

Right There, in the Midst of It: Impacts of the Therapeutic Relationship on Mental Health Nurses

Angela C. Morck, RN, PhD

Abstract

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

Keywords

mental health nursing, therapeutic relationship, hermeneutics, narratives, distress

Mental health nurses frequently confront situations in their work that elicit intense emotions in both their patients and themselves. Nurses can unexpectedly find themselves in perilous territory. Warne and McAndrew (2005) reminded us that it is the nurse's responsibility to "acknowledge the complexity of the human experience and to navigate the therapeutic relationship" (p. 683). What happens, however, if the navigators find themselves in uncertain waters, in danger of being pulled under, or in peril of drowning in the intensity of emotions? My intent in this paper is to

Corresponding Author:
Angela C. Morck, RN PhD
Email: amorck@ucalgary.ca

provide an overview of the findings of my philosophical hermeneutic master's research (Morck, 2009) exploring the understandings, meanings, and processes by which mental health nurses take up and navigate the illness and life narratives of their patients. There was a focus on discovering the impact this position as listener of often emotion-laden narratives has on nurses and their ability to be present within the therapeutic session, and ultimately what the impacts are on the therapeutic relationship.

Background and Literature Review

The relationship between nurse and patient is central to the practice of mental health nursing. This therapeutic relationship has been deemed the "essence" (Forchuk, 2002, p. 93); "crux" (Peplau, 1962, p. 53); "core" (College of Nurses of Ontario, 2006); and the "heart" (Perraud et al., 2006, p. 224) of the discipline. Peplau has been credited as the "mother" of modern mental health nursing and bringing the nurse-patient relationship forward and central to practice (Forchuk, 1994; Tomey, 2006). The relationship between nurse and patient was developed in predictable stages and viewed as helping relationship wherein the exploration of the patient's feelings and concerns leads to personal growth in both patient and nurse. The nurse remained aware of his/her own needs but there is a detachment of self-interest to become an agent of change for the patient (Peplau, 1988, 1992; Tomey, 2006). This belief is also reflected in the work of Orlando (1961) who stressed the reciprocity of the therapeutic relationship and believed the nurse and patient represented a dynamic whole each affecting the other. Travelbee extended and synthesized the interpersonal relationship theories of Peplau and Orlando (Tomey, 2006). Her work was an admonishment to the premise of remaining emotionally uninvolved with patients (Shattel et al., 2007). The therapeutic use of self is a fundamental characteristic of a nurse and that a therapeutic relationship is deliberately and consciously planned. Emotional involvement is necessary to establish a relationship; complete objectivity is neither possible nor desirable (Tomey, 2006).

Beyond the phases and progress of the therapeutic relationship, what happens in the relationship has been explored in attempts to understand how it is helpful to the patient (Forchuk & Reynolds, 2001; Hagerty & Patusky, 2003; Walsh, 1999). Hagerty and Patusky (2003) challenged Forchuk and colleagues focus on the linearity and temporality of the therapeutic relationship with a reconceptualization on human relatedness. As in the broader psychotherapy stream, current nursing theory on the therapeutic relationship has become increasingly focused on integrative relational approaches situated in postmodern, social constructionist, and feminist perspectives. The therapeutic relationship has come to be viewed with a collaborative nonhierarchical stance that involves a weaving of the nurse's expertise with those of the patient (Wright, Watson & Bell, 1996). Mental health nurses journey with, and learn from, people experiencing mental distress (Barker, 2001). There is an interconnectedness of the relational commitment and an acknowledgement of self and other (Hartrick Doane & Varcoe, 2007) and an appreciation of the moral space of the therapeutic relationship (Bergum, 2004; MacDonald, 2006).

In alternate attempts to delineate components of the therapeutic relationship, other concepts studied have included empathy (Hardin & Haralis, 1983); connection (Miner-Williams, 2007; Wiebe, 2001); commitment and involvement (Morse, 1991); transference (Evans, 2007); nurturance (Raingruber, 2003); and boundaries of the relationship (Austin, Bergum, Nuttgens, &

Peternelj-Taylor, 2006; Milton, 2008). Therapeutic relationships have also been explored in the context of a variety of patient populations, clinically depressed (Beeber, 1989), and with suicidal individuals (Sun, Long, Boore, & Tsao, 2006). These studies, while emphasizing the importance of therapeutic use of self and the development of relationships with patients as the core of mental health work, do not address the meanings of the relationship for the participants, nor do they identify the skills that the nurses used to develop and maintain the relationships.

While seemingly central to mental health nursing practice, the therapeutic relationship has continued to remain elusive. Nurse scholars have long attempted to portray and illuminate its complexity. While we know a great deal about what patients want and what nurses are supposed to do within in a therapeutic relationship, we continue to know very little about the meaning of this everyday experience for mental health nurses. The majority of current research has been conducted on the concepts held within the relationship. While these investigations have been vital in revealing the complexity of the relationship, they have failed to explore its meaning to, and impact on, mental health nurses. This gap opens space for an interpretive look into these phenomena through conversations with nurses who live within the everyday experience of the therapeutic relationship.

Research Design

Method

This research project was guided by the philosophical hermeneutics of Hans-Georg Gadamer (1900-2002). Gadamerian hermeneutics was chosen because it specifically seeks to understand and interpret language and experience. As a sophisticated research approach to understanding within the human sciences, hermeneutics has been shown to have invaluable applied utility (Moules, McCaffrey, Field, & Laing, 2015). Gadamer asserted the task of hermeneutic understanding lies in the attempt to grasp the “unpredictable character of the spiritual and mental life of human beings” (Gadamer, 1996, p. 165). I would further that so too is the task of mental health nursing. Mental health nurses are situated in the midst of stories, of lives lived in shifting contexts, histories, and relationships. The given task is to navigate situational particulars, and through interpretation place these particulars into an understood whole (Moules, 2000, 2002). As a broker of understanding (Moules, 2000) the researcher is not considered separate from, nor a non-influencing factor of the research, but rather a vital component of the understanding offered.

Recruitment of Participants

After ethical approval was obtained from the University of Calgary Conjoint Health Research Ethics Board (CHREB), participants were garnered through a purposive selection to provide a detailed rich encounter of their experiences with the topic. Inclusion extended to any nurse registered with the College and Association of Registered Nurses of Alberta (CARNA) and presently working in the Calgary Health Region in a mental health clinical practice area. Five mental health nurses agreed to participate in this research study, met the inclusion criteria, and were interviewed.

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

Data Generation

After informed written consent was obtained, I conducted semi-structured interviews with individual participants at a mutually agreed upon time and location. Each interview took between one to one and one half hours and was audio recorded. Basic demographics of the participants were obtained at the time. The interviews were then transcribed verbatim into written text for ongoing analysis. Field notes were written after each interview to capture contextual details and beginning interpretations.

Analysis and Interpretation of Data

The process of data analysis and interpretation began with the research interviews. Aligned with the tenets of philosophical hermeneutics, the research process was guided not by methodological procedures but rather by thoughtful systematic attention to the topic (Moules, 2000; Moules et al., 2015). The fusion of horizons provides a description of how understanding comes together. Hermeneutics thus provides an opening into the understanding of an experience of something by being present and aware of the pre-understandings brought into a topic. The hermeneutic circle provides a descriptor of movements between the part and the whole. This movement from the specific to the general, from the general to the specific is an attempt to understand the whole in terms of the detail, and the detail in terms of the whole. It becomes a circular process of movement back and forth that leads to understanding (Gadamer, 1989). Reading, re-reading, and writing formulate an understanding of the parts and creativity is emergent with the reconstruction of the whole in a meaningful, purposeful, insightful way that offered understanding about the topic (Jardine, 1992).

The remainder of this manuscript offers an overview of select findings and interpretations. It ventures into the world of mental health nurses entwinement with the often emotion laden narratives of their patients. This venture necessitates a change of rhythm, tone, and form that matches these experiences. At this juncture, philosophical hermeneutics upholds and supports while giving way to the voice of the topic.

Interpretive Analysis

The Shelter of Home

I think ...it is very important for nurses to be able to have these relationships with our patients and that it isn't necessarily something that can be taught. I think it is one of those

things that you learn in the fundamentals of what a nurse-patient relationship should look like and you find your own way from there.

Mental health nurses journey with, and learn from, people suffering mental distress. In this process, there is a continual involvement and immersion in the narrative of others who are attempting to make meaning of what is happening to them (Barker, 2003). These journeys, and the therapeutic relationships in which they dwell, are complex, dynamic, contextual, and full of impact. There exists no topographic map or perfect formula that can be taught and reproduced; it is rather about joint discoveries with our patients and finding our own way as nurses. Finding our own way evoked, to me, a discovery journey of self and our place as mental health nurses in the world. It is also a journey of language, conversation, and uncovering new, or perhaps different, understandings of dwelling in the place of our patients' narratives. Ultimately, this journey as mental health nurses of the therapeutic relationship has been about finding a way home.

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

When however your chosen vocation is to listen to the painful, evocative, and often disruptive narrative of others this disruptive force can and does invade your at home way of living.

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

This stepping into the life of another and the opening of your home, your being, to another is the working realm of a mental health nurse. People are constantly being confronted by life situations that cause disruptions to their comfortable, familiar, at home way of living (Svenaeus, 2001). Life's stressors, large and small, positive and negative, have the potential to create unrest, concern, and distress. In this instance, the self as nurse was being brought home into awareness as self as person. Henderson (2001) spoke of the recursive nature of the nurse-patient relationship, and of the inherent risks and rewards to both professional and personal self of this occupation of care. The therapeutic relationship was described as containing intrinsic tensions and pitfalls of emotionality that were left to the individual nurse to mediate.

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

Preservation is the act or process of keeping something safe, or from injury, destruction, or decay. Self-preservation is part of an animal's instinct that perpetuates survival. It is also a condition of being human. As humans we are subject to typical biological responses to threats (stress reactions, fight and flight, adaptation, and renewed homeostasis). Pain and fear are parts of this mechanism. Pain causes discomfort so we endeavor to stop the pain while fear acts as a warning to seek safety and protection from difficulties and danger (Donatelle, Munroe, Munroe, & Thompson, 2008). There was a need to keep safe and to seek shelter and a place of refuge from work. In this sense, preservation also afforded a sense of self-observation, watchfulness, and guardedness. There is also an element of covering, concealment, or camouflage in an attempt to diminish detection and the perceived threat to self. In this, the partition of self as nurse and self as person are separated and protected. With the shutting of the door a measure of self-protection is afforded in the holding of fears, anxieties, and worries of work at abeyance. There is a requisite need for separation and sheltering of the emotional self in the need to retreat homeward into a familiar way of being in the world (Dreyfus, 1991).

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

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

In retreating homeward and reviewing her life as safer than her patients' lives, this participant was attempting to understand, to separate out her life in order to make sense of what was happening to her. As she reviewed the situation, she remained and stood in the midst of her relationship with her patient. Through this search of discovery, and preservation of the house of our being, we learn to care about our home, not just its content, but also its context (Svenaesus, 2001). When you provide treatment to someone as a nurse, you are offering to them comfort, care, and connection. If this is turned on self, in terms of retreating to a place of refuge, one can be seen as needing to retreat into self, to "lick one's wounds in private" before reentering the community. This speaks to the fundamentals of mental health nursing that one must know oneself, reflect in order to reach out and be an effective nurse (Peplau, 1988). Additionally, we are called to know explicitly that this work will be challenging, not only in a physical sense, but also in a guarding of one's house. Home is thus a metaphoric foundation that provides us, as mental health nurses, a safe place to reflect, process, and honor the work of that day.

Fragmented Images: Reflections of Home

It's so fascinating for me to reflect on myself and what do I think about the world and what do I think about my life. I think my biggest fear was that I would keep taking stuff home and I would just crumble, like, I would just be unable to cope with my own stuff now, in my own life.

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

This comparison with another caused this participant to reevaluate how she should be as a nurse. She began to review her conceptualizations of what it meant to be strong and protected. She saw value in opening herself and revealing part of herself to her patients even while being cautious of what this could mean for her.

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

Vulnerability is often perceived in our western positivistic thinking as a frailty, a fatal flaw or weakness. It is related to the Latin *vulnerabilis*, meaning to wound or open (Oxford English Dictionary, 1971). To Levinas (1996), this opening of self, being susceptible to physical or emotional injury in being vulnerable, is the inescapable call revealed in the face of the other. This sense of vulnerability does not point to frailty, dependence, or loss of social autonomy. Rather, it is connected to recognition of the suffering of another. We are signifying an openness and nearness available for the other. According to Levinas (1996), it is the pivotal loci of responsibility for another human being. As nurses, we need to be able to listen to the otherness first in ourselves before we can truly be open to another. Protection can thus be reconceptualized as a repetition of the ethical conditions of vulnerability and an "apriori proof of vulnerability itself" (Frank, 2004, p. 48).

Intertwined in the therapeutic relationship, this vulnerability was evident in how nurses are influenced by their interactions with their patients.

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

David Hilficker, an American physician who left his prominent Minnesota practice to work with the poor of Washington D.C., has often written of his experience. In his attempts to respond to the wounded and chaotic lives of his patients, his own chaos was triggered. This has caused him to alter his perceptions of himself as a healer. "All of us who attempt to heal the wounds of others will ourselves be wounded. It is after all inherent in the relationship...In healing we ourselves take on the wounds of others" (Hilficker, 1994, p. 39). Hilficker perceived that we are all vulnerable beings, each harboring our own brokenness. While this brokenness inextricably binds and entangles us with one another, it does not diminish the risk (Hilficker, 1994). Rather, it

allows us to be open to the deserving values and responsibilities to the risks of being human (Frank, 2004).

This is, however, not an easy process. The ensuing anxiety and fear left this participant feeling exposed, open, and unguarded without shelter or defense.

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

Whether or not she was cut out for work as a mental health nurse began to take hold, as she questioned her abilities, resilience, and competence at work. It reflects an inner questioning tension of “Am I good enough, doing the right thing?” She began to only view herself as not fitting the social and cultural expectations of what a nurse is cut out and templated to be.

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

Rogers (1995) claimed our language in mental health is laden with an us/them split. We, as nurses, behind the desk, hold the pretense of having no difficulties, while imploring our patients to discuss whatever issue holds our attention at any given time. She argued that it is this entrenched belief of “well nurse, ill patient” that has continued to foster the image of the self contained, unaffected nurse. Beyond this, it is the nurse's responsibility to not only navigate the therapeutic relationship but also to save both parties from the vulnerabilities, hurt, and losses that may ensue. She likened this scenario as the nurse being responsible for “holding two stories, or two plays, together” (Rogers, 1995, p. 319).

The juggling of these two stories, of nurse and patient, can become precarious and blurred. While the stories and situations are often emotionally charged, nurses are required to be attentive, attuned to hear the story, and provide safety through containing the story and the expressed personal suffering (Gallop & O'Brien, 2003; Warne & McAndrew, 2008). This participant echoed this tensioned position in her encounter with a patient that left her feeling vulnerable.

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

Becoming emotionally overwhelmed by a relationship with a patient was a weakness or frailty in her professional identity. This prevailing view of a professional nurse as detached and self-aware perpetuated her own doubts about herself as competent (Dowling, 2006). The culture of mental health nursing has predicated a belief about the right amount of emotional involvement, with detached empathy and conscious rational detachment (Henderson, 2001; Warne & McAndrew, 2008). While there exists an acknowledgment that the therapeutic relationship affects both parties, the ideal remains for the responsible nurse to use theoretical concepts to guide the patient to health. The nurse remains depicted as a detached removed expert. This has fostered the belief that one is able to grasp this theoretical construct and has perpetuated the reluctance to acknowledge when things in the relationship are not as they should be (Dowling, 2006; Gallop & O'Brien, 2003; Warne & McAndrew, 2008).

While protective, windows also distort and alter in their reflective projections. In entering mental health nursing, we have taken on a particular window that has wittingly and unwittingly become our lens on the world. Lenses may provide protection or alter our perceptions without our being consciously aware of them doing so. We are always under this influence of history, and traditions of our chosen profession, situated in it and can not extricate ourselves from it (Gadamer, 1989).

Homesickness and Masked Messages

Mental health nursing is not a landscape of black and white, or diagnostic certainty. Rather, it is imbued with the rich vibrant colors that lie in-between, interlaced with infinite shades of gray. There is no map of the human psyche, no chart to follow to find one's way through and back home. It can be an easy day's wander, or a shared descent into black depths of human despair. It is a landscape filled with separation, and protection, where emotions and frailties of the human spirit are positioned against societal norms and expectations. Can there be any wonder that those who wander this land become momentarily or otherwise overwhelmed? This is a land of paradox: of the need to open oneself up, yet keep oneself safe and separate, to maintain professionalism yet be vulnerable. It is, as Warne and McAndrew (2005) articulated, working at the edge of the abyss. I question if, to be more precise, mental health nursing requires a jump into the midst of the abyss, in the space between realms. In this opening to other, and the inherent vulnerability, there is a wish to retreat to a familiar way of being, a place, we trust to be safe. Homesickness is essentially the universal impulse to be home. In this premise, I am not referring to a physicality of home but rather the ontological search for a place in which Being can be (Dreyfus, 1991). The Germanic *heimlich*, or canny, means familiar, close, while the not-at-home, *unheimlich*, or uncanny, means that which is out of the ordinary, unhomey, strange, and frightening. True home requires an effort to both embrace and ultimately integrate the *heimlich* and the *unheimlich*, the familiar and the strange in order to become more authentically at home with ourselves and the world (Dreyfus, 1991; Harries, 1978; Woolley, 2007).

In all professions and communities, there are teachers and inheritances. Ghosts, strangers, tricksters, and monsters drift in the liminal. Their presence is at times to scare us, at times to impose and unsettle, calling our attention to the particularity of their presence and arrival. They speak to teach us something of ourselves (Jardine, 1994). According to Kearney (2003)

Most strangers, gods and monsters, along with various ghosts, phantoms and doubles who bear a family resemblance are deep down tokens of fracture within the human psyche. They speak to us of how we are split between the conscious and unconscious, familiar and unfamiliar. (p. 4)

For Freud (1919, cited in Woolley, 2007), the not-at home experience of wandering in the liminal realm involved a perceived element of magic or supernatural. It is a return of the dead in spirit or ghostly forms to frequent ones home. It is a haunting.

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

In the boundary-laden space of the therapeutic relationship, these participants had been affected and have wrestled with the inherent implications. According to them, a code of silence exists in mental health nursing. We do not speak about the negative impacts of the therapeutic relationship, nor its marks and impressions. This code of silence is a strong social relationship that functions to internally sanction and control, while evoking support from its members, the nurses. The most renowned version of a code of silence is the Omerta of the Italian mafia. Omerta means manhood, and refers to the need for a man to resolve his own problems whilst maintaining a stoic silence (Oxford English Dictionary, 1971). The code of silence and the coinciding fear of being viewed as inadequate, incompetent, or lacking ability has marked these nurses.

A code of silence functions by controlling and internally policing its members. A deviation from expected norms heralds a consequence and punishment. Within mental health nursing, it has been shown that a key strategy for controlling nurses who deviate from socially acceptable norms has been to label them as over involved with their patients. Additionally, nurses have been described as vulnerable, weak, or having their own psychiatric problems. These strategies, along with the maintenance of silence, have perpetuated the code upon the nursing profession (Dowling, 2006; Handy, 1991).

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

I mean you have to put on a mask around here that you're doing good work and you're not experiencing any ill side effects because of it.

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

This sense of wearing a mask evoked to me a *monere*, or an omen or warning (Jardine, 1994). While at once frightening, they are meant to provoke thought and challenge elements of the “taken-for-granted” (Jardine, 2006). “Like monsters in fairy tales, they wouldn’t whisper to us or stop us in our tracks if they didn’t have something to tell us” (Jardine, 2006, p. 271). With it arrived an opportunity for me to reflect upon my own involvement with the demands of this topic and my history as a mental health nurse. “Opportunities are not plain, clean gifts, they trail down dark and chaotic attachments to their unknown backgrounds, luring us further” (Jardine, 1998, p. 154). The monsters that bring these openings to understanding need not look monstrous to teach (Jardine, 2006). At times, monsters appear in the tear-rimmed eyes of a young girl. Yesterday, such a monster came calling and demanded I retrace my steps and history.

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

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

Filled with a sense of repulsion, of wishing to distance myself from the task, it was time to follow the lure down into the powerful current of relationship and follow the tears (Jardine, 1994).

Masks hide us away, keep us separate but also hold in, hide, and perpetuate our suffering. With the opening of tears, we have discovered a portal to that which has remained hidden about our practice as mental health nurses. In this way, “dwelling with the stories that haunt us” (Rashotte, 2005, p. 34) has the capacity to read us anew but also to bring us to places of untold danger. Such is the paradox of the in-between. Rather than accept the mask, we are called to interrupt our taken for granted experiences and to discover what lies beneath. In the realm of the liminal, in the in-between filled with monsters, ghosts, and shadowed teachers, the participants found themselves in new ways. They bumped up against themselves in an unmasking of emotional encounters within the therapeutic relationship. There had come a recognition that emotions stay close to home, exist in the being human, and in the ordinary day-to-dayness of being a nurse.

It brings it back to being human because you are able to see that yes ok somebody else had this reaction as well. It is human, it's ok or it is normal.

This participant's words have begun to reveal a conscious awareness of the dialectic between home and not at home, the canny and uncanny (Woolley, 2007). It reveals the inherent paradox of being a listener of narrative as a mental health nurse, exposing self to anxiety, and the need to simultaneously protect self from the induced fear. The extent or measure by which we are able to unify the paradox of existence is the extent to which we are authentically home, *gedankengang*, the process of consciousness becoming home with itself and its environment (Hayes, 2007). For the participants, this process of consciousness involved means of finding ways to cope with the anxiety and fear they faced in their ways of being in the world as mental health nurses. They were attempting to find a balance, as well, between home and work, familiar and unfamiliar. To me, this represents a quest for a return to a state of homeostasis, and recognition of the passages, potentials, and possibilities of finding self along the way.

Homeostatis: Finding Balance, Finding Home

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

We are always living disrupted as a being in the world. Each new episode that pulls us from our familiar and sets us to wander the in-between holds the potential to teach us about our selves and offers to navigate our way through and back to a sense of familiar and homeness (Dreyfus, 1991; Svenaeus, 2001). Learning how we negotiate the leaving of home, the return, and the journey in

the in-between speaks to us of our wish to be authentic and genuine. To Gadamer (1989), this is likened to becoming experienced, getting to know the landscape of mental health nursing, its hazards, joys, histories, and traditions. It also predicates that we are aware that we continually shift and live in the in-between of past and future. Which each new situation, our past is redefined and our “future exists as a space in which the unfulfilled potentials of past understanding can be realized” (Davey, 2006, p. 61).

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

K: He wanted me there and so I’ll sit there. At some point you do draw the line though, there are some people who want you to sit in their misery forever and you’ve just kind of get out of there and say I’m done. I’ve given you what I can give you today.

A: And what is that like to say I’m done?

K: That’s tough to say, because I’m here to help you but, I can’t sit here with you anymore in this hopeless, miserable place, and so I’m going to leave you here. And you feel like you’re kind of abandoning somebody in that place.

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

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

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

In the maze of narratives that exist in therapeutic relationships, there also arises recognition of the delicate balance of truly being at home. As mental health nurses, we listen to and are situated

in often-emotional evocative narratives with a patient. With each new arrival, our equilibrium is unexpectedly shifted and redefined as it tumbles over onto our at home way of being (Gadamer, 1996). In this struggle to realign balance, there is a need to accommodate this new weight. This requires holding the narrative long enough to acknowledge and witness its presence but not so long as to injure self by its absorption into one's being.

This living of equilibrium and the swinging pendulum divide of separation and protection predicated a need to get the narrative out. For all five participants, this need to get the narrative or emotion out was consistent.

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

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

The Rough Ground of Home

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

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

form of ‘there’ in which not only the ‘there is’ but also withdrawal, retreating and holding within are experienced” (p. 180).

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

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

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

Concluding Thoughts

The topic of this inquiry focused on the impacts of the therapeutic relationship as experienced by mental health nurses. In going into the everydayness of their practice, in the space they exist in relationship with their patients, I aimed to extend our understandings. Further discourse about the meaning of the therapeutic relationship, and its impacts on not only the nurses’ home lives, but also their nursing practices brings to the forefront the ways in which nursing practice, education, and research are reciprocally moved by the practical day-to-day activities of being in therapeutic relationship.

Mental health nursing is a relational practice. Beal et al. (2007) asserted there exists “no doubt that the therapeutic relationship creates the foundation for care, continuity and recovery. Everything flows through this relationship. When the therapeutic relationship fails, it causes great pain, when it succeeds it is experienced as transforming” (p. 16). Within the therapeutic relationship, there is a supportive space of listening created within which our patients can begin to make sense of their world and heal. It requires a commitment and a risking of self.

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

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

References

- Austin, W., Bergum, V., Nuttgens, S., & Peternelj-Taylor, C. (2006). A re-visioning of boundaries in professional helping relationships: Exploring other metaphors. *Ethics & Behavior, 16*(2), 77-94.
- Barker, P. (2001). The tidal model: The lived-experience in person-centred mental health care. *Nursing Philosophy, 2*(3), 213-223.
- Barker, P. (2003). The tidal model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing, 12*(2), 96-102.
- Beal, G., Chan, A., Chapman, S., Edgar, J., McInnis-Perry, G, Osborne, M., & Mina, E.S. (2007). Consumer input into standard revision: Changing practice. *Journal of Psychiatric and Mental Health Nursing, 14*(1), 13-20.
- Beeber, L. (1989). Enacting corrective interpersonal experiences with the depressed client: An intervention model. *Archives of Psychiatric Nursing, 3*(4), 211-217.
- Belton, N. (1999). *The good listener: Helen Bamber, a life against cruelty*. New York, NY: Pantheon Books.
- Bergum, V. (2004). Relational ethics in nursing. In J. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 485-503). Toronto, ON, Canada: Pearson Education.

Canadian Nurses Association (2008). *RN workforce profile by area of responsibility* (2006 ed.) Retrieved from www.cna-aiic.ca.

Caputo, J.D. (1987). *Radical hermeneutics: Repetition, deconstruction and the hermeneutic project*. Bloomington, IN: Indiana University Press.

College of Nurses of Ontario (2006). *Practice standard: Therapeutic nurse-client relationship* (2006 rev. ed.). Accessed from www.cno.org.

Davey, N. (2006). *Unquiet understanding: Gadamer's philosophical hermeneutics*. New York, NY: State University of New York Press.

Donatelle, R.J., Munroe, A.J., Munroe, A., & Thompson, A.M. (2008). *Health: The basics* (4th Canadian ed.). Toronto, ON, Canada: Pearson Education Canada.

Dowling, M. (2006). The sociology of intimacy in the nurse-patient relationship. *Nursing Standard*, 20(23), 48-54.

Dreyfus, H.L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time*. Cambridge, MA: Division I. MIT Press.

Evans, A.M. (2007). Transference in the nurse-patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 14(2), 189-195.

Forchuk, C. (1994). The orientation phase of the nurse-client relationship: Testing Peplau's theory. *Journal of Advanced Nursing*, 20(3), 532-537.

Forchuk, C. (2002). People with enduring mental health problems described the importance of communication, continuity of care, and stigma. *Evidence Based Nursing*, 5(3), 93-97.

Forchuk, C., & Reynold, W. (2001). Clients' reflections on relationships with nurses: Comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing*, 8(1), 45-51.

Frank, A.W. (2004). *The renewal of generosity: Illness, medicine, and how to live*. Chicago, IL: The University of Chicago Press.

Gadamer, H.G. (1989). *Truth and method* (2nd rev. ed., J. Weinsheimer & D.G. Marshal, Trans.). New York, NY: Continuum. (Original work published 1975).

Gadamer, H.G. (1994). *Heidegger's ways* (J. W. Stanley, Trans.). Albany, NY: State University of New York Press.

Gadamer, H.G. (1996). *The enigma of health: The art of healing in a scientific age*. (J. Gaiger & N. Walker, Trans.). Stanford: Stanford University Press.

Gallop, R., & O'Brien, L. (2003). Re-establishing psychodynamic theory as foundational knowledge for psychiatric/mental health nursing. *Issues in Mental Health Nursing, 24*(2), 213-227.

Hagerty, B.M., & Patusky, K.L. (2003). Reconceptualizing the nurse-patient relationship. *Journal of Nursing Scholarship, 35*(2), 145-150.

Handy, J.A. (1991). The social context of occupational stress in a caring profession. *Social Science and Medicine, 32*(7), 819-830.

Hardin, S., & Halaris, A. (1983). Nonverbal communications of patients and high and low empathy nurses. *Journal of Psychosocial Nursing and Mental Health Services, 21*(1), 14-20.

Harries, K. (1978). *Fundamental ontology and the search for man's place in Heidegger and modern philosophy*. New Haven, CT: Yale University Press.

Hartrick Doane, G., & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Science, 30*(3), 192-205.

Hayes, H. (2007). (Be)coming home: An existential perspective on migration, settlement and the meanings of home. *Existential Analysis, 18*(1), 2-16.

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). San Francisco, CA: Harper (Original work published 1927).

Henderson, A. (2001). Emotional labor and nursing: An under-appreciated aspect of caring work. *Nursing Inquiry, 8*(2), 130-138.

Hilficker, D. (1994). *Not all of us are saints: A doctor's journey with the poor*. New York, NY: Random House.

Jardine, D.W. (1994). *Speaking with a boneless tongue*. Bragg Creek, AB, Canada: Makyos Press.

Jardine, D.W. (1998). *To dwell with a boundless heart: Essays in curriculum theory, hermeneutics, and the ecological imagination*. New York, NY: Peter Lang.

Jardine, D.W. (2006). On hermeneutics: "Over and above our wanting and doing". In J. Kincheloe, & K. Tobin (Eds.). *Doing educational research: A handbook* (pp. 269-288). Rotterdam, The Netherlands: Sense.

Kearney, R. (2003). *Stranger, gods and monsters*. New York, NY: Routledge.

Levin, D. M. (1989). *The listening self: Personal growth, social change, and the closure of metaphysics*. London, UK: Routledge.

Lévinas, E. (1996). *Basic philosophical writings* (A.T. Peperzak, S. Critchley, & R. Bernasconi, Trans & Eds.). Bloomington, IN: Indiana University Press.

MacDonald, H. (2006). Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing*, 57(2), 119-126.

Milton, C.L. (2008). Boundaries: Ethical implications for what it means to be therapeutic in the nurse-person relationship. *Nursing Science Quarterly*, 21(1), 18-21.

Miner-Williams, D. (2007). Connectedness in the nurse-patient relationship: A grounded theory study. *Issues in Mental Health Nursing*, 28(11), 1215-1234.

Morck, A. (2009). "Right there in the midst of it with them": Impacts of the therapeutic relationship on nurses. Unpublished master's thesis, University of Calgary, Calgary, AB, Canada.

Morse, J.M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing*, 16(4), 455-468.

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

Moules, N.J. (2002). Hermeneutic inquiry: Paying heed to history and Hermes: An ancestral, substantive and methodological tale. *International Journal of Qualitative Methods*, 2(3), Article 3, <http://www.ualberta.ca/~ijqm>.

Moules, N.J., McCaffrey, G., Field, J.C., & Laing, C.M. (2015). *Conducting hermeneutic research: From philosophy to practice*. New York, NY: Peter Lang.

Oxford English Dictionary (1971) (Compact ed.). Oxford: Oxford University Press.

Peplau, H.E. (1962). The crux of psychiatric nursing. *American Journal of Nursing*, 62(6), 50-54.

Peplau, H.E. (1988). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. London, UK: Macmillan Education.

Peplau, H.E. (1989). *Interpersonal theory in nursing practice: Selected works of Hildegard E. Peplau* (A.W. O'Toole, & S.R. Welt, Eds.). Ann Arbor, MI: Springer.

Peplau, H.E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly*, 5(1), 13-18.

Perraud, S., Delaney, K.R., Carlson-Sabelli, L., Johnson, M.E., Shephard, R., & Paun, O. (2006). Advanced practice psychiatric mental health nursing, finding our core: The therapeutic relationship in 21st century. *Perspectives in Psychiatric Care*, 42(4), 215-226.

Raingruber, B. (2003). Nurture: The fundamental significance of relationship as a paradigm for mental health nursing. *Perspectives in Psychiatric Care*, 39(3), 104-112.

Rashotte, J. (2005). Dwelling with the stories that haunt us: Building a meaningful nursing practice. *Nursing Inquiry*, 12(1), 34-42.

Reinders, L., & Van Der Land, M. (2008). Mental geographies of home and place: Introduction to the special issue. *Housing, Theory and Society*, 25(1), 1-13.

Rogers, A.G. (1995). *A shining affliction: A story of harm and healing in psychotherapy*. New York, NY: Viking Books.

Shattell, M.M., Starr, S.S., & Thomas, S.P. (2007). 'Take my hand, help me out': Mental health recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, 16(4), 274-284.

Sun, F., Long, A., Boore, J., & Tsao, L. (2006). A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing* 53(6), 680-690.

Svenaesus, F. (2001). The phenomenology of health and illness. In K. Toombs (Ed.), *Handbook of phenomenology and medicine* (pp. 87-108). Dordrecht, The Netherlands: Kluwer Academic Publishers.

Tomey, A.M. (2006). Nursing theorists of historical significance. In A.M. Tomey, & M.R. Allgood (Eds.), *Nursing theorists and their work* (pp. 54-67). St. Louis, MO: Mosby.

Vandemark, L.M. (2006). Awareness of self and expanding consciousness: Using nursing theories to prepare nurse-therapists. *Issues in Mental Health Nursing*, 27, 605-615

Vandusen, W. (1998). Wu wei: No-mind and the futile void in psychotherapy. In A. Molina (Ed.) *The couch and the tree: Dialogues in psychoanalysis and Buddhism* (pp. 52-57). New York, NY: North Poin Press (Original work published 1958).

Walsh, K. (1999). Shared humanity and the psychiatric nurse-patient encounter. *Australian and New Zealand Journal of Mental Health Nursing*, 8 (1), 2-8.

Warne, T., & McAndrew, S. (2005). The shackles of abuse: Unprepared to work at the edges of reason. *Journal of Psychiatric and Mental Health Nursing*, 12(4), 679-686.

Warne, T., & McAndrew, S. (2008). Painting the landscape of emotionality: Colouring in the emotional gaps between the theory and practice of mental health nursing. *International Journal of Mental Health Nursing*, 17(2), 108-15.

Wiebe, L.M. (2001). *Connection in the therapeutic relationship: Sharing a subjective world*. Unpublished educational dissertation, University of Toronto, Toronto, ON, Canada.

Woolley, J. (2007). Home truths: The importance of the uncanny for Patrick Suskind's critique of the enlightenment in *das parfum*. *German Life and Letters*, 60(2), 225-242.

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