start over.

A: What does that do?

L: It kind of pushes it to the side and when I go back I feel like I've kind of regrouped and that I can start over.

This was not a tabula rasa or starting over from the beginning on the part of knowing and knowledge. Rather it was receptivity, a clearing or emptying of space that can be seen as an opportunity to begin anew with the patient. This sense of starting over allowed an opening of self to the patient by an afforded reflection and self-renewal.

Kaylee found she needed to remove herself from the environment of the hospital. This allowed her time to remember herself away from work in a new positive way:

K: I go to Starbuck's every night...and get my coffee and come back and it just gets me out of there for a little bit...It lets me be free of it for a little bit...Just being out of the smell of it, and being in a coffee shop is like, here's real life, it's okay, it's still here, everything's fine.

The time away, for Kaylee, appears to intimate the retreat brought forward in the concept of nothingness as a sense of renewal and fullness. It allowed Kaylee time to reposition

her experiences with her patients into her being as it readjusts her sense of her self forward. Upon return to the unit and the remainder of the shift, she was able to continue in a renewed, invigorated manner.

Dianne found this process of renewal occurred for her through journaling:

D: It is a good way to get it out on paper and put it aside and reflect and look back on...if I had a rough day or something sort of touched me, or made me upset or whatever, I find it nice to go home write about it and then I can not think about it.

Dianne recognized that she required a means of leaving her thoughts of paper. In the immediacy of placing pen to paper, she was afforded a means to leave the issues there and walk away. The pages could hold the emotion, situation, or issue that occurred within her relationships so she no longer needed to.

Meg recognized, as well, this need to get the narrative out and leave it behind. She offered she was able to due this through conversation:

M: I like to talk. I think that I cope with things by talking, like telling. You know when our patients come in they want to tell their story, well when I hear their story, I want to tell someone else their story because it makes me feel better. I want to get it out I guess.

For all of the participants, conversation, particularly with their teammates and colleagues, offered an important means of getting the emotion and narrative out. This connection and support with others who understand the work and intimacy of the therapeutic relationship

was vital to their ability to continue their occupation within the field of mental health nursing.

> *K: I think one of the most important parts of mental health nursing is the other mental health nurses that are in the room just as much as you are, doing the things that you're doing, and talking to them. We absorb the stories of our patients and what's going on, but then we, we talk about it with each other. I think if you didn't have that, nobody would survive this job. You need a strong team and you need the other people to hear you and relate.*

There is a sense here of us as mental health nurses holding the stories of our patients. As Kaylee intimated, the stories are absorbed, held inside as perhaps could be equated to a vessel, bowl, or container holding something of value. Helen Bamber, who at the age of twenty, left her sheltered London home to sit with the wounded skeletons of Bergen Belsen spoke of this idea of holding. She had no training, no experiences that could, for her, reconcile the images and words barraging her first days at the newly liberated camp. She recognized that what she could offer was her presence, and "to receive, not to recoil, not to give the sense that you were contaminated by what you have heard but rather that you were there to receive it all, horrible as it was and to hold it with them" (Belton, 1999, p. 23). For the five nurses in this inquiry, the need to have others who understood their work, standing beside them, holding alongside, helped them endure and sustain their ability to be in relationship with their patients. It became a sense of holding the story together such that the burden was lessened.

L: Sometimes when you are overwhelmed and burnt out you will talk I will talk and I mean with staff about that.

A: What is helpful about talking?

L: I think it is helpful so it's not bottled up in side of you it's a way of letting it go. It's a way of releasing it...where as before your emotions were a lot stronger but in talking to somebody you can make lighter sense of it somehow and you can let go of it.

In holding the story alongside our colleagues and in sharing of the burden through conversation, there affords a feeling of release and lightness of emotional weight akin to a catharsis.

Catharsis

Kaylee described this process of release of the emotions and her belief in the importance of talking with her colleagues such to lessen the damage to self. This came through the purging of the destructive narrative:

K: You absorb it and you carry it, kind of, to the charting room and then you...barf it all over the charting room and then it just kind of stays there. There's obviously some that stick, some come home, some, but you try to minimize it and I think by spewing it out there, you get rid of it in some cases.

To spew is connected etymologically to catharsis from *katharus* meaning to purify, cleanse, to make pure (Oxford English Dictionary, 1971). This ritualistic purging of self could be seen as an attempt by Kaylee to rid her body of the poisonous narrative. It was an endeavor to prevent her home from being intoxicated and endangered by the

internalization of others thoughts. In this cleansing, her spirit was rejuvenated and those thoughts and feelings that were taken in through listening and dwelling in her patient's narrative were shed.

This sense of emotional shedding or cleansing is attributed to Aristotle in his work Poetics (Aristotle, 1996). He referred to a cathartic event as a release of pent-up emotion or energy that would come over an audience upon watching a dramatic tragedy. It equates to a sudden reversal and revitalization (Hoe, 1996). In this way, it is a corrective feat of equilibrium or homeostasis that brings fear and anxiety into their proper position (Gadamer, 1996). It can be likened to the equilibrium described by Gadamer (1996) as a sense of rhythm, flux, and continual movement.

We live in language in the same way we live in the world. If narrative- language - is the natural way of being and sense making in the world, it follows that the person who has heard the distressing and disruptive narrative of another will need to formulate their own narratives (Frank, 1998). Kaylee shared her views on her need to talk with her colleagues and re-tell a patient's narrative through her own context.

> *K: I don't think it gets carried by the listener the same way...It is the same thing where you just have to get it out... I almost think that part of that is coping. If you're using humor to get it, get it out, if you're angry... I don't say that to that patient. None of that comes back to that patient and I can maintain my professionalism with that patient and I can also just kind of get it out and then become who I really am.*

This newly formed narrative placed the disruptive narrative in a context that allowed it to be processed and the haunting diminished. In this re-telling and re-contextualizing, the narrative of self is no longer alienated and angst ridden but rather becoming home.

Becoming Who I Really Am

We are always in the midst of becoming who we are. It is a journey of alienation, of going where we are not and returning changed. In this intertwining of narrative journeys, there arises recognition of the delicate balance of true home. It is a dynamic, rhythmic movement that is open to the future as a possibility of the past. There exists a difference of understanding the black and white of a given situation and the relevance and opening of understanding that comes with viewing the colors in-between. There is recognition that empty and full, separation and protection are not polarized opposites, but rather two sides of a swinging shifting arc of perpetual motion. To Gadamer (1994), "Being is more than simple "presence",... it is also just as much "absence", a form of "there" in which not only the "there is" but also withdrawal, retreating and holding within are experienced" (p. 180).

We stop at times along this movement journey. In times of deep suffering, or loss of way forward, we linger. Perhaps it is in these times, when motion stops, or when the rebound of movement stalls that we feel stuck, or in the vernacular of mental health nursing, are "burnt out". This sense of humanness, of becoming who we are and living our life, does not promise that we shall always be happy, or safe from harm and danger. Rather, it forwards an authentic way of Being at true home with self as nurse and self as person (Dreyfus, 1991; Gadamer, 1994, 1996).

There is a reciprocal relationship between the experience of being at home, canny, familiar, and the not-at-home, uncanny, unfamiliar. Some of our most powerful experiences of Being happen between the homes interior and exterior, in the in-between (Dreyfus, 1991; Harries, 1978; Woolley, 2007). These stances are in continual flux, changing, striving, and creating self and those around us. They inform and establish our means of being authentic with ourselves and for those for whom we care. It is our encounters with others in language that we discover our historical, social, and traditional horizons and our home of meaning (Gadamer, 1989; Heidegger, 1962).

It is also, too, in these moments of encounter and the openness of self that we are deeply vulnerable and subject to attack, wound, and suffering (Davey, 2006). However, if we become open to suffering as inevitable to being human we may be afforded a portal to new experiences and understanding. In this way, suffering, or the sense of to undergo a situation, is how we might come to know the meaning of the human condition and develop compassion (Caputo, 1987; Hilficker, 1994). In order to be open to this flux of separation and protection, we develop a sense of the world as requiring a sanctuary. This ontological place of true home is the extent to which we feel safe and sheltered in order for this process of becoming to happen (Harries, 1978; Woolley, 2007).

CHAPTER TEN

Rough Ground of Home

My purpose in this research inquiry was to explore and extend the understandings of mental health nurses dwelling in the illness and life narratives of their patients. I was interested in discovering the impacts this position as listener of often emotion-laden narratives has on the nurse, within the therapeutic session, and ultimately what the impacts are on the nurse-patient relationship. The word impact is from the Latin *impactus*, meaning to press closely, push into or strike forcefully against something. There is a carried sense or effect of coming into contact with a thing or person (Oxford English Dictionary, 1971). I wrote that I am of this topic, the sixth participant and in this too I was also affected; I have experienced and continue to experience the impact. To Gadamer (1989), "understanding begins when something addresses us" (p. 298). This topic of the impacts of the therapeutic relationship has long held interest for me. Its ghosts and ancestors have called to me, wondering aloud my abilities as a nurse, situated in relationship with my patients.

This sense of address, or call of a topic, according to Jardine (2006), can also "*strike* us, catch our fancy, … *speak* to us, *call* for a response, *elicit* or *provoke* something in us, *ask* something of us, *hit* us, *bowl* us over, *stop* us in our tracks, make us *catch our breath*" (p. 270). There is an element of surprise, of springing back as if from the force of impact. This was my experience of exploring and writing about this topic area. This is not the thesis I originally imagined it might be. The topic of my call, the impacts of the therapeutic relationship on mental health nurses, was central, yet the landscape that

surrounded me took me by surprise. It caught me off guard, bowled me over, stopped me in my tracks and then lured me down into places I had not anticipated going (Jardine, 2006). With each question I asked my participants about the impacts they experienced in their relationships, the answer inevitably returned with a story attached of how they had been helped or hindered, supported or beaten down by their colleagues. The landscape of the therapeutic relationship was much fuller than I first imagined possible. I was struck by the multitudes of voices that spoke in the space between and around the relationship. Each voice carried the ability to shape and determine how this relationship could be. These voices felt like unseen, unheard, unspoken ripples effecting outward, and outward, and outward. They spoke of how to be a good nurse, and whispered stories of codes, masks, and emotions into our ears as we dwelt with our patients. As we continue to sit "right there in the midst of it with them", in the midst of stories, relationship, and practice with our patients, how does their collective voice impact? How do their tales of history and tradition influence, shift, and alter our relationships?

I see this landscape anew and yet somehow I continue to remain struck. These new experiences of the therapeutic relationship hold images, constructs, and ideas that have shaped our practice as mental health nurses. I have become aware again of the therapeutic relationship's limits and overt boundaries, and how much suffering it has the ability to perpetuate. It was a place I did not wish to go to even once I saw it. The currents of emotion it held were powerful and dangerous. Yet it held me there, shaped my thesis analysis and restructured the past of my nursing practice and projected forward what it can be. Gadamer (1989) wrote "the individual is never simply an individual he is

always in understanding with others" (p. 304). In this way, I too have come to recognize that in each instance of relationship with my patients is carried the voices of many. As I struggle to find my equilibrium of Being truly at home, I am reminded by Gadamer (1989) that:

> This world in which I undergo or suffer experiences, is not just inhabited and formed and fashioned by myself and by and within my own(ed) experiences, but is always and already been formed and fashioned by shared contested inheritances, voices and ancestries, up out of which I must slowly and continually "find" myself becoming who I am. I am surrounded by a "multifariousness of voices". (p. 295)

My task in this inquiry was not to join the voices, to make them speak of the same uncontested view of relationship and impact. Rather it was to bring them closer, enliven them to speak their views so we can hear, see, and feel them again in the clearing of the rough ground. There is a need to acknowledge their voice-full impact in the room of therapeutic relationship before we can move forward and change their effect on us as nurses.

Bringing it Back to Nursing Practice

The topic of this inquiry focused on the impacts of the therapeutic relationship as experienced by mental health nurses. In going into the everydayness of their practice, in the space they exist in relationship with their patients, I aimed to uncover new understandings. In addition, I sought new portals of the in-between of the relationship landscape and players. Dialogue among and between nurses and patients, in the situated-

ness of the therapeutic relationship, is essential in gaining a clearer understanding of the relational impacts. Further discourse about the meaning of the therapeutic relationship, and its impacts on not only the nurses' home lives, but also their nursing practices brings to the forefront the ways in which nursing practice, education, and research are reciprocally moved by the practical day-to-day activities of being in therapeutic relationship.

There is an enormous amount of writing which concerns the therapeutic relationship in the nursing and psychotherapy literature. Much of this writing has affected the professional practice of nurses. The work of Hildegard Peplau is one such author who has imparted a vast and enduring legacy on the way we practice as mental health nurses. While her focus is on the relationship between nurse and patient, the scientific focus on objectivity may have encouraged a view of relationship that is distanced. This view afforded a perspective that arose when the nurse pulled back from concerned involvement and observed or studied the patient in a distanced manner (Gallop & O'Brien, 2003; Warne & McAndrew, 2008). This predicated a perspective that lost sight of the full landscape of relationship. Newer relational theories have brought the in-between of the therapeutic relationship to the forefront of practice. With these theories has come an understanding that the relationship between nurse and patient is ever evolving, and is a co-created dynamic fluctuating domain (Bell, 1996; Hartrick Doane &Varcoe, 2007). However, as this thesis has surprisingly uncovered, this too does not forward a full perspective of the demands and challenges of the therapeutic relationship. In order to

grasp a broader perspective, we need to assess and take into account the dynamics that are also in play between nurse colleagues, and with our storied traditions as a profession.

Implications for Nursing Practice

Mental health nursing is a relational practice. Beal et al. (2007) recently asserted there exists "no doubt that the therapeutic relationship creates the foundation for care, continuity and recovery. Everything flows through this relationship. When the therapeutic relationship fails, it causes great pain, when it succeeds it is experienced as transforming" (p. 16). Within the therapeutic relationship, there is a supportive space of listening created within which our patients can begin to make sense of their world and heal. This is listening so that the truth is felt within the body's sense of the heard truth, and available to the experience of *aletheia*, the unconcealment. It requires an opening-up toward truth that is vibrant, resonant, echoing. It cannot be certain, cannot be controlled (Gadamer, 1989; Levin, 1989). It requires a commitment and a risking of self.

Truly listening to the stories patients believe are important to share brings relational caring to life. It is a central tenet by which nurses influence patient outcomes (Stickley & Freshwater, 2006). However, when we truly listen we do something else as well. In listening, we begin to compile pictures of individual people, their illness stories, their experiences and progress as well as creating composites of stories and people. It is in this attention to the particular that we formulate "maxims for practice" (Benner, 2000, p. 103). We move from the particular story of an individual to the phenomena of human experience.

In this recursive and shared narrative of human experience, new understandings can be opened (Hyden, 1997). In listening to others, accepting them in their irreducible difference, we as mental health nurses, are enabled to listen and attend, as well, to the telling of our own body of experience and to reconstruct ourselves into our new identity, in the context of being in the world as listeners of stories (Levin, 1989). This reconstruction and re-alignment of self appear to be characteristics needed to maintain and remain in the practice of being a mental health nurse.

This concept of the therapeutic relationship that is mutual and reciprocal has found its way into nursing literature. However, as was evidenced by the way it was spoken to by the participants, there appears to be a gap between how it is understood and how the parameters and reality of mental health nursing allow it to be. With the legacy of detachment and emotional reserve, the tendency may continue for nurses to not share the stories with one another of how they are affected and impacted by relationships with their patients. With this, then continues the feelings of isolation and hopelessness that were evidenced in several of the participants. We need to enable a place and space of safety to begin dialogues about these topics with one another. The code of silence and the mask of suffering need to be brought out from their shadowed corners and challenged. To not do so will continue to push to the boundary those who dare to speak of their suffering within the sanctum of the therapeutic relationship.

If we nurse by rote and tradition without challenging our inherited templates of what a good nurse is, we are at risk of moving into "autopilot" and becoming, as three of the participants articulated, therapy robots. The unquestioning and unconscious risk is not

only of losing the individual patient in the process but also losing ourselves. While situated in tradition, we can begin as Gadamer (1986) stated, not to blindingly preserve but rather learn from our encounter with it.

> Tradition is not just the careful preservation of monuments, but the constant interaction between our aims in the present and the past to which we still belong. It is a question, therefore, of allowing what is to be. But this "letting be" does not mean the repetition of something we already know. We let the past be for us as we are now, not by repeated experience of it, but through an encounter with it. (p. 49)

These complex and often emotionally laden experiences of mental health nurses require consideration from continuing professional education, professional associations, and hospital administration for support and shelter. In these times of increasing patient acuity, nursing shortages, and an aging nursing population, there becomes an even greater need to protect these practicing nurses so that they do not, as many before them have, leave the doors of mental health behind (CNA, 2008).

Implications for Nursing Education

Mental health nurses are an aging group. The 2008 statistics of nurses in Canada revealed we are the second oldest group of nurses, at an average age of 47. 3 years, following closely behind geriatrics and long term care (CNA, 2008). Given statistics showing our aging population of nurses, one of our pressing needs is attracting new nurses to the area. While there is limited research into attrition rates in mental health nursing in Canada, it has been identified as an area of high occupational stress (O'Brien-

Pallas, 2008; Ryan & Quayle, 1994; Sullivan, 1993). Examination of nursing students during mental health clinical rotations has found that students feel unprepared for the complexities they encounter. Students may be particularly vulnerable to stress and emotional trauma in their experiences with patients distress, and uncertain how to proceed (Ewashen & Lane, 2007; Warne & McAndrew, 2005, 2008). Scholars argue that this preparedness, as a vital component of education and curriculum process, is missing in nurses training and the results are evidenced in stress, burn out, low morale, and ultimately in lowered treatment outcomes for those they encounter in the nurse-patient relationship (Cameron, Kapur, & Campbell, 2005; Warne & McAndrew, 2005).

The work we do as mental health nurses is often invisible. Perhaps making this practice more visible to nursing students, through the experience of the everyday life of the therapeutic relationship, may encourage others to enter the profession. It at the very least would demystify some of the issues surrounding how to speak with and listen to patients' stories. In conjunction, one might argue that there needs to be forums for students to deal with the emotional experiences they encounter within their clinical rotations. We need to open dialogues about what really happens in relationships, that emotions may be brought forward not only by our patients but also in ourselves. Students need time to experience the process of relationship and to debrief about what their experiences were like in a safe and sheltered learning environment (Cameron, Kapur, & Campbell, 2005; Ewashen & Lane, 2007; Warne & McAndrew, 2005). Vandemark (2006) asserted that it is imperative for education to clear a space for processing, talking, and decontaminating the fear and anxiety associated with dwelling in patients' narratives.

To do so may make the specialty area of mental health nursing a more inviting and less feared area of clinical practice.

Return to the Rough Ground and Continued Possibilities

> Interpretive inquiry is thus itself, in its own way, a living topography, inhabited by a rich, complex, contested, substantive images of the workings of human life, a topography which bears, at the outset, a deeper inner affinity to the life and understandings and discourse of nursing... --primary paradoxes that humans must learn to live with - of human experience and human life. (Jardine, 1996, p. 201)

Spending time with the text, reflecting on the movement from part to whole, whole to part, whiling with the multifarious voices brought forth the complexity of understandings found within the therapeutic relationship. This world of text and the world of researcher have interpenetrated each other through a fusion of horizons journeying full circle, back to the rough ground with new understandings of the therapeutic relationship. This inquiry has demonstrated that this is not only the known factual content of listening to narratives within the therapeutic relationship, it has been opened, laid bare and altered our at home way of Being. How are we able to listen to others in an open, welcoming, and receptive way. Are we able to hear, greet, and dwell in what the other shares regardless of how painful, disruptive or threatening it may be. Finding a way to truly be at home ultimately expands our capacity to care, be compassionate, and authentically human (Gadamer, 1989; Levin, 1989).

Interpretive inquiry is a potentially unsetting process filled with a surrendering to a yet unknown journey (Jardine, 1992). In this way, it reflects the inherent risk of 'self loss' articulated in the undertaking of a profession of care such as nursing (Henderson, 2001). In spite of these risks, to self, this experience of listening and sharing in the narratives of our patients is "worthy of rest and repose, worthy of returning, worthy of tarrying and remembering, of taking time, of whiling away our lives in [its] presence" (Jardine, 2008, p. 1). It is for this purpose that I chose to use hermeneutics as my means of interpretive inquiry into the experiences of mental health nurses dwelling in relationship with their patients. Hermeneutics offers the opportunity to conduct a more thoughtful practice, a desired outcome in the important work of nursing where prescription and assumed practices should not adequately satisfy the complexity of therapeutic and interventional environments. By moving towards a deeper understanding of the nurses' experiences, new openings for exploring the nurse-patient relationship may be broached. It is anticipated the outcome of this analysis will bring our nursing experiences toward a deeper, richer, and more profound experience, enabling our patients to reap the benefits of these new understandings.

This journey of finding our true home of Being pauses at this juncture for rest and repose. The participants and I have meandered to a new understanding of the interconnected and impactful nature of relationship and self. As the horizon sets on this particular expanse, it is with awareness that this offering is but a small glimpse of what the arduous perilous journey of interpretation and hermeneutic wanderings has in store on a new day.

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Appendix A

Recruitment Poster

Impacts of the Therapeutic Relationship on Mental Health Nurses: --A Research Project--

What is the research about?

- The nurse-patient relationship is central to mental health nursing practice. It is the means by which we assist our patients to heal. What however is the impact on the nurse?

Why are you asking me?

- There is limited literature on the impact of the therapeutic relationship on the nurse. As a practicing mental health nurse, you hold the key to understanding how this relationship impacts our practice.

Who is doing the research?

- My name is Angela Morck, RN. I am a practicing mental health nurse. Along with my supervisor, I am conducting this research as my thesis project toward a Master's of Nursing at the University of Calgary.

What would I have to do?

- If you are interested in becoming a participant, I am asking for approximately one hour of your time for a one-to-one interview. The interview would occur at a place and time convenient for you.

How do I contact you?

- If you would like to participate, or need more information, please contact me at the following email address or phone number:
- amorck@ucalgary.ca
- Home phone: 647-938-7745

Appendix B

Guiding Research Interview Questions

I am curious about a time when a patient's story has stayed with you, come home with you, what has been its biggest impact?

In what ways has this impact influenced your nursing practice?

In what ways has this impact influenced your home life?

Are you ok with this impact? Or not ok with it?

How would you describe your relationship with your patients?

What does being in a therapeutic relationship mean to you?

What, if anything, has this experience brought to your life?

What has been most helpful to you in this experience?

What has been the least helpful to you in this experience?

Appendix C

Consent Form For Interview

TITLE: "Right There in the Midst of It with Them": Impact of the Therapeutic Relationship

INVESTIGATORS:

Dr. N.J. Moules, RN, PhD
University of Calgary, Faculty of Nursing
Associate Professor (403-220- 4635)

Angela Morck, RN, (MN student)
University of Calgary, Faculty of Nursing
Master of Nursing Program

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Mental health nurses frequently confront situations in their work that illicit intense emotions in both their patients and themselves. In this research study we intend to explore the impact of the therapeutic relationship on the mental health nurse, in the context of listening to the illness narratives of their patients.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to discover the impact this position as listener of, often emotionally laden, narratives has on the nurse, their ability to be present within the therapeutic session and ultimately what the impact is on the nurse patient relationship.

WHAT WOULD I HAVE TO DO?

You are eligible to be in this study as you are a currently practicing Registered Nurse working in a mental health specialty area. If you take part in the study Angela Morck will interview you about your experience. The interview is expected to last approximately 1 to 1/2 hours, it will be held at a location of

your choice, at a mutually convenient time. The interview will be tape recorded and transcribed (typed out word for word). Everything you say will be confidential.

WHAT ARE THE RISKS?

There is very little risk to you in taking part in this study. It is possible that you may remember unpleasant memories during this discussion, which may make you feel uncomfortable. Should you experience any lasting distress, as a result of the interview, and are not presently in counseling, counseling will be provided for you (should you wish it) by Dr. Moules.

All responses from the interview will remain confidential. A fake name will be used in any written information, publication or presentation of the study results. There is a small risk that the something that you had to say in the study would be quoted in material used for publication or teaching. These quotes would be used in a way, which does not identify you.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study you may or may not benefit from the discussion. The information we get from this study may help us to better understand the dynamic complexity of the nurse-patient relationship and ultimately provide better care for patients and nurses alike.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary. You may stop the interview at any time. You can pull out of the study at any time up until data analysis has started. After data analysis has begun, there will be no way to pull out your information as it will all be blended in with others' information. Should you wish to withdraw, contact Angela Morck at the number listed at the end of this form. Any audiotapes or written transcripts will be destroyed.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for taking part in this study. If you have expenses such as parking, you will be reimbursed.

WILL MY RECORDS BE KEPT PRIVATE?

No identifying work details, patient or colleague names will be used in this study. The interview is confidential, and your name will be removed from the typed interview and substituted with a pseudonym (fake name). The only exception is, if urgent risk to self or others is reported. In which case, the appropriate legal authorities will need to be contacted. Written and audio recording of interviews will be kept in a locked cupboard at the University of Calgary. Written transcripts will be kept for five years and then destroyed. Audiotapes will be erased when the study is complete. Only the research team will see the complete transcripts. It is possible that a member of the Conjoint HREB will look at the information for audit purposes.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Nancy Moules (403) 220 - 4635

Or

Angela Morck (647) 938 -7745

If you have any questions concerning your rights as a possible participant in this research, please contact The Chair of the Conjoint Health Research Ethics Board at the Office of Medical Bioethics, 403-220-7990 or the Ethics Resource Officer, Internal Awards, Research Services, University of Calgary, at 403-220-3782.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

FACULTY OF UNIVERSITY OF
MEDICINE | CALGARY

2008-10-30

OFFICE OF MEDICAL BIOETHICS
Room 93, Heritage Medical Research Bldg
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Dr. Nancy J Moules
Faculty of Nursing
University of Calgary
Calgary
Alberta
T2N 4N1

Dear Dr. Moules:

RE: "Right There, in the Midst of it with them": Impacts of the Therapeutic Relationship

Ethics ID: E-22053

Student: Ms. Angela Morck

The above-noted proposal including the Research Proposal , Consent Form (version 1.0, October 30, 2008), Poster ("Impacts of the Therapeutic Relationship on Mental Health Nurses: A Research Project"), Ethics Approval Form (Faculty of Nursing Graduate Program Approval of Thesis Proposal (October 10, 2008).), Interview Question Guide (Guiding Research Interview Questions) has been submitted for Board review and found to be ethically acceptable.

Please note that this approval is subject to the following conditions:
(1) appropriate procedures for consent for access to identified health information have been approved;
(2) a copy of the informed consent form must have been given to each research subject, if required for this study;
(3) a Progress Report must be submitted by **October 30, 2009,** containing the following information:
- i) the number of subjects recruited;
- ii) a description of any protocol modification;
- iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
- iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
- v) a copy of the current informed consent form;
- vi) the expected date of termination of this project.

4) a Final Report must be submitted at the termination of the project.

Please note that you have been named as the principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Glenys Gudlovitch, BA(Hons), LLB, PhD
Chair, Conjoint Health Research Ethics Board

GG/emcg
c.c. Ms. Gladys Glowacki (Health Records) Ms. Donna McDonald (RTA) Dr. Debbie White (information) Ms. Sharon Van Oort, Research Services, Main Campus Ms. Angela Morck (Student)
Office of Information & Privacy Commissioner