Being a Psychiatric Nurse: Shared Humanity and the Nurse

Patient Encounter

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This is a phenomenological study aimed at uncovering meaning and generating understanding of being a psychiatric nurse via the phenomenon of the nurse-patient encounter.

The study was informed by Heideggerian phenomenology and the philosophical hermeneutics of Hans Georg Gadamer. Seven psychiatric nurses were interviewed about their experience of the nurse-patient encounter. These interviews were transcribed and interpreted using a method of hermeneutic analysis that was inspired by the writings of Hans Georg Gadamer.

The elements to emerge from the interpretation of these encounters are the existentials of Being with as understanding, Being with as possibility, and Being with as care-full concern in the horizons of Time and the World. Each of these existentials and horizons have modes which are also described in the study.

An underlying theme of shared humanity emerged from the encounters and had the effect of unifying the existentials. Shared humanity informed and guided the encounters and the projected possibilities envisaged by the nurses. In the shared humanity of the encounter the patient is perceived as a fellow human being more similar than different to the nurse. Shared humanity is seen as essential to understanding the patient as an immediate living human being and to the projection of possibilities in the encounter.

The modes of the “Self” nurse and the “They” nurse also emerged from the study and are described in the study. The nurses in the study chose to approach the
patient in the "self" nurse mode of psychiatric nursing which appreciates the common grounding of shared humanity in the encounter rather than the "They" nurse mode which covers over such shared humanity and denies the possibility of a true being to being encounter.
This work contains no material which has been accepted for the award of any
degree or diploma in any university or other tertiary institution and, to the best
of my knowledge and belief, contains no material previously published or
written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University
Library, being available for loan and photocopying.

Signed:
   Kenneth David Walsh

Date: 7/2/97
DEDICATION

To my parents whose love taught me to believe in myself.
ACKNOWLEDGMENTS

Professor Alan Pearson has been supervisor, friend and mentor to me. I am indebted to him for his support, sound advice and inspiration.

This thesis owes much to the support of my wife Yvonne and the patience of my children Tanya and Declan. Without their help this thesis would have been difficult, if not impossible, to complete.

Patrick, my brother, contributed to this thesis by instilling in me a thirst for knowledge and my sister-in-law, Merilyn, has been a role model more often than she perhaps realises. I wish her well with her own thesis.

I have gained much from the friendship and scholarship of my fellow students (The Ducktors); Mary Fitzgerald, Mary Ebbott, Ploenpit Thaniwattananon, Pat Hickson, Jenny Watson, Camillus Parkinson, Helen Cox, Jill White, Karen Francis, Deanne Gaskill, Jane Stein-Parbury, and Danny Vholand. My thanks also to Ysanne Chapman who gave of her time to edit this thesis.

In my short time in Adelaide I have made good friends and I number amongst them all the staff of the Department of Clinical Nursing. The departmental staff have welcomed a stranger into their midst and made me feel at home.

My grateful thanks also go to the nurses who participated in this study.

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CHAPTER ONE
INTRODUCTION TO THE STUDY

BEING A PSYCHIATRIC NURSE: SHARED HUMANITY AND THE NURSE-PATIENT ENCOUNTER.
CHAPTER ONE: INTRODUCTION TO THE STUDY

BEING A PSYCHIATRIC NURSE: SHARED HUMANITY AND THE NURSE-PATIENT ENCOUNTER.

My interest in the study

An encounter

I had driven to Brisbane to attend a Centre for Psychoanalytic Studies public lecture. As a psychiatric nurse with an interest in things Freudian, I was a regular attendee at these lectures and it was my usual practice to visit my brother afterwards. On this occasion my brother was not home so I went to the local fish and chip shop to buy a hamburger. The fellow behind the counter looked vaguely familiar and as I waited to be served I watched him wrapping prawns for the woman in front of me. He obviously recognised my face and would glance at me from time to time and smile in a comfortable and familiar way as if I was a well known and valued customer.

I was starting to feel uncomfortable. He obviously knew me but try as I may I could not remember where we had met. There was something there on the edge of my memory, it was something significant but I couldn’t quite grasp it. As he handed the woman her change I rehearsed a variety of lines designed to save face.
The best ploy was to say “Nice to see you again” or “How have you been?” carefully avoiding names or places, and hope for the best.

As the woman left and I breasted the counter he said, “Hello Ken, you don’t remember me do you? I’ll never forget you”. I mumbled something about the face being familiar and he said, “It was (at a psychiatric hospital) eight years ago, you admitted me”. Then the penny dropped and the memories flooded back. The shop was empty of customers now. Interspersed with questions as to how I wanted my hamburger, we reminisced about the events of eight years ago.

It was my last day in the hospital. I was leaving to get married, settle in a new town and start a new job. My last official duty was to admit the new patient who had just arrived.

Stephan came in accompanied by his wife and young child. He had that haunted look of someone tormented by “the voices”. We were much of an age and as he and his wife recounted the background to his admission to hospital I found it easy to identify with him. I was supposed to gather his details in the proscribed form. I was supposed to record his history, list his symptoms. The hospital and the psychiatrist needed these details but at the time Stephan didn’t need to be asked them. I put the forms aside. We spent two hours talking but all I can recall now is that I tried to support his decision to come to hospital and reassure him that he would be cared for and that there was hope for the future. I told him that we would not meet again because it was my last day in the hospital but I introduced him to the other staff. When it came time for me to leave I wished
him all the best and I meant every word of it, in some ways I was wishing the same for myself as well.

I recall driving home at the end of the shift and contemplating the similarities between us. He was a young man recently married and newly a father, starting a new job. I was leaving to start a new job, get married and start a family. For him it had all proved too much. The worry had turned to paranoia and then persecutory voices. I hoped things would turn out well for him in the future. Our encounter made me reflect upon my own possibilities in a way that was laden with hope and fear. How would I face up to my future?

So here we were in the future. Things had indeed gone well for both of us. He proudly told me that he owned the business in which we were standing. But why should he remember me, someone he had met for only two hours some eight years ago? His answer was, because I had given him hope for the future when he so desperately needed it.

I still see Stephan occasionally (he makes good hamburgers) but we don't talk of psychoses now. We have found we have a mutual interest in sports cars; he owns an Alfa and I an MG. But all those years ago (now twelve) he found in me a source of hope and I found in him the embodiment of my fears.

I am a psychiatric nurse. I have lived and do live in the circle of being a psychiatric nurse and a person as I hope the above encounter shows. My personhood is partly defined by my nursehood and my nursehood helps me
define who I am. I am not the person I would have been if I had not taken up psychiatric nursing but the person I was, perhaps pushed me in that direction. The whole of my being is partly defined by my being a nurse yet to understand my being a nurse one has to understand me as a being. This may seem a trite piece of obvious circularity but that which is the most obvious and closest to us can be the most profound. Our being is closest to us yet it is something which has been largely ignored as self evident. Many aspects of psychiatric nursing have been explored but the one that is closest to us has often gone unexamined; what it is to be a psychiatric nurse? The emphasis here should be placed on “be”. I do not mean to explore the activities that make up psychiatric nursing, its job description so to speak, but something more primordial. I mean to explore the being in the world of the psychiatric nurse; the lived experience of psychiatric nursing.

How does one go about such an enterprise? As Heidegger says, in order to explore a forest we first need a path to follow; this path cannot be any path, it needs to be a path that goes through the forest and not around it (Steiner, 1978:26). What path would lead into the forest that is psychiatric nursing? Is there a sign post? For the sake of what or whom, does psychiatric nursing exist? or to reverse the question, what or who would need to cease to exist for psychiatric nursing to cease to exist? Psychiatric nursing exists for the sake of psychiatric patients. I shall therefore take psychiatric patients as my sign post. But where does this sign post point, after all sign posts have a destination? The destination I believe is the meeting point between the nurse and the patient, the nurse-patient encounter.
If psychiatric nursing and psychiatric nurses exist for the sake of patients and being a psychiatric nurse is essentially being with patients, then the encounter between the nurse and the patient should illuminate what it is to be a psychiatric nurse. Who should I ask about what it is to be in the world with patients? Psychiatric nurses.

The question is not uniquely mine, it has been asked of me many times. For many years now I have taught psychiatric nursing. Students would often ask about the nurse-patient relationship. This request was despite the fact that psychiatric nursing texts are full of references to various aspects of the nurse-patient relationship. These aspects include empathy, warmth and caring, positive connectedness and transference. They also include techniques which are taught to nursing students as the road to the nurse-patient relationship; paraphrasing, reflection, immediacy, therapeutic touch and self-disclosure, to name but a few (see for example Stuart and Sundeen, 1995).

In discussing nurse-patient relationships in class rooms in Schools of Nursing, my experience as a teacher has been that invariably the question is asked, ‘Yes but what is it like to have rapport?, How do you know when the relationship is working? What do you say when...’ In response I find myself telling stories, like the one discussed earlier; stories of my experience of psychiatric nursing. Through this process I became aware that these stories explored elements of nurse patient relationships which were not found in the texts, elements of the lived-experience of the nurse-patient relationship that went beyond the usual discussions of the skills employed and the stages encountered. Perhaps the
question students were asking was, what is it to be in the world with patients? What is the lived experience of psychiatric nursing? It is as if the more we examine the various aspects of the psychological dynamics of the nurse-patient relationship the more obscured the answer becomes. The stories of my experience tell not only of how various techniques can be used but they seem to convey to these nurses something of the reasons that I love psychiatric nursing, something of the humanity of psychiatric nursing, something of what it is to be a psychiatric nurse. It is something difficult to define but nevertheless present. The reaction to some of these stories is often contemplative silence. Just as a painting is more than a collection of spots of paint on a canvas and music is more than a collection of sounds, psychiatric nursing is something more than a collection of actions which follow the eight stages of the helping relationship (Brammer, 1973).

At about the time I was contemplating these questions I began to study nursing from a more scholarly perspective and I decided I wanted to understand more of the lived-experience of being a psychiatric nurse.

Development of the question
My initial thought was to ask nurses about nurse-patient relationships. As it turned out, nurses appeared to find the term nurse-patient relationship too far removed from the reality of being in the world with patients to be meaningful to them. Asking nurses about their experience of the nurse-patient relationship would usually elicit blank stares or I would get a psychological treatise on Egan's "The Skilled Helper" (Egan, 1990). Asking directly of the experience of being in
the world with patients had a similar effect. Then the following quote from Rollo May caught my eye:

...I emphasize the importance of the "encounter" and use that word rather than "relationship". I think the term relationship psychologizes it too much. Encounter is what really happens...In this encounter I have to be able, to some extent, to experience what the patient is experiencing...the therapeutic encounter requires that we ourselves be human beings in the broadest sense of the word. This brings us to the point were we can no longer talk about it merely psychologically, in any kind of detached way, but must "throw" ourselves into the therapeutic encounter (May, 1967:108).

This description struck a chord with me in many ways. But importantly it provided a way to get at being with patients in a way that had the possibility of illuminating what it means to be a psychiatric nurse, that is, via the phenomenon of nurse-patient encounter. Now when I asked nurses about encounters they had with patients there were no more blank stares, just rich description.

Aims and intentions of the study

The aim of this study is to uncover meaning and generate an understanding of being a psychiatric nurse via the nurse-patient encounter, in order to more fully understand the experiences of those members of the community who are responsible for the day to day delivery of mental health care, namely, psychiatric nurses. Such understandings can only be generated via the lived experience of the nurses involved. The research therefore intends to explore the nurse-patient encounter as it is lived by psychiatric nurses. I intend to provide descriptions of the nurse-patient encounters and a hermeneutic analysis that I hope will illuminate the elements of the experience of being a psychiatric nurse which
have hither-to remained hidden. Such insights will be valuable in the future planning of mental health care delivery in Australia and in the education and training of mental health professionals.

Theoretical grounding of the study.
The study aims to uncover and come to a better understanding of the phenomenon of the nurse patient encounter. It is a study grounded in being and existence and seemed to me to be ontological. In order to understand the phenomenon I believed I needed to enter the world of the individual nurse (their lived-experience). A phenomenological methodology appeared to be most suitable in this regard as this research is intended to make meaning explicit, rather than test some preconceived notions about the nurse-patient encounter or related measures. Because phenomenology is a methodology which ‘...acknowledges and values the meanings people ascribe to their own existence’ (Taylor, 1993:173) and its primary intent is to make, ‘...things whose meanings seem clear, meaningless, and then discover what they mean’ (Blumonsteil, 1973 quoted by Omery, 1983:50), it seemed reasonable that it would form the theoretical underpinning needed to study the phenomenon of the nurse-patient encounter.

Method
As a psychiatric nurse I was in a good position to undertake the study. I knew many psychiatric nurses and decided that I would use my network in order to find nurses who were willing to help me understand more about the phenomenon. I found seven nurses willing to participate.
By the time I was about to commence the research I had already discovered that asking nurses about nurse-patient relationships did not help them to describe the experience of being with patients. Each nurse was therefore asked to describe an encounter with a patient that they could remember. None of the nurses appeared to have difficulty in recounting an experience to me.

The nurses were all well known to me and some are my friends. We had all worked in the same hospital and I was considered to be an insider. They all appeared at ease with me during the interviews which generally lasted between 30 minutes to one hour. The interviews were recorded with the nurses' permission, onto audiotape and were later transcribed by me.

The method of analysis for this study had to take into account and be compatible with, the research methodology and the data itself. The methodology was to be phenomenology, informed by the ontological, hermeneutic position of Martin Heidegger. The data would be in the form of personal descriptions of lived experience, essentially language. Any study of phenomena from a Heideggerian perspective, must be approached as an interpretation rather than objectively. A Heideggerian perspective rejects any notion of a privileged position of "objective" knowing in the study of lived-experience (Leonard, 1989:50). Researcher and participant are "of the world", they share common beliefs, values and everyday understandings of the world. The researcher is not naive to the world of the participant. Yet even though they share these things each individual is essentially self interpreting, therefore, "...understanding human action always involves an interpretation by the researcher of the interpretations being made by those
persons being studied’ (Leonard, 1989:50). One such approach to analysis is hermeneutics.

A study of hermeneutics led me to the work of Hans Georg Gadamer. It was from Gadamer’s work that I eventually forged a method of analysis based on the four concepts of prejudice, play, the hermeneutic circle and the fusion of horizons, which are discussed in Chapter Four.

Organisation of the thesis

Chapter One gives a broad introduction to the thesis and provides the reader with a background to the development of the study.

Chapter Two explores the historical background of the significance of Being to nursing.

Chapter Three overviews the contribution phenomenology has made to nursing research and contrasts Husserlian and Heideggerian phenomenology. It explains the reasoning behind my choice of phenomenology as a methodology generally and Heideggerian phenomenology in particular. Finally hermeneutics as a method and philosophy is explored, in particular the philosophical hermeneutics of Hans Georg Gadamer.
Chapter Four describes how a hermeneutic method, inspired by the work of Hans Georg Gadamer, was developed and employed in the thesis.

Chapter Five introduces the seven nurses and goes on to describe their world; the psychiatric hospital, its past, present and future. This is done in order to help the reader understand the background context in which the nurse-patient encounters took place.

Chapter Six. This chapter tells the stories of the nurse-patient encounters upon which the study is based. The chapter contains abridged transcripts of each of the encounters followed by an interpretive summary.

Chapter Seven makes an interpretation of Being with patients as it is revealed by the encounters as a whole.

Chapter Eight summarises the previous chapter and returns to Heidegger as a means of further illuminating the phenomenon.

Chapter Nine is a creative synthesis of all that has gone before in the thesis and examines how shared humanity is manifested in the encounters.

Chapter Ten concludes the thesis and explores what it means to be a psychiatric nurse. The thesis is then evaluated.
Glossary of terms

Affect: A pattern of observable behaviours that are the expression of a subjectively experienced feeling state (emotion) (DSM-111-R 1987:391).

Capable: A term which denotes that the patient is capable of handling their own finances and is capable of making decisions regarding their finances.

Seclusion: Provision of the mental health act which provides for the placing of a patient in a locked single room in situations where the patient has displayed extreme violence.

Constant observations: (constant obs) A person who is a danger to themselves or others is placed under the constant observation of a nurse. The patient is never out of the nurses’sight.

Dasein: A Heideggerian term. Literally “To be there” or human existence (Gelven, 1989:31).

Hermeneutics: Initially a method used to decipher ancient and sacred texts especially where meanings appeared to be unclear or equivocal. The term has now come to mean both a method of interpretation and a philosophy.

ICA: Intensive Care Area. Typically a four bed locked area where patients can be detained under the 24 hour care of a nurse.
Leave: Short for "leave of absence"

Lived-experience: ‘...our immediate, pre-reflective consciousness of life’ (Van Manen, 1990:35).

Loosening of associations: A symptom of mental illness. ‘Thinking characterised by speech in which ideas shift from one subject to another that is completely unrelated or only obliquely related to the first, without the speakers showing any awareness that the topics are unconnected’ (DSM-111-R, 1987:400).

Modecate: A major tranquilliser (fluphenazine decanoate) given by depot injection. In some cases it replaces the need for regular daily medications as its effects last from weeks to months.

Ontology: A philosophical term which means, ‘...concerned with what it means to be, with the Being of things or entities. Heidegger (1962) calls ontology the phenomenology of being’ (Van Manen, 1990, p.183).

Psychotic: A psychiatric term meaning to be out of touch with reality. Psychotic states may be accompanied by delusions and/or hallucinations.

Schizophrenia: A severe form of mental illness characterised by emotional blunting, and disturbances of thinking and perceiving, such as hallucinations and delusions.
Solicitude: A Heideggerian term meaning Dasein’s concern for others.

Termination: The last phase of a helping relationship. In this phase the nurse prepares the patient for the ending of the relationship.

A note on style: Please note, that in the transcribed texts of conversations, dots such as this ... indicate a pause in the conversation, the more dots the longer the pause. Three dots in bold type ... indicates that some text has been edited out.

A note on language. I acknowledge that language can and has been used as a tool of oppression. I have kept this fact in mind in the preparation of this thesis. The term patient has been used in this thesis in preference to client, consumer or customer because it was the term that the nurses in the study most consistently used. I have used “her/his” alternating with “his/her” in preference to the grammatically awkward “their”. Direct quotes from all sources have been reproduced without recourse to the inclusion of “[sic]”. However I wish to emphasise that in all such quotations I take the authors now dated use of the exclusive masculine to mean all of human kind in common, regardless of gender, race or creed.
CHAPTER TWO

ONTOLOGY AND NURSING
ONTOLOGY AND NURSING

To choose a work vocation is to accept two sets of historical bonds that tie our biographies to ongoing natural history, and the bonds that link our fate to man’s collective history. Both sets of bonds disclose human labor as the means for exploring what we can become - through our participation in the history of natural events and through reciprocal relations among men. To choose a form of work for our own is, then, to choose our history; for work defines our biographies, not as linear behaviours, but as a convoluted web of shared bonds between men and between men and nature (Louis Schaw, 1968 quoted by Styles, 1982:81).

Introduction

This chapter aims to explore the relationship between the concept of ontology and nursing. This chapter argues that ontology is a significant concern for both nursing and the understanding of mental illness, it further argues that the “ontological substance” of psychiatric nursing is not be found in the nurse-patient relationship as what is meant by relationship has been psychologised to the extent that it has lost its ontological significance. Rather, it is through the lived experience of the encounter between nurses and patients that ontological substance is to be found.

To inquire into the meaning of being a psychiatric nurse is basically to ask an ontological question. That such a question is important to myself and the students I teach begs the question, “Is the question of Being in nursing an issue or concern for nursing?”

At this point it is worthwhile considering what is meant by ontology. According to Van Manen ontology is that which is;
concerned with what it means to be, with the Being of things or entities. Heidegger (1962) calls ontology the phenomenology of being (Van Manen, 1990, p.183).


If being in nursing is an issue for it, evidence of this could be expected to be found in nursing practice and the work of nursing scholars, and this is indeed the case.

**Ontology in nursing practice**

**Four encounters**

That ontological significance can be found in nursing practice is illustrated in the encounters between nurses and patients as the following encounters from my own experience show.

**Reg**

Reg was dying. The cancer was everywhere. He had perhaps hours or, at most, days to live. I had first met him several months previously following his bowel resection and colostomy operation. I had been assigned as his primary nurse whilst he received TPN (Total Parenteral Nutrition). We became well acquainted. We shared a love of gardening and we spent as much time as we could wondering the grounds of the hospital. Reg’s wheel chair bristled with drip stands strapped on with miles of “elastoplast” but it gave us a mobility we would
otherwise not have had. Reg’s favourite spot was the rose garden in front of the morgue and he used to laugh with black humour at the irony of it.

We often talked about death and about life and he taught me by example to open my eyes to life. He taught me to see the ordinary as extraordinary. To fail to be astonished by life and living was, to Reg, a sin. He faced his death with courage. I still wonder if I will have that courage when the time comes.

So there I was several months later sitting with Reg and holding his thin bony hand as a visitor this time (I now worked at another hospital). I came every day to see Reg since he had been readmitted. He was too weak to talk much now so I would generally do the talking or just sit, we were comfortable with silence.

On that last afternoon as I said, “Goodbye Reg, see you tomorrow, same time” Reg, with much effort, pulled himself up on one elbow, looked me in the eye and said “Goodbye Ken, Good-bye Ken.” Reg knew what I did not want to know, he died 20 minutes later.

JD

JD was the tallest man I have ever met. I remember once he was standing at the bottom of a staircase as I came down. I was still two steps from the bottom when we were on eye level. But the day I remember most was the day I asked JD (everyone called him JD) if he would help me teach a student nurse interviewing skills including how to conduct a mental status examination. Yes he would, so we set about the interview.
JD told us something of his history, how he had always been a loner and shy. He told how his single minded determination had earned him a place in medical school. How insidiously the paranoid delusions had grown and how he eventually had to leave university. The last 20 years since then have been spent in and out of psychiatric hospitals. He lives in a boarding house now and makes a little money on the side typing assignments, mostly for student nurses, but it's a far cry from a career as a doctor. The student asked him had he ever been depressed, ever felt like killing himself? Yes he had. Why? Because he knew that the things he wanted for himself in his life, his dreams and aspirations, “things you want too”, like a good job, a house, a partner and children, he could never have.

David

David was 28. You could see how fit he was, not an ounce of fat as the surgeons cut open his flat abdomen and muscled chest. He probably hadn’t seen the car that hit him as he rode home on his bike. The surgeon held David’s beating heart in his hand, turning it slowly this way and that. Yes it was a strong heart. It would be beating again tomorrow, but in another’s chest.

Lee

It wasn’t long into the afternoon shift, perhaps 3 o’clock. I hadn’t expected the phone call. Lee had seemed so happy yesterday as she went home on leave. She so much wanted to make a good impression on her parents, prove to them “I’m not crazy anymore.” But there had been a fight, just like always, nothing had
really changed she told me. Her parents were both at work now and she was alone in the house. She had really wanted to die when she took all of her mother’s antidepressants and then cut her wrists, but now.... Her voice trailed off and she dropped the phone. I hung up and phoned an ambulance.

**Ontology and nursing**

These four stories are from my own experience of being a nurse. They are not particularly unusual and similar stories could be told by any and every nurse. These stories are not however just about nursing but also about life and Being, because nursing is about life and Being.

The questions posed by health, illness, death, disability and suffering are at base ontological. As such they are not the unique province of the patient, her/his family or the nurse. They are human questions — questions of Being.

As nurses therefore, we are exposed to questions about what it is to Be, not only as a nurse but as a human. Our exposure to these existential questions sometimes pose more questions and sometimes points to an understanding of Being which illuminates our own Being and that of others in such a way that we, as nurses, are better able to nurse. What it was for me to Be in the world with Reg, David, JD, and Lee enriched my experience of being a human being and of being a nurse. Through these experiences I believe my nursing and my own existence have been enhanced.
If ontology is that which is concerned with what it means to Be, then nursing is concerned with ontology. Of course this is not to suggest that nursing is unique in this. Ontological concern is not an isolated introspective activity nor is it unique to nursing. Rather our being with others defines, to some extent, our Being-in-the-World and vice versa. Ourselves and others fall within the circle from which our understanding of Being arises and lends meaning to the experience of nursing. It is for this reason that it is important to study being in the world with patients.

For Boykin and Schoenhofer (1991:248) the ontology of nursing can only be discovered through the study of nursing situations. Similarly Retsas, (1994:24) comments that: 'It is in the “messy swamp” of nurses' daily activities that the most important and challenging problems arise and the ontological “substance” of nursing is to be found.'

The encounter with patients is the ground upon which our mutual understanding of Being is played out in the existential of care. To care we have to have a shared understanding of what it is to Be. To understand what it is to Be we have to care about ourselves and others. This seemingly vicious circularity is not vicious but lays the ground of an understanding of Being a nurse.

Caring ontology

For Benner and Wrubel (1989) the shared humanity of nursing and its ontological base is clearly seen in what these authors believe to be primary to nursing; caring:
In the best of nursing practice, we experience a common humanity. Nurses find it important to convey to patients that they consider it possible to experience the same fate as patients and family...caring has nothing to do with possessing privileged information that increases one’s control and domination of another. Rather, expert caring unleashes the possibilities inherent in the self and the situation. Expert caring liberates and facilitates in such a way that the one caring is enriched in the process (Benner and Wrubel, 1989:398).

Pearson states that caring has always been central to nursing. Historically the ‘...core of nursing [has been the] provision of care or nurturance’ (Pearson, 1991:193) and as such has its ontological base in shared humanity.

These insights into nursing and humanity are very similarly expressed by another influential nursing scholar, Jean Watson (1989). Like Benner and Wrubel, Watson believes that the ontological base of nursing can be clearly articulated through our shared humanity and caring.

It is on this capacity of one human being to receive another human being’s expression of feeling and to experience those feelings for oneself that the artistic activity of nursing and caring is based (Watson, 1988:67).

This “artistic” activity of nursing and caring is carried on in a variety of settings some of which entail the manipulation of complex technology. Nevertheless nurses have shown the ability to maintain an ontological focus on the being of the patient. In Walters’1992 study of the phenomenon of caring in the intensive care unit he found that nurses’appreciation of a shared humanity with patients enabled them to care for patients in a humanistic manner despite the presence of “objective technology” (Walters, 1992:1).
Taylor (1991) sees the nature of being a nurse as situated in the phenomenon of ordinariness in nursing.

Within the context of caring, the nurses were ordinary people, perceived as being extraordinarily effective, by the very ways in which their humanness shone through their knowledge and skills, to make their whole being with patients something more than just professional helping (Taylor, 1991:455).

**Being with**

Paterson and Zderad (1976) describe being with patients and being a nurse from an existential perspective (O'Connor, 1993:12). They have endeavoured to weave together, in a meaningful way, nursing epistemology and ontology into a theory of humanistic nursing which sees the nurse-patient encounter as becoming (what might be), ‘...the nature of person is both to be and to become ever more’ (O'Connor, 1993:19). For Paterson and Zderad humanistic nursing ‘...calls for an existential involvement, that is, an active presence with the whole of the nurse’s being’ (1976:15).

Parse draws on the work of Martha Rogers, Heidegger, Sartre and Merleau-Ponty to craft a theory of interrelated concepts about man and health (1981:13). The ontological ground of Parse’s theory is man-living-health (1990:10). Man-living-health denotes a becoming through an interaction with the environment. For Parse nursing focuses on the quality of life from the perspective of the individual (Parse, 1987:136) and hence on individual being.

Why then is nursing concerned with ontology? Perhaps Hall gives a clue. According to Pearson:
Hall (1966) posits that nurses alone engage in intensely human activity in their professional role and that this gives rise to opportunities for human closeness which can be used to therapeutic effect (1991:193).

It is difficult, to be with a fellow human in illness and suffering, in joy and in health, in the comedy and the pathos that is living and see this other predominately as a constellation of learned behaviours or a disease process.

Campbell sees nursing as a "being with" not just "doing to." He likens it to companionship, a companionship which has its costs through the mutuality of the relationship in which nurses are in the presence of illness (and hence suffering) constantly. In this companionship, ‘...there is a personal involvement and a giving to the other which transcends skill or technique’ (Campbell, 1984:51).

None of the above is to suggest that other professions are not concerned with ontology or that nursing is not concerned with epistemology. Rather nursing through its unique position of being with the patient places more emphasis upon balancing the ontological with the epistemological than perhaps other professions. Nursing, some argue, is endeavouring to find a balance by moving from a previous grounding in the natural sciences to a grounding in the human sciences. According to Parse:

...natural science nursing has, since its inception, dealt with the quantification of man and his illness rather than the qualification of man’s total experience of health. Man has been approached through the study of parts rather than through the study of man as a living unity. Man’s participative experience with health situations has been virtually ignored (1981:3-4).
A lot has changed since Parse wrote those words. The proliferation of nursing research from a human science perspective is testimony to this. Yet still some nurses believe we have yet to get the balance right. For both Boykin and Schoenhofer (1991:248) and Retsas (1994:24-25) nursing’s concern with ontology is to be found in nursing situations. It is necessary for nurses to study the ontological grounding of what nurses do, in order to develop fully nursing knowledge and practice in ways that take account of nursing’s epistemological and ontological perspectives.

**Ontology and psychiatric nursing.**

In the psychiatric nursing literature, reference to ontology, or for that matter the nurse-patient encounter, is seldom found. The most common reference to nurses being with patients is to nurse-patient relationships or nurse-patient interaction. These references date back as far as the 1950s.

In 1952, Hildegard Peplau gained prominence in nursing with the publication of *Interpersonal Relations in Nursing*. According to Forchuk and Brown (1989:30) this ‘... heralded the introduction of the first systematic theoretical framework for psychiatric nursing and focused on the nurse-client relationship.’ Since then, literature on the nurse-patient relationship has proliferated (the term “encounter” being seldom used). The 1960s saw literature of a more experiential, philosophical even existential nature, being produced on concepts not readily quantifiable. It is possible that such papers (see for example, Holmes,1960 and Hoffman,1969) reflect the dynamic and existential forces emerging in the field of
Psychiatry at the time, which were embodied in works such as Laing’s *The Divided Self* (1960) and Szasz’s *The Myth of Mental Illness* (1972). But as the 60s faded so too did the influence of these philosophies.

More recently, literature on the nurse-patient relationship in psychiatric nursing, and nursing in general, has become more technocratic in nature, that is it focuses on the nurse-patient relationship and nurse-patient interaction as ‘... therapeutic technology through which treatment may be delivered, generating ideas about nurses’ productivity in dealing with the communicative needs of patients...’ (May, 1990:312). This has lead to “how and what to do” papers such as, *Effective Limit Setting; How to Avoid Being Manipulated* (DeLaune,1991) or *Nursing a Difficult Patient* (Reaburn,1993). At the same time another type of paper has emerged in the literature. This second type of paper investigates limited aspects of the nurse-patient relationship such as connectedness and expressed emotion, which these papers then attempt to quantify, (see for example, Forchuk, 1992, Byrne and Sebastian, 1994, Heifner, 1993, and Scott and Philip, 1985). Typically these papers attempt to “operationalise” key concepts of the nurse-patient relationship so that they may be measured. This kind of investigation is of course necessary, but it is interesting to note that it has emerged from a background of literature which has, to a large extent failed to examine the lived-experience of being with patients. It may be that this situation has added to the confusion, noted by some authors (May,1990:307) surrounding the notion of the nurse-patient relationship, by contributing to the fragmentation and decontextualisation of the integral elements which constitute the lived-experience of that relationship.
Some of the current literature on nurse-patient relationships and interactions is less than flattering as the submissions to the Human Rights and Equal Opportunity Commission, (1993) Report of the National Inquiry into the Human Rights of People with Mental Illness (The Burdekin Report) show. Take for example the following accounts from mental health consumers who gave witness in the Burdekin report:

There seems to be a fear of spontaneity (with) the patients and a rigid adherence to routine...We have the distinct impression that these routines are more for the benefit of staff than of patients (The Burdekin Report, 1993:259).

I felt extremely vulnerable...The nursing staff were cold and distant...(their) main job was to enforce the taking of medication and I did not receive what I would consider therapeutic nursing (The Burdekin Report, 1993:261).

With few exceptions, nursing staff tend to minimise their interaction with patients, so that they are in a position of control rather than care - the “them and us” mentality (The Burdekin Report, 1993:261).

We spent the day in the lounge room, while the staff spent their day in the adjoining room with a large one-way mirror. I felt like an animal in a cage. I was conscious that every move I made was possibly being watched and interpreted for signs of insanity (The Burdekin Report, 1993:236).

From an ontological point of view then, these submissions to the Burdekin Inquiry, may be seen as evidence of the objectification of nurse-patient interaction. As such they deal not with what nursing is, but what it is not.
Personal knowing is essential to "being" in a nursing situation. Nursing cannot occur from the exterior. It occurs through entering the world of the person(s) being cared for, understanding that world and the calls emerging from it, and responding to them. Any approach short of this cannot be identified as nursing (Boykin and Schoenhofer, 1991:247).

But if, as Retsas suggests, the ontological "substance" of nursing is to be found in the "messy swamp" of nurses' lived experience then perhaps that is where it is necessary to look to find the ontological substance of psychiatric nursing; being a psychiatric nurse. Unfortunately, aside from isolated case studies used to illustrate various psychiatric nursing skills, literature derived from research into the lived experience of psychiatric nurses is rare. Occasionally one does find a gem which, whilst not being scholarly in the conventional sense, conveys with great clarity the ontological substance of being a psychiatric nurse through being with patients. One such work is Reflections of a Mental Health Nurse in the 1950s (Nolan, 1995:150-157).

Nolan's paper is largely a precis of a paper delivered by a psychiatric nurse, Thomas Catherell, in 1971. Catherell was a frequent speaker on psychiatric nursing in the 1950s and 1960s and stressed the need for nurses to understand and appreciate the uniqueness of patients and their individual experiences. The paper precised in Nolan's article shows Catherell's capacity to understand and appreciate patients in their humanity despite behaviour which, on the surface, seemed bizarre. The paper is a celebration of the life of a unique individual, an Irishman christened Edward but known by all as Paddy. Paddy suffered from paranoid and other delusions but in the words of Catherell;
To say that because he was handicapped by mental disorganisation, he had slipped out of the ranks of humanity would be wrong, and it would be wrong to imagine that he did not feel that he belonged to the human race, that he did not achieve, that he could not enjoy job satisfaction, that he could not attract respect from me, my family, my friends and colleagues, the respect born of significant human relationships (Catherell, 1971, quoted by Nolan 1995:154)

Respect for human dignity and humanity and a willingness to see patients as "thou" in terms of "I" and "thou" (Buber, 1958), that is, another human being who is more similar to me than he/she is different, is perhaps implied in contemporary psychiatric nursing literature and texts. It is, I believe, necessary to return to the lived experience of being with patients in order to reassert the primacy of a being to being encounter as the central element in psychiatric nursing practice. It is too easy to see nurse-patient relationships as psychological processes and therapeutic change purely as a function of altered biochemistry, rather than a complex interaction between a number of factors not the least of which is a being to being encounter. Failure to see and appreciate our shared being in the world makes it all too easy to fall into a therapeutic nihilism stemming from a belief that cure is of primary importance over care. In many cases of mental illness cure is not possible.

Conclusion

Ontology is of concern to nursing and nursing is concerned with ontology. The ontological substance of nursing is to be found in the practice of nursing which is at base a being to being encounter. This thesis will explore the encounter in
psychiatric nursing with the aim of uncovering what it means to be a psychiatric nurse.
CHAPTER THREE

METHODOLOGY
METHODOLOGY

INTRODUCTION

This chapter explores the philosophical underpinning of the methodology of the thesis as well as the implications this methodology has for nursing research generally. This thesis is informed by the hermeneutic phenomenology of Martin Heidegger and the philosophical hermeneutics of Hans-Georg Gadamer.

PHENOMENOLOGY

In the introduction to Being and Time, the German philosopher Martin Heidegger states that phenomenology is a branch of philosophical research which is:

primarily a methodological conception...[that] does not characterise the what of the objects of philosophical research as subject matter, but rather the how of that research...the term ‘phenomenology’ expresses a maxim which can be formulated as ‘To the things themselves’...phenomenology means - to let that which shows itself be seen from itself in the very way in which it shows itself from itself (Heidegger, 1962:50).

Van Manen (1990:9) puts it somewhat more succinctly (though no more clearly). According to him phenomenology is, ‘...the study of the lifeworld - the world as we immediately experience it pre-reflectively rather than as we conceptualise, categorise or reflect on it.'
As such phenomenology is concerned with and acknowledges ‘...the values and meanings people ascribe to their own existence...’ (Taylor, 1993:173). It is therefore not surprising that phenomenology as a philosophical underpinning for nursing research, has been attractive to nurses (Walters, 1994:135).

That there is (or was) a phenomenological movement is contentious (Roche, 1973:1). Certainly there are differences in ideology between those thinkers who have commonly been referred to as “Phenomenologists”. Some like Heidegger even refused to be known by the term (Spiegelberg, 1971:290-291). Nevertheless, there does appear to be a core of ideas which are generally well accepted enough for a phenomenological movement to be identified.

These core ideas include the basic belief that a distinguishing feature of humans is the ability to know they are aware of things, that is we are conscious of being conscious. Secondly, phenomenologists would all agree with the maxim stated above, “to the things [or facts] themselves”. This maxim does not appear to be much different to the maxim of naturalistic science except that for phenomenologists the description of experience, as it presents itself, reveals facts about consciousness and hence about ways of experiencing the world as well as facts about the world. Phenomenologists do not give to sensory experience (empiricism) special claims to validity over other forms of experience as do the naturalistic sciences (Roche, 1973:38). Nursing research has been heavily influenced by phenomenology, especially by the Transcendental Phenomenology of Edmund Husserl (Walters, 1994:135) and, to a lesser degree, the Hermeneutic Phenomenology of Martin Heidegger.
The Transcendental Phenomenology of Edmund Husserl

Phenomenology is a philosophy which, from its beginnings attempted to reassert the place of philosophy as the premier science over the science of empiricist epistemology and the logico-deductive method which threatened to make philosophy redundant (Anderson, Hughes and Sharrock, 1986:83). This endeavour is first seen in the phenomenology of the mathematician turned philosopher and acknowledged father of phenomenology, Edmund Husserl (1853-1938).

Husserl did not wish to denigrate the accomplishments of so called natural science or deny its power, however he, and other philosophers, were concerned that scientism was beginning to see itself as ‘...not just the paragon of knowledge but also the only proper topic of philosophical inquiry’ (Anderson, et al, 1986:83). Husserl was critical of a science which had so far lapsed into naturalism that it left no room for the discussion of ‘...ideal entities such as meanings or laws as such’ (Spiegelberg: 1971:81). According to Husserl this stemmed from a basic flaw in the empiricists argument:

The fundamental defect of the empiricists’argument lies in this, that the basic requirement of a return to “facts themselves” is identified or confused with the requirement that all knowledge shall be grounded in experience. Accepting the intelligible naturalistic limitation of the field of knowable “facts”, he [the empiricist] takes for granted without further question that experience is the only act through which facts themselves are given ...[hence all judgements must be grounded in experience]. To maintain straight away that all judgements permit of being grounded in experience and even demand such grounding, without previously submitting to study the essential nature of judgements with due regard to their fundamentally distinct types, and without considering at the same time whether this
declaration may not in the long run be absurd, that is a “speculative construction a priori” which is none the better for proceeding ...from the empiricist side (Husserl, 1931:83).

According to Husserl the empiricists have wrongly maintained that all knowledge must be grounded in experience, that is what I can see and feel, which is at base sense data. They mix up the call to return to the facts themselves (a call with which Husserl agreed) with the belief that all facts are at base derived from sense data, that is from the natural standpoint (Soloman, 1972:162-163). From the empiricists point of view consciousness is merely a reflection of sense data and hence a reflection of the world of objects. This view point is philosophically redundant because it assumes facts are the reflection of objects in consciousness. This would appear to bring about a subject/object distinction and hence the possibility that these so called facts are actually based on individual subjectivity and could not therefore yield necessary truths.

Husserl wanted a foundation for science that was presuppositionless and uncovered necessary truths that were not grounded in this or that time or culture but were true for all time. He wanted to free the concept of truth from facts that were dependant upon sense data. To do this it was necessary to return to pure consciousness, a consciousness that was not dependant upon reflections of the natural standpoint but was independent of such a standpoint.

It became obvious to Husserl that the presupposition that all consciousness derived from sense data, and as such was a reflection of objects in the natural world, had to be suspended. In this way what presented itself to “pure”
consciousness could be apprehended without any presuppositions. Such transcending of the natural attitude is the basis of the radical doubting of Husserl's transcendental phenomenology, and represented what he believed to be a true return to the facts themselves without any presuppositions as to the origin of those facts, phenomenology would rely on "pure description" (Soloman, 1972:151). This, he believed, would form the foundation for a truly rigorous science and yield objective knowledge. This is achieved by performing what Husserl calls the Epoche (also known as the suspension of the natural standpoint or bracketing). Unlike Descartes, whose doubting extended to doubting the existence of the external world, Husserl merely requires that judgements about that world be suspended or put in brackets. "[A]bstain from accepting it" is, according to Soloman (1972:164), the literal translation of "epoche". As Spiegelberg (1971:134) states,

...it [epoche] does not mean a sceptical withdrawal from the world of facts in order to play safe. The primary function of all reduction is to prepare us for a critical stock-taking of what is indubitably given, before our interpreting beliefs rush in.

Epoche is achieved by a "systematically critical attitude" characterised by neutrality and disengagement (Zaner, 1970:136). This neutrality and disengagement can be seen in everyday life. When I, for example, think back with some nostalgia on a previous episode of my life. I can then distance myself from this episode (disengage) and wonder what it is that made me feel nostalgic and then endeavour to neutrally describe the features of nostalgia which make it what it is (Zaner, 1970:181). In the epoche this is done in a systematic way, the purpose of which is to uncover the unvarying features (eidetic characters) of
What I as phenomenologist am seeking are those features of any possible consciousing...without which it would not be that which it is...I seek the eidetic characters of a particular type of psychic process, by systematically varying examples in order to ascertain the invariant features (Zaner, 1970:136-137).

Phenomenology for Husserl is descriptive of what presents itself to consciousness. The centrality of consciousness is clearly stated in Husserl's "wonder of all wonders". Unlike Descartes, whose wonder of all wonders was thinking; "Cogito ergo sum" (Descartes, 1985:53), for Husserl, 'The wonder of all wonders is the pure ego and pure consciousness' (Husserl, 1922 quoted by Spiegelberg, 1971:284).

The Hermeneutic Phenomenology of Martin Heidegger

Despite his criticism of empirical science, Husserl's phenomenology was nevertheless compatible with its major tenets. Husserl was a mathematician and Husserlian rigour is, according to Spiegelberg, '...a rigour of the deductive sciences familiar to the mathematician...' (1971:77). As has been seen, his dictum was, '..."To the facts [or things] themselves" (Zu den Sachen Selbst)...' (Gelven, 1989:38). His argument with the empiricists centred upon what it was that constituted a fact.

A more radical departure from empiricism, and therefore also from Husserlian phenomenology, came from Martin Heidegger, Husserl's assistant at The University of Freiburg.
This departure may be seen in what Heidegger considered to be the wonder of all wonders, that ‘Man alone of all existing things...experiences the wonder of all wonders: that there are things-in-being’ (Heidegger, 1962 quoted by Spiegelberg, 1971:284). Husserl’s phenomenology attempted to avoid the fundamental defect he saw in empiricism by abstracting itself away from the world. In so doing, Heidegger believed Husserl, and every other philosopher from the time of Plato, had abstracted themselves away from the fundamental fact of human reality; that we exist (Anderson et al. 1986, 95-96). For Descartes the most basic starting point for philosophy was the cogito, “I think therefore I am.” For Heidegger the most basic starting point is that I exist or “I am therefore I think.” Philosophers down through the ages have dismissed the Being question (what it means to Be) as self evident and meaningless (Heidegger, 1962:23). Heidegger’s challenge, according to Steiner, is;

[how] can there be a particular doctrine or method of understanding if there is not, first and foremost, a general grasp of being; what are the methodologies of the distinct sciences and disciplines other than an artifice or evasion of the underlying question? (Steiner, 1978:79)

Heidegger believes that humanity has lost the distinction between Being (what it means to Be, the ontological) and things in being (the ontic). When what it is to Be is seen as self evident, Being is relegated to a mere categorising of things that exist. Heidegger believes that the neglect of the distinction between the two is responsible for the increasing failure of western civilisation and western philosophy.

...they [philosophy and western civilisation] become more and more diverted from the contemplation of
Being to a study of, and finally to the subjugation of, the things in being. Thus metaphysics, science and technology increasingly take the place of what should be properly called ontology or the study of being. (Spiegelberg, 1971:286).

This major departure from Husserl's starting point led to Heidegger's scepticism with Husserl's phenomenological reduction (so frequently referred to in nursing research) and with Descartes' purely rational ego. For Husserl, phenomenology is a discipline that endeavours to describe how the world is constituted through conscious acts; how we apprehend the world (Van Manen 1990:184). The essence of Husserl's point of view can be summed up by his statement that, 'The wonder of all wonders is the pure ego and pure consciousness' (Husserl, 1922 quoted by Spiegelberg, 1971:87) that is, how we know. He is seeking truth in unselfconscious consciousness. Husserl described his phenomenology as transcendental because the phenomenologist temporarily suspends all claims about reality except for consciousness directed towards an object (Soloman, 1972:157-159).

Heidegger, however, contends that one cannot begin an analysis of the self (and therefore of other "selves") from an objective and isolated "I" of pure consciousness or the purely rational ego of Husserl. Bracketing and doubting cannot succeed if the self is primordially involved in the world and this involvement is a priori to conscious knowing (Gelven, 1989:70-71).

By asserting that the authentic self is a self already in a world and already in association with others, Heidegger is undermining a great tradition in which the self was pictured in its "purity" as totally denuded abstractness (Gelven, 1989:71).
It follows from this that the Husserlian notion of a presuppositionless consciousness is also undermined. According to Heidegger we find ourselves thrown into the world and have a primordial kind of knowing which is prior to conscious knowing. As Thompson (1990:234) puts it ‘...we live our lives by experiencing the world and not primarily by “knowing” it.’ To try to understand ourselves and our world from the position of a presuppositionless isolated “I” of pure consciousness is to ‘...have “presupposed” not too much, but too little’ (Heidegger, 1962:316).

If the point of departure of Heideggerian phenomenology is very different from that of Husserl, all that follows is likewise very different. This led to an irrevocable split in relations between the two men which was to last until Husserl’s death in 1938 despite (according to Heidegger) Heidegger’s attempts to reconcile their differences (Wolin, 1993:100).

Whereas Husserl wanted a phenomenology untainted by interpretations, Heidegger’s phenomenology is hermeneutic; it is interpretive (Gelven, 1989:38). Heidegger’s philosophy is not concerned with the maintenance of objectivity, in fact, for Heidegger, background practices and the natural standpoint are integral, and therefore inseparable, elements of Being, they cannot and should not, be bracketed. Leonard makes the point that:

We are beings who are engaged in and constituted by our interpretative understanding. Contrary to Husserl’s belief that these interpretations are a product of the individual consciousness of subjects, Heidegger claims that these interpretations are not generated in individual consciousness as subjects related to objects, but rather are given in our linguistic traditions and
Heidegger, like Husserl, would agree with the dictum “To the facts [or things] themselves” but would maintain that there is no such thing as an uninterpreted fact (Gelven, 1989:38). This then begs the question, “Do facts speak for themselves?” If facts do speak for themselves then Heidegger’s hermeneutic phenomenology is unnecessary. But some would argue that the facts never speak for themselves:

...the weatherman, for example, does not read the facts from the skies; he interprets the facts from the basis of a theory... Theories without facts are empty; facts without theories are blind (Gelven, 1989:39).

Facts are not separate from the meaning of facts. The emphasis from the Heideggerian perspective is not just on that which presents itself (the phenomenon) but what the phenomenon means (its interpretation). Take the weather again as an example. The fact of a low pressure system and upper atmosphere instability is not separate from the meaning of this fact which is reached through interpretation, that is; it is going to rain and I need a new umbrella.

Heidegger has moved away from epistemology to ontology and from description to interpretation. Heidegger’s phenomenology is a hermeneutic phenomenology.

But how is it possible to ask the question of Being? Heidegger believes that in order to ask any question we must already have some idea of what constitutes an
answer. The questioning is guided by the answer, or as Heidegger puts it, ‘Every seeking gets guided beforehand by what is sought’ (Heidegger 1962:51).

To ask the question about the meaning of Being we must have some knowledge, or foreunderstanding, of what it is to Be. In fact we must be the kind of being which is capable of inquiring into Being. But Being is both a state and an entity and traditionally the question, any question, will be asked of an entity, that is, an entity will be interrogated in order to yield an answer. This entity will usually be judged beforehand as the best entity to use for this inquiry as having a quality necessary for the inquiry. In the inquiry into the meaning of Being the best entity would be an entity which is capable of asking the question and by this already knows something of what it means to Be. Heidegger asks in which entities is the meaning of Being to be discerned? And the answer is ‘we ourselves’ (Heidegger, 1962:15).

Looking at something, understanding and conceiving it, choosing, access to it - all these ways of behaving are constitutive for our inquiry, and therefore are modes of Being for those particular entity’s which we, the inquirers, are ourselves. Thus to work out the question of Being adequately, we must make an entity - the inquirer - transparent in his own Being. The very asking of this question is an entities mode of Being; and as such it gets its essential character from what is inquired about - namely, Being. This entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term “Dasein” (Heidegger, 1962:26-27).

In colloquial German “Dasein” means everyday human existence (Dreyfus, 1993:13) or literally translated “Being there” (McCall, 1983:68). What Heidegger is saying is that what it means to Be can be found in our everyday Being there in the
...from the internal and self reflective awareness of my own existence I discover principles, which, being of a rational nature, are universal and hence applicable to all Daseins...[therefore] the procedure of analysis must be hermeneutic self reflection (Gelven, 1989:50).

Dasein has a preontological understanding of Being [or it should not have been able to ask the question in the first place] (Dreyfus, 1993:16), it holds this understanding within it, it understands itself, ‘...in terms of its existence - in terms of a possibility of itself: to be itself or not itself’ (Heidegger, 1962:33).

Heidegger moves from this preliminary analysis of Dasein to Dasein’s ways or modes of Being which, because they are to be understood in terms of Dasein’s existence, are called existentials. These existentials include Being-in-the-world, understanding, care, death, authentic existence, and time (Gelven, 1989). Heidegger’s analysis of Being is not that of abstracted logic but is grounded in astute observation of our Being. In order to clarify this point two brief examples of Heidegger’s existential analytic will be given. The first concerns Heidegger’s analysis of the use of equipment in the world and the second is part of the analysis of Being with others.

**Equipment**

In analysing how we find and make use of the world, our dealings with the world, Heidegger does not assume that our consciousness is directed towards a world of objects. Our dealings with the world are not: ‘...a bare perceptual cognition but rather that kind of concern which manipulates things and puts
them to use; and this has its own kind of 'knowledge' (Heidegger, 1962:95). As Heidegger points out, we use the door latch to open the door before we think of what the door latch is or how it is made (Heidegger, 1962:96).

**Being with others**

Likewise we find ourselves thrown amongst others in the world. The world consists of other Dasein. We experience these others environmentally; they are "Beings-in-the-world-with". Most of the time they and we are, "das man" (the public undifferentiated) with jobs to do and tools to use — unreflective. (Heidegger, 1962:118). An existential characteristic of "das man" is that it maintains an "average everydayness" which is imposed by the public, by no-one in particular.

This being-with-one-another dissolves one's own Dasein completely into the kind of Being of "the others", in such a way, indeed, that the others, as distinguishable and explicit, vanish more and more. In this inconspicuousness and unascertainability, the real dictatorship of the "they" is unfolded. We take pleasure and enjoy ourselves as they (man) take pleasure; we read, see, and judge about literature and art as they see and judge; likewise we shrink back from the "great mass" as they shrink back; we find "shocking" what they find shocking. The "they" which is nothing definite, and which all are, though not as for some, prescribe the kind of Being of everydayness (Heidegger, 1962:126).

The above examples serve to illustrate that Heidegger has moved the focus of attention of phenomenology from an abstract analytic of logic and denuded consciousness to the most elemental of facts that we and things exist and that our existence is a basic issue for us. His analytic is grounded in the everyday. Reading Being and Time is revelatory, one constantly finds oneself giving the nod to
Heidegger’s astute observations and interpretations saying, “yes, that is how it is”.

He does not commit hubris by suggesting that his analytic will uncover the meaning of Being, as if it could be set out as some formula, but that the question of what it means to Be is a question worth the asking. In asking the question we give a kind of answering to Being.

We must ‘open our ears, to make ourselves free for whatever speaks to us in and out of the tradition as the Being of being’. By listening, by making ourselves answerable to the summons of the problem of being, we may achieve, or at least come nearer to, genuine response (Ent-sprechung) and the light that comes from astonishment (Steiner, 1978:34-35).

As a child I recall looking skywards on a clear night and coming to the realisation, for the first time, that there doesn’t have to be anything and it is so astonishing that there is. Heidegger has kept that astonishment, which most of us lose over time, and turned it into his life’s work and his gift to humanity.

HERMENEUTICS

There appears on the surface to be a dichotomy between Heidegger’s call to return to the facts and there being no such thing as a uninterpreted fact. This seeming dichotomy can be resolved by understanding the concept of the hermeneutic circle and the philosophy and method of hermeneutics.

The word Hermeneutics derives from the name of the ancient Greek God, Hermes the messenger. ‘Hermes was responsible for changing the unknowable
into a form that humans could comprehend or understand' (Thompson, 1990:230).

Hence, what was traditionally a method for dealing with sacred and other texts when the meaning was equivocal or obscure became known as hermeneutics (Kisiel, 1985:3). Since then it has come to mean both a method of interpretation and a philosophy.

The ground for this shift towards a philosophical hermeneutics was laid by Martin Heidegger who, in the words of Kisiel, maintained that, '...man’s existence in the aporia of Being is Hermeneutical through and through' (1985:3). The import of this radical realignment of the understanding of existence becomes obvious when viewed in the light of the preceding critique of the epistemological and empirical phenomenology of Husserl. If in fact all existence is hermeneutical, then the position that there is any kind of pure, objective, detached, knowing observer becomes very tenuous. Gadamer takes the position outlined by Heidegger and builds upon it by focusing on, ‘...the “fact” that the actual situation in which human understanding takes place is always an understanding through language and tradition...' (Kisiel, 1985:4).

The Philosophical Hermeneutics of Hans-Georg Gadamer

Gadamer, like Heidegger rejected the idea that knowledge could only be obtained by pure reason without reference to social, historical and cultural contexts.
Gadamer introduced the idea of the plurality of possible meanings;

Texts, events and so on come to acquire different meanings as they become part of new hermeneutical situations; as the interpreter's horizons change with the understandings which he acquires so he reconsiders and reviews the texts, etc and what they mean for him. (Anderson et al, 1986:72)

This then brings us to the matter of truth. If meanings are plural, what constitutes truth? In Truth and Method (1975) Gadamer asks the question; 'Is it right to reserve the concept of truth for conceptual knowledge? Must we not also admit that the work of art possesses truth?' (Gadamer, 1975 quoted by Hekman, 1986:97).

For Gadamer truth is broader than that which fits the narrow methods of modern science. He recognises the pervasiveness of this concept of truth and asks how it is that the truths of the human sciences have come to be measured by a standard foreign to them, ‘...namely the methodical thinking of modern science’ (Gadamer, 1975:24).

It is useful to postpone further discussion of truth at this point because what Gadamer means by truth will become clearer after the examination of some of his other concepts.

Language

Both Heidegger and Gadamer place primary importance upon language as a medium of interpretation but as also the very ground of Being itself.
Man speaks. We speak when we are awake and we speak in our dreams. We are always speaking, even when we do not utter a single word aloud, but merely listen or read...we are continually speaking in one way or another...This does not mean that along with other faculties, man also possesses the faculty of speech. It means to say that only speech enables man to be the living being he is as man. It is as one who speaks that man is - man (von Humboldt, quoted by Heidegger, 1971:189).

Gadamer and Heidegger both reject the common view of language as an instrument or tool (Thompson, 1990:239) which gives the impression that language is somehow secondary to Being and can be used or discarded at will. Language is fundamental to Being. Through language we become acquainted with the world, even ourselves. It is, according to Hekman ‘...the universal mode of being and knowledge’ (1986:110). Our communities and culture, our interpretation and understanding of others, rely upon, take place through and are possible because of, language. Language is the background of shared meanings which form our preunderstandings or prejudices which determine what we find intelligible (Thompson, 1990:241). It follows from this that our prejudices, our culture and our situation in history, are a precondition of truth and necessary for its disclosure and not an obstacle to it (Hekman, 1986:117).

There is an “I” lessness to language in that I cannot choose to use words as I like or to place upon them meanings that I ascribe (Hekman, 1986:110) as Humpty Dumpty does in Alice in Wonderland. To some extent language speaks me rather than I speak language. This means that when language is written as text it has a meaning in itself, independent of who wrote or spoke it. In interpreting this text I enter into a dialogue with the text such that I question what the text means and
assume an answer based on my prejudices. Sometimes I will be brought up short by the text such that my foremeanings are not realised. I then need to look again, I have misunderstood. The process is similar to a conversation in which two people are endeavouring to understand each other. First each has to be open to the possible meanings of the other. The way this understanding occurs is through language, a common language that both share. Gadamer even suggests that a common language is created within the conversation.

Hence reaching an understanding on the subject matter of a conversation necessarily means that a common language must first be worked out in the conversation. This is not an external matter of simply adjusting our tools; nor is it even right to say that the partners adapt themselves to one another but, rather, in a successful conversation they both come under the influence of the truth of the object and are thus bound to one another in a new community. To reach an understanding in the dialogue is not merely a matter of putting oneself forward and successfully asserting one’s own point of view, but being transformed into a communion in which we do not remain what we were (Gadamer, 1975:378-379).

Language is central to Gadamer’s philosophical hermeneutics and to the formulation of his concepts of prejudice and the fusion of horizons.

**Prejudice**

As discussed previously, for Heidegger and Gadamer, the ground for understanding others is through linguistic traditions and our background of significance (Leonard, 1989:47), in other words our language and history. This means that the researcher is not naive to the world of the participant. In fact in order to ask a research question we must already have some understanding of what is sought, or in Heidegger’s words, ‘Every seeking gets guided beforehand by
what is sought’ (Heidegger 1962:51). We have pre-understandings or fore-structures of understanding. Pre-understanding is essential to interpretation. Weinsheimer gives an example of pre-understanding from biblical interpretation saying:

...we can interpret and appropriate the Word of God because we pre-understand it; we already know what it would mean to be saved, already recognise the poverty of our existence and believe in the possibility of enriching it. This belief, common to all people though more intense in some, is the precondition of interpretive understanding. Suppressing pre-understanding does not promote correct interpretation but simply renders the text non-sensical and unintelligible (Weinsheimer, 1991:11).

Gadamer built upon and widened these expositions into the concept of “prejudice” (Bleicher, 1980:108). Prejudice for Gadamer means ‘...a judgement that is rendered before all the elements that determine a situation have been finally examined’ (Gadamer, 1975:270). In this context it does not have the negative connotations that are usually ascribed to it.

The implications of this position for nursing research are that the nurse taking this approach would not endeavour to achieve pure objectivity or bracket the natural standpoint. Rather the nurse would use her/his prejudgments, made up of pre-understandings and fore-meanings of being a nurse and a person, in order to come to a preliminary understanding of the other as revealed in the text or narrative.

This initial understanding represents the initial horizon of understanding in which the interpretation takes place. This horizon is expanded as the nurse
examines again the initial interpretation, based on prejudice, in the light of what is subsequently revealed by the text. With prejudices examined, and remaining open to the possible alternative meanings of the other, the nurse further expands the horizon of understanding. This does not amount to bracketing because we are not holding in abeyance our fore-meanings and prejudices but ...'situating the other in relation to the whole of our own meanings or ourselves in relation to it' (Gadamer, 1975:268). Our prejudices are '...constitutive of our being...' and cannot be suspended by an act of pure self reflection (Bernstein, 1985:275).

As a nurse I carry certain prejudices about nursing. I may imagine that other nurses feel as I do in their nursing work and with my prejudices unexamined, I may interpret the narrative of these other nurses without true recourse to the facts themselves as revealed by these nurses. I may therefore render an account not grounded in the experience of these nurses but rather grounded in my prejudices. But by examining my prejudices and placing them alongside those of my colleagues I may in fact be attuned enough to ask questions that would otherwise have gone unasked and come to understandings that would otherwise not have been reached had I tried to, in some way, either remain objective, and therefore detached, or acted purely on prejudice.

This then is an example of the Heideggerian aphorism; to the facts themselves, but there is no such thing as an uninterpreted fact (Gelven, 1989:38). The interpretation I put upon the lived experience of my fellow nurses, when using prejudice as a tool, is my interpretation (and everything we do entails interpretation) but it is anchored in the facts, or experience, of my fellow nurses.
Through this interaction a new richer understanding emerges which is greater than the original individual understandings. This process occurs through what Gadamer calls the "fusion of horizons".

The fusion of horizons.

Gadamer believes that ‘...the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices’ (Gadamer, 1975:306). As temporal beings we project an historical horizon from the past, from the tradition from which we come. “Horizon” then is a metaphor which, according to Gadamer represents ‘...the range of vision that includes everything that can be seen from a particular vantage point’ (Gadamer, 1975:269). Understanding takes place when the horizon of the other intersects or fuses with our own horizon and changes and extends our range of vision.

So understanding takes place against a background of pre-understandings which make up our prejudices, which are then situated against, or alongside, the text in order to illuminate it. If this situation is approached with openness to other possible meanings of the text a new horizon is formed through which understanding is generated. The horizon is never closed but is always in motion (Gadamer, 1975:288). This process is not automatic and requires the development of a hermeneutic attitude.

...the fusion of horizons is more like a posture, a style, a way of living, or a way of conducting oneself than it is a way of knowing...[and it] usually results in greater self-understanding, a greater moral awareness, and an appreciation of other vantage points...(Thompson,
This process of interpretation is obviously circular in nature and takes place within the circle which is defined by our horizons of understanding. This circle is called the hermeneutic circle.

The hermeneutic circle

If all interpreting takes place on a background understanding that it presupposes - a background, moreover, that conditions from the start what questions can be formulated and what counts as a satisfactory interpretation, yet that can never be made completely explicit and called into question - all interpreting is necessarily circular (Dreyfus, 1993:200).

The beauty of a circle is that it has no beginning or end. This implies that interpretation taking place within the circle is dynamic in nature and does not truly have a final end point. Circles also have no top or bottom. The "round table" is a common symbol of equality and democracy. Within the hermeneutic circle we avoid the pitfalls of subject-object distinctions.

References like those above to fore-structures and background understandings can perhaps best be understood in terms of context. We understand and make sense of phenomena in relation to shared meanings or context, much of which is imperceptible. Such meanings are not cognitively constructed. This is why hermeneutics is ‘...an art and not a mechanical process (Gadamer, 1975:191).’

Because interpretation is an active process involving the fusion of horizons, the
subject-object distinction commonly found in logico-positivist research becomes meaningless. In fact the imposition of an objective standpoint (as in the natural sciences), in which pre-understandings are eliminated, moves one out of the hermeneutic circle and can lead to spurious interpretations

Dreyfus gives an example of this in describing how an “objective” psychologist saw the concept of talkativeness. “Talkativeness” the psychologist found, was a meaningless concept. People classed as talkative did not actually utter a greater quantity of words than so-called “normal” people. Of course the psychologist has lost the background meaning - talkative people may utter no more words as such - but they do so, ‘...during other people’s lectures, with their mouths full, etc.’ (Dreyfus, 1993:204). It is essential that interpretation in the human sciences takes place within the hermeneutic circle in order to avoid the loss of background meaning.

This is not to say that hermeneutic interpretation is arbitrary or that its necessarily circular nature is an impediment. Heidegger believed that,

...if we see this circle as a vicious one and look out for ways of avoiding it, even if we just “sense” it as an inevitable imperfection, then the act of understanding has been misunderstood from the ground up (Heidegger, 1962:153).

He saw within this circle ...‘a positive possibility of the most primordial kind of knowing...’ (Heidegger, 1962:153).

An everyday example of how the hermeneutic circle and horizon of
understanding works may be found in how language is used, learned and understood.

A whole sentence...is a unity. We understand the meaning of an individual word by seeing it in reference to the whole of the sentence; and the sentence’s meaning as a whole is dependent on the meaning of the individual words. By extension, an individual concept derives its meaning from a concept or horizon within which it stands; yet the horizon is made up of the very elements to which it gives meaning. By dialectical interaction between the whole and the part, each gives the other meaning; understanding is circular, then. Because within the “circle” the meaning comes to stand, we call this the “hermeneutic circle” (Palmer, 1969 quoted by Thompson, 1990:243-244)

An example from nursing research is useful in this context. In my own research for this thesis I interviewed nurses about their experience of the nurse-patient encounter. I was initially dismayed when I asked nurses to describe a significant encounter with a patient. The nurses would seldom stick to what I would call “the encounter”, that is, a proscribed period of time, from minutes to hours, in which the “phenomenon of interest” occurred. Instead they would invariably describe their feelings for the patient, how long they had known them and many other contextual details. These nurses would often end their story of their encounter by telling me what eventually happened to the patient, sometimes years after the initial encounter. It appeared important for these nurses to “tie off” the story. As I have said, initially I was dismayed by this. These nurses weren’t only describing the encounter, they were describing the relationship, and relationships were not my phenomenon of interest. What was I to do?

What I now believe these nurses were in fact doing, was giving me a first hand
example of the hermeneutic circle of understanding. They were moving between
the "whole" of their relationship with the patient to the "part" of the encounter.
How was I to understand the encounter if I did not situate it against the whole of
the relationship?

When I engaged in transcribing the interviews with these nurses I too found
myself in the hermeneutic circle of understanding as I moved from the part, a
word in a sentence, to the whole of the sentence. From a paragraph on the page,
to the whole of the page. From the intonation placed on a word to the emotion
expressed by the whole of the story. In the process I Situated my prejudices of
being a nurse and a colleague (for they were all my colleagues) beside what they
were saying to me (and, I was no longer dismayed).

These two horizons, mine and theirs, are then fused to form a new horizon from
which I find my "vision" of what it means to Be-in-the-world-with patients
extended as if from a new vantage point.

Play
The question now arises, "If we have now described the hermeneutic circle, how
do we get into and then comport ourselves within, the circle?" Certainly, if
Gadamer's lead is taken, we cannot comport ourselves within the circle
subjectively or objectively. As discussed earlier, both Heidegger and Gadamer
dispute the Cartesian endeavour of objectivity in pure consciousness which is
seen in Husserlian and positivist approaches to interpretation (and hence to
understanding and truth). But this does not mean Gadamer is falling back upon
subjectivity. For Gadamer subjectivity and objectivity are very similar. From Gadamer's perspective objectivity is a highly subjective concept because it entails, '...a distinct arrogance insofar as it makes individual self consciousness the locus and arbiter of truth (Weinsheimer, 1991:13)'.

Gadamer does not orientate himself toward interpretation from either a subjectivist or objectivist position. Rather he sees himself as a player. In a game the player who sees the game as an object does not really participate in it, does not take it seriously. We call those people spoilsports (Weinsheimer, 1991:14). But equally, being a player is not subjective either because it is the game that is played not the subject who plays it: 'The structure of play absorbs the player into itself' (Gadamer, 1975:105). The concept of play thus avoids subject-object distinctions.

In playing there is always a moving to and fro; playing with a ball, playing against an opponent. This is seen clearly in the use of the word "play" in such phrases as, "the play of colours" or "the play of a breeze" (Gadamer, 1975:101-110). Such an analogy of moving to and fro within a game in which we lose subject-object distinctions is clearly useful in understanding how to comport oneself within the hermeneutic circle in which we move from part to whole and back again in order to expand our horizon of understanding. The concept of play is also useful in understanding how to get into the circle; that is with spontaneity and a belief in the game. This is an active process, when we play we perform. Weinsheimer sums up this notion of play thus:

Playing consists in a performance of what is no object, by what is no subject. And if interpreting is like playing, as Gadamer argues, then it always involves something
like performing a drama, for the player who takes the play seriously interprets it from within, by belonging to and playing a part in it (Weinsheimer, 1991:14).

Nurses engaged in research from this perspective would focus more upon how they comport themselves toward the research participant as revealed in the text or narrative than on prescriptive methods, though a method may evolve from the game. They would endeavour to enter into the circle of interpretation as a game to be played from neither a subjective nor objective standpoint. The to and fro motion of this game would be used to situate their prejudices against the meanings emerging from the text to broaden the horizon of understanding and fuse into a new horizon.

Perhaps again an example from my own research may make the concept of play clearer. As I worked with the transcripts of the interviews I found myself involved. After a time I found myself fascinated, engrossed or absorbed in the text. I was no longer a detached observer but moved to and fro within the text with the unselfconsciousness of one who is lost in a game. Method became less important than the genuine desire to understand through which true understanding develops. (Perhaps this is the reason Gadamer always denied that Truth and Method described a method for doing social science research). And what is true understanding? It is understanding which comes from the text and "fits" the text. It does not come from the forced mould of blind method nor from unexamined and egocentric prejudice. Rather it flows from that which is neither subject or object. It is the type of understanding which brings a smile to your face, not because it is clever but because the fit is right. To paraphrase Weinsheimer, it
is interpretation that comes from within the text because you have situated yourself within the text (1991:14). It is motivated or moved by the truth of that into which we are inquiring. So what is “Truth”? 

TRUTH

All flowers are plants
All roses are flowers
Therefore all roses are plants.

The above is a argument that can be said to be valid. Valid, in this case means that the argument is stated in a logical form such that the conclusion is drawn out of the premises and is the only conclusion that can be so drawn.

The argument is also true in that it corresponds to the facts as they are known.

All flowers are red
All roses are flowers
therefore all roses are red

This argument, like the previous one, is also valid (in logical form) but it is untrue because the facts are known to be otherwise.

According to Heidegger, ‘Agreement with what is has long been taken to be the essence of truth’ (1971:37). Therefore the proposition that all roses are plants is
true only because it is revealed, it can be seen to be so. It is uncovered.

Whether one begins with a sentence, a meaning, or an event, the truth of it is the manner in which it is made available to us; thus for something to be true is for it to be revealed (Gelven, 1989:128).

Or as Heidegger puts it;

To say that an assertion [judgement] is true signifies that it uncovers the entity as it is in itself. Such an assertion asserts, points out, ‘lets’ the entity ‘be seen’ in its uncoveredness (1962:261).

But the terms roses, plants and flowers are merely conventional signifiers for what is revealed (Ingram, 1985:35).

These conventional signifiers are derived from culture and language and as such limit the range of possible understandings and are therefore, part of the hermeneutic circle of understanding. ‘...[T]herefore understanding and truth will necessarily be partial and incomplete’ (Ingram, 1985:37) because understanding within the hermeneutic circle never reaches a final rest point.

To uncover truth I must use my prejudices, as has been shown in the example of the concept of talkativeness. But such use of prejudices must in fact involve both a situating of these prejudices alongside the text or person we are trying to understand and a opening up to other possibilities through questioning. According to Gadamer a prejudice which is operating is one that we are unaware of. But such prejudices can be “provoked” through questioning which opens us up to other meanings and reveals our prejudices.
As discussed earlier, if language and culture are relevant to truth and understanding, prejudice is likewise relevant, in fact necessary, for truth to be uncovered. All understanding is therefore prejudicial (Bleicher, 1980:108). This then means that there can be no Archimedean point of objectivity. This does not mean however that understanding and truth are, from a hermeneutic perspective, arbitrary. Rather they are situated in ‘...and constituted by the self reflective analysis of prejudice from within a human linguistic community’ (Hekman, 1986:115). Another consequence of this view of truth is that a truth can have a ‘...plurality of articulations...’ (Caputo, 1987:111).

For Heidegger and Gadamer both, a view of truth as that through which what it means to Be is revealed (Heidegger, 1962:261) means that truth can and does dwell in many things including poetry and art. An example of this is given by Heidegger when he says of Van Gogh’s painting of a pair of peasant shoes, ‘This painting spoke...Van Gogh’s painting is the disclosure of what the equipment, the pair of peasant shoes, is in truth’ (Heidegger, 1962:36). For Heidegger the painting is more than blobs of paint on a canvas. It is more than mere representation, through it is revealed truth as the following quote from Heidegger (which I could not bring myself to cut) shows;

From the dark opening of the worn insides of the shoes the toilsome tread of the worker stares forth. In the stiffly rugged heaviness of the shoes there is the accumulated tenacity of her slow trudge through the far-spreading and ever-uniform furrows of the field swept by the raw wind. On the leather lie the dampness and the richness of the soil. Under the soles slides the loneliness of the field-path as evening falls. In the shoes vibrates the silent call of the earth, its quiet gift of the
ripening grain and its unexplained self refusal in the fallow desolation of the wintry field. This equipment is pervaded by uncomplaining anxiety as to the certainty of bread, the wordless joy at having once more withstood want, the trembling before the impending childbed and shivering at the surrounding menace of death. This equipment belongs to the earth, and it is protected in the world of the peasant woman. From out of this protected belonging the equipment rises to its resting-within-itself (1971:33-34).

From a hermeneutic phenomenological perspective truth is not the exclusive domain of the method of the natural sciences. Truth is not dependant upon sample size (truth can be uncovered in one pair of peasant shoes) nor the objectivity of the observer. Indeed, as previously discussed, for Gadamer objectivity is a highly subjective notion and can lead to a covering over of that which we wish to uncover (see talkativeness, above). Also truth can be conceived of as having a pluralistic nature, which may change over time.

HERMENEUTIC PHENOMENOLOGY AND NURSING

In 1981 Jean Watson expressed the concern that: 'In following the traditional philosophy of science espoused by “objective” scientists, nursing submerged its heritage and art in its quest for a scientific foundation for its practice' (Watson, 1981:413).

Watson was concerned that nursing, and especially nursing research, would be constrained by a slavish adherence to the logico-positivist “Received View” of the world dominant in the natural sciences. This view, she felt, was not suited to
many of the notions of what constituted nursing, its knowledge and its practice (Watson, 1981:414). Watson felt that notions such as subjectivism, wholism and humanism, did not lend themselves to research of the received kind (Watson, 1981:414), a view one could imagine Husserl to have shared. Other nurses have also been sceptical of the call of the received view and some, like Watson (for example, Benner) have been instrumental in helping nurses explore paradigms which are arguably better suited to nursing. Consequently nursing began to move away from the constrains of the positivist paradigm, but not without difficulty.

Taking different and often innovative approaches to nursing work, nursing knowledge and nursing research has proved difficult. For example, thirteen years after Watson expressed her concerns, Horsfall (1994:2-3) stated that she perceived a lack of a declared conceptual framework in much nursing research and that this was due to a; ‘...pre-existing, non-declared conceptual framework, that is incorporated into the research by drawing upon scientific methodology.’ She goes on to say that such, ‘...scientistic, ways of approaching situations are antithetical to nursing values and to constructive social change for the benefit of patients, nursing and nurses’ (1994:2).

It is not surprising that moves away from the positivist paradigm have proved difficult. Since its beginnings with August Compte in the early 19th century positivism has had a major influence not only on the way we live our lives but also on how we see our place in the world and what counts as knowledge and truth. It has even pervaded nursing’s moves into other paradigms where nurses have attempted to locate a conceptual and philosophical framework other than
Porter (1993) sees evidence for this in published nursing research. The linguistic conventions of nursing research such as the sanctions against the use of the first person singular, even in reporting research that is grounded in qualitative methodologies, coupled with the "naive" belief that pure objectivity is somehow possible, reinforced his impression that, '...a powerful and fixed epistemological conception dominated the nursing research community...[and that] The influence of the conventions of positivism upon nursing research remain strong' (Porter, 1993:138-139).

All this has laid the ground for the development of a tension between what nurses believe they ought to be doing in nursing research to be "scientific" in the natural sciences sense, and what they believe to be the humanistic philosophical base of nursing practice (Playle, 1996:982). That there is such a tension is reflected in published nursing works such as; Reid's, Developing and documenting a qualitative methodology (1991); Schultz's, Exploring the benefits of a subjective approach in qualitative nursing research (1994); and Wilde's, Controversial hypotheses on the relationship between researcher and informant in qualitative research (1992), to name but a few.

Take Wilde's work for example. Her "controversial" hypothesis that, 'It is difficult and disadvantageous for the nurse researcher to maintain a detached relationship with the informant in qualitative research...' (Wilde, 1992:240), may be controversial from an Husserlian position where '...the researcher's
perceptions of the phenomenon...must be eliminated’ (Rose, Beeby and Parker, 1995:1125), but not from a Heideggerian or Gadamerian perspective. The fact that Wilde needs to hypothesise this indicates that differences between the diverse methodologies within the qualitative research rubric may not, until recently, have been fully appreciated.

Since the 1980s phenomenological research has become more common in nursing and social science research. Exponents of this particular approach have become well regarded in nursing circles (eg, Benner and the educationalist Van Manen). However, until recently nursing literature tended to refer to phenomenology as if it were a homogeneous school (Walters, 1995:791) and failed to locate itself in a particular philosophical position within phenomenology (see for example Salsberry, 1988 and Knaack, 1984). Even though, as Walters points out, most of the phenomenological research in nursing has been Husserlian in nature (Walters, 1994:135), the Husserlian influence has not always been acknowledged. Phenomenology has been cited as nursing’s foil against the constraints of the positivistic method (Omery, 1983:49-50) yet Husserlian phenomenology is more similar to the positivistic scientific view than many nurses realise. Koch (1995:834) goes so far as to suggest that, ‘Husserlian phenomenologists...have become unwitting positivists.’

Husserl’s position corresponds more closely to what nurses have understood research to be; methodical, with the researcher as a detached observer. The “methodical” element in the phenomenological nursing research equation usually comes via the phenomenological techniques derived from those
developed by psychologists such as Van Kaam, Giorgi, and Colaizzi and commonly cited in the nursing literature (Walters, 1994:135, Omery, 1983:52).

The Heideggerian hermeneutic perspective has many implications for nursing research. From this perspective researchers would be less preoccupied with conventional notions of validity, truth and rigour and the bracketing of preconceptions and more concerned with how the researcher can use their preconceptions (fore knowledge) to make meaning of phenomena in plausible ways. The researcher would be less concerned with describing experience than with uncovering meanings about what it is to be. Finally the researcher would be less concerned with method than with the appropriate way of relating to or comporting oneself toward, the phenomena.

This, however, is not to suggest that interpretation from the Heideggerian perspective is ad hoc. Heidegger reminds us that:

...our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conceptions to be presented to us by popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves (Heidegger, 1962:195).

Whilst it would seem valid to criticise some nurses lack of appreciation of the different approaches within the qualitative paradigm and especially within phenomenology, I nevertheless agree with FitzGerald (1995:90) that given the difficulties in understanding the underpinning of interpretive phenomenology, the early nursing researchers are to be praised as they have made these philosophies more accessible for those of us who have followed after. Nursing
researchers today such as Benner, Diekelmann, and Tanner show an appreciation of the use and limitations of the interpretative approaches to nursing research especially phenomenology as do nurses such as Leonard (1989) and Thompson (1990), the writings of whom have helped me to struggle with the difficult concepts inherent in phenomenology and hermeneutics.

Some outside of nursing (Crotty, 1996 and Paley, 1995) have been critical of nursing’s use of what I have heard called “the geriatric German philosophers”. However, I believe that some of these studies have in themselves shown a less than fulsome understanding of these difficult philosophers. Whilst it is true that nurses need to articulate clearly the methodological grounding which informs their research, it is not true that the innovative use of elements of the great legacy of western philosophy is wrong because the philosophers in question did not envisage their philosophies as informing human science research, or more specifically; nursing.

Conclusion

The methodology which informs this nursing research is derived from the ontological philosophy of Martin Heidegger and the philosophical hermeneutics of Hans-Georg Gadamer. Phenomenology is not a homogeneous school of philosophical thought and this chapter has endeavoured to present the main features of phenomenology whilst recognising that the two best known philosophers associated with phenomenology, Edmund Husserl and Martin Heidegger, differed from each other in substantial ways. Both Husserl and
Heidegger have influenced nursing research though the differences between the two have not always been appreciated. The philosophical hermeneutics of Hans-Georg Gadamer also has applicability to nursing research and some of the main features of his philosophical thought have been explored here as a prelude to the next chapter. Chapter Four will discuss the impact all that has been outlined in this chapter has had on shaping this research project and in particular the development of a research method, especially how I have been inspired by Gadamer’s ideas to develop a research method.
CHAPTER FOUR

METHOD
METHOD

Introduction

As has been outlined in Chapter One, this research is aimed at uncovering something of the lived experience of what it means to be a psychiatric nurse. As such, it has an ontological orientation. It does not aim to generate objective descriptions of experience from the standpoint of pure consciousness.

In the beginning it seemed unclear what this illusive thing was that we, the students and I, were looking for and seeking to understand. It seems that somehow it was to be found in the lived experience of the nurse-patient encounter. No, it wasn't the techniques of counselling and it wasn't a psychological explanation of the dynamics of nurse-patient interaction. As it turned out it seemed that what we were endeavouring to understand was something much more basic, much more primordial than that, it was what it means to be in the world with patients and therefore what it means to be a psychiatric nurse.

This chapter will detail how a hermeneutic method, inspired by the work of Gadamer, was developed and employed to achieve the aim of the research; to uncover an understanding of being a psychiatric nurse via the nurse patient encounter.

Orientation of the project.

I already knew that one orientation to studying lived experience was via
phenomenology. My initial reading into phenomenology soon uncovered the work of Edmund Husserl. Certainly much in the way of nursing research has been influenced by Husserl’s work and those who have built upon his foundation.

It soon became clear that unless I was willing to change the focus of the study, (to a description of lived experience rather than an interpretation of that experience) the epistemological character of Husserl’s work would not be suitable as a methodological grounding.

However the work of Heidegger and Gadamer appeared eminently suitable. As has been discussed in the previous chapter, phenomenology for Heidegger means letting something shared show itself. This something can never be totally articulated or proven (Dreyfus, 1993:30). This will include shared ways of behaving which contain in them an understanding of Being and so must (from an ontological point of view) be studied as an interpretation rather than objectively as a “scientific” discipline (Dreyfus, 1993:19) which would have a more epistemological than ontological objective.

The orientation of Being which is capable of inquiring into the possibility of Being is called by Heidegger “Dasein” (Heidegger, 1962:28). Dasein is capable of inquiring into Being and has prior, or pre-reflective, knowledge of Being. Dasein has a pre-ontological understanding of Being in so far as it is capable of inquiring into it. It has some primordial pre-understanding of itself or it should not be capable of asking the question, “who am I” (Dreyfus, 1993:31). Yet such
understanding is not fully accessible because, according to Dreyfus, it is embodied in skills (Heidegger’s concept of the world being equipment-ready-to-hand) and ‘...we dwell in our understanding like a fish in water’ (Dreyfus, 1993:35). So Dasein hides in its everydayness which is twofold; Being “undiscovered” - the background practices of everydayness which, because of their familiarity, are invisible: and Being “buried over” - Dasein’s way of covering up aspects of itself which unsettle itself - a denial of painful truth (Dreyfus, 1993:33). It is these understandings which are sought in ontological research - in the present case; how Dasein decides its existence in Being a psychiatric nurse. If this approach was to be taken then it became obvious that a greater understanding of the nature and process of interpretation was necessary. Thus the inquiry led to hermeneutics and in particular to the philosophical hermeneutics of Hans-Georg Gadamer.

Neither Gadamer (1975) nor Heidegger (1962) detail a method for doing interpretive research. In fact Gadamer is adamant that his major work Truth and Method is not a description of a method for doing social science research, ‘I [do] not wish to elaborate a system of rules to describe, let alone direct, the methodical procedure of the of the human sciences’ (Gadamer, 1975 :xxvii). This meant that if the approach to this research was to be grounded in the work of these two men it would be necessary to develop my own method (or adapt an existing method such as was done by Koch, 1995 and Walters, 1992) which would be true to the philosophical insights of both Gadamer and Heidegger and to what was to be achieved. There are a number of methods for phenomenological research derived from those developed by psychologists such as Van Kaam, Giorgi, and Colaizzi (Walters, 1994:135, Omery, 1983:52) or the sociologist Schutz (1980) and
commonly cited in the nursing literature. According to Koch (1995:830) such structured analysis procedures are seen by some nurses (Koch cites Oiler, 1986, Drew, 1986 and Santopinto, 1988, as examples) as being processes via which validity can be ascertained. I have chosen not to use these methods because they appear to be based on philosophical underpinnings which are at odds with my chosen methodology as outlined below.

The method had to be guided by an orientation to the data based on the chosen methodology. The assumptions of hermeneutic phenomenology have been well summarised by Plager (1994:71) as being:

1. Human beings are social, dialogical beings

2. Understanding is always before us in the shared background practices; it is in the human community of societies and cultures, in the language, in our skills and activities, and in our intersubjective and common meanings.

3. We are always already in the hermeneutic circle of understanding.

4. Interpretation presupposes a shared understanding and therefore has a threefold forestructure of understanding. [fore-having, foresight, and fore conception].

5. Interpretation involves the interpreter and the interpreted in a
dialogical relationship.

By way of a summary of Chapter Three the following can be added to Plager's list.

6. I already know something of what I am researching by virtue of the fact that I have asked the question.

7. Understanding requires that a common language must first be worked out in the conversation with the text.

8. There is no objective Archimedean point and hence all understanding is necessarily interpretive.

9. In interpreting a text I enter into a dialogue with the text such that I question what the text means and assume an answer based on my prejudices.

10. Through this interaction a new richer understanding emerges which is greater than the original individual understandings. This process occurs through what Gadamer calls the "fusion of horizons".

11. The interpretation I put upon the lived experience of my fellow nurses, when using prejudice as a tool, is my interpretation but it is anchored in the facts, or experience, of my fellow nurses.

12. Understandings are not arbitrary but are situated within a human
linguistic community and within the natural standpoint and should not be bracketed.

13. To inquire what it is to be-in-the-world with patients, is essentially to ask an ontological question.

14. Truth can have a '...plurality of articulations...' (Caputo, 1987:111).

15. Our prejudices, our culture and our situation in history, are a precondition of truth and necessary for its disclosure and not an obstacle to it.

16. Truth is not dependant upon sample size nor the objectivity of the observer.

17. The concept of play is useful in understanding how to get into the hermeneutic circle.

18. Prejudices can (and should) be "provoked" through questioning which opens us up to other meanings and reveals our hidden prejudices.

With reference to the above, the methods to be employed in the study were developed.
The question

This study aims to uncover an understanding of being a psychiatric nurse via the nurse patient encounter. The question is what does it mean to be a psychiatric nurse?

The participants

The participants were seven psychiatric nurses who had all worked or trained in a particular psychiatric hospital. The number of participants was governed by the belief that, given the constraints of the study in terms of time and size, a larger number of participants would have necessitated a more cursory analysis of their individual experience. It is conceded that in phenomenological research from a Heideggerian perspective the numbers of participants is not of itself of major significance.

The research context.

Given that all interpretation takes place within a background of meanings, the background of myself, the participants and the encounters they describe is explored. This background is twofold. First it includes the shared world in which the nurses, the patients and myself exist as psychiatric nurses and patients; the psychiatric hospital. Secondly, it includes our individual background as nurses.

The nurses

The nurses in the study have known me for many years and I have worked with all of them and consider them my colleagues. The interviews were on the whole relaxed and even initial concerns about the presence of the tape recorder quickly
disappeared as the interviews progressed. The interviews took place either in the nurses’ homes or in a private place within the hospital in the nurses’ own time (Meal break etc). The interviews varied in length and ranged between one hour and thirty minutes.

Methods of analysis and interpretation.

All the nurses in the study had no difficulty in thinking of, and talking about an encounter with a patient. The interviews were approached in a conversational way in that I was willing to share an experience or make a comment from time to time but always being mindful that the participant’s story was the focus of the interview. I endeavoured to remain myself in the interviews rather than take on the persona of “researcher” which would be seen as false to these people whom I knew well. Nevertheless, it was clear to the participants that the interviews were expressly for the purpose of research. Each interview started with the question “Can you think of an encounter with a patient that stands out for you, that you remember? Please tell me about it”.

At the conclusion of the interviews I transcribed the interviews onto a word processing programme. In order to immerse myself in the text of the interviews as much as possible I transcribed the interviews myself. I did not return to validate the interview transcripts nor did I (as recommended by Benner, 1994:107) conduct multiple interviews in order to clarify meaning or obtain richer descriptions. To go back over the ground of an interview again with a participant is to reinterpret the interview with the participant and once this process begins it begs the question “when will it suffice to say enough is enough?” In keeping
with my understanding of hermeneutic phenomenology, to have done this would have been to disavow (points 9, 10 and 11 above) that by entering into a dialogue with the text, situating my own prejudices alongside those of the text, a greater understanding may emerge through the fusion of horizons. The interpretation upon which this understanding is based is my understanding. Van Manen puts it this way:

The notion of hermeneutic understanding for Heidegger was not aimed at re-experiencing another’s experience but rather the power to grasp one’s own possibilities for being in the world in certain ways. To interpret a text is to come to understand the possibilities of being revealed by the text (Van Manen, 1990:180).

Interpretation and analysis of the text begins immediately upon hearing it. I am already making judgements, and interpreting what is being said in the light of my own experiential, historical (and therefore temporal) and cultural background. Of course not to do so would render my conversation, with these my colleagues, unintelligible. I did not therefore attempt to bracket my own assumptions in the way described by Swanson-kauffman and Schonwald (1988:97-98) in order that my prior assumptions not influence my interpretations. To do so would have been to disavow (points 2,3,4,8,9,11, and 12 above) that we dwell in our shared understandings and there is no objective Archimedean view point. However, this is not to say that interpretation is an arbitrary process as will be seen. The process used is based upon the Gadamerian concepts of Play, Prejudice and the Hermeneutic Circle.

In order to dwell in the data and develop an attitude toward it that was neither subjective or objective I transcribed the interviews and read and reread them. In
this process I found myself absorbed by the text, I came to dwell within it and become a part of it. This is not something that one can do at will but is rather something that happens. It is perhaps akin to reading a novel; you become absorbed to the extent that you feel with the characters, you cease to be sitting in your chair in the comfort of your own home, you are rather, situated in the story. The difference is that the purpose is different. So I can become absorbed, not just in the story but in the intellectual process of interpretation, moving back and forth between the text and my own prejudice.

This moving from part to whole was done in a number of ways. First each text was read as a whole to get a general impression of what the text was saying to me about the nature of the phenomenon; the nurse-patient encounter. I wrote notes on these impressions. Next the text was divided into paragraphs that appeared to say something distinct about the nature of the phenomenon. I wrote notes on these impressions. The paragraphs were then interpreted further by highlighting the key words that lent the essential meaning to the paragraph. I wrote notes on these.

At times I found that I did not understand what was meant by a particular phrase or word (or that the initial meaning I placed on certain parts of the text was no longer tenable in terms of the whole). In these circumstances it was found that by asking the question “What does this experience tell me about the phenomenon?” I would often gain an insight into its meaning. At other times by going back and looking at the difficult passage or word in the light of the whole of the paragraph or in some instances the entire story, it would become clear. In the process I
would sometimes find that I would become aware of a prejudice that, far from helping me understand the text better had, because it was undisclosed, prevented my understanding. This I think, is what Gadamer means by false prejudice. (see point 9 and 18 above)

Finally, an interpretive summary was written based on all of the above. Along side this I made a list of the ways in which being with patients manifested itself in this encounter (remembering that this study is ontological in nature). I called ways of being “modes “.

The above procedure was repeated with all seven encounters and then a description of the findings, which incorporated all of the modes of being with patients pointed up by the study, was written. Considering that the frequency of a particular mode occurring in the conversations was not important (point 16 above) all modes were included.

On reflecting upon the whole of the interpretive process it became obvious that the modes appeared to be pointing to particular ways of existing with patients. The modes could be clustered under these headings. To these headings was given the title “existentials” (because they appeared to be reminiscent of Heidegger’s existentials in Being and Time).

It is recognised that the interpretations described in Chapter Six could be different were if they were analysed by someone else, even if the same process was used. This is in keeping with point 14 above and does not weaken the study provided
that my interpretation of the meaning of Being a psychiatric nurse via the nurse patient encounter is firstly, plausible, and secondly can be demonstrated to have arisen from the things themselves. This is in keeping with Heidegger’s aphorism; To the facts themselves, but there is no such thing as an uninterpreted fact. The art of interpretation is, according to Rabinow and Sullivan (1979 quoted by Allen and Jensen, 1990:245) ‘...to explicate context and the world, not to uncover universals or laws.’ This leaves open the possibility of more than one interpretation of the data, depending on the interpreter. This is acceptable provided the interpretation shows good “fit”, that it is probable in terms of its context and sheds light on other situations outside of the study context (see Leonard, 1989:53, Allen and Jensen, 1990:245 and Sandelowski, 1986:32). Any interpretation is necessarily subjective, but this does not mean that such interpretation is valueless. We live within a plurality of interpretation yet we understand each other (Leonard, 1989:54-55).

The study therefore does not give the definitive answer to what it means to be in the world with patients as a psychiatric nurse, rather it gives a response which illuminates the phenomenon and in so doing asks more questions of the phenomenon. This is to be expected in an interpretive study which is always in the hermeneutic circle. The two and fro, part and whole nature of the analysis is, I hope, clear in what has been described above, but likewise it should also be evident that still more questions can be asked of the phenomenon.

**Ethical considerations**

Informed consent was be obtained using guidelines outlined by Field and Morse
and incorporating a signed consent form and plain language statement adapted from that used by Field and Morse (1985:44-45, see appendix 1). In order to ensure anonymity for both the nurse and the patient certain demographic and other details of little or no consequence to the research have been omitted or changed.

Ethical clearance for the research was given by The Pro Vice-Chancellor’s (Research) Advisory Committee on Ethics in Experimentation on Human Participants, of The University of New England Armidale in 1994 where I was a PhD candidate before transferring to The University of Adelaide.

Evaluation of the research

Much has been written on the trustworthiness and rigour of phenomenological research (Koch, 1994, 1995, Plager, 1994, Knaak, 1984, Munhall, 1994, and Rose et al 1995, to name but a few). As has been discussed in Chapter Three, the goals, philosophy and methods of phenomenology and empirical science differ markedly. But perhaps not so markedly as hermeneutic phenomenology and empirical science. This is especially so in relation to the conception of what constitutes truth. The hermeneutic phenomenological conception of truth is very different from the search for absolute and generalisable truth of the natural sciences. Likewise the hermeneutic phenomenological perspective on objectivity not only differs from the empirical science perspective but also from the Husserlian phenomenological perspective. It seems clear then that tests of trustworthiness and rigour as applied to empirical science and phenomenological (Husserlian research) cannot be fairly applied to hermeneutic phenomenological research.
The major difference in evaluating the trustworthiness of Husserlian phenomenology and hermeneutic phenomenology lies in the notion of objectivity. Many writers on nursing research look to bracketing to defend phenomenological research from allegations of bias and subjectivity. Munhall (1994:187) quotes Mezquita (1993) as suggesting that researchers practice "bracketing" to prevent '...the introduction of biases, from allowing assumptions or preconceived judgements to influence the process of data gathering and analysis.'

Similarly bracketing is seen by Koch (1995:830) as a central notion in guarding against bias and maintaining objectivity for many nursing researchers including Davis (1973), Oiler (1982) Knaack (1984) and Santopinto (1989). Rose, et al, 1995 also suggest that bracketing is '... one of the processes in ensuring trustworthiness in phenomenology' (1995:1125). Other ways of defending the methodological rigour of phenomenological and qualitative studies, it has been suggested, is to mix these methods with other research methods (Reid, 1991:549). Such triangulation, suggests Playle (1995:892) belies an underlying attitude within nursing that the '...'scientific method’...and, specifically, the use of quantitative methods, is more scientifically credible.’ This general argument is also to be found in the writing of Porter (1993:138-139) who suggests that nurses still hold the “naive” notion that pure objectivity is possible. Plager makes the point that humans can be reduced to objects and studied in the “natural science mode” but that in so doing something about the essential nature of human Being will be lost (Plager, 1994, 71).
It would seem then that some of the criteria for evaluating phenomenological research appears to be based on the (sometimes unacknowledged) assumption that the research takes a Husserlian perspective. A second problem that arose was that other evaluation criteria did not appear to be in keeping with what I understood the tenets of hermeneutics to be. For example, Munhall (1994:189), in outlining criteria to maintain rigour, suggests returning to the participants as they are the only ones who can tell the researcher if she/he has captured, '...the meaning the experience had for them.' This advice would not seem to be in keeping with the notion of understanding and interpretation as discussed above.

Where does this leave the study? It leaves the study in the position where I still believe it needs to be evaluated but in a way that is in keeping with the tenets of the method and the methodology as described in this and the preceding chapter. To evaluate the research using an overtly or covertly Cartesian set of criteria is to set myself up to fail. Not to evaluate the research at all is to fail both myself and those nurses who participated in this project with me. I have therefore chosen to utilise the principles for evaluating phenomenological hermeneutic research formulated by Madison (1990) and outlined by Plager (1994:79). These principles include the following:

Coherence,  Comprehensiveness,  Penetration,  Thoroughness,
Appropriateness, Contextuality, Agreement, Suggestiveness, Potential

The evaluation will form part of the final chapter of this thesis.
Conclusion.

This research utilises a method which is in keeping with its stated philosophical underpinnings. The method has been inspired by the work of Hans-Georg Gadamer but interpreted and employed in ways that perhaps Gadamer had not foreseen. Nevertheless I believe that the method as described has an internal consistency and logic which allows it to be so utilised.
CHAPTER FIVE

ASYLUM
Introduction

This study aims to illuminate the experience of being a psychiatric nurse via the phenomenon of the nurse-patient encounter. In order to understand such being it is also necessary to understand the world of the nurse. It is possible for me to do this as an insider because the nursing world of the nurses in this study has also been my nursing world. I can therefore use my fore knowledge to help me understand the experience of these nurses.

All the nurses in this study (including myself) trained and/or worked for some years in the same hospital. Most of the patients in the study had, at sometime or other, been patients in this hospital and all but one of the nurse-patient encounters described in the study took place in this hospital or one of its satellite services. It is therefore important to describe something of this hospital and its culture which forms so much of the background of this study.

The Hospital

The hospital is situated on the outskirts of a moderately large non capital city. When it was built between 1886 and 1890 (Thompson,^ 1990:6-7) it must have been a considerable distance from the then town. The hospital, through necessity, was a closed community. Distance from the town and the stigma attached to the mentally ill kept it isolated. Like many of its kind it is built on a hill and the original buildings are modelled on the British standard of the time; two story red brick with the only concession to the Australian climate being the addition of
The first thing that strikes you as you enter the hospital is its beautiful grounds which regularly win gardening awards. The streets, lined with oak, pine and English plane trees, wind their way between the old double story red brick wards, many said to have been built from bricks shipped to Australia as ballast in sailing ships (Thompson, 1990:7). The old wards are interconnected by covered walkways which still retain the fancy fretwork at the top of each support post. Towards the northwest of the grounds stand the newer buildings of the 1960s and 1970s typical of the uninspiring architecture of the period now mercifully somewhat hidden by trees and shrubs.

The newest building is the new medium secure ward. It is built in the shape of an X with a central nurses station like a panopticon. Surrounded by its high barrel fence it sits conspicuously on the edge of the hospital amongst the newer buildings.

On higher ground is the football and cricket oval and the little clubhouse where staff gather each Friday night for football practice (in season), cheap beer and a barbecue. Overlooking the oval are the staff houses (not all of them used now) for the deputy medical superintendent, chief engineer, principal nurse and medical officers. The large old medical superintendents house is quite a way from the main hospital and is reached via a path and foot bridge over the creek. Towards the east of the hospital stands the two storey timber and brick nurses quarters now derelict with the last nurses leaving it in the late 1970s.
History

Asylum 1965-1995

All the participants in the study trained and/or worked in the hospital within the period 1965-1995. Three of the participants have worked for approximately twenty years in the hospital, three have worked for ten years in the hospital and one has worked on and off in the hospital for the past thirty years.

When I was young in the 60s the hospital was the subject of much rumour and gossip as I suppose were most psychiatric hospitals. One of the worse insults one could level at anyone was to accuse them of having a mother or father in the local “loony bin”. I can still recall the guilt of arguing with a childhood rival and spitefully accusing him of having a mother who was a patient in the “loony bin” only to find out that she was indeed a patient.

In 1965 the hospital held well over 1,000 patients only slightly down from its peak in 1950 of 1,400 patients (Thompson, A 1990:31). This included patients suffering from all manner of illness and disability including profoundly intellectually handicapped patients varying in age from children to adults and elderly.

The hospital was physically split down the centre into “the female side” and “the male side”. Except for some male staff who assisted in the more “difficult” female wards, the segregation of the sexes included the staff. Care was largely custodial and the hospital was, to some extent self sufficient with its own prize
dairy herd and vegetable gardens which were run by patients and staff. The vegetable garden and dairy were closed by 1970 because the prevailing view at the time was that neither could be justified economically or therapeutically (Thompson, 1990:36).

Jean, one of the nurses I interviewed for this study, told me something of what it was like in those days. She described two wards in which she worked in 1966. I'll call them Ward A and Ward B. Neither ward now houses patients though Ward A, because of its mass of windows, is used for arts and crafts.

Ward A

It was just a lovely environment because it's enormous, although there was probably a hundred patients there. The upstairs sleeping arrangements were way far advanced to what they even are now, you know in the (psychiatric annex attached to a general hospital). They had lovely partitions, enormous areas for their own personal space, the bed, wardrobe, locker and everything, was really, really nice, lovely and clean and always really bright. And although there was only probably three or four staff for all these patients

...there were some really colourful people, like people who were grandiose; [one] lady thought she was the Queen of England, she really thought she was the Queen of England and that she ruled us and that she was really Queen of the ward but at the same time she was incredibly productive, she
used to do all of this beautiful tatting and crotchet and fancy work and just wonderful stuff. She was a great person, she was famous, and she was just happy, she was wonderful. And the whole environment in those days was, was one big happy family. Ah, ...(laughs) the charge sister had been there many, many years and knew each and every one of them so well. Um, ...

But not all the wards were as pleasant as Ward A. Jean went on to describe Ward B which housed the most disturbed female patients.

... now I'm talking of [Ward B] where there were really very disturbed and quite dangerous people. One big islander woman who, (laughs), who's name was Olga, she used to have legs about six miles long and wrists sort of like a bird, like the brolga, you know. And she used to always intimidate me because of her height. I'm tiny [Jean is about 4'11" ] and she used to sort of um, stand over me and, and I used to always feel anxious when Olga was around. And I'm sure that she knew this and used to play on that. But looking back I can have a giggle now at how clever she really was. But this other lady. One particular night, it seemed to be well documented that premenstrually she used to go quite crazy, she was really creating havoc this night and we, there was only ever two of us, again about 120 really badly disturbed patients, and those, single rooms? Ah, well she was in there with just an iron bed. I was quite frightened to go in there this particular night. She was actually bending that bar, the iron bar of the bed. The strength that...to this day I can't explain it. Even when I went in there very early the next morning I was still...quite frightened of her. Because I
saw this little lady who was really crazy and physically...so, so strong that, those old iron hospital beds, she was literally bending it!

Yeah, you know to think of that environment with the 120 patients, compared to the previous environment I talked about, yeah, I mean [Ward B] was cold and horrible and clinical, there was a lot of disturbed people. You know we had what was called the canvas room were there was 5 people locked up and they were just on beds of canvas and nobody ever opened that door on their own. That's were Olga was (laughs) the one that really intimidated me. It always scared me that, always scared me, I always made sure I had my back to the wall and that I was never inside the room on my own and ah. You know on reflection a lot of that was probably ignorance on my part too, in those early days, my fear.

By 1973 the positions of Chief Male Nurse and Matron were abolished and a new position known as Principal Nurse was established (Thompson, 1990:35). The segregation between the sexes ceased and all the wards gradually became integrated. By 1976 the patient population had dropped to 770 (Thompson, 1990:36) due largely to improvements in treatment including medication and a change in treatment attitude from custodial to rehabilitative care. By 1977 the wards were unlocked most of the time and the high fences which had once surrounded them were demolished.

The hospital, with the support of the health department, bought two blocks of flats in the town as “half way houses” for the rehabilitation of patients back into
the community. A small group of community nurses drawn from the larger hospital staff pool, was established to assist with patients ongoing care in the community following discharge. These nurses spent their time going from patient to patient in the community sometimes by hospital car but more often on foot or in taxis. Any nurse could apply to work as a community nurse and the positions were generally for two to three years so that staff who wished to could be rotated through the community area.

During this time nurse training changed as well. By 1953 nurse training had been organised by a state nurses registration board (Thompson, 1990:32). Most of the lectures however were given by doctors. In 1974 a formal school of nursing was established and three nurse educators appointed. The school provided training for the three year basic psychiatric nursing and for a shortened course of two years for those nurses already registered as general nurses. Some of the nursing staff took advantage of the reciprocal nature of this arrangement and completed their general nursing certificates in two years from the local general hospital. By 1978 the hospital was graduating some 90 new psychiatric nurses per year.

In the late 1970s and early 1980s more community services were established. A community preparation ward was established in one of the wards now surplus to requirements due to the reduction in the patient population. This ward was only staffed during the day. Patients cooked meals themselves, taking shopping and entertainment trips to town and generally cared for themselves.

An aged care respite and assessment centre was established in the city and staffed
by hospital staff. This centre caters for aged people with a mental illness and also has amongst its staff complement a number of community nurses who visit patients in their homes.

In the early 1980s a community mental health centre was established in the city staffed by a multidisciplinary team from the hospital. This service provided free individual and group therapy for anyone between the ages of sixteen and sixty suffering from a mental illness who did not require inpatient treatment. Patients included those suffering from anxiety disorders, depression, personality disorders and schizophrenia.

By the mid 1980s a mental health team of hospital staff, including two nurses, established a psychiatric community service to rural and remote areas within the catchment of the hospital (some 100,000 square miles). This team either flies or drives to rural and remote areas and holds clinics in local GP offices.

The mid to late 1980s saw an expansion and consolidation of these services. A small unit for the long term rehabilitation of people suffering from acquired brain injury was also established as was a hydrotherapy unit, gymnasium and heated indoor swimming pool. The increase in services saw a subsequent increase in the morale and professional standing of the staff. It was now commonplace for nursing staff to be adding Bachelor degrees to hospital based certificates and pursuing other nursing qualifications. In these endeavours staff were supported by the hospital administration.
Today

The 1990s see the hospital as home to a modest 450 patients. The canvas rooms are gone as are the fences and, in most cases, the locked doors. The old wards which once held 120 patients now hold about thirty. The hospital now is made up of some fourteen wards (another four wards are unoccupied) spread over some 175 acres of land much of which is clothed with shady trees and beautiful gardens. Several hundred more patients are cared for in their own homes, or other accommodation in the community, by community psychiatric nurses. Some of these patients also attend a variety of outpatient services.

Like most psychiatric hospitals in Australia this hospital has not escaped the effects of economic austerity measures heralded in with the 1990s. The hospital budget has reduced in real terms every year for many years now. Short staffing and other money saving measures have left staff angry and disillusioned. Staff have also been dismayed by the revelations made by enquires such as the Burdekin report into mental health services, the Carter inquiry into Ward 10B in Townsville Queensland and the Chelmsford inquiry. Despite the fact that the hospital enjoys a good reputation, many nurses feel disturbed by the revelations of abuse contained in these inquires and feel vaguely uneasy by association. Nevertheless they are proud of the work they do which goes largely unseen and (they believe) unrecorded by the broader community.

The period of time in which I conducted the interviews with the participants in the study was one of great change in the hospital. The National Mental Health Strategy saw the hospital facing the prospect of “downsizing” or (as rumour had
it) perhaps even closing. For some staff this caused considerable anxiety. Many staff had worked no where else and had no other qualification other than a psychiatric nursing certificate. Most staff felt that psychiatric hospitals had an important, if reduced, role to play in the provision of mental health services and were sceptical that governments’ “mainstreaming” plans were for anything other than economic purposes. These staff do not believe resources taken from psychiatric services will be reallocated into community services.

The painful reality remained that the hospital was to be “downsized” from 450 beds to approximately 295 beds in the next few years. In the midst of this came the new nursing career structure, the fruit of many years of nurses’ struggle with government. New positions needed to be filled and it seemed everyone was studying to increase their chances of promotion. Support for study became harder to get as the hospital budget decreased.

There was also a view that with the move to a single register for nurses and the establishment of psychiatric nursing as a post graduate speciality offered by universities, psychiatric nursing as an entity would cease to exist. Many nurses felt that psychiatric nursing, with its low prestige compared to other nursing specialities, would not be able to complete for tertiary places and would eventually die. 1994 saw the establishment of a graduate year program for tertiary qualified nurses. Registered nurses, with a “comprehensive” Bachelors Degree but without a specialist psychiatric qualification, worked in psychiatric hospitals for the first time. This further fuelled fears of a “whiz kid” take over.
The hospital seemed to be assailed from every quarter. It had been classified as a hospital for "chronic" sufferers of mental illness, yet staff daily had to care for patients with acute episodes of illness especially in the medium secure unit which regularly got admissions from all over the state due to the lack of mental health resources elsewhere.

The hospital is at present facing the most momentous changes it has seen in its 106 year history.

The Nurses

Vic: Vic trained as a psychiatric nurse in the mid 1970s. He has worked all of his working life as a nurse in this psychiatric hospital. He holds no other nursing qualification but has degrees in psychology and industrial relations. He is at present undertaking a Masters degree in nursing and now works as a nurse educator. He is noted for his expert nursing care of people suffering from severe psychotic conditions.

Julie: Julie trained in the mid 1980s. Like Vic she has worked in this same hospital all of her working life as a nurse. She works as a level one nurse in a variety of settings. She is noted for her ability to form rapport with "difficult" patients.

Jean: Jean trained as a psychiatric nurse in the 1960s in this hospital. She holds a general nursing qualification and has worked in both psychiatric and general hospital settings in hospitals and the community, in Australia and overseas. Jean
has held positions up to level 3 and at present works part time in a psychiatric annex attached to a general hospital.

**Lyn:** Lyn holds both general and psychiatric nursing qualifications gaining registration as a general nurse in the early 1980s before training as a psychiatric nurse. She has a wide variety of experience in psychiatric nursing settings both in hospitals and the community. She has recently taken up a position as a nurse educator. She holds a Bachelor degree in nursing and is presently undertaking a Masters degree in nursing.

**David:** David trained as a psychiatric nurse in this hospital in the early 1980s. He holds a general nursing qualification and has worked extensively in community psychiatric nursing settings. Presently he is the clinical nurse consultant and clinical coordinator of a community mental health facility. He is seen by his nursing, allied health and medical colleagues as an expert clinician. He is studying for a degree in sociology.

**John:** John trained as a psychiatric nurse in this hospital in the mid 1970s. He also holds a general nursing qualification. Noted for his sense of humour and calmness in difficult situations John presently works as a clinical nurse consultant of a medium secure ward.

**Judy:** Judy trained in this hospital in the mid 1970s. She holds no other nursing qualifications but has a wealth of experience caring for people suffering from psychoses and dementia. She is noted by her colleagues for her calmness and
astute decision making in difficult nursing situations.

Whilst the hospital still sits on its hill, the city has grown out to meet it, yet the area remains largely semi-rural. Even though many of those who would once have been locked away are now living outside the hospital and the patient population is now a modest 450, a sense of community still persists. Perhaps it is because, for the patients and staff, there is a shared experience that not even the most empathic outsider can truly understand. Long years of living and working together have built a familiarity and sense of community and asylum that is hard for outsiders to appreciate. Walking through the grounds one will witness the easy familiarity between staff and patients and staff and staff of whatever rank or discipline. It is not uncommon for nursing staff to be related, with husbands and wives, fathers and mothers, and sons and daughters, working in the hospital. Nursing staff work together but also socialise together. The hospital has a social club and successful football team with its own club house. The staff have, to some extent, developed a special language and way of looking at the world to which outsiders are not privy and outsiders in this case can include non psychiatric nurse spouses. “In" jokes, jargon, strange phrases and funny vocal inflections, gleaned from favourite patients, as well as a “Goonish” sense of humour can leave those not “in the know” feeling even more like outsiders.

It is entirely possible, and not uncommon, for staff and patients to have known each other for 20 years and sometimes more. Behaviour which would be seen as aberrant elsewhere is tolerated more easily within the walls of the institution and over the years friendships develop. John, the Clinical Nurse Consultant of a
medium secure ward puts it this way;

I suppose in dealing...with these people for long period of time you tend to...I tend, I suppose to see them as almost normal, (laughs)...they're a part of your social scene you might say. And sometimes it becomes more difficult to relate to, to so called “normal” people (laughs)...There is a genuine rapport...not so much in the ward that I'm currently working in, [medium secure ward] but in previous wards were the people with psychiatric disorders are not necessarily violent or aggressive or dangerous. Ah, there's even more of a rapport with those sort of people and...you can develop genuine friendships and genuine non pretentious relationships with them.

**The Patients**

The patients in this study are anonymous. Names and certain other details have been changed to protect their identity. Because of the shared nature of the nurse-patient encounter this study is to some extent their storey also. All of the patients except for Gwen and John suffer from schizophrenia. John and Gwen suffered from depression.

**The Wards**

Because the wards have been built over a period of 100 years they vary widely. Some of the older two storey brick wards have been painted inside in soft pastel shades and decorated to give a more homely atmosphere. In most of the wards institutional bedspreads have been replaced by multicolours and patients are
encouraged to place their own belongings around their beds and put posters and paintings on the walls. The less long stay wards tend to have a more institutional look. Most of the wards are no longer used for the purposes intended when they were built and the accommodation represents something of a compromise. The one exception to this is the newly built medium secure unit.

The unit features electronic locks, video surveillance of seclusion rooms and corridors, a secure exercise yard with barrel fences, and low self harm architecture such as perspex windows, recessed lights and tamper proof electrical switches. The unit is built in the shape of an X with the nurses' station at the centre. The nurses' station has perspex windows on three sides and houses the control panels for the intercom, video controls, electronic doors and alarm system. An array of video screens monitor the corridors and seclusion rooms.

To enter the building it is necessary to enter an air lock. The electronically controlled door into the unit will only open after the door behind closes. Through an intercom, staff ask the business of all who enter, before admitting them to the unit. Regular staff are heard to make comments in the air lock such as "Beam me up Scotty". Many staff carry personal "distress alarms". As a matter of policy the ward has a higher male nurse to female nurse ratio. This policy is somewhat controversial, some of the staff believe it breeds a "Macho" attitude which actually encourages violence rather than discourages it.

Although it was built to house forensic patients the ward also accommodates any patient who is a potential danger to themselves or others. Patients are categorised
depending on the level of risk of harm they present to themselves or others. On the basis of this assessment patients may be allowed various levels of freedom from unrestricted freedom in and out of the ward to totally restricted to the unit. For example, as a patient improves he or she may be allowed time out of the unit in the company of a nurse. Further improvement may see unaccompanied leave from the unit for specified periods and finally unrestricted freedom to leave the unit and eventual discharge to an open ward.

Conclusion.

Despite the changes which have taken place over the intervening 106 years the hospital is still similar to the total institution described by Erving Goffman (1976). Nevertheless it would be true to say that some of the worst vagaries of the total institution have been moderated in this more open and innovative institution. The spectre of the dark and frightening institution has been lifted with community access and involvement and the environment of the hospital is largely a peaceful one that for many people offers a place of asylum.
CHAPTER SIX

THE ENCOUNTERS
Introduction

This chapter presents the encounters of the seven nurses. There are eight encounters in total one each from Julie, Jean, Lyn, Judy, John, Vic and, two from David. Presented here are the abridged encounters followed by a brief interpretive summary. These interpretations are expanded upon in Chapter Seven.
JULIE AND ROBYN
Julie and I were sitting in the sun on a fine still afternoon when she told me about a memorable nurse-patient encounter. She didn’t hesitate when I asked if she could recall an encounter that stood out for her. The encounter she described took place over a two day period but to Julie this time frame had coalesced into one distinct encounter.

On the day when the encounter occurred she was working in the admissions ward where she had worked for some time. The ward, like most of the hospital, is old and not really designed for the job it now has to do. Julie was working in the ICA (the intensive care area). This is an area where patients who are disturbed enough to be a danger to themselves or others are confined under the 24 hour care of a nurse. It consists of a room large enough to accommodate four beds and an adjoining bathroom. One of the doors of the area opens onto a small courtyard surrounded by a tall wire fence. The room is painted pale blue and contains no furnishings save for the beds, a chair for the nurse and a clock on the wall behind a perspex screen. The windows have no curtains and the doors are equipped with observation panels.

On the day the encounter took place it held one patient, Robyn, a young woman in her early twenties. She had been a patient in the ward for about a month and suffered from schizophrenia. Julie knew and liked her and told of the encounter with the warmth and genuineness of someone who had been touched by the sharing of an experience. They got on well together despite Robyn’s occasional angry outbursts, physical aggression and threatening behaviour which had the effect of alienating her from some of the other staff. Some of the staff felt that
Julie was overinvolved with this patient and later told Julie she had been “sucked in.” But on that day, and the days to come, Julie was allocated to the ICA with Robyn, “because they wanted to try and maintain some sort of consistency with her [Robyn] staff wise...”

When Julie walked into ICA at 6 o’clock that morning Robyn was lying on the bed in the foetal position and even though she was a big woman she somehow appeared small and helpless. This obviously made an impact upon Julie who was used to seeing this patient exhibiting a great deal of bravado and sometimes aggression. She described the scene that greeted her. Her voice conveyed some of the incredulity she felt at the time to see a patient, whom she knew and liked, in such a state.

...she was, she was lying in the bed in the ICA room,... in the foetal position. Like...the best foetal position I’ve probably ever seen, and she, she’s a very large woman, and she was lying there in...filthy dirty clothes and boots. Like her boots were just...covered in mud and, and she was dirty, her hair was caked with, with mud...and I can remember thinking...this, this is really, this is really horrible you know, she’s in bed in this ICA area, and she, she looked so ...helpless...

Robyn’s bravado, her need to be “cool”, tough and in control, had evaporated. Despite Robyn’s past behaviour Julie was able to separate the person from the behaviour and feel for her in her plight. In the ICA Julie could see nothing of the Robyn she knew.
Yet to see her in the ICA area, there was no, there was, there was nothing, there was just, this big... person curled up in a little heap you know, just so frightened, so frightened. So um, so, like really A-LONE if, if she'd ever been, you know.

Slowly she began to tell Julie her story. She had been granted day leave the day before by the psychiatrist on the condition that she returned to the hospital by a certain time. She and another patient had gone into town together. They had been drinking heavily and had decided to walk back to the hospital and became lost. Eventually they hailed a cab which dropped them at the entrance to the hospital. By this time it was dark and late. They decided to walk across the grounds by the creek. After that point Robyn could remember no more.

Robyn had been found later that night wandering the grounds, severely intoxicated and covered in mud. By the time Julie came to work, Robyn's companion had still not been found. Robyn was terrified of what may have befallen him and that in some way she may have been responsible. But for what, she could not remember.

Robyn talked constantly to Julie asking had she done something wrong, had she had an argument with the other patient?

and she...she was sort of touching herself, touching the mud on her shoes and touching her hair and, and not under...not having a clue why there
was mud in her hair and why she'd been wet and why her shoes were muddy and all those sorts of things.

Julie spent the rest of the shift with Robyn trying to remember the events of that night and feeling helpless to help her but desperately wanting to. She expressed the following:

...I almost felt some of her distress, you know I felt some of her...her fear I guess, and I, I did and I sat there and I thought what it would be like to be in that situation where you....I felt she genuinely could not remember...what she, what she had done or had not done the, the previous night...and just that, you know, just the frustration of not being able to help her...was, was really incredible...That's just how I felt, yeah. I felt really inadequate, absolutely totally inadequate, couldn't, couldn't, make her feel better in any way, yeah.

The next morning Julie again found herself in ICA with Robyn. It wasn’t long before a senior nurse and the medical officer came into the ICA to tell Robyn that her companion had been found during the night, dead in the creek. Robyn was to be interviewed by the police and in the meantime was to stay in ICA. Their attitude was very matter of fact. However, the attitude of some of the other staff both shocked and angered Julie. Some of the other staff believed Robyn “should be TOLD” , the other patient was dead. They believed that Robyn probably did have something to do with his death. They said (in Julie’s words),
"Well you know, that's what you get, when you're that screwed up...Well, she could have done it, she's so rough" she's so this, she's so that, "wouldn't put it past her".

Julie felt herself to be different from the other staff. She was angry with the way things had been handled and believed that Robyn and her needs had been forgotten in the emotion of the moment.

Robyn was now very distressed and confined in a room with no opportunity to be by herself and think things through. Julie, being the only person with Robyn, found the situation very difficult.

yeah I felt really helpless...there was nothing much I could do...but listen and, and probably ...reassure her at times...I felt really...inhumane almost, you know? I felt...like we'd almost forgotten that she was a human being.

The emotion that Julie recalled most readily about this time was anger. It was a theme that she returned to again at the end of the interview when she said,

I was, I was furious because...people that maybe should have been more professional were quite unprofessional...It was all quite judgemental I felt, yeah...and that made me, that made me very angry...

Julie had already been feeling helpless to help Robyn and now Robyn's worse nightmare had come true.
It just stands out so clearly in my mind because I felt so...(draws on cigarette).....For her to be in an ICA area like that...so tormented...by what she was unsure about and was unclear about in her own head, and then...to be told that the patient that she had been with had been found dead, was a really.....probably one of...the times that stands out in my head, out of all the years I've been nursing, one of the most difficult things I've ever had to sit and deal with...umm...like she was extremely distressed and...slightly psychotic at the same time, which was a really, I found a really hard thing to deal with......yeah...

Robyn's initial reaction to this news was stunned silence but it wasn't long before her anger, fear and frustration were directed against the only person physically or emotionally close to her, Julie.

she just stared at me and she said, “Told ya, I told ya.”...from then it sort of escalated into an incredible anger, like, very quickly, and she yelled at me and she screamed at me...” Yeah I told you so and you sort of lied to me and said that oh, oh, It'd be OK”, which is not what I said to her at all but, you know, and “and how would you feel and what would you know”, and “you don’t know what it feels like and I’m just a schizophrenic and, and, and you know I’m an alcoholic and”, and I’m a this and I’m a that and, yeah. She was just really angry, really angry...she didn’t say a whole lot more... it was a bit scary to think that I was in there with somebody that was feeling all those things and it would have been so traumatic.
Julie had tried her best to be of some solace to Robyn but ended up feeling:

Useless, hopeless, absolutely wasting my, you know, wasting everybody’s time...I...felt inadequate, you know.

...I just felt that there was nothing I could do for her, other than just be there and listen, no matter what she was saying back to me.

Yet despite this Julie remained engaged with Robyn and Robyn’s anger dissipated.

...she said to me many, many times, “Julie I’m scared...I’m scared...tell me I didn’t do anything to him”. ..you know, “I’m scared” was something that was repeated many, many times.

She, she asked me what would happen to her if she had done something to him, um...would there be anybody with her when the police spoke to her, that she was frightened of talking to the police. She asked... me, “do girls go to (names the medium secure “lock up” ward) if they do this sort of thing, if I’ve done something to him?”. ..Yeah, um she used to stand out at the back door of the ICA there and just stare at (the medium secure “lock up” ward with its barrel fences which you can just down the road) and start crying..and she’d talk about her family and her mother and home....and how she felt, because now she’d never go home again.
She talked to me about...her alcohol consumption...scared, was basically what she was, yeah really, really scared...I sort of felt that all I could do was offer her reassurance, and, and, and you know, yeah the things that were worrying her like, I certainly told her that I couldn’t tell her that she hadn’t done anything to that other particular patient but, but also that...we were there, at this stage to care for her...there would be somebody with her when she saw police...that she was safe...

I certainly told her I couldn’t...um, predict what was going to be ahead for her. Yeah, it was awful you know, it was, it was an awful situation to be...

there were times when it was very tense, when she’d become very angry...and say that she wasn’t going to tell anybody anything...even if she did remember it. And she’d go from being quite angry to... to just sobbing...she spent a lot of time talking to me. She wanted to talk...

But through all of this Julie felt frustrated because:

...you know.....you couldn’t protect her, you could not protect her, you know as much as you would have liked to...that was just totally out of our hands.

At the end of the interview Julie again returned to her anger with some of the other staff for what she saw as their judgemental views and lack of humanity. She conceded that Robyn was very unpleasant to be around but that could not
excuse judgemental attitudes on the part of the staff.

I just felt we probably didn’t give her a fair go, you know, as a...team of um, supposed caring professionals I really, yeah, I don’t think we really did as well as we...could have for her.

It sounds dreadful but the fact that you’re not really allowed to care for people. Yeah..But I think it gets to the stage where...even though, yeah, you’re in the hospital and you’re, you’re a nurse, you’re also a human being and you can relate to, to maybe what somebody’s...feeling.

Particularly in a very stressful time like that..um...(Ken: And we’re human beings first) You’re a human being first...that gets to me a little, that you’re not allowed to actually say well, “You know I really think this person’s a great person” , ‘cause you get that, “WHAT” ! (Ken: you’re overinvolved) You’re overinvolved, yeah. And it, it’s not, I think there’s times when it’s not an overinvolvement...

This girl was...a really lonely behind the eight ball individual, you know she...had not had a chance and I don’t think she’d ever had a soul that had said, before she got here, that had ever said to her, “Look, you know, you’re, you know, you are OK, you are OK”. Umm...there was definitely that...yeah not allowed to, to think that she was OK.

Finally the police report cleared Robyn of any wrong doing.
she was just over the moon, she squealed, she screamed, she sang, she hugged ever person in the ward, she ran 'round like an idiot and said, “Get me a drink “ ha,...this was after days of saying, “I'm never going to drink again” (laughs) But she was so delighted and yet, there was really nobody about much that, that shared that with her you know. That, that was another thing I thought you know, God...you know, look at her, she was so relieved, so genuinely relieved but nobody else much...gave a stuff, yeah. It was very sad.

Before she was discharged she approached Julie who was still wondering if she had been of any assistance to Robyn at all.

And I remember actually, when she left, when she was discharged, finally, she ...she walked into the office, and she, her mum had come to pick her up, she walked in and she just sort of, looked at us all you know, and she...had to be tough you know, she had to be tough and cool and all those things and she said, “Hey, Jul’, thanks” and walked out you know. But it was, it just said heaps and heaps to me and that was, that was great you know, that was really good. Ha, she was so...ha, yeah.
SUMMARY

Julie being with Robyn

At the end of the encounter Robyn walked into the nurses’ station. I got the impression that there were a number of nurses there, but Robyn picked out Julie to thank her. Julie knew the significance of this. She didn’t have to decipher Robyn’s thanks. It seems likely that Robyn’s actual meaning in those three words, “Hey jul thanks” was, “I want to thank you for being there, for listening to me and caring even when I was upset and abused you. I want to thank you for not judging me as others did, I won’t forget you”.

All of that remained unsaid but Julie appears to have understood. There also seems to be an immediacy about this understanding, it did not rely upon a conscious mental understanding of the encounter but was grasped in its entirety in the moment.

The encounter with Robyn uncovers this immediacy of understanding in a number of places. Going back to the beginning of the encounter Julie walked in and saw Robyn, whom she knew and liked, looking helpless, lying in a foetal position, covered in mud and wet. Julie took this in at first glance. The Robyn she knew was not there. The tough, cool, violent and aggressive Robyn was gone to be replaced by this helpless sobbing muddy figure. Another example of this immediacy of understanding may be found in the fact that Julie says she felt some
of Robyn’s distress but she appears to have felt it in the moment, immediately upon seeing Robyn.

This immediacy of understanding appears to be connected with an immediacy of feeling and doing characterised by a concerned being-in-the-world-with Robyn. There appears to be a caring in this concern. Again such care appears not to be initially thought out. Julie was reacting to Robyn on the basis of care. Later it appears that she reflects upon her actions and starts to doubt her care. Other nurses said she was overinvolved and had been “sucked in”. But at the time, in the moment was Julie thinking and acting upon that? “No I wasn’t thinking that at the time I was just doing...doing it the way I would...do it again. “ This, “just doing” does not appear to rely upon a conscious thought through plan of care but is carried out in the moment.

Care in the encounter with Robyn was manifested in a number of ways. The attitude which had arisen out of Julie’s understanding was a concerned attitude of wanting to help. I think the understanding that is uncovered here is not the simple cognitive understanding of a cause and effect relationship—I understand Robyn because I can explain her behaviour in terms of her delusional system, but rather the understanding of one human being for another. I, in my shared Dasein of Being in the world with and in the primordial givenness of that being, understand you as I understand myself. Wanting to help in this situation is revealed by its negative, the frustration of not being able to help. “Just the frustration of not being able to help her...was, was really incredible...” The fact that Julie felt frustrated by what she saw as her inability to help Robyn, means
that she wanted to help.

Julie stated what form this helping took. It meant protecting Robyn (from those who did not understand her or care for her eg police, other staff, and perhaps from herself?), "...you know....you couldn't protect her, you could not protect her, you know as much as you would have liked to..."

And it meant easing her distress. "That's just how I felt, yeah. I felt really inadequate, absolutely totally inadequate, couldn't, couldn't, make her feel better in any way, yeah."

That frustration aroused a number of emotions in Julie. "I was angry, I was angry at probably how it had been dealt with. I felt it was a little...uncaring..." This anger stemmed from the attitudes of other staff. As shall be seen, the other staff were looking at Robyn in terms of patient rather than being.

I felt really helpless, I didn't, there was nothing much I could do ...but listen and, and probably ...reassure her at times.

It was difficult for me...

one of the most difficult things I've ever had to sit and deal with.

I felt really inadequate, absolutely totally inadequate, couldn't, couldn't make her feel better in any way, yeah.
Useless, hopeless, absolutely wasting my, you know, wasting everybody's time.

Care, as uncovered in this encounter, is at once an attitude and an act as well as an attitude embodied within acts. Care arises out of a shared social environment. Some examples from Julie's encounter illuminate this point.

Care is also manifested through listening which, Julie felt, was all that she could do at times. "I didn't, there was nothing much I could do...but listen"

At one stage it seemed that Julie's listening assumed the proportions of a penance to atone for her guilt at not being able to help.

I just felt that there was nothing I could do for her, other than just be there and listen, no matter what she was saying back to me. (Robyn was at the time verbally abusing Julie)

Julie may have resorted to false reassurance in order to make Robyn feel better, in fact Robyn said to Julie on numerous occasions, "Julie 'I'm scared...I'm scared, tell me... I didn't do anything to him". But Julie would not lie to Robyn even though the truth may have been painful. "I certainly told her that I couldn't tell her that she hadn't done anything to that other particular patient..."
It must also be said that Julie displayed a ready acceptance of Robyn in the good times and the bad. Yes she could understand why the other staff maybe didn’t like Robyn. But Julie had had difficult times with Robyn too.

I had had lots of hassles with her...myself you know...she used to put on these great big gorilla slippers...and go around kickboxing people in the face. You know she, she wasn’t very pleasant at times to be around.

There was a distinct lack of a judgemental attitude in Julie’s story of the encounter with Robyn. Take for example the following:

*they decided they might have a drink or three before they came back which they did...so they bought another bottle of grog and decided they’d drink it on the way and think about it...*

The way this was said conveyed to me an amused attitude of “aren’t they mischievous” but that’s all.

Even when Julie was bearing the brunt of Robyn’s anger she did not blame Robyn for it but rather understood that it was a product of impotent rage.

And when Robyn was cleared of involvement in the death she was so relieved and Julie could appreciate her happiness.

*... she was just over the moon, she squealed, she screamed, she sang, she*
hugged ever person in the ward,... But she was so delighted and yet, there was really nobody about much that, that shared that with her you know. That, that was another thing I thought you know, God...you know look at her, she was so relieved, so genuinely relieved but nobody else much ... gave a stuff, yeah. It was very sad.

Other staff were indifferent.

Julie and Robyn appeared to be close and I wondered if it had anything to do with the environment in which the encounter took place. Shared social environments lend meaning to encounters. For example punching someone unconscious in a boxing ring is a socially acceptable behaviour within the environment of a boxing club and will usually lead to accolades from club members. Doing the same thing in the street will usually lead to a charge of assault. The social environment of the encounter needs to be examined if the meaning of being with patients is to be fully understood. The shared social environment in which the encounter between Julie and Robyn took place was the Intensive Care Area.

To some extent both Julie and Robyn found themselves thrown into that environment where there was an enforced closeness at least in a physical sense. Julie had ample opportunity to see and experience things with Robyn that other staff could not. Robyn and Julie shared an experience and hence an intimacy that was reflected in the ending to the encounter where Robyn singled Julie out for thanks.
VIC AND KERRY
And spirits white as lightning would on my travels guide me. And the stars would shake and the moon would quake whenever they’d espied me (Bonny Boys of Bedlam, old English traditional folk song).

Vic has been nursing for some 18 years. He is a quiet man and a father of four children. In a quiet but intense voice he began to tell me about his encounter with Kerry. Despite his years of experience this encounter clearly left its mark on him.

On the day the encounter took place he was working as a replacement staff in an acute admission ward of a large metropolitan psychiatric hospital. (In fact it was the same ward and the same ICA in which Julie’s encounter with Robyn took place). Although he was not a permanent staff member of this ward he had, in recent weeks, been working in the ward on a semi-permanent basis.

It was mid afternoon, about 3pm, when Kerry was admitted. The ward had received a phone call telling them to expect the admission of a woman who had tried to kill her child. The ambulance arrived, complete with a police escort, and Kerry, already heavily sedated, was transferred from a stretcher straight to a bed.

Kerry was a young woman in her mid twenties. She was suffering from a psychosis. She had attempted to kill her young child by cutting his throat and placing him in an oven following what she believed was a command from God. The child was seriously injured but survived. Kerry was admitted to the
intensive care area of the ward and was placed on constant observation. Vic was assigned as her nurse. As he sat beside her bed and waited for her to awaken he had ample time to think.

As previously described, the intensive care area is a four bed area situated behind the nurses station of the ward. The area can be viewed from the nurses' station via a slit window in the door. The room is painted pale blue and is bare save for four tubular frame hospital beds bolted to the floor and a chair for the nurse. Kerry was placed on one of these beds and Vic sat at her head and waited.

She slept for three hours. During this time Vic had to decide what he would say and do when Kerry finally awoke. I asked him what feelings he had as he sat beside the bed.

\[\text{ahmm, I suppose [the feelings were] predominated by apprehension...ahm...the circumstances of the assumed problem, the scant information we had, probably led us to assume an horrendous event had occurred and the killing or attempted killing of a child being a...a terrible event, an event that sort of is beyond comprehension, obviously, to, to a loving caring parent. And ahm I suppose it may have been tinged with a background anger...but I wasn't really conscious of any strong feelings of anger.}\]

And what were Vic's feelings when Kerry awoke?
The feelings were...ahm...trepidation I suppose is the best word, I ah, I had doubts about my own skills as to how to handle somebody in this sort of predicament. I had...I had doubts about what I would, ah, encounter when I actually first spoke to her about the event. I had doubts about whether I might retreat into a...into a ah..an easy sort of um...conversational approach based on, on trivia and not actually focusing upon the events that had led to her admission, whether I would sort of choose to just, ah avoid the issue, just out of fear of my own ability to handle what might come out or, or, or what ah, behaviour she might display...So I think yeah trepidation was probably, probably the feeling....probably a really good description of, of how I felt.

And Vic was concerned that Kerry too would retreat into a psychotic state and not face what she had done and that, in a psychiatric service starved of resources, it would be easier for everyone but counterproductive for Kerry.

I had that um, [the feeling] that possibly with this woman people were saying ah..." you're psychotic, ahh, schizophrenia is a chronic debilitating illness therefore we'll expect you to regress into a chronic debilitated state and then that will be comfortable for us because, because we won't have to talk to you about this horrible thing you've done to your child and you won't have to be...you won't have to recall it to mind, you won't have to justify it in any way, you'll be allowed to withdraw into yourself and everything will be fine. We'll be able to just carry on as is. So I was operating from that point of view..I, I felt that um, you know, this is
somebody coming to hospital for the first time, this is an acute psychotic illness, this is somebody who, who has done something really horrible but, potentially, can be helped and can have some form of life afterwards if everything is done properly for her.

Vic believed that his anger at the time was “with a system” (the public mental health service) and that it “stung” him into action, into doing his best for Kerry. His anger stemmed from his belief that large psychiatric hospitals had been left to run down, purported to look after only the chronically mentally ill and take a “chronic caretaker role”, yet would admit someone who was obviously acutely ill. This he saw as doing a disservice to the patient and the staff.

I can remember expressing that to the student [With whom he was working that day], I can remember saying probably what will happen with this woman is that people will go into ICA, they’ll take their magazine or book or whatever, they’ll avoid contact with her, they’ll sit their chair in the far corner of the room, they won’t want to talk about it, that’ll be more comfortable for everybody. And then she will er... her illness will take a progressive sort of course and possibly over time she’ll get better but it’ll take a lot longer than, than perhaps it really should. [pause] ...this [situation] was something which stung me into actually trying to put some skills into use, actually trying to develop a relationship with somebody, actually trying to ah, ah...make descriptions of er what was going on into the clinical file that would be of maximum benefit to the the patient. To convey as much information as I could to assist the person following on
after me, to ah, to ah, slot in and take over..pick up on the theme and try
and get this woman to um... to come to terms with what she'd done.

Vic believed that Kerry needed to express some normal emotion about the event.

Well upon awakening, as I said, I sort of, I had, I had made up my mind to
be fairly confronting, 'cause I thought it was important that this
person...have...as close to an appropriate emotional response to...what had
occurred as, as could be expected...

To this end Vic confronted Kerry at the earliest opportunity with what she had
done.

...she slept for possibly..as I say, about three hours and in the meantime I'd
sort of made the decision to be, I suppose comparatively confronting when
she did awake and to sort of, ascertain immediately whether she was aware
of what she had done and I, I recall my first question as being one along
those lines to her, sort of introducing myself and then saying “and are you
aware of what you have done?” or something of that nature.

But what was it like being with Kerry after she wakened? Vic mentioned that
what Kerry had done was an “horrendous event”. Did he have a sense of horror
as well as trepidation?

Ah yes and that horror became more prevalent as, as..in subsequent
conversations with her, that sense of horror actually...the um...the magnitude of this, this, this..event and what she'd actually done to this child...that sense of horror become stronger and stronger as more and more details, in her own words, came out.

Vic listened as Kerry, still in a psychotic state of mind and quoting long tracts from the Bible, told her story. Kerry had been home alone with the child. She had been reading the Bible intensely for some days and her delusions led her to believe that God was commanding her to kill her child.

I recall her describing...events leading up to the actual..the mutilation, as it turned [out]...she described things like ah, a postman or a messenger of some description calling to the house and that having some special significance in terms of biblical quotations, I cannot recall, I obviously cannot recall the biblical quotations. ...then subsequently evening had arrived and she was describing the natural phenomena of evening such as the breeze picking up and blowing through and that having connotations of, of messages from, I think, I think if I recall correctly, some messages were satanic messages and others she was interpreting as um messages from God. ...the ultimate event...the event that finally, I think, persuaded her that she had to go ahead with this..this ah, act was ah, she had...the moon shine through her window or something of that nature which, which was a profound message for her...it was a message from God or ah, or ah, an angel, I've forgotten how she interpreted that. So, these sorts of events had been happening in the lead up to the actual mutilation. ...Then
it transpired that she proceeded to take up a sharp kitchen knife, I think she placed the child on the kitchen table...having connotations of this being some sort of sacrificial table...I believe she um, in her words, she described cutting the child’s throat and then, and then, turning on the oven and placing the child in the oven.

Kerry was interrupted not long after placing the child in the oven and despite severe burns and cuts to the throat, the child survived.

Vic was working with a student nurse who relieved him in ICA.

And I still remember comments from the student that when he was in the ICA at the time. The atmosphere was...I think he described it, as thick enough to cut with a knife...there certainly was an aura...an atmosphere of.......ah, I don’t know ah, it’s hard to describe it was er, like a gut wrenching sort of atmosphere...it was almost like you had witnessed something really horrendous. The, the woman’s descriptions of it were that.. were that vivid it was almost like you were witnessing it. I’m sure, you know, like your emotional reactions were like you were actually seeing this poor mutilated child, you know, with its throat slashed.

Vic found being with Kerry challenging, demanding and exciting and despite the horror of the act which had been performed, he could find a measure of understanding for what had been done.
Well...on the one hand it was challenging and demanding and, I suppose, slightly exciting. On the other hand it was, it was ah, horrifying and loathsome, it was a loathsome sort of...a novelist would describe it, you know, like having a, an, aura of evil or, or something of that nature. It was almost like that...although the woman's intentions clearly weren't....this woman clearly wasn't motivated by any evil, she was motivated by an absolute, confusion. She knew on the one hand that she'd done something terrible. She knew on the other hand that God was The Almighty who would never ask her to do something that wasn't ah, perfectly good and in tune with God's Holy Plan or, something of that nature.

Kerry recovered in what Vic thought was a remarkably quick time and was eventually reunited with her family. But Vic, who was transferred to another ward shortly after this encounter with Kerry, was left wondering if his decision to confront her about what she had done was significant to her recovery.

It was an amazing, it was an amazing example of the psych' system actually working the way the text books say it can work, it really was. And I, I do wonder whether, ahm, having sort of decided to confront her in that very initial stage was actually ah, ah, the good thing, the right thing to do. I don't know if that was significant, I like to think it was significant. I like to think that it was the case of a good decision....and its always left me wondering

I suppose that ultimately I believe that I did make a right choice and that it
was a helpful thing for her because she could have, she could to this day possibly be in, you know, in a locked female ward somewhere as the baby killer.
SUMMARY

Vic Being with Kerry

The beginning of this encounter is characterised by waiting. Vic had time to wait. First he waited for Kerry to arrive knowing only that she had attempted to kill her child. Later, knowing little more, he waited by the heavily sedated Kerry, for her to awake.

Vic had time to think, to reflect on what he was about to encounter. I can picture him there, looking at her, hearing the rise and fall of her breathing and wondering how, why and for what, did this woman cut the throat of her young child and place him in an oven. To Vic, "a loving parent" with four children of his own, it was "beyond comprehension". His waiting was concerned waiting as opposed to indifferent waiting.

He said he felt apprehensive at the time and that his feelings may have been "tinged with a background anger" but that he was "not conscious of any strong feelings of anger". Indeed many would feel such anger justified but no where in the story is there evidence of anger towards Kerry.

Vic was in ICA alone with Kerry but was he being-with Kerry? I think he was. In the ICA situation it would be possible to be in the same room as the patient and not be-with the patient. Vic was aware of this alternative and rejected it. He chose
to be-with Kerry. This being-with was manifested by careful listening as Kerry told her story. He was absorbed in her story and even remembered the details well enough afterwards to allow him to look up the Bible passages she quoted.

This careful listening was not without cost to Vic and it is possible to understand perhaps why he had doubts about facing up to the situation. He said that being-with Kerry was, "horrifying and loathsome". Vic was with Kerry, transported into this horrific situation with her and through this he understood her. Vic did not view Kerry as horrifying or loathsome but rather as someone who was confused and perplexed.

Vic said that he was apprehensive and had a sense of trepidation as he waited for Kerry to awaken because,

I had doubts about my own skills...I had doubts about whether I might retreat into a ... into a ah...an easy sort of um...conversational approach based on, on trivia and not actually focusing upon the events that had led to her admission, whether I would sort of choose to just, ah avoid the issue, just out of fear of my own ability to handle what might come out or, or, or what ah, behaviour she might display.

He was concerned.

Vic wanted to face this unpleasant issue he wanted to be able to "handle" Kerry's behaviour. Certainly such an approach would not be easy, as easy as avoiding the
issue by falling back on trivia. Vic also said he had a choice and he chose the hard option. Why?

The reason appears to be concern. In his own words, "I thought it was important that this person...have, have um, as, as close to an appropriate emotional response to, to ah, what had occurred as, as could be expected...". Vic felt that there was, "...potential for her to um,...totally regress as a way of escaping from ever having to face the reality of going back to her family and facing what she had done to her child." He did not want this to happen. "...this is somebody who, who has done something really horrible but, potentially, can be helped and can have some form of life afterwards if everything is done properly for her." He cared. This care appears to have been motivated, at least in part, by his sense of injustice that patients who were so acutely ill and disturbed should be admitted to a hospital that was designated as "chronic". He believed that this was doing a disservice to both the staff and the patient.

...this was something which stung me into actually trying to put some skills into use, actually trying to develop a relationship with somebody, actually trying to ah, ah...make descriptions of er what was going on into the clinical file that would be of maximum benefit to the the patient. To convey as much information as I could to assist the person following on after me, to ah, to ah, slot in and take over..pick up on the theme and try and get this woman to um... to come to terms with what she'd done.

Vic did not to take the easy way out that he suspected others would.
...they'll take their magazine or book or whatever, they'll avoid contact with her, they'll sit their chair in the far corner of the room, they won't want to talk about it, that'll be more comfortable for everybody.

Instead he strove for possibility for both himself and Kerry. He did not retreat from facing the basic "horror" of the situation, in this case the potential death of a child. There is a striving for possibility which characterises this encounter. Vic saw the possibilities for both himself and Kerry. For Kerry the possibility was to recover and for Vic it was the possibility to play a role in that recovery and in so doing regain some of the zest for nursing and being with patients which had, I gather, been lost through his disillusionment with "the system".

So to this end Vic attempted to stimulate an emotional response in Kerry. He confronted Kerry about the reality of what she had done saying, "and are you aware of what you have done?" For both Vic and Kerry this was the beginning of facing the reality of what had occurred.

Vic seemed to know clearly what he must do in the situation in order to help Kerry. Perhaps he had thought it through, he certainly had the time.

I can remember sort of thinking, you know, what is really right and what is really wrong in that sort of situation and sort of, not having a really good grounding in theory as to how you actually approach a problem like this.
But what is clear is that his actions were not based on an understanding of the situation obtained from the psychiatric literature or his training but based on "...a pure gut belief".

Kerry did eventually go through a "tearful" period and did eventually recover and was reunited with her family. Vic described it as "an amazing example of the psych' system actually working the way the text books say it can work..." But despite this he was left wondering whether he had done the right thing, and whether his confrontation of Kerry in those early hours of her admission was significant in terms of her subsequent recovery?

I do wonder whether, ahm, having sort of decided to confront her in that very initial stage was actually ah, ah, the good thing, the right thing to do. I don't know if that was significant, I like to think it was significant. I like to think that it was the case of a good decision...and its always left me wondering...

In the end Vic could see what the other possibilities for Kerry could have been.

I think I suppose that ultimately I believe that I did make a right choice and that it was a helpful thing for her because she could have, she could to this day possibly be in, you know, in a locked female ward somewhere as the baby killer.
I heard the old, old men say,
'Everything alters,
And one by one we drop away.'
They had hands like claws, and their knees
Were twisted like old thorn-trees
By the waters.
I heard the old, old men say,
'All that's beautiful drifts away
Like the waters.'
(The Old Men Admiring Themselves in the Water, by W.B. Yeats)

Judy trained in the large psychiatric hospital in which she has been nursing for about twenty years. In more recent years she has been working on an acute psychogeriatric admission and assessment ward. She is regarded by the other staff as an expert gerontological nurse.

The ward in which the encounter took place was built in the early 1960s as a ward for patients suffering from TB. Like many of the wards in the hospital it is no longer used for the purpose for which it was intended and as a psychogeriatric ward it is not ideal.

Our conversation took place over lunch. Judy said she knew exactly the encounter she wanted to tell me about but warned me that even though it happened some time ago she still gets emotional when talking about it. She spoke freely and with feeling, the inflections of her voice lending colour to the story she told. At the end of our conversation Judy was moist eyed and her lunch sat on the table in front of her, untouched and forgotten.
The encounter with John took place one afternoon. The ward had received a phone call telling them to expect the admission of a depressed elderly gentleman. Sometime later a car pulled up, right on the back door of the ward, which was most unusual, and out stepped and incredibly thin frail man.

And the car pulls up at the back door, right on the back door, which never ever happens here right, and this tiny very very slim person gets out of the vehicle...so undernourished...eyes shut, refusing to even look at us or anything. And um...he goes to about half way through the room and we sort of called for help like a wheel chair etc because this person was just like so badly depressed, so undernourished, so dehydrated we sort of, took him in, put him in on the bed...

The thought that was going through Judy's mind was how has this person survived? Judy described her initial feelings as "motherly".

That feeling of "come here I want to look after you" , you know, "look at the state you're in, come on let's, let's help you, let's, you know, try and fix a few things up here".

And umm, the whole time there was just no, no reaction from, from the person at all, there was just no reaction, no nothing. We'd been told by the relatives there'd been no food or fluid past the lips for at least three days, so our main concern was to get fluid in...I'd never seen anyone so small, so little, it turned out that this person was in fact 30.9 Kilos and was a little
taller than myself, about 5/5, 5/6-yeah.

Judy and the other nurses gently tried to coax some fluids into John who up till this stage had said nothing and then;

[He] opened his eyes and looked at us and just started abusing us, like you wouldn't believe, up hill and down dale, for prolonging the agony, "for making me have things that's going to prolong my agony", um, and that just threw all of us...[he] just, like straightened, sat up, like, stiffened and sat up by himself- opened the eyes, and just clenched the fist and the teeth and said, "LEAVE ME ALONE, you're prolonging my agony by forcing this stuff down my neck, I don't want it!" and proceeded to repeat those kinds of things for about the next five minutes...I guess my next feeling was, "Oh, OK, so we've got a lot to work with here haven't we? We're very feisty, we've got it, good." And I started feeling a lot better then, because...if someone's really depressed and they're not showing any emotions, you think, well, you've got nothing to work with, but when you see someone with some of that intense sort of feeling you think, well, "how depressed are they, what really is the problem?"

Like other participants Judy spoke of the encounter as encompassing the time right up to John's eventual discharge and beyond.

During the period of John's admission [some 6-8 weeks] Judy felt she had developed some rapport and had gotten to know John, but John presented a
problem for Judy and the other nurses. He would refuse to eat and hid his medications only pretending to take them. Food became his bargaining tool and staff were "split" on how best to deal with this.

...so it presented a big challenge and we all sort of were gritting our teeth, and you know, getting right into it...and conversations around cups of tea centred on this person. And it was such an intense thing the whole time. And then a decision was made one day, by, not nursing staff but others, that well we can’t do anything more for this person, he wants to go, his family wants him to go, we should just let him go. When the leave is not successful then when he comes back we will have a different set of...of plans, well have a different plan...set in line and um that’s what we’ll do.

Judy felt the decision to discharge John was like, “a slap in the face.”

well it’s just like a slap in the face because we’ve tried really hard, we’ve tried, tried, tried and look, there he goes and he’s still really thin and he’s still really feisty and not as depressed but knows exactly, you know, what he wants to do and everything just all centred around this one person and we didn’t consider anything else......

The day he was discharged John suicided. Judy recalled that day with obvious emotion; both anger and sadness.

We got the news the next day. We all had tears in our eyes, we all didn’t
know quite what to think, it was all...um...how dare you, how dare you do that, how dare you...do that...after all we've done for you, well after all we didn't do for you, you didn't give us a chance, you didn't LET us, you didn't let us do anything, then you went, and this is what you did and all the time you kept saying, “I just want to be back with my friends, with people”, what were you really saying?

Judy was also worried that she and the other staff had failed the relatives, especially John’s daughter with whom she had had much contact. She imagined that the daughter would blame the staff for John’s death. After a number of phone calls, contact was made with John’s daughter.

And she in fact was going through these terrible thoughts, “Oh they’re going to think I’m terrible because I said I wanted to take him home and I did and now I’ve let him die.”

John’s daughter thought that it would be appropriate for one of the nurses to go to the funeral.

One of the staff did go to the funeral and when she came back, this was the next big cruncher...I mean we had this picture of this person in our minds, of someone who lived in their own little world, was totally self centred and didn’t really care about anyone else because of, you know just, everything that was said was all very, very self centred... I thought I was right and I imagine other people would agree that this person was so self
centred and, "By gee you know you’re going to listen, you’re going to find out there’s more in life than just you and whatever this is, whether it’s the anorexia or the depression that’s the base or which way it goes “...at the, at the funeral, at the funeral, yeah the brother got up and spoke about this whole big set of friends and how everyone was happy now that he was at rest and at peace and, the funeral was all these people that were just so distraught by this very kind person that had been through a lot over the years, and, basically the picture was painted, and we never thought, you don’t tend to think of it, of the patient’s...I mean you think about it but it never comes home to you like it did with this person.

We were stunned when they came back from the funeral and told us about how, you know, the other brothers that were really distraught by it and how...the patient had been the centre of the family for a lot of years, had held everyone together, had maintained contact with everyone...was the local person who grew all the vegies and flowers and was good friends with all the neighbours, and everyone who, ah, did all sort of like charity work and was well respected and loved, and that was the final thing, everyone was in tears again including me because....it just summed it all up and we’d sort of missed that...and so then the emotions went back to “How dare you, again then because now that you ah, you haven’t sort of left us feeling like we’ve done nothing, look what you’ve done, the ultimate, the ultimate sort of like self-centred act, you went and took your life when all those people who still loved and cared for you, even though we didn’t see them at the time, were all there and very affected by it.
The encounter with John left Judy thinking about patients in a different way.

So the whole story was just one of, um, surprises, the whole way through, and I've never had to change my mind about a patient so much, in such a short amount of time, from what, start to finish, and I think it's, well it's left for me in particular, it's when we get an admission in I look at them and sort of think, you know, I wonder what you were doing, not just where have you come from, which is I think typical history and things you get from someone but you know, who were you involved with and, and your whole life apart from this place....(Ken: Who they are) Who are...yeah, basically, who they really are.

Looking at the whole experience it seemed to me that John had triggered off a lot of emotions in Judy and the other staff right from the moment he walked through the door. I asked Judy to describe her feelings right from the moment John first walked in.

Oh well it was horror at first, like, how can anyone look so bad, but like feelings of probably motherliness if anything. That was the immediate emotion for me, I was sort of thinking, "you poor thing come here, like the TLC side of things I guess was the first thing ...Just the look on the face, the look on the face of the patient was just one of total despair, and lost, even without eyes open, you could just...like he was just there this tiny little shadow of a thing, eyes shut and shaking.
...so the initial, the initial feeling was, "Yeah look come here and let us look after you, but the emotions and the ideas, like, I've never, I don't think I've become emotionally involved...I think I always become somewhat involved with all patients, but I don't think I've become as involved with anyone else for a long time, and I know that's not completely professional, but can't always be avoided I don't think, and I think it's because it changed so much that it's leaving such a mark on me. It went from "you poor thing, let me look after you" to, "I'm going to succeed here" to, "what on earth is wrong with you? Why won't you let me help you" to.......(Ken: Frustration?) frustration, anger, and (pause) being given a false sense of succeeding, not that I guess we should refer to our patients as “succeeding” because that's not a good word, but it's actually achieving a goal for them, helping them to achieve a goal, that is to become well or to become more well than what they were when we first saw them... do something that's going to help them.

This patient always gave you, like after the first couple of weeks, gave you the impression at times that you were doing that, you could sit and talk and [he] would, reveal things, and you'd come round to thinking "OK, so he's spoken to me and he's been very sincere, but he's not really said anything... you know how people can talk and generalise and not say anything?" (Ken: Yes)...you could see, like, a little game that probably even then was evolving. Well not a game, it was very serious for him obviously, but the little game that was happening all the way along and it
wasn’t until very much at the end when he was about to be discharged, that I could see what was happening...I was able to sit back and say, “Yeah well, you know, you knew me better than I knew you I think.”

You know, like, he could sit back and, have each one of us summed up, very very carefully because...he used to sit and watch, and observe and was obviously very intuitive of people, and had us picked, had us picked, a long time beforehand, yeah, makes me wonder...and it probably, well, that’s the next thing probably, [it] probably cast doubt, it did, it cast doubt on myself, sort of thinking “why didn’t I see that, why didn’t I see that before” you know, and that was when the doubt went to, like, “How dare you” and then anger, and then you’d get back to that terrible frustrated feeling, and ooh! yeah. I guess there’s been other situations like that but nothing quite so....... with so much impact as this one.

After John’s suicide some memories of things John had said came back to Judy.

He was head of the family.....within the wards you need to have some sort of routine, just really because of the logistical things within the hospital, as in, like, meal times have to be at this time, yeah, and something’s been asked of him, as in, you know, have a shower now or, get dressed now, have breakfast first or whatever, I can’t remember what it was, and he said, “no, I’m not used to this, I’d better behave myself hadn’t I? I’m used to being the head of the family but here I’m at the bottom of the pile again,
aren't I. And now I'm listening to you, I thought I'd gone past all of that."
Or similar words to that, and at the time I thought, "yeah that's true".

And umm, then I thought, "oh wow," this person, and then we found out...because of the funeral, that this person had been the head of the family, had been well respected and well loved and had sat up so high that everyone had respected them, and then in the midst of the depression or, whatever, he comes into a place, into a hospital and um, hit the bottom of the pile again, "but don't be, don't be depressed will you."

I mean how? ...we're so contradictory...

Then you say, yes you respect their...you give them...dignity and let them maintain their dignity but by the very fact of their being here...then, then they can't really maintain all of it, or retain all of it can they? Yeah so that really made me think...and there's just, there's just lots of little comments and they just keep coming back...and the things that were said and it all fits into...the incredible puzzle at the end which still feels very jumbled to me and probably always will but...that's life.

Yes that's life but you could hear the frustration in her voice and then she said;

You know, I just, (sighs) yeah, I'd like to get him and say, "right, you've got a few questions to answer here, (laughs), I want to know!" Yeah, but because other patients, like towards the end of...their stay here, they'll talk
to you about things, I mean you must have found that, and they'll say, "oh yeah, OK so I remember this and I don't remember that, and I did this and yeah well I didn't mean that," and you sort of like put the, the well person together in this picture at the end and, well you sign off the letter don't you, and off they go.

This wasn't signed off and it can't be signed off and I think that's why it's left an impression, yeah because, yeah, in one breath you say you've understood them, and then by the very nature of it you didn't. You know you think you've created a rapport but maybe you didn't really because you didn't have that trust for them to be able to express any kind of thoughts that they were really having, and believe me, everything was so planned, was so planned by that person, so well planned, yeah, so that's that.
SUMMARY

Judy being with John

The things that struck me about this encounter were the honesty, the painful self-disclosure and the mix of emotions that Judy expressed. Right from the first moment, John was an unusual patient (he came to the back door and he was so thin) but so much that comes out of this encounter has great bearing on the "usual" nurse-patient encounter.

Judy described her first reaction to John as being motherly. By this she meant a wish to nurture, to care for John. This response appears to have come unbidden from her reaction to John's obviously dire predicament. He looked helpless, depressed and frail. And yes he was all of those things, except helpless.

Judy soon found that John and she had differing agendas. Judy wanted John to do what patient's are supposed to do, get better. John wanted to die. Judy's wish to care was being thwarted. John abused the nurses for prolonging his agony. Initially this did not worry Judy, in fact quite the opposite. Judy saw this as an indication that there was hope for John, there was possibility, he was not so severely depressed. This was based on the experiences she had had with other patients who were depressed. It was likely that this, to some extent, caused her to underestimate John's tenacity.

Both were determined to have their way. Judy described her feelings as going
from motherliness to puzzlement, as she found that John and she did not share the same goals, to frustration and then to anger. She put it quite clearly when she said,

...it went from “you poor thing, let me look after you” to, “I’m going to succeed here” to “what an earth is wrong with you? Why won’t you let me help you” to......(Ken: Frustration?) frustration, anger, and (pause) being given a false sense of succeeding,....

Food and medication became the focus and battles ensued, with Judy and the other staff using vitamin C (something John wanted to take) to get him to eat and John only pretending to take his medication. All nursing staff attention (including conversations in the nurses tea room) was focused on John or more accurately, focused on getting John to conform. It became a challenge, they “grit their teeth” the word “intense” came up time and again, all their efforts were “focused” and this person; “we’re going to fix this.”

Despite their best efforts (and it is interesting to note that all through this account of the encounter with John, Judy made frequent reference to “us” and “we”, meaning the other nurses) John was discharged, much against the nurses wishes. Judy described this as being like a “slap in the face” as if their work had been for nought. And she commented “we didn’t consider anything else”. This comment was left hanging in the air. It’s not clear what she meant by it but it seems likely that what wasn’t “considered” was John. Judy was so caught up in the battle that neither she, nor any of the other nurses, had really considered John. This became
clearer after John’s death.

Judy was very upset about the news of John’s suicide. Watching and listening to Judy describe how she felt when she heard the news I was impressed and moved by her intensity of emotion. She cared for John deeply. I was also struck by the fact that so many competing emotions can co-exist. Judy felt angry by what she perceived as John’s self centeredness, “how dare you...how dare you...how dare you...”, betrayed by his refusal to “let” Judy help and betrayed by his lies “what were you really saying?”. I also believe she felt a deep sense of loss and self doubt “why didn’t I see it”.

For Judy to be with John was to genuinely care even though he angered, frustrated and perplexed her. But what now became clear was that during his time in the ward she never really understood him.

The encounter with John did not end with John’s death. Being with a patient does not always require their presence. In some ways Judy is more with John now than when he was alive. She understands him more in the light of his death.

After John’s death revelations about who he really was came to light. At the funeral the myth that John was a lonely, self centred, helpless man were exploded. “[W]e were stunned....it just summed it all up and we’d sort of missed that...” Nevertheless Judy still saw the act of suicide as self centred.

Other moments with John now came back to Judy, which caused her to wonder.
Did she ever really know him or merely a shadow of him. Judy was operating from the familiar territory of the hospital and John was seen as "patient." His history and who he really was became lost. In John's own words;

...no, I'm not used to this, I'd better behave myself hadn't I, I'm used to being the head of the family but here I'm at the bottom of the pile again, aren't I, and now I'm listening to you, I thought I'd gone past all of that.

Judy wondered whether she ever really knows a patient and whether much of what nurses and patients do is an elaborate game. John didn't fit the "picture". His story can't be "signed off." The realisation came to Judy that she never really understood John.

I believe that John will stay with Judy and the questions she would like to ask of him will be asked of another John and she will come to understand.
LYN AND EDNA
Lyn has been nursing for fifteen years. She initially trained as a general nurse and then trained as a psychiatric nurse about eleven years ago. She has worked in the mental health field ever since.

The encounter Lyn described took place when she was working as a community nurse attached to a community psychogeriatric clinic. The community nurses are responsible for the follow up and assessment (in consultation with the multidisciplinary team) of people over the age of sixty, suffering from a mental illness, referred to the clinic. The clinic is situated near the city centre in an old house. It provides assessment, day respite and ongoing day care for many elderly mentally ill people. Each community nurse has a case load of clients to follow up.

Before we recorded the interview Lyn told me that her encounter with Edna was not exciting, not topical, but very ordinary. It stuck in her mind because she felt she had been able to be of practical help to Edna. She obviously liked Edna and spoke of her with evident affection.

Lyn was one of two community nurses attached to the clinic. Between them they had upwards of ninety patients to follow up. In these circumstances it was easy, Lyn said, to lose track of some patients. It was noticed that one patient, Edna, an elderly woman who suffered from schizophrenia, had not been seen at the clinic for some time. Lyn, who did not previously know Edna, was sent to visit her.

I was struck by the vivid description Lyn gave of her first meeting with Edna. Nurses often say to be a good nurse one needs to be observant. What follows is a
good example of the observant nurse.

Um, so I was selected to go, I really wasn’t sure what to expect with this lady and I drove up to the house and it became quite obvious to me which house was her’s when I drove up the street, it was quite old and run down,...front fence was falling down and the grass was a bit long, broken window...and when I pull up I was a bit hesitant to actually go in, because you don’t know what to expect and I’d never met this woman before.

But anyway I went into this house, into the yard, it was a little bit eerie actually...and I knocked on the front door - it really didn’t look as though anyone was home...and I knocked a couple of times, it was quite funny, actually I was almost hoping that there’d be no one there (laughs) ‘cause I didn’t know what to expect. But I knocked a few times, and then I saw this little lady peering through the window...and when I saw her I smiled and waved and then with that she came out, she opened up the front door...but she came out of the front door and then shut the door behind her as though she was actually hiding something, she didn’t want me to see inside. And just from that I picked up that, just by the smell of the house and just by...having a brief look inside when the door was open, it was really quite unkempt, and dirty and the outside of the house indicated that as well. And then when she came to the front, when she’d shut the door behind her, I introduced myself to her and told her that I worked at [names clinic]. And really I was, I think I was expecting someone to be a little bit more suspicious than what she was but she certainly wasn’t she was...she
was um, quite, she was quite talkative actually but she had a really inappropriate affect, like she’d be talking about something and then she’d start giggling and she had really strange mannerisms, she wouldn’t look at me when she was talking to me, she kept looking on the verandah floor and every now and then she’d just sneak to have a look and then quickly, gaze back down. Very difficult to understand what she was saying at times and I had to...um, keep clarifying what she was saying ‘cause it was difficult to understand - she had a lot of loosening of associations. Um, but she certainly was talkative. And then I asked her why she hadn’t been coming to [the clinic]. She just told me that she hadn’t got round to it. It wasn’t because of any specific reason. So all I could get out of the conversation was simply that she hadn’t had the chance to get there.

...her clothing, the way she was dressed, was really quite bizarre. She had all different layers of clothing on. She had long dangly ear rings, really heavy and chunky, quite cheap, and then on her hand she just had all these rings right up to the knuckles, and you could see that some were quite tight on her fingers as well. And the ear rings were so heavy...that they’d actually torn the ear lobes and her ear lobes were quite dark as well. Um, her hair was very long and tied up in a matted knot at the back of her head. And she had funny high heel shoes on.

[A] very eccentric little lady. And she had a galah [Australian native parrot] that was actually on the verandah and she, she talked to me about this galah as well. But it was obviously...obviously her friend basically. So that,
even in the first encounter she was very, quite talkative and wanted to tell me about the bird. It was almost like she was happy that someone had come to visit her.

Because of Edna’s mental state Lyn suspected that she had not been taking her medication. She encouraged her to come to the clinic and Edna said she would come the next week.

The next week Edna did come to the clinic where her medications were reviewed and she attended some group activities. Lyn continued to visit her in her home each week. With each visit Edna became more trusting and more problems became apparent.

...it wouldn’t have been until about the fourth visit that she actually let me inside the house, and I think it was probably on about the third visit that she actually came out to the verandah again and she showed me an electricity bill that she had and it was really quite expensive. It was (pause), I think it was about $290.00, and she really didn’t have, um even though it was winter, she didn’t have any heating as such and she just had light bulbs...and I thought that it was quite odd she would have such a high electricity bill, and the old house that she lived in was actually divided into two flats, and she used to rent out the other flat, and she was really quite fond of the people who lived next door, and she considered that they were friends....But they didn’t pay any rent...they lived there free, and they used to do a few chores for her she told me, like he used to mow the grass, and
when I looked at the grass, I mean it was quite long, so he obviously wasn’t um, even though that was his chore, he obviously didn’t do it very often. And the more I thought about this electricity bill the more I thought, gee you know, she could not be using this much electricity, so I rang the electricity board and they informed me that there was only one meter for that house... It seemed likely that all of the young couple’s electricity usage was going onto Edna’s bill.

So what we ended up doing was we had two meters put on the house and then I think Edna’s electricity bill went down to something like $40. (laughs)

Nevertheless Lyn was careful not to interfere with Edna’s relationship with the young couple.

And I got, I guess I felt really angry with this, cos I thought how could people take advantage of this poor little old lady, and I, I became quite angry with it, but I had to be very careful in how I dealt with it as well because these people meant the world to Edna. But whether they were ripping her off or not, it didn’t matter because they were very important to Edna, so I had to be very careful in dealing with issues that I didn’t loose that support for Edna because basically it’s all she had, apart from her galah...so even though they were ripping her off I had to be very careful that I didn’t upset that relationship. And I guess that’s why we just put the electricity box on, cos they couldn’t argue with that, yeah.
As Lyn continued to visit, a trusting relationship developed and Lyn was eventually allowed into Edna’s house. It became obvious that Edna had little food and vermin were a problem. With Edna’s permission the house was fumigated and Meals on Wheels were contacted and to Edna’s delight, delivered meals five days a week.

Edna’s hair had not been brushed or washed in years and was tied up in a bun and resembled a “birds nest”. Lyn persuaded Edna to let the nurses cut and wash her hair and then to have it styled by a hairdresser. Edna’s ear lobes, damaged from her heavy ear rings, had to be surgically removed but this didn’t change Edna’s behaviour. The next week Edna arrived at the clinic wearing the same ear rings, just clipped higher up her ears.

Lyn continued to visit Edna at home and Edna continued to attend the community clinic. Edna’s mental state improved as did her social skills and personal hygiene.

But she was very likeable, and even though lots of her behaviour we didn’t change, we did improve her living situation. Like even though the bottoms of her ear lobes didn’t appear to bother her, and her hair didn’t appear to bother her, I think that people accepted her better once we’d tried to improve her hygiene a bit. She continued to dress quite eccentrically, um, there wasn’t a lot we could do with that.
...I guess there wasn't one particular incident, it was just an accumulation of events over a period of time, that made the whole relationship with her then very significant...when I look at specific encounters as such, a lot don't stay in my mind cos like you don't feel as though you've achieved a lot over a brief period of time, but because this...she was a likeable person, quite bizarre and eccentric but friendly, almost helpless as such because she was a little old lady and quite thin. I guess those characteristics, um, drew me more towards her anyway, and it was obvious that she was a woman that you could do a lot for...It's significant for me because when I look back, I really feel that we did achieve a great deal with her, and not just psychologically but socially as well.
SUMMARY

Lyn being in the world with Edna.

The world of the community nurse can be very different to the hospital bound nurse. There is often more autonomy as well as a greater degree of responsibility. The work is usually solo and the community nurse has to rely heavily upon her/his own skills and knowledge of community resources. Lyn said her encounter with Edna was a story of the ordinary. She said she could tell me of other encounters that had been more exciting, topical or sensational but this "ordinary" encounter meant more to her. Much of psychiatric nurses' being in the world with patients is ordinary. In the ordinary can be hidden much of what it means to be a psychiatric nurse.

For Lyn meeting a new client was anxiety provoking. "I was a bit hesitant to actually go in because you don't know what to expect and I'd never met this woman before." She showed an honesty with herself when she said "I was almost hoping that there'd be no one there (laughs) 'cause I didn't know what to expect."

Lyn is a community psychiatric nurse. The community nurse's clients are often not as severely disturbed as in-patients. Hence the work of the community nurse may often be focused on practical matters of day to day living as well as problems of mental state. At the end Lyn said she found the encounter significant because
she felt she had been of some practical help, Edna "... was a woman that you could do a lot for".

In this "doing" Lyn was sensitive to Edna’s needs, she understood Edna. She did not impose her own solutions based on her own feelings but was sensitive to Edna’s needs and point of view in planning care. A good example of this was solution to the electricity problem.

Lyn was angry with the tenants for taking advantage of Edna but through her understanding of Edna she knew how much these people meant to her.

I had to be very careful in how I dealt with it as well because these people meant the world to Edna. But whether they were ripping her off or not, it didn’t matter because they were very important to Edna, so I had to be very careful in dealing with issues that I didn’t lose that support for Edna because basically it’s all she had apart from her galah.

Lyn had set aside her own feelings and acted in accordance with her understanding of Edna gleaned through being-with Edna.
JEAN AND TRACEY
Jean has been nursing since the mid 1960s. She trained in the same hospital as most of the other participants and has since worked in a variety of settings both in Australia and overseas. The encounter with Jean is the only encounter in the study not to have taken place in the old psychiatric hospital or one of its satellite services. This encounter took place in a psychiatric annex attached to a general hospital. Like the wards in the psychiatric hospital, this annex was not designed for the present job it has to do. Initially it was a maternity ward. The ward lacks the picturesque surroundings of the psychiatric hospital and a private space is hard to find. So it was that Jean and Tracey were in the foyer of the annex when the encounter took place.

Tracey, a young woman of seventeen, was under constant observation because of suicide threats. It is interesting to note that when asked to describe an encounter with a patient Jean immediately though of this encounter because another staff member played a prominent part in the encounter.

Jean was on “constant observations” with Tracey. This in itself is a difficult situation, wherever Tracey went Jean would follow. Building rapport with Tracey had been a long, slow process but Jean felt there was some trust developing. They were sitting together on a bench in the foyer of the annex when a doctor walked in and sat down very close to Tracey.
Because it was the front foyer the doctor just happened to walk in the front door and just happened...I mean the girl never drew her attention, wasn't asking for her, for any reason. The doctor just sort of sailed straight in and sat down really very close to her.

Jean could see Tracey stiffen and become tense as her personal space was invaded. Jean can't really remember but she thinks that Tracey, some time before the encounter described here, had requested leave.

Really tense, yeah, and um, and she was starting to get really defensive, and, and er, the doctor started sort of lecturing to her like, "you don't, you're not going to get anything from me [leave, for example] until you do what I want, you do these certain behaviours." And with that the girl just really laid into her, just laid into her, you know, Yeah started hitting her, assaulting her, yeah, hands, feet the lot...she [the doctor] was this really overbearing person, telling her what she could and couldn't do, and she just straight away struck out at her...I could see it, on reflection I could see it all happening, with the body language, the tensing up, and hearing the verbals from the...but I was really still shocked when she actually physically assaulted her.

Um, it seemed like an eternity, I just sat there thinking, my goodness me, you know, it was obviously probably only fifteen seconds till I got up and tried to, well I couldn't, couldn't hold her myself, I couldn't...she was just
really laying into her, and I guess that’s why that episode sticks. I called for help and we had to really restrain her quite heavily, took a lot of people, she was um really very, very angry, but she was tense to start off with.

I asked Jean how she was feeling at the time.

...with young girls like that, I think I’m of the age now, and why this sticks in my um, mind I think was because I was feeling very motherly I suppose, I was using that sort of motherly...thing, and thinking this could be my daughter and she’s , you know, she’s had a really tough upbringing, she trusts nobody and um,...Yeah I was feeling very protective towards her.

And then when the doctor disrupted the rapport Jean felt;

More or less... serves you [the doctor] right. (sigh)...I guess there’s mixed feelings. Hey...you’ve just come in and disrupted the rapport I was building. There was no, “Is this, a suitable time, for me now?” This was just, bingo, just disrupted...was really annoyed with her. Um, and part of the annoyance was um, “Ha, you disrupted what we were establishing!!!!”. .. and you probably deserve to get, this is terrible, probably deserve to, not get hit but, look what’s happened as a result....

and, and because of her approach the kid flared up and she was locked up straight away, you know, because she’d assaulted the doctor, it was then a charge. ...the whole thing sticks in my mind I guess because if she’d been
approached in a totally different way and knowing her case like she should have known, and she did know it, she should never have approached [the patient] that way. So the patient, sort of...lost out, through lack of expertise and skill.

Tracey was placed in a seclusion room and the doctor laid charges of assault [the charges were latter dropped].

And I guess that’s why I was really annoyed at this person [who came] and charged in and was really standing over her and ah, “you, you’re gonna behave this way,” you know, which ...is probably what she had all her life ...I was, yeah I was feeling motherly, I was feeling “hell this poor kid” , You know, she is only a kid after all. ...[she] wouldn’t trust anybody all her life.

...even after the episode, I guess which really hurt me, I felt I was building some rapport and part of the abuse was hurled at me, “I’ll get you, I’ll kill you” , you know, me, um, all that negative stuff was directed at me as well as the, the other person...but um, um, “I’ll never forget you, I’ll pay you back for this” , and all that sort of... any little bit of rapport that was being developed or maybe that sort of slight tiny little bit of trust that we were there to help her and...she didn’t believe a word of it, I mean, she didn’t believe a word of it. No she obviously didn’t...I didn’t get a chance to finish what I’d started.

Oh I was angry [with the doctor].
SUMMARY

Jean being with Tracey

As nurses and patients we are beings with a history, a past, a future and a culture which shape who we are. When we meet in the nurse patient-encounter we bring those qualities with us. Jean, a mother with a daughter, cared for Tracey in a motherly way. She wanted to protect her.

The encounter gives the sense that Jean understood Tracey, this girl with a very "tough" up bringing who can't trust anyone, and saw for her possibilities that went beyond her present situation. If this were not so there would be no point in nursing. No matter whether it be giving pain relief, performing pressure area care, or forming rapport, we as nurses are projecting our possibilities (for the sake of which we perform this or that act) and those of the patient, into a "has not yet been" future. It therefore causes us great unease when those possible future projections are thwarted by another. In this case a doctor.

Jean understood Tracey in the light of her history, non judgementally. Non judgemental is perhaps not accurate. She had judged Tracey and accepted her and she had judged Tracey's behaviour and found it to be understandable (though perhaps not acceptable). Jean said she was trying to develop a rapport with Tracey and she described what this meant.

*I was just trying to um, establish the fact that we were human and that,
that I was a person and I was empathising with her. Um, just trying to get
her to accept that we were there and we did care about how she felt but we
weren’t um, necessarily going to do her any harm...that we really did want
her to get well, that we did understand what had happened to her and
what was happening to her.

For Jean, developing rapport meant conveying a sense of shared humanity,
breaking down the sense of estrangement and developing a sense of trust and
working together. It was a way of conveying understanding and acceptance. And
there was a glimpse of this starting to happen when the doctor walked in.

The intervention of the doctor affected Jean in four ways. Firstly Jean was angry
and the anger was that of a mother for a wronged daughter;

...this could be my daughter...Yeah I was feeling very protective towards
her. And I guess that’s why I was really annoyed at this person that came
and charged in and was really standing over her.

Secondly, she was angry because of the lack of understanding shown to Tracey
(after all, Jean had taken time to try to understand Tracey), “...hell this poor kid,
You know, she is only a kid after all.”

Thirdly, the doctor had destroyed that which Jean had been trying so hard to
develop; trust. “Ha, you disrupted what we were establishing!!!! and you probably
deserve to get, this is terrible, probably deserve to, not get hit but, look what’s
Fourthly the intervention of the doctor hurt Jean deeply because Tracey identified Jean with the doctor and turned her anger on Jean also.

I felt I was building, building some rapport and part of the abuse was hurled at me, “I’ll get you, I’ll kill you”, you know, me, um, all that negative stuff was directed at me as well as the, the other person.

The possibilities for Jean and Tracey, for the sake of which Jean was building rapport, were now gone. In the end it was Tracey who lost out and that saddened Jean deeply, her possibilities were now other than Jean had anticipated.
John has been nursing for some eighteen years. He has worked in the old psychiatric hospital all of his working life as a nurse, apart from the eighteen months he took off to train as a general nurse. John is a quiet, affable man with a good sense of humour, although I suspect many would not find him particularly funny because his humour is of the kind that perhaps only psychiatric nurses would understand. It is insider humour. He is presently the Clinical Nurse Consultant of a medium secure ward and is well liked and respected by both patients and staff.

Tony was a young man with a confused diagnosis who was prone to be violent.

Ah, we had several encounters with him, usually of a violent nature, the ones that stand out anyway....Um,.....His problem was...[that] he had been to various hospitals, with a psychiatric diagnosis, however nebulous, it was still psychiatric, and he couldn’t accept that. He thought that it was worse...to be diagnosed as mad as [opposed to] bad. So he tried, he committed various crimes....or, or at least he thought that he had committed various crimes and that people were labelling him as, as mad as part of a conspiracy

...eventually when he wasn’t labelled, or wasn’t sent to prison he intentionally committed a crime so that he could be labelled as bad....I think with the hope of being labelled as bad, and then excluding the diagnosis of being mad. I can think of a fairly recent encounter [with Tony],
within the last month

The encounter basically was one were he was totally out of control, extremely violent, trying to, trying to hurt nurses, ah, masturbating at the same time, he was getting a lot of sexual thrills from this encounter, apparently. Ah, he, he, more or less set himself up to be man handled, and ah, he claimed later that he enjoyed every minute of it.

At the time of the encounter John was in the nurses station of the medium secure ward talking to a female doctor when he saw nurses all running in the same direction. This is a sure sign of trouble but it did not overly concern John as it is not an uncommon occurrence. He left the doctor in the nurses station and went to investigate.

by the time I'd got there, he [Tony] was held by a couple of staff...just managing to hold him, and so everyone joined in to, to secure him. Ah, so as to ensure that there was a minimum of harm to anybody, including him of course.

[He was] Ah, struggling fairly violently, Ah, screaming...cursing...and...still threatening the ah, the resident [patient] that he had the initial altercation with. Saying things like, you know, “I’ll kill you next time I...have contact with you". “Let me get at him” and, and ah, “take me to ICA (The intensive care area), take me to ICA”. ..and, “I’m not having any
medication, the only way I'll take medication is if it's IMI”, which was all part of...his intention to maximise the encounter I think, the physical nature of the encounter.

There was no need for John to help restrain Tony so he endeavoured to talk him down, to counsel him. John didn't feel particularly frightened in the situation, although he does admit to fear in most violent situations with patients. He had encountered Tony before in similar situations and had a theory about why Tony behaved this way.

I think that ...these episodes of which this particular example is one, his violent episodes, are related to, a slight dawning of, of ah, insight. A realisation that, that possibly, um, he is genuinely schizophrenic, has a psych' illness.

And I think that really angers him and really upsets him and then he tries to, he acts out, he acts out, in a violent aggressive manner, um, for all sorts of reasons. I think he gets some sexual gratification, people think that he does and he claims that he does and also I think he's trying to prove something; that, that he is a nasty person,[and that] he's not actually mad. Ah I felt there was a fair bit of acting out, So I wasn't particularly frightened.

The situation was at once amusing and puzzling.
...it was a, as I can remember, it was a fairly intellectual question, I was wondering, and I think the other staff were wondering as well, you know is this...a real situation. ...are we playing into his hands? Should we be using reverse psychology, should we just ignore it? We couldn’t ignore it ‘cause he was involving other patients and threatening their safety.

I asked John if there were any other feelings going on in him at the time?

(long pause) Interested. Ah, ah,...enthusiastic, sort of, almost, almost elated...incidents like that, particularly when you’re in control, tend to ah, to make you perform at peak ability and I suppose it’s a bit of self actualisation. You think, you know, I’m actually performing to the level that I’m capable of. ...I’m sure that’s a fairly common feeling. ...particularly if the situation is being controlled...and you’re sort of making some sort of logic out of it and particularly if you’ve contributed significantly, it’s a, it’s a reasonably satisfying thing.

A little bit of exhilaration from the adrenaline rush. Um, maybe even feelings of safety and security because I was confident in the other staff’s ability, a little bit like being in...your bed during a thunderstorm. I suppose it accentuates the, the security of the situation...so I was confident of the staff and ah, there, there was a little bit of expectation, you know. I thought...this is going to provide some interesting food for thought and, and fodder for discussion. Ah, bit of annoyance because I realised the amount of documentation that was going to occur; incident forms and
seclusion orders and etc, etc, etc.

John tried to talk Tony down and because he felt that Tony wasn’t totally out of control and was acting in accordance with some plan to prove himself bad. John tried to logically reason with him.

I felt...what he was doing was trying to prove, in a logical way, from his point of view... even though ...his thinking was distorted, he was trying to be logical, he was, he was trying to prove...his lack of madness in a logical fashion, to the best of his abilities. Um, I thought possibly that he would respond to some sort of logical argument in return.

Which he didn’t, ha (both Ken and John laugh)...and he didn’t because, you know every time we released the physical restraint he, he’d swing around and continue to behave in an aggressive manner. I don’t think with the intent of being particularly violent, or wanting to hurt someone, but trying to give that impression, that he was capable of doing that. Nevertheless we couldn’t take the risk that he, he mightn’t accidentally hurt someone so we had to seclude him.

I asked John to describe the process of Tony’s seclusion.

It was a fairly simple process, as it normally is. Well we just unlock the door, explain to the person, or in this case, this particularly patient, as to why we were doing it. And ah, explain to him that we’d be keeping a close
eye on him and we'd be releasing him when he was more settled. And ah, he appeared to accept that, and ah, lay down on the bed that we provided and ah, and once we were removed from the situation he did appear to settle....[The seclusion room is a secure single room with a locked door fitted with an observation hole. It is also under video surveillance].

He probably couldn't do much. He er, had no choice. I mean, I suppose he could have banged on the door and ran around but, I think he saw the futility of that and he just lay down and...he was probably exhausted as well, emotionally, and physically to a lesser extent.

John offered Tony oral medication which he refused. He accepted IMI medication and then settled down to sleep. The incident from the beginning to Tony being secluded took about twenty minutes and afterwards...

Afterwards he was, basically remained in seclusion and, ah, I'm not sure of the exact period of time, I think he was, he was there for twenty four hours. But ah, we did certainly care for his physical needs and ah, did provide counselling on fairly regular intervals.

Some of this "counselling" was provided by John and consisted of....

Ah, Basically reassuring him that he wasn't going to spend forever in that situation, that as soon as he was settled he would be released.
That ah, that we took the action that we did, not because we like doing it, or enjoyed doing it, we did it ah, for his own safety and for the safety of others, that ah, we utilised a lot of staff to, to ah, I suppose maximise our advantage and to reduce any likelihood of injury to anybody.

[I] also stated that, I hoped that this [incident] didn’t impair the relationship between him and the nursing staff. ...I emphasised the we, we realised that he had a psychiatric problem...I said that knowing that [it] would offend him to some extent. ...[I] conveyed that that was just a natural assumption on our parts; that he did have a mental illness. ...I think he was feeling fairly bad, I don’t know if it was embarrassment or, thinking that he had cooked his goose or that, you know that he had um, manifested his madness.

How did John feel after Tony was put in seclusion?

I mean after any incident the adrenaline’s flowing a little bit and you tend to get… you’re still a little bit ah, a little bit high.

It is an interesting time and this, this episode was no different to most… The staff still have emotions running fairly high. They possibly go into the situation thinking that they…there’s a possibility that they might get hurt. I suppose it’s almost comparable to going into war. And then once, once it’s over, similar I suppose to coming back from war, coming back from a battle. You feel a high degree, or a fair degree of unity with the people who,
the participants in that...struggle you might say. (Ken: You were feeling that way then?)

I did, yeah. Well I did...not as much as sometimes because, as I said before, I didn’t feel that there was a lot of, that there was that much risk in this particular incident. ...there was some, some, euphoria and [a] feeling of bonding with the others, because we’ve all been through a potentially dangerous situation and come through and possibly helped each other and, and people tend to skite a bit saying, “you know, we did this and we did that well and, and ah, you ah, grabbed that arm very rapidly and ah, and ah, you didn’t flinch”, etc etc. And people tend to, to build each other up a bit...a bit of...mutual adoration goes on...which is probably good I think...and I suppose that’s all part of the debriefing thing.

What did the staff say to John?

Yeah people might have, people might have said oh, well you know you, “you did that well, you did that well” or, “I, I like the way you said, said this and that and ah, and ah, handled those comments at that particular point in time”. And people probably say that in the hope that, that you’re going to say, well you did well (laughs), people looking for a little bit of a return of praise I suppose...at that stage there was some fairly inexperienced people, some people who were newly arrived in the ward and I think that may have been their first...experience of potential violence and they sort of come through it so they felt as if they had earned their
strips a bit. They’d proven themselves and they felt, ah, a few of them felt, fairly ecstatic I think. (Ken: Sort of like an initiation?). Initiation, yes. Sort of like the rights of passage you might say.

...we all went back to the nurses’ station and just talked about the incident...and tried to analyse and dissect the incident. Ah, usually I try to build people up...and usually I ask them if there was anything they saw [that] was wrong or happened that was ah, not according to their preconceived ideas or that maybe...someone could have done something better in their opinion.

Ah, you basically try, you know, to build people up and give them a pat on the back more that anything else. And in this instance no one was hurt or no one was emotionally hurt so there was no need to sort of ah, ah, comfort anybody or debrief specifically. ...half the people went around for a cup of tea, then people start talking about previous old experiences when such and such happened and they did this and then...it was sort of [an] instigation of more discussion, sort of, in a historical sense.

I think in this instance, people were more concerned about their own performance. I think the patient was probably not even thought of. Maybe only in passing. But I think people were, people were just mainly... you know, “did I, did I show any fear” , or “did I let anyone down” , or “was I really good” , or....(Ken: ‘cause they’d be appraised by their peers?)
Yeah, yeah, I think so. I think everyone, everyone, particularly the people who hadn’t been through it [before], thought you know, “I wonder what they thought of me or how did I go”. .more so than the patient.

After the incident John felt no animosity towards Tony. John says he feels sympathy for people who suffer from schizophrenia and that he believes he can empathise with and understand them. After years of working with people with schizophrenia he considers that he has formed close friendships with people who have the disease and sees them as forming part of his social circle. He remembered using humour in his discussions with Tony following the incident.

I can’t remember any specific humorous things that were said but... certainly, you know using humour to... [show] the silliness of his actions and maybe the silliness of...our actions. Not that, not ah, disparaging what we did but maybe, you know...I might have said that...”I was shivering in my boots” , or something like that you know,...trying to show him that maybe, that we were human as well and had emotions similar to him.

And just to laugh at the situation. If you can get them to laugh at their situation, the fact that they’re in a, in a, mental institution in ICA and you’re in there with them and you sort of say, “well we’re going to both be growing old together in, in ICA”, (laughs). It sort of gets, gets a bit close to the truth I suppose. You see the ridiculousness of the, of the situation.

...showing him that he’s part of the whole world community, that we all
basically...are the same. That we all have problems and weaknesses, fears and hopes and all the rest of it. And that basically he's no different to us.

It sounded as if John felt warm towards Tony despite the violent incident.

Yes that's true, yeah. There's certainly no animosity. I think....there have been times when I've been angry with him...for his sort of, intransigence and sort of stubbornness...and for his actions as well. But ah, overall there's still that warmth there. (Ken: Even despite his intransigence and his irrational behaviour and his violence?)

mmm, yeah, sure. And probably that is one skill that psych' nurses have to have...is to ah, ah, submerge judgemental attitudes a little bit...I mean we all have judgemental attitudes to, to certain people.....but maybe we have to submerge them to, to ah, to a greater percentage than non psychiatric nurses.

And what was it about Tony that made him stick in John's mind?

Probably, actually I hadn't mentioned it, but probably his humour. ... [He] used to laugh at what I said occasionally and I'd laugh at what he said. ...and his intelligence I suppose. And I suppose the tragedy of it to some extent. The fact that you can have a intelligent reasonably functioning person in society with a good job, reasonable prospects and suddenly ah, you come to the point where you're man handling him into ICA, into
And all those sort of things flash through your mind I think, instantly, during those sort of events.
John being with Tony

The thing that struck me about John’s encounter with Tony was the matter of fact description. Violent situations, in most people’s experience, are emotive in the extreme. Whilst John does speak of his feelings, his description of the entire encounter has an over riding feeling of the ordinary and the everyday. This sort of encounter with a patient is not uncommon in the medium secure ward in which John works. From John’s perspective then, being with patients, even when it entails unusual behaviour, is ordinary and everyday. In some respects it’s just another incident to be documented (“more paper work!” ). In his description I am reminded of police reports..” and the assailant was apprehended close to the scene of the crime and a scuffle ensued.” Matter of fact. John’s voice and demeanour also conveyed a lack of censure or judgement of Tony even as John spoke of Tony masturbating and trying to hurt nurses and patients.

It may very well be that this ordinariness takes the edge off the encounter and prevents it from being taken personally. Nowhere in John’s description does John give the impression that there was any animosity towards Tony. In fact quite the opposite. John states he still feels warm towards Tony (based on their previous encounters) despite his behaviour and reassured John that his relationship with the staff was still intact.
I remember one staff member in this ward (a hobby farmer in his spare time), when he was asked to report being assaulted by a patient, commenting, “Why? I cop worse than that at the calf sales”.

It was assumed by John that Tony’s behaviour could be understood despite his mental illness and he formulated a hypothesis; Tony’s behaviour was related to, “a slight dawning of, of ah, insight,” and Tony hoped to prove that, “...he [was] a nasty person...not actually mad.” There was also a curiosity about John’s encounter and I get the impression that the understanding John has for Tony is based on intellect first rather than a sense of Being with Tony as another human being in the world. It is curiosity rather than being with.

Such understanding has then a distinctly cognitive feel to it, (“...food for thought and, and fodder for discussion...a fairly intellectual question...Interested...”) . John felt in control of the situation and not scared; “...I wasn’t particularly frightened...it was almost funny, almost ludicrous...” It may be extrapolated from this then that not understanding a situation may be scary. Being in control is linked to making sense of the situation (understanding).

There was a satisfaction derived from being in control and the sense of security it delivered, “...a little bit like being in, in, in your bed during a thunderstorm...”.

Security and control appeared to be tied up with being with other staff. John used some interesting analogies when he likened a violent encounter to being in a battle. This analogy also struck a chord with being with other staff. There was an
esprit de corp present in the situation and a need for staff to prove themselves to other staff. There appears here to be a danger, hinted at by John, that in their being with other staff, the patient can be forgotten.
DAVID AND GWEN
David has been nursing for some twelve years. Despite his youth he rose quickly to positions of responsibility and is now seen by his nursing and non-nursing colleagues as an expert clinician. David is the Clinical Coordinator and Clinical Nurse Consultant of a psychiatric community clinic based in the business district of a city.

The encounter with Gwen took place in a community psychiatric clinic on the fringe of the central business district. The clinic was situated in an old hall, once used by the local musical society and had been badly converted into office space. The clinic was run on multidisciplinary lines with all staff doing the same work. Each staff member would conduct assessment interviews and take on a case load of clients. At the time David met Gwen he was a very new, very young and junior member of the team.

I started the interview with David by asking if he could tell me about an encounter with a patient that was significant to him.

Yeah, actually I can, um, and I suppose that's because when I look back over my, my clinical practice, the thing that was really important in what I've done over the last twelve years, was the time I spent at the (mentions name of community mental health clinic).

So I went to work with this really remarkable group of people who were really into psychotherapy and group work and I sort of felt the...new boy
out on the block. I was full of initiative and enthusiasm but in terms of hands on experience I felt like I was about two years behind the rest of them.

I tend to remember firsts, and I remember my first interview, the first person I ever actually assessed. But I also remember the first time I think I ever moved away from...just collecting information...to actually...it meant something, like what you had in front of you suddenly created an impression or a picture and what you did was deal with the picture...previous to that I felt like you had to gather all the information, go away think about the mental status examination, try and get it all right for the, the consultant and the team so I didn’t look like a dill, and at some stage through that I’d come up with a plan and a, and an impression of the patient. This day, it happened for me right there and then...and um...it was pretty amazing.

The woman’s name was Gwen and she was a school teacher who had been referred to the Clinic by her private psychiatrist.

And um this, this lady presented for assessment by me, she was about, um 45/50 years of age. She was a real little lady and my impression of her is that she was a dark lady, so that she sort of had a closed body posture, dark hair, darkish clothes, very conservative, school ma’am, in fact she was a, a school teacher off on sick leave.
David started asking the usual questions such as date of birth and so on. Gwen’s responses were clipped and angry. Her eye contact was over direct and there was “hostility and tension coming off this lady”.

And I’m still sort of remembering this decision in my head that goes...” if I keep interviewing this lady I’ll get all the questions, I’ll get her diagnosis right, I’ll have a wonderful treatment plan, I’ll... but she’ll never come back. There is something that this lady is really upset about, she’s not telling anyone...” Her problems were ongoing, she’d been on sick leave as a school teacher, umm..I think she’d reported anxiety symptoms but basically she had an inability to deal with her anger and the teachers were trying to pension her off basically.

And I can still see myself sort of going...just thinking about this, and all of a sudden going, “well, If I’m going to keep this lady I’m gonna have to...I’m going to have to, I’m going to have to um..talk to her”.

So I literally shut the file, [and] put the pen down...In the [clinic] we used to sit like we are now across the corner of a desk with another chair over there, and I went and sat in the old red armchairs, straight across from her and said that basically I felt that she was really angry and upset about something and that...I wanted to talk about that and, and just leave the rest of it go, go out the window...

Gwen was angry. She had been seeing Dr Jones, her private psychiatrist, for many
years and now here she was being sloughed off to the public system and being interviewed by some young nurse. David felt Gwen wanted a fight.

and um being incredibly fearful of um, school teachers I didn’t want a fight with her (both Ken and David laugh) ‘cause intellectually she was probably my superior in terms of she was...as I was to find out later, she was very articulate, very intelligent lady in terms of her intellectual abilities. Emotionally she was very difficult to deal with and very immature...

David believes that this encounter was a significant point in his development as a nurse. He was able to trust his judgement as to what was the best cause of action and use some budding psychotherapy skills. Gwen wanted to know how old David was. Was he a nurse or a doctor or what? David believed that to enter into these discussions was merely to provoke a fight so instead he helped Gwen explore what these things meant to her, for example the anger she felt towards Dr Jones for sending her to this lad.

So it wasn’t just avoiding the question it was all that reflective stuff about, you know, why is it important for you to know that, what is it about status or whatever. So it was that sort of line I was following...about age, what does it mean to you to be addressed by people who are younger than you and that you see as being young...and she, she talked about it once she got those things off her chest... She didn’t feel that I had avoided her, although initially they were her comments. Like she’d say, “ah you’re not answering my question, I’d like you to answer me”. ..and so once again I’d use her
anger to reflect back to her and elicit some more information.

...that was the time when it all come together, and I suppose your confidence comes from [that], even though in retrospect they [the counselling skills] were very simple things, I mean I, I probably find that I do them with staff now, um, without even thinking, but for me to actually apply them in a clinical setting..ah, without direction was just wonderful for me..

But the encounter didn't end there. Gwen entered into a three month programme of individual psychotherapy and group therapy. Years after completing the programme she tracked David down to thank him.

...she actually tracked me down some years later through my uncle who runs [a business] and she knew my last name was ----- and so he, he told her what my phone number was.

And she rang me up and she, she'd been pensioned off ...as a teacher and she was actually in charge of a day care for kids...which was incredibly different from teaching kids. She was actually providing day care. So in my mind [she had gone from a] very dark, punitive, critical old school ma'am, to some one who was actually...wanted to be with kids. It wasn't about a career structure, it certainly wasn't about money... And the things that apply to day care are things like um letting kids run around in mud and have bright colours and stuff like that so it was a totally different picture I
had of her.

...that she felt that to finish things off she had to tell me, it was a need that she had, and part of me said well, if she had that need maybe she's unwell again. But it was like we, we had a history together, that she entered with a (pause), perception that we weren't going to help...and that...to tie up that part of her life she had to track me down and tell me, that she'd done well.

...it just must have been, just, tying it off.

Yeah, this is..." I've done all the hard work, um, I've got myself away from school, I've started day care, I've got my relationships back with my kids". ..and all this is important...but so to is the acknowledgment from someone who meant something in our life...which presumably for me was her. [there is a transposition here that I don't think David intended].

...the reason why I thought of her was that she actually rang up this morning...some six, eight years later to refer a daughter of hers who has a difficult alcohol problem and she sung my praises to the person on call (laughs).

And it was interesting 'cause I was, I was thinking about um Gwen just this morning and over the weekend and it was just interesting that she had also rung up today.
SUMMARY

David being with Gwen

David remembered this encounter because it was the first time he moved from, 
"...just collecting information... and, and and assessment...to actually...it meant 
something, like what you had in front of you suddenly created an impression". 
Previously David had been concerned with gathering data, doing the mental 
status examination and getting, "...it all right for the, the consultant and the team 
so I didn't look like a dill."

It is likely that up until the meeting with Gwen, David's being-with patients was 
characterised by an objectification of the patient into the object of data source, in 
which case David wasn't really with the patient in an existential sense. David 
implied that this situation was far from satisfactory or satisfying. This being the 
case, David's first move away from pure data collection to a more open 
interaction would be memorable.

At David's first meeting with Gwen, David was his usual data collecting self but it 
didn't take long for him to notice Gwen's anger,

I started getting the details and she was really hesitant, she, she wasn't just 
hesitant she was actually angry. She was clipped in her responses and quite 
sharp...her eye contact, from what I, from what I can recollect, was over
direct. So she wasn’t avoiding my eye contact, it wasn’t pleasant. There was, there was hostility or tension coming off this lady.

Gwen’s hostility was the catalyst for a major change in David’s approach. David moved from a nurse collecting data and trying to “get it right” to a care-full being-in-the-world-with Gwen. Gwen’s Being had intruded in a way that could no longer be ignored. David’s priorities change from developing a good treatment plan to helping Gwen, “...if I keep interviewing this lady I’ll get all the questions, I’ll get her diagnosis right, I’ll have a wonderful treatment plan I’ll, but she’ll never come back...” David was now in the world with Gwen.

David now made a conscious effort to listen to Gwen and to convey that to her. He closed his note pad and sat in the arm chair opposite. I suspect that this was as much aimed at concentrating his mind on what Gwen was saying as it was aimed at reassuring Gwen that he was listening and interested. Either way I think it took courage.

I wasn’t confident but I, I knew that this was, this is what I need to do so I sort of had this sense of...um I need to do it but I was unsure because for me to, sort of, move away from that initial contact of being, um..asking the questions or directing, through to sitting straight down from her and making that conscious decision, was very difficult.

But unfortunately Gwen was not assuaged by that. David now took the next step, he encouraged Gwen to talk about her anger. Gwen was angry about being, as she
saw it, sloughed off by her private psychiatrist onto the "public system." David did not try to convince her otherwise, partly out of fear, "I felt she wanted a fight, and um being incredibly fearful of um, school teachers I didn’t want a fight with her." He wisely side stepped all of Gwen’s other attempts to fight with him and instead helped her explore her anger. David managed to be with Gwen to the extent that he recognised how she felt, realised her anger was not directed personally at him but that he was its object at the present. He then helped Gwen come to that realisation herself.

David moved away from an objectification of the patient to recognising a shared humanity through being with Gwen as another human being-in-the-world. What was happening with Gwen was there to see if David would but look. Up until then he had been blinded by the data.

It was the first time I could say I don’t need to get all the information ‘cause I can make a judgement right in front of me about who this person is, what I need to do...and that they’re, they’re safe [not suicidal or likely to harm others] but that they’ve got major problems.

But to understand Gwen was not enough, David needed to be able to help her. There was a happy confluence of his psychotherapy skills, which had been “budding away” being guided by his understanding of Gwen. And the result?

I could actually feel that inside I was beaming, I was like smiling but outside I, well oh God I hope I wasn’t, well in fact I wouldn’t have been
because I'm sure that if I'd smiled or laughed at this lady she would have torn me to bits or thrown me out the window, she was a pretty scary lady. But I had this like um, you feel warm and you glow because you think...is what it's about and it's um, it's exciting.

Gwen did come back and entered into three months of five day a week group and individual psychotherapy. For David the encounter didn’t end there. Some years later Gwen “tracked down” David through David’s uncle. Gwen had opened a day care centre for children. David saw this as a major departure from the school ma’am he met that first day. He felt that Gwen was contacting him to thank him.

The shared humanity of the encounter comes through here even though David’s initial reaction to Gwen’s call was to see the situation in terms of what we might call the psychiatric gaze: “part of me said well, if she had that need [to re-contact] maybe she’s unwell again.” David makes an accidental transposition that perhaps more clearly expresses the importance of endings in human, rather than clinical, terms. He says...“and all this is important...but so to is the acknowledgment from someone who meant something in our life...which presumably for me was her (My emphasis).” Later he says, “And I think, you know, that’s...perfectly natural and OK...to feel like somebody’s been significant in your life and thank them for it.” Gwen had been significant in David’s life as well as he being significant in hers. This is the shared humanity of the encounter and perhaps part of its enduring significance.
DAVID AND JIM.
In conversation with David he talked generally about the "balancing act" between being "objective" with a client to the point of being impersonal and becoming over involved. Even though he is "conservative" in his views he thinks there is something to be said for the notion of intuition. He went on to tell of his encounter with Jim.

I can recall this event myself. Being a nurse educator I had regular contact with David. He and I would sometimes run mock group therapy sessions for students. When he had a student placed in his area I would be a regular visitor. I recall the concern and worry the staff had for David following Jim’s suicide.

And I’m a very, as I said, a very conservative person and if someone came to me and said “look this doesn’t feel right” I’d say to them “go away, you need to be clear about it”, but I mean I’m...time and time again made aware that, that a feeling just makes me prickle, you know.

I had a client who, probably six months ago...I’d only seen him once, he had a very difficult history, and I got a phone call from his place of work and he [the client’s employer] said, “look Joe Blow hasn’t turned up to work today um, I haven’t seen him, when did you see him?”, and he hadn’t kept an appointment with me the previous Friday.

None of that was odd, I get those phone calls all the time, I have people who don’t turn up and see me, in fact this fellow hadn’t turned up to see me on two, on two previous occasions but then had walked in a day later,
made another appointment or I saw him or whatever, so that none of those things in themselves were significant. I just had this feeling.

David had never had a patient with who he was working suicide and had no prior experience to help him deal with the situation.

But when his boss rang I just put the phone down, turned to the student and said, “You want to come for a home visit?” and she said “yeah” and she said “where” and I said, “To see a dead body” and she said “what do you mean” and I said “oh it’s alright” so, [we] jumped in the car and drove around and he was, he was dead in the house.

This fellow had overdosed and had been there two or three days. (pause) And um,....when I said to the student “oh to see a dead body” , part of me was saying...you say silly things like that, you know it’s just like it crosses through your head, you say really dumb things all the time. But then part of me was um,...part of me was saying that that was a real...thing.

When David got to the house there was no answer but he could smell that Jim was dead and had been for some days. He rang the police who opened the house.

I, I, I’d seen him twice I think and I couldn’t recognise him, I wasn’t prepared to ID the body, it was bloated, it was a..terrible sight. (pause)

Um...and I just had that sense, it was, it was really difficult ‘cause I’d never
actually had anyone who had suiciided...suiciided in that way. I'm sure I've had people of mine, that I've looked after, who've, who've you know, turned up two years later in the paper and you say "Oh they're dead" but they've been looked after by some other service or left town or something.

So how did the death of Jim affect David?

..Um.....(long pause) it was a, it was a difficult time because, I mean, he, he's dead, so, he'd died and first of all I couldn't actually be sure it was him. So all these things go through your head about um, about what if it isn't him? Is it some sinister plot. He was sharing [the flat] with some other people.

But one of the...I'd done all the interviews and handed all the statements into the police and these sorts of things,... that you all of a sudden start thinking about... [is] "what did I do that I could have done differently?" "I mean that's as crude as..." God I've, I've missed something" on the way through the..I mean, I didn't know that he was all that particularly suicidal, umm and certainly the stuff in the house showed that he was psychotic and religiously preoccupied and he'd not, he'd not mentioned any of that to me.

He had copious posters and writings in the place that talked about him saving the world and being God's son and saviour of the earth and really bizarre stuff, and ah he'd not said any of that to myself...or his private
psychiatrist and um Alan [another psychiatrist] had seen him as well.

Yeah it really played on my mind, I mean it got to the stage were I would constantly repeat a summary of the case over in my head like ..” a twenty eight year old single male um.. recently finding work in [mentions name of city] at [name of business] he was six-one.” It's something I practice on everyone which is sort of age, date, diagnosis, treatment plan and referral source and the reason.... I just had this going over in my head all the time. So I'd actually moved away after a period of time, so I'd actually stopped saying to myself, “Did I do the right thing or not?”, to just replaying it through my head. Yeah it was a very weird experience.
David being in the world with Jim

The question had been put to David "Can you think of an encounter with a patient which stands out for you, can you tell me about it?" In reply David told me about Jim, an encounter in which Jim was absent most of the time. In fact David does not even describe the last time he saw Jim alive. Does this then mean that this "encounter" should be deleted from the study on the grounds that it is not representative of the phenomenon? I must admit I did entertain the idea. However, on reflection, I now believe that David’s story does say something about Being a psychiatric nurse in the nurse-patient encounter. Patients do not have to be physically present for nurses to be with them.

David was with Jim when he made the leap from the actual to the possible, when his "intuition" told him that Jim was dead. Jim will also be with David each time he assesses a patient. David will be looking for a way of understanding what he believes he had missed with Jim. But perhaps by the very fact that David understood that Jim must be dead indicates that he actually understood more about Jim than he realised.
CHAPTER SEVEN

BEING A PSYCHIATRIC NURSE IN THE NURSE PATIENT ENCOUNTER
A person becomes a person in the encounter with other persons and in no other way (Secord and Backman, 1964, quoted by Watson, 1985:23).

**BEING A PSYCHIATRIC NURSE IN THE NURSE PATIENT ENCOUNTER**

**Introduction**

Some of the encounters described in Chapter 6 are dramatic, unusual and interesting. Others appear mundane, everyday and ordinary. Yet if the detail of these encounters is stripped away what is left is people trying to understand and help each other.

As I read and re-read these stories certain elements of what it is to be with patients began to emerge. Some of these elements appeared in only one encounter, whilst others appeared in many encounters but perhaps in various guises. The elements I have called existentials and the guises I have called modes.

**Summary of Existentials and Horizons**

**Existentials**

The three existentials and two horizons that have emerged from the data are the existentials of; Being with as Understanding, Being with as Possibility and Being
with as Care-full Concern, and the horizons of Being with in Time, and Being with in the World. The existentials also contain modes of Being which "actualise" them (to borrow Bev Taylor’s term).

**Being with as Understanding**

Being with as Understanding includes the modes of understanding:

- Being with as Immediate Understanding
- Being with as Intuition.

Understanding, in the sense that it is meant here, is not seen as the end outcome of a conscious cognitive process but something that arises out of our essential and shared humanity, which is a way of Being in the world with one another.

**Being with as Possibility**

Possibility appears to be the uncovering of the future in the present and a striving towards such a future. Sometimes possibility is a shared view of the future and at times it is apprehended by only one of the parties. For nurses it would appear to be a way of Being with patients that directs the nurses efforts towards a future goal.
Being with as Care-full Concern

By care-full concern I mean that nurses are concerned with and for, patients. Such concern however, is imbued with caring, that is; it is full of care. The encounters uncovered many modes of Being With as Care-full Concern;

- Being with as being motherly
- Being with as listening
- Being with as being truthful
- Being with as accepting
- Being with as self doubt
- Being with as being practical
- Being with as being observant

- Being with as being emotional, including;
  - Being hurt, feeling powerless, being frustrated and angry
  - Being anxious
  - Being excited
  - Being sad
  - Being with as warm feelings

- Being with as controlling, including;
  - Being determined
  - Being with as object
  - Being with as being in control
Being with other staff

Being with for the sake of

Being with other staff

Being with staff as “we” and “I”

Being with as being angry for the sake of

Being with as being sensitive

Horizons

The two horizons appear to be the ground upon which Being with the patient is played out. These horizons lend more meaning to Being with in that they contextualise the experience of these nurses.

Being with in Time

It became evident that the nurses did not experience the temporality of Being with patients in a time linear fashion. The encounter was seen as a temporal whole regardless of how long this encounter lasted in linear time. Also, to some extent the encounter or Being with a patient did not restrict itself to the actuality of physical Being with. Much of David’s encounter with Jim was Being with in the absence of Jim. Being with in time includes;

Being with in absence

Being with in endings
Being in the World

The world in this sense is the shared world of the hospital and situations in which the encounter took place, such as ICA.

- Being in familiar and foreign territory
- Being isolated
- Being thrown
- Being within a shared social environment.
EXISTENTIALS

BEING WITH AS UNDERSTANDING

It seems to be that we are less likely to see that to which we are closest. So it was that the simplest element of these nurses Being with patients nearly escaped me. Even when it presented itself to me I nearly dismissed it as too basic to be of consequence. However, from an ontological point of view anything which speaks of what it is to Be is important. The element of Being with to which I am referring is understanding.

Being with as Immediate Understanding

It was in Julie’s encounter with Robyn that I first glimpsed this mode of Being. It wasn’t what Julie said that initially alerted me but the way she said it. She did not hesitate in her telling of the encounter, she did not cognitively interpret, I got the impression she knew immediately what Robyn meant when she said to Julie “Hey Jul, thanks.” It, according to Julie, “said heaps and heaps.” Julie didn’t explain what these “heaps and heaps” were, she didn’t have to. After listening to her story I knew. If I were to go back and ask Julie what it was that these three words meant she could, no doubt, articulate it, that is, bring her intellect to bare upon it. That is not what I believe happened in the moment. In the moment the meaning was grasped immediately.
Similarly, Julie saw Robyn curled up and helpless with nothing of the old Robyn left and it was "horrible." Again this was grasped in the moment. At first glance she understood that Robyn was in anguish. Later Julie said she felt Robyn's distress. It is evident that she meant this literally.

I felt really ....I almost felt some of her distress, you know I felt some of her.....her fear I guess, and I, I did and I sat there and I thought what, what it would be like to be in that situation where you....I felt she genuinely could not remember...what she had done or not done the, the previous night...

Taking the sequence of events described by Julie at face value, Julie first felt some of Robyn's fear and then thought what it would be like to be unable to remember. It was only on feeling this that she then contemplated why. That this was the case, points to a foreground of meaning which was grasped in advance.

A degree of immediate understanding is of course necessary to be able to comprehend each other at all but I think there is little doubt that such understanding as described above is, to borrow Heidegger's expression, "more primordial". There is the strong impression all the way through Julie's encounter with Robyn of an understanding that was, first and foremost, that of one being with, for another.

This immediate understanding was not only uncovered in the encounter between Julie and Robyn but revealed itself in slightly different ways in the
encounters between Vic and Kerry, David and Gwen, David and Jim and Lyn and Edna.

Vic sat beside Kerry’s bed and wondered what to do, how to approach the situation. He was convinced that Kerry could be helped, he wanted to help despite this “loathsome, horrible” act she had performed. Despite the time he spent beside her bed pondering what to do when she awoke, his eventual strategy was based on “pure gut belief.” He understood what had to be done. I am not suggesting that we, as human beings, possess some infallible agency which, if we will but heed it, will guide our actions, but that our being with patients is often characterised by an understanding which is a priori to conscious cognitive reflection. At times this can bring us in touch with our shared humanity, our shared Being in the world.

Sometimes this immediate understanding gets covered over by tasks. The consequence can be to lose sight of what the encounter with the patient is actually for. As discussed later, David’s encounter with Gwen commenced as a task orientated activity. The task was to collect data in order to make an appropriate diagnosis so as not to look like a “dill” in front of the consultant. Gwen didn’t change during the encounter but David did. He began to heed Gwen rather than just hear her. He went from seeing Gwen as a data filled object to another being in the world who not only could be understood but needed to be understood. "well, If I'm going to keep this lady I'm gonna have to...I'm going to have to...talk to her".
Being with as intuition

Similarly, it would appear that David’s immediate understanding of Jim had been covered up and later manifested itself as what David calls “intuition.” How can sense be made of “intuition” in this case. By intuition is meant “the power of obtaining direct knowledge without evident rational thought and the drawing of conclusions from the evidence available.” (Penguin English Dictionary). The evidence of Jim’s suicidal ideation was not present in the way that evidence is normally taken to be present in an empirical sense, that is, direct verbalisations of suicidal intention, veiled threats, or the giving away of possessions. This was what David was looking for in repeating the details of the case over and over in his mind, “God I’ve, I’ve missed something.” But it may be that the evidence was there in an ontological sense, in the way we each understand the other, by direct and immediate apprehension. It was significant that David, whose work load was such that often his case notes had been brief or had been written up days after sessions with patients, had nevertheless “Been on the ball” with Jim.

...I’d done some things that I probably wouldn’t do in an average case, and things like I’d um, I rung Alan [psychiatrist] and talked to him about my impressions from the case, and I documented them all in the file...just little things that, you probably do, but, you’re not always on the ball, you know they might take a couple of days to write up, or you don’t necessarily write the doctor’s answer verbatim, you just sort of, “I spoke to Doctor so and so and continue treatment plan,” or something like that, but for some reason when I look back through the file, I’d been on the ball, which was
particularly difficult for me at that time 'cos I'd been carrying both the team leaders job and my CNC job, and I'd been saying to everyone that I wasn't doing either job particularly well, therefore the quality of what I was putting out in both areas wasn't particularly good, and that people could make reasonable criticisms about my file notations and the legibility of it, [and] the fact that I wasn't writing in some of them...[but in relation to Jim's case] if I'd been at all slack with any of my recording or with the following through of the home visit, or maybe if that employer hadn't rung...[or if David had said] "well that's all right, um but no, I've got some interviews to do for staff this afternoon, I'll go out tomorrow or something," then it would have been really difficult...for me to justify. But I'd, I'd, I'd given it the urgency it needed. Within the whole sort of mess, the chaos that was going on, it was the one sort of thing that I'd done right. And it made me really scared, I really thought...I could have been basically held up by the balls and crucified over this if I'd got it wrong...if you touch the ball you're in the game, that's all there is too it.

It may well be that this direct apprehension gets covered up by an overly empirical way of dealing with each other. Such direct apprehension, when it is uncovered, manifests itself as the sort of revelation that is called intuition. What is perhaps being revealed in intuition is the immediate understanding of one being for another without which all human intercourse would cease and we would all become isolated subjects in a world of objects, unable to understand or communicate with each other.
Understanding is also developed over time through being with one another. Lyn understood Edna’s need to keep her relationship with her tenants despite the fact she was “being ripped off.” Lyn’s understanding of this situation led her to sensitively find a practical, creative solution.

Summary

Humans have the capacity to understand each other. This understanding can present itself as a priori understanding based in shared humanity or be developed over time as the nurse comes to know and understand more of the shared humanity and life world of the patient.

BEING WITH AS POSSIBILITY

The mode of being with as possibility first became visible through the encounters of Vic, Jean and Judy. Vic made the following comment about Kerrie,

...this is, this is somebody who, who has done something really horrible but, potentially, can be helped and can have some form of life afterwards if everything is done properly for her.

Similarly Jean, before her efforts were thwarted by the intervention of the doctor, felt she was, “...starting to get somewhere...there was a little tiny bit of trust
sneaking through”. The development of trust was a possibility. Finally Judy, in commenting on John’s abuse of her for “prolonging my agony”, says,

...if someone’s really depressed and they’re not showing any emotions, you think, well, you’ve got nothing to work with, but when you see someone with some of that intense sort of feeling you think, well, “how depressed are they, what really is the problem?”

John’s recovery then became a real possibility to Judy.

The potential that nurses can see that points to the possible, can direct their purposeful action. Because they can see the possibility of something positive there must also exist the possibility of something negative occurring. In the encounter with Kerrie, Vic projects a possible negative outcome for Kerrie being, “...she could to this day possibly be in, you know, a locked female ward somewhere as the baby killer.” The actions of the nurse, therefore, may be directed at stopping such a negative eventually or bringing about a positive eventually. The encounter that brought this to light was the encounter of Vic and Kerrie.

Vic saw the future in terms of possibilities for both himself and Kerrie. Kerrie, he believed, had the potential to regress and retreat into a psychotic state in order to avoid facing the horrible thing she had done. Likewise, Vic had the potential to let this happen,
I had doubts about whether I might retreat into an easy sort of conversational approach based on, on trivia and not actually focusing upon the events that had led to her admission, whether I would sort of choose to just, ah avoid the issue, just out of fear of my own ability to handle what might come out.

He feared that other nurses will do the same thing,

...people will go into ICA, they’ll take their magazine or book or whatever, they’ll avoid contact with her, they’ll sit their chair in the far corner of the room, they won’t want to talk about it, that’ll be more comfortable for everybody.

Vic chose to act in a way that he believed would bring about the possibility of a positive outcome for Kerrie and for himself. He confronted Kerrie and in so doing he also confronted his own fear that he wouldn’t be able to "...handle what might come out".

The efforts of these nurses were based on the apprehension of possibility, of a future dwelling in the present. It seems that this "possibility" applied to themselves as well as to the patient; there was the possibility of a positive outcome for both the nurse and the patient.

With this point in mind it becomes apparent that all the nurses in the study were purposefully engaged with the patient in the encounter and such purposefulness
points to an apprehension of the possible. Jean was engaged building rapport, Vic was engaged in eliciting emotional expression, Judy was engaged in a war of wills over a number of issues, John was engaged in logical argument, Lyn was engaged in assessing and David was engaged in maintaining engagement with Gwen and searching for what he missed with Jim. All this purposeful activity was aimed at striving towards, with and on behalf of, the patient. This should not be dismissed as some vague hope about the patient’s unforeseeable future, as in, “wouldn’t it be nice if...” Rather, possibility is sometimes striven for, and fought for, and its denial or thwarting is as much a blow to the nurse as to the patient. Vic, so passionate in his striving for Kerrie. Judy, tenaciously going about trying to make John live. Julie, willing to be seen as “over-involved” with Robyn (and over-involvement in the culture of psychiatric nursing is anathema).

The fact that the nurse was engaged with the patient with a purpose means that the nurse was operating in terms of the possible and therefore in terms of a future that has yet to be. This future was being projected by the nurse. What is meant by this seeming contradiction is that the nurse has understood the possible and therefore the future and projected this into the here and now in an effort to realise this possibility.

The nurse is operating now for the sake of something that is not yet but can become. Sometimes there was a more or less thought out plan, such as was seen as John tried to “talk down” Tony. At other times the nurse projected possibilities for the patient in a more primordial way, to ease suffering, to build
rapport, in the moment. But in each case the nurse had a projected an image of what was possible.

Understanding is necessary to do this, though this understanding may in fact turn out to be misunderstanding as in the encounter between Judy and John. Possibility stems from an understanding which is embedded in the nurse’s Being in the world with.

Interestingly, this projection of future possibilities cannot be one sided. If the nurse is working with the patient to bring about the possible then that projected future also relates to them. Vic for example saw himself as being instrumental in Kerrie’s recovery, before Kerrie recovered. To stop Kerrie being hurt by the system, as he had been, was to triumph over it to some extent, a system with which he was angry. The achievement of, or failure to achieve, a projected possibility affects the nurse in terms of feelings of accomplishment or failure as can be seen in the feelings expressed by all the nurses in the study.

Summary
Possibility is apprehended by the nurse in the encounter with the patient. It would appear that possibility is the projection of a future into the present and relates to both the being in the world of the patient and the nurse. The projection of viable future possibility is linked to being with as understanding.
All nurses are in the world with patients and exist for the sake of patients. To be a nurse is to be with patients. Even the physical being without patients does not take away the basic fact that all nurses are with patients. The nurse administrator, who may not often nurse a patient, still exists for the sake of patients and is with patients, however physically distant. Being a nurse presupposes someone to care for and be concerned about. All the nurses in this study expressed a concern for patients through various modes of Being with patients.

The existential of Being with as Care-full Concern presented itself in a variety of ways. Again it was an existential that did not draw attention to itself. After all wanting to help, and just basically caring are all things we like to think we do. That of course is precisely the point, they are ordinary things which tell something essential about being with patients and should not be dismissed for their ordinariness.

**Being with as Being motherly**

Being motherly as a mode of careful concern presented itself in the stories of Judy and Jean. For Judy it was a feeling in response to the awful state of John who was little more than a walking skeleton.
Oh well it was horror at first, like, how can anyone look so bad, but like feelings of probably motherliness if anything. That feeling of “come here I want to look after you”, you know, “look at the state you’re in, come on let’s, let’s help you, let’s, you know, try and fix a few things up here”. That was the immediate emotion for me, I was sort of thinking, “you poor thing come here”, like the TLC side of things I guess...

For Judy the experience of motherliness was a reaching out to another. Recognising their plight and wanting to help. “I want to look after you” generally means to take away care and concern, to take on responsibility on behalf of another, “to fix a few things up.”

For Jean the experience was somewhat different.

I think I’m of the age now, and why this sticks in my um, mind I think was because I was feeling very motherly I suppose, I was using that sort of motherly..thing, and thinking this could be my daughter and she’s, you know, she’s had a really tough upbringing, she trusts nobody and um...Yeah I was feeling very protective towards her.

For Jean being motherly was being protective, tapping into her own experience of being a mother and identifying Tracey with her own daughter.

The desire to protect was also an experience that Julie had with Robyn, although she doesn’t mention feeling motherly.
...you couldn’t protect her, you could not protect her, you know as much as you would have liked to...

Being motherly can mean taking care and responsibility for another and being protective. Judy, Jean and Julie were tapping into their rich resources of shared human Being to respond to another, the care of and concern for another human being was an issue for them.

**Being with as listening**

What is meant by “listening” is not the act of hearing but rather of attending and being attentive. Listening presented itself in Vic’s encounter with Kerrie. Listening was one of the purposeful actions to come out of his being with possibility with Kerrie. He listened in order to convey information to other staff as well as to understand. In so doing he exposed his care.

...this [situation] was something which stung me into actually trying to develop a relationship with somebody, actually trying to ah, ah,...make descriptions of er what was going on into the clinical file that would be of maximum benefit to the patient. To convey as much information as I could to assist the person following on after me, to ah, to ah, slot in and take over...pick up on the theme and try and get this woman to um... to come to terms with what she’d done.
Vic listened so intently that he could later find the actual biblical references Kerrie was quoting. But his attentiveness to Kerrie’s vivid descriptions had the effect of transporting him to the time and place of the attempted “sacrifice” of her child.

[Kerrie’s] descriptions of it [the mutilation of her child] were that...were that vivid it was almost like you were witnessing it, I’m sure, you know, like your emotional reactions were like you were actually seeing this poor mutilated child, you know, with its throat slashed.

Listening has its price which is perhaps why Vic believed the other nurses would read their magazines; they would sit in the room with Kerrie but not be with her. Listening was for Vic part of Being with.

Listening also presented itself in the encounter between Julie and Robyn. Again this illustrates listening as a way of Being with patients in care-full concern. Julie felt frustrated that she could not tell Robyn all would be well, she couldn’t tell her that she had nothing to do with the death of the other patient. But what she could do was listen attentively and through this listening Be with Robyn despite the abuse that Robyn was hurling at her.

...there was not much over that two day period that I could say...that I was...do you know when you walk away from something and you feel, maybe that you’ve been of some assistance to somebody?...I just felt that there was
nothing I could do for her, other than just be there and listen, no matter what she was saying back to me.

This points to an capacity for caring and also for understanding, understanding that she was the object of Robyn’s anger because she was there, not because she was Julie. Robyn needed someone to maintain engagement with her despite her behaviour. And was this active Being with through listening enough? Yes it was.

when she had um, come out of ICA and it had all settled down and she’d been cleared and all the rest of it and then she did speak to me and she spoke to one other nurse as well...and sort of...was very, very grateful that we had listened to her and had sat with her and she was very full of apologies for being so cranky and screaming and, and so difficult to get along with in that, in that period of time...So I guess maybe it was beneficial to her.

The contrast between hearing and listening is brought to light in David’s encounter with Gwen. David began the encounter with Gwen by asking questions and listening for an answer. This type of listening is merely hearing in that what is heard is an answer to the questions posed. What counts as an adequate response has been prescribed before hand by the question. Hence we are likely to hear what we expect to hear or dismiss what we do not expect to hear. The person as a whole is not being listened to. For David the consequence was,
...if I keep interviewing this lady I'll get all the questions, I'll get her diagnosis right, I'll have a wonderful treatment plan ... but she'll never come back...

So David closed his file, sat in the arm chair opposite Gwen and listened. And Gwen did come back.

Obviously all the nurses in the study listened to patients but not in so explicit a way as that described by Julie, Vic and David. The type of listening they described is an attentive listening which presupposes an understanding which points to this kind of listening as an action to bring about a envisaged possibility. It is listening with understanding. It stems from, and is based upon, understanding. If it were not so Vic would not have been transported by his listening and Julie would not have foreseen listening as a necessary and sufficient action to keep herself and Robyn engaged during a difficult encounter. Perhaps the following quote from Heidegger sums it up, 'Only he who already understands can listen' (1962:208).

**Being with as being truthful**

This mode of being with only explicitly presented itself in one encounter, that is, Julie and Robyn. Robyn in her distress repeatedly asked Julie to give her reassurance, false reassurance, that she had done nothing to the other patient.
"Julie I'm scared...I'm scared, tell me I didn't do th...tell me I didn't do anything to him". ...you know, "I'm scared" was something that was repeated many, many times.

Despite the fact that it would have been easy to give false reassurance that would possibly have calmed the situation for a time, Julie remained truthful.

I certainly told her that I couldn't tell her that she hadn't done anything to that other particular patient.

Such truth telling was painful because it meant a continuation of Robyn's suffering. "I certainly told her I couldn't, I couldn't um predict what was going to be ahead for her. Yeah, it was awful you know..." The fact that this was painful to Julie, gives an indication of the care and concern that Julie felt for Robyn. Perhaps this hurt was compounded by the fact that despite this steadfast refusal to give false reassurance Robyn, in her anger, later accused Julie of just that.

Yeah I told you so and you sort of lied to me and said that oh, oh, It'd be OK" , which is not what I said to her at all but, you know...

Being with as accepting

Being with as accepting shows a concern for and a caring about patients regardless of their behaviour. Being with patients means Being with strange, violent and sometimes unpredictable behaviour. Despite this, Being with patients for many
of these nurses is characterised by a ready acceptance of the patient that is most clearly presented in the stories of Jean, Vic, Julie, John and Lyn. There is a clear separation between the Being of the patient and the patient’s behaviour. (with the exception of Judy).

John, in his encounter with Tony was confronted by a man masturbating and trying to hurt nurses and patients. Nevertheless John reassures Tony afterwards that even though his behaviour had been unacceptable and the nurses had to restrain him, John, “...hoped that this didn’t impair the relationship between him [Tony] and the nursing staff”.

This attitude seems to imply that the value of the patient is seen as independent of her\his behaviour. Being with as accepting is also seen in Vic’s encounter with Kerrie. Vic found the behaviour of Kerrie (and even listening to Kerrie describe the events with her child), horrifying and loathsome.

...it was ah, horrifying and loathsome, it was a loathsome sort of...ha..it was...a novelist would describe it you know, like having a, an, aura of evil or, or something of that nature. It was almost like that, it was like, it was er... although the woman’s intentions clearly weren’t....this woman clearly wasn’t motivated by any evil, she was motivated by an absolute, confusion.

Vic saw Kerrie’s behaviour as “...a terrible event, an event that sort of is beyond comprehension...” yet he accepted Kerrie as someone deserving the very best of care and he strove to give her such care.
Similarly Julie accepted Robyn despite her aggressive and sometimes violent behaviour, including the possibility that she may have been involved in the death of another patient. Other staff however did not necessarily feel the same way.

...you know there was just that air of, “she probably did it, she probably did do something”. ...and I found that very difficult to deal with like, psych illness or no psych illness..it was, there was just that underlying.....I don’t know Ken...it was almost a, “Well you know, that’s what you get, when you’re that screwed up...Well, she could have done it, she’s so rough, she’s so this, she’s so that, wouldn’t put it past her”.

Nor did all the nurses in this study show acceptance of patients regardless of their behaviour. Judy gives a very good description of her angry feelings after John’s suicide.

How dare you, again then because now that you ah, you haven’t [have] sort of left us feeling like we’ve done nothing, look what you’ve done, the ultimate, the ultimate sort of like self-centred act, you went and took your life when all those people who still loved and cared for you, even though we didn’t see them at the time, were all there and very affected by it.

Paradoxically it is very clear that Judy cared for John. Perhaps that care can be measured by the strength of her anger.
A clue to the acceptance, or otherwise, of patients may be found in a comment John made when I asked how he could still accept Tony despite his behaviour [Tony suffered from schizophrenia]. John said;

I suppose I, I figure...that people with personality disorders have more control over their lives and more control...as to the circumstances and, and the direction that their life can take. And I think people with schizophrenia have a lot less say in the, the direction of their life and are more or less ah, motivated and guided by their, by their, their, their gross disability than....their...the word escapes me. But basically ah....their not as responsible for their actions.

John also suggested that strange behaviour, even violent behaviour, behaviour which is extraordinary is very ordinary in some settings. In the medium secure ward in which John works such behaviour as that of Tony’s is not uncommon and is perhaps more readily accepted, even expected.

**Being with as Self-Doubt**

For some of the nurses in this study self-doubt has come to haunt them. For others it emerged during the encounter and was then laid to rest. But for all the nurses it tells something of their experience of being psychiatric nurses and is a measure of their care and concern. It is also an indication that the experience of
Being with patients can be burdensome and takes its toll in terms of emotional pain.

"God I've, I've missed something (David)."

David had only seen Jim twice but when he found Jim dead David was haunted by self doubt. Had he missed something? For days he went over the details of the case in his mind looking for the clue to Jim's suicidal intent that he had perhaps missed. Eventually he was reduced to repeating Jim's details over and over in his head as if they were a mantra. Even now he can repeat them,

...a twenty eight year old single male um... recently finding work in [mentions name of city] at [a service station] he was six-one... so I'd actually stopped saying to myself 'did I do the right thing or not' to just replaying it through my head.

But no amount of pondering could take away the fact that Jim was dead.

I suppose for me it was really difficult, I was really um... really distressed by the death of someone that I knew, so regardless of what my profession or anything was there was a young man, that, that had been failed... that had died.

Similar feelings surfaced in Judy after John's suicide. "Why didn't I see it?"
Even now, a long time after the original encounter, Judy, like David, still ponders.

...and there's just, there's just lots of little comments and they just keep coming back...and the things that were said and it all fits into...the incredible puzzle at the end which still feels very jumbled to me and probably always will but...(pause)...that's life.

"That's life", but her faith in her abilities had been shaken. Were there other patients whom she thought she had understood that she really hadn't?

...in one breath you say you've understood them, and then by the very nature of it you didn't. You know you think you've created a rapport but maybe you didn't really because you didn't have that trust for them to be able to express any kind of thoughts that they were really having, and believe me, everything was so planned, was so planned...[by John], so well planned, yeah, so that's that.

The fact that she did not see the suicide coming indicated to Judy that she hadn't really understood John at all. She wasn't really as close to John as she thought she was and the trust she thought she had earned was to her, a sham. She says she would like to question him, she wants to know and the anger and frustration in her voice is plain, but so too is the self-doubt.

"what is really right and what is really wrong (Vic)."
Vic’s doubt came early in the encounter. He doubted his ability to follow through with his belief that he needed to confront Kerrie about what she had done. He also had doubts that this was actually the correct approach to take in this situation.

*I can remember sort of thinking, you know, what is really right and what is really wrong in that sort of situation and sort of, not having a really good grounding in theory as to how you actually approach a problem like this.*

Eventually though he did confront Kerrie and even though Kerrie recovered remarkably quickly, Vic still has doubts about whether his actions were “right” and if it were those actions which, in the final analysis, made the difference.

*I do wonder whether, ahm, having sort of decided to confront her in that very initial stage was actually ah, ah, the good thing, the right thing to do. I don’t know if that was significant, I like to think it was significant. I like to think that it was the case of a good decision....and it’s always left me wondering...*

**Being with as Being Practical**

This mode of Being with presented itself through the encounter between Lyn and Edna. Lyn ends the story of her encounter with Edna by saying that the reason she found it significant was that she felt she had been of some practical help.
...she was a woman that you could do a lot for, it's significant for me because when I look back, I really feel that we [the team at the clinic] did achieve a great deal with her, and not just psychologically but socially as well.

This practical focus pervades Lyn's encounter with Edna. Being with Edna meant understanding the practical day to day issues of living that impacted upon Edna and her quality of life. It meant using Lyn's knowledge of Edna based on what Edna told her and her own reactions to Edna to bring about changes that she felt would be in Edna's best interests. These changes were often small and sometimes needed to be sensitively handled (the electricity bill), and they didn't always have the desired effect (the earings).

**Being practical** includes; solving the electricity problem, without antagonising the tenants, by connecting the second meter; organising meals on wheels; having the medical officer attend to Edna's ears; cutting Edna's hair thereby improving her hygiene as well as improving her social acceptability; fumigating the house; reviewing Edna's medication which had the effect of improving her mental state and hence her social acceptability. All of these ways of being practical belie a caring and concern which manifests itself through these practical measures.

Being practical as such does not come through strongly in the other stories presented here. However, I suspect that the projection of possibility through an
understanding of needs is a precursor of being practical. Hence a potential for practicality exists in all the encounters.

**Being with as Being observant**

Like listening, which is the attentive attitude of hearing, being observant is an attentive attitude of seeing. Like listening it would appear to be linked to understanding. Once again this mode of Being with presented itself in the encounter between Lyn and Edna.

Much of the background of the practical measures taken by Lyn stemmed from her acute observational abilities. Lyn shows an ability to be absorbed in the situation, even though she was initially anxious and was hoping no one was home. Three things were revealed in her Being with Edna in those first few minutes after meeting her.

Firstly Lyn was able to acutely observe Edna and her environment. Lyn’s being was very much concentrated in the moment, in what presented itself. She was with Edna. It would have been possible to go to visit Edna, discharge her duty of asking Edna to return to the clinic and all the while be thinking of lunch. It was possible to be indifferent rather than concerned. But Lyn was acutely aware of what Edna said and did and from these observations she made meaning. It would seem therefore that being observant is linked to interpretation and hence to meaning and understanding. For example;
she opened up the front door...but she came out of the front door and then shut the door behind her [observation] as though she was actually hiding something, she didn't want me, to see inside [meaning]. ...And she had a galah that was actually on the verandah and she, she talked to me about this galah as well, [observation] but it was obviously, um, she, was obviously her friend basically [meaning]. So that, even in the first encounter she was very, quite talkative and wanted to tell me about the bird, [observation] it was almost like she was happy that someone had come to visit her [meaning]. (The reader can read other instances of thick description quoted in the conversation with Lyn.)

Lyn also used her knowledge of psychiatric illness to make meaning of Edna's behaviour.

Very difficult to understand what she was saying at times and I had to...um, keep clarifying what she was saying 'cause it was difficult to understand - she had a lot of loosening of associations.

Psychiatric jargon can have the effect of covering up the essential humanity of the patient but in this instance Lyn seems to have struck a balance. Her psychiatric observations enabled her to draw some tentative conclusions such as perhaps Edna had not been taking her medication.

Being observant also presented itself in the encounters between Jean and Tracey, Vic and Kerrie, Judy and John, and David and Gwen.
Jean observed Tracey's unease and suspicion. She knew she had to move slowly to build up trust and rapport. The doctor, even though she knew Tracey, failed to observe, failed to see Tracey's body become tense. Jean saw it,

...my gut feeling was straight away that when the doctor sat down beside the girl you could see her body language, was, you know, her space had been invaded. (Ken: So really tense?)

Really tense, yeah, and um, and she was starting to get really defensive, and, and er, the doctor started sort of lecturing to her like, you don't, you're not going to get anything from me until you do what I want, you do these certain behaviours. And with that the girl just really laid into her, just laid into her, [kicking and punching] you know...I could see it all happening with the body language, the tensing up, and hearing the verbs from the doctor I think ah, my goodness, you know, but I was really still shocked when she actually physically assaulted her.

The meaning of Tracey's body language was "keep away" but in order to make that interpretation one first had to observe what was there to be seen. Vic also observed what was there to be seen and from this made meaning.

She, she herself displayed the, the best example that I have ever seen of the symptom of perplexity. She was just utterly perplexed. She knew she had done something horrific yet she knew it was right, but she couldn't
reconcile what she had done, yet she knew it had to be right because it was, it was God's plan that this be done.

Julie observed Robyn and through her observations came to the inescapable conclusion that Robyn genuinely could not remember the events of that night. Other staff doubted this but they did not see what Julie saw. They did not see the way she touched her hair, the expression on her face.

she was sort of touching herself, touching the mud on her shoes and touching her hair and, and not under...not having a clue why there was mud in her hair and why she'd been wet and why her shoes were muddy and all those sorts of things.

David gave another example of being observant,

I started getting the details and she [Gwen] was really hesitant, she, she wasn't just hesitant she was actually angry. she was clipped in her responses and quite sharp....umm, can't quite remember but her eye contact, from what I, from what I can rec, recollect was over direct so she wasn't avoiding my eye contact, it wasn't pleasant, there was, there was hostility or tension coming off this lady.

Nurses are proximally alongside patients and have the opportunity to observe patients and draw conclusions from these observations. But nurses are alongside patients in terms of meaning making also. Observation does not lead to
psychiatric formulations which then lead to understanding but rather observation leads to understanding which is then elaborated upon or converted into psychiatric formulations. Vic did not observe the psychiatric symptom of perplexity, rather he understood, grasped in advance (through his Being with as observation), Kerrie’s confusion. This was then translated into the psychiatric term “perplexity”. Similarly, Lyn did not observe “loosening of associations” she observed that she could not understand Edna, she felt confused. This was then translated into the psychiatric term “loosening of associations”. In the words of Michael Gelven, ‘…interpretation makes explicit what is already in the range of human awareness… My existence precedes my knowing of it’ (Gelven, 1989:93-94).

Being with as being emotional

All of the nurses in this study have been affected by their encounters with patients. All of them told of their experiences with feeling. For Jean the encounter with Tracey has left feelings of anger (towards the doctor) and regret, for Tracey and for herself, for not being quick enough to prevent the situation. Judy felt a deep sadness and frustration which left her glassy eyed in the telling. Vic still feels wonder, firstly, that Kerrie should recover so quickly and so completely and secondly, he is left wondering if it were he who had made the difference. Julie, told of her encounter with obvious affection for Robyn and a brooding anger towards the other staff whom she felt acted in an uncaring way towards Robyn. John recounts the encounter with Tony with the sort of affection one would feel for a friend who was a bit of a rogue. Lyn holds a deep affection for Edna and I sensed she felt it had been a pleasure and a privilege having known
her. Lastly David tells of Gwen with affection and pride and of Jim with sadness and self recrimination. These emotions endure despite the distance of time but there were emotions which presented themselves during the encounters as well. Each of these emotions tell something of what it is to be with patients.

**Being hurt, feeling powerless, being frustrated and angry.**

In this section a number of feelings will be explored. This is because these feelings stand in a certain relation to each other such that they cannot easily be separated.

Being hurt was a feeling experienced by both Jean and Julie and in similar circumstances. Both Jean and Julie had been building rapport and trust in difficult circumstances when, despite their hard work, that trust was destroyed by the intervention of others.

The trust Jean had been building with Tracey had been destroyed when the doctor intervened. As Tracey was led away to the seclusion room her anger was not only directed at the doctor but also at Jean;

> I felt I was building some rapport and part of the abuse that was hurled at me, “I’ll get you, I’ll kill you” , you know, me, um, all that negative stuff was directed at me as well the other person. [then Tracey said] “I’ll never forget you, I’ll pay you back for this” ...any little bit of rapport that was being developed or maybe that sort of slight tiny little bit of trust that we were there to help her and...she didn’t believe a word of it, I mean she,
didn’t believe a word of it. No she obviously didn’t,...I didn’t get a chance to finish what I’d started.

For Julie a similar situation occurred. She had been careful to be truthful but caring with Robyn but when Robyn was told of the death of the other patient and that she would be interviewed by the police, she accused Julie of lying to her.

“Yeah I told you so and you sort of lied to me and said that oh, oh, It’d be OK” , which is not what I said to her at all but, you know and, “and how would you feel and what would you know” , and “you don’t know what it feels like and I’m just a schizophrenic and, and, and you know I’m an alcoholic and” , and I’m a this and I’m a that and, yeah. She was just really angry, really angry...she didn’t say a whole lot more...

Both Jean and Julie were angry with the other staff whom they felt had been instrumental in damaging the good work that they had started. Julie, also felt;

Useless, hopeless, absolutely wasting my, you know, wasting everybody’s time....do you know when you walk away from something and you feel, maybe that you’ve been of some assistance to somebody...I just felt that there was nothing I could do for her, other than just be there and listen, no matter what she was saying back to me.

Neither felt angry towards the patient who had abused them. For both these nurses there was a sense that they had in some way let the patient down. Jean
would have liked to have handled the situation better and hence have avoided the negative outcome for both the patient and the inexperienced doctor. Julie seems almost to be prescribing penance for her “uselessness” when she says, “I just felt that there was nothing I could do for her, other than just be there and listen, no matter what she was saying back to me (my emphasis).” In so doing it would appear that she believed that she should be able to help, no matter what the circumstances. This attitude can only stem from a Being in the world with patients that is grounded in a Being with as Care-full Concern. This is highlighted by the fact that Julie felt her inability to help was “inhumane”. Even though nothing in her actions could be construed as inhumane.

This wanting to help and being unable to was frustrating for Julie;

> and just that, you know, just the frustration of not being able to help her...was really incredible, in fact I wondered...at the end of the day really...how much benefit I’d been to her...

Frustration and anger were feelings experienced by Judy also but their source was somewhat different. As has already been seen, Judy’s initial Being with John was characterised by motherliness. However, Judy soon found that her goals and John’s did not coincide. She describes her feelings as going from motherliness to puzzlement and then to anger and frustration as her determination that John should live comes face to face with his determination to die.
it [Judy's feelings] went from “you poor thing, let me look after you” to, “I'm going to succeed here” to “what an earth is wrong with you? Why won't you let me help you” to.......(Ken: Frustration?). Frustration, anger, and (pause) being given a false sense of succeeding, not as I guess we should refer to our patients as “succeeding” because that's not a good word, but it’s actually achieving a goal for them, helping them to achieve a goal, that is to become well or to more well than what they were when we first saw them... do something that's going to help them.

Whereas Julie and Jean were angry with other staff, Judy was angry with John and frustrated by his intransigence. And her anger and frustration continued after his suicide; “How dare you...” Similarly John [the nurse] was also frustrated at his inability to fully make sense of Tony’s behaviour and angered by Tony’s intransigence. When I asked John about his feelings for Tony following Tony’s aggressive behaviour he stated he felt no animosity. However;

there have been times when I've been angry with him...for his sort of, intransigence and sort of stubbornness...and for his actions as well. But ah, overall there's still that warmth there.

So even when these nurses were angry with the patient, that anger still belied a care-full concern, even warmth.

Anger was also expressed by Lyn and Vic and once again seemed to express a care-full concern for the patient. Lyn was angry with Edna’s tenants whom she felt
were “Ripping off” Edna. Vic was angry “at the system” which was geared to help those with chronic illness yet still admitted acutely ill patients to the detriment of both patients and staff.

Being anxious

Anxiety was an emotion experienced by a number of nurses in a variety of situations. Vic’s anxiety stemmed from his doubt about his ability to handle what he knew would prove to be a difficult encounter.

The feelings were... ahm...trepidation I suppose is the best word...I had doubts about my own skills as to how to handle somebody in this sort of predicament.

John’s anxiety was linked to the possibility of personal harm although he says the degree of anxiety was fairly mild, it being ameliorated by the trust he had in the other staff present.

Julie’s anxiety also appears to be linked to the perception of personal harm although this is not explicitly stated.

it was just a strange situation...it was a bit scary to think that I was in there with somebody...that was feeling all those things and it would have been so traumatic.
Robyn was at the time very angry and distressed as well as not fully in touch with reality (Psychotic).

David suffered some anxiety in the face of Gwen’s hostility and in his encounter with Jim, his fear that he could have been “crucified” over Jim’s suicide.

Lyn’s anxiety stemmed from a more nebulous fear of the unknown, of what might be, which, on her first visit to Edna, led her to wish Edna wasn’t at home.

But anyway I went into this house, into the yard, it was a little bit eerie actually...and I knocked on the front door - it really didn’t look as though anyone was home...and I knocked a couple of times, it was quite funny actually I was almost hoping that there’d be no one there (laughs) ’cause I didn’t know what to expect.

It would seem then that the experience of Being with patients is a rich source of anxiety for nurses. These anxieties can stem from self doubt, the projection of the possibility of self harm and the possibility of the unpredictable and unknown.

**Being excited**

But Being with patients can also be pleasurable, even exciting. John’s anxiety has the reward of “A little bit of exhilaration from the adrenaline rush.” This experience is echoed by David;
...you feel warm and you glow because you think this is, ah this is what it's about and it's...exciting and the adrenaline's pumping but there's no danger, it's just pure excitement and...comes out of... being confident...

For David this excitement came after he felt he was “getting it right.” Vic did not have the same confidence in what he was doing, but nevertheless he felt some excitement, although this was mixed with other feelings.

on the one hand it was challenging and demanding and, I suppose, slightly exciting. On the other hand it was, it was ah, horrifying and loathsome,

Encounters with patients can be exciting. Part of that excitement can stem from a sense of challenge. John, David, Judy and Vic all felt the encounters in which they were engaged represented a challenge, a difficult situation to be understood and surmounted. But, as has been seen, for these nurses there were many other emotions as well and as Vic points out, above not all were pleasant.

Being sad

Sadness presented itself most obviously in Jean’s encounter with John. Her sadness at telling the tale was obvious in her glassy eyed countenance. The sadness and confusion and anger attendant upon the death of John persists and seems to be connected to Judy’s self recriminations and self doubt. “Why didn’t I see it?”
A sense of sadness also pervaded Jean’s encounter with Tracey and seems to be linked with the idea that Jean had failed Tracey by not seeing the potential of the situation earlier and intervening. “I would like to have handled the situation differently.”

Julie spoke of sadness but it was a sadness stemming from an appreciation of the situation rather than a sadness within herself such as was the case with Judy and Jean. Robyn was ecstatic after being cleared of any involvement in the death of the other patient but no one else, apart from Julie, seemed to care.

God...you know look at her, she was so relieved, so genuinely relieved but nobody else much gave a, gave a stuff, yeah. It was very sad.

Sadness in these encounters seems to stem from the nurses perceived inadequacies or from an understanding and appreciation of the patients situation. Both indicate a care-full concern for the patient.

This care-full concern is also evident in the warm feelings associated with these encounters.

Being with as warm feelings

The word “warm” is used rather than “positive” or “good” as I do not wish to imply that some of the feelings that have been discussed thus far have been bad or negative. The word is used to convey an uplifting feeling that was evident as I listened and watched these nurses tell of their encounters.
For Vic the encounter with Kerrie left a lasting impression. He felt good in having contributed in a positive way to Kerrie’s recovery, “I sort of felt that there was a really positive contribution...[from Vic].”

For Julie, the warm feeling came from the qualities of Robyn. Julie stared past me smiling as if seeing Robyn again in her mind and said;

Oh she was a great person,...yeah she was great, she was really good. She had lots and lots of problems you know. She had a long, long way to go, long way to go .....but yeah.

John also felt warm towards Tony as is indicated in his summing up of the qualities of Tony that make the encounters with him memorable.

Probably, actually I hadn’t mentioned it, but probably his humour. You know, he used to, used to, used to laugh at what I said occasionally and I’d laugh at what he said. And, and his, and his intelligence I suppose. And I suppose the tragedy of it to some extent. The fact that you can have a intelligent reasonably functioning person in society with a good job, reasonable prospects and suddenly ah, you come to the point where you’re man handling him into ICA, into seclusion.

Tony is seen here as more than the object of patient, he is another being in the world with his own individual qualities and he is appreciated as being so by John.
David mentions that some years after that first interview with Gwen she contacted him again to let him know how her life had changed for the better, she had left teaching and now ran a day care centre for children and enjoyed a better relationship with her own children. It was a way for Gwen to say;

"I've done all the hard work, um, I've got myself away from school, I've started day care, I've got my relationships back with my kids"

The warmth David felt for Gwen was betrayed in a slip of the tongue when he then went on to say;

Yeah, this is.....and all this is important...but so to is the acknowledgment from someone who meant something in our life...which presumably for me was her.

There is little doubt he meant to say "which presumably for her was me" , meaning that Gwen saw David as someone significant in her life. But there is also little doubt that his slip of the tongue was nonetheless true; Gwen was someone significant in David’s life.

Lyn found it easier to feel warm toward Edna because she was so likeable.

Yeah and I think that’s probably because she was such a likeable person. I guess when you work in psychiatry you tend to come across a lot of
patients who are withdrawn and paranoid and suspicious, whereas Edna wasn't like that at all, so I guess it's much easier to develop a more, well, warm...relationship towards her, yeah.

Jean wouldn’t, I think, have described Tracey as likeable. Certainly, like Robyn much of her behaviour was far from likeable. However, there was nevertheless a warmth in the relationship which possibly stemmed from Jean’s view of Tracey as a vulnerable kid; "hell this poor kid, You know, she is only a kid after all."

I’ve puzzled over the encounter between Judy and John. I’m not sure that Judy actually felt “warm” towards John. I can’t say she believed she even made a positive contribution to him. Nevertheless, there is a deep sense of care-full concern which has been mentioned before. It appears that, despite the trauma of the encounter, Judy would nevertheless have wanted to have known John. Once again is seen the ground of Care-full Concern uncovered by the emotions of these nurses. Nevertheless, it does however seem that the encounter with John was very different from say Julie’s encounter with Robyn or Jean’s encounter with Tracey. These differences are explored shortly.

Reading through the encounters described in the previous chapter it appeared that the encounters pointed to two ways in which Care-full Concern can be exercised. In everyday life Care-full concern for those significant to us can be a controlling influence, however well intended, or a force for emancipation. The former may be seen in the overly anxious parents who over protect their child to the point of controlling and stifling the child’s individuality. Or the friend who
takes over the troubles of another with the consequence that the other looses control and becomes dependant. Care-full concern as an emancipating force may be seen in the wise teacher who, through care-full concern, leads the student towards his/her own wisdom and thereby liberates, or the friend who supports temporarily in order that her/his friend maintain control of their life. I have called these modes of Care-full Concern, Being-with-as-controlling and Being-with-for-the-sake-of.

Being with as controlling

Being with as controlling presented itself in a number of ways in the encounters such as Being determined, Being with as object, Being with as being in control and Being with other staff.

Being determined

Judy’s Care-full concern in her encounter with John manifested itself as determination and was expressed by Judy in a number of ways. Judy was determined that John was going to put on weight, was going to live. She wanted to take his cares from him and make it all right.

come here I want to look after you...lets help you, lets, you know, try and fix a few things up here...you poor thing come here.

John, however, was not about to abrogate his cares to anyone. From the beginning of the encounter it became apparent that a battle of wills was emerging between John and the nursing staff, including Judy;
he was far...[more] clever than any of us and the whole time it was a real challenge, everyone was really...oh, very intense...saying we're going to fix this, we're really going to work out what's happening here,

Even the staffs' breaks were taken up talking about John;

so it presented a big challenge and we all sort of were gritting our teeth, and you know, getting right into it....and conversations around cups of tea centred on this person. And it was such an intense thing the whole time.

But eventually John was discharged;

all the opinion was, well it's just like a slap in the face because we've tried really hard, we've tried, and tried, and tried and look, there he goes and he's still really thin and he's still really feisty and not as depressed but knows exactly, you know, what he wants to do and everything just all centred around this one person and we didn't consider anything else....

It wasn't until John's discharge that Judy could see the dangerous game that had developed, a game no one could win.

we had our ways of getting him to take medications as in not forcing him or anything like that, but...[he] insisted that he had vitamin C, so I suppose
it was a bargaining [tool]..." Here's your vitamin C but first here's your Prozac..."

you could see...a little game that probably even then was evolving, well not a game, it was very serious for him obviously...it wasn't...'til very much at the end when he was about to be discharged, that I could see what...was happening...I was able to sit back and say, "Yeah well, you know, you knew me better than I knew you I think."

Then Judy remembered snippets of conversation she had with John, the possibilities for understanding that had past. The next quote is quite lengthy but no words of mine can adequately get across the poignancy of Judy's recollections. Judy had asked John to do something (get dressed or have breakfast or some such thing), in order to fit into the ward routine and John replied;

"No, I'm not used to this, I'd better behave myself hadn't I, I'm used to being the head of the family but here I'm at the bottom of the pile again, aren't I, and now I'm listening to you, I thought I'd gone past all of that." Or similar words to that ,and at the time I thought ;" yeah that's true." I guess we are like that cos I mentioned it to someone else, and I said, "yeah we probably do sound a bit custodial," specially in the mornings when you're trying to get things done "come on, do this, do that" you know, "let's get on the go," and umm, then I thought ,"oh wow,"...because like afterwards, because of the funeral that this person had been the head of the family, had been well respected and well loved and had sat up so high that
everyone had respected them, and then in the midst of the depression or, whatever, he comes into a place, into a hospital and hit the bottom of the pile again, "but don't be, don't be depressed will you." ...we're so contradictory...but that in itself must be very difficult. Then you say, yes you respect their...dignity and let them maintain their dignity but by the very fact of their being here...then...they can't really maintain all of it...can they? Yeah so that really made me think...and there's just, there's just lots of little comments and they just keep coming back...and the things that were said and it all fits into...the incredible puzzle at the end which still feels very jumbled to me and probably always will...

...it [John's death] did leave the imprints on people, not just because the result was...the, the end of a life, but it was afterwards finding out this other whole world that they really were involved in, and that sort of dropped the enormity back on it...[it] changed, changed my opinion of people and of patients...no, [it] didn't change my opinion of patients, it just made me think a little more deeply about other patients...[it made me] consider the whole person, their whole life...we don't really consider...who they really were, "who are you, who are you, yeah." You think you know, but you don't.

The Care-full Concern of Judy and the other staff, manifested as determination “to fix this” situation, covered up the possibility of understanding John until after his suicide.
Being as object. (Objectification)

Seeing the patient as an object presented itself in the encounter between David and Gwen. This being with a patient is still a mode of Care-full concern in that David is still interested and concerned about Gwen, is not dismissive. Nevertheless, the potential for understanding Gwen is covered over by David’s preoccupation with getting answers for his questions so that he does not look like a “dill” in front of the consultant. To this end Gwen is viewed, to some extent, as a data producing object. In a way this is similar to Judy’s wanting to take away the cares of the patient. If David gets the diagnosis right, the treatment plan will be a success and the patient will get better. The problem, he soon realises, is that the patient won’t come back in order to get better.

The early part of the interview was dominated by David’s need for information. Gwen too is dominated in so far as she has little say in the course the interview takes, despite the interview ostensibly being for her benefit. Gwen’s hostility finally breaks through David’s preoccupation and he realises;

"well, If I’m going to keep this lady I’m gonna have to ... I’m going to have to,...talk to her.” So I literally shut the file, put the pen down, and...went and sat in the old red arm chairs, straight across from her

The possibility for understanding was then opened up and Gwen did stay and did enter treatment.

Being with as Being in control
The need for the staff to be in control in violent or potentially violent situations with patients would seem necessary for both the safety of the staff and the patient. In the violent encounter with Tony this was one of John’s priorities;

The first thing that I think I did was to portray a calm confident type of attitude, an attitude of ah, whilst he may not have been in control at least we were and knew what we were doing and ah, to give, give him the message that we would not let him get totally out of control, we would put a limit on it, and um, and um, stop him from, ah...getting to the stage where he was a, he was uncontrollable, basically to put that, to put that, that barrier to further deterioration.

I did portray a very calm approach, showed him that we were in control, told him that we would not tolerate that sort of behaviour....confronting more than counselling...or placating.

In this encounter with Tony, John felt in control of the situation and not frightened; “...I wasn’t particularly frightened...it was almost funny, almost ludicrous...” This was partly because John thought he was making sense of the situation;

Um,...yes it’s particularly [satisfying] if the situation is being controlled and things...and you’re...making some sort of logic out of it and particularly if you’ve contributed significantly it’s a...it’s a reasonably satisfying thing.
and partly because of the sense of security afforded by the presence of the other staff; "...a little bit like being...in your bed during a thunderstorm..." Being in control and being secure contribute to one another and both are perhaps dependant upon the reciprocal relationship with the other staff.

there was some, some, euphoria and ah, feeling of bonding with the others, because we've all been through a potentially dangerous situation and come through and possibly helped each other and, and people tend to skite a bit saying, you know, we did this and we did that well and, and ah, you ah, grabbed that arm very rapidly and ah, and ah, you didn't flinch, etc etc. And people tend to, to build each other up, a bit of... mutual adoration goes on...which is probably good I think. Ah, ahem...and I suppose that's all part of the debriefing thing. (Ken: Did people say things like that to you?)

People do yeah... (Ken: After that incident?)

Yeah, yeah.

Being in control means in turn controlling and so Tony was controlled by being placed in seclusion.

**Being with other staff**

Being with patients in these circumstances is stressful and Being with other staff can become important. John describes Being with the other staff following the encounter as like coming from a battle,
... its almost comparable to going into war...you feel... a fair degree of unity with...the participants...in that struggle...

I was intrigued by this analogy and asked myself; what are the similarities between this encounter and a battle which tells us something of being in the world with patients?

Battles are dangerous and John refers to the potential danger the staff face. Battles are won or lost and in this encounter the staff overpower Tony and place him in seclusion. However, it is doubtful that John would class this as winning. Battles are team efforts and this is obviously the case here. In fact there are even rituals described which reinforce the esprit de corp of the nursing team.

[a] feeling of bonding with the others...people tend to skite a bit...build each other up...

The first violent encounter is likened to an initiation, again not uncommon in military circles. The new comers amongst the staff that day had;

proven themselves...like the rights of passage...earned their stripes a bit.
They'd proven themselves and they felt, ah, a few of them felt fairly ecstatic I think,

The telling of legends has its parallels in the military analogy also,
...people start talking about previous old experiences when such and such happened and they did this and then...it was sort of...[an] instigation of more discussion, sort of, in a historical sense.

Battles are also fought against others rather than for or with them. These others are usually hated, or feared. This is not necessarily the case, as W. B. Yeats (1994:111) reminds us in his poem, An Irish Airman Foresees his Death, "Those I fight I do not hate. Those I guard I do not love." It is of course possible to view the enemy with indifference.

It is not suggested here that merely because John likens an encounter with a patient to a battle that all that holds true for a battle also holds true for the encounter. John certainly John does not view Tony as an enemy. But nevertheless it is worth pushing the analogy a little further because whilst Tony is neither feared nor hated, there does appear to be a measure of indifference, perhaps tempered by curiosity and an everyday routine, that leads nurses to go through the motions of counselling and reassuring the patient that he is cared about which lacks a certain genuineness.

John tells the patient they do not enjoy such encounters but in fact, whilst John and his staff may not seek such encounters, they (including John) obviously do get some satisfaction out of it, "it's a reasonably satisfying thing." It is what they do regularly, albeit with good reason, and it is exciting,
A little bit of exhilaration from the adrenaline rush...you tend to get...a little bit high...there was some...euphoria...

In their efforts to prove themselves the patient can be lost;

...people were more concerned about their own performance. I think the patient was probably not even thought of. Maybe only in passing. But I think people were...just mainly, you know...did I show any fear, or did I let anyone down, or was I really good, or....

Being with patients seems to be a way of Being with other staff and that Being with other staff runs the risk of becoming more central than Being with the patient. It is Being with patients for the sake of Being with other staff, rather than Being with the patient for the sake of the patient.

That John feels warmly for Tony has already been explored. But feeling warm towards a patient is not mutually exclusive of dominating by exercising control, however necessary and well intended. As with Being with as object, exercising care-full concern via control entails the possibility of covering over understanding, taking away cares, and hence dominating the patient.

Control can be exercised in many ways

...not only me but ah, a few of us, have ah, have possibly engaged in some fairly lengthy conversations, very convoluted, very circular conversations,
trying to ah, logically prove to him that he is crazy ah, you know, utilising his history and going over his story in minute detail. Attacking, attacking his paranoid thoughts and his, his ideas of reference and delusions of persecution and all of that and sort of ah, analysing, analysing all of, all of his, all of his comments and his story in fairly minute detail. Looking for contradictions in his story and, and ah, using his own words to contradict him, and almost like a game of chess, he's a fairly bright person, sometimes he, he ah, he wins the confront...he wins the argument. So people were quite, including myself, were quite eager to, to have conversations with him, for the, for the sort of intellectual ah, stimulation I suppose as well. It's quite enjoyable. So I think the score...the score was probably 50/50. I think when, you know, at times when we have proven that he has contradicted himself or we've shown the fallacy of his arguments, he tends to ...terminate, tries to terminate the conversation or turn the conversation to something else or, or become angry or become depressed, ah, if he can't, if he can't answer that line of discussion in, in a, in a fairly ah, logically appropriately defensive manner, or you know, defend his position.

I am reminded of the quote in R. D. Laing's The Divided Self about an argument which took place between two patients in group therapy;

Suddenly one of the protagonists broke off the argument to say, "I can't go on. You are arguing in order to have the pleasure of triumphing over me. At best you win an argument. At worst you lose an argument. I am arguing in order to preserve my very existence" (Laing, 1960:43).
John would, no doubt, be surprised if the above were to be seen as controlling but wherever a unequal power relationship exists the potential for the domination of the patient also exists. It would seem that Being with as controlling is not mutually exclusive for Being with as care-full concern but is a mode of care-full concern. Nevertheless there is the risk of seeing (understanding ) what we expect or want to see rather than what is actually there to be seen.

**Being with for the sake of**

Being with for the sake of, suggests itself in the data in a number of ways including being with other staff in very different ways to those describe above.

**Being with other staff**

Being with other staff for Lyn, John, Judy and David appeared to have been a positive experience. One gets the impression of team cooperation and sharing that was important to them. Judy and the other nurses talk about John during their tea break. Judy’s grief at John’s death is shared by the other nurses. Lyn makes reference to “we” even though much of her encounter with Edna is experienced on her own. David speaks of the staff support he had following Jim’s suicide. And John speaks of the bonding with other staff in situations of potential danger. For other nurses the experience of Being with other staff is less positive.

**Being with staff as “we” and “I”**
Being with other staff as “we” was very difficult for Julie. To Julie many of the decisions made and the actions taken in relation to Robyn did not show, in her opinion, a regard for Robyn’s basic humanity. She believed that staff were too caught up with the death of the other patient rather than the person who was there with them and needed their assistance and that, “...the person that she [Robyn] was, was forgotten there for awhile.”

As has been seen, because of her observations of Robyn in the close confines of ICA, Julie believed that Robyn genuinely couldn’t remember what had happened to the other patient. This, she felt, separated her from the rest of the staff. She believed the other staff had judged Robyn on her past behaviour and her “rough” looks and found her guilty.

I guess...yeah I was really different to quite a lot of other people...that were around at the time. ...I was angry at probably how it had been dealt with...I felt it was a little...uncaring.

She was angry with the way Robyn was approached and told of the death and that she would remain in ICA and be interviewed by the police. Nevertheless, as a part of the team Julie felt somehow implicated in these decisions and she “hated it.”

I felt really...inhumane almost, you know? I felt really....like we’d almost forgotten that she was a human being.
Julie was "furious." She believed that people who should be "...more professional were quite unprofessional..." and that the whole matter had been handled in a judgemental way. The general impression that Julie formed, through being with other staff during the encounter, is summed up in the following quotes.

"even though yeah you’re in the hospital and you’re, you’re a nurse, you’re also a human being and you can relate to, to maybe what somebody’s...feeling.

You’re a human being first... yeah, that gets to me a little, that you’re not allowed to actually say well, “You know I really think this person’s a great person”, ‘cause you get that, “WHAT!...You’re overinvolved”.

It sounds dreadful but the fact [is] that you’re not really allowed to care for people.

as a...team of supposed caring professionals I really...I don’t think we really did as well as we...could have for her.

**Being with as being angry for the sake of**

Julie was torn between being “I” and being “we.” She also expressed anger at Robyn’s treatment for the sake of Robyn.
Like Julie, Vic too perceived himself to be out of step with the other staff. As has been discussed earlier, he decide to confront Kerrie about her behaviour in order to, "...extract some natural grief reaction." He perceived that the other staff would,

...take their magazine or book or whatever, they'll avoid contact with her, they'll sit their chair in the far corner of the room, they won't want to talk about it, that'll be more comfortable for everybody.

Vic felt angry for the sake of Kerrie, though his anger was directed towards the more nebulous "system" rather than other staff.

the fact that we were still having acute admissions brought in, but the majority of nursing staff were attuned to a chronic caretaker role, and that as a result acute patients were being "inculturated" if you like, into, ah, an atmosphere of chronicity; they were being encouraged to display chronic illness behaviours because that was what nursing staff were comfortable with, and I'm not apportioning blame, my anger was with the system.

Like Julie, Jean was very angry with other staff. She was angry with the doctor who so intrusively and abruptly interrupted the work she was doing with Tracey. She was angry for the sake of Tracey because the doctor's untimely intervention led directly to Tracey's seclusion and loss of trust in the staff.
Being with as being sensitive

Being with as being sensitive to the needs of others as a being for the sake of mode of Being in the world with patients is expressed through many of the encounters. Vic shows a capacity to understand Kerrie’s need to grieve. Julie shows the capacity to understand Robyn’s need for support and engagement with another (despite her difficult behaviour). Jean shows an understanding of Tracey’s need to develop trust before a relationship and behaviour change can take place. David shows a sensitivity towards Gwen in his eventual realisation that Gwen needs to express her anger. Similarly, Lyn shows a sensitivity towards Edna’s need to keep her relationship with her tenants. Lyn was “really angry” with these tenants whom she felt were “ripping off” Edna, however,

...I had to be very careful in how I dealt with it as well because these people meant the world to Edna. But whether they were ripping her off or not, it didn’t matter because they were very important to Edna, so I had to be very careful in dealing with issues that I didn’t loose that support for Edna because basically it’s all she had apart from her galah. The other support she had in the community were these people next door, so even though they were ripping her off I had to be very careful that I didn’t upset that relationship.

As has been described above in Being practical, Lyn’s solution to the problem was innovative and showed sensitivity towards Edna’s needs. Lyn was able to
suppress her own feelings of righteous indignation for the sake of Edna’s relationships.

Being with as Being for the sake of has now been uncovered through these modes that have been described as Being with other staff, Being with staff as “we” and “I”, Being with as Being angry for the sake of and Being with as Being sensitive.

Julie, Jean, Lyn, Vic and David have all projected possibilities for Being with patients that are emancipating, that is, have the potential to give control back to the patient. Sometimes this projected possibility came into conflict with the beliefs, attitudes or actions of other staff and at times caused them personal pain and self doubt. In each case their Being with patients had the potential to be emancipating: Kerrie would face her pain and not retreat into a psychotic state, Lyn would maintain her independence, Robyn would receive the support she needed to move on from her ordeal, Tracey would gain the trust to form relationships with others. All these encounters were characterised by a sense of Being in the world with through working with rather than upon the patient. There is a sense of not imposing solutions but rather finding them together even if for the moment all one can do is be honest, or be with.

Nevertheless, Both Being with for the sake of and Being with as controlling are modes of Care-full Concern. It is not suggested here, nor does the data show, that Judy and John, for example do not care for John or Tony. It is quite clear they do.
Being with in time (Temporality)

The first realisation that time was not experienced in a linear and conventional way in the nurse-patient encounter became obvious very early in the study. All the nurses were asked to describe a nurse-patient encounter. However, the nurses would seldom stick to what I called at the time “The encounter”, that is; a proscribed period of time, from minutes to hours, in which the “phenomenon of interest” occurred. Instead they would invariably describe their feelings for the patient, how long they had known them and many other contextual details including the final outcome or ending of the encounter. For them the encounter was not limited to a specific time frame or event (although a specific event or events was often at the core) but extended to the whole of their interaction with the patient which sometimes spanned weeks (Lyn and Edna) or years (David and Gwen).

What I believe these nurses were in fact doing was giving a first hand example of the hermeneutic circle of understanding (Gadamer, 1975). They were moving between the “whole” of their relationship with the patient to the “part” of the encounter. How was I to understand the encounter if they did not situate it against the whole of the relationship? How was I to understand the relationship if they did not situate it against the significance of the encounter? To them,
encounter or relationship, from minutes to weeks, was all the same. It was their lived experience of being with the patient.

It was also clear that the nurses experienced time in non linear way; elapsed time and the perception of time did not always coincide.

Julie describes her experience of time whilst waiting for Robyn to react to the news that the other patient had been found dead.

*I don’t think she moved for an hour...it was probably 15 minutes you know but it felt like a long long time*

Jean describes a similar experience as she struggled to react to Tracey assaulting the doctor

*Um, it seemed like an eternity, I just sat there thinking, my goodness me, you know, it was obviously probably only fifteen seconds*

This experience is common to most people in traumatic situations. Most people describe their experience of time in a car crash for example as an experience of time slowing down.

But there are other experiences of Being with patients in time described by the nurses. It would seem that Being with a patient and the nurse-patient encounter
does not rely upon time as past, present or future. In some circumstances these notions appeared to become meaningless.

**Being with as being with in absence**

It is intriguing to note that it was possible for these nurses to Be with patients in a very real sense in the absence of the patient’s physical presence. David was with Jim (metaphorically) when he was going over in his mind the details of the case trying to divine what he had missed.

Judy’s encounter with John did not end with John’s death. In some ways Judy is more with John now than when he was alive. After John’s death revelations about who he really was came to light. She now understands him more in the light of his death.

**Being with in endings**

The nurses also appeared to want end the story of their encounters by telling what eventually happened to the patient, sometimes years after the initial encounter. It seemed important for them to “tie off” the story.

Julie had come to know Robyn. The understated, ‘Hey, Jul, thanks,’ was high praise coming from the ultra cool Robyn and Julie knew this. Julie’s care-full concern was rewarded. The ending was a happy one.
In contrast, even though Kerrie recovered Vic did not know if it was his intervention which had made the difference. To know that is important for Vic and the lack of that knowledge has become an enduring frustration.

and it's always left me wondering...I would perhaps have liked the opportunity to talk to her...[and] find out from her whether she felt it was important...

So years later Vic is still left wondering how significant his actions had been. He says the details of the encounter are still fresh after all this time. This sort of wondering, which could not be described as idle curiosity, is possibly even more frustrating when the nurse thought she had understood the person, only to have them suicide. Like Vic, Judy would like the opportunity to speak again to the patient, “to sign things off” , but she will never be able to.

You know, I just, (sighs) yeah I’d like to get him and say, “right, you’ve got a few questions to answer here,(laughs), I want to know!” Yeah, but because other patients like towards the end of, of their stay here, they’ll talk to you about things, I mean you must have found that, and they’ll say, “oh yeah, OK so I remember this and I don’t remember that, and I did this and yeah well I didn’t mean that,” and you sort of like put the, the well person together in this picture at the end and, well you sign off the letter don’t you, and off they go. This wasn’t signed off and it can’t be signed off and I think that’s why it’s left an impression, yeah because, yeah, in one breath
you say you've understood them, and then by the very nature of it you didn't.

David and Gwen's encounter got tied off years later. Gwen phoned to let David know about her new job and new relationships with her children. David had been significant in Gwen's life but she had also being significant in his. This is the shared humanity of the encounter and perhaps part of the enduring significance of endings.

But as with Judy, David's encounter with Jim did not have a happy ending and like Judy, David searches to understand and perhaps find what he missed, that vital clue, that question he should have asked. It would seem then that the past for David and I think for all of the nurses is no less meaningful for being past. It lives on.

For Judy the encounter with John lives on in her mind because it was not tied off and not tied off in this instance seems to mean it did not conform to Judy's ideas and experience of how encounters should end, "you sort of like put the, the well person together in this picture at the end and, well you sign off the letter don't you, and off they go." But this encounter wasn't like that. John had gone off and killed himself. It put Judy in a state of discomfort which lifted her out of the average everydayness of being in the world with patients and enabled her to look at her encounter with John in a new way. In the light of this encounter she questioned her knowledge of John and also of other patients. Had she really understood them?
For Julie the encounter with Robyn lives on because of how it was tied off, doubt followed by confirmation that she had been of help, “Hey Jul thanks.”

For Vic the encounter with Kerrie lives on because he rose to the challenge of the encounter, he strove for possibility for the client and for himself and the outcome was positive, the mother and child were reunited, but was it he who made the difference? The tantalising question he can’t answer.

It may be that endings live on because they are in some ways a distillation of the encounter. That the totality of the encounter lives in the ending, can be seen in the way David constantly repeats Tom’s details over and over in his head as if trying to find some clue to understand what he had missed.

Expertise as nurses may also be encapsulated in endings and carried over to new beginnings. The questions Judy would ask of John will be posed to and perhaps be answered by someone else in a similar situation. The clue to understanding Jim will be looked for and perhaps found by David in another suicidal patient.

The past is with us and influences the present, that is our actions now. The future is no less meaningful for having not yet been. The future engages us in possibilities. So unlike the linear concept of time, the lived experience of endings captures the totality of the encounter over time. These encounters and their significance live on in the present and in some ways these nurses are still with those patients.
Being With in the World

For most of the nurses and patients in this study the world was the shared social world of the psychiatric hospital. It is worthwhile exploring this world in some detail.

Familiar and foreign territory

The world of the hospital, annex and mental health centre, is the familiar world of all the nurses in the study. These places are however foreign to the patients. For some of the long stay patients these places become more familiar but nevertheless there are places within them that are still foreign, such as the Intensive Care Area.

The psychiatric hospital: The hospital (community mental health centre, psychiatric annex) is familiar territory to the nurses but is, initially, at least, foreign to the patients. For some the hospital offers welcome asylum away from the cares, prejudices and judgements of the outside world. For others it is a frightening foreign place where they are forcible keep against their will. The epitome of this perspective can be focused into one area, the ICA. Although it should also be noted that for some patients ICA is a haven where they can feel safe from their real or imagined persecutors or safe from themselves.
ICA: There are some things that can generally be said about the ICA. Firstly it is in the nurse’s domain. It is familiar territory. Most regular nurses of this ward have spent many hours in this area. It would certainly be alien territory to most others. It is a territory in which people are locked against their will. The nurse, whilst locked in, is not held captive. They can leave, have a cup of tea and go home at the end of the shift.

For Robyn and Kerrie ICA is foreign territory. It is set up to be short term accommodation, it contains little furniture and the patient belongings allowed into the area are severely restricted. They are not free to leave and they have no privacy, being under constant surveillance. They did not enter the area of their own free will and cannot leave. They are locked in.

Being Isolated

Even though the nurse should be relieved every two hours in ICA, this does not always occur. In Julie’s case she was in ICA most of each shift for some days. The nurse is generally unaware of what else is happening in the ward. Phones ring, voices can be heard, but the ICA nurse is often none the wiser. Things may be put in train that pertain to the patient but sometimes without the nurse’s knowledge or input. It can also be a taxing and frightening area. The nurse is locked in with patients who are very disturbed, unpredictable and likely to be a danger to themselves and others.

The experience from the patient’s point of view, can be imagined to be frightening and isolating. He or she is in a different environment away from
fellow patients and staff with no one else to interact with except the assigned nurse who may or may not be the nurse the patient would prefer to be with.

The nurses familiarity with the territory is however reversed in the situation with Lyn where the territory of Edna’s house is foreign to Lyn. This also means that the power over that territory is also reversed. Lyn does not have the same control over the environment as she would have in say a hospital. This is reflected on the subsequent care she needs to take in interacting with Edna and being sensitive in her problem solving with Edna. Lyn is also isolated, away from the support of other staff and this isolation is reflected in the initial anxiety she felt in approaching Edna’s house.

**Being thrown** (Thrownness)

There is a thrownness about the experience for both Robyn and Julie, Vic and Kerrie. They suddenly find themselves in ICA. Julie and Vic when they come to work and found themselves assigned to ICA and Robyn and Kerrie following their confused and half remembered nights. These are perhaps obvious examples of thrownness but to some extent all the patients and staff find themselves thrown in the world as nurses and patients. Lyn and David, Judy, Jean and John all find themselves thrown together in the world with Edna, Gwen and Jim, John, Tracey and Tony. A good example is to be found in the words of John, as repeated by Judy,
“No, I’m not used to this, I’d better behave myself hadn’t I, I’m used to being the head of the family but here I’m at the bottom of the pile again, aren’t I, and now I’m listening to you, I thought I’d gone past all of that.”

Understanding in the shared social environment

The shared social environment of ICA influenced Julie’s understanding of Robyn and hence her experience of Being with Robyn. Firstly it is worth noting that Julie is with Robyn in ICA. As described by other participants it would be easy to be in the same room as a patient but not be with them. The nurse who isolates her/himself from the patient by putting their chair in the corner and reading a magazine is in the same room as the patient but not “with” the patient in the sense that is meant here.

This is certainly not the case with Julie. From the very beginning it can be seen that Julie is very much with Robyn as has already been explored.

Julie was there in ICA alone with Robyn and saw Robyn,

sort of touching herself, touching the mud on her shoes and touching her hair and, and not under...not having a clue why there was mud in her hair and why she’d been wet and why her shoes were muddy and all those sorts of things.
Julie was there as Robyn asked, "do girls go to [the medium secure ward] if they do this sort of thing, if I've done something to him, do girls go to [the medium secure ward]." Julie was there when Robyn,

...used to stand out at the back door of the ICA there and just stare at [the medium secure ward] and start crying..and she'd talk about her family and her mother and home....and how she felt because now she'd never go home again.

Julie was with Robyn when she "talked and talked and talked" she was with her when Julie was the target of her impotent rage against her fate. She was there when Robyn was cleared of involvement in the death of the other patient when, "she squealed, she screamed, she sang, she hugged ever person in the ward.”

Julie was with Robyn when she said "hey Jul thanks" and like any people who have shared an experience they also share an understanding and those three words "just said heaps and heaps."

Similarly, Vic was with Kerrie in ICA and saw and understood things the other staff could not. He tried to convey these by careful documentation in the notes.

Conclusion

Lived-experience cannot easily be compartmentalised and tends to sit uneasily into the boxes of categories to which it is assigned. It is fitting therefore that there should appear to be an intimate interrelationship between the existentials and
the horizons uncovered in this study, with each lending meaning to the other and, in turn, generating more meaning through their situatedness, one with the other. As I attempted to interpret these existentials I began to find that they appeared to be interrelated and in fact led back to one another in a circular way. For example, the actions of the nurses are, more often than not, based on possibility, that is, they see the patient as a being with potential for the future. Such possibility would not be recognised without a wish to understand the patient and such understanding cannot come about without a concernful attitude for the person. So whilst each existential is presented here in it’s own right, it owes much to other existentials of the phenomenon of Being with patients. But if we, like Heidegger, see existence as hermeneutical it would seem fitting that such circularity, as outlined above, should be uncovered in the experience of nurses.
CHAPTER EIGHT

SUMMARY OF INTERPRETATIONS AND A RETURN TO HEIDEGGER
Summary of Interpretations and a Return to Heidegger

Introduction

Being a psychiatric nurse essentially means Being with patients. This Being with is Being with understanding, possibility, care-full concern and in time and space. This chapter summarises these existentials and horizons and returns to Heidegger as a means of further illuminating the experience of being a psychiatric nurse.

The Existentials

Understanding

Understanding is not always experienced as a thought through cognitive process but is grasped immediately in the moment and is possible through these nurses’ shared humanity because it is based in understanding the patient as an immediate living human being.

Possibility

Possibility appears to be the projection of these nurse’s aspirations and fears for themselves and the patient onto the present. The nurse grasps the nature of what is possible (through understanding) for both her/himself and the patient and then directs energy to achieving what is possible. Possibility requires understanding of the patient and the self in order to make it meaningful, that is, in order to make possibility become actuality. Nurses in this study understand what is possible for both themselves and the patient and then strive towards it
with skilled action. This does not always produce the desired result but the striving towards possibility does point to a care-full concern for the patient.

Care-full Concern

Care-full concern manifested itself in numerous ways in this study. These varied from acts carried out with the intention of helping the patient, to the emotions experienced by the nurses which revealed their care-full concern. All of these modes of care-full concern indicate that the patient matters to the nurse, and this was even true when the nurses experienced unpleasant emotions such as anger towards the patient (Judy for example) as that anger belied the concern they had for the patient.

The Horizons

Time

The encounters with patients were not experienced as discrete temporal events which have now past. For all of the nurses the fruits of the encounters with patients are still with them, whether these fruits are bitter or sweet, and inform their nursing practice now and in the future.

World

The encounters with patients were experienced together in a shared social world that was sometimes foreign, sometimes familiar, sometimes overtly with other patients and staff, sometimes not. But in every case the world of the encounter
influenced the existentials of understanding, possibility and care-full concern and was the ground in which understanding and possibility grew.

Returning to Heidegger

This study is grounded in the phenomenological hermeneutics of Martin Heidegger. Heidegger’s main concern is with the meaning of Being. The concern of this study is the meaning of being a psychiatric nurse illuminated by the phenomenon of the nurse-patient encounter. It is not surprising that some of Heidegger’s thoughts on Being find reflection in the encounters. However, Heidegger’s main concern is with Being, not necessarily and not primarily Being-with others. Being-with others is of course examined by Heidegger as part of our Being-in-the-world.

As being a psychiatric nurse is essentially Being with patients in the nurse patient encounter, it would be logical to look briefly at Heidegger’s thinking on this subject to see if it can further illuminate the experience of Being a psychiatric nurse.

Being-with-others, understanding and possibility.

In analysing how we find and make use of the world, our dealings with the world, Heidegger does not assume that our consciousness is directed towards a world of objects. Our dealings with the world are not, ‘...a bare perceptual cognition but rather that kind of concern which manipulates things and puts them to use; and this has its own kind of ‘knowledge’” (Heidegger, 1962:95).
As Heidegger points out, we use the door latch to open the door before we think of the what the door latch is or how it is made.

Similarly, others are not encountered as objects out there rather we find ourselves thrown amongst others. The world consists of other Dasein. These others are experienced environmentally; they are "Beings-in-the-world-with". Most of the time they and we are, "das man" (the public undifferentiated) with jobs to do and tools to use - unreflective (Heidegger, 1962:118). In this Being with others I do not distinguish myself from these others.

By 'others' we do not mean everyone else but me - those over against whom the "I" stands out. They are rather those from whom, for the most part, one does not distinguish one's self - those among whom one is too (1962:154).

Heidegger states that we share the world with other people, our Being-in-the-world is Being-with. This has implications for how other Dasein are understood. Others are not first and foremost reached via psychological devices such as empathy but are understood against, "...a background of shared concerns and activities..." (Dreyfus, 1993:151). Therefore,

Being-with is such that the disclosedness of the Dasein-with of Others belongs to it; this means that because Dasein's Being is Being-with, its understanding of Being already implies an understanding of others (Heidegger, 1962:161).

Hence others are already understood and means such as empathy are only necessary in special cases where such understanding breaks down. In the
experience of Being-with patients, the nurses in the study seemed to grasp
immediately an understanding of what was happening with the patient in most
circumstances. According to Heidegger this grasping in advance is a common
state of our Being-in-the-world. In the following quote he uncovers grasping in
advance by contrasting hearing and hearkening.

Hearkening is phenomenally more primordial than
what is defined “in the first instance” as “hearing” in
psychology - the sensing of tones and the perception of
sounds. Hearkening too has the kind of Being of the
hearing which understands. What we first hear is never
noises or complexes of sounds, but the creaking wagon,
the motor cycle. We hear the column on the march, the
north wind, the woodpecker tapping, the fire
crackling...It requires a very artificial and complicated
frame of mind to “hear” a “pure noise”. ...Likewise,
when we are explicitly hearing the discourse of another,
we proximally understand what is said, or to put it
more exactly - we are already with him in advance...
(Heidegger, 1962:207)

Julie on seeing Robyn, understood Robyn’s distress even before she knew fully of
the circumstances. She had harkened to Robyn and understood, she was with her
in advance.

In contrast to this, David had to stop his questioning of Gwen and attend to her.
In psychiatric nursing parlance it would be said that what happened next was
guided by empathy. Through putting himself in Gwen’s shoes (asking the
question of himself, “what is it like to believe you had been dumped by your
psychiatrist, what is it like to be confronted by a boy just out of short pants asking
about your private life?” ) he came to a better understanding of Gwen. But could
it be said that empathy of that sort is operating in all of these encounters? No, I
don’t think so. Empathy, as it is understood in psychiatric nursing and psychology
is where, 'The helper makes an active effort to put himself in this internal perceptual frame [of the client] without losing his own identity or objectivity' (Brammer, 1973:30).

As such empathy is a conscious cognitive process, it is something employed when primordial understanding gets covered up. I do not believe this is what was happening with Julie and Robyn or Vic and Kerry. It is on the basis of Being-with that empathy (or for that matter misunderstanding) can happen at all (Mulhall, 1993:116). Therefore the understanding of others, derived from the existential of Being-with, is prior to empathy.

Being-with-others and Care

Care for Heidegger is fundamental to the way in which Dasein exists, it is the most important of his existentials (Gelven, 1989:111). It is the unifying existential that lies at the heart of all the other existentials (1989:113). Heidegger shows this through an analysis of dread, the details of which are unnecessary for the present purpose.

Heidegger describes care as either “concern”, that is caring about, this term is only used in reference to things, and “solicitude”, or caring for, this term is only used in reference to caring for people (Gelven, 1989:121, Heidegger, 1962:237). However, being concerned with things that are used to care for people, with the expressed intention of caring for people, is still solicitude. So Lyn caring about fumigating Edna’s house is caring for Edna in solicitude.
According to Heidegger solicitude has deficient and positive modes. Heidegger believes that there is a difference between “indifference” and “not mattering” hence an deficient mode of solicitude is a taking away from a solicitude that exists (through not mattering), rather than a primary absence of solicitude (through indifference). Heidegger believes that Dasein maintains itself for the most part in its deficient modes of solicitude; ‘...passing one another by, not “mattering” to one another...’ and that these modes ‘...characterise everyday, average Being-with-one-another (Heidegger, 1962:158).’ It is because of this, Heidegger contends, that society has invented “welfare work” as a social arrangement (1962:158). Certainly all this seems to be intuitively the case.

Heidegger then goes on to describe the positive modes of solicitude. He states that positive solicitude has two extreme positions and he calls these “to leap in” and “to leap ahead” (Heidegger, 1962:158-159). These two modes would seem to be of relevance to psychiatric nursing.

To leap in is to take over the concerns of another so that the other is displaced from her/his position. In this mode of solicitude the other has the potential to become dominated and dependant (Heidegger, 1962:158). To leap ahead, in contrast, is to give back authentically the other’s potentially for Being. ‘It helps the other become transparent to himself in his care and to become free for it’ (Heidegger, 1962:159).

From a Heideggerian perspective, the modes of care-full concern, that were uncovered in the data, that I have called Being with as controlling, including:
• Being determined
• Being with as object
• Being with as being in control
• Being with other staff

and Being with for the sake of, including:
• Being with other staff
• Being with staff as “we” and “I”
• Being with as being angry for the sake of
• Being with as being sensitive

appear to be analogous to Heidegger’s leaping in and leaping ahead. The encounters have illuminated a number of ways of Being in these modes going beyond Heidegger’s brief description in Being and Time.

Being with as controlling, would appear, like Heidegger’s “Leaping in” , to have the potential to dominate the patient and foster dependency. Nevertheless it is a mode of care-full concern (perhaps what Heidegger would call Solicitude) in that the nurses’ intentions are that their actions are for the good of the patient and that in this instance the patient’s good lies in being controlled (what Heidegger would call a positive mode). Certainly this is clearly seen in Judy’s encounter with John. It is clear that Judy’s Being determined is intended to be for the positive benefit of John. Unfortunately, this mode goes on to dominate the encounter so that a true being to being understanding cannot emerge until much later. In this case the potential to dominate has been realised. However, if this mode has a “potential” to dominate, is this not also to suggest that it has other,
perhaps less problematic, potentials? Certainly it would seem possible that in some circumstances such a Being with patients has the potential to be of value to the patient.

This other potential is initially seen in the encounter between John and Tony. It was certainly in Tony’s interests that he be controlled if he could not control himself. However, the potential to dominate still exists, as was seen in the previous chapter, in the discussion of John’s debates with Tony which to some extent ran the risk of becoming ends in themselves rather than a means to Tony’s liberation.

Being-with as Being for the sake of, appears to be analogous to Heidegger’s “Leaping Ahead”. The effect of the ways of Being-With-For-The-Sake-of was a liberation, but not only for the patient. A common humanity was touched in this mode of Being-with that had clear representations in the encounters. This common human understanding manifested itself in the nurses’ anger with others for what they perceived to be their lack of human understanding. It was also manifested in the sensitive way nurses handled situations (Lyn and the tenant). But if “leaping ahead” can be described as helping the Other, ‘...become transparent to himself in his care and to become free for it’ (Heidegger, 1962:159) then “leaping ahead” as Heidegger means it, is to be found in all the encounters and in many of the modes of Being with, not just Being with for the sake of. For example, the encounters nurses had with patients aroused in the nurses, as well as the patients, questions of what it means to Be in our common, or shared, humanity. The nurses to some extent became transparent to themselves. The
encounters shook them out of their average everydayness of Being a psychiatric nurse and led them to question their behaviours and attitudes (see Being with as self doubt).

Often then being with one another can be seen as based on common concerns and according to Heidegger such concerns can be the basis for a mistrust of others or, if we choose to work together, for an “authenticity” which frees each for him/herself (1962:159).

**Authenticity**

So what is authenticity? To be authentic is to be aware of the self (and the possibility of an end to the self in death). To be inauthentic is to lose one’s self, one’s identity, in the ‘...impersonal prattle of the they...’ (Gelven, 1989:74). It is a failure to ask the question “who am I”. Inauthentic existence is concerned with the actual, authentic existence, whilst not dismissive of the actual, is concerned primarily with the possible. Dasein, according to Heidegger, does not have a universal nature but has possibilities (Soloman, 1972:221). What this means is that we “make ourselves”. To be authentic is;

...the recognition of this responsibility [of creating or making ourselves] and the open-ended range of choices one has concerning his own “mode of existence.” Inauthentic life is the refusal to recognise this responsibility and one’s choices. The inauthentic life is the life of das Man, who has his alternatives handed to him and his responsibility taken away for him (Soloman, 1972:222).

In inauthenticity, understanding is degraded from a questioning of one’s own existence and possibilities to a curiosity about things. Curiosity is yet another way
of losing ourselves to the world. Curiosity seeks novelty only to leap ahead to a new novelty. In this way life would appear genuinely lively (Heidegger, 1962:216).

However;

What is crucial to curiosity is that it will not let itself ask itself fundamental questions [about Being]...The curious man operates within a framework...established by others (by *das Man*), but within this framework he may be very 'intelligent' or 'clever' indeed. What the curious man will not do--what makes him inauthentic--is that he will never push a problem far enough to touch his own Existenz. (Soloman, 1972:220)

So as Dasein we are all fundamentally ontological, we are all concerned with what it is to Be us. That we cover over our concern with Being by such modes as inauthenticity and by such devices as curiosity only serves to highlight our concern with Being.

However, as previously discussed, our Being-in-the-World is a Being-with-Others. It is therefore possible that by approaching the Other in the positive mode of solicitude, authentic possibility for each can be achieved. That is, that each can become what she/he is capable of potentially through a Being-with that '...frees the Other is his freedom for himself' (Heidegger, 1962:159).

From this perspective I think it is clear that in many of the encounters described in this study the nurses have indeed 'pushed the problem far enough to touch their own existence.' Some examples of this are described under the headings, Being-with-as: Understanding, Possibility, Being Motherly, Listening, Self-doubt, and generally under the heading of Being-with-as-being-Emotional.
Being-with-others and Time

For Heidegger, that astute observer of human existence, time is not experienced in a linear way. The past is 'I am as having been' and the future is 'I am as coming towards' and the present is made meaningful through what I am engaged in doing now (Gelven, 1989:180-181). Viewed in this way the past is no less meaningful for being past. The past is with us and influences the present, that is, our actions now. The future is no less meaningful for having not yet been. The future engages us in possibilities. In the encounters described here, nurses experienced time differently to our conception as time as an unchanging linear phenomenon. Both Lyn and Julie experienced short periods of linear time as very long. But also the past and the future show their influence in the present in the encounters in ways similar to those described by Heidegger. These have been described under the headings of Being-with-in-Absence and Being-with-in-Endings in the previous chapter. Being-with-as-Possibility also entails the concept of Time. For Being-with-as-Possibility engages us in projecting future possibilities in the present, the future is to some extent with us in the present or we are dwelling in the future. All of the nurses see a possibility for the future now in the present and strive towards it. As noted in the previous chapter, “The nurse is operating now for the sake of something that is not yet but can become.” Being with the patient is a process of becoming.

It is not however a future only for the patient but a future for the nurse also, the nurse too is in the process of “becoming.” For example, in identifying Tracey with her own daughter, Jean was seeing future possibilities for herself and her
daughter. Similarly in my own encounter with Stephan I projected a future possibility for myself through my encounter with him. I, like Stephan, may have been overwhelmed by the pressures of a new job, marriage and a family. It is perhaps partly on this basis of identification that a shared humanity takes place such that a true being to being relationship can unfold.

**Being-with-others and the World.**

The previous chapter examined the various modes of Being with in the world that came out of the nurse patient encounters. It was said that because of the shared nature of the encounters, the nurse and the patient were in a very real sense with each other. Heidegger takes this notion of Being-with and expands on it. For Heidegger in our relations with others in the world it is possible to be along side someone and not Be-with them. Gelven gives the example,

Suppose I go to the theater (sic) with a friend and due to the popularity of the play we are assigned separate seats. I am therefore next to a stranger but with my friend. The difference between “being next to” and “being with” cannot, then, be determined by spatial considerations alone. Nor is it determined by pure psychological attitudes or how I feel about my companion, for I can be with someone I dislike or even one to whom I am indifferent. I can even be next to my friend but with my enemy. Since these determinations are neither spatial nor psychological, they precede such empirical or physical considerations and are hence a priori. (1989:59)

For the nurses in the study it would seem that they were with the patient in the encounter rather than next to or alongside.
Conclusion

Being in the world with the patient is a close encounter in which the nurse utilises understanding, possibility and care-full concern in a shared social world in time and space. The encounter with the patient opens up the nurse to themselves and the patient in what Heidegger would call authentic existence. Nurses strive for possibility for both themselves and the patient and in so doing express their care-full concern. They face the question of what it is to Be and are, in a very real sense, with the patient although this Being with would appear not to be limited by the conventional notions of linear time and distance with which we are familiar. Such Being in the world also points to an underlying unity which makes all of the above possible and hence makes psychiatric nursing possible. This underlying theme or unity will be explored in the next chapter.
CHAPTER NINE

SHARED HUMANITY AND BEING.
Introduction

Psychiatric nursing is steeped in the background of Psychology and Psychiatry which are in turn concerned with how to understand the behaviour of people in wellness and illness. People are seen as individuals who are separate subjects, alone and isolated. This view then poses the problem, “how do we get over to them” how do we connect with them? Both psychology and psychiatry have formulated various answers to this problem, the most well known of which is the notion of “empathy”. Paradoxically psychiatric and psychological formulations themselves (psychodynamics, behaviour modification, cognitive restructuring and various other theoretical formulations) are based on an understanding that we share a psychological functioning which is generalisable to others.

All of this has the effect of obscuring the fact that from an ontological point of view, we, as nurses, in our Being-with patients, do not encounter patients as essentially isolated subjects. That being in the world with patients is essentially Being-with others and such Being-with has as its structure a primordial understanding of other Dasein.

Mostly we go about our business in what Heidegger would call deficient modes of solicitude “passing one another by, not mattering”. Occasionally something
happens which shakes us out of our average everydayness and reminds us of our capacity to understand others and of our basic human commonality.

As I write this chapter I am aware of a shared humanity for those I have never met and can never know. A few days ago a gunman shot dead 35 people at Port Arthur in Tasmania. The front page of today’s paper (The Adelaide Advertiser, May 2nd 1996) is covered with their faces. Their faces look up from the page, from the pictures taken from family albums of happy days past. Zoe Hall in a fancy dress hat, Royce Thompson in black bow tie and black jacket, little three year old Madeline Mikac with curly hair and gap toothed grin. As I look at them I can guess something of their aspirations and hopes and something of who they were. I can do this because I too am a human being. I share an understanding of what it is to Be human. Although we are individuals, there is a commonality of Being human which unites us, which is often covered over, but is none the less there. The last sentence on the front page of the paper says, ‘They will be remembered because, quite simply, they are us.’ This tragedy has shaken a nation out of its average everydayness and wakened in us all, if only for a moment, a recognition of our shared humanity and finite existence.

In our average everyday existence as nurses it is easy to be swallowed up in the undifferentiated mass of the public nurse “they”, to lose ourselves, not only to our patients, but to ourselves. To this I will return shortly. The point for the moment is that we, nurses and patients, share a basic understanding of what it is to be human.
In the previous chapters a number of existentials were described which arose from the phenomenon of Being with patients in the nurse-patient encounter. As previously discussed, being a psychiatric nurse for the nurses in this study, means being with patients in understanding, possibility and care-full concern, in time and in the world. But is there a unifying theme that unites these existentials and gives them greater meaning and which therefore further illuminates the phenomenon of the encounter and hence being a psychiatric nurse?

Shared humanity and Being-with as understanding.

As has been discussed, Being with as a psychiatric nurse means Being with as understanding. It appears that such understanding is grasped in advance, that there is an immediacy about such understanding. Also examined previously was understanding as intuition, which is really another form of grasping in advance. But all of this begs the question how is such understanding possible?

How is it possible that Vic, a loving and devoted father of four, could understand, a woman who had mutilated her child, enough to know that it was necessary for her to grieve, that she was not motivated by “evil”, that she loved her child despite everything and had a chance of recovery? He said himself that he had no theory to guide him. How did Lyn know the significance of the relationship that Edna had with her tenants? How did Julie know the significance of those three words of Robyn's “Hey Jul thanks”? Perhaps how we are as humans will help illuminate these questions.
Humans walk, they also understand. To walk it is necessary to be the type of creature that walks and it is necessary to have something to walk upon. Humans are the kind of creatures which are capable of walking, they have legs and they have at hand something to walk upon, namely the earth. But they do not always walk, they sit, drive, ride and run. In fact today walking has become something we do less of. Humans are also the kind of creatures that understand, they are capable of understanding. But in order to understand they need a ground upon which understanding can take place. They need, if you will, something "under" them upon which to "stand."

Understanding stands upon a common ground of shared meaning. I cannot understand that $2+2=4$ unless I share with the mathematician the common ground of mathematics. What is it then that is the common ground of Being-with as understanding? It is, I venture to suggest, Shared Humanity. But as with walking, humans do not always understand, but like walking this is not to say they can't or are not capable of understanding but rather that at times we choose not to understand or our understanding gets covered over. In understanding it is necessary for us as nurses, to open ourselves up to our essential shared humanity with patients.

This is what appeared to be happening in the encounter between David and Gwen. David's Being with as understanding was covered over by his need to get the diagnosis right. Eventually he opened himself up to Gwen. By sitting opposite her and "listening" to her he came to understand her anger. Many people would call this the use of empathy and some may say that what has been described as
shared humanity is, at base, empathy. However, to assert this is to reverse the significance of the terms; empathy is, at base, only able to come about through shared humanity; a Being in the world with patients that is more primordial. Heidegger is instructive at this point,

Empathy does not first constitute Being-with, only on the basis of Being-with does empathy become possible: it gets its motivation from the unsociability of the dominant mode of Being-with (Heidegger, 1962:162).

To call shared humanity “empathy”, ‘...psychologises it too much’ (to borrow Rollo May’s phrase). This is especially true when the way in which empathy is often meant, as a conscious process or technique, is considered. This is of course not to denigrate the usefulness of this process but merely to emphasise that shared humanity is a priori.

Shared Humanity and Being-with as possibility.

As discussed in Chapter Seven, Being with as Possibility is the nurse operating now for the sake of something that is not yet but can become. Again the question may be asked “How is this possible, What is it that makes this possible?”. In Being with as possibility the nurse projects an image of what is possible for both themselves and the patient. This image is based on what they can conceive of as being possible through their understanding of Being human themselves and their encounters with other humans. Judy for example projects an image of John as recovered, recovery is a possibility, this is based on her understanding gleaned from experience and knowledge of human Being.
...if someone's really depressed and they're not showing any emotions, you think, well, you've got nothing to work with, but when you see someone with some of that intense sort of feeling you think, well, "how depressed are they, what really is the problem?"

It seems that understanding is necessary to do this and if understanding stands upon a ground of common meaning, that which I call Shared Humanity, then possibility stands there also.

Possibility entails a choice. As has been discussed, nurses in this study, in projecting possibilities, have chosen to strive towards these possibilities for and with the patient. It would be possible for nurses to grasp possibilities and do nothing. These nurses do not. If, as has been discussed, Being with as Possibility entails possibilities for the nurse as well as the patient, what then is the possibility or possibilities that these nurses have chosen to pursue for themselves?

A choice that is clearly taken by nurses in this study is the choice of Being in (what shall be called) a “They” nurse mode or to Be with in (what shall be called) a “Self” nurse mode (Please note the terms “they” nurse and “self” nurse are not to be taken as value judgements or in any way pejorative but merely modes of Being Psychiatric nurses).

Shared humanity and The “They” nurse mode.

The mode of “they” nurse is alluded to by the nurses in this study. Vic says of the “They” nurse mode;
...they'll take their magazine or book or whatever, they'll avoid contact with her [Kerrie], they'll sit their chair in the far corner of the room, they won't want to talk about it, that'll be more comfortable for everybody.

...acute patients were being “inculturated” if you like, into, ah, an atmosphere of chronicity; they were being encouraged to display chronic illness behaviours because that was what nursing staff were comfortable with,

...it probably suited the system that, they [the patients] be encouraged to become chronic...and I suppose that...and I suppose that, that was sort of a background, sort of...feeling I had that um, that possibly with this woman people were saying ah... “you’re psychotic, ahh, schizophrenia is a chronic debilitating illness therefore we’ll expect you to regress into a chronic debilitated state and then that will be comfortable for us because, because we won’t have to talk to you about this horrible thing you’ve done to your child and you won’t have to be... you won’t have to recall it to mind, you won’t have to justify it in any way you’ll be allowed to withdraw into yourself and everything will be fine. We’ll be able to just carry on as, as is.”

Julie also spoke of the “they” nurse mode.

I guess...yeah I was really different to quite a lot of other people like that were, were around at the time I...I was, I was angry, I was angry at probably
how it had been dealt with...I felt it was a little...uncaring (the way Robyn had been treated following the discovery of the body of the other patient).

...the person was forgotten, the person that she [Robyn] was, was forgotten there for awhile I think, yeah. Everybody was, was quite, quite um, worked up about the.....the actual incident that had happened down at the creek rather than the person that was, that was still here and needed to be dealt with...yeah. I think it was probably a very, very frightening lonely time for that girl,

...there was just that air of she probably did it, she probably did do something....and I found that very difficult to deal with like, psych illness or no psych illness.

...sometimes you start to question your own, your own um...what you're thinking yourself in your own...what's going on in you own head about, about that particular incident you know, when you...when you're sometimes the only one that....that has a differing idea. Wh...when you yeah when you're amongst a group of people who are generally thinking the same way. [they were saying] She's done this to him, she's done this to him. And I just umm, yeah I just felt I couldn't, I couldn't say that, I couldn't say that...
you're not allowed to actually say well, “You know I really think this person's a great person”, 'cause you get that, “WHAT!...You're overinvolved”.

In the “they” nurse mode nurses act as “they” act, as nurses in an everyday passing-each-other-by-mode, “that'll be more comfortable for everybody.” It is not to strive for positive possibility and hence to strive for a “becoming” who I am as a nurse and a human being, but rather to let the possible happen.”. schizophrenia is a chronic debilitating illness therefore we'll expect you to regress into a chronic debilitated state (Vic, talking about the attitude of other nurses).”

In the “they” mode the nurse is not transparent either to themselves or the patient. If we are not transparent to ourselves, cannot “see” our shared humanity, then we cannot “see” the shared humanity in the patient. If shared humanity is the basis of understanding, then the patient and we, are estranged from the possibility of an authentic Being-in-the-world and hence, from the possibility of becoming through Being-with as possibility.

Shared Humanity and The “Self” nurse mode

If the “they” nurse mode disguises or covers over shared humanity, the “self” nurse mode does not. In the “self” nurse mode the nurse is transparent to the humanity of her/himself and to the humanity (or “self” ) of the patient and is “open” to him/herself and patients. How is this manifested? Again it is necessary to return to the encounters.
Shared humanity and Being-with as Care-full Concern

Care-full Concern is perhaps the existential in which shared humanity and the “self” nurse mode reveal themselves most clearly.

Once again the question can be asked what makes it possible for nurses to Be-with patients in Care-full Concern? It may be useful to again consider what is meant by Care-full Concern. It means that nurses are concerned with and for patients, this, as has been seen is, the nature of nursing. This concern is full of care; the giving of comfort and the meeting of needs through skilful Being-with. This giving is based on an apprehension of the needs of the other based on an understanding of him/her through our shared humanity. How is this known?

Take for example the fact that patients do not always ask for what they need or indeed know what they need. So how do the nurses know what to do? How did Julie know that staying engaged and listening to Robyn, even though she was being abused, was the right thing to do? How did David know he had to stop writing and attend to Gwen? How did Vic know he needed to confront Kerrie? Vic says he did not know that what he did was right, it wasn’t based on “this or that theory” but on “pure gut belief.” Certainly it may be said that what to do in some cases was learned by them as psychiatric nurses. Certainly David said he knew the theory behind the skills he used in attending to Gwen. He had learned them but they only made sense in the application. The knowledge of when to apply them, however, was problematic.
I can remember when I first made the decision not to actually take the notes that I was feeling um...I sort of had these mixed feelings ...I wasn’t confident but I, I knew that this was what I needed to do...but I was unsure because for me, sort of, move away from that initial...asking the questions or directing through to sitting straight down from her and making that conscious decision was very difficult. I only had basic counselling skills, but to use them in the right place...had been a, sort of constant problem for me...

In a case like this empathy could, once again, be called upon. By being empathic towards Gwen, David grasped the time was right. This may well be the case but it still demonstrates the primacy of shared humanity. It has already been discussed that empathy has as its base, shared humanity. Heidegger puts it this way;

Of course it is indisputable that a lively acquaintanceship on the basis of Being-with, often depends upon how far one’s own Dasein has understood itself at the time; but this means that it depends only upon how far one’s essential Being with Others has made itself transparent and has not disguised itself (Heidegger, 1962:162).

In order to be empathic we need first to have a basic grasp of what it is to be human with others. This transparency or openness of shared humanity is seen in the modes of Being with uncovered in the data which also uncover Being with as the “self” nurse.

If it is said that the “self” nurse mode is open this begs the question, Open to what? As previously discussed, the “self” nurse mode is open to possibility, the
possibility of Being in a "self" nurse or a "they" nurse mode. But the "self" nurse mode is also open to possibility for the patient, positive possibility.

...this is, this is somebody who, who has done something really horrible but, potentially, can be helped and can have some form of life afterwards if everything is done properly for her (Vic).

But what else is the "self" nurse mode open to? Again it is necessary to inquire of our Being-with patients in the encounter. It would seem that the "self" nurse mode is open to feelings as uncovered in the mode of Being-with as being emotional. In being emotional we cannot be indifferent, we cannot pass the patient by, the patient cannot "not matter."

...it was ah, horrifying and loathsome...(Vic)

I was really um...really distressed by the death of someone that I knew, (David)

[I felt] Useless, hopeless, absolutely wasting my, you know, wasting everybody's time...(Julie).

The feelings were... ahm,... trepidation I suppose is the best word...(Vic)

It was very sad (Julie).
it's just like a slap in the face because we've tried really hard, we've tried, and tried (Judy).

Yeah I was feeling very protective towards her (Jean).

Frustration, anger (Judy)

it was a little bit eerie actually...I was almost hoping that there'd be no one there...I didn't know what to expect (Lyn).

...you feel warm and you glow (David).

But if Being with in a “self” nurse mode is based on “shared” humanity then this Being with as being emotional cannot be solely for the purposes of isolated introspection but must in some way relate to the patient, and this would appear to be the case.

...and just that, you know, just the frustration of not being able to help her... was really incredible, (Julie).

...overall there's still that warmth there (John).

I sort of felt that there was a really positive contribution...[from Vic].

Shared Humanity and Opening ourselves up to ourselves and to the patient
Shared humanity in the “self” nurse mode can be painful. This can be illustrated in the pain experienced by David at the death of Jim and of Judy at the death of John and by Jean at her “failure” to prevent the situation between the doctor and Tracey. It can be dangerous in that we may find ourselves at odds with our colleagues, as experienced by Julie and Vic. It can be uncomfortable as it can arouse in us uncomfortable and distressing feelings, feelings of self doubt, of sorrow, of anger, of anxiety, of self revelation. But it can also be uplifting. This uplifting does not have to have the quality of a spiritual experience but rather is the uplifting which comes from ordinary human experience in the encounter.

*Oh she was a great person,...yeah she was great, (Julie).*

*You know, he used to...laugh at what I said occasionally and I'd laugh at what he said (John).*

This simple ordinary shared humanity is denied us in the “they” nurse mode.

**Shared Humanity and the power of the ordinary**

But ordinary shared humanity can be a powerful thing. David recounted the following story of an encounter a student nurse had with a patient and the effect it had upon the patient.

A teenage girl, Fiona, had come in to the mental health centre for treatment and entered the group therapy programme. One night whilst out roller skating with
friends, Kit, the young student nurse on placement at the centre, encountered Fiona and found herself in the dilemma of not knowing whether to acknowledge her or not.

It's always a bit difficult to know whether you should identify that you know people 'cause then their friends go well how do you know him, and they go oh he's my therapist at the (clinic). Anyway, Kit says "well I didn't know what to do, Fiona was there and I just sort of introduced her to my friends and she skated with us...the dilemma at that time was about oh, you know, should I acknowledge myself or not."

[months later] I [David] did the three month evaluation with Fiona and she'd done wonderfully well, she was a very intact young lady... And when I asked her what...had contributed to the change, thinking you know any moment now she's going to say "working with you, and your attention and your genuineness", and she said well you know that student who was here? ...I met her out at skating and she just accepted me like I was someone who didn't have a mental illness and it was then I decided that I was worth saving and I changed my life". (Ken and David laugh delightedly). Look at that, all, all the high fowling stuff and basically if I'd gone out and gone roller skating with her she probably would have been fixed as well, (laughs) hey it's not that simple but I think often that sometimes ah, yeah, sometimes it's as simple as being...just acknowledged in a social setting. (Ken: Being accepted as another human being?)
David: Yeah, not treated as a sick person ...and basically skating, skating with them with no stigma...it was amazing...

The theme of the ordinary has been taken up by Taylor in her research into the phenomenon of ordinariness in nursing (Taylor, 1994). For Taylor, nurses who can be “just themselves” bring a humanness to their professional life that makes the nurse-patient relationship therapeutic (Taylor, 1994:4). Taylor is not suggesting that nursing skills are unimportant but rather that,

Patients recognise and respect nurses’ knowledge and skills and they trust in these professional prerequisites, but they are pleased when they find that nurses are humans, just like themselves. It is this affinity as humans, this thing that I have called ‘ordinariness’, that allows nurses and patients to acknowledge each other as humans and share in the transitory imposition of illness (Taylor, 1994:4).

In approaching a patient in our ordinary humanness of just ourselves, we indicate to the patient that the things which separate us are insignificant compared to those things which bind us together in our shared humanity. Perhaps what Fiona is saying is that if someone else can accept me, can understand me, can enjoy being with me then the possibility exists that I can understand, accept and enjoy myself.

Shared Humanity and time
In the horizon of time, Being with in absence and Being with in endings were discussed. Again one may ask how is it possible to Be with in absence and what makes the significance of the encounter endure after it has ended.

**Being-with-in-absence and Being with in endings.**

Ontologically speaking it is possible to Be with someone and not be with them in a spatial and temporal sense. The Heideggerian view of this was discussed in the previous chapter as the difference between being next to (or along side) and Being-with. It is analogous to the common experience of “Being miles away.” This being miles away knows no temporal or spatial bounds. We can go back in time and travel great distances, we can even go into the future (which was also discussed in Being-with-as-possibility). When we are “miles away” it is often because we prefer that destination to where we are now, as in when we are fantasising, or because what has happened to us in the past (or will happen in the future, as in worry) is of pressing significance and we become preoccupied with it or have it easily brought to mind. The latter would appear to be the case in the encounters described by these nurses. The past (encounter) was of such significance that it can easily be brought to mind, in fact in some cases is pressing to be brought to mind (Judy). When something is easily brought to mind it is usually because it has touched us in some way. It is impossible to remember what I had for dinner on the 23rd September 1989 but I can remember what I had for dinner on my 23rd birthday as my friends took me to a surprise birthday party at my favourite restaurant, I was touched by their caring.
Each of the nurses had no difficulty in recalling a significant encounter. For some the encounter had occurred years previously yet the details had been indelibly etched into memory (Vic, Judy, Julie, David). In recalling the encounter these nurses were Being-with in absence and in the endings. This is possible because they had been touched by the encounter, it was significant. But why were these encounters significant? What was touched?

For Vic (see Chapter 7) the encounter was significant because he played a role in helping another recover in difficult circumstances but also because he had extended himself through his striving for possibility. This striving was partly a way to overcome the "system" with which he was angry and which he felt would do a disservice to Kerrie as, he believed, it had done for him. What this means is he had a shared concern for himself and Kerrie.

For Judy the encounter with John shook her out of her average everydayness of Being with patients to asking the question who was this person and who are patients in their humanity, "Who are you?"

For Julie the encounter with Robyn was significant because she could see Robyn's basic humanity, despite her behaviour, which was less visible to the other nurses.

For John the encounter with Tony was significant because of the human tragedy he encountered in Tony's circumstances; an intelligent, humorous and likeable individual now spending his time trying to prove to nurses (so John believed) that he was bad in order to prove to himself that he was not mad.
For Lyn the encounter was significant because she was able to do something practical to improve the lot of another human being.

For Jean the encounter was significant because she believed she was unable to adequately help a young woman who could have been her daughter.

For David the encounter with Gwen touched him because she was as significant to his development, as a person and a nurse, as he had been significant in her rediscovery of herself. The encounter with Jim was significant because of the reality of our shared mortality and the possibility that he had failed another human being.

Underlying all of this is that which makes such significance possible, that makes understanding possible, that makes empathy possible, that makes possibility possible, that makes caring possible, and that, in the course of the encounter, was touched: shared humanity. Shared humanity is the ability to relate to another human being as a human being because we can know something of their experience. Because we too are human.

**Shared Humanity and the world**

In the “they” nurse mode it is likely that the nurse is “next to” rather than “with” the patient. Whereas in the “self” nurse mode the nurse is “with” the patient and this Being with can be in the physical and temporal distance from the patient as in Being with in endings above. Being with allowed the nurse to share more fully
in the human experience of the patient because it becomes (or rather the nurse allows it to become) part of their experience also: shared humanity.

Examples of this Being with have already been cited; Julie, seeing Robyn touch her muddy hair and shoes in puzzlement, feels her distress, Vic, seeing Kerrie’s perplexity and through Being with her he is transported to the time and place of the mutilation of her child as if he were witnessing it. Judy, who after the death of John can imagine him as head of a family and a respected and loved member of a community.

**Shared Humanity and The safety of the “they” mode**

From the above it would seem that the “They” mode is less painful than the “self” mode. It entails less personal involvement and less painful emotion and personal identification: such detachment is safer. But it would perhaps be less rewarding. For some nurses the detached attitude of the “They” is the professional attitude. Walsh (1994) however, argues that: ‘The “professional attitude”...is sometimes used as an excuse in relationships which, in the name of “professionalism”, objectify the “other” ’(1994:118).

**Shared humanity for the sake of the patient.**

Shared humanity is the ability to relate to another human being as a human being because we can know something of their experience; we too are human, we share a ground of common meaning and experience. However sharing implies a giving and taking. Such give and take is evident in the way that the nurse and
the patient enrich each other’s experience of being human. The patient and the nurse would appear to touch one another. Examined above is how the nurses were touched in the encounter, how the encounter was significant to them. Even though for the purposes of this study patients were not interviewed, it would appear that they too were touched in the encounter. This is evident from what is known of Gwen and Robyn.

As has been discussed, Shared Humanity is a unifying theme which underlies the modes of being a psychiatric nurse as described by these encounters. So far it can be said that these existentials are common to all encounters because they are ontological. But what is it that makes the nurse patient-encounter different from other encounters? It is the expressed purpose of the encounter ie to be of therapeutic benefit. So whilst nurses may be in an encounter with a patient and may share a common humanity, and whilst nurses may gain personally from such an encounter, the encounter, and psychiatric nursing, is for the expressed purpose of helping another. It is Being with in shared humanity for the sake of the patient. Psychiatric nurses are Being in the world with patients in understanding, possibility, care-full concern, in time and the world, but as psychiatric nurses. There is an intentionality or directedness to encounters with patients, a pointing towards a potential positive outcome guided by shared humanity.
Shared humanity as guidance

Psychiatric nurses possess knowledge and skills gleaned from their academic training and experience. But skills and knowledge in a practice discipline need to be applied with sensitivity and astute timing. An appreciation and recognition of shared humanity is necessary in order for this to come about. In this way shared humanity can be seen as providing a kind of guidance in the nurse patient encounter.

Shared humanity guided: Vic on the path to confront Kerrie; Julie on her path to stay engaged with Robyn; Judy on her long path to understand John and hence, in the future, other patients; David on his path to understand Gwen; Lyn on the path to sensitive practicality with Edna; Jean on the path to building rapport with Tracey; and it also guided John’s warmth towards Tony despite Tony’s behaviour.

If the analogy of a forest is once again used, the forest can be said to be treed with possible outcomes in the encounter with a patient. Attention to shared humanity provides a direction to the journey, much like the attraction of a compass to magnetic north which leads into the forest of possible outcomes and guides the nurse’s endeavours in the encounter so that they may arrive at the best possible outcome. Shared humanity is not always easy to follow, the compass needle may at times be deflected and the path of shared humanity may not always be the smoothest but the nurse and the patient can both grow on the journey even if they occasionally lose their way. It is the magnetism of the humanity of the patient which guides the compass needle if the nurse can but be sensitive to it. The compass does not direct the nurse through the forest but rather to that
clearing in the middle of the forest. The clearing is the “encounter” and it is here that the patient is met as an immediate living human being, it is here that psychiatric nursing takes place. Then the patient finds his/her own way out of the forest.

Conclusion

The unifying theme present in all of the encounters, that makes possible the ways of Being described here, is shared humanity. Shared humanity guides the encounter and the projected possibilities envisaged by the nurses. Shared humanity makes the ordinary extraordinarily effective in helping patients. Shared humanity underlies understanding and care-full concern.

The next chapter will examine shared humanity and psychiatric nursing in more detail through the modes of the “they” nurse and the “self” nurse.
CHAPTER TEN

SHARED HUMANITY AND PSYCHIATRIC NURSING.
Shared Humanity and Psychiatric Nursing.

Introduction

Psychiatric nursing is

...positive regard, respect and a bit of humour and a bit of compassion and a bit of humility, on your part...you are not indicating...that you’re the therapist and they’re the patient, [but] that we’re all sort of, in it together, that we all have a common existence, here on earth together, a short time (John).

There are seven nurses in this study. They do not see themselves as remarkable nurses, the encounters they have had are, for psychiatric nurses, not that remarkable. Yet there is quite a lot about psychiatric nursing and these nurses that is remarkable.

This can be illustrated by contrasting the two modes of Being with patients initially discussed in the previous chapter, modes in which shared humanity is either disclosed or covered over; The “They” nurse mode and the “Self” nurse mode. This chapter will further explore shared humanity and psychiatric nursing through these modes.

The “They” nurse mode.
As discussed earlier, shared humanity is the ground upon which the existentials and horizons, that have been described in this thesis, stand. This shared humanity guides nurses’ efforts in utilising their psychiatric nursing skills and in bringing about positive change in a patient’s condition. The recognition of shared humanity in the nurse patient encounter is not a magic panacea but it would seem that when such shared humanity is covered over, the likelihood of developing a therapeutic relationship is remote (Examples of this may be seen in the submissions to the Burdekin inquiry cited in Chapter 2).

Some possible reasons for this have been posited by R. D. (Ronnie) Laing the Scottish psychiatrist. Laing (1960:39) coined the term “primary ontological insecurity” for what he saw as the underlying phenomenon of mental illness. By this he meant that mental illness is at base being insecure, in a primary and fundamental way, as to who one is and what it is to be. People with low ontological security see even the everyday pressures of living as threatening (Laing, 1960:43-44). In this Laing is drawing upon the existentialism of Jean-Paul Sartre. Briefly Sartre’s position is as follows. Consciousness is one of Sartre’s fundamental concerns. Consciousness for Sartre, is always intentional, that is, always consciousness of something, directed towards something (Kruks, 1990).

If all consciousness is intentional, then a study of consciousness is a study of subject and object; “subject” being that which is conscious and “object” that which consciousness is directed towards. Intentionality must lead to a differentiation of ‘... self as a subject in relation to a possibly unknowable object’ (Scruton, 1981:266). This separation of self as a subject cleaves us from the world
with the axe of self-consciousness and brings about "nothingness." With this sense of nothingness comes "anguish" (Scruton, 1981:266).

Anguish can be felt when we catch ourselves unaware under a starry sky and feel insignificant or when we feel undifferentiated and alone in our sufferings. 'I emerge alone and in anguish confronting the unique and original project which constitutes my being...' (Sartre, 1958:39).

Anxiety about one's own non-existence (death) is present in most humans. But it is anxiety about non-existence in life that is the hallmark of the ontologically insecure person (Roche, 1973).

...death of the body and continuing life of the spiritual self is a theological hypothesis; on the other hand, death of the spiritual self and continuing life of the body is an all too common and tragic psychiatric fact (Roche, 1973:217).

If the separation of self as a subject from objects brings about anguish then to escape this we may be tempted to objectify the self and hence jump the chasm between self and object by becoming an object (Scruton, 1981). I may do this by taking on roles and beliefs, that others ascribe for me. Laing calls this '...the false self system' (Laing, 1960:94). Sartre calls it being in '... bad faith' (Scruton, 1981:267). Both of these would seem to be similar to the "They" nurse mode uncovered in the encounters described in this study.

In the "They" nurse mode I alienate myself from patients (and myself) through the covering over of shared humanity.
It is only from the stand point of shared humanity that one being can reach out and touch another (and perhaps even fully understand ourselves). Otherwise others and ourselves are like shadows whose substance is illusory.

It would seem that at times nurses cover over their shared humanity, taking on roles and attitudes in "self-forgetfulness", which obviates any possibility of a Being to Being relationship with patients who are themselves lost in ontological insecurity.

The "self" nurse mode

In contrast to this, the nurses in this study have described sad, and tragic circumstances, perhaps some of the saddest and blackest life has to offer. Yet in every case they are able to see the positive possibility for change, albeit change in small increments, no matter how small. They are able to see the humanity of the patient shine through the confusion, anger, violence and despair of mental illness. In each case they approach the patient as an immediate living unique human being. They approach the person as a person to be understood, a person who is able to be understood. They use their psychiatric nursing skills but in the context of the humanity they share with the patient, a humanity which guides them. They care deeply for the people they nurse. The patients' tragedies are felt by the nurse, they are moved by them, sometimes to tears. They have high expectations of themselves, they blame themselves for their perceived wrongs, they are plagued by self doubt, they are less than perfect, but they are human, they
are not detached. They take risks, they put themselves in danger. They learn from their mistakes, they bring to each encounter the accumulated wisdom of previous encounters, yet with each encounter they learn about themselves and patients in our “common existence”.

They lessen burdens by sharing them as much as they can. They are with people in the good and the bad and they accept people without judging them for their weaknesses or their behaviours. They carry the memories of these often forgotten people with them and see them as having worth when society sees them, all too often, as worthless.

**Shared humanity**

Such Being to Being encounters have the capacity to be painful because they awaken in the nurse, through shared humanity, the realisation of their own vulnerability. Yet such relationships have the capacity to be profoundly moving, opening up each person to their shared humanity and all its possibilities. To shun such an encounter is to turn a potential I-thou relationship into an I-it relationship which may lead to

... social ostracism; turning the patient into an object of avoidance, pity and judgement ... in this way people in a social world of the ‘mentally ill’ subject exclude the possibility of an I-thou relationship as well as the possibility of everyday, let alone deep communication with him (Roche, 1973:212)"

In collecting, telling and interpreting the experiences of these nurses I have found myself surprised, awed, occasionally moved to tears, and occasionally moved to
laughter. These feelings I take to be testimony to our capacity for humanity and the power of such shared meanings.

Being a Psychiatric Nurse

If nurses begin to appreciate their potential for understanding interpersonal relationships, they can come to understand themselves as humans who share commonalities with people in their care. In this way nurses may begin to understand nursing itself, so that long-sought-after quest of nurses to define nursing as a human endeavour may be accomplished at last (Taylor, 1994:3).

At this point it is important to define psychiatric nursing on the basis of this study. This is an onerous task, for having had the privilege of working with these remarkable nurses any definition will fall short of the complex realities. Rollo May (1967) in his excellent book Psychology and the Human Dilemma, fantasises about a psychologist going to heaven and being called to account before Saint Peter. Saint Peter accuses him of Nimis Simplicandum, (oversimplifying) and he says this to the hopeful psychologist,

> You have spent your life making molehills out of mountains - that's what you're guilty of. When man was tragic you made him trivial...When he suffered passively, you described him as simpering; and when he drummed up enough courage to act, you called it stimulus and response. Man had passion; and you were pompous...You made man over into your image of your childhood Erector Set or Sunday School maxims - both equally horrendous (May, 1967:4).

I hope I shall not be accused of Nimis Simplicandum. I am well aware of the complexity of psychiatric nursing which stems from the complexity of shared
human Being as such. I am also well aware that this thesis has merely scratched the surface of psychiatric nursing. Psychiatric nursing is more than “stimulus and response” it is more than the techniques we learn in counselling and communication theory. It is more than is written in patients’ files, it is even perhaps more than what we, as nurses, are willing to reveal to others.

As was said at the outset, the study represents but one interpretation and I have presented it here for critique and review. It in no way represents all there is to know about psychiatric nursing but is my attempt to bring to light some of the complexities of the profession which has moved, intrigued and delighted me in my nearly 20 years of nursing.

Psychiatric nursing is a standing in relation to another in which the nurse brings to bare her/his shared humanity for the sake of the patient. The patient, despite their mental illness, is grasped as a being in the world who can be understood. An individual whose differences from the nurse are seen as less than their shared similarities. An individual who has future potential dwelling in the present. An individual who deserves and requires care. The nurse is concerned for the patient. This concern is experienced genuinely by the nurse as is manifested in the nurses’ emotional experiences of being with the patient. Psychiatric nursing skills are utilised thoughtfully through the guidance of shared humanity which ensures the patient is at all times seen first and foremost as a person and not as the object of “psychiatric patient”.
Psychiatric nursing is not an externalisation of the nurses’ skills or experience. It is intimately bound to the shared humanity of the nurse and the patient. It is for this reason that psychiatric nursing is experienced by the nurse as moving. Shared humanity in psychiatric nursing informs its practice and makes a therapeutic encounter possible. Psychiatric nursing is dynamic and circular. The therapeutic encounter further informs and builds the nurses’ understanding of her/himself and patients in our shared humanity which is in turn called upon in subsequent encounters.

The Future

In psychiatric nursing today there are many challenges. The reality is that funding for psychiatric services is likely to fall. Psychiatric care is changing as government policies such as “mainstreaming” take effect. New drugs such as Prozac and Clozapine, combined with a more biologically determined view of mental illness, are changing our view of these illnesses. It remains to be seen if these changes will be for good or ill. If history has anything to teach us, it is that it is likely that these changes will bring mixed blessings. History can also teach us that anything, be it technology, ideology, economics or philosophy, which covers over our shared humanity only leads to inhumanity and the worse excesses that such inhumanity can bring. It is only on the basis of covering over our shared humanity that events like those seen in The Gulf War, Bosnia, Port Arthur, or for that matter, Chelmsford and Ward 10B, can occur.

Psychiatric nursing is still firmly based on the interaction between human beings and a recognition of our shared humanity. It is based on a one to one encounter. It is human to human. The true measure of that encounter cannot be fully grasped by others but it is grasped by the two who meet in that common ground and are
It is human to human. The true measure of that encounter cannot be fully grasped by others but it is grasped by the two who meet in that common ground and are transformed. This is the true power of psychiatric nursing (and for that matter, of nursing). It cannot be eclipsed by new drugs or treatments but it can be covered over. The only way for someone who is lost to themselves to find themselves is in the common ground of shared humanity in a being to being encounter.

**Evaluation of the Thesis**

As stated in Chapter four, the thesis is to be evaluated utilising Madison’s nine principles: Coherence, Comprehensiveness, Penetration, Thoroughness, Appropriateness, Contextuality, Agreement, Suggestiveness, and Potential (Madison, 1990:28-30). In developing these principles Madison has relied heavily on Gadamer’s *Truth and Method*. Whilst Madison is concerned with the interpretation of literary texts, the same principles can be applied to the present study because the accounts given by the participants have been transformed by me into text.

**Coherence:** the account is coherent, presents a unified picture and does not contradict itself. There should be a harmony between the details and the whole.

At all times the encounters as described by the nurses have been referred to whenever an interpretation has been made. Understandings have been generated by the nurses’ descriptions of the encounters themselves.
**Comprehensiveness:** the account gives a sense of the whole. This principle is concerned with the ‘...relation of the interpretation to the work itself which is interpreted (Madison, 1990:29).’

A sense of the whole is necessary for a text to be intelligible (Madison, 1990:29). Each encounter describes not only the interaction between the nurse and the patient but the background of significance associated with the encounter. It is significant, for example, that David is young and inexperienced when he meets Gwen and that Vic is “angry with the system” when he meets Kerrie. Meaningful interpretation can only be made via a comprehensive account of the phenomenon and in each case such an account is given.

**Penetration:** the account brings out a “guiding and underlying intention” in the text it “attempts to resolve a central problematic” (Madison, 1990:29).

The central problematic of the study is concerned with the phenomenon of the nurse-patient encounter which is central to being a psychiatric nurse. This phenomenon has guided the study from beginning to end and has resulted in the interpretations presented in chapters seven to ten.
Thoroughness: the account deals with the questions posed by the interpreter or posed by the text to the interpreter.

At various points in the study questions were posed by the text or posed of the text, for example; What makes understanding and possibility possible? Is Being with as being in control a mode of Care-full Concern? Is there a unifying theme which underlies the existentials uncovered? These questions arose from the dialogue with the text and the interpretive account given here is an attempt to illuminate these questions. However, as hermeneutic interpretation is never closed, more questions could certainly be posed of the text.

Appropriateness: the interpretation deals with those questions raised by the text itself.

Throughout the study whenever a question has been raised either by the text or of the text, the place in the text at which the question first arose has been cited. In this way a focus on the “things themselves” has been maintained and the reasoning behind various interpretations made explicit.

Contextuality: the interpretation is in keeping with the historical and contextual nature of the text.
Chapter four gives an account of the context of the study by examining the world of the nurses; the psychiatric hospital and its historical and temporal context.

**Agreement:** the account must agree with what the text says, that is it should not go against the grain of what the participants say by, for example, asserting that they actually mean something other that what they are saying.

Throughout the study an explicit dialogue with the text has been maintained. The degree of agreement between the text and the interpretations presented and the reasoning underlying these interpretations, can be judged by the reader. It is conceded that interpretations other than those presented in this study may be made of the encounters presented. However, I believe that the interpretations presented here are in agreement with, and “fit”, the accounts of the encounters as described by these nurses.

**Suggestiveness:** the account stimulates future work.

This study did not aim to generate generalisable “facts” but to illuminate a phenomenon. The encounter between nurses and patients in whatever setting is central to nursing and as such is open to future research.

**Potential:** the account is capable of being extended, ‘...the implications it contains unfold themselves harmoniously...’ (Madison, 1990:30). The account has
implications which can be utilised to illuminate future events and situations (Plager, 1994:79).

As already noted, this study did not set out to generate generalisable "facts". Nevertheless, the insights gained in this study may be useful in illuminating other events and situations. The centrality of shared humanity to nursing practice is a notion that would bare further examination and the modes of the "they" nurse and the "self" nurse uncovered in this study, may be useful in illuminating other aspects of therapeutic nurse-patient

Conclusion

Psychiatric nursing is more than the sum of the techniques that are taught as essential in bringing about therapeutic change. Psychiatric nursing takes place in the common ground of the nurse-patient encounter. In this encounter nurses are "with" patients in understanding, Possibility and Care-full Concern, in Time and the World. Underlying all of the encounters is a Shared Humanity which guides the nurse’s actions in the mode of the "self" nurse. Shared Humanity makes possible a genuine being to being encounter in which the patient and the nurse meet as beings in the world, as first and foremost, human beings.

It is only when the individual recognises the other in his very otherness, as a human being other than himself, and when on this basis he effects a penetration to the other, that he can break the circle of his solitude in a specific, transforming encounter (Gabriel Marcel, 1967:42).

All real living is meeting (Martin Buber, 1958:46).
APPENDICES
APPENDIX 1

PLAIN LANGUAGE STATEMENT FOR PARTICIPANTS.

Project Title. An Examination of the Psychiatric Nurse's Lived-Experience of Being-in-the-World with Patients via the Nurse-Patient Encounter.

RESEARCHER: KENNETH D. WALSH.

The purpose of this research project is to uncover the meaning the nurse-patient encounter has for the psychiatric nurse. It is hoped that by exploring the meaning that the nurse-patient encounter has for you, a greater understanding of nurse-patient encounters will result. This understanding may help other nurses to better comprehend their own relationships with patients and enhance patient care. If you agree to participate in this project you will be asked to share your thoughts and feelings about nurse-patient encounters in an interview with the researcher. The interview should last no more than one hour and will be audiotaped.

It is possible that discussing your experiences of nurse-patient encounters may, at times, be distressing to you. The researcher is experienced in supporting people in times of distress and will arrange for further support, of your choice, if you wish. You may stop the interview or withdraw from the project at any time.
All information gathered in the course of the project will be treated as confidential. Information may be published but your identity, or information which may lead to your identification, will not be disclosed.

Any questions may be directed to:

Kenneth Walsh  Ph. (076) 968068

THIS IS TO CERTIFY THAT

I, ____________________________________________

(print name)

agree to participate as a volunteer in the above named project. I give permission to be interviewed and for these interviews to be tape recorded. I agree that the information may be published, provided my name and any information which may lead to the identity of any person or institution becoming known, not be associated with the research. I understand that, as a nurse, I am bound by confidentiality not to divulge any information which may lead to the identity of any patient becoming known. I understand that I am free to refuse to answer any questions during the interview and that I am free to withdraw my consent and end my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

__________________________________________  ____________________________  ____________
Participant.       Researcher.       Date.
(adapted from Field and Morse, 1985:44-45.)
APPENDIX 2

ETHICS CLEARANCE
THE UNIVERSITY OF NEW ENGLAND

Pro Vice-Chancellor (Research)'s Advisory Committee on Ethics in Experimentation on Human Participants

MEMORANDUM TO: Prof A Pearson / Mr K Walsh
School of Health

This is to advise you that the Pro Vice-Chancellor (Research)'s Advisory Committee on Ethics in Experimentation on Human Participants has approved the following:

TITLE OF EXPERIMENT: An Examination of the Psychiatric Nurses Everyday Lived Experience of Being in the World With Patients

COMMENCEMENT DATE: 1 December 1994

APPROVAL VALID TO: 30th November 1995

COMMITTEE APPROVAL NO: HE 940158

COMMENTS: Nil

Approvals are normally granted by the Committee for a maximum twelve month period. A Final Report should be submitted on completion of the project if this occurs within 12 months. If the research project is to continue beyond twelve months the person responsible is required to submit an application for renewal. In the case of routine class demonstrations, approval may be given for a period of up to five years. In this case an Annual Report is required indicating that (i) no ill effects were reported, (ii) no procedures were changed, and (iii) there were no staff changes.

A copy of the Annual/Final Report Form (Part II) is attached.

8th December 1994
T. Moore
Secretary
REFERENCES


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