DOCTORAL THESIS

What is the need, if any, for therapeutic education in mental health nursing?

An empirical phenomenological study of mental health nurses' responses to this question

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What is the need, if any, for therapeutic education in mental health nursing? An empirical phenomenological study of mental health nurses' responses to this question

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Abstract

This study explores how some mental health nurses are therapeutic, in terms of the art of healing, and how they have learned to be this way. The study originated in my experience of feeling abject while working as a mental health nurse. The research question addressed this situation through exploring whether or not therapeutic education was needed in mental health nursing. Ten mental health nurses participated in the study. Giorgi's (2009) empirical phenomenological method was chosen because of its established status, and its grounding in Husserlian phenomenology which places a primacy on experience. A review of the literature included commentaries, qualitative empirical studies, case studies, and theoretical models, and indicated that mental health nurses may be therapeutic in idiosyncratic ways. A crucial aspect to these ways unfolded in this study as openness, through which the other may come to be in her own truthfulness. Significant methodological considerations were how we 'constitute' meaning, how meaning can 'force itself' like a gestalt, empathy may be self-alienating, and words 'sedimented' in tradition. These linked to how we can question being captivated in 'experiences of truth'. Findings from Giorgi's (2009) method were that mental health nurses are therapeutic through 'being with' others, through innate characteristics, that learning is through openness, and is facilitated through a therapeutic environment. Giorgi's (2009) method is critiqued, and compared to a phenomenology of the therapeutic in relation to the research interviews (after Husserl and Merleau-Ponty). It was shown that the phenomenological 'opens up' language while method narrows meaning. The phenomenology showed that allowing an uncertain relation between two people was crucial, and how recognising the sensual aspect of meaning opened a healing space for another to be, through which a person's own truthfulness may emerge. Openness appears to be innate, indicating one question for further study.

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1. Introduction

1.1 Introduction

This chapter outlines how this thesis is organised, including key ideas, and why I was interested in researching what some mental health nurses 'do' that is 'therapeutic', what and how they 'know' what they do, and how they have come to learn this 'knowing and doing.' The inverted commas are there to indicate something uncertain that I will explore throughout this research, which evolved as part of this research in itself. The study has been like an unfolding of understanding, in ways in which I was unaware of sometimes, until certain things seemed to reveal themselves as insistent, and so worth following further.

The research question is, "What is the need, if any, for therapeutic education in mental health nursing?" The question is primarily aimed at exploring what it is that some mental health nurses know and do that is therapeutic, as the art of healing as opposed to the medical psychiatric sense of cure, and how they have learned to be therapeutic in this way. The emphasis on the therapeutic as the art of healing is aligned with Gadamer (1990, p. 190 cited in Moran, 2000, p. 281) who sees art as countering the "*hubris* of concepts," meaning that theories or rigidly held ideas would get in the way of something more important. Therefore, to try to define what 'therapeutic as an art of healing' might be here, from the outset, would be the wrong place to start. I can say that it is not about the medical psychiatric cure, which can be viewed as therapeutic in one strict sense which aligns precisely with the implementation of a concept. There is a certain uncertainty regarding definitions, as what emerges here will be something that either evades being pinned down in technical terms, or may appear banal on description.

I think of healing as being like a kind of 'salve' which may not be so much about a cure than with making something possible, to do with being with another person. This way of thinking about the therapeutic in mental health nursing is based on everyday experiences of

working in mental health nursing settings, where it seemed that some nurses appeared to be therapeutic without relying on any theories. Yet it appeared that they 'knew' something important, and were doing something important, in terms of being therapeutic, while this practice was 'invisible' to those who prescribe psychiatric and psychological treatment in mental health settings. Patients would ask for those mental health nurses, or seek them out to spend time with them. The research question is not intended to address the content of what type of education is needed, if any, and how this might be implemented or organised, although, drawing on the research, implications with respect to what a therapeutic education for mental health nurses might mean are discussed.

This chapter firstly looks at the origins of the research question, and secondly, the origins of the methodology, which are closely linked through being phenomenological. Thirdly, it outlines an overall view of mental health nursing as a discipline that is under the sway of mainstream psychiatry, and to a lesser extent, psychology, unable to establish itself as a therapeutic discipline in its own right. Finally, a summary of each chapter is outlined.

1.2 The origins of the research question

The research question is rooted in the experience of working as a mental health nurse in acute care settings (in-patient units) while also training as a psychotherapeutic counsellor and psychotherapist, and subsequent work as a nurse therapist in community mental health settings. Some years prior to working as a mental health nurse, and creating a tension with it, I also had an academic training in science, leading to work as a geologist, then, after some time, in philosophy as part of a vocational life of spirituality as a Franciscan friar. This tension is important to this research as it helped to reveal something significant about the work of mental health nurses which led to the research question, principally around the phenomena of belonging and recognition, which will be outlined here. The work involved in geology was valued by others, seen as significant, where a person's training and ideas were taken seriously,

encompassing a knowledge that was significant or 'visible' to others. In a similar way, life as a Franciscan was recognised by others as about significant knowledge, including spirituality. The move to mental health nursing however, was disturbing, in that the knowledgeable, therapeutic activity of that discipline counted little to others apart from patients. For example, at a ward meeting once, while discussing a patient, I was advised, by a well-meaning psychiatrist, to "leave the therapy to the professionals." I wondered what I had spent the last three years qualifying *as* in mental health nursing if it had little to do with being therapeutic. I wondered why there was apparently nothing 'professionally therapeutic' about the mental health nurses who I had seen taking care of someone who had just been admitted after attempting suicide. It is those kinds of mental health nurses who I hoped would respond to the research question, to share their understanding of what it is, for them, that is therapeutic in their 'work,' to catch something of how each one might be therapeutic and how this has been learned. I had noticed, in everyday ways, that if I were worried or upset about something in my own life, I would somehow be able to find myself near certain mental health nurses and talking with them, without feeling that I was a burden, or a trouble, or a problem to be solved.

The environment of mental health nursing began to create for me an experience of invisibility in terms of recognition as being therapeutic, within an overarching framework of psychiatric medicine, and clinical psychology, as well as the more abrasive effects of feeling powerless and helpless. It took time to register this whole experience for what it was, as not being regarded as important in terms of what is therapeutic. The immersion in a framework of knowledge that marginalised the importance of how mental health nurses were with patients, was particularly striking. It appeared that many other nurses in practice did not have a difficulty with this situation. In the literature of mental health nursing, however, the aspect of not being significant has been noted (Cutclffe & Happell, 2009; Happell, 2004), although

this has little impact on mental health care (Barker & Buchanan-Barker, 2003; 2011a; b; 2012). This sense of 'invisibility' has also been theorised in general nursing as being due to a "structure that prohibits" (Bjorklund, 2004, p. 119), and commented on by prominent mental health nurse academics, with some resignation (Barker, Buchanan-Barker, Rolfe & Cutcliffe, 2005). There is a tragic side to this lack of recognition also, as it has been identified, along with lack of autonomy and power, as a factor threatening a nurse's sense of identity, which has been linked to high suicide rates amongst nurses (Alderson, 2006; 2008; Alderson, Saint-Jean & Rhéaume, 2011; Alderson, Parent-Rocheleau & Mishara, 2015). Beginning a separate education in counselling and psychotherapy brought some distance from this experience, opening up new avenues of understanding and academic pursuit. This therapeutic education, involving group therapy, the 'giving and receiving' of individual therapy, and extensive supervision, introduced a way of articulating experience which was phenomenological but also explored ideas on being 'subject to' culture, embodiment, something unconscious, and language (Loewenthal & Snell, 2003).

My experience of mental health nursing left several questions, two of which were: What was the attraction of mental health nursing, and what was being rejected in the distancing from it? These questions are personal and have taken some time to answer, and were central to the progress of the research. The answer to both questions is linked to once feeling a sense of belonging as a Franciscan friar, of the Roman Catholic Order of Friars Minor. This religious order follows the charism of Saint Francis of Assisi, who, in the 12th century, made it his occupation to care for, and live with, the lepers who were excluded in squalor outside the walls of his home town (Sweeney, 2015). St Francis, "who stayed with lepers and bathed their wounds, sponging pus and sores," is taken as an exemplar in the work of the psychoanalyst, Julia Kristeva, of the link between grace and the abject, in so far as in embracing what is excluded and rejected, one comes into a reconciliatory communication

again with others and the Other (God, for the Christian mystic) (Kristeva, 1982, p. 127). For the Franciscans, modern day lepers included the homeless, refugees, those dying alone in hospices, the learning disabled and those with mental illness. Indeed, as leprosy died out in medieval Europe, the leprosarium became the place where the criminal and the 'mad' were housed (Foucault, 1962). Being Franciscan encouraged the encounter with one's own abjection, or spiritual poverty and humility in the language of the religious. When I eventually left the Friars, due to not being able to accept religious dogma, I wanted to remain Franciscan in spirit and live in this way, impossible as it seems now. Mental health nursing seemed to offer a way of being a 'secular Franciscan,' living in a way that seemed the only way to live in the world at that time. But the effects of being a mental health nurse slowly made me feel abject, and there was no spirituality or religious order to give meaning to such an experience in a community to which I belonged. In working as a mental health nurse, there seemed to be something in play which created an overbearing weight which I experienced as 'given' in the phenomenological sense. I recognised a need to be designated by some other word rather than 'nurse' (mental health nurse or not) and this also drove a need to qualify as a counsellor or psychotherapist.

It was as if in mental health nursing that I had moved into a 'field of significance' which was bigger than my own determined activity to be a Franciscan in a secular way. Something far more influential was at work, which Lacan would call the Other (Fink, 1995). Lacanian theory was helpful as a means to speak of something that was 'given' phenomenologically, as it facilitated an understanding of the difficulty of being a mental health nurse in that I needed recognition as 'masculine' by others (those from whom I needed recognition), and the Other. Intermingled with this need for recognition, perhaps, I was speechless with disappointment at the question from Lacan's hysteric, directed at me, 'Are you a man or a woman?' (Fink, 1995).

Here is Lacan, on desire and recognition (showing Hegelian influences):

> "Man's desire finds its meaning in the desire of the other, not so much because the other holds the key to the object desired as because its first object of desire is to be recognised by the other" (Lacan, 1977, p. 58 cited in Borch-Jacobsen, 1991, p. 132).

It is only now possible to interpret my experience, outlined above, in terms of being subject to, and 'subjected to', something by qualifying and working as a mental health nurse, which could be described as something like a field of feminine signifiers, created by culture and society, but which were not 'just words or signs' but carried with them effects which for me were destructive. A way of thinking about this is that the Order of the Friars Minor is a recognised religious order of the Roman Catholic church, whose aim is to spread the Gospel, and crucially, it is a 'masculine' pursuit, due to its acknowledgement as such by the Other, and embedded in this, its central role to represent, and embody, 'The Word.' The 'Word' comes from a masculine culture and institution (Fink, 1995). For example, the optional diploma courses in Franciscan spirituality in Rome, which I wanted to do, were entirely filled with women, taught by men; while the theology and philosophy degree courses required of my training were mainly enrolled with men, and taught by men. Nursing had to do with something that was linked to spirituality, with a long association with Christian monastic, and more recently, conventual, traditions (Foucault, 1962; Fry, 1998; Rogers, 1970). While Lacanian theory here seems seductive, leading into another field of significance, phenomenologically the theory seemed to coincide with my ordinary experiences. In nursing, the signifiers of the discipline were feminine, not recognised by the Other as masculine - for example, the call bell in the toilets had a diagram of a woman in a skirt and nursing headgear. They were feminising, which I could not accept 'as mine.' I tried to understand this experience of feminisation in terms of abjection, in that it may also be that what nurses do is beyond signification, to do with the feminine, abject in a Kristevan psychoanalytical sense (McSherry, Loewenthal & Cayne, 2015). But abject also in the ordinary sense is what

someone might feel if they take on an identity that is feminine in the eyes of the Other, or indeed others who count (such as my father), while he, or she, is embodied with a masculine identity. One cannot simply put on another self like one was "changing a coat" (Kierkegaard, 1954, p. 186 cited in Friedman, 1999, p. 371). What all of this experience seemed to indicate phenomenologically was that I was "overrun with words" in some way, culturally inscribed as an infant as 'masculine' but idiosyncratically written (see Merleau-Ponty, 1968, p. 155).

Coming to understand this experience was how the interest in researching mental health nursing developed, and then it felt important to try to contribute something to the overlooked field of what mental health nurses 'know and do' that is therapeutic, and how they learn this. Through this also, it was felt some understanding could be contributed as to the 'nature' of the therapeutic in general. Significantly for me, also, it seemed important to gain recognition from the Other of some kind.

1.3 Origins of the methodology

The methodology emerged from taking experience seriously. This is what Husserl asks us to do essentially, to take seriously how we experience the everyday world, and to look seriously at that experience of "the things themselves" (Husserl, 1984, p. 10 cited in Moran, 2000, p. 93). This simple idea appears to be revolutionary, and may indicate why Husserl is "arguably the most influential figure in 20th century continental philosophy" (Polt, 1999, p.14). Allowing the 'things themselves' to emerge felt like trying to get out of the way, to not hinder something that the other person may be going through that will help him in some way, yet my being there is needed. I have also tried to get out of the way of myself, in coming to understand the experience of being a mental health nurse. This involves being open to experience, which is phenomenological, involving a "prohibition" to explain (Heidegger, 1962, 59/35) something which is revealing, and fundamentally descriptive in the sense of

being disclosed "into words for the very first time" (Heidegger, 1962, p. 362/315; Polt, 1999). Although this sounds simple, it is deceptively complex and difficult in real life.

Phenomenology has given words to be able to express some of this. 'Constituting subjectivity' and 'intersubjectivity', for example, point towards an idea of what may be going on here between two people (Husserl, 1973, p. 427). There is also a sense that to impose thoughts on someone else is ultimately aggressive, but further along this train of thought it could be seen that to speak *at all* may well be violent as words may 'hit' home, somehow. This 'hitting' gives another angle to Lacan's words, "… that we do our dissecting with concepts, not with a knife" (Lacan, 1988, p. 2). Merleau-Ponty is more explicit, in speaking about how reflection and decision are acts that are "violent whose truth is confirmed through its being performed" (Merleau-Ponty, 2014, p. xxxv/21) (see Verhage, 2010). Phenomenology seems to be not about imposing anything, and more about allowing something to be revealed, or reveal itself in its own time, if at all.

The approach to this research reflects some of this. There is an attempt at not trying to grasp at ideas too vehemently, and trying to allow something to become discernible in exploring different aspects, trying to be open to others, and being with thoughts that appear. This approach seems more amenable to catching the sense of how I might be blocking something from 'coming through' about mental health nursing, including my relation to it. Writing and throwing things away, and even writing things that said what I did not intend when read by someone else. For example, in my attachment to showing how symptoms of some kind may be susceptible to description because they 'take hold' in some way, it came to light that the need for description as defining something may be a 'symptom' of some kind also. Symptom is not intended in any medical, or psychoanalytical way here, but as something that 'repeats,' or captivates us. For example, my experience of abjection as a mental health nurse would not change, even though I tried to change it, or 'shift' it, through therapy and

with others. A broader example would be a *credo*, such as the Christian Apostle's Creed, which starts, "I believe in God, the Father Almighty…" (www.catholic.org); these are not 'just words' for some, because they may gain purchase on a person in such a way that they repeat throughout a life, establishing a sense of certainty.

It is perhaps no coincidence that Heidegger's interest in hermeneutics was sparked when he was studying theology, as hermeneutics sprang from an exegesis which places such certainty under scrutiny (Inwood, 2000; Moran, 2000). For Heidegger, phenomenology is descriptive in that it is not explanatory (see Heidegger, 1962, p. 59/35), while descriptions are always in a process of development and illumination and are therefore interpretations (see Heidegger, 1962, § 32; Polt, 1999). This is a compelling idea, but it does not account for the 'repeat' of a dogma, for example, or how an individual may *not* be "constantly compelled to face the possibility of disclosing an even more primordial and more universal horizon from which we may draw the answer to the question, 'What is "Being"?'" (Heidegger, 1962, § 49/26-27; Polt, 1999, p. 41). Phenomenology opens up such problems, of course, and Heidegger would critique this one in terms of "metaphysics of presence" perhaps (Polt, 1999, p. 5). For Heidegger (1984, p. 185 in Polt, 1999, p. 92), "*the* misunderstanding of human existence in general" is the setting up of a universal ground of its meaning (Polt, 1999, p. 92). However, the idea of a more substantial reality behind this one of semblance, which can account for everything, has not given up its grip, as in the *Credo*, but also in other *credos*, and of how, for example, in that of science, genetics may explain 'mental disorders' (Gournay & Ritter, 1997; cf. Dawson, 1997; 1998; Lego, 1997). Heidegger was against these kinds of *credos*, through his hermeneutical phenomenology, indicating that 'things do not have to be this way' because human Being is temporal and so it can change (Polt, 1999). At first impression, Husserl's phenomenology appears to lend itself more to the idea that consciousness gives an essence to how things can be known, reflecting a more static ontology

as a "science of essences" (Polt, 1999, p. 14). However, Husserl's investigations revealed, especially because of their closeness to such a position, some of the complexities in which we are involved with in the world, and Merleau-Ponty's development of these is also taken up in this research (Zahavi, 2003; Moran, 2000).

Deciding on what strand of phenomenology to follow as a methodology was also based on a previous study, my own unpublished MSc Thesis (McSherry, 2007), rooted in an interest in the claims of an empirical method (Giorgi, 1997; 2000; 2006) 'applied' to meanings. Giorgi (2009) claims that Husserl's phenomenology can be adapted to underpin a psychological method in order to give adequate findings of essential structures of meaning. However, in my MSc thesis, questions arose as to how the central moves in Giorgi's (1997) method, free imaginative variation, and the normative use of language, undermined and restricted any findings. Choosing Husserl's phenomenology, and following this, Giorgi's (2009) method, is therefore a way of addressing these concerns in a more thorough way. Exploring Giorgi's (2009) empirical method also addresses the research question obliquely, in that what mental health nurses know and do therapeutically is not recognised as an empirically validated therapeutic endeavour (Barker, Buchanan-Barker, Rolfe & Cutcliffe, 2005), perhaps for significant reasons regarding what is therapeutic.

1.4 Definitions as 'family likenesses' and non-technical

A sense of definition is followed here which is in accord with Wittgenstein's concept of 'family likenesses' (Kenny, 2006, p. 122), pointing towards how the meaning of a word is found in its use,

> "They form a family, the members of which have family likenesses. Some of them have the same nose, others the same eyebrows and others again the same way of walking; and these likenesses overlap. The idea of a general concept being a common property of its particular instances connects up with other primitive, too simple, ideas of the structure of language" (Wittgenstein, 1958, p. 17 in Kenny, 2006, p. 122).

I am indicating that it is important to prevent a reification of a picture into a metaphysical illusion that the word reflects an unchanging essence (Stolorow & Atwood, 2017), although clearly it can be believed that this is the case (as in a credo). The meaning which a concept acquires is linked to its *use* in different settings, so the therapeutic, and other terms such as 'education,' are not to be understood in this research as technical terms; they are terms which acquire a meaning depending on their use, or what the explanation of the meaning explains (Kenny, 2006). "Familiarity with context" allows such meaning to be revealed (Kenny, 2006, p. 121). The noun 'therapeutic,' refers to the art of healing, as well as that branch of medicine which is concerned with the remedial treatment of disease (Oxford English Dictionary, 2014). The adjective may refer to the healing of disease (Oxford English Dictionary, 2014). This study emphasises the therapeutic as pertaining to the art of healing, and, as noted, following Gadamer (2000, p. 281), sees art as a "corrective to the hubris of concepts." These definitions from the Oxford Dictionary (2014), and those which follow, are intended to be read more as 'food for thought' rather than technical, fixed meanings. The noun, healing, may refer to restoration to health, recovery from sickness, curing and cure. It can also refer to mending and reparation; restoration of wholeness, well-being, safety, or prosperity; spiritual restoration and salvation (Oxford English Dictionary, 2014). Definitions miss out something of the 'art' that is woven into the context of a term's use, as will be shown in the Methodology chapter. This indicates that what is happening here is that the subject of the research refers to something that is not reducible to technical terms, but rather that which has something more to do with a 'gesture' in context:

> "Just think of the words exchanged by lovers! They're loaded with feeling. And surely you can't just agree to substitute for them any other sounds you please, as you can with technical terms. Isn't this because they are *gestures*? And a gesture… is instilled, and yet assimilated… For the signs of assimilation are that I want to use *this* word, that I prefer to use none at all to using one that is forced on me, and similar reactions" (Wittgenstein, 1982, ¶712 in Heaton, 2010, p. 204).

The definitions of these terms are left 'loose,' in context, as the 'game' in which meaning is assigned, depends on a "form of life" - a way of living in a communal setting - in which that game has developed (Wittgenstein, 1953, I, ¶ 23 in Kenny, 2006, p. 130). Keeping words in context has relevance for this research in particular, linked to what may take place between a mental health nurse and another person. Trying to define meaning too strictly would go against what the argument is trying to convey, which is about how being therapeutic may have to do with being open to the other, or understanding complex situations, or knowing one does not understand them, often following a process that is not deductive but tacit, in relation, and intuitive, while not excluding representational knowledge.

Bearing in mind the above argument, the following outlines some meanings of 'education,' 'knowledge,' 'nursing' and 'nurse;' words which are not intended to define.

Education

The noun, 'education,' can refer to the process of receiving, or giving, a systematic instruction; or refer to a body of knowledge acquired while being educated; or information about, or training in a particular subject. It can also refer to an enlightening experience (Oxford English Dictionary, 2014). While each of these definitions is relevant to the research, the ones which appear most relevant for mental health nursing are acquired knowledge, and an enlightening experience. *Therapeutic education* might then be akin to an enlightening experience of the art of healing, which may possibly be linked to acquired knowledge.

Knowledge

The definition of knowledge that appears most relevant for this study is that which refers to the fact or condition of knowing something; referring to the fact of knowing, or being acquainted with a thing or person, or familiarity gained by experience (Oxford English Dictionary 2015). Knowledge linked to familiarity and acquaintance is seen as most relevant

to mental health nursing. It is anticipated that this knowledge is not only representational but is also embodied.

Nursing and nurse

The statutory body responsible for the registration of nurses in the United Kingdom, the Nursing and Midwifery Council (www.nmc.org.uk), defines nursing as:

> "the use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability until death" (Royal College of Nursing 2003).

Following the European Tuning Project (Tuning Project, 2009), the Nursing and Midwifery Council adopted the definition of *the nurse* as:

> "A professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. The nurse is a safe, caring, and competent decision-maker, willing to accept personal and professional accountability for his/her actions and continuous learning. The nurse practises within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of individual clients (patients) and diverse populations."

What is perhaps most significant for this study is the characteristics of nursing that involve judgement and personal accountability. This potentially places the individual nurse in ethical situations which are beyond ethical frameworks and codes of practice. Willis, Grace and Roy (2008, E32-E33 in Wright & Brajtman, 2011, pp. 22-23)), based on a synthesis of nursing theories and models, proposed that the discipline be defined as "facilitating humanization, meaning, choice, quality of life, and healing in living and dying." The person is seen as a unique individual capable of wholeness and integrity.

1.5 An overall view of mental health nursing

In the literature, there is a concern that mental health nursing is dying out as a therapeutic endeavour as it remains completely aligned to a biomedical model of psychiatry, such that a more generic kind of mental health worker would be required, resulting in a loss of identity for the profession and deterioration in expertise (Clarke, 2006; Cutcliffe & Lynn, 2008; Happell, 2014; Hercelinskyi, Cruickshank, Brown & Phillips, 2014; Holmes, 2006; Stickley, Clifton & Callagahan, *et al*., 2009). Under the dominance of the biomedical model, which these authors lament, interventions would emphasise cognitive and behavioural approaches to correct "faulty thinking" (for example, England, 2006, p. 735; Gournay, Denford, Parr & Newell, 2000), and involve assessing risk and encouraging compliance with medication (as encouraged, for example, by Gournay, 2000; 2001; Rice, 2008a; b; c; 2011). McCabe (2005, p. 182) perhaps summarises this view when she claims, "We need to get to a place where we make the automatic links in our head as psychiatric nurses between neurobiological functioning and psychiatric symptoms" (cf. Bjorklund, 2006). A systematic literature review showed how there is a split between mental health nurses who adhere to this medical model and those who favour more relational or complex views (for example, Cutcliffe, 2009a; Dziopa & Aherne, 2009; Holmes & Gastaldo, 2004), which has been discussed by Cutcliffe (2000). Even the movement towards recovery-oriented, destigmatising practices in mental health services (Repper, 2000), which was meant to encourage interdependence (that is, relationships with others) in, and through, changes in society, is becoming "co-opted" as a field for psychiatric and psychological "experts" (Edgley, Stickley, Wright, & Repper, J., 2012, p. 121; see also Buchanan-Barker & Barker, 2009; Davies, 2013), with a focus instead on 'resilience and self-agency' aligned to a biomedical approach (for example, Frost, Tirupati, & Johnston, et al., 2017). This shift in the 'recovery model' was warned against (Thornton & Lucas, 2011), and is not surprising, especially perhaps in view of Barker's (2003) sense of psychiatry as a 'colonising' power.

Linked with the dominant biomedical model in psychiatry (Carlyle, Crowe & Deering, 2012), mental health nurses still have no clear professional identity which could define educational programmes and what it is they actually do (Hercelinskyi, Cruickshank, Brown & Phillips, 2014). Barker (2006) goes so far as to say that those mental health nurses who 'follow orders' in this paradigm, for example, assisting in restraint, in electro-convulsive therapy, administering psychotropic medication without informing the person of the effects, are ethically derelict. In a study on the therapeutic relationship in in-patient mental health settings, Cutcliffe, Santos, Kozel, Taylor and Lees (2015) found that this setting is often "devoid of warm therapeutic relationships, respectful interactions, information or choice about treatment and any kind of formal/informal 'talk therapy.'" They follow this by saying that the 'care' environment instead is dominated by "coercion, disinterest, inhumane practices, custodial and controlling practitioners, and a gross overuse of pharmacological 'treatments'" (Cutcliffe, et al., 2015, p. 375). They note that it is remarkable that, in this milieu, some mental health nurses still continue to work therapeutically (Cutcliffe, et al., 2015). Winship's (2006) acknowledges that physical restraint is sometimes necessary in psychiatric settings, but he calls for a greater focus on the interpersonal and psychological, as well as Winnicottian, aspects of 'holding' another. In this respect, Winship (2006, pp. 56-58) calls for mental health nurses to "develop the confidence and repertoire" to become "therapeutic agents themselves," through "talking to patients as a technique of dealing with emotional distress," rather than relying on other disciplines (see also Bak, Brandt-Christensen, Sestoft, & Zoffmann, 2012; Buchanan-Barker & Barker, 2005; Lakeman & Cutcliffe, 2009; Moran, Cocoman, Scott, Matthews, Staniuliene & Valimaki, 2009).

Barker's (2006) argument seems of enormous importance, and in a sense, reflects the background at the heart of this study, in that what is being noticed is that a mental health

nurse, in being therapeutic, responds according to the person so that she 'may not follow orders'.

The issue of psychiatric power is not being directly addressed, although it is the background to all mental health nursing (McKeown & White, 2015). Against this background mental health nursing does not qualify as a profession, as it does not prescribe treatment (Clarke, 1999), and neither is it perhaps a science, art or vocation, but is a job (Lucas, 1993; Clarke, 2006). Not much appears to have essentially changed in nursing since Freidson (1970, p. 20) noted that "there is great weakness in the position of the occupation," with respect to its professional status. Collins (2006) argues that mental health nursing is not nursing at all, and it may be time for a complete change in order to separate from psychiatry and nursing. Morrall (2006, pp.56-57) proposes that any attempt to break from psychiatry, however, is "self-aggrandising" and unrealistic, going so far as to say some mental health nurses are "asinine." From a Foucauldian perspective, he argues that mental health nursing is subordinate to psychiatry but in a relationship in which it 'enjoys' something of psychiatry's power and hegemony. These arguments are left aside here, to focus on the therapeutic, although they are revisited.

Despite the influence of psychiatry, it appears that mental health nurses practise in idiosyncratic ways to form therapeutic relationships, while also struggling to define what it is they actually do with patients (Barker, Jackson & Stevenson, 1999; Browne, Cashin & Graham, 2012; Dziopa & Aherne, 2009; Hanson & Taylor, 2000). An important view of mental health nursing for this research is that in order to be therapeutic a mental health nurse needs to be able to tolerate ambiguity and uncertainty (Cutcliffe, 2000; Philbin, 1997), and chaos (Holmes & Gastaldo, 2004). Over forty years ago prominent nurse theorists and practitioners such as Peplau (1988) and Altschull (1972) observed the lack of willingness

and/or ability of mental health nurses to articulate what they do, and this appears to have changed little (Browne, Cashin & Graham, 2012).

A more recent exception to mental health nursing finding a voice, the Tidal Model (Barker, 2001), emphasises the importance of the patient's own understanding and words to describe his experience (Brookes, Murata, & Tansey, 2006). However, this has become marginalised as a model for recovery and psychiatric care (Barker & Buchanan-Barker, 2011a; b). As noted, some mental health nurses may also choose not to engage much at all with patients (Stenhouse, 2011), reflecting perhaps a difficulty in staying open to what patients in mental distress invoke in others. Yet it is consistently reported in the literature that patients often find the activity of mental health nurses to be therapeutic within the context of a relationship, which includes providing one-to-one time talking (Coatsworth-Puspoky, Forchuk & Ward-Griffin, 2006; Hopkins, Loeb & Fick, 2009; Latvala, 2002; Latvala, Saranto & Pekalla, 2004). The variety of approaches found in this context is in line with other studies across Europe which indicate that mental health nurses tend to use a plurality of therapeutic approaches without necessarily following management guidelines (Chambers, Kantaris, Guise & Valimaki, 2015). This appears significant because it implies that mental health nursing potentially occupies an open space therapeutically, where engagement with the other person can be a creative process; although this open space is framed and encroached upon by orthodox psychiatry. Holmes, Gastaldo and Perron (2007, p. 85) praise nursing in general in being able to accept diversity, and "polyvocality," while also challenging "totalising perspectives."

However, commentaries in the literature reflect a discipline that is in decline (Barker, 2006; Cutcliffe, 2008; Happell, 2014; Koekkoek, Van Meijel, Schene, & Hutschemaekers, 2009), or perhaps a return to the attendants of old (Nolan, 1993; Peplau, 1994), to a means of supplying technical assistants to psychiatry (McKeown & White, 2015). Nursing's governing

body, the Nursing and Midwifery Council, continues to promote the biomedical model of mental health nursing (Nursing and Midwifery Council, 2010), with the additional element, which applies to all nursing, of caring as indicated by the 6 C's (care, compassion, courage, communication, commitment and competence), devised by Cummings and Bennett (2012). It is important to keep in mind what Bradshaw (2016, p.73) notes, that Cummings and Bennett (2012) offer no "references or acknowledgements" to give depth to the idea of the 6Cs, and likens this kind of move to "McDonaldised dehumanisation" (after Ritzer (2011)), which has turned "virtues into commodities." The governance of mental health nursing continues a trend towards technologizing the discipline, geared towards audit and risk management, where even clinical supervision and reflective practice are technologies of governance (Banks, Clifton, Purdy & Crawshaw, 2015). In contrast, in their review, Cutcliffe, Santos, Kozel, Taylor and Lees (2015, p. 380) noticed that what service users wanted most from mental health nurses as 'treatment' were "practises of being open, offering human attention, and unrestrained respect of human dignity," including being listened to and taken seriously.

1.6 Summary of chapters

The Theory chapter derives from a review of the literature and focuses on the 'personal process' aspects of mental health nursing, as opposed to those aspects which relate to medication and containment as 'cure'. It outlines how a mental health nurse's openness to others may be therapeutic, as the beginning of healing, and in uncertain, and abject encounters. There is a distinction made between ways of 'being open' to another through theory or method, and being open without such theories or methods, which is viewed as enabling a unique encounter with the other person. This encounter perhaps may reflect how a person has come to be amongst others throughout their lives. Understanding this 'coming to be' may involve 'truthfulness,' and is seen as a way into thinking about the kind of therapeutic education mental health nurses may need. The literature indicates that mental

health nurses primarily learn through practice, including learning from peers and mentors or more experienced practitioners.

The Methodology chapter outlines a philosophical background to, and aspects of, Husserl's phenomenology, which then links to Merleau-Ponty. Significant is how Husserl speaks of the world as 'constituted' by subjectivity, and this idea is made more complicated by subjectivity being linked with constituting intersubjectivity, including 'sedimented' meanings. What appears important is that certainty may feel like an "experience of truth" (Husserl, 1970a, ¶ 51 cited in Welton, 1999, p.21), which may emerge like a familiar pattern (Merleau-Ponty, 2014). Husserl shows how science is a tradition, and examines how language, especially writing, is seductive, so that it can be as if it speaks of something real, and conveys "idealities" separating subjectivity-relative origins (Husserl, 1989, p. 269 cited in Zahavi, 2003, p. 136). These ideas are explored with respect to meaning, as it is meanings we look for in research, and I also focus on the aspect of Husserl's examination of empathy which he refers to as "self-alienating" (Zahavi, 2003, p. 124).

The Method chapter principally describes and explores Giorgi's (1997; 2006; 2009; 2012; 2014) descriptive phenomenological empirical method. Giorgi (2009) argues that it is possible to describe empirically what is given phenomenologically, and in such a way that interpretation is minimal, which was its attraction as a research method in this study. His method is organised so that it fulfils what he sees as the scientific criteria of being systematic, methodical, general, and critical (Giorgi, 1997). Key stages of the method are illustrated with examples from this research. Of particular importance is the practice of free imaginative variation to come to arrive at essential aspects of a meaning, through careful attention to the responses of the research participant. Giorgi's (2009) method is critiqued, including from the standpoint of an assumption that "people in a shared cultural and linguistic community name

and identify their experience in a consistent and shared manner" (von Eckartsberg, 1998, p. 15).

The Findings chapter presents the findings of Giorgi's (2009) empirical research method with respect to responses to the research question from participants in the study. These are presented as an individual general synthesis for each participant, as well as a general synthesis regarding all participants. Findings indicate that the therapeutic as the art of healing is a minor aspect of the work of those mental health nurses interviewed, while it is the main reason most of them became nurses. A key theme in the findings is 'being with', which includes that what is therapeutic occurs in idiosyncratic ways. The mental health nurses interviewed appear to have learned to be therapeutic mainly through life experience, as well as learning through practice. Being therapeutic appears to link with the person of the mental health nurse. Characteristics and activities that nurses speak about which they see as therapeutic cannot be removed from the situated context of how a nurse has come to be. Being open to others was present, to varying degrees, in all mental health nurses interviewed. Learning to be therapeutic is vulnerable to the communities of learning, the psychiatric environments, in which nurses practised. Five key themes related to the research question emerged from the method as findings. These themes are, that therapeutic activity is subordinate to administrative and medical activities, therapeutic activity is 'being with' clients over time, and how this happens depends on personality characteristics; learning is through practice and openness with others, including patients, and learning is facilitated by a therapeutic environment.

The Phenomenology chapter (Chapter 6) presents a phenomenology of the therapeutic in relation to the interviews and this study. This phenomenology is in contrast to Giorgi's (2009) method, whose 'scientific' criteria force it along a certain path. What emerged was a way of thinking about meaning, and being in relation, which reflected back upon, and put into

question, all that went before in the study. Distinctions emerged regarding meaning and openness which seemed to clarify how mental health nurses may be therapeutic, and may learn to be therapeutic, which involves a certain truthfulness. This is complex, linking back to ideas on empathy, being 'held captive' in meanings, and how words, language, and speech, can define, restrict, and open up, experience. These aspects are explored in some detail. The phenomenology gives precedence to the "originary giving intuition… [as]… the source of all knowledge" (Zahavi, 2003, p. 45 - after §24 of Husserl's *Ideas I*), and stands in contrast to method.

The Discussion chapter (Chapter 7) concludes the study. It provides an overview, looking back at the study, and then divides into six overlapping areas. The experience of abjection is revisited, in terms now of meaning. Coming to be therapeutic is discussed in terms of how there is a 'circularity' to learning where the circle does not close, and this is spoken of in a sense of an 'unfolding'. Openness appears to be a condition of such learning. A third area looks at how being in relation to another person is vital to being therapeutic, involving being called into question. The fourth area discusses the sense of meaning as 'given' and 'sensual', the latter perhaps being vital to what is therapeutic. The former sense of meaning is addressed further in the fifth section, and appears to be what an empirical method especially 'finds'. Such meanings from the empirical method are like 'sign posts', indicating that something else is needed. A final area addresses what is implicit throughout the study, that meaning of some kind is conveyed which is understood (as in this writing here, for example). However, these meanings are conveyed through certain aspects of empathy and the tradition of spoken speech (Merleau-Ponty, 2014), with implications for the research study. A deceptively simple distinction emerges with respect to the phenomenological and the empirical, in that the former 'opens up' speech, and along with it, our experience. How this 'openness' can be allowed, and happens, may be a question for further research.

In conclusion, this chapter has attempted to summarise the process of the research study, spanning its origins to its findings. The study evolved from taking seriously the experience of being a mental health nurse, how that could be researched through phenomenology, and what phenomenology meant with regard to that experience. This evolved in an unfolding way, each shift and change linked to being open to others, and oneself, which in itself spoke of what the study was researching. Empirical method seemed to fall short, 'indicating' only something else that eluded definition but was not beyond speaking about. The phenomenology opened up this 'speaking', showing how the research now was in relation to what was therapeutic, seen, viewed, and clarified, through the experience of being with the research participants in the interviews, and also that of this study. The circularity is clear, but in an 'unfolding' that does not close itself, or complete itself so that something might be 'closed out'. This 'unfolding' traces out the whole trajectory of the study, and there is the inevitable, and welcome, sense that it opens out onto something else.

2 Theory

2.1 Introduction

This research addresses the question, "What is the need, if any, for therapeutic education in mental health nursing?" As outlined in the Introduction chapter (Section 1.1), this question is aimed at the therapeutic relating to the art of healing, without defining 'art' too strictly. A looser sense of 'definition' has to do with putting theory aside or under question. This includes not defining healing too strictly either, even though I have envisaged it as being like a 'salve' that may be about allowing something different or new to become possible, through being with another person (Introduction, Chapter 1, Section 1.1). The focus is on what mental health nurses know, and do, that is therapeutic and how have they learned to be therapeutic. This may indicate what kind of education, if any, may facilitate a mental health nurse in being therapeutic.

The approach to this study is one in which I have tried to 'let things show themselves' in the spirit of Husserl's phenomenology. There are reasons for this wanting to 'allow experience' to 'speak'. Firstly, as discussed in the Introduction chapter (Section 1.2), while trying to follow a *credo* in doing mental health nursing, I was struck by the experience of feeling abject, which emerged in an awareness that seemed to give precedence to something that comes to be 'felt.' The experience as a mental health nurse then held a certain 'truth' which was more insistent than a *credo*. Some of the complexity here will be left for the Methodology chapter. Secondly, and for example, in following through on Lacanian theory, inspired by some of Lacan's insights, what I noticed was that 'theory' ended up in an ever more narrowing view of others so that I became enclosed, for example, reduced to thinking of others as 'subject positions' as opposed to persons. But it appears that we need *credos* to live, to help us feel secure and, as I will note here, perhaps protect us from an unbearable despair (see Methodology, Chapter 3, Section 3.4.3). A difficulty then was how to walk along

a path that did not stray too much into theories, or *credos*, so that to be surprised by another, through an openness, would still be possible. This can be difficult as we are always caught up in something, as will be discussed. So, my approach to this Theory chapter has been to read and to leave aside, to follow paths and to walk back along those paths in the opposite direction, until something seemed to follow me along to 'speak for itself'. I was hoping to 'find' something this way, or perhaps that something would 'find itself' beside me, as opposed to seizing too hastily on a meaning.

Looking at the Nursing and Midwifery Council's guidelines for nurse education was disappointing, in that there was something 'lifeless' in the way that nursing was thought of as 'caring' (see Appendix 1; Nursing and Midwifery Council, 2010; Nursing and Midwifery Council, 2017a), perhaps because nothing seemed to be critically called into question or problematised. Paley's (2002; 2008; 2011) criticism on 'care' in nursing, was refreshing, and counterbalanced by Dowling (2004) saying he had missed out something about the reality of care. I will come back to these points. On exploring the mental health nursing literature, it felt as if there was nothing coherent in this body of knowledge, and it felt at times like foundering in confusion. There was the over-riding impression that the academics who wrote the literature were mainly ignored by most mental health nurses in practice, reflected in a lack of interest in research (Bahtsevani, Khalaf, & Willman, 2005; Fisher & Davis, 2008; Fisher & Happell, 2008; Gournay & Ritter, 1997; Happell, 2004; Lines, 2001). This reflected my experience, in that most mental health nurses I knew (many of them women) were not concerned with academic recognition. This led into theory again, especially Lacan, who gives reasons as to why 'the feminine' is not so caught up in 'making a name for itself' (Fink, 1995), which I then set aside without dismissing this idea as it may indicate something liberating (in my view) about 'being feminine.' What I felt came through in such views was that the 'feminine' (whatever that meant) slipped through those 'masculine' (whatever that

meant) nets. This struck me as being important and as having to do with why many nurses I knew were happy being nurses but I was not. These ideas were set aside in order to open up wider views as to what may be therapeutic about mental health nursing, while still the Lacanian influence remained in looking at the feminine through Kristeva's (1982; 1986) theory of the semiotic. Importantly, it seemed that not being overly influenced by research or theory could also signify that what mental health nurses know and do may be difficult or impossible to say or write, and this is one thread of thinking which will be explored in this chapter (Section 2.6.1).

Regarding the literature review, I first started in a systematic way, and then abandoned this, putting aside a lot of material relating to what Cutcliffe (2000) calls the 'contain and fix' strand in mental health nursing (see below, Section 2.3). A different approach to the literature as outlined above, reading and setting aside, and waiting for something to emerge became more important. It felt mistaken to follow a thread too wishfully. Exploring the literature in this way was anxiety-provoking, as it seemed for a while that there was nothing to be found but a wide range of diverse ideas on how mental health nurses ought to practise.

It began to become clear, in the literature and in everyday interactions with mental health nurses in working environments, that there was a confusion at the heart of mental health nursing care, as to what mental health nursing is *for*, and what some mental health nurses actually *do*. Finding some clarity in this confusion has taken time, as discussed in the Introduction (Chapter 1), and also involved being open to others in everyday practice. It appeared that some mental health nurses were therapeutic in an encounter with the other person, through openness, involving being with the other person in unique, idiosyncratic ways.

This sense of idiosyncrasy is supported in the guidelines for mental health nursing education in that there is recognition of the 'therapeutic use of self' (Appendix 1), and in the

diversity of approaches, including that of 'care,' in the mental health nursing literature (Section 2.3). In the former, there appears to be a tacit acknowledgment of something ineluctable to 'care,' while also being uncritical of what 'care' may mean and the wider field of psychiatric power to which nursing is allied and subservient (Cutcliffe & Happell, 2009; Cutcliffe & Wieck, 2008). In the latter (the mental health nursing literature), 'care' is put under question, while the wide diversity in therapeutic approaches discussed and advocated, apart from the standard practices of assisting psychiatry, appears to indicate that it does not really matter how mental health nurses practise therapeutically as it is not relevant to the field of psychiatric care, and so, those mental health nurses who have an interest in being therapeutic can 'do their own thing' (see Browne, Hurley & Lakeman, 2014).

There is an ambiguity revealed here however, a 'something' that is hard to define, which is linked to what happens in the encounter between a mental health nurse and another person. I will try to elucidate in this chapter this 'something' without falling into the step of the language of any one approach to 'theorising' because this may narrow thinking. In trying to understand what may be difficult to speak about in mental health nursing, certain aspects of the literature stayed with me, and seemed important. For example, Peplau's (1952) idea that the nurse learns *from* the patient, was striking.

From reading, and talking to mental health nurses, and others, and thinking about what emerged, this chapter took shape as an exploration of how it appears that in mental health nursing being therapeutic is not primarily about learning a theory, or having a formal education, although these may be helpful in some way, but depends on how a person has 'come to be' in his, or her, life. Being with another in a certain 'openness' to him, I argue, is what facilitates healing, or the therapeutic, and this openness perhaps cannot be taught, or even learned, yet it is itself what enables learning (since if I am closed to the other person how can I learn from him?). This openness, I argue, has to do with a person's being, and is

also explored further in the Methodology chapter (Chapter 3, Section 3.5.4). Such openness can also be potentially dangerous at times, as in some cases, it leads into an encounter with what is abject, or violent, which may place one's own person at risk.

The chapter is organised so that, firstly, the focus of the research question within the wider view of the therapeutic in mental health nursing is outlined, reflecting on educational guidelines and examples of nursing models. There is a focus on mental health nursing as 'care' while also being invisible as a treatment, invisibility perhaps having to do with the nature of the therapeutic in mental health nursing. The notion of 'care' is problematised to an extent. Secondly, the therapeutic as relating to the art of healing is addressed with respect to the 'personal process' strand in the mental health literature, being to do with something that happens between the nurse and the other person, as compared to a 'contain and fix' strand of 'medical cure' (Cutcliffe, 2000). Thirdly, it outlines how openness to another person may form the basis of the therapeutic as the art of healing in mental health nursing, through staying with the other person in an uncertain encounter, and with what may be abject in such an encounter also, involving examples from the literature.

Abjection is briefly explored through Kristeva (1982) as her language and thought is helpful in thinking about experiences of being open to the other person in which meaning has collapsed. Being 'open' as a therapeutic way of being may be 'prepared for' perhaps through theories or methods, although I argue that these may 'close down' the other person, and that being open to the other without depending on such presuppositions, allows for a unique encounter with the other person which is in itself healing. It is argued too that this latter openness is phenomenological in that it allows space for the other person to be. For example, I view Husserl's reduction (see Methodology, Chapter 3, Section 3.5.1), in which he tries to achieve a presuppositionless perspective (Zahavi, 2003), in terms of being potentially therapeutic as it facilitates a movement towards 'getting out of the way' of the other ('leading

back' out of oneself). But such openness is problematic, as shown through captivation in credos, and theories. I will argue that the unique encounter cannot be described adequately in words, nor outside of unique events, and this is illustrated with an example from outside of nursing. I am not trying to 'mystify' the therapeutic here through phrases like 'unique encounter', but rather indicate something that 'unfolds.' Fourthly, implications regarding how some mental health nurses are therapeutic, through being open to the other person, are outlined in terms of situated learning, intuition, emotional labour and tacit knowledge. It appears that being 'open' to the other person may be facilitated in an environment, or community of learning, where how one has 'come to be' may be freely explored and understood, to a significant extent. This can be understood in terms of 'truthfulness' as outlined here (after Wittgenstein, 1998, cited in Heaton, 2010). This would not however, imply that being 'open' can be taught or learned, as there appears to be something mysterious or unknown involved that is perhaps to do with the tacit dimension (Polanyi, 1983).

2.2 The focus of the research question within the wider view of nursing

It is worth noting that the literature has been created by a minority of nurses who are academically minded, as well as directives from the professional nursing body, the Nursing and Midwifery Council. While there are many models of nursing (for example, Peplau, 1988; Rogers, 1970; Parse, 1981; Roper, Logan & Tierney, 1980; Watson, 2012), and principally two which relate directly to mental health nursing (Barker, 2001; 2003; Peplau, 1988), along with other proposed approaches (see Section 2.3, this chapter), none of these has gained any consistent purchase in mental health nursing, either perhaps because no single way fits its eclectic, pragmatic practice (McCrae, 2011), or the evidence-based paradigm is now dominant (Beebe, Adams, & El-Mallakh, 2011; Stein, 2009; 2013; Watson, 2012). Nevertheless, reflected in these models and approaches, mental health nurses perceive their roles as therapeutic through developing and maintaining supportive relationships, facilitating

personal development, and attending to physical and emotional needs, as well as administering medication (Barker, Reynolds & Stevenson, 1997; Fourie, McDonald, Connor & Bartlett, 2005; Hopkins, Loeb & Fick, 2009; Nolan, 1993; Peplau, 1988).

Despite appeals to establish nursing as a science based on scientific method, much practice, and learning in placements, is still based on a tradition of caring, trial and error, and authority (Cutcliffe, 2009b; Crook, 2001; Zauszniewski, Bekhet, & Haberlein, 2012; Zauszniewski & Suresky, 2004). The vast majority of mental health nurses learn through practice in placements, strongly influenced by other nurses, and patient contact, as well as communication skills in basic training (Appendix 1; Dowling, 2004; Koekkoek, Van Meijel, Schene & Hutschemaekers, 2009; Zauszniewski, Bekhet & Haberlein, 2012). A negative aspect of learning through practice is that the reliance on cultures of already established nursing practices can lead to hostile environments for newly qualified mental health nurses, or those who wish to be innovative (Cutcliffe, 2009b). McCrae (2011, p. 224) notes that nursing models, and theories applicable to nursing, are often regarded as "unrealistic dogma" and as "diversions from intuitive care." But also, it is widely acknowledged that mental health nurses do not see research as clinically relevant to practice, although they respect it (Beech, 1998; Browne, Cashin & Graham, 2012; Carrion, Woods & Norman, 2004; Happell, 2004; Yadav & Fealy, 2012). These factors may indicate that theories or models fail to put words on what is difficult, or perhaps impossible, to speak about definitively, as does the failure of scientific method to influence everyday mental health nursing (Clarke, 1999).

Nursing as a result is vulnerable to 'top down' directives, for example, from the Nursing and Midwifery Council, in promoting the 6 C's, care, compassion, competence, courage, communication and commitment (Cummings & Bennett, 2012), as a reaction to the Mid Staffordshire NHS Foundation Trust scandal of failed care (Francis, 2013). Indeed, the Francis Report (Francis, 2013) has been influential in driving proposed changes to

undergraduate nurse education, the current curriculum being seen as not focusing enough on patient care (Hemingway, Clifton & Edward, 2016). As a result, *The Shape of Caring Review* (Health Education England, 2015) proposed changes to the current three-year degree specialist training to a more generic training, comprising a two-year core curriculum of general nursing followed by one year of specialisation (adult, child, learning disability, mental health or public health) and a fourth year of preceptorship when in employment (Rosser, 2015; Hemingway, Clifton & Edward, 2016). The implication here is that nursing is simply about 'caring' along with some technical skills. A new nurse associate role for 'hands-on' work, has also been created, which frees qualified nurses to do more technical and clinical interventions (Hemingway, Clifton & Edward, 2016, p. 331; NHS Employers, 2017), as well as proposals for an apprenticeship in nursing (Donohue, 2016). The emphasis on physical health shows that the biomedical model of care is dominant (Hemingway, Clifton & Edward, 2016, p. 332), reflected also in how the authors of the *Shape of Caring Review* "made no direct attempt to engage with academics responsible for teaching and researching mental health nursing" (Coffey, Pryjmachuk & Duxbury, 2016, p. 738).

Hemingway, Clifton & Edward (2016) fear that the real reasons for new routes into nursing are about economics rather than improving nursing care. It appears that mental health nursing environments, and education, are now "fully embedded in a business model predominated by cutting costs, increasing efficiencies and increasing productivity" (Hemingway, Clifton & Edward, 2016, p. 335). Currently, the Nursing and Midwifery Council is in consultation regarding new standards of proficiency and a framework for education for nurses, with an emphasis on technical skills, and these new standards, as well as the current guidelines, will be briefly discussed below (Nursing and Midwifery Council, 2010; 2017a; b).

The following paragraph sketches what the Nursing and Midwifery Council (2010, pp. 17-18) expects from a mental health nurse in training, regarding therapeutic interpersonal

interactions. The mental health nurse is expected to show "therapeutic use of self", as well as maintain therapeutic relationships using a range of interpersonal approaches and skills. It is not specified how 'therapeutic' is meant to be understood in these guidelines for training. It is explicit that the mental health nurse herself be therapeutic, while also being able to use learned conceptual knowledge to promote the therapeutic; the latter involves exploration of the patient's experience and making sense of it with him. But at the same time, he or she, is required to "draw on a range of evidence-based psychological, psychosocial interventions and other complex therapeutic skills to provide person-centred support and care." There is recognition then in the guidelines for practice and education that mental health nurses use a range of learned concepts, but as well as these something more, which is to do with the person of the nurse. Unfortunately, this 'something more' is not developed in the guidelines, and it is interesting to note whether this may be a tacit reference to something that nurses know and do but cannot speak about.

The new guidelines, currently in consultation (Nursing and Midwifery Council, 2017b), still focus on care that is meant to put the patient first (person-centred care), but with a greater emphasis on all nurses being competent in medical technical nursing procedures, while preserving the four strands of nursing (adult, child, learning disability, mental health). Applicants for nurse training will have to possess, and be able to develop, "inherent strengths" of "emotional intelligence and resilience," as well as possessing the "attributes" of "being caring, empathetic and compassionate" (Nursing and Midwifery Council, 2017a, p. 5).

In the new draft guidelines, these 'strengths and attributes' will be assessed continually during training, "alongside knowledge, skills and competencies" (Nursing and Midwifery Council, 2017a, p. 5). There is a sense here then that being therapeutic has something to do with the person of the nurse, and the focus on this is in response to such scandals as highlighted in the Francis Report (Francis, 2013). Yet, these ways of being

become described as ‘skills,’ as if anyone could learn them as technical competencies. In the new draft guidelines, there is an assumption that nursing is a profession and that nurses are autonomous, “working in partnership with other healthcare professionals to meet health and nursing care needs of people, families, communities and populations” (Nursing and Midwifery Council, 2017a, p. 3); not noting that professional status has been the subject of intense debate (Morrall, 2006; Clarke, 2006). The outcomes for learning also specifically note the need for candour and self-awareness, including of one’s own vulnerabilities. Those outcomes which appear most relevant for this study give a sense that there is something already known of what the qualified nurse ought to be like, and despite the descriptions, this cannot be made explicit. For example, Outcome 1.6 says, “Understand the meaning of resilience and emotional intelligence and explain their influence on judgements and decisions in complex, challenging and unpredictable situations” (Nursing and Midwifery Council, 2017a, p. 8). There is a sense here that meaning can be pinned down, regarding being resilient and emotionally intelligent, or what a nurse may be tacitly ‘doing’ in being therapeutic. It is seen as a communication skill to be aware of one’s “own unconscious bias in communication encounters” (Nursing and Midwifery Council, 2017a, p. 23), but how a nurse would develop this awareness is not discussed.

Regarding mental health nursing in the draft guidelines there is an expectation of a more intensive training in communication skills, including solution focused therapies, cognitive behavioural therapy techniques, talking therapies, and developing therapeutic relationships (Nursing and Midwifery Council, 2017a, p. 24). The ‘learned concepts’ of the 2010 guidelines are made more explicit in the 2017 draft guidelines as ‘skills,’ and as can be seen, are part of the theories and ideas in the psy-complex to which Parker (1997) refers. Unfortunately, there is nothing critical in these guidelines, as to how, for example, toxic learning communities might influence a student nurse (see Cutcliffe, 2009b), or what is meant

by ‘care’ and other words like ‘empathy’ and ‘compassion.’ It appears that assumptions are being made here that it is already understood what these words mean, that they mean something which is already defined.

The mixture of ‘professional’ care, learned concepts of the above-mentioned therapies, and psychiatry, points to a confusion then right at the heart of mental health nursing as to what it is mental health nurses are there to do. Questions come to mind: Are nurses meant to uphold a certain way of thinking about what it is to be a person, as communicated through the psy-complex, and therefore, in standard psychiatric care? Are they meant to believe they are part of an autonomous profession while also being subject to psychiatry? The discipline is in a confusing state, on the border between an academic pursuit (in the wider, dominant paradigm of psychiatry, and psychology, this is ‘evidence-based’ practice (Rice, 2008a, b, c; Caldwell, Scalafani, Swarbrick & Piren, 2010; cf. Holmes, Perron & O’Byrne, 2006a)) and one which involves other ways of relating and being, while also being subject to psychiatric medicine (Hewitt, 2009). There appears a tacit indication here, however, that mental health nurses work therapeutically in idiosyncratic ways through being with a person (therapeutic relationships, talking therapies, therapeutic use of self), although their main role is to provide safe psychiatric environments, and assist psychiatry. None of this tension is made explicit in the guidelines, although it is debated in the mental health nursing literature in different ways.

To give a sense of what some nurses may be struggling to express tacitly or indirectly regarding being with, and caring for, another person, I will mention three nursing models here, developed by M. E. Rogers (1970), Parse (1981) and Watson (2012). These theorists speak of ‘care’ in a kind of language that is attacked in the nursing literature, from different perspectives, for example, as ‘slave morality’ (Paley, 2002), as lacking scientific rigour (Gournay, 2001; Beebe, Adams & El-Mallakh, 2011), and as inventing a metaphysical,

private language (Barker & Reynolds, 1994). Paley's (2002) critique is particularly incisive as it addresses caring as an ideological practice. I will argue that Paley (2002) has missed out on something to do with nursing, regarding healing, which evades theory or description, although agreeing with him that 'caring' may, in some cases, disguise something pathological.

Theorists like M. E. Rogers (1970), Parse (1981) and Watson (2012), believe there is something healing about being with another person, and they are trying to put words on that experience either through establishing a science of caring, or an overarching 'methodology of caring.' M. E. Rogers (1970) speaks of a person as an expression of a rhythmicality with the universe in a constant flow of energy which has patterns. Nursing can become a 'science' of this rhythmicality. At the same time, she follows Carl Rogers (1961, p. 93 in Rogers, 1970, p. 69) in emphasising "the warm, subjective encounter of two persons" as being more effective in facilitating change than any set of techniques. Parse (1981, p. 4), trying to separate nursing from medicine, emphasises how a person must be understood as a "living unity," not a "study of parts." Nursing ought to focus on "caring and healing," through this view of a person *not* being a bio-psycho-social sum of parts (Parse, 1981, p. 8; cf. Askew & Byrne, 2009). For her, nursing's frame of reference is "patterns of living health" and its "starting point" of inquiry ought to relate to the "inter-human" processes of caring and healing (Parse, 1981, p. xi). Striking phrases which she uses to try to express the sense of a person being 'unitary' and in a constant flow of energy, and choices, are worth noting, for example, a person is, "a living unity continuously co-constituting patterns of relating," "Man is transcending multi-dimensionally with the possibles [freedom to choose]," and "Health is unitary man's negentropic [becoming more complex] unfolding" (Parse, 1981, pp. 25-33).

Watson (2012) takes a step further than Rogers and Parse, by saying she believes we all have an eternal soul and that the goal of nursing is to "develop harmony". Illness is not

necessarily disease but can be "subjective...disharmony," in that "the self is separated from... one's soul" (Watson, 2012, p. 60). Healing can come through "heart-centred caring presence and conscious intentionality" (Watson, 2012, p. 75). She supports phenomenology and poeticising as research methods since human phenomena such as caring "cannot be studied in the manner of objects" (Watson, 2012, p. 95). However, for Watson, in nursing education and research, such art and science are now eclipsed by evidence-based practice (Watson, 2012). For her, caring values of nursing have become submerged by technology and bureaucracy (in industrialised countries) (Watson, 2012), while nursing as a human caring science restores "unitary notions of beauty, art, ethics, and aesthetics...and even love back into nursing practice" (Watson, 2012, p. 24).

There appears to be something important in these models in so far as the words being used indicate that there is something that 'needs a different language' about nursing as caring; perhaps linked to how there may be something ineluctable in being with certain others who are therapeutic, to do with 'openness' to the other person. Also, it is interesting to note that the idea that there is something intangible about being therapeutic in nursing may emerge in the notion of the 'therapeutic use of self' in the educational guidelines (Nursing and Midwifery Council, 2010). However, to try to define this 'ineluctability' through an 'ideology of caring,' which Watson (2012) does especially, seems problematic. Paley's (2002) view, which will be outlined below, is that attempts to establish 'care as ideology' reflects a 'slave morality'. It seems clear that being 'open' also involves being open to one's own motivations for wanting to be caring, motivations which may be pathological. When a nurse says he, or she, 'cares', it can be difficult to know what this means, and this is what Paley (2002) addresses. Is the 'therapeutic relationship' just a form of covert social control, for example (Morrall & Muir-Cochrane, 2002)?

Paley (1997) condemns nursing knowledge of caring in the literature as poverty-stricken, and a useless pursuit, resulting in lists of word associations which could just as easily be found in a thesaurus. It appears to me that he has a certain point here, in that lists of 'characteristics' and attributes tend not to say much about how or what these are like in practice and how can they be learned (for example, Lakeman, 2012). Paley (2002) gives a cutting analysis of how leading nurse theorists (such as Rogers (1970), Watson (1985), and Benner and Wrubel (1989)) have misled nursing through trying to define caring as an ideology in order to separate it from, and place it in a morally superior position to, the medical model of care. These nurse theorists do this, he claims, through a "caring-phenomenology-holism axis," which makes its ideology immune to the rigour of scientific method (Paley, 2002, p. 26). Trying to define nursing as an ideology of caring, he interprets as reflecting a 'slave morality' (after Nietszche, 1994), in which those who care are weak, or slaves, and harbour strong resentments towards those who have power, the nobles (the doctors). The slave 'priests' (nurse theorists), paralleling Nietszche's terminology, have invented a morality of compassion to assert power over the nobles in the only way they can. He argues that nurse theorists have therefore misled nursing from its true focus, which is the science (as researched through scientific method) of recovery and rehabilitation (Paley 2002).

There is always the danger that lying beneath any caring ideology, or even an individual act of care, is the "unconscious wish to exercise power over others" (Paley 2002, p. 31). It seems important to hold in mind such a criticism, at least since it indicates there may be other reasons why a nurse may 'care.' Coming from a psychodynamic perspective, Teising (2000, p. 449) makes a similar point, that mental health nurses' sometimes exaggerated use of power and control may result from denial of "dependency" on and "relatedness" to, their patients. Such views could address coercive and violent practice, for example, as documented in Cutcliffe, Santos, Kozel, Taylor and Lees (2015). This is perhaps why Peplau (1988; 1994)

encourages nursing education to be about the nurse coming to know herself, to know why it is she wants to 'care.'

Dowling (2004) responds to Paley (2002) by saying he would not hold his view if he had personal experience of relationships with patients, and she may be indicating here something about the nature of individual acts of care which cannot be described clearly in words. Barker (2001), in describing the Tidal Model in mental health nursing, with its focus on narrative and meaning, which he and others have given an empirical research base (Barker, Jackson & Stevenson, 1999), adds that ultimately the Tidal model provides a medium through which the patient may be healed "by Nature or by God" (a reference to Nightingale, 1969 cited in Barker 2001, p. 221), indicating that the mental health nurse is a catalyst for something more mysterious to occur. Stickley and Freshwater (2002, p. 253) in reference to the therapeutic relationship in mental health nursing, call for a "re-enchantment of the therapeutic nature of nursing" based on a "therapeutic alliance that is founded within love." This is in response to a "technological and a masculine mentality" (the 'contain and fix' strand) in nursing, and they call for a re-assertion of love as central to human existence (Stickley & Freshwater, 2002, p. 255). They appeal against technology and the language of technology (when they refer to Cognitive Behavioural Therapy manuals, for example) to something more intangible, but present in the complex dynamics of the nurse-patient relationship. This kind of thought in nursing could be seen as a continuation of an expression in nursing of something intangible. For example, following de Chardin (1967), Watson (2012, p. 42) is sure that human caring and love are "cosmic forces," the primal and universal psychic energy. It seems reasonable to suggest that this kind of intangibility perhaps may serve to make the practice of mental health nursing invisible as a treatment.

It has been noted that mental health nursing is so subject to psychiatry that it becomes invisible as being therapeutic in its own right as a 'treatment' (Barker, Buchanan-Barker,

Rolfe & Cutcliffe, 2005), a characteristic it may have in common with general nursing (Alderson, Parent-Rocheleau & Mishara, 2015; Bjorklund 2004; Liaschenko, 1995; Rodney & Varcoe, 2001; Walker, 1998). Invisibility may link to something that appears 'ordinary' about mental health nursing, that is learned through situated ways of living that are not necessarily academic (Barker, Jackson & Stevenson, 1999; Beech & Norman 1995; Cutcliffe, 2000; Cutcliffe, Stevenson, Jackson & Smith, 2007; Hellzen, 2004), along with something that cannot be spoken (Dowling, 2004).

It is interesting to note that the invisibility of nursing therapeutic activity is not entirely a negative phenomenon. It appears that mental health nurses can practise therapeutically in ways they see best, as long as they keep the patient safe and administer medication, and assist in other interventions, according to the dominant biomedical model of psychiatry (cf. Morrall, 1997; 2006, who would say mental health nurses collude with psychiatry). It may be one of the few remaining State-funded disciplines that is not entirely under the sway of institutionalised models of the mind, which, under the control of professional psychiatry and psychology, define a network of theories and practices which govern how ideas of deviance, illness and cure should be understood, the 'psy-complex' (Rose, 1985; Parker, 1997). Because of its invisibility, it appears to me that mental health nursing may offer a space for therapeutic activity that can involve a plethora of creative and idiosyncratic approaches, and where a certain a-theoretical freedom is still possible, in which the particularity of being a person can be given primacy. What is more, it appears that some mental health nurses may also 'escape' the dominant paradigm of psychiatric medicine, including other methodologies, through an openness to the person which is itself therapeutic.

2.3 The therapeutic as the art of healing

I will follow Cutcliffe (2000) here, who separates mental health nursing practice in terms of two different mentalities, or attitudes, to mental health: the 'contain and fix' and

'personal process' attitudes, which involve understanding of the therapeutic either as a cure, or as something more like an art, respectively. The 'contain and fix' mentality in mental health nursing essentially enables the biomedical model of psychiatry to function since it provides the containment and safety necessary for medication, or other medical intervention, to take effect. The role of mental health nurses in this strand is to ensure the safety of the other person and compliance with medical treatment (Gournay, 2000). This thinking in mental health nursing is in line with the dominant view of orthodox psychiatry that mental disorders are probably genetic in origin, resulting in chemical imbalances in the brain, requiring drug treatments in order to be 'cured' or managed (Barker, Buchanan-Barker, Rolfe & Cutcliffe, 2005). The therapeutic element of such interventions relates to that branch of medicine which is concerned with the remedial treatment of disease, and there is a commitment to this view in practice. Medication and its management comprise the therapy in this case. The management of medication, involving encouraging patients to comply with medication regimes, and monitoring side-effects, as well as training in cognitive behavioural skills to encourage compliance, is seen as a mainstay of therapeutic practice in the 'contain and fix' strand (Gournay, Curran & Rogers, 2006; Grant, 2009; Gray, Wykes, Edmonds, Leese & Gournay, 2004; Gray, White, Schulz & Abderhalden, 2010; Hamrin, & Pachler, 2007; Jones, 2009). Gray, Wykes, Parr, Hails and Gournay (2001) are critical of community psychiatric nurses for not ensuring medication compliance. Gray and Gournay (2000) see a critical role for mental health nurses in detecting side-effects of medication. Jones' (2009) study may illustrate the pressure mental health nurses are under to become 'evidence-based' and aligned with the medical model. He evaluated the effects on mental health nurses, in an in-patient setting, of training to implement evidence-based cognitive behavioural therapy for psychosis, as well as psychosocial interventions and medication compliance. Staff burnout and stress increased and morale decreased. Jones (2009) considered that these effects were due to the

more complex nature of the evidence-based work with no corresponding remuneration. It is interesting to note that Jones (2009) did not consider such effects as perhaps being due to the lack of recognition of what staff were already doing through their existing practice, and neither that the nature of therapeutic practice in mental health nursing may not conform to evidence-based methodologies (see Section 2.6.1, this chapter).

However, this does not mean that those mental health nurses who work more in the 'contain and fix' way do not experience working with mental distress and do not try to develop therapeutic relationships with patients (Moran, Cocoman, Scott, Matthews, Staniuliene & Valimaki, 2009). It is more that in following established orthodox psychiatric theory and practice, the primary emphasis is on *medication as cure* (accompanied by cognitive behavioural strategies (Jones, 2009)) rather than other factors. This approach in mental health nursing is becoming increasingly dominant, as it coincides with a corporate mentality in which the "centrality of relationship to healing… is dissonant with the outcome driven... philosophy of managed care and contemporary biomedical psychiatry" (Coleman & Jenkins, 1998; Wheeler, 2005, p. 152).

The 'personal process' attitude in mental health nursing is more likely to allow uncertainty and ambiguity, seeing mental distress in terms of 'problems of living,' a term first used by the psychiatrist, Harry Stack Sullivan (Barker, Jackson & Stevenson, 1999), emphasising more interpersonal and psychotherapeutic approaches, and widening what is conceived of as evidence (McKenzie, 2007). Mental health nurses in this strand may be more attuned to working in the "fundamental personal processes" that characterise "human-to-human spiritual connection" (Cutcliffe, 2000, p. 633). This strand draws from a diverse range of therapeutic knowledge from other disciplines, principally counselling, psychotherapy, and psychoanalysis, as well as from the practice of mental health nursing itself (for example, Cahill, Paley & Hardy, 2013). The boundaries between these two strands in mental health

nursing are not clearly defined. It appears that a mental health nurse may work in both ways at times. The question remains open as to how much a mental health nurse who firmly believes - or 'lives' - the biomedical approach ('contain and fix') can be open to, and provide openness for, the client or patient in other ways.

There is a multiplicity of approaches put forward in the literature to guide practice with respect to how mental health nurses may be therapeutic with the other person in the 'personal process' strand. These can be summarised here, with indicative references, as:

- Integrated models and theories focusing on the therapeutic relationship and intersubjectivity (Armstrong & Kelly 1995; Browne, Cashin & Graham, 2012; Carlyle, Crowe & Deering, 2011; Dziopa & Aherne, 2009; McCrae, 2011; O'Brien, 2001; Pierson, 1999; Walker, 1996; Wilshaw, 1997; Wheeler, 2011)

- Relational, embodied, situated learning, practical wisdom; practice-based evidence, against generalised systems of knowing, and for ethical practice in the moment, intuition and tacit knowledge (Bjorklund, 2004; Borthwick, Holman, Kennard, McFetridge, Mesruther & Wilkes, 2001; Crider & McNiesh, 2011; Cutcliffe & Koehn, 2007; Koehn & Cutcliffe, 2007; Eriksen, Dahl & Karlson, 2014; Hewitt 2009, Welsh & Lyons, 2001; Wright & Brajtman, 2011; Yadav & Fealey, 2012)

- Empirically validated knowledge, through qualitative research based on existential principles, including hearing the person's story, deriving new meaning, commitment and choice (Barker, 2003; Parse, 1981).

- Emotional labour, care and love, primarily as practice prior to knowledge or theory (Codier, 2010; Como, 2007; Dowling, 2004; Jacono, 1993; Mann & Cowburn, 2005; Stickley & Freshwater, 2002;)

- Emotional intelligence, empathy and poetry, involving complex and rhizomatic thought (Holmes & Gastaldo, 2004; Roberts, 2010)

- Interpersonal, psychotherapeutic and psychoanalytic theory (Cameron, Kapur & Campbell, 2005; Crowe, 2004; Evans, 2007; Feely, 1997; Franks, 2004; Gallop & O'Brien, 2003;

McSherry, 2013; Merritt & Proctor 2010, Nyström, 2007; Peplau, 1988; Stockman, 2005; Winship, Repper & Hinshelwood, 2009)

What these approaches indicate is the importance in mental health nursing practice of communication with the other person, through language and sometimes touch, the making of meaning, and emotional availability. Communication in these 'personal process' ways is not often a straight-forward process, and may involve complex, rhizomatic thought (Holmes & Gastaldo, 2004) akin to the development of wisdom (Nussbaum, 1986). This is complex and its complexity is perhaps reflected in the variety of approaches that mental health nurse academics put forward as good therapeutic practice; each one coming from varying conceptual backgrounds. What is not so clear in this body of literature is any focus on how to be in contact with another who is in mental distress in a way that is 'open' to the person, or how this might be learned, if at all. It is interesting that being open was valued by Peplau (1952/1988) almost 70 years ago. In their review, Cutcliffe, Santos, Kozel, Taylor and Lees (2015, p. 380) noticed that what service users wanted most from mental health nurses as 'treatment' were "practises of being open, offering human attention, and unrestrained respect of human dignity," including being listened to and taken seriously. While saying this sounds clear and straight-forward, learning what it actually may entail in practice, and including how one comes to learn to be this way, it will be argued here, are different matters.

2.3.1 Openness to others and one's self

It will be argued here that being 'open' (also to one's self) appears to be key in relation to the therapeutic and learning, but in a way in which 'openness' has something to do with the being of a person. Learning and the therapeutic may then be linked, since, I would say, 'if I cannot learn from you how can I be open to you in a way that does not already close you down.' Arendt (2005, p. 8 cited in Murray & Holmes, 2013, p. 343) shows that since Plato thinking has been regarded as "a soundless dialogue between me and myself." Following Arendt (2005), Murray and Holmes (2013, p. 343) ask what happens when, for example, "the

mediating terms of one's self-understanding become increasingly narrow." The difficulty is that "we can neither *know* nor *feel* with certainty that we are doing wrong… knowledge and feelings measure one's social conformity or non-conformity to received principles, rules, codes, behaviours and mores. These are always situated, social, historical, and bound up with the world in complex ways" (Murray & Holmes, 2013, pp. 343-344). 'Openness,' therefore, is not viewed here as a modular characteristic that can be 'learned,' as if it is something malleable that can be manipulated and formed through an education, for example, when Swami, Persaud & Furnham, (2011) indicate that the personality characteristic of 'openness to experience' can make a person more amenable to accepting psychiatric diagnoses as real disorders; or when Strickhouser, Zell & Krizan, (2017) find that it is a predictor of health and well-being.

I would argue that the kind of openness that is more open to "getting outside the mediating terms of one's self-understanding" (Murray & Holmes, 2013, p. 343) may be found more in certain ways of being in phenomenology, as well as some psychoanalytic and meditative practice, which Adams (1995) outlines, yet would not have to be 'classified' in any way at all in these terms. It is like Keats' (1817, p. 261 in Adams, 1995, p. 474) "Negative Capability" – "when man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact and reason." This sounds similar to Cutcliffe's (2000) idea of mental health nurses in the 'personal process' strand being able to tolerate ambiguity and uncertainty. This kind of 'being with,' and 'listening,' is close to Freud's (1912, p. 114 in Adams, 1995, p. 475) "open mind, free from any presuppositions." A certain discipline is needed for this kind of phenomenology, which, for Laing (1967, p. 11 in Adams, 1995, p. 475) is "an intensive discipline of unlearning…necessary for *anyone* before one can begin to experience the world afresh, with innocence, truth and love." This is like Bion's (1970) radical eschewal of memory and desire (Adams, 1995, p. 475). It is interesting to note how

Medard Boss (1975, pp. 109-114 in Brooke, 1993, p. 158) speaks of a relative openness or closed-ness of existence, and for both Boss and Carl Jung "openness softens and brightens the face of the world" (Brooke, 1993, p. 158). The sense here that the difficulties of living can be somehow ameliorated by an 'openness' in certain others seems particularly important, and is in tune with my own experience of certain others. Making presumptions of knowing can even be *unconsciously* "omniscient,"

> It is difficult to overestimate the role unconscious omniscience plays in deadening the capacity to experience. If one knows what is going to happen ahead of time, one does not have to experience it… Our sense of knowing has a way of spreading through our mental field and acting like an anaesthetic. What we know may lead to or block the new, it may heighten or dull experience (Eigen, 1993, pp. 245-246 in Adams, 1995, pp. 476-477).

Indeed, one's own language (mother tongue) tends to have an "anaesthetic effect" (Hawkes, 1977, p. 30). As Adams (1995, p. 477) notes, new perceptions are often "foreclosed unconsciously in favour of our sedimented certainties and presuppositions, all that we think we already know." Speaking as a phenomenologist, Adams (1995, p. 477) is aware that culture, history and language "influence every perception," which shows why a phenomenological attitude - in the sense of the reduction as 'leading back out of oneself' as I use it here - is required to at least catch sight of some of the effects of this. This is the attitude of certain kinds of counsellors and psychotherapists influenced by phenomenological philosophy (Cayne & Loewenthal, 2007; Lee & Prior, 2013; Snell, 2012), the artist, analysts and meditative people (Adams, 1995), and perhaps indicates a way of being that some mental health nurses may have. T. S. Eliot attests to this "perennial wisdom" for Adams (1995, p. 479),

> "Knowledge imposes a pattern, and falsifies,
> For the pattern is new in every moment"
> (Eliot, 1943, p. 26).

This is not to say that mental health nurses are, or must become, 'psychoanalytic' in some way. The 'art' of the analyst may involve "suspending the subject's certainties until their final mirages have been consumed" (Lacan, 2006, p. 209/251). The therapeutic 'art' of a mental health nurse may be more concerned with accepting such 'mirages,' and being open to their experience of these in the other person. This leads into Husserl's phenomenology in terms of the asymmetry in the subject-subject relation which will be explored in the Methodology chapter (Zahavi, 2003).

There are other ways to think about this 'openness' that are pointing towards a similar place, namely, in the Open Dialogue movement (Seikkula & Olson, 2003; Seikkula, Aaltonen, Alakare, Haarakangas, Keränen & Lehtinen, 2006) and McNamee's (2015, p. 373) idea of "radical presence" as an "alternative to the therapeutic state" (the psy-complex). The Open Dialogue approach to psychiatric care emerged in Finland, and focuses on problems of language and dialogue, particularly with respect to psychosis (Seikkula & Olson, 2003, p. 407). It developed through a confluence of influences (see Seikkula & Olson, 2003, pp. 404-405), including Bateson (1962) on paradox, and Bakhtin (1984) on meaning, into a practice in which a patient's family (including the patient) and the psychiatric practitioners work together in a reflective way in a group, so that everyone's voice may be heard, and decisions made together, aiming towards "joint understanding… rather than striving for consensus" (Seikkula & Olson, 2003, p. 410). It reveals the role of speech and language in a psychotic crisis. There is "tolerance of uncertainty" (Sekkula & Olson, 2003, p. 408), and these authors note that the process is like what Rilke (1984, p. 42) meant in the words, "live your way into the answer." It is interesting to note that this sounds phenomenological, as something is 'allowed' to emerge in a dialogue. There also appears to be the consistent theme of 'staying with uncertainty' (see Cutcliffe, 2000; Philbin, 1997). An aspect of the phenomenological background can be seen in Brown (2012), in her reflections on the Open Dialogue approach,

who draws on Stern's (2004) work on the present moment in which he closely follows Husserl (see Methodology, Chapter 3, Section 3.7). There is a movement towards reducing isolation so that the person can build a communicative relationship with those around him (Seikkula & Olson, 2003, p. 409). For Seikkula and Olson (2003, p. 410), the "therapeutic ingredient comes from the effect of dialogism on a social network as new words and stories enter the common discourse." Seikkula & Olson (2003) believe that any professionally trained person can acquire the skills involved in Open Dialogue. However, I would argue that these skills are premised on 'being open' which is more a 'way of being' and needs to be 'sheltered and developed' rather than taught, since it may be that it cannot be taught like a skill.

McNamee's (2015, p. 373) idea of 'radical presence' offers another way of thinking about diagnosis and treatment, shifting the focus to "broader relational and institutional contexts." She follows Rose (1985; 1999), who in turn is largely implicitly "in debt" to Foucault (see Rose, 1999, p. ix), in proposing that how we conceive of ourselves is constructed by 'science' and in particular the psy-disciplines (psychiatry, psychology, psychotherapy, psychoanalysis, sociology and anthropology). The psy-disciplines regulate what is 'normal' (McNamee, 2015, p. 375). It is interesting to draw attention here to how Husserl also noticed that what is 'normal' in society is judged to be so only by those accepted as 'normal,' resulting in language having a seductive power through tradition and idealisation (Chapter 3, Section 3.5.2.2). We are all caught up in this 'normalisation,' as we "offer ourselves to the surveillance of experts" (McNamee, 2015, p. 375). She argues that a "move beyond" this would "open space" to reflect on how our society and institutions create isolation and competitiveness, and "how we collaborate" with this which can make a person unwell (McNamee, 2015, p. 376). She speaks of there being "no technique" to radical presence (McNameee, 2015, p. 377), and cites Stewart and Zedicker (2000, p. 232) to show how this is about taking a certain position in the world, "letting the other happen to you while holding

your ground." She gives several examples of how this kind of presence does not jump to conclusions, and pays attention to the person's relational environment. Perhaps what is most striking is her example from Holzman's (2015) study, asking 'ordinary people' what they would advise regarding emotional distress and mental health diagnoses. The answers were that the person should have a talking therapy of some kind, as well as talking to family and friends, and interacting with others through hobbies and activities. McNamee (2015, p. 381) asks whether the focus should not shift from diagnosis and treatment to "how 'problems' might actually be logical responses" to "broader social conditions." She concludes that the psy-disciplines simplify a world that is complex, and it is time we shifted our focus to the complexity, a lot of which is about how social institutions and structures, and "ways of living in community," produce difficulties in living, as opposed to problems being 'in the mind' (McNamee, 2015, pp. 381-382). I would conclude from this that 'radical presence' then is an openness to new ways of seeing things, although it may not necessarily imply an 'openness' to the other person in that I envisage that 'giving ground' may be part of making room for someone else.

2.4 Openness to oneself and others through method

What will be explored in this section is the sense that openness to others often occurs through a theory or method of some kind, even if this theory is one of 'care,' for example, regarding the 6Cs (Cummings & Bennet, 2012). What is outlined here are approaches informed by psychodynamic, existential and humanistic 'theory,' not to promote these but to draw attention to how we often rely on a 'theory' through which to orient ourselves with others. The argument is working towards how being open to another is therapeutic, but 'method' or theory, however it may at times be helpful, may also get in the way of this.

2.4.1 Peplau's psychodynamic nursing model

Peplau's *Interpersonal Relations in Nursing*, first published in 1952, is considered the origin of modern mental health nursing theory (Barker, 1998; Haber, 2000). Certain aspects of her views from this book are outlined here, because of her insistence throughout her career that *the kind of person the nurse becomes* has a therapeutic effect on the patient (Peplau, 1994), "rather than the mechanism of the therapy" (Winship, Bray, Repper & Hinshelwood, 2009, p. 511). The idea that the nurse herself is therapeutic rings 'true' in my own experience of being with some mental health nurses, and connects with how I first noticed mental health nurses being with extremely distressed patients in what I felt was a therapeutic way, and yet their practice was not seen as a 'treatment.' Peplau was an American psychiatric nurse, who was strongly influenced in her training by Harry Stack-Sullivan's work on early therapeutic communities and his focus on the importance of interpersonal processes in infancy (as opposed to Freudian drives) (Winship, Bray, Repper & Hinshelwood, 2009). She was also strongly influenced by Frieda Fromm-Reichmann (Eric Fromm's ex-wife) through regular meetings, her unconventional approach, and her lectures on "dreams, myths and symbols" (Winship, Bray, Repper & Hinshelwood, 2009, p. 510). In a letter to Winship in 1998, Peplau described Frieda as "an Avant-garde humanistic therapist" (Winship, Bray, Repper & Hinshelwood, 2009, p. 510). Peplau worked in a military hospital in England from 1943 to 1944, where she introduced group therapy, and social activities as opportunities for therapeutic time with patients, and was influenced by British psychiatry especially through attending seminars by John Bowlby. Although she was a psychiatric nurse, she felt her model was relevant to all nursing (Winship, Bray, Repper & Hinshelwood, 2009). She believed that being therapeutic has something to do with the nurse through acquiring theoretical knowledge, and also through intuition, life experience, learning from and with the patient, and wanting to help, with an attention to the patient's words (without imposing a meaning).

Her views have been influential in the mental health nursing literature (Armstrong & Kelly, 1995; D'Antonio, Beeber, Sills & Naegle, 2014; Haber, 2000; Nyström, 2007; Stockman, 2005), but are becoming absent from educational curricula, with the decreasing focus on interpersonal relationships (Jones, 2012).

It appears that Peplau's (1952/1988) book, at least in part, was a formal expression of pre-existing practices which can be traced at least to the work of the attendants in the early public and private asylums (O'Brien, 2001). It is interesting to note that perhaps her emphasis on a psychodynamic understanding was the only way to get her book published, which although written in 1948, was not accepted for publication until it was endorsed by a doctor in 1952 (Barker, 1998). Peplau (1988) holds the view that exploration of the patient's experience is facilitated by the nurse who is continuously open to new learning about herself in each interpersonal relationship. Including references to myth and intuition, she places primacy on exploration of feelings and experience in the present. This kind of nursing is open-ended, and attempts to not "impose… values on others" (the values mediated by culture and the idiosyncratic values of the nurse), but aids the patient in arriving at his own judgement (Peplau, 1988, p. 144). Peplau (1988) indicates that being open to new learning in relation to the other person has an essential *reciprocal* aspect which defines it as being therapeutic - both the nurse and the patient learn in this process, participating in the relationship, and being affected by it. This leads her to believe that,

> "It is likely that *the nursing process is educative and therapeutic when nurse and patient can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solutions of problems*" (original italics) (Peplau, 1988, p.9).

For Peplau the main task of nursing education is to enable the nurse to understand and become "a person who is aware of how she functions" in interpersonal situations. This involves promoting a maturing and development of the nurse's personality, as well as learning interpersonal skills and methods to encourage such change. Such a process of personal

development allows the nurse to be capable of being interested in others in difficulty ("release of human interest"), to have greater capacity to be more 'freed up' ("liberation of emotional and intellectual capacity to make choices"), and reach an "enlightened self-interest" which can only result in productive relationships with others (Peplau, 1988, p. x). A nurse who has gone through such an educational process would then have the developed capacity to be therapeutic. The basic aim of nurse education for Peplau should be the gradual development of each nurse into a person who *wants* to nurse patients in a helpful way (Peplau, 1988, p. xi). She seems to think this is possible.

For her, a nurse learns to attend to the patient in a psychodynamic way, tolerating anxiety and exploring feelings, by "working through her own problems and concerns that arise in her relations with others" (Peplau, 1988, p. 124). She also links anxiety and creativity, following May (1950), where the tension between expectations and one's experience in reality can lead to new understandings. She discusses guilt and its links with anxiety, following Menninger (1942), Symonds (1946), Reik (1941) and Fromm (1941), and self-punishment, masochism and suicide. She is making the case for a nurse being able to work with these kinds of ways of relating, and being, through understanding and tolerating her own anxiety. Identifying what the nurse may "actually feel" as opposed to what she is instructed she should feel is an important part of this work (Peplau, 1988, p. 141).

Peplau (1988) believes that a nurse first attends to knowing what might be happening for a patient through a hunch, or an "intuitive impression," garnered from the nurse's previous experiences in life - "her feelings, ideas and other evidences" (Peplau, 1988, p. 265). Also, after Langer (1942) and Dunbar (1949), Peplau advocates for attention to the literal script of a patient's speech. This is because words can disclose meaning which could be missed by a nurse who takes them to mean what she thinks they mean. By sticking with the patient's actual words there is more room for opening up a dialogue that can lead to further meanings which

are pertinent to the patient. The language the patient is using ("the language of [his] illness") needs to be interpreted with the patient; the words used to connect with other events or meanings in the patient's life (Peplau, 1988, p. 295). She emphasises that attending to the patient's words is an ability that the nurse needs to develop, in order to recognise the multiple meanings and actions to which the words may refer. This involves the nurse not acting from a presumption of clear meaning, but tentatively clarifying the words of the patient to arrive at new conceptualizations that may be helpful to him (Peplau, 1988). Following Fromm (1951), Peplau advocates that nurses attend to "non-rational" symbols, as expressed in dreams, as well as the meanings that patients attach to such experiences. She includes the emphasis that patients may place on meaning carried in folk tales and myths. These may convey meanings that cannot be expressed directly which may reveal hidden wishes and longings, emotional ideas and desires. After Symonds (1949), she notes the significance of gestures, and bodily symptoms, as representing a form of communication, to which the nurse can be sensitive (Peplau, 1988).

The ability to stay with the experience of the other person in distress is particularly significant to mental health nursing (Barker, Reynolds & Stevenson 1997). I argue that this 'staying with' involves an openness to learning from the other person, which involves a reciprocal learning as Peplau (1988) indicates, through her attention to the importance of the client's words, how the nurse may affect the client, learning from the client, and being intuitive. However, although her approach points towards an openness to being with others, in my view she tends to see this through a psychodynamic and existential 'method' so that there is a closure, an end-point, to how a nurse comes to know how she 'functions,' comes to 'know' herself and another person. Peplau's way of being open to the other person is 'contained' through the theories she uses, which, while helpful at times, may also 'close down' the other person, framing their chaotic experiences (as well as the nurse's) in an

imposed (given) language or idea. This may be necessary at times perhaps (Teising, 2000; see this chapter, Section 2.4.2), and perhaps unavoidable (Kristeva, 1982; see this chapter, Section 2.4.4), yet the restriction imposed through this closure, may not allow him (or the nurse) to be in other ways. Nevertheless, Peplau's view is to encourage learning from the patient, and openness to that person using ideas, and so she is pointing towards a way of being with others that puts the mental health nurse under question regarding how she has come to be a person, which appears to me of utmost importance.

2.4.2 Openness to the other person in distress

If the mental health nurse is 'open' to the other person, then this openness may involve being open to specific forms of traumatic distress the other person may be experiencing, such as a loss of meaning and coherence, extremely distressing emotions, a sense of being wounded and unsure of one's sense of self; living with horror, emptiness, feeling estranged, guilt and shame (Holm, Bégat & Severinsson, 2009; Pierson, 2009). These forms of distress can also be spoken of in terms of more psychiatric language such as depression, anxiety and delusions (van Dusseldorp, van Meijel & Derkson, 2010). For a mental health nurse to 'care' for the other person, therefore, this involves direct 'contact' with these forms of distress. This encounter with the other person in distress and emotional pain, who may also be feeling deeply hurt and humiliated, has been considered as the foundation for, and the beginning of, healing by some (Holm & Severinson, 2008; Holm & Severinsson, 2011). The other person may have deep vulnerabilities, marked by confusion, despair, self-destructiveness to the point of being a danger to themselves and others, self-harm, a wish to die, and an inability to explain their inner pain (Holm & Severinsson, 2008). The other person can have pervasive feelings of fear of others, fear of being invaded, hurt, rejected, beliefs of having failed as human beings, afraid of trusting anyone, including himself, but desperately in need of trusting someone (Holm, Berg & Severinsson, 2009). For Holm and Severinsson (2011, also citing

Benner, 1994), to respond adequately to the nature of such distress the mental health nurse must be deeply intuitive, with a foundation of life experiences, who acts as a catalyst for the other *to begin their own healing process*. There is a need for the mental health nurse to shed the guise of technical expert, and to accompany the other towards a healing experience, the nurse being open to her own vulnerabilities also (Cutcliffe, Hummelvoll, Granerud, & Eriksson, 2015; Wilkin, 2006).

It appears that such openness involves listening, engaging through words, and being available affectively to the other person (McAndrew, Chambers, Nolan, Thomas & Watts, 2014). While McAndrew (2013, p. 375) points out that the mental health nurse needs the ability to "assimilate experience" and to "accept and validate" the experience of the other in distress, she acknowledges that this distress may be manifested in such a way that "one's own security becomes challenged." When this happens, it may be extremely difficult to be open to the experience of the other person, and the mental health nurse can feel helpless, become defensive and retreat into orthodox psychiatric views (McAndrew, 2013, p. 375). Indeed, being subject to violence and aggression is a complex problem in mental health nursing practice (Cutcliffe, 1999; Cutcliffe, 2013; Cutcliffe & Riahi, 2013). In psychosis, there may be a loss of sense of self, experiences and feelings of losing control over oneself – causing harm to others or oneself, being controlled by outside powers, being killed – creating high levels of fear, anxiety, anger, tiredness, exhaustion, sleeplessness and physical pain (Koivisto, Janhonen & Vaisanen, 2003). Barker (2001; 2003) and Barker, Jackson and Stevenson (1999), strongly influenced by Peplau (1988; 1994), indicate that the interpersonal interaction between the mental health nurse and the other person involves hearing the other's experience, and arriving at a meaningful narrative that makes sense *for the patient*. But, it seems evident that being 'open' may involve reducing one's own defensiveness, as well as a reluctance to be open to something that may be threatening.

Teising (2000) regards the work of the psychiatric nurse as providing a cohesive relationship in containing the 'raw material' of the patient's psychosis through a process of empathy. This results in a cohering narrative of meaningful connections with the patient's inner world which 'seals up' the chaos of the psychotic world. The nursing relationship forms a "sort of virtual membrane which is a point of intensive and accelerated change" (Teising, 2000, p. 449). For Teising (2000) the psychiatric nurse does this through the ability to denominate – apply words to experience – and the complex ability to contain:

> "…the nurse gave me a bath with many words of comfort, like a child, after I felt neglected for weeks in my psychotic state" (Ruhl, 1998, p. 227 in Teising, 2000, p. 451).

It seems that the importance of the right words here is significant in that they provide an anxiety-relieving 'making sense' with a reference to the outside world. The right words may provide a triangulation that prevents the development of uncontainable anxieties developed in a fusional dyad between the patient and the other person, especially in psychosis. Such effects can be shown in nursing practice, while the language of triangulation and 'dyadic fusion' comes from psychoanalysis (Kipp, Unger & Wehmeier, 1996 in Teising, 2000).

The meaning of engagement can be understood in a more ordinary sense as a process of being able to hear and tolerate emotional and psychological distress, through 'caring', empathy, or 'being with' (as opposed to 'looking on' (Bowles, Dodds, Hackney, Sunderland & Thomas, 2002, p.259); see also Cutcliffe & Barker, 2002). But the difficulty and danger of assuming full empathy, especially in relation to psychosis, is illustrated by Teising (2000):

> "A nurse accompanied an acutely ill patient on a walk and, contrary to the agreement of the team, was tempted into going into a café with the patient because the nurse felt he had become especially close to the patient. The nurse was convinced that he had shared a deep elementary experience of the patient and gained an especially intensive insight into his emotions. The nurse was horrified to witness that this patient set his room on fire shortly after returning from the walk… The nurse felt ejected from the patient in a volcanic

> eruption. Only much later the nurse understood that the patient had sensed the closeness as being extremely threatening and had to reject it vehemently" (Teising, 2000, p. 452).

Teising (2000, p. 452) notes how relating to someone with psychosis often involves engaging with the person's confused and bizarre language and behaviour which may be at first incomprehensible. Such language and behaviour has to be 'contained' by the nurse: There is an interplay between maintaining both empathy and distance, while also processing through words everything the nurse "receives" from the patient, including feeling helpless:

> "The function of receiving everything inferior, confusing and threatening is only possible if the nursing personnel manage to digest the remarks thrown at them… this also means that, as certain feelings and behavioural patterns cannot be understood, nurses must bear the helplessness resulting from this" (Teising, 2000, p. 452).

Again, the ideas from a method, or theory, are helpful in orienting a mental health nurse in 'knowing what to do,' however, they also may close down the experience of the other person, in the senses of in both making oneself 'unavailable' to that person, and/or 'receiving' his meaning through one's own meanings imposed upon him.

2.4.3 Openness to an uncertain encounter in mental health nursing

A case study example may illustrate to some extent the nature of the kind of encounter between the mental health nurse and the other person which is more 'open,' less bound by theory. The following is part of Hem and Heggen's (2003) published abridged version of an interview of a mental health nurse's experience of working with a difficult patient:

> "It seemed to be more and more difficult for me to be myself when I was with him… my communication with him became more and more difficult. He was psychotic and anxious… I managed to calm him and give him a sense of security… He was always studying me closely… It was as if all of me was being closely observed, he was trying to find out who I was… and he yelled at me day after day…'Shut your mouth, you fucking cow.'… … Every day all of this negativity directed towards me... … I suppose he used me as a shock absorber. I tried not to let it get to me. I tried to just put up with it and act normally… It would have been easy for me just to trade insults with him. I felt I was being affected, I became insecure because I was continually provoked. My communication with him became unclear and incongruent. I was becoming more and more

> unclear… I felt that I was side-lined, and that I lost my grip over him and others. I experienced something of an identity crisis…
>
> But sometimes we communicated very well… We told each other stories… And I saw something in him, that he was a vulnerable boy who was carrying a lot of pain. I don't think that his parents ever really saw him. I don't think he could bear to sit alone with all that suffering… …but he also said, 'We mustn't talk about it', 'I don't want to be looked at in that way while I'm here', 'Don't dig too deeply – I can't handle it.' He simply couldn't tolerate that we tried to pierce his defences. I said that this was alright, that it was enough… … there was understanding and contact between us - …" (Hem & Heggen 2003, p. 103).

Hem and Heggen (2003) point out the paradoxical nature of the encounter, in that the mental health nurse sees the dignity of the person and through her vulnerability gains insights into his problems, but this is deemed unprofessional by her, and her colleagues. She is uncertain what to do, and despite feeling like a "shock absorber," she retains a "stubborn empathy" for the patient (Hem & Heggen 2003, p. 104). She thinks it is unprofessional for her to feel out of control with the patient, and to lose her perspective on what is happening, yet it is these characteristics that may have facilitated communication with him. Significantly, she is exposed to a situation where she is expected "to be both intimate and distanced" (Hem & Heggen, 2003, p. 106).

The mental health nurse's openness here is the premise of any interaction with the patient. Openness and the ability to tolerate the "inconclusiveness" this brings, is demanding emotionally, and intellectually (Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013; Eriksen, Dahl, Karlsson & Arman 2014, p. 715). But this nurse's openness also exposed her to an experience that eroded her sense of self and integrity. This resulted in the loss of her ability to communicate clearly, and she became unsure of what she wanted to say. As Hem and Heggen (2003, p. 104) emphasise, she becomes 'uncertain,' 'unclear,' and 'split.' She also feels isolated from her colleagues and others, as if she is doing something that is unprofessional and misguided in how she is with this patient. Her colleagues are wary of her

approach, perhaps with good reason, and encourage her to gain some distance from this patient. While she is the one who probably knows the patient best and has been working therapeutically with him, she is not included in discussions with the psychologist (who it is likely would be coming from a conceptual position following the guidelines in the 'psy-complex' (Rose, 1985; Parker, 1997)), and so she feels excluded and marginalised both by her colleagues and her patient.

There is a sense here that she has touched on something repellent, and is cast out because of it, that she is bordering on the margins of language and the margins of meaning. She manages to stay with this experience only through a 'stubborn empathy,' and a belief that her patient's problems are rooted in his vulnerability as a young boy and can be healed through communication with him at this level. It could be argued that she is providing just what patients have said they value most: 'the human touch,' the ability to be compassionate, being treated kindly and respected, being attentive and engaged (Gunasekara, Pentland, Rodgers, & Patterson, 2014). As Barker (2001, p. 238) has emphasised, for many mental health nurses, working with "disturbance (whatever we call it)", involves "extraordinary acts of courage and compassion." It seems important to go further than this, as the language of 'courage and compassion,' for example, as advocated in the 6 C's (Cummings & Bennett, 2012) does not do enough justice to the experience of working therapeutically with the 'disturbance' of mental distress. Although not wishing to exclude such language, its use may tend to dissipate and devalue the complexity involved in being actually attendant to the other person, through thoughtful presence and speech, in particular as it is difficult, sometimes impossible, to express conceptually (see Introduction Chapter, Section 1.4).

It is possible to speculate that other therapeutic approaches advocated in mental health nursing would encourage her to interact in a different way. But what stands out is that the experience of the nurse was indicating that she was approaching something abject, or rejected,

side-lined, both in herself and the other person. Maintaining a tension between intimacy and distance, empathy and confusion, and disappointment with herself and others, as well as feelings of rejection and disintegration of the self, conveys the sense that the nurse is finding it difficult to manage and make sense of her experience, as well as the other's experience. It appears that it is this struggle that mental health nurses - those who try to be therapeutic - are exposed to on a daily basis and offers the opportunity to become therapeutic in a way that is more to do with an art of healing. How a mental health nurse responds to such a situation may be very loosely framed in theory - or outside of theory altogether apart from the theory of the 'human touch' - and depends on the nurse's ability and capacity to respond in the moment, moment by moment, to the patient in a way that maintains contact with him (Carlsson, Dahlberg & Drew, 2000), or perhaps, I would argue, openness to him (as 'contact' may be linked to a confused understanding of empathy which may oppress the person, as in the example above, in which the person set fire to his room). I would argue that theory being approached with some scepticism and taken lightly is significant, as otherwise it comes with "heavy tread" (Rabaté, 2002, p. 1); not being adhered to too rigidly allows space for more pre-reflective, tacit, and embodied knowledge, or something else, to come into play that may have something to do with the person of the nurse (or anyone). The theory of the abject in psychoanalysis may provide one way to think about the difficulties that mental health nurses face in the encounter with the other person in distress, especially extreme distress which could be described in psychiatric terms as psychotic. It will be discussed here, without implying it needs to be 'the theory' of mental health nursing, but seen more as providing some more 'words' to help articulate what is involved in the art of healing in mental health nursing, and to what the nurse may be open in this art.

2.4.4 Openness to abjection in mental health nursing

According to the Oxford English Dictionary (2015), abjection is the state or condition of being cast down or brought low; humiliation, degradation; dispiritedness, despondency. To abject is to cast off or away; to cast out, exclude, reject, especially as inferior, unworthy, or repugnant; to lower, degrade, debase; to subject, subjugate. That which is abject is cast down, brought low; of low status; downtrodden or desperate. There is an ordinary sense here that abjection involves pushing something away that is repugnant or unacceptable. As noted in the Introduction, it is what the mystic embraces (Kristeva, 1982; Chapter 1, Section 1.2).

The psychoanalytical sense of abjection (Kristeva, 1982) is framed with a similar sense:

> "…what is *abject*... is radically excluded and draws me towards the place where meaning collapses… A weight of meaninglessness, about which there is nothing insignificant, and which crushes me. On the edge of non-existence and hallucination, of a reality that, if I acknowledge it, annihilates me (Kristeva 1982, pp. 1-2).

Kristeva (1982) adapts Lacanian psychoanalytical theory to propose that, in 'accepting' language for the infant there is a shift from a feminine signifying system of the semiotic to a masculine system of the symbolic. For her, abjection is a universal phenomenon associated with the effects of the symbolic order (the rules and norms of society mediated through language) upon the fusional "archaic dyad" of infant/mother (Kristeva 1982, p. 58). No matter what the symbolic order defines (specific cultural rituals, social norms and practices), its effect upon the child/mother dyad produces abjection. Accepting of the symbolic by the infant involves abjection, or exclusion, of the fusion with the other, which cannot be returned to except through "madness, holiness and poetry" (Sarup, 1993, pp. 123-124), the 'other side' of social and cultural codes. One encounters abjection,

> "as soon as the symbolic and/or social dimension of man is constituted, and this throughout the course of civilisation. But abjection assumes specific shapes and different codings according to the various "symbolic systems"" (Kristeva 1982, p. 68).

Kristeva's notion of abjection has been discussed infrequently in the nursing literature. The current literature review found only three papers on this subject with respect to nursing, all of which include reference to mental health nursing. For Holmes, Perron and O'Byrne (2006b) speaking of the abject in mental health nursing is breaking a taboo, which is an emancipating act that will advance understanding of the nature of nursing work, the therapeutic relationship, the uniqueness of nursing, and some nurses' hardiness and endurance. They discuss abjection in public health nursing, community nursing and forensic psychiatric nursing. They regard abjection as fruitful in understanding nurses' reactions to distressing situations which people normally shy away from. But the abject is something that nurses find difficult to discuss despite being exposed to it in different ways on an everyday basis. The nurse is supposed to be able to sublimate negative feelings such as disgust and repulsion. In forensic nursing (Holmes, 2002 in Holmes, et al., 2006b), some nurses referred to patients as "dog," "rats," and "pieces of pigs." Holmes, et al. (2006b) write how Lupton (1999) believes that such terminology serves to unconsciously establish an impermeable barrier between the self and the contemptible Other. When dealing with the mentally ill, Holmes, et al. (2006b) suggest that nurses may feel the need to separate themselves from their patients in order to reassert their own integrity and subjectivity. Contact with "abject matter" - psychical and physical - may invoke disruption of their own boundaries, placing them at risk of being perceived, and self-perceived, as abject themselves Holmes, et al. (2006b, p. 313). Jacob, Gagnon and Holmes (2009) used abjection to explore the experience of forensic nursing, a sub-speciality in mental health nursing. Evocation of feelings of empathy as well as feelings of disgust, repulsion and fear caused conflict for nurses in this setting. What was particularly important were the effects of abjection on the therapeutic relationship, which if unrecognised leads to breakdown of psychical boundaries. Kristeva's (1982) description of what she calls the abject appears to hold true regarding the kinds of mental distress that mental

health nurses encounter, in the other person in extreme distress, and/or psychosis, and the effects of this upon themselves, but I regard it as illustrative rather than prescriptive. Similarly, Peplau (1988) is talking about how a nurse may become therapeutic, through knowing herself and learning from the other person, or patient; how a nurse may come to *want* to be helpful, and is helpful. Similar thoughts could be applied to the other approaches outlined in this section (Section 2.4), whether through humanistic, existential or psychoanalytical ideas, but there is something about 'ideas' that, I argue, misses the point about being with another person which is also linked to learning from the other.

2.5 Openness to one's self and others through speaking and 'being with'

There is an indication so far that there is something about nursing as 'care,' or perhaps, 'being with,' that cannot be put into written words that is expressed in speech, and speech fails too sometimes, so that there are elements of mental health nursing - perhaps any interaction between people that is therapeutic - which fall outside language and thus cannot be represented, yet are vital to the art of healing. That which is brought into language is done so through speech mainly, and not writing. This may link to a failure in 'written words,' in theory, to represent the person and the therapeutic (Heaton, 2010). Heaton (2010, p. 33) broadly defines the fundamental practice of psychotherapy as an activity in which people speak and listen to each other, trying to be truthful. It can be seen from the mental health nursing literature that such a definition - speaking, listening, and trying to be truthful - would also hold true for mental health nursing in its therapeutic practice. While in most psychoanalysis and psychotherapies there has been the filtering of speech through the development and application of written theory, it is interesting to note that for mental health nursing this is far less so, such that mental health nursing could be thought of as closer to an oral tradition than a theoretical, written, one, for example, drawing on personal knowledge

from other nurses (Dowling, 2004; Eriksen, Dahl, Karlsson & Arman, 2014; Yadav & Fealy, 2012).

Heaton (2010) outlines how writing, making marks on a page, alters or loses the experience of speech, the practise of making meaning that the written is trying to capture. In 'the talking cure' (not necessarily psychoanalysis) the "full resonance of oral utterance, imbued with the personality, gestures, tone of voice and physical presence of the speaker is at play," whereas "marks on paper" - writing - reduces this to silence, explanations and theory (Heaton, 2010, p. 33). The use of writing in human history was a technological breakthrough, a human creation, as opposed to speech which is an innate, evolutionary characteristic (Houston, 2004 in Heaton, 2010, p. 34). Writing is not about mere transcription of oral utterances - it was a system developed by specialists, and a deliberate attempt at creating a new mode of communication using signs. Writing involves a different kind of creativity, separate from speech. Alphabetical scripts in particular tend to convey simplistic senses of meaning, for example, "This (a word) means that (an object pointed at)" (Heaton, 2010, pp. 34-35). Theory then, may reduce the other person to the silence of 'an object pointed at.' Therefore, it is significant that the mainstay of what mental nurses do therapeutically - 'being with' - cannot be adequately represented in written theory or form. 'Openness' as therapeutic may involve something that 'allows' this speaking and being. This point about language will be taken up again in the Methodology chapter (Chapter 3, Section, 3.5.5).

The following example is a recollection of being a Franciscan novice 'in formation,' to try to illustrate some of this 'being with.' When feeling depressed, or miserable, I would often go to the kitchen to be in the company of Brother David. He was very old by then and he moved slowly around the kitchen, somehow keeping it in order and preparing food for the friary (others would also help). He would also make sure any 'men of the road' who passed by were fed and could use the bathrooms and showers. I would help wash the dishes or peel

the potatoes, and we would make some tea and sit talking for a while about nothing consequential. Slowly, being in this man's company made me feel better, even though he never asked me about my problems or tried to give me any answers. He was more concerned with talking about the chickens, his childhood, the state of the biscuits, and sometimes his health which was always deteriorating. He would tell strange stories that others thought were gibberish because they could not understand his Waterford accent. He was the youngest son of a farmer and worked as a labourer. He joined the Franciscans because they were the only religious order he had approached who would give him his own room. He never gave a sense of being a burden, or of complaining, and he would often chuckle to himself about "something ridiculous" one of the friars had done. There was something healing about this man, who had been ignored most of his life, spending his time doing the menial tasks of the friary. During the course of this research, he has sometimes come to mind when certain mental health nurses have been trying to describe what it is they do that is therapeutic, or also just being near them, or observing how they are with others. It would be always an interpretation to try to describe what David did that made me feel better. What comes to mind are acceptance, recognition, and warmth, but all of these were something to do with what he was, or had become. He was not 'working on characteristics' to develop a sense of being a whole, spiritual man, as some of the younger friars would do, meditating and seeking awareness. It was nothing to do with that, although he perhaps had not always been this way. It is tempting to think of how he was therapeutic in terms of 'grace,' but not in religious or spiritual terms. It may have been something to do with me also, about something that I needed from him that I did not understand; perhaps recognition or acceptance. I was sure that if he were asked in an interview what it was that he did that was 'therapeutic' for others that he would sincerely say that he did nothing at all and they should go and talk to one of the other friars.

There was nothing of the resentful 'slave morality' here. He was not trying either to 'connect' (cf. Murphy, 2013; Pieranunzi, 1997) with me at some deep level, or show empathy, and neither could it be framed as 'spiritual' (cf. Fry, 1998). There was a space with him, an openness that did not confine, and which gave me room to breathe. It was a kind of welcome in that he made room for me. Words start to falter for me around about here with respect to what was going on. But he did not meet me with a set of ideas, theories, rules for living, or a *credo* - which was a great relief. He was not trying to do anything to me yet welcomed me. "A therapeutic alliance founded within love" (Stickley and Freshwater, 2002, p. 253) may have nothing or little do with this either, although these authors may be trying to express something similar that cannot be written. It was more to do with something that falls between the lines of words, and/or linked to a smile, a touch, a way of not speaking - a way of 'being with' another person.

2.6 Implications of openness for mental health nursing

The failure of words - theoretical frameworks, theories, methods - to provide a consistent rationale that informs and defines mental health nursing as a discipline may be due to a number of factors, and three are noted here. Firstly, its closeness to the limits of language and meaning; secondly, its closeness to what is difficult, or sometimes impossible, to bear, and describe fully; thirdly, the idiosyncratic and mysterious aspects of 'being with' another person.

The ideas, or theories, explored here imply that the effects of an experience like the abject on mental health nurses would be found in facing meaninglessness, as well as working with a lack of adherence to accepted social codes, including the physical touch this may involve. This would involve introducing meaning through naming and delineating what has been inexpressible and frightening, and perhaps also involve a certain kind of touch and care, as well as "Winnicotian holding" (Winship, 2006, pp. 56-58). Returning to the patient cited

in Teising (2000) - "…the nurse gave me a bath with many words of comfort, like a child, after I felt neglected for weeks in my psychotic state" (Ruhl, 1998, p. 227 in Teising, 2000, p. 451) - it can be seen that speech is being used as well as touch and the acceptance by the mental health nurse of what may have been abject (both in the ordinary and the analytic sense) in this person. Engaging through words would be a way of introducing meaning and establishing a boundary between potentially lethal 'fusional dyads' imagined by the other person.

In the case presented in Hem and Heggen (2003), some colleagues warn the nurse away from her approach with the patient. It is not explained as to why they do this, but it could be speculated that their reasoning resides in experience, in tacit knowledge and intuition, or something else, regarding a situation that could potentially harm her. It is reasonable to suggest also that these nurses have learned and 'know' something about what is therapeutic but do not know how to explain it. At the same time, the mental health nurse in this case may have learned and 'know' something too, allowing her to bear with the 'uncertainty, ambiguity' (Cutcliffe, 2000) and 'chaos' (Holmes & Gastaldo, 2004) of the encounter with this patient, approaching something like the abject in order to be therapeutic. After Teising (2000), the balancing of empathy and distance, and the introduction of a third term through language, may indicate what this nurse was intuitively doing to become therapeutic. But she was feeling the abrasive effects upon herself of being close to such a 'psychical boundary,' eroding her sense of self and identity through loss of meaning. She was also being 'abjected' herself, from the 'mainstream' way of working with the patient, excluded, along with her understanding of the client, from the meetings with the psychologist. It is interesting to ask whether she too was being 'tainted' with something abject, by being different? In another way, the nurse in Teising (2000) felt the effects of assuming 'full' empathy, not realising that the lack of a boundary to such closeness - the lack of 'difference'

- was experienced by his patient as a lethal fusion. As noted in Teising (2000), a boundary in this case may have been established by the nurse naming and indicating the *difference* between each person involved in this potentially therapeutic encounter. Adding the idiosyncratic, ways of being of a person, to this milieu, gives a sense of what kind of situation a mental health nurse may be involved in while 'caring' for a patient. It is reasonable to envisage that there will be a constant process of decision-making, tacit or otherwise, on the nurse's part, in an involved, complex dialogue with the other person. What informs this tacit, or otherwise, 'decision-making', will be crucial to the outcome of any interaction with the other person.

Rather than pick up any of these approaches as 'methods' to become therapeutic, or any method, whether psychodynamic, psycho-analytical, existential, humanistic, or in the language of care and love, what is followed here is what may be involved in being open to an encounter with the other person, as it appears that it is the openness itself, this 'making room,' which is therapeutic and may involve something mysterious or unknown. It is not that the other 'methods' are excluded, but that if they only comprise a method then there is something about them that will fail as they are not 'open.' If we are always trying to "catch the drift" (Freud, 1923, p. 239), there will be no room for a different spontaneity or being surprised, a certain freedom, and perhaps being human.

2.6.1 Situated learning, intuition, emotional labour and tacit knowledge

Taking into account what may be abject, what presents itself as extreme mental distress, and a collapse of, or struggle for, meaning, and what is an individual's way of understanding her world, a picture is emerging here of how a mental health nurse's therapeutic involvement with a patient may be a complex engagement that cannot be expressed easily, if at all. I argue that what is therapeutic involves being 'open' to the other through 'allowing' them to be. If something cannot be expressed as a theory, then those

mental health nurses who work through being 'open' to the other may therefore be drawn towards practise first. Mental health nurses appear to favour everyday knowledge gleaned from colleagues and from patient contact (Burnard, 2003; Dowling, 2004; Gunasekara, Pentland, Rodgers, & Patterson, 2014). This appears to indicate that some mental health nurses recognise (perhaps tacitly) that therapeutic practise is prior to acquired knowledge; that is, learning to be with someone therapeutically arises from practise first, which appears to be reflected in the range of ideas on ways of being with the other person, which are complex, sometimes intangible, hidden, sometimes spiritual, poetic, rhizomatic, and reflecting practice with others (see Section 2.3.1 above).

Ways of speaking about things, including being therapeutic, come from practice. But language which represents theory distances one from the particular case (Heaton, 2010), and crucially therefore from the individual person. Such language that offers representations of the mind, or pictures of the mind, is a way of "not being present" to the other person since it puts the (re)presentation (not the presentation) first and does not call into question the one who is representing (Heaton 2010, p.7). There are links here with Husserlian phenomenology, where perception - or 'givenness' - is given precedence over representation (Zahavi, 2003). The 'forms of practice' found in therapeutic interactions in mental health nursing appear to involve the 'human touch', tacit knowledge, intuition, and emotional labour, along with, and without excluding, explicit, theoretical or representational knowledge, and perhaps something to do with 'mystery' (Barker, 2001) or being open and 'not knowing.' There is something intangible here, to do with 'being with,' that perhaps is reflected in the diversity of approaches to being therapeutic in the mental health nursing literature, since the diversity itself seems to indicate that there is *no one way* of coming to 'theorise' this.

This may have something to do with how a mental health nurse has learned from experience as a child, through life experience, what may have brought her into nursing, and

what she considers to be 'therapeutic.' The child 'learns' through actions and situations, responding to certain roles - responding to the particular human world of which they are a part; the 'community of practice' to which they belong (Lave, 1991). Lave (1991) cites Jordan's (1989) study of apprenticeship of Yucatec Mayan midwives:

> "Apprenticeship happens as a way of, and in the course of, daily life. It may not be recognised as a teaching effort at all…. Girls in such families, without being identified as apprentice midwives, absorb the essence of midwifery practice as well as specific knowledge about many procedures, simply in the process of growing up…" (Jordan, 1989, p. 932 in Lave, 1991, p.71).

For Lave (1991, p. 71), Jordan (1989) has described situated learning, which occurs through "peripheral participation in ongoing activity." A key part of this kind of learning is that knowledge and skills develop as a process of participation, and of becoming like "master practitioners within a community of practice." Learning is not primarily through formal avenues but through gradual and increasing participation, including with peers who are less and more adept at practice. This is a gradual, community-based process, involving the development of an identity. Mental health nurses may develop therapeutic practice in a similar way, although the cohesive sense of community described by Jordan (1989) may be absent or not so pronounced in psychiatric settings, while they may have been in the nurse's other life experiences. This also makes mental health nursing therapeutic practice vulnerable to 'communities of learning' that pass on knowledge that may be somehow pathological (Cutcliffe, 2009b; Hazelton, Rossiter, Sinclair & Morrall, 2011). Situated learning is poorly documented in the mental health nursing literature (Crider & McNeish, 2011).

Lave (1991) is close to describing what Polanyi (1983) has demonstrated in a more formal way regarding tacit knowledge, which in turn links to Husserl and Merleau-Ponty (Fuchs, 2007). In addition, the intimately intricate process of forming an identity as part of a community appears to show how embodiment, language and knowledge become inextricably

linked in a social process (Lather & St. Pierre, 2013, p. 630) so that "language, the human and the material [are] not… separate entities mixed together but… completely imbricated." There is an implication that words themselves are 'situated', perhaps in a landscape (see Merleau-Ponty, 1968). Embodiment is not intended to mean something that is therapeutic necessarily, involving a 'connecting' with oneself or others (for example, Finlay, 2005; 2006; Seikkula & Trimble, 2005; Laitinen, Ettorre & Sutton, 2007; Virtbauer, 2016), although this can be the case, but to refer to also what has come to be embodied as 'pathological,' or in other ways, which may be ideological (Zizek, 1989), or a way of confusing love with hate, for example (Heaton, 1999).

Also, as noted above (Section 2.3), what happens when, for example, "the mediating terms of one's self-understanding become increasingly narrow" (Murray and Holmes, 2013, p. 343 after Arendt, 2005). The difficulty is that "we can neither *know* nor *feel* with certainty that we are doing wrong… knowledge and feelings measure one's social conformity or non-conformity to received principles, rules, codes, behaviours and mores. These are always situated, social, historical, and bound up with the world in complex ways" (Murray & Holmes, 2013, pp. 343-344). Tacit knowledge, therefore, could also *get in the way* of being therapeutic, being open to the other, and indeed, Polanyi believed it could be responsible for the perpetuation of "thoughtless", embedded practice (Gill, 2000; Sennett, 2008, p. 51). The same could be said for situated learning (see Cutcliffe, 2009b).

Tacit knowledge is acquired through the kind of learning involved in learning a craft, learning from the 'master', through a process of repetition and mimicry until one 'knows' (Gill, 2000). Polanyi's (1983) exploration of the tacit mode of knowledge shows the importance of focal and subsidiary awareness, and embodiment. When one is focused on reading, for example, the focal activity is following the meaning of the words, while there is a myriad of subsidiary activities that make this possible, which are embodied. Polanyi drew

on the work of the phenomenologist, Merleau-Ponty, who in turn drew on Edmund Husserl (Gill, 2000), in developing his ideas on 'embodiment'; in particular, Husserl's (2001) notions of passive syntheses, and reflective and pre-reflective awareness (Zahavi, 2003), developed further by Merleau-Ponty through the idea of operative intentionality (Fuchs, 2007; see Methodology, Chapter 3, Section 3.5.4). Polanyi (1983) named the interaction of the body with the particulars of which one is subsidiarily aware as *indwelling*: the key point being that one reacts as if one understands at first without fully understanding. Learning to speak one's mother tongue is an example of such a process (Gill, 2000).

Initiation into one's mother tongue is not like teaching and learning a second language because the infant cannot know what it is to learn. The infant is "bathed in speech" - learning what to say involves joining in with others spontaneously: "It involves particular people, who are familiar, to whom it responds as an authority" (Heaton, 2010, p. 104). The infant follows this initiation blindly and only "much later in life… may be able to look back and see her initiation was perverted in some ways" (Heaton, 2010, p. 104). Therefore, how a person may 'know' about the therapeutic may be about believing they are being therapeutic when in fact they are not. The child learns to speak by taking part in the adult's activities, not by mapping words onto perceptual experience (Heaton, 2010). For example, an infant has to learn the language-games of requesting and wanting based on gestures, such as pointing, that are part of a cultural practice. This early learning of language is idiosyncratic, concrete and particular: "There is individuality and concreteness everywhere, signs of broad-based rules nowhere" (Tomasello, 1992, pp. 264-265 cited in Heaton, 2010, p. 106). Therefore, meaning-making involves coming to understand how this particular individual was initiated into language, how she mastered "sense making through the use of signs" (Heaton, 2010, p. 107). Drawing on Lave (1991), it might be added that the *meanings* which she has been 'given' are 'situated'. An example from a Japanese psychoanalyst and linguist may illustrate how this can go wrong:

> A female patient used to write down questions to ask prior to her interviews with me, which made me feel a little uncomfortable. She would even ask me how to phrase … answers when she tells her sister. This patient thought that words were meant to be memorised and repeated word for word. She could not speak with her own words. She believes that there is always a right answer to everything. I understood why her sister, who is her only family, has been refusing to live with her (Takemori, 2006, p. 64).

This woman was diagnosed with Obsessive Compulsive Disorder (Takemori, 2006). It could be envisaged that if this woman were being cared for by a mental health nurse in the 'contain and fix' mentality she might be encouraged to take prescribed medication for the disorder, and perhaps be referred to Cognitive Behavioural Therapy for Obsessive Compulsive Disorder. In contrast, a mental health nurse oriented to a 'personal process' mentality might encourage her to find and 'speak with her own words.' It is likely that this latter approach, however, in the field of mental health, would be 'invisible' as a treatment, or therapy, and would be seen as 'nursing.'

Polanyi (1983) demonstrates how even when one is learning through imitation of the 'master' one is learning tacitly what the master does not know he knows, and as such one cannot fully know what one knows explicitly. This is because the 'master' has embodied tacit knowledge such that he could not tell fully how he 'knows.' In this way, one has always learned to know more than one can tell (Gill, 2000). The interaction of subsidiary awareness and bodily activity gives rise to tacit knowing:

> "As one immerses oneself in the various disassociated particulars of subsidiary awareness by indwelling them through repetitive imitation, at some point they come together in a holistic pattern of meaningfulness" (Gill, 2000, p. 46).

Separate particulars come together as embodied skills through an 'integrative act.' Learning to ride a bicycle or to swim demonstrates this phenomenon (Gill, 2000). Tacit knowing comes 'before' explicit knowing which is represented by focal awareness and conceptual knowledge. References to the tacit in mental health nursing literature include a wide range of references to intuition, embodied knowledge and emotional labour, as well as

the tacit knowledge implied in notions such as compassion (McAndrew, 2013; Carlsson, Dahlberg & Drew, 2000). Intuition, as described by Claxton (2000) and Bastick (1982), appears to be closely linked to the tacit.

Claxton (2000) notes that a principal characteristic of the intuitive way of knowing is its contrast to abstract, logical or analytical thinking. He cites Bastick's (1982) comprehensive review of the psychological and philosophical literature regarding intuition. First, there is consensus that intuition is a different way of knowing that does not rely on fluency of articulation. Second, in contrast to analytical thinking it grasps a sense of the whole which may be greater than the sum of the parts. Third, intuition involves a reorganisation of the conceptualisation of the problem, often as a result of breaking through an unconscious assumption blocking a solution. Fourth, intuition draws creatively on a wealth of tacit knowledge from experience – paradoxically, knowing too much, due to consequent entrenchment, can block this creativity. Entrenchment here, in my view, is one way of being 'closed down', not open. Fifth, the knower is emotionally affected. Sixth, intuition relies on mental processes that are not conscious and are impeded by efforts to bring them under conscious control (which may link to Merleau-Ponty's operative intentionality; see Chapter 3, Section 3.5.4; Freeman, 1993). Seventh, intuition is coupled with a subjective feeling of 'rightness' on a scale of certainty. It is important to note that intuition however is not infallible. It is considered best to regard it as providing a working hypothesis (Claxton, 2000).

In cognitive psychology, intuition has been categorised as belonging to "naïve," or "folk" theories by some, getting in the way of "more accurate, scientific theory" (Boynton, 2016; Gasparatou, 2010; Shtulman & Harrington, 2016, p. 119). However, in an extensive review, Hodgkinson, Langan-Fox and Sadler-Smith (2008, p. 11) conclude that intuition involves "a complex interplay of cognitive, affective and somatic elements." Nevertheless, these studies reflect a dominant view of the mind as a kind of 'information processor' comprising two

'systems', one linked with the tacit and intuitive, and the other linked with analytic and explicit reasoning (Hodgkinson, Langan-Fox & Sadler-Smith, 2008). It seems important not to think of the mind as an 'information processor' as this thinking leads away from the complexity of situated, embodied ways of 'knowing'. This will be addressed in more detail in the Methodology chapter (Chapter 3, Section 3.6).

The forms of distress particular to mental health nursing practice involve a high degree of emotional labour, for example, in being with people who are suicidal or who self-harm (Mann & Cowburn, 2005; Hogg & Warne, 2010; van Dusseldorp, van Meijel & Derksen, 2010). Emotional labour is about regulation of emotional expressions and feelings as part of the paid work role, and managing emotions in situations to the benefit of that situation or the patient (Hochschild, 1983). There are two aspects to emotional labour: Deep Acting and Surface Acting (Hochschild, 1983). Deep Acting means the person can recognise his or her own experience and feeling, and is able to manage and express the related emotions according to preferences. In Surface Acting, control of emotions and behaviour is more important than expressions of personal feelings. Surface Acting and stress are positively correlated, and so Deep Acting appears to be more beneficial to mental health nurses (Mann & Cowburn, 2005; van Dusseldorp, vanMeijel & Derksen, 2010, p. 560). The claim that emotional labour involves acting - through suppression of feelings - raises questions as to genuineness, or congruence (Rogers, 1961). Yet, being able to bear with one's own distress appears to be a significant feature of being therapeutic for some mental health nurses (Jones & Cutcliffe, 2009; Moran, Cocoman, Scott, Matthews, Staniuliene, & Valimaki, 2009), and therefore may involve elements of emotional labour. It appears to be largely implicit and invisible, and goes unrecognised in educational curricula (Mann & Cowburn, 2005). It also has a quality of being sustained over long periods of time (Gray, 2009; Smith, 1992). The nurse in Hem and Heggen (2003) appears to have learned tacitly in that she is struggling to say what she 'knows.' It may

also be likely that intuition and emotional labour are in play in how she is with the patient, but for her to put words on this 'activity' is difficult.

In addition to the emotional labour involved in 'being with,' it is possible that mental health nurses in situations analogous to that in Hem and Heggen (2003), engage potentially in a complex interaction involving understanding ambiguity. Taking Wittgenstein's example of the function of a rule - "A rule stands there like a sign-post" (Wittgenstein, 2009, ¶85 in Heaton, 2010, p. 207) - it can be seen that there is always an ambiguity involved in judgement. The sign-post is a pointer but that does not mean it has to be followed. It takes discernment and judgement to know what to do, and perhaps, 'not to follow rules' (see Introduction, Chapter 1, Section 1.4; Barker, 2006).

Alongside this, words can be gestures, which take a certain sharing in a form of life - an understanding of how they have been assimilated - to interpret or make sense of (Heaton, 2010).

> "Just think of the words exchanged by lovers! They're loaded with feeling. And surely you can't just agree to substitute for them any other sounds you please, as you can with technical terms. Isn't this because they are *gestures*? And a gesture doesn't have to be innate; it is instilled, and yet assimilated… For the signs of assimilation are that I want to use *this* word, that I prefer to use none at all to using one that is forced on me, and similar reactions" (Wittgenstein, 1982, ¶712 in Heaton, 2010, p. 204).

This word, a particular word, means something to the 'lover' that no other word can replace, showing how much it is embodied, unique and individual, perhaps 'situated.' This throws light on the tacit knowledge and intuition involved in Cutcliffe's (2000) observation that mental health nurses work with ambiguity and uncertainty, and Barker's (2003) insistence that the patient is encouraged to come to terms with his difficulties in his own words. It is possible that Barker's (2003) careful attendance to the other person's words, and Cutcliffe's (2000) emphasis on tolerating ambiguity, indicate a certain tacit understanding

that words do not only signify how meaning has been assimilated in individually unique ways, but also how they may have been assimilated as unique gestures. Even in Wittgenstein's (1982, ¶712) observation on words as gestures, there is perhaps a tacit acknowledgement that something else is 'spoken' in speech which cannot be represented. As MacLure (2013, p. 660) puts it, referring to speech, "language cannot achieve the distance and externality that would allow it to represent, that is stand over, stand for and in for." MacLure (2013) is following a theory of language developed by Deleuze and Guattari (2004), and others (for example, Barad, 2007), which will not be taken up here, although it appears significant.

Each of these factors, as well as what may be understood through theory, or concepts, involves judgement, also tacit, and personal accountability. How tacit knowing, intuition, and language may emerge (also 'pathologically') as embedded 'meanings', will be taken up in the Methodology and Method chapters through Husserl's phenomenology and as particularly developed by Merleau-Ponty in his treatment of operative intentionality (Methodology, Chapter 3, Section 3.5.4).

2.7 The therapeutic as openness to others

If something cannot be spoken of then it cannot be symbolised, or written, and so it cannot be encoded; if meaning is collapsing, and a person is struggling to understand his world, himself and others; and if he, is idiosyncratic and individual, it can be envisaged that such a person may require a certain 'openness' from the other. Responding to what is abject, for example, may require something beyond tacitly embedded knowledge, depending more on intuition and emotional labour, and perhaps something else, more like a radical openness to the other person, and a refusal to impose a meaning on that person. Working with this kind of distress perhaps cannot be prepared for by learning tacitly, but may be more analogous to responding to an encounter through openness. How is it possible to be prepared for such an encounter? Holm and Severinsson (2011) suggest that intuition and sensitivity on the part of

the nurse are the best strategies for engaging in the encounter with deep emotional distress and pain. Elements of care that remain outside of language, akin to Kristeva's (1982) idea of the semiotic, may be in play here also, and may perhaps be what is indicated by language such as Watson's (2012) when she refers to a 'flow' between two people. As Heaton (2010) has shown, speech is an embodied phenomenon, far removed from writing. Whatever the elements of this therapeutic encounter are, they appear to be embodied phenomena, just as speech is, and are different to what is represented in writing.

If working with mental distress involves an encounter, this places an extraordinary onus on the individual mental health nurse to respond ethically in the moment, perhaps through tolerating what cannot be spoken. Sjöstedt, Dahlstrand, Severinsson & Lützén, (2001) regard the first nurse-patient encounter as a moral commitment in which the unique humanity of the other person is confirmed, and he is encouraged to enter into relationship with the nurse. The concept of an encounter also indicates that it is the individual person of the mental health nurse who is therapeutic in the first instance, rather than the knowledge frameworks she may favour, since the encounter with the other may come before 'knowledge' that is even learned tacitly. Being able to be in such an encounter is here thought of as 'openness.'

In summary, this chapter set out to explore what it is that mental health nurses know and do that is therapeutic, and this may be learned, regarding the nature of the therapeutic as the art of healing. It appears that how mental health nurses practice therapeutically is difficult, if not impossible sometimes, to say or write, and this has been the experience in writing this chapter. In current nursing educational guidelines, mental health nurses are supposed to work therapeutically with those in mental distress through the 'therapeutic use of self' (apart from communication, and evidence-based, skills). How being therapeutic may happen has been

explored through reflecting on nursing models, as well as the literature on the 'personal process' strand of mental health nursing practice, contrasting this against the background of a 'contain and fix' mentality more aligned to standard psychiatric medicine. The main thread that has been followed has led to the sense that 'openness' to the other person, through which the other person is 'allowed' to be, is the premise for the therapeutic as healing, and is therapeutic in itself. There are many theories to inform practice suggested in the mental health nursing literature, the diversity of which has been taken to indicate that mental health nurses work idiosyncratically with the other person, reflecting the diverse ways in which people may come to be. The focus on practice-based learning in educational guidelines, as well as how practice is often based on being with another person, appears to affirm this idiosyncrasy. It has been argued that theory, or method, while sometimes pointing towards an openness to the other person, ultimately closes down the other person (as well as the mental health nurse 'working' from theory). What appears therapeutic is an openness to the other person in a kind of encounter, where the mental health nurse can be affected, and learn from the other person, but this may involve the nurse facing a threat to herself and her identity. How this encounter can be traumatic and difficult has been explored through examples, and has been illustrated through Kristeva's (1982) view of abjection (not intending that her theory is 'a theory' of mental health nursing practice but rather to facilitate thinking about everyday situations which a mental health nurse may face).

Learning appears to involve situated knowledge, tacit understanding, intuition, and emotional labour (rather than emphasising explicit knowledge of theory), along with being able to stay in ambiguous situations, and tolerating uncertainty and chaos. Above all, being able to remain open to an encounter with the other person that can affect the mental health nurse, which may also involve deeply disturbing distress in the other, and herself, rather than cutting off from the possibility of such an encounter, appears key to being therapeutic. The

tacit, situated aspect of the therapeutic, as the art of healing, particularly points to an understanding of 'knowing' as to do with one's situation in the world; that we are embodied and embedded in the world in such a way that we are not 'objects' functioning against a background of the world, but rather we are situated in an intersubjectivity, and what we know may be intricately a function of this inter-relationship. Learning then would not be primarily about acquiring theories, although these may be helpful, but through a learning community, and process, where how one has come to be with others is allowed to be revealed in such a way that one does not block the other's potential to be healed, and indeed, can facilitate it. This kind of openness may be innate and perhaps cannot be taught. It is argued that such openness involves 'being with' another person so that space is made, room is made, that is like a welcome, or a 'salve' in the sense of something restorative or healing.

How this experience can be researched through phenomenology will now be discussed in the Methodology chapter.

3 Methodology

3.1 Introduction

This research has arisen from the experience of working as a mental health nurse. It is phenomenological in nature as it was felt that something had been revealed directly about mental health nursing that was given pre-reflectively in perception, although it took some time to trust this experience as opposed to beliefs about meaning in life linked to having been a Franciscan friar. Having read some of Husserl, I realised that it was this kind of 'direct revelation' that he was talking about when he spoke about a return to 'the things themselves.' So, it struck me quite clearly that this experience was more congruent with something 'in me' than any belief I held which may have given meaning to my life. However, as will be argued in this chapter, following Husserl, and also Heidegger and Merleau-Ponty, experience and belief may be impossible to separate also, arriving like a credo. This chapter in a significant sense is about trying to think about how something may be 'given' in experience as a meaning that affects us and persists as if it were a 'truth.'

I will follow Husserl primarily, because in my view, he gives a better sense than Heidegger does, of how we can become captivated by ideas, so that they become as if they were eternal essences. But I could not have thought through the sense of 'being captivated' without reading Merleau-Ponty. 'Givenness' in Husserl seemed of primary importance to any research, and I was interested in how Giorgi (2009) made room, or not, for this in his method which he based on Husserlian phenomenology, in which he focuses so much on the reduction and the epoché.

The research question, "What is the need, if any, for therapeutic education in mental health nursing?" arose from a revealing experience of being a mental health nurse, which indicated that, while some mental health nurses were clearly 'therapeutic,' their work was ignored in terms of being recognised as 'formally therapeutic' in psychiatry or clinical

psychology. What I am trying to say here reflects a difficulty in defining what is 'therapeutic' and the kind of words that come to mind are, 'the art of healing,' but where this art and this healing can link to almost anything that comes to be 'given,' of being of some meaningful help to a person. It has been a struggle to arrive at having the confidence to purposefully show that trying to define 'therapeutic' would not be helpful, to go around in wandering paths when it comes to definition here, because what I think may be therapeutic could be the simplest thing like a touch at the right moment, or something more complex which may even be mysterious. To try to define what might be therapeutic and turn that definition into the product of a technique would be to miss the point, and I believe this 'missing the point' is what much of the 'psy-complex' gets caught up in (Parker, 1997; Rose, 1985; 1990). Some mental health nurses avoid this net, as I am sure, other people do also. And phenomenology, to me, offers a way to cut through the net.

Husserl's original idea of trusting the experience which is 'given' in perception, for me, took precedence over how I might give meaning to that experience, but again this is complex, and I hope to throw some light on this complexity in this chapter referring to some of Husserl's writings and commentators. I do not mean to reify Husserl. I think of him as someone who, while working towards a goal of trying to reveal consciousness as transcendental, discovered numerous ideas which he left for others to follow (Zahavi, 2003). But I seem to feel a certain sympathy for him, as I feel he was overshadowed by Heidegger's gift with words, and I imagine he was like an eccentric explorer in the wilderness who continually finds interesting things which he sends back home for further work but is not credited with his discoveries. In trying to understand some of his writings it has seemed clearer that phenomenology is nothing but an exploration, an openness, a noticing of things, of being curious and wondering. I am sure I am biased, but this is very much like field work as a geologist in that all that there is to do is notice things, be curious, and be open to seeing

things differently, rather than constrict what is found into a theory. There was no question in the geological field that this kind of observational work was not science. But it is in stark contrast with how Giorgi (2009), and his tradition, views science, which is so contradictory as Husserl was so critical of scientific method being the only way of knowing validly (Zahavi, 2003).

This chapter addresses how the research question may be explored then through Husserl's phenomenology, in which he often followed threads of innovative ideas and then moved on from those, sometimes returning to them many years later (Zahavi, 2003). I tried to read Husserl in this way, tracing an idea that 'speaks' to me, and touches on my own difficulties in understanding experience, including also my experience of others. Reading Husserl was a struggle also because his style can be so arid and his thinking so intricate (Sousa, 2014). There was also the sense of a slow realisation that there was something missing in his views which I read, which I then found in Merleau-Ponty, and then found that those ideas Merleau-Ponty had found in Husserl and so I returned to Husserl. I began to get the sense of what Zahavi (2003) had spoken of, of how Husserl moved quickly through ideas, on a constant search to find an ultimate ground of knowing. So, there was a movement back and forth between Husserl and Merleau-Ponty, which helped me in coming to understand, to an extent, some ideas on intentionality and meaning, which I will try to outline here. Viewing Husserl in this way, which does not define his work too tightly, for me, allows his work to stand up to the post-structuralist critique (of the de-centred subject) and the critique, rooted in Heidegger, that accuses him of continuing a philosophical tradition of a 'metaphysics of presence' (Sass, 2014).

As discussed in the Theory chapter, it appears that when mental health nurses are being therapeutic they are working in complex ways with mental distress, deciding on what to say and do, sometimes where meaning has collapsed, involving tacit knowledge, intuition,

emotional labour and complex decision-making, including having a crucial openness to their own experience and openness to others. It has been suggested that this openness itself enables a response to an encounter with the other person that is therapeutic, while it may also draw the mental health nurse into an encounter with abjection. The literature indicates that while there are many approaches to being with another therapeutically, including a dominant idea of 'caring,' mental health nurses primarily learn through practice, which includes learning from peers and mentors or more experienced practitioners.

This chapter is organised so that firstly, there is an exploration of why Husserl has been chosen over Heidegger, regarding methodology, linked to how appearances 'captivate' us. Secondly, some of the philosophical background to Husserl's 'breakthrough' into phenomenology is outlined, in order to trace how scientific method is like separating being and knowing, and the background includes alternative strands in philosophy such as Montaigne's scepticism, as well as how Husserl can approach a kind of Platonism at times. There is a movement towards how we may come to live in our descriptions, or how we have come to be situated in the world, which links with the Theory chapter and how nurses may learn through situated learning. How we come to know anything may be linked to what we already know, and this is followed from Plato, which gives some credence to the idea that therapeutic openness is perhaps innate, beyond learning. This may indicate that in response to the research question, there is no need for therapeutic education at all. Thirdly, against this background, a discussion of Husserl's phenomenology is outlined. There is a focus on the following interlinking aspects of Husserl's phenomenology:

1. The epoché and the reduction, which are complex, *intuitive* processes, partly involving imaginative free variation, aimed at establishing what is essential to a phenomenon.

2. Constituting subjectivity and intersubjectivity; empathy as 'self-alienation;' self-reflection as being 'always too late' so that how meaning, or an experience, is revealed may not be reflected on, but is 'felt'; ideas of 'normal' and 'anormal.'

3. The 'experience of truth,' which relates to truth being situated and in context, is linked to subjectivity. The 'experience of truth,' one's own, and another person's, may become distorted through methods that impose 'meaning' through language, and further still with Giorgi (2009), through psychological language. An experience of truth is one which is at least partially intersubjectively 'acquired' and found within oneself, through language, but which then may be imposed upon the other person's attempts to communicate (also unknowingly) which blocks that person's meanings from being revealed.

4. The effects of intentionality, in that the researcher 'targets' what is 'given' as a phenomenon. 'Act intentionality' is linked to how a method may be applied, such as a hermeneutic analysis of language, for example. Operative intentionality is something that is 'always already' active in any such process, so that how a phenomenon might be examined contains within it an 'already' which cannot, if at all, be noticed (at least beforehand). There is also the non-intentional, such as feelings. Husserl's 'functioning intentionality,' as operative intentionality in Merleau-Ponty, offers a way to understand how meaning may be like a gestalt that 'captivates' a person.

5. Husserl's idea of givenness, linked to Merleau-Ponty's idea of an intentional arc that situates us in the world. This section further looks at how the present moment has a 'width' in a horizon of the world that is prereflectively given. It was Husserl's considerations on inner time consciousness which gave rise to his idea that meanings become 'sedimented' into a pre-reflective associative consciousness (Sousa, 2014, p. 53). This has implications as to how, if at all, the effects of anticipation and recollection can be removed from data analysis, and also the interview, when similar factors are 'built-in' to the present moment. In this way,

some considerations on how meaning arises from spoken speech, and speaking, as a gestalt, are discussed.

Linking to the above, the conclusion of the Methodology focuses on how meaning may be revealed as a *gestalt* - one which conveys an 'experience of truth' - one similar to meaning in perceptual experience, but now informed also through language. This draws on Merleau-Ponty's (1968) final work, *The Visible and the Invisible*, in attempting to understand the link between language, thought and perception. It will be explored to an extent how language, as a system of differences, after Saussure, conveys meaning as a pattern (Shaw, 2014). Meanings can exist as patterns in sedimented language, after Husserl (Sousa, 2014), of a culture, but new meanings can also emerge in speech, after Merleau-Ponty (1964), as an embodied pattern of differences. Finally, I argue that what may come to stabilise meaning is an effect of sedimented experiences, and appearances, and so we can be made captive (after Wittgenstein) in a picture of reality. In this way, we might believe that we can describe a persistent reality, as can be seen in the persistence of *credos* in life. These considerations are carried forward into the Method chapter in order to throw light on what Giorgi's method attempts to do, what its shortcomings are, and what it actually does.

3.2 Arriving at a research methodology

As discussed in the Introduction Chapter (Section 1.2), arriving at a research methodology emerged from an experience that was 'given' as a mental health nurse, and taking this experience seriously. In this way, a phenomenological methodology appeared to coincide with experience, as it was to do with description, as disclosing something "into words for the very first time" (Heidegger, 1962, p. 362/315). Choosing a descriptive rather than a hermeneutic approach is linked to exploring what the former may reveal, as my own experience as a mental health nurse appeared to strike me as something that was 'given' once and for all, which would not change.

3.3. Descriptive and hermeneutic approaches to phenomenology

Husserl's and Heidegger's expressions of phenomenology will be broadly outlined here, and then Husserl's approach focused on in more detail. While it is a tautology to call phenomenology descriptive (Heidegger, 1962, ¶ 7, §35), phenomenology as a philosophy and guiding a psychological science can be divided broadly into those approaches which are descriptive, following the Husserlian tradition, and those which are interpretive, or hermeneutic, following the Heideggerian tradition (Hein & Austin, 2001). For Husserl, the phenomenological researcher tries to set aside his presuppositions and biases, including any previous knowledge of a phenomenon in order to investigate it, in order to see it as if for the first time. This is called the phenomenological reduction and involves rigorous self-reflection. The first step in this reduction - although this step is really an ongoing activity (Zahavi, 2003) - is the suspending of the 'natural attitude,' or what is taken for granted in one's life, such as one's theories and assumptions (Giorgi, 2009). This step is also called the epoché, a term borrowed from Pyrrhonian scepticism, meaning a cessation, or suspension of judgement (Moran, 2000). Husserl believed in the possibility of a presuppositionless perspective through rigorous self-reflection. However, others, such as Heidegger and Merleau-Ponty, believed this an impossibility because one is always in the world and cannot break with it entirely - meaning that one is always subject to 'interpreting' what a phenomenon is, rather than as Husserl believed was in theory possible, being able to reveal a phenomenon in its completeness through rational attention (Hein & Austin, 2001; Gadamer, 2004). From this distinction emerge the two strands of phenomenological research, the empirical stressing the possibility of grasping a situation directly, and the hermeneutic stressing the importance of interpretation in understanding a situation (Hein & Austin, 2001, p. 8). A Husserlian procedure may aim at an 'essential structure,' while a hermeneutic procedure will aim at a provisional interpretation (Moran, 2000). It is important to note that there is no single, correct way to conduct phenomenological research and the distinction between empirical and

hermeneutic approaches is not absolute (Davidsen, 2013; Finlay, 2014; Hein & Austin, 2001). In addition, Merleau-Ponty occupies a place closer to Husserl than Heidegger, in that he does not move towards hermeneutics but rather an understanding of the pre-reflective revelation of the world and its links with language (Moran, 2000).

Hermeneutics is concerned with studying texts, and in phenomenological research results are texts that are regarded as interpretive accounts offering insights into the phenomena rather than replicable structural analyses (Hein & Austin, 2001). This approach resists a set method of research and assumes there are many possible perspectives on a phenomenon. The etymology of words in the data may be investigated extensively, and a wide range of sources such as literature and art may be used to throw light upon the data. There is an acknowledgement that researchers cannot bracket their history or themselves from the data so there is a strong emphasis on finding one's horizon, or vantage point, as a researcher with respect to the phenomenon in order to acknowledge it. Results are a fusion of several horizons that the researcher attempts to draw out, situated within his 'being-in-the-world' (Gadamer, 2004; Von Eckartsberg, 1998). 'Being-in-the-world' is Heidegger's term, signalling a philosophical emphasis in hermeneutic phenomenology where understanding is intimately and intricately linked with being in the world - understanding is only possible because of a "clearing" of being which is the individual person (Heidegger, 1962, ¶133). Being is understood in terms of temporality, and understanding is the fundamental characteristic of the being of human life (Gadamer, 2004). Hermeneutic work is an open-ended process of drawing out meanings in context rather than searching for fixed 'essences' of a meaning. Human activity in all its forms can be seen as a "text analogue" open to and in need of interpretation, the horizons of the text and the interpreter fusing in one or more possible interpretations (Von Eckartsberg, 1998, p.51).

Heidegger's (1962) interpretation of presence as temporal rests on the Greek word *parousia*, which is associated with the word for being, *ousia* (Inwood, 2000, p. 64). While drawing on this association to show how tradition links being with temporal presence, Heidegger goes on to critique this tradition, through showing how human being, *Dasein*, links the present moment with the future and the past, reaching back and running ahead of itself (Inwood, 2000). Heidegger was addressing the problem of how human beings are aware of a temporally enduring world, the past and the future, if awareness is only ever given in a moment of time - a problem that occupied Aristotle, St. Augustine, Kant and Husserl (Inwood, 2000). We tend to lose ourselves in the present, forgetting we are coming from somewhere and going towards something (Polt, 1999).

The hermeneutical problem has been stated by Gadamer (2004) as one dealing with understanding:

> "Long before we understand ourselves through the process of self-examination, we understand ourselves in a self-evident way in the family, society, and state in which we live. The focus of subjectivity is a distorting mirror. The self-awareness of the individual is only a flickering in the closed circuits of historical life. *That is why the prejudices of the individual, far more than his judgments, constitute the historical reality of his being*." (Gadamer (2004, p. 278) original italics)

This needs to be held in tension with how Heidegger (1962) describes how interpretive understanding occurs through the hermeneutic circle. In *Being and Time*, Heidegger (1962, pp. 192-195 [151-153]) addresses how is it that interpretation can lead to knowledge that is not already circumscribed in the investigation itself because interpretation occurs with concepts that restrict it. His solution to this 'vicious circle' is the hermeneutic circle:

> "In the circle is hidden a positive possibility of the most primordial kind of knowing. To be sure, we genuinely take hold of this possibility only when, in our interpretation, we have understood that our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to

> make the scientific theme secure by working out these fore-structures in terms of the things themselves" (Heidegger, 1962, p. 195 [153]).

It is interesting to link Heidegger's (1962, p. 195 [153]) "hidden… positive possibility of the most primordial kind of knowing," that which breaks a 'vicious circle,' with Husserl's 'givenness' in the reduction (Zahavi, 2003). Is this not what learning may be - a break from what one already 'knows' through something that is 'given' phenomenologically?

In hermeneutics, every revision of meaning projects new possibilities for further revision. Every "correct interpretation" will put aside prejudice and "direct its gaze on "the things themselves"" (Gadamer, 2004, p. 269). The 'constant task' of putting aside one's prejudices to get to the things themselves comprises a "process of new projection [constituting] the movement of understanding and interpretation" (Gadamer, 2004, p. 269). In Gadamer's (2004, pp. 270-271) words, "How do we discover that there is a difference between our customary usage and that of the text?... How can we be protected from misunderstanding from the start?" This is like Arendt's (2005) question as to how do we know we are doing wrong (Theory, Chapter 2, Section 2.3.1). Regarding meaning, how is it possible to know that a misunderstanding has taken place? This questioning is part of the hermeneutic task: "This kind of sensitivity requires a fore-grounding and appropriation of one's own fore-meanings and prejudices." Gadamer (2004, p. 270) says that we notice a difference by being "pulled up short by the text" by which he means that it either does not give any meaning at all, or else it gives a meaning that was not expected. The hermeneutic task, while arriving at interpretations, is also in itself a questioning of things and is always defined in this way (Gadamer, 2004). My argument here is that if something 'captivates' a person - "*the prejudices of the individual, far more than his judgments, constitute the historical reality of his being*" (Gadamer, 2004, p.278 original italics) – then its meaning emerges like a

description that is ‘fixed’ for that person, even though for someone else it may appear as an interpretation. We may become caught up in appearances.

Heidegger’s involvement with the Nazis, for example, causing him to side against Husserl and others, shows that this ‘captivation’ happens even to the best minds. It appears that even Heidegger is in need of a multiplicity of others to come to see things more clearly. It could be said that his development of hermeneutic phenomenology still failed to reveal the ‘now,’ what was right before his eyes in his life at a crucial moment, with tragic consequences. The ‘natural attitude’ may encourage closure of the hermeneutic circle in an interpretation, to place one’s beliefs, or intellectual discoveries, first, so that openness to the experience of what is ‘other’ is lost. It could be argued that Heidegger’s “fallenness” (Polt, 1999, p. 76) into the everyday world was about being caught up in the ‘natural attitude.’ It appears also however, that he was part of something which he did see clearly (see for example, Heidegger’s (1933) address, promoting Nazism, “The University in the New Germany” in Schneeberger, 1962, cited by Friedman, 1999, p. 528).

For Heidegger, the most enduring experience of Being is shown by what is there, right before us, or “readiness-to-hand” (Heidegger, 1962, p. 98/69). In this he appears to show his Husserlian phenomenological roots in that we can trust the ‘givenness’ of objects and our relation to them. Nevertheless, Heidegger’s main criticism of Husserl was that he was still caught up in categories of thought, such as ‘object’ and ‘substance,’ handed down through the history of philosophy and which covered over the essential historicity of Being and the ‘ready-to-hand’ nature of everyday experience (Moran, 2000). Heidegger’s hermeneutic approach attempted to go back to a more ‘originary’ understanding of philosophy, to the pre-Socratics, which had been covered over by layers of later thought. Influenced by Dilthey and others, who applied a hermeneutic method to Biblical texts, Heidegger was applying a similar method to the study of Being.

Heidegger's *"destruktion"* of philosophical texts was an attempt to uncover an originary sense of Being (Moran, 2000). But later, Heidegger turned to language, for example, in his *Letter on Humanism* (Heidegger, 1993, p. 217) describing it as "the house of Being," and became influenced by the German idealist poets, especially Hölderlin (a friend of Hegel) (Polt, 1999, p. 175). In his essay, *On the Essence of Truth*, written in 1930, Heidegger speaks of 'letting beings be' (*Gelassenheit*) (Heidegger, 1930, p. 129-130, in Polt, 1999, p. 127; see also Zizek, 2006), that is, to show themselves as they are, involving an attentive involvement rather than passivity, as if faced with an inexplicable mystery (Polt, 1999). This 'letting beings be' appears to be akin to the openness noted in the Theory chapter (Chapter 2, Section 2.4), as being therapeutic. It is an activity, which Polt (1999, pp. 128-129) describes in an example, "In order to let the rain show itself to me, I cannot just stare at it indifferently; I have to care enough about it, it has to make enough of a difference to me, that I properly notice it." But there is unconcealment and mystery here also and Heidegger (1930) refers to attunement as to how beings are disclosed, for instance, "as oppressive or uplifting" (Polt, 1999, p. 129). For Heidegger, we tend not to notice the mystery of how things reveal themselves to us in the first place, and therefore lose ourselves in making catalogues of facts, for example, missing out how the mystery of being reveals itself as both hidden and open (Polt, 1999).

Heidegger's inaugural lecture at the University of Freiburg in 1929, *What is Metaphysics*? marked his turn to language, and was understood by Wittgenstein as indicating he was trying to express something beyond the limits of language (Critchley, 2001). What appears clear is that Heidegger (1930) is talking about an experience to which we can easily close down, and it is possible to imagine someone who is closed in this way to others, not allowing the other person's being to be. As noted in the Introduction Chapter (Section 1.2), 'closedness' may account for a 'fixed' sense of 'meaning,' the oppressive sense, of the 'repeat' of a dogma, for example, or how an individual may *not* be "constantly compelled to

face the possibility of disclosing an even more primordial and more universal horizon from which we may draw the answer to the question, 'What is "Being"?'" (Heidegger, 1962, § 49/26-27; Polt, 1999, p. 41). For Heidegger (1984, p. 185 in Polt, 1999, p. 92), "*the* misunderstanding of human existence in general" is the setting up of a universal ground of its meaning (Polt, 1999, p. 92). I agree with this. However, the reality is that people set this universal ground in place all the time, and therefore this may emerge as something that repeats, albeit possibly in a 'pathological' way at times. It seems clear then that the insistence that we can describe a person's meanings in a fixed way, that can be repeated and relied on, may well be a pathology reflecting a pathology. This is clearer if I imagine an example of someone insisting another is 'bipolar' and occluding other ways of thinking and relating to them as a result. The pathology in the belief is imposed on the person as a real pathology (the imposition is the pathology) that then repeats in the descriptions of that person.

A way of looking at how descriptions become pathological, using Husserl's work, is how language reflects tradition, 'sedimented' in culture, and as having major effects on intersubjectivity, and therefore subjectivity. Husserl's main concern was about revealing what he felt to be the transcendent (essential) structures of consciousness, a project he never could complete (Zahavi, 2003). But on the way, he developed certain ideas which will be explored here which, I believe, are helpful to show how 'meaning' becomes 'stuck' or repeats, developing into a credo which feels like an 'experience of truth' (Husserl's term, see Section 3.5.3, this chapter). Phenomenology, and especially Husserl's phenomenology, have been subjected to post-structuralist critique, from thinkers such as Lacan, Althusser, Foucault and Derrida (Sass, 2014). The central points are that we are de-centred, through language, and that when we think we are 'in touch' with some form of "self-presence," we are in fact, not (Sass, 2014, p. 326). To take Foucault as an example, he strongly rejects phenomenology as a "theory of the knowing subject" and prefers instead "a theory of discursive practice"

(Foucault, 1966, p. xv in Sass, 2014, p. 331). For Foucault, we are caught in an era of post-Kantian "transcendental narcissism" (the subject is both the basis and object of knowledge) (Foucault, 1969, p. 203 in Sass, 2014, p. 331), following after "divinely ordained" ways of being in the Renaissance and the "purely objective order" of the Enlightenment (Sass, 2014, p. 331). What Sass (2014) tries to show here is that Foucault is working like a Heideggerian phenomenologist, trying to trace out how being is revealed through temporality, "disclosing forms of disclosure" (Sass, 2014, p. 333). Sass (2014, pp. 331-332) cites Foucault's (1966, p. 48) way of expressing how something could be 'known' differently in the Renaissance, with the words "raw being" of language (as words held a link to the essence to which they referred). It can also be read between the lines, perhaps, that Foucault could not have thought through 'forms of disclosure' if he had not experienced his own disquiet in the world which was 'given.'

I would draw attention to the point that I have to start from my own uncomfortable subjectivity and work from there. If not, I suddenly will find myself in a room, for example, of theorists, talking about how they may be obsessives or hysterics, when clearly most of them are not admitting they are lonely (and it might be nice to feel they belong somewhere). It is this simple point that I think is important, that 'discursive practices' may encourage a person to take leave of himself, or herself, missing out what is 'given' in the moment, or being closed to it. Husserl was not good at describing his own experience and perhaps this may have made his writing style so arid, while clearly Heidegger and Merleau-Ponty, along with other phenomenologists, were. For example, one listener reported, "…I was speechless…. I felt as if I had had a glimpse into the ground and foundation of the world…" on attending Heidegger's famous 1929 lecture on "What is Metaphysics?" (Polt, 1999, p. 122). This also goes to show how we can be captured by the talents of a great wordsmith, or another person's words. Finding one's own words is a different matter. It has gradually dawned in me, in a

tentative stuttering way, that I cannot start from someone else's subjectivity, although later on I might discover that my ideas are confused and my subjectivity is a mirror of the beliefs of others, and it is then that personal despair is important (what is 'given' in the moment). If I am not open to that despair, in terms of my own experience as 'given' then how will I start to know what it is to be at all, in the sense that I am closing down on something? It appears so important then to defend Husserl's basic idea that we take what is 'given' in experience seriously, without having to reify it.

3.4 Philosophical background informing the research methodology

The aim of this section is to draw attention to Husserl's work regarding some aspects of philosophy and indicate the importance of his phenomenology with respect to 'knowledge' and 'being.' Knowledge linked to familiarity and acquaintance is seen as most relevant to mental health nursing, and I have argued that this is linked to the person of the nurse (her being). It appears clear from the Theory chapter that this knowledge is not only representational (following a theory, for example) but is also situated, involving tacit and intuitive knowing, and has to do with a person's being. Coming to 'know' something, it has been argued in the Theory chapter, also involves a crucial openness to 'not knowing' so that the other person is not confined and restricted by one's ideas or theories, and is 'allowed' to be (see Chapter 2, Section 2.3.1). A question arises as to in what way being and knowing may 'interlock', or 'become' in a person, and this section looks at some background to this philosophically, which is then followed in more detail through an exploration of some aspects of the phenomenology of Husserl and of Merleau-Ponty. I will also try to trace some aspects of the background to Husserl's (1970b) view of the crisis of the European sciences here, in order to throw light on where Giorgi (2009) may be coming from when he tries to make phenomenology empirical and scientific.

3.4.1 Husserl's view of the 'crisis' of science

Husserl's view of the crisis in the European sciences reflects a view on how knowledge for Husserl, what could be validly known, had become static. The crisis for Husserl was that there was no crisis, in that science and technology had become unassailably the only legitimate means of gaining knowledge of the world as phenomenon, as correlative of intentional experience (Moran, 2000; Zahavi, 2003).

In an unpublished text of Husserl's from the 1930s, Moran (2000, p. 183) shows how Husserl admired the achievements of science, and saw the scientific as motivated by a playful curiosity:

> Special motives are required in order to make the theoretical attitude possible, and against Heidegger, it does appear to me, that an original motive lies, for science as for art, in the necessity of the game (*Spiel*) and especially in the motivation for a playful "intellectual curiosity", one that is not springing from any necessity of life, or from calling, or from the context of the goal of self-preservation, a curiosity which looks at things, and wants to know things, with which it has nothing to do. And no "deficient" praxis is at stake here (Husserl Archiv B 1 32 Nr. 17 translated by Moran, 2000, p. 183).

He observed how empirical scientific successes and theories gradually became absorbed into the everyday language and became unthinkingly 'true,' with no questioning of the premises, or assumptions, upon which such knowledge was founded (Zahavi, 2003). Husserl believed the claims that the scientific world-view originated with Plato (Moran, 2000).

3.4.2 Background to Husserl's view of the crisis

In 1883, a dispute which began in economics over methodology spread to the human sciences in general, and became known as the *Methodenstreit,* or controversy over methodology. The dispute divided into two aspects, whether the logic in the human sciences is different to that of the natural sciences, and whether the 'data' of the human sciences

requires ‘understanding’ whereas the data of the natural sciences requires explanation (Walker, 1994a).

Walker (1994a) examines this controversy through an exploration of Jasper’s descriptive phenomenology, through the views of William Dilthey, Max Weber, and Georg Simmel, all of whom were in the ‘understanding’ tradition. By the early twentieth century, German universities were influenced by a neo-Kantian movement, attempting to understand the connections between experience and reality through a return to Kant. Jasper’s had an enduring respect for his teacher, Max Weber, and an intense dislike for Heinrich Rickert due to the latter’s attempts to denigrate Weber’s work (Walker, 1994a). Nevertheless, Jaspers would agree with Rickert (1962, p. 32 cited in Walker, 1994a, p. 257) when he describes reality as an “unsurveyable multiplicity,” and refers to a Heraclitean view of reality as constant flow and change, so that science can only ‘select’ aspects to examine (Walker, 1994a). Jaspers major work, *The Phenomenological Approach in Psychopathology* (1912), would repeat this theme, so that phenomenology is the appearance of psychic life in consciousness, out of which “we make a representation that divides into intuitive content and conceptual form” (Walker, 1994a, p. 259). In 1874, two important books on psychology were published, reflecting the difference between the ‘understanding’ and ‘explanation’ traditions: the first being Wundt’s *Principles of physiological psychology*, the second, Brentano’s *Psychology from an Empirical Standpoint* (Walker, 1994b). Brentano means empirical in the sense that it is experiential, deriving from experience, based on direct intuition; Wundt’s view involves the experimental and observational (Walker, 1994b). Brentano recognised the value of both approaches, but saw descriptive psychology as offering *a priori*, certain knowledge (Walker, 1994b). Brentano saw philosophy as having become stagnant and saw the solution to this in it becoming a psychological science. Husserl’s first book, *The Philosophy of Arithmetic*, tried to show how the concept of number was located in empirical facts of

experience. However, Frege's critique – "that there is an irreducible difference between the number 4 which has a square root, and the idea of the number 4 which does not" (Walker, 1994a, p.124) - changed Husserl's mind as to the possibility of psychology providing an a priori 'science of sciences' and this invoked his work in *Logical Investigations*, resulting in his breakthrough to phenomenology. Descriptive psychology would be about empirical facts such as the square root of 4, but an *a priori* science (phenomenology) addresses the very comprehension of the idea of number (Walker, 1994a).

3.4.3 Idealised 'Ideas' as transcendent in tension with experience

This sense that Husserl is impressed by the 'Idea' of number appears to lead him towards a kind of Platonism (Zahavi, 2003). I think this is important for a number of reasons that may be worth exploring briefly. One question for Plato was regarding how we come to learn anything, and he addressed this through his Theory of Ideas. He felt that we come to learn through recollection of Ideal forms from a perfect, divine Ideal reality beyond this one (Waterfield, 1987). Such learning is therefore connected to the divine, and can be drawn out, maieutically (Socrates being like a midwife) in any person as it is innate. Knowledge and 'being' are here joined through the divine, the 'Good' (Plato, 1993). This was not just an intellectual debate, as Plato's search for the 'Good' appears to have been motivated by a need for social harmony (Waterfield, 1987). It seems clear that this question is still unresolved for many, as it can be seen that 'knowing and being' are still very much united through credos of the divine through various religious ideas, as well as credos in certain ways of thinking, such as in scientific method (see, for example, Rawlins (2008)). Whether or not the therapeutic is innate then, having to do with one's being as it appears to be (although perhaps not divine), has a long history. Another question is regarding whether we really need 'Ideas' to live, as otherwise we cannot tolerate the despair involved, as Kierkegaard (2005) seems to imply,

> "If there were no eternal consciousness in a man, if at the bottom of everything there were only a wild ferment, a power that twisting in dark passions produced everything great or inconsequential; if an unfathomable, insatiable emptiness lay hid beneath everything, what would life be but despair?" (Kierkegaard, 2005, p. 14).

Method in research then may be reassuring as it may make us feel less despairing in our quest to be understood and recognised perhaps. For Zizek (2014), Plato did not fully appreciate his own Theory of Ideas as he did not consider that Ideas may not be the hidden reality behind appearances, but rather nothing but the very form of these appearances. Plato wanted to reconcile the spatio-temporal world of change (Heraclitus' view) and the eternal, unchanging, more substantial world of Being (Parmenides' view) through his ontological theory of Ideas (Kenny, 2012). Instead, Zizek (2014) sees Ideas as virtual and insubstantial, but nevertheless significant, appearing fleetingly on the surface of things as if they signified a more profound reality. 'Ideas' as being virtual also speaks to me in reading Husserl, who seems to get caught up in the 'Idea' that he will be able to see how consciousness 'works' so that its 'functioning' could be regarded as 'transcendental', since 'knowing how it functions' would define how all knowledge could be 'apprehended'. I view this as how we can 'transcend' our own consciousness to then understand how 'knowing' comes to be known (the knower coming to know how she knows seems an impossibility however). Husserl was a mathematician, and it could be imagined how he would link the ability to comprehend what he might consider an 'eternal truth' of Euclidean geometry, with a corresponding consciousness able to comprehend such 'truths.' These kinds of concern are what preoccupied him in *Logical Investigations* (Zahavi, 2003). One of the ways I connect this to method in this current research is that no matter how flamboyantly or disguised we may make a triangle (for example), its essential, 'Ideal' structure in a Euclidean world is that its internal angles always add up to 180^0, and Giorgi (2009) is trying to find similar types of 'structures' in verbal descriptions. At the same time, Husserl did not agree with this kind of transposition of

mathematics onto 'nature,' as can be seen from the following comment in which he sees Galileo as being partly responsible for

> "…the surreptitious substitution of the mathematically substructed world of idealities for the only real world, the one that is actually given through perception, that is ever experienced and experienceable - our everyday life-world" (Husserl, 1970b, §9 (H) cited in Welton, 1999, p. 353).

It appears that experience tells us something important and it should not be substituted by a 'mathematical' method.

3.4.4 Descartes and the origins of the scientific method

Since Descartes, the history of epistemology has been largely about attempts to fit empirical knowledge into a mathematical model (Westphal, 2003), and as Heidegger (1962) shows, forgetting the 'being' involved in this move, or in Husserl's (1970b, §9(H) cited in Welton, 1999, p. 353) terms, "the experienced and experienceable."

Pre-Kantian modern philosophy is traditionally divided into two strands: rationalism, of which the main proponents were Rene Descartes, Baruch Spinoza and Gottfried Leibniz, and empiricism, of which the main proponents were John Locke and David Hume (Copleston, 1963). Philosophers such as Descartes, Spinoza and Leibniz accepted the idea of innate (*a priori*) truths or self-evident principles - we are able to innately understand a truth through a particular experience. This truth precedes experience although it takes an occasion of perception of this innate truth by means of an experience in order for it to be revealed. Logically the innate truth precedes experience of it (Copleston, 1963), just as Socrates (in *Meno*) says he shows when he draws out in the slave boy understanding of a geometrical problem (Plato, 1970, § 85a-c). This seems important, as it may imply that we may not know we are therapeutic until an experience draws it out in us, with some help from another (like Socrates) perhaps also. What further characterises rationalism is the ideal of attempting to establish a deductive system, analogous to a mathematical system, which would provide

factual information about the world from these self-evident truths (Copleston, 1963), as seen, for example, in Descartes' *Discourse on Method*. It is widely accepted that the modern notions of science and knowledge originate with Descartes (1596-1650), although he was working in a cultural milieu that questioned dogmatic notions of metaphysics and the world (Kenny, 2012). It is worth noting Descartes' four rules to guide sound reasoning and the search for truth in the sciences, outlined in *Discourse on Method* (published in 1637 as a preface to his writings on dioptrics, geometry and meteorology (Kenny, 2012)), summarised by Gill (2000): 1. Be certain of one's beginning point. 2. Analyse every idea and proposition into its smallest components to discern clearly what is being claimed. 3. Move from one proposition to the next in logical order. 4. Number and review each step of the argument. It is interesting to note that Giorgi's (1997; 2009) method also follows similar steps in principle, in what appears to be a reflection of his adherence to scientific method (see Method, Chapter 4, Section 4.7).

Descartes' great precursor could be said to be Galileo (1564 - 1642) who Husserl regarded as the discoverer of physics and "at once a discovering and concealing genius" (Husserl, 1970b, §9(H) cited in Welton, 1999, p. 356). The concealment involved here is that the mathematization of nature has led to an objectivism which conceals the subject's involvement with (and in) reality, so that questions such as "What is truth?", "What is knowledge?" and "What is a good and meaningful life?" have been lost from sight. The uncritical acceptance of the scientific method - stemming from Galileo's, and others', original insight - is a crisis in that the sciences have become bankrupt ethically and philosophically. It is not that Husserl does not recognise that science has something helpful to offer, it is just that "its method excludes other forms of knowing" (Zahavi, 2003, pp. 125-126).

It is interesting to note that one could draw similar conclusions regarding the dominance of randomised control trials in the human sciences currently. The mathematical

treatment of probability has displaced other forms of knowing (see Guy, Loewenthal, Thomas & Stephenson, 2012; also see Rawlins, 2008).

Descartes was also responding to a revival of scepticism, represented, for example, in the works of Michel de Montaigne (1533-1592), who noted the unreliability of the senses, and inter-dependence and conflicts between sense and reason (Copleston, 1963; Bakewell, 2010). In his *Essays* Montaigne proceeded by "heaping up case studies" in a kind of cornucopia which illustrated in a benevolent manner how unreliable human reason is, including his own (Bakewell, 2010, p. 122). Montaigne was strongly influenced by Pyrrhonian scepticism, originating with the Greek philosopher, Pyrrho (died circa 275 BC), and further developed by Sextus Empiricus in the second century AD. Sextus Empiricus posed the "Dilemma of the Criterion", which is that we cannot reliably establish 'first premises' to establish justification of knowledge without an infinite regress to find new criteria for those 'first premises' (Westphal, 2003, p. 38). Pyrrho found peace and tranquillity by suspending judgement on questions of certain truth and knowledge both in philosophical and everyday terms. While dogmatic scepticism asserts that certain knowledge is impossible, "Pyrrhonian scepticism would also doubt such an assertion" (Bakewell, 2010, p. 123-124). This 'holding back' or suspension of judgement was further defined as *epokhe* by Sextus Empiricus and expressed in various ways, for example:

> "I now feel in such a way as neither to posit dogmatically nor to reject any of the things falling under this investigation" (*Outlines of Scepticism* 49-51 (Book I: 197) cited in Bakewell, 2010, p. 125)

In stark contrast to Montaigne and the sceptical tradition, Descartes' fundamental aim was to attain philosophical truth by the use of reason, aiming to establish certain 'first premises' without an infinite regress. Philosophy at this time included metaphysics, and physics (natural philosophy) with branches to all the sciences, including medicine, mechanics and morals (Copleston, 1963). He did not set out to discover a "multiplicity of isolated truths"

but to establish "a system of true propositions" which were "self-evident and indubitable" (Copleston, 1963, p. 77). To do this he broke with the past although did not preclude insights from previous philosophers. He wanted to work with clear and distinct ideas, and challenged those who relied on authority:

> "But as regards all the opinions which up to this time I had embraced, I thought… once for all to sweep them completely away, so that they might later on be replaced either by others which were better or the same when I had made them conform to a rational scheme*"* (*Discourse on Method* 2 (vi), pp. 13-14 in Copleston (1963, p. 80)).

The reference to a rational scheme shows how Descartes wished to proceed from truths self-evident to reason and deduce from these further truths. Like Socrates, he was impressed by the certainty of the axioms of mathematics and geometry and wished to apply a similar process in his new method, which would rest on truths which had intuitive immediacy (Kenny, 2010). For Descartes, there was only one kind of knowledge, that which was certain and evident, and all other forms of knowledge stemmed from this, so there could be only one scientific method for ascertaining such knowledge (Copleston, 1963). His move from medicine to philosophy, and the search for certain truth, perhaps was invoked by a tragedy of fate, as it coincided with the tragic death of his daughter, aged 5, of scarlet fever (Shorto, 2008). I mention this because it may imply that there was a 'private' meaning to his search for certainty, which is an aspect of meaning that only emerged clearly 'late' in this study, during the Phenomenology (see Chapter 6).

Descartes' major assumption is that all the sciences are "identical with human wisdom which always remains one and the same, however applied to different subjects" (*Rules for the Direction of the Mind* 1 (x), p. 360 cited in Copleston, 1963, p. 81).

For Descartes, there are two capacities of the mind which can be trusted: intuition and deduction. His method comprises a set of rules which will allow these capacities to be applied so that they are "not misled by factors such as education, prejudice, passion, impatience, and

the desire to attain results" (Copleston, 1963, p. 84). Intuition and deduction are "two mental operations by which we are able, entirely without any fear of illusion, to arrive at the knowledge of things" (*Rules for the Direction of the Mind* 3 (x), p. 368 cited in Copleston (1960, p. 84)). Intuition is "not the fluctuating assurance of the senses" nor the "fallacious judgement of the imagination" but is "the conception, without doubt, of an unclouded and attentive mind, which springs from the light of reason alone" (*Rules for the Direction of the Mind* 3 (x), p. 368 cited in Copleston (1960, p. 84)). Intuition is then a purely intellectual seeing that leaves no room for doubt (Copleston, 1963). Deduction involves "a certain movement or succession" involving inference from already certain facts, as opposed to intuition (Copleston, 1963, p. 84).

Descartes' fundamental intuition is the *cogito*: I think, therefore I am. He believed that he could not be deceived on this fundamental intuition, as God would not allow it, and God also guaranteed that this "thinking substance" (*res cogitans*) could have reliable knowledge of the material world (which included his own body), or 'extended substance' (*res extensa*) (Copleston, 1963, p. 129). The 'I am' indicates that the 'I' is a thinking substance only, somehow lodged in the body, which is an unthinking, 'extended substance'. Descartes' dualism is apparent here, although even for Descartes the relationship between the thinking substance and the body was not clear:

> "I am not only lodged in my body as a pilot in a vessel, but I am …very closely united to it… so intermingled with it that I seem to compose with it one whole. For if this were not the case, when my body is hurt, I, who am merely a thinking being, should not feel pain, for I should perceive this wound by the understanding only…" (*Meditations 6* cited in Copleston, 1963, p. 130).

In contrast to rationalists, for empiricists innate truths refer only to relations between ideas and do not give factual information about the world. Generally, what characterises

empiricism is the belief that facts about the world and reality can only be found through experience, which is "a combination of sense-perception and introspection" (Copleston, 1963, p. 36-37). Such knowledge is induced from experience and can only ever be true in terms of probability and never certainty. Relations between ideas give certainty but yield no factual information about reality (Copleston, 1963). David Hume (1711-1776) represented empiricism brought to its logical conclusion in that the argument goes that causality can never be induced from experience, but can only at best be regarded as a conjunction of events, which results in scepticism. Hume held that practical, everyday life and thus knowledge, "rested on beliefs" (Copleston, 1963, pp. 40), and "conditioning" (Gill, 2000, p. 21). One can think of this in terms of causal links resulting in an infinite regress, or else the process is stopped by deciding on an arbitrary point of cause (Gill, 2000).

Immanuel Kant (1724-1804) responded to Hume's scepticism by attempting to show that sensory perceptions *and* the structure of the mind form human cognition. Categories such as space, time and causation form the conditions of the possibility of knowledge. Kant called that which can be known by the structures of the mind the "phenomenal world", and that which cannot be known as the "noumenal world" - the actual "thing itself" remains noumenal for Kant, because 'existence is not a predicate' - saying that something 'is' does not mean that it exists (Gill, 2000, pp. 22-23). Husserl believed that Kant has missed out that being can be revealed intuitively - "categorial intuition" - which was an idea of Husserl's that captivated Heidegger (Moran, 2000, p. 121). But for Kant knowledge of the world was valid because *the objects of our representations conform to the concepts we have about them sufficiently*. The empirical world is real but this is because consciousness unites intuitions of it under concepts. Kant also wanted to unite understanding (epistemology) with reason (ethics), a project that can be understood as trying to unite theory and practice, "uniting the formal structures of consciousness with human freedom" (Critchley, 2001, p. 19). Critchley (2001) writes how

Kant was criticised immediately by his friend, Johann Georg Hamann (1730 - 1788), for over-emphasising the formal character of knowledge, as well as thinking that reason could be separated from experience; that is, Hamann believed that understanding comes with experience and cannot be known beforehand. Hamann also uncannily predicted the importance of language here by saying that reason and experience could not be separated since all thought depended on language which came from a mixture of both (Critchley, 2001). It is interesting to note that Hamman is said to be "the only author by whom Kierkegaard was profoundly influenced" (Lowrie, 1938, p. 164 cited in Grimsley, 1973, p. 115). Hegel departed from Kant by asserting that categories of knowledge are not static, that human cognition is rooted in human action, including affect, and not only the intellect; for example, using Sophocles play, *Antigone*, to demonstrate that self-understanding, at an affective and intellectual level, was necessary to know and judge rightly, and also depended on what others knew in the social world, including linguistic tradition or ways of understanding concepts through ordinary language (Westphal, 2003).

3.4.5 Living in descriptions

Reading Husserl, and trying to understand the 'roots' of his ideas, as indicated to an extent in the above section (Section 3.4.4), began to have the effect of a picture emerging from a background of conflicting thought, that 'thinking, understanding and meaning' are interlocked in some way, which would include that which is therapeutic. What may come close to summarising this is Wittgenstein's 'forms of life,' which reflect an interlinking between language and being, so that it is like we live in our descriptions (Heaton, 2010). Wittgenstein's (2009, ¶115) insight, "A picture held us captive. And we couldn't get outside it, for it lay in our language, and language seemed only to repeat it to us inexorably," states this 'state of affairs' while giving a sense that it is possible to get out of this captivity.

How the philosopher lives his life might reflect more about his ontology and epistemology (interleaved) than what he says about those subjects. That is, what we say, or write - what we think we think - can become, and may be, removed from what we are. As discussed in the Theory chapter, the tacit, the intuitive, openness, and the openness to make decisions in a complex setting, function as embodied and intersubjective actions, events and processes which cannot really be defined but can be 'seen' perhaps in actions. Would this not imply perhaps, that going for a walk with somebody, or simply talking together, would be a better way to understand how they are therapeutic than asking them about their 'philosophy' in an interview? As Critchley (2001, p. 62) notes, "…a philosophy fuses with a way of life."

The ordinary term, 'a way of life', points towards how coming to be is situated in communities of practice (Lave, 1991; Lave & Wenger, 1991). This has implications as to how to understand any data, or findings, in psychological research (MacLure, 2013) and will be addressed in the Method chapter as to the limitations of method. For example, Giorgi's (2009) method presents a meaning in words but based on an "intuitive accomplishment" (Applebaum, 2012, p. 49; see also Cloonan, 2012a; b) that is not fully demonstrable. I would argue that phenomenology ought to lead us out of the captivity to which Wittgenstein refers, because the emphasis is on 'what hits us' and what we may try to 'cover over' from that experience, but for this to happen it appears a certain openness is involved.

3.5 Husserl's phenomenology

Phenomenology could be said to be a rejection of a "realistic and naturalistic objectivism" that claims that the nature of meaning, truth and reality can be understood without taking subjectivity into account (Zahavi, 2003, p. 52). Husserl is interested in the strictly invariant and essential nature of consciousness (any consciousness, not necessarily human) and therefore he believes he must proceed from the first-person perspective just as consciousness is given. Phenomenology should therefore reflect a faithful description of what

appears, or is given in consciousness in the first-person (Zahavi, 2003). This sounds very simple, but as indicated above, it appears to require a certain openness to allow something previously excluded to come through, which in Husserl's terms may be akin to a return to "the things themselves" (Husserl, 1984, p. 10 in Moran, 2000, p. 93).

What Husserl means by 'things' can be what "words may be found to signify when their significations are correctly intuited by the right kind of *Anschaaung*" (footnote by translators Macquarrie & Robinson in Heidegger, 1962, p. 50). *Anschaaung* is "an intuition immediately given in experience" (Smith & Woodruff Smith, 1995, p. 86). The 'things themselves' however have different meanings, as it may be a direct perception or also an ideal state of affairs such as a mathematical equation or a logical relation (Welton, 1999, p. 367). Here is Husserl, in the *Crisis of the European Sciences* talking about the 'thing itself' given as an experience of the 'self-givenness' (self-evidence) of the world around us:

> The life-world is a realm of original self-evidences. That which is self-evidently given is, in perception, experienced as "the thing in itself," an immediate presence, or, in memory, remembered as the thing in itself; and every other manner of *intuition* is a presentification of the thing itself (Husserl, 1970b, §34 cited in Welton, 1999, p. 367 italics added).

These intuitions are the *a priori* structures of meaning-intending, distinct from an empirical meaning or logic (Moran, 2000). This meaning-intending is not only linguistic interpretation as there are also forms of "pre-linguistic meaning" (Zahavi, 2003, p. 150). Macquarrie and Robinson's (1962) comment (a footnote in their translation of *Being and Time*) indicates their intention that only that which can be represented in words is what Husserl is interested in; however, this is not the case. Husserl gives perception - that which is immediately intuited, or given - primacy over representation (re-presentation), although the intuition can be "fulfilled" - 'full' - if described linguistically (Zahavi, 2003 p. 18). Describing an intuition linguistically is not an easy task (Moran, 2000), and it is argued here that it is not possible in a 'full' sense, and it is perhaps for this reason that signitive intuitions can be

thought of as "empty" (Zahavi, 2003, p. 28). What appears to be implicit here in Husserl, is that language has to be 'connected' to the world, or in other words, 'situated', in order for it to have purchase on what is given in perception. For Husserl, the 'things themselves' which he is mainly concerned with are the "conditions of the possibility for appearance" (Zahavi, 2003, p. 94).

The influence of Descartes on Husserl may be that intuition can be trusted to give certain knowledge (Zahavi, 2003). In contrast to Descartes however, for Husserl the link between the mind and the world has no need of a guarantee by God, as instead it is intrinsic to consciousness itself that consciousness gives reliable information about the world. For Husserl, "the world appears, and the structure of this appearance is conditioned and made possible by subjectivity" (Zahavi, 2003, p. 52). The "nature of meaning, truth and reality" depends on understanding subjectivity which is intrinsically linked to "that which shows itself and actually appears" (Zahavi, 2003, p. 52). Crucially, Husserl came to believe that this subjectivity is also linked to intersubjectivity (Zahavi, 2003).

Husserl's thought evolved through his lifetime. He was concerned with how objective truths (such as a mathematical formula) could be known in subjective acts of knowing (Zahavi, 2003). There is a movement from the analysis of mathematics and logic to intentional phenomenology, to transcendental phenomenology to a dynamic phenomenology, although he revisited and reworked earlier themes throughout (Zahavi, 2003). His first major work, *Logical Investigations*, published in 1900-1901, founded the discipline of phenomenology, and attempted to "go beyond the alternatives in philosophy of realism and idealism, subjectivity and objectivity" (Welton, 1999, p. ix). What is meant by "idealism" is that the only entity existing is the internal, intra-mental one, and by "realism", that mental representations correspond to an extra-mental and mind-independent reality (Zahavi, 2003, p. 71). The former posits that subjectivity can exist without the world; the latter that the world

can persist without subjectivity. Husserl rejects both of these views (Zahavi, 2003). For example, Husserl noticed that we see objects in perspectival profiles. I see a book at a certain angle and 'fill in' those perspectives I cannot see so that it is grasped as whole; but the 'givenness' of the perception of my own consciousness does not work this way. On reflection, I do not become aware of my consciousness in "profiles" (although there is a temporal incompleteness to reflection) (Husserl, 1982, p. 94 in Zahavi, 2003, p. 16). Merleau-Ponty was to develop this direction in Husserl's thought, so that we neither construct the world (through an intra-mental idea) nor represent it (through a passive 'registering' of it in sense 'data') (Shaw, 2014).

What will be explored in this section is how intentionality has a re-presentational aspect and a pre-predicative aspect (act intentionality and operative intentionality respectively) and both of these ways of 'thinking' about how anything comes to 'mean' something is an intricately interwoven experience of language, perception and embodiment (or the sensual). Merleau-Ponty developed this in his work on perception:

> We uncovered, beneath act or thetic intentionality - and in fact as its very condition of possibility – an operative intentionality already at work prior to every thesis and every judgement; we discovered a "*Logos* of the aesthetic world," [after Husserl in *Formal and Transcendental Logic*, p. 292] or a "hidden art in the depths of the human soul," [after Kant in *Critique of Pure Reason*, A141/B180] and that, like every art, only knows itself in its results (Merleau-Ponty, 2014, p. 453/492).

Husserl considered *Logical Investigations* (1900-1901) as his 'breakthrough' to phenomenology; it includes a detailed analysis of intentionality and a rejection of psychologism (that psychology as an empirical project established the 'foundations' of knowledge) (Zahavi 2003). In *Logical Investigations*, he is not concerned with whether, or how, consciousness can attain knowledge of a mind-independent reality, as for him these are "metaphysical questions" with no place in epistemology (Zahavi 2003, p. 8). In his later

works he would insist that there was a relationship between consciousness and the world, through intersubjectivity and the cognitive act itself, and defended himself against the accusation of solipsism (Zahavi, 2003). Husserl's *Ideas I* (1913) was his next major publication (volumes II and III were published posthumously) and marked his turn to transcendental philosophy (Zahavi, 2003). Amongst other concepts, in *Ideas I* he introduced the concepts of noesis and noema as *a priori* correlatives of the intentional act. In his lecture manuscripts at this time he was also developing the transcendental reduction, focusing on transcendental subjectivity (his Cartesian way to the reduction), and as a result, to "counter accusations of solipsism", he developed the concept of transcendental intersubjectivity in the Fifth Cartesian Meditation (Welton, 1999, p. x-xi). He is trying to get beyond empiricism, and this seems important for this study, as it indicates that there is 'something else' at work, for example, in being therapeutic.

In this respect, in an article appearing in 1927 in the *Encyclopaedia Britannica* he speaks of the relation between psychology and phenomenology:

> … psychology… remains a "positive science," as science operating within the natural attitude, in which the simply present world is the thematic ground…. Phenomenological reduction serves as psychological only to the extent that it gets at the psychical aspect of animal realities in its pure own essential specificity… it is merely related to possible real worlds… Even as eidetic phenomenologist the psychologist is transcendentally naïve: He takes the possible "minds" ("I"-subjects) completely according to the relative sense of the word as those of men and animals considered purely and simply as those in a possible world … The theme of transcendental philosophy is a concrete and systematic elucidation of those multiple intentional relationships, which in conforming with their essences belong to any possible world whatever as the surrounding world of a possible corresponding subjectivity… Like every meaningful question, this transcendental question *presupposes a ground of unquestioned being*, in which all means of solution must be contained. *This ground is here the [anonymous] subjectivity of that kind of conscious life in which a possible world, of whatever kind, is constituted as present. …this ground presupposed as beyond question is not confused with what the transcendental question… puts into*

> *question*… the realm of this questionability includes… every possible world claimed in the natural attitude (Husserl, 1927(19, II, 8) in McCormick & Elliston, 1981, cited in Welton, 1999, pp. 329-330) (my italics).

Husserl appears to be saying that the subjectivity he wants to understand is not one which 'reflects' upon itself (see Section 3.5.2, this chapter also). It is rather an 'I' that 'acts' - that 'constitutes' the world as present. This subjectivity is the 'ground' of any possible further understanding of the world, and others. He appears to be saying that the project of phenomenology is to describe how consciousness acts, knowing that 'who' is acting is a consciousness that paradoxically is 'anonymous.' Doing an empirical study would not be able to uncover the 'anonymous I' of the researcher's consciousness at work and it is the latter that is the interest in transcendental phenomenology. I would argue that the empirical researcher cannot escape this 'anonymous I' and it informs a multiplicity of tacit (or perhaps 'anonymous') decisions throughout any method. Being therapeutic may be informed also in such a way perhaps.

In his writings, there is a movement from this kind of "static" phenomenology, or description of how consciousness acts, to a "genetic" one; a movement from static analysis of concepts like the *noema* towards the interconnected relationship between subjectivity and intersubjectivity, tradition and culture (Welton, 1999, p xii).

In *Logical Investigations*, Husserl distinguishes between the object of knowledge and the act of knowing. The act is a psychical process that elapses in time (subjective experience with a temporal duration), whereas the object of knowledge in logic, or mathematical principles, refers to something atemporal, objective and eternally valid. For the latter, we remain conscious of something *ideal* that is irreducible to and different from the *real* psychical act of knowing. This distinction between the ideal and real is fundamental to Husserl, and at times approaches a kind of Platonism (Zahavi 2003). For Husserl, if ideality

were susceptible to the temporal, real, and subjective nature of the psychical act then it would be impossible to repeat or share meaning, just as it is impossible to repeat a concrete psychical act the moment it has occurred (never mind sharing it with others). He therefore concludes that there is something essential to consciousness that allows ideality to be comprehended (Zahavi, 2003). It is interesting to note that he has not yet appealed to language as being like a 'carrier' of these 'idealities' (see Zahavi, 2003). Husserl, in the tradition of Plato, Descartes and Kant, is attempting to establish foundational knowledge (Gill, 2000), to place knowledge on a sure and certain footing, or ground, the conditions, or essential acts of consciousness that allow knowledge to be known at all. His final published work, *The Origin of Geometry* (1936), shows that he continued to struggle with this theme of how ideality is maintained in subjectivity, or how meaning can be stable (Shaw, 2014). This work in particular will be taken up by Merleau-Ponty to reveal the importance of language (Shaw, 2014). The sense of how meaning can be 'stable' is important for this research, as what an empirical method like Giorgi's (2009) is implicitly saying is that meaning can be stable enough to be validated by others.

3.5.1 The epoché and the reduction

Husserl was also concerned with how our everyday assumptions 'form' experience. The main assumption that Husserl focuses on is the 'natural attitude,' that is, the implicit belief that there exists a mind-independent, experience-independent, and theory-independent reality, that can be accessed objectively (Zahavi, 2003). This assumption is particularly misleading when it is made in reference to subjectivity. The founding principle of phenomenology is to "let the originary giving intuition be the source of all knowledge" (Zahavi, 2003, p. 45 - after §24 of Husserl's *Ideas I*). For this reason, the 'natural attitude' has to be suspended - a procedure he called the epoché, after Sextus Empiricus - in order to

perceive the originary givenness, and to address any dogmatic attitude towards reality by taking a neutral stance to any such attitude (Zahavi, 2003).

In *Ideas I* (§ 35 in Moran, 2000, p. 153) Husserl gives an example involving perception of a sheet of white paper. Consciousness reveals the white paper in a special way, intending it in different modes of givenness, for example, as visual perception and not as an hallucination. In addition, it is surrounded by a "halo of background intuitions" (Husserl, 1977, p. 62 cited in Moran, 2000, p. 153) both of other entities around it (the table, books, etc) as well as other conscious acts. And even if the sheet of paper does not exist it is still being comprehended in a conscious act. Husserl is trying to demonstrate here how 'paying attention' by means of the the epoché shows that there is a difference between perception and imagination, and "this shows there is an essence to the conscious", as consciousness is distinguishing between two modes of giveness (Moran, 2000, p. 153-154). This is complex, however, as it appears here that he is trying to 'get behind' (or 'above' as he notes in the following excerpt) his own thinking to see it 'working.'

> What must be shown in particular and above all is that through the epoché a new way of experiencing, of thinking, of theorizing, is opened to the philosopher; here, situated *above* his own natural being and *above* the natural world, he loses nothing of their being and their objective truths (Husserl, 1970b, p. 152 cited in Zahavi, 2003, p. 45).

The epoché and the reduction are dynamically linked in one movement. I see this as making a kind of 'clearing' for something else to emerge, as in the example of the piece of paper, instead of latching onto the 'realness' of the paper, Husserl sees it could just as easily be an hallucination. The reduction - from the Latin, *re-ducer*, to lead back - leads back to the essential, or transcendental, "foundation of the correlation between subjectivity and the world" (Zahavi, 2003, p.45).

There is disagreement as to what Husserl meant by the reduction (Sass, 2009). Sass (2009, p.173) notes how Husserl's writing style, characterised by "arid, at times almost bureaucratic tedium," gives the impression that the vitality of experience is being removed in the reduction. Max Scheler, who was Husserl's contemporary, and developing his own phenomenology "of the heart" (Lehmann & Klempe, 2015, p. 478), saw the reduction as an impoverishment of the reality of experience (Cutting, 2009; 2016). However, Sass (2009) argues that Husserl did not intend the reduction to remove anything of the 'being of the world.' For Merleau-Ponty, the reduction allows us to 'catch sight of ourselves', and be in ""wonder" before the world" (after Fink (1970, p. 109) in Merleau-Ponty, 2014, p. xxvii/14), hence implying that far from making experience abstract, it rather sharpens and heightens it. This certainly seems to be the case from the following excerpt.

> 'The' world has not been lost through the epoché – it is not at all an abstaining with respect to the being of the world and with respect to any judgement about it, but rather it is the way of uncovering judgements about correlation, of uncovering the reduction of all unities of sense to me myself and my sense-having and sense-bestowing subjectivity with all its capabilities (Husserl, 1973, p. 366 cited in Zahavi, 2003, p. 46).

For Husserl, the phenomenological reduction (or transcendental reduction) is nothing but the "thematization of the correlation between subjectivity and the world" (Zahavi, 2003, p. 46). The subjectivity that Husserl is referring to here is his own – that which is given in the first person (Zahavi, 2003). It appears that the reduction involves a complex and intuitive process, partly involving imaginative free variation, and can be approached through attention to subjectivity (the Cartesian way, starting with subjectivity), objectivity (the Ontological way, starting with objects), or a third way, the psychological reduction (Zahavi, 2003). This latter reduction is what Giorgi (2009) employs, in that it does not 'reduce' acts of consciousness but focuses on the objects of experience through eidetic reduction. Imaginative variation is a method involved in eidetic reduction, or variation, and comprises a conceptual

analysis in which one attempts to "imagine the object in different ways" so that eventually what is essential to the object emerges (Zahavi, 2003, p. 39). It is this eidetic reduction, made by means of imaginative variation, that Giorgi (2009) employs in his scientific method as though the descriptions from the research are 'objects'.

I would link the reduction with therapeutic 'openness' in the sense that 'not homing in' on one aspect of an 'intuition given' allows other aspects to 'come through' and allows a real space to open up for the other person who may be struggling to speak or understand her experience. An empirical scientific, or psychological attitude, employs a 'natural' reflection, and provides one with a "constituted, objectified, and naturalized subject, but it does not provide" access to the transcendental, constituting aspects of subjectivity (Zahavi, 2003, p. 49).

Applying eidetic reduction to the 'I' itself is more problematic - Husserl claims one can achieve this, revealing structures essential to any consciousness as such, the principal one being that of intentionality (Moran, 2000; Zahavi, 2003). For Husserl, the act of consciousness comprises the act (noetic element) and 'what is thought' (the noematic element). While Husserl believed that these two could be separated through the transcendental reduction, Heidegger and Merleau-Ponty did not share his view (Moran 2000). It appears that the latter position is more reasonable, as will be discussed below; subsequently this has ramifications for Giorgi's method, as the act of thinking cannot be separated from the 'meaning' (noema) linked to that act. What I see in this is that 'thinking' cannot be removed from 'being', that is, I cannot think about how I think about an object of thought (at least not thoroughly). Again, this might imply that I do not really know what I am doing in a research method, and neither if I am being therapeutic. The problem of the link between the act of thinking and what is thought links to the concepts in Husserl of constituting subjectivity, intersubjectivity, and empathy, which I will try to explore.

3.5.2 Constituting subjectivity and intersubjectivity, and empathy

The concept of 'constitution' in Husserl's later works (*The phenomenology of Intersubjectivity*) has been problematic in that questions remain as to whether constitution is a creative process that 'produces' reality as an idea; or whether it refers to how knowledge is acquired between the subject and object; or refers only to meaning and not being (Zahavi, 2003, p. 72). Husserl never gave a clear answer as to whether constitution is "a creation or a restoration of reality," but it appears it is not a causal process (Zahavi, 2003, p. 72). Constitution lies in the place between the mind neither 'making up' reality nor mirroring it (Zahavi, 2003, p. 72 after Putnam, 1978), which certainly appears to fit with the unpredictability of others. As in reflection, constitution appears more linked to tacit knowledge and disclosure rather than 'production' of its themes (Zahavi, 2003, p. 89):

> "When I say 'I,' I grasp myself in a simple reflection. But this self-experience is like every experience, and in particular, every perception a mere directing myself towards something that was already there for me, that was already conscious, but not thematically experienced, nor noticed" (Husserl, 1973, pp. 492-493 in Zahavi, 2003, p.89).

This sense of an 'already' seems so important for this research, as it appears that there is 'already' something going on even when we are trying to be objective, say in a method. Heidegger viewed constitution as "letting the entity be seen in its objectivity" (Heidegger, 1979, p. 97 in Zahavi, 2003, p. 73). Zahavi (2003, p. 73) proposes that constitution is a "process" that allows manifestation and signification, finding in Husserl's unpublished manuscripts (Ms C 10, 15b) from 1931, indications that this process has two, inseparable, primal sources: the primal ego, and the primal non-ego. So, although subjectivity is necessary for constitution, it is not sufficient. Husserl identifies the non-ego, the transcendental non-ego (Ms C 7 6b) with the world, and therefore Zahavi (2003, p. 73) proposes that he is positing an inseparability between the ego and the world, so the constituting process "involves several intertwined transcendental constituents" of subjectivity, intersubjectivity, and the world.

Constitution includes a "passive pre-givenness" of an element of facticity (Zahavi, 2003, p. 73 after Husserl, 1973, p. 427); Husserl is close to Merleau-Ponty (2014) here, or vice versa perhaps:

> The world is inseparable from the subject, but from a subject which is nothing but a project of the world, and the subject is inseparable from the world, but from a world which the subject itself projects. The subject is a being-in-the-world and the world remains "subjective" since its texture and articulations are traced out by the subject's movement of transcendence (Merleau-Ponty, 2014, p. 454/493; see Zahavi, 2003, p. 73).

It appears that as a person, one is completely inseparable from the world, which appears to mean the whole way one has come to be, know and think amongst, and from, others. While Husserl focussed on the first-person experience of subjectivity in his early works, he became increasingly occupied with how each person - each transcendental ego - lives in a shared world, in intersubjective relations with others, sharing "meanings", language and an environment (Moran, 2000, p. 175). In his *Fifth Cartesian Meditation,* he changed the problem of understanding others to one of how the other enters into consciousness, or how is the other "constituted" by one's subjectivity (Moran, 2000, p. 176). The other as such is a kind of modification of oneself, yet there is something about the other that cannot be known - "there is an apprehended gap, or emptiness in my experience of the other" (Moran, 2000, p. 176).

This seems to be a crucial point for research, as well as the research question, in that how one comes to respond to another depends on how one 'constitutes' (discloses) that other person through one's own subjectivity. But this subjectivity, or the transcendental ego, has gone through a 'genesis' in which it has acquired fixed and abiding properties through habits that become convictions, and is given in temporal profiles so that it has a history (after Husserl, 1991a, pp. 100-101; p. 179 in Moran, 2000, p. 173-175). But even if this subjectivity is in relation to a 'transcendental intersubjectivity' it still apprehends this intersubjectivity

through its own transcendental subjectivity (Zahavi, 2003, p. 123) - "the world is continually there for us, but in the first place it is there for *me*" (Husserl, 1974, p. 249 cited in Moran, 2000, p. 178, original italics). The circularity here between subjectivity and intersubjectivity appears to make it likely that we fall into credos that are intersubjective.

In addition, while the body of the other is originally given, the experience of the other is not; the experience of another is known in an *analogous* way through the experience of one's own subjectivity, as something 'indicated':

> The character of the existent "other" has as its basis in this kind of verifiable accessibility of what is not originally accessible… Whatever can become presented, and evidently verified, originally – is something I am; or else it belongs to me as something peculiarly my own. Whatever, by virtue thereof, in that founded manner which characterises a primordially unfulfillable experience – an experience that does not give something itself originally but that consistently verifies *something indicated* – is "other" (Husserl, 1991a, p. 144 cited in Moran, 2000, p. 177 italics added).

It is interesting to note that Husserl's view of 'constituting subjectivity' opens up questions as to the constricting aspects of such a 'constituting subjectivity.' This leads to the difficulties in assuming 'that the other is like me' – it appears that part of the natural attitude in our 'everydayness' is to assume this but such an attitude may need to be suspended in order to practice phenomenologically, to give leeway to the "apprehended gap and emptiness in my experience of the other" (Moran, 2000, p. 176). In one sense, this means remaining open to an experience that one knows nothing about, and which may only at most be partially known, not constricting the other into one's own view or subjectivity. This links with the idea of 'openness' in the Theory chapter as being therapeutic (Section 2.2.2). Its opposite, pretending the 'gap' is not there, or being blind to it, is perhaps linked to a kind of despair, which perhaps is what Kierkegaard was registering when he wrote in his journal,

> "I have come just from a party where I was the moving spirit. Witticisms streamed from my mouth, everybody laughed and admired me - but I went out, and, yes, the dash should be as

long as the radius of the earth's orbit - and wanted to shoot myself" (*Journals* §53 in Dru, 1938, cited in Grimsley, 1973, p. 15).

This 'apprehended gap' invokes complexity it appears, which bears on Giorgi's (2009) method, or any method, as to how such an experience can be researched. Some of the complexity may link to Hegel, in that we depend on others for recognition (Borch-Jacobsen, 1991). What comes to mind is a question as to what kind of recognition was Kierkegaard not finding at the party. For example, an immediate question arises as to whether it is possible to be recognised without becoming like the one who recognises. Will the one who recognises only do so if that recognition is based on a kind of self-recognition in the other through 'constituting subjectivity'? In research, does the researcher only recognise that which is familiar, or is already 'found' by his 'constituting subjectivity' in the participant's speech? It appears that at least therapeutically it may be better to 'not know' at all if one wants to 'know,' which is a contradiction.

3.5.2.1 Empathy and knowing the other

The above discussion relates in certain ways to empathy. Husserl never came to a definitive position on empathy, and it occupied him throughout his philosophical life (Zahavi, 2014. p. 124). One aspect which Husserl developed was how empathy involves an interruption to the "temporal flow of consciousness" of the subject (Zahavi, 2003, p. 124) and this interruption involves "self-alienation" (Husserl, 1970b, p. 189 in Zahavi, 2003, p. 124). Empathy then directs the subject towards alterity, an openness towards the other, which involves the asymmetry between self-experience and other-experience as a "necessary and persisting existential fact" (Zahavi & Rochat, 2015, p. 544). This is in direct contrast to views of empathy, for example, as a merging of self and other, of emotional contagion, mimicry, imaginative projection and sharing the other's affective experience (Zahavi, 2001; Zahavi, 2014; Zahavi & Rochat, 2015). Some considerations on empathy will be explored here, as it is a fundamental factor involved in Giorgi's method in finding meanings in descriptions and

it is important to note that Giorgi takes his version of empathy from the therapeutic tradition, after Spiegelberg (1995 in Giorgi, 2000; Giorgi, 2009), something Husserl was careful to avoid (Zahavi, 2003).

The issue of empathy appears to be a central question in phenomenology, one which preoccupied Husserl and has significant relevance to how research can be conducted that aims to know and understand the other (Zahavi, 2014). It relates specifically to intersubjectivity, the relation between self and other, involving tradition and culture. Along with Husserl, his student, Stein (2008), saw empathy as a special form of intentionality, and is the basis for apprehending others and their experiences (Zahavi, 2014, p. 125). Husserl's most intensive work on empathy is to be found in the research manuscripts on intersubjectivity, *Husserliana* 13-15, written between 1905 to 1937 (Zahavi, 2014, p. 124). He never settled on a definitive view on empathy, and the one presented here mainly follows Zahavi (2014). That Husserl never settled on a definitive view of empathy perhaps shows the difficulties in play regarding 'knowing the other.' Husserl is not concerned with empathy as something we have to 'work on' to develop as a skill, for example as in Rogerian therapy (Rogers, 1961). Husserl is concerned with empathy as a phenomenon in itself, or a kind of intentionality that allows us to 'know' the other experientially. How is it that we come to 'know' others at all? Empathy in Husserl's writings is treated in different ways, and these will be briefly outlined here, in order to highlight some difficulties involved in researching others' meanings.

(Zahavi, 2014, p. 124) notes that Husserl was interested in empathy "because intersubjectivity is involved in the very constitution of objectivity", which I read as how others come to understanding and agreement involves how we come to 'know' one another. For Husserl, understanding of empathy also involves the other's subjectivity transcending my own; that is, I cannot 'know' the experience of another person like I know an object which I can perceive in a multiplicity of "profiles" (Zahavi, 2014, p. 129). Husserl makes an astute

point when he says, in 1909, that, "All the difficulty disappears if empathy counts as the mode of presentation of foreign consciousness" (Husserl, 1973, p. 20 in Zahavi, 2014, p. 129). This makes me think of empathy as a presentation of something 'other' to me, and therefore something I cannot presume I know about, or can know about completely, in any 'full' way how I might know a rock or a shoe (an object). This comes home in my view when thinking of how someone we thought we 'really knew' can shock or disappoint traumatically. 'Objectivity' it appears, gets thrown into extreme doubt by such happenings.

> Here we have the only transcendence that is genuinely worthy of its name, and everything else that is also called transcendent, such as the objective world, rests upon the transcendence of foreign subjectivity (Husserl, 1959, p. 495 cited in Zahavi, 2003, p. 115).
>
> All Objectivity, in this sense, is related back constitutionally to what does not belong to the Ego-proper, to the other-than-my-Ego's-own in the form, 'someone else' - that is to say: the non-Ego in the form, another-Ego (Husserl, 1969, p. 248 cited in Zahavi, 2003, p. 115).

It appears then also that the transcendence of the other is necessary in order for me to become aware of myself as a separate person or subject; the *in*ability of me to reduce the other to an object means I may come to recognise the asymmetry in the relation with the other (even though reducing others to objects - things that can be measured, known and 'dealt with' - seems to be common place). For Husserl, this recognition is not so much an empirical one but one that has been originally constituted (because otherwise I could not become aware of being separate) - "I experience the Other as experiencing myself" - after which all acts of subjectivity are in reference in some way to this Other intersubjectivity (Zahavi, 2003, p. 117). Husserl implies this in *Cartesian Meditations* (Husserl, 1960 in Zahavi, 2003, p. 116) when he says that even if he were the only survivor of a world-wide plague that his subjectivity would still depend on "co-functioning transcendental intersubjectivity". This asymmetry and transcendence is the condition through which I become a subject, as otherwise we would be like 'copies of the same story in a newspaper' (Zahavi, 2003, p. 116, alluding to

Wittgenstein (2009, §265)) and intersubjectivity would not be discernible. For Husserl, this is an *a priori* constitutive relation between intersubjectivity and subjectivity (Zahavi, 2003, p. 116). Husserl also sees 'transcendental intersubjectivity' at times as 'built in' to intentionality, and also in "linguistic normality" (Zahavi, 2003, pp. 118-119). From this it seems to me that the other could both define us and alienate us at the same time, being defined by intersubjective relations, intentionality, and 'linguistic normality', but also alienated in these.

Husserl struggled with whether empathy allowed a direct experience of the other, or whether it was always mediated (Moran, 2000; Zahavi, 2014). The attitude we have in our everyday life towards others, Husserl calls "personalistic," and for him is more fundamental than a 'scientific' attitude. In the former, the other is given as whole, and he may be talking, laughing or dancing, so that I see him as an expressive unity (Zahavi, 2014, p. 128, after Husserl, 1952, p. 228; 235). Sometimes, in empathy, I somehow grasp this wholeness in one go, without having to break anything down into component parts. This is Stein's (2008) position also (Lebech & Gurmin, 2015; Moran, 2000). It may also be linked to Heidegger's (1930) idea of 'unconcealment' and 'attunement' as being mysterious. Husserl compares this kind of empathy to how we gather an object in its wholeness even though we only perceive it in profiles - we 'intend' it as a whole through an intentional consciousness of its absent profiles (Zahavi, 2014). The absent profiles are not 'deduced' or inferred rationally; they are 'filled' by intentionality, which can be seen as a special kind of interpretation or "meaning-intending" (Husserl, 1962, p. 183 cited in Zahavi, 2014, p. 129). The experience of the 'foreign other' contains an ambivalence, however. It proceeds on the basis of something like an analogy, or memory, but may ultimately be a "phenomenological modification of myself" (Moran, 2000, p. 177). Husserl expresses this relation to the other then in three ways, as self-alienation, a revealing of the whole as an experience of the other, and also as an analogy to

one's own experience. The different ways of seeing empathy appear to be of major significance, as it could be that the other's experience, both in therapeutic encounters and research, becomes 'a modification of myself.' Giorgi's (2009) emphasis is on empathy based on analogy, which will be addressed in the Method Chapter (Section 4.4).

Husserl's arrives at a point where he views 'constituting' as an interleaving of 'subjectivity-intersubjectivity-world' (Zahavi, 2003, p. 76) where 'world' here appears to mean language, culture and tradition. Criticising his own presentation of constitution in *Ideas I,* he begins to speak of "full subjectivity as being a world-experiencing life" (Zahavi, 2003, p. 74 after Husserl, 1973, p. 287). Fink (1933; 1988), would write that phenomenology was concerned with the "becoming of the world in the self-constitution of the transcendental subject" (Zahavi, 2003, p. 75). In a supplementary volume to *The Crisis of the European Sciences*, Husserl writes that "the transcendental subject can only constitute an objective world if it is incarnated and socialised" (Zahavi, 2003, p. 75 after Husserl, 1993, pp. 160-165). Understanding is still based on subjectivity - the transcendental ego - but this leaves a question which has not been fully resolved by Husserl. As Merleau-Ponty writes:

> Now if the transcendental is intersubjectivity, how can the borders of the transcendental and the empirical help becoming indistinct? … all the other person sees of me - all my facticity – is reintegrated into subjectivity, or at least posited as an indispensable element of its definition…. [A]utonomous subjects no longer know themselves to be subjects simply in relation to their individual selves, but in relation to one another as well (Merleau-Ponty, 1988, p. 421-422 in Zahavi, 2003, p. 159).

In Husserl's reflections on inner time consciousness, Merleau-Ponty's view seems to be mirrored, as Husserl reaches a point where the distinction between the constituting and the constituted no longer belong to two different dimensions. This becomes evident through distinguishing between the prephenomenal, being prior to reflective thematization, and being as phenomenon (reflected upon) (Zahavi, 2003, p. 91 after Husserl, 1991b).

> We say, I am who I am in my living. And this living is a lived-experiencing, and its reflectively accentuated single moments can be called 'lived-experiences', insofar as something or other is experienced in these moments (Ms. C3 26a in Zahavi, 2003, p. 91).

Pre-reflective awareness is a stream of consciousness before being reflected upon ('I am in my living'), but the act of reflecting means that this reflection "always arrives too late" (Zahavi, 2003, p. 92). In *On the Phenomenology of the Consciousness of Internal Time* (1893-1917), Husserl points to the impossibility of separating subject and object because "prereflective self-manifestation" cannot be captured by self-reflection or intentional conscious acts (Zahavi, 2003, p. 91). Husserl (1977) frequently speaks of this prereflective self-awareness as 'anonymous,' in *Phenomenological Psychology: Lectures* (1925) and in his writings on intersubjectivity (Zahavi, 2003, p. 92 after Husserl, 1997, p. 478). It is anonymous in the sense that language fails to apprehend it (Zahavi, 2003, p. 93). In the Bernau manuscripts (1917-1918), Husserl is describing an 'I' that 'functions' and any act of positing about it in language is not what it is:

> In this sense it [i.e. the I] is not a 'being', but the antithesis to all that is, not an object (counter-stand) but the proto-stand (*Urstand*) for all objectivities. The I ought not to be called an I, it ought not to be called anything, since it would then already have become an object; it is the ineffable nameless, not standing, not floating, not existing above everything, but rather 'functioning' as apprehending, valuing, etc (Husserl, 2001, pp. 277-278 in Zahavi, 2003, p. 93).

He believes that the 'core' of subjectivity remains transcendental (Moran, 2000, p. 190). Trying to define the 'I' in language misses out the experiencing subject. If such a radical 'functioning' 'I' lies at the heart of subjectivity, then this has major implications for research. The idea that there is an anonymous 'functioning I' appears to imply that when we reflect on something that the reflection does something to what has already happened so that our reflections lose something vital of what happened (was happening). I will try to follow this

here through Merleau-Ponty, who developed Husserl's thought in a direction in which perhaps it was already moving.

3.5.2.2 Science as a tradition

Husserl tried to "delimit the validity of the scientific notion of truth" by showing how it is a tradition (Zahavi, 2003, p. 137). He spoke about how language "seduces" and 'gets between' idealities and constituting subjectivity such that it appears that objectivity can be attained (Zahavi, 2003, p. 136). Zahavi (2003, p. 136) notes that this position resembles Heidegger's view of how *Dasein* becomes 'lost' in the publicness of the 'they' and idle talk (Heidegger, 1962, §35). For Zahavi (2003, p. 138), Husserl, through his discussion of 'normality' and 'anormality', brings into question 'objectivity' as a static concept, and links it to history, when combined with the implications of intersubjectivity. Experiences guide our anticipations of normality. If what we experience clashes with these anticipations, then there is an experience of "anormality", which then modifies anticipations (Husserl, 1966, p.186 cited in Zahavi, 2003, p. 133). Normality is based on conventions which are based on traditions (Husserl, 1973, pp. 428-429; Zahavi, 2003, p. 134). But crucially it is only disagreement between 'normal' members of a community that is taken seriously in deciding on disagreements; only the 'normal' (at first) is "apprehended as co-constitutive" (Zahavi, 2003, p. 134 after Husserl, 1973, p. 162). It is the disagreement of these 'normal' people that leads to the motivation for science, that is, an objective way of deciding on truth valid for all (Zahavi, 2003, p. 135).

Husserl views writing in this context of science as linked to two dangers, both of which are responsible for the crisis in the sciences. Firstly, that language has a seductive power, conveying particular interpretations, understandings and assumptions (Zahavi, 2003, p. 136 after Husserl, 1970b, p. 372). Secondly, language separates idealities from their subjective-relative origins, that is, constituting subjectivity (Zahavi, 2003, p. 136 after

Husserl, 1989, p. 269). Science then is a tradition, a development out of culture over time in a community (Zahavi, 2003, p. 137). He also acknowledges his own 'formation' as part of a historical community:

> What I generate from out of myself… is mine. But I am a 'child of the times'; I am a member of a we-community in the broadest sense – a community that has its tradition and that, for its part, is connected in a novel manner with the generative subjects, the closest and most distant ancestors. And these have 'influenced' me: I am what I am as an heir (Husserl, 1973, p. 223 in Zahavi, 2003, p. 138).

Husserl's notes on constituting intersubjectivity bring him to a point, in *Formal and Transcendental Logic*, where he comes close to the later Wittgenstein (Zahavi, 2003, p. 138):

> It is high time that people got over being dazzled, particularly in philosophy and logic, by the ideal and regulative ideas and methods of the 'exact' sciences – as though the In-itself of such sciences were actually an absolute norm for objective being and for truth (Husserl, 1969, p. 284 cited in Zahavi, 2003, p. 138).

In summary, this section on constituting subjectivity, intersubjectivity, and empathy, has tried to show how a person may be 'alienated' in trying to understand the other, and it may be better to think of empathy as trying to understand 'how my subjectivity constitutes him' rather than 'trying to understand or grasp the other.' This leaves a 'gap' between the other and me that cannot be crossed, although I imagine attempts to cross it result in 'closing down' of some kind. This relation is made more complex as intersubjectivity also plays a role in constituting subjectivity. Husserl sees the importance of language in forming meanings that circulate as tradition, but he does not appear to consider that there may be a 'transcendental' (to use his terminology) role of language as informing the 'functioning I'. Nevertheless, the implications that could be drawn from the 'functioning I', as well as empathy as self-alienation, would appear to indicate that there will be a failure in any method that 'tries to understand the other,' or ascribe 'objective' meaning to what is spoken as

Giorgi's (2009) method does, as the researcher will only find himself - his own subjectivity - in the process, and /or a 'normalised' sense of meaning, such as in a tradition or sedimented field of language. This is a complex problem, and may reflect how Husserl noticed that language distances us from our 'originary experience,' that is, our embodied experience of what it is to be the 'I' referred to above. This will be explored further here through Husserl's and Merleau-Ponty's views on intentionality, and through the work of Merleau-Ponty on meaning as a *gestalt*, and the differences between speaking and spoken speech. The idea being explored here is regarding how we can be struck by an experience that resonates with us as a 'truth' yet another person's truth may be quite different. This has implication as to what 'truth' might be in a method of research.

3.5.3 The experience of truth – the truthfulness of experience

In *Logical Investigations* (Husserl, 1970a, § 51 in Welton, 1999, p.21) Husserl asks how ordinary experiences have "authority". "What gives such a special feeling authority?" when it is understood, for example, that 2+1=1+2, or one knows one is in pain when one is burnt. How does such a special feeling manage to "proclaim its truth?" Against Hume, and empiricism, Husserl is saying feelings and perceptions can be trusted, that they mean something about the 'truthfulness' of experience. For example, "Two persons… have the same sensations but are differently affected in their feelings," would show that "inner evidence is nothing but the "experience" of truth." For Husserl, "Truth is… only experienced in the sense in which something ideal can be an experience in a real act." It is worth noting here that Wittgenstein says something similar - that while a 'truth', for example, a proven mathematical formula, can be stated by someone, that someone can only say that 'truth' in 'truthfulness' if he understands the formula through and through, and likewise about his own truth (Heaton, 2010):

"One *cannot* speak the truth; if one has not yet conquered oneself. One *cannot* speak

it – but not because, one is still not clever enough" (Wittgenstein, 1998 in Heaton, 2010, p. 32)

There appears to be real complexity here. How can anyone come to know his, or her, own truth? I have often spoken something, feeling it to be 'mine and true,' only to realise later on that it was something someone else said, and I have acquired it somehow. This would be how intersubjectivity 'constitutes' subjectivity perhaps. How does one find one's own words to speak? Are the research participant's views just a 'product' of the times as Husserl implies regarding tradition? Is the research method itself not just a product also? How can one get around this? It appears to me that phenomenology has something to offer here if it privileges what is 'given' in experience, without reifying that experience, while one difficulty is to say what one's experience may be.

In *Logical Investigations,* Husserl refers to how something adequately perceived offers a givenness that reveals something of truth: "*Truth is an Idea, whose particular case is an actual experience in the inwardly evident judgement*" (original italics). This "inwardly evident judgement is… an experience of primal givenness" (Husserl, 1970a §51 in Welton, 1999, p. 21). The experience of 'primal givenness' may need to be then linked to Husserl's view that subjectivity is always linked to intersubjectivity, that subjectivity cannot be displaced from 'objectivity' (of traditions, for example) - so that what is revealed in the act of consciousness also says something about the intersubjective world (Zahavi, 2003). One's experience of truth then is probably entangled with the 'experiences of truth' of others.

The feelings of abjection as a mental health nurse could be understood as one of 'primal givenness,' and so in these terms, approaching 'truth' and 'truthfulness,' but also in terms of an 'experience of truth' that says something about my 'constituting subjectivity,' linked to intersubjectivity. What is being researched then methodologically is an 'experience

of truth' but the 'primal givenness' of this experience for the research participants, informed by constituting subjectivity, and intersubjectivity.

3.5.4 Intentionality and operative intentionality

Husserl pays particular attention to a group of experiences that are characterised by object-directedness, and this attribute is called *intentionality*:

> "One does not merely love, fear, see, or judge, one loves a beloved, fears something fearful, perception, thought, judgement, fantasy, doubt, expectation or recollection, all of these diverse forms of consciousness are characterised by intending objects and cannot be analysed properly without a look at their objective correlate, that is, the perceived, doubted, expected object" (Zahavi 2003, p. 14).

From this phenomenon, it can be seen that consciousness is not cut off from the world but is intrinsically directed towards and embedded in the world (Sass & Parnas, 2003). Intentionality is a Scholastic term, rooted in Aristotelian metaphysics, and was taken up by Franz Brentano (1838-1917) to indicate the immanent object (the content) of mental phenomena such as thoughts. The data of consciousness for Brentano are of two kinds: physical and mental phenomena. Physical phenomena are things like colours, images and smells (Morrison, 1970). The word 'intentional' has to do with mental phenomena and as Brentano meant it is derived from the verb *'intendere'*, used by the Scholastics, which means to pull a bow string as one aims at a target: an intentional object then is related to the target of a thought (Kenny, 2010, pp. 815-816; Von Eckartsberg, 1989). Husserl felt that Brentano's greatest contribution was to show the intentionality of consciousness, that consciousness was always 'consciousness-of' (Morrison, 1970, p. 5). When we say 'it is raining,' for example, normally the focus is on this fact (that it is raining), but Husserl, after his teacher, Brentano, is interested in the act of consciousness that allows this fact to be revealed as a fact. This feature of consciousness that bestows meaning - it is raining - is called 'intentionality'

(Moran, 2000, pp. 96-97). Meaning is understood in terms of how something is constituted for us, however, where subjectivity constitutes the object 'in consciousness' ((Zahavi, 2003).

It appears that the heart of a Husserlian approach to research, or any method, is what it is that allows identical and stable objects to be apprehended by consciousness - or how meaning comes to be 'stabilised'. But how can there be stability when perception involves living through a changing manifold of sensations (vision, touch and so on)? These sensations are non-intentional experiential elements, moments that make up part of the perceptual act. Note also that other experiences besides sensations are non-intentional, for example, anxiety, happiness, fear (Zahavi, 2003). The act of consciousness is conscious of the object (intends it) but the sensations are not intended: The act and its immanent component are lived through "unthematically and prereflectively" (Zahavi, 2003, p. 26). Sensations are then interpreted, "To see a pen is to group a manifold of sensations with an objectifying and synthesising interpretation" (Zahavi, 2003, p. 27). So, the core of intentionality involves interpretation which 'constitutes' the objects of consciousness - something is interpreted "*as* something" (Moran, 2000, p. 234). But the intentionality being addressed here is intentionality as thematic or reflective (Sass & Parnas, 2003). As Husserl writes in *Logical Investigations*:

> "[T]he objects of which we are "conscious", are not simply *in* consciousness as in a box, so that they can merely be found in it and snatched at in it; … they are first *constituted* as being, what they are for us, and as what they count as for us, in varying forms of objective intention" (Husserl, 1970a, p. 385 in Zahavi, 2003, p. 27).

For example, looking at a friendly dog, I can tell someone who is scared of dogs that it is friendly because I can see its tail is wagging and other aspects also. But I already knew it was friendly without having to 'thematise' it in my mind. I may have to thematise how I might tell someone, to 'target' certain phrases and so on. In this way, it slowly 'dawned through' to me that there must also be an intentionality in our pre-predicative encounter with the world, which Husserl developed in his later works, for example, in *Experience and*

Judgement (Zahavi, 2003, p.30), which Merleau-Ponty (2014, p. xxxii) developed as operative intentionality (Freeman, 1993). It appears it can also be found in the above excerpt from the Bernau Manuscripts, on the anonymous 'I' that apprehends the world (Section 3.5.2.1). In Husserl's (1969) discussion of evidence, in *Formal and Transcendental Logic*, he speaks about the fundamental mistake of those looking for absolute certainty ("the usual theorist") as imagining that a validating 'mental process' can be 'torn' from the lived mental world:

> "Thus it happens that evidence is usually conceived as an *absolute apodicticity*, an absolute security against deceptions – an apodicticity quite incomprehensibly ascribed to a single mental process torn from the concrete, essentially unitary, context of subjective mental living. The usual theorist sees in evidence an absolute criterion of truth… being unable to explicate evidence as a functioning intentionality…" (Husserl, 1969, §59 cited in Welton, 1999, p. 262).

It seems important to emphasise here that Husserl is saying that 'meaning' cannot be 'torn' from the context of 'living.' It appears that this is precisely what 'method' tries to do, both regarding research and being therapeutic, and perhaps learning. What he appears to be saying is that 'evidence' is found through a 'functioning intentionality' which appears to be a kind of 'anonymous' activity of subjectivity.

Merleau-Ponty (2014, p. xxxii/18) takes up this 'functioning intentionality' in his development of phenomenology, calling it operative intentionality. This form of intentionality does not refer to ways of speaking about meaning and intention in everyday language, such as 'that's not what I intended,' or 'that's what I meant,' or as Shaw (2014, p. 44) puts it, "reflective mental states with representational content"; it refers instead to a 'constituting' that occurs between the subject and the appearance of the world, the "in-between" space that links the subject with the subject's experience of the world (Vagle, 2009, p. 586). Operative intentionality can also be envisaged as "intentional threads" that connect us to the world, which can be tightened or loosened (Merleau-Ponty, 1995 in Dahlberg, 2006,

p. 16). Merleau-Ponty emphasises operative ('functioning') intentionality as "that which produces the natural and antepredicative unity of the world and of our life" (Freeman (1993); Merleau-Ponty (1945), pp. xviii; xiii in Moran (2000), p. 402).

Operative intentionality is 'between' the subject and the experience of the subject (Matthews, 2004). As Vagle (2009) writes:

> "… the researcher is always, already in an intentional relationship with the phenomenon under investigation… therefore, the researcher can never decide to invoke intentionality nor escape it; the researcher can only try to make fleeting sense of it as he or she reflects on it" (Vagle, 2009, p. 586).

As noted above, an aspect that is striking here regarding intentionality as reflective, in Husserl's usual sense of intentionality, and pre-reflective, primarily in Merleau-Ponty, with respect to research, is the implication that in a participant's speech, and in the researcher's involvement, there will be something that is targeted which the researcher can be open to by being open to the 'primal givenness' of what is apprehended, but at the same time the researcher's intentionality will affect what is apprehended in a way that means perhaps it can at best be 'glimpsed.' This seems to mean that it cannot really be known what is going on, unless through an 'act intentionality' we 'thematise' a person's 'givenness' and words in, for example, an interview, as, I argue, Giorgi (2009) does through his method (see Method, Chapter 4).

Trying to understand intentionality has lead me, not only as someone who is researching the experience of the other, but also as a person, to think that coming to understand each other is complex, almost always missing the mark, with alternative but not necessarily mutually exclusive factors involved. At the same time, understanding is caught up in language and unless one comes to understand the other's 'language game' - intentional threads perhaps - then one will only ever be guessing at what the other means. Along with this, there is something else involved that is beyond representational meaning, namely that

sensuous communication does not rely on language but is perception in all its forms, in which language is rooted, and 'shows itself' in the embodied intersubjective relation between people, that language and the sensuous are embodied in such a way that they cannot be separated. I will try to explore these aspects further in the following sections.

3.5.5 Givenness in Husserl, and the intentional arc and *gestalt* as revealing sense in Merleau-Ponty

In how a phenomenon 'gives' itself to consciousness, Husserl comes to privilege perception over other forms of articulating experience. But the intended object also comes to us in different ways or modes of givenness. Zahavi (2003, p. 31) gives the example of talking about his notebook, picturing it in his mind, and actually writing in it. The modes of givenness of the notebook here are different to the intentional meaning of the book - it is always still *meant* as his notebook under different modes of givenness - but is now *given* to consciousness in different ways. It is still the same notebook but given in different ways.

Husserl assigns a hierarchical arrangement to this 'givenness': All types of *re*-presentation are derived acts that refer to a proper presentation, the latter being the mode of givenness in which the object is given directly and as "optimally as possible" (Zahavi, 2003, p. 28). Linguistic (signitive) and imaginative (pictorial) givenness are less important than the perception itself. Therefore, Husserl believed that linguistic intentions are less original and fundamental than perceptual intentions, so that linguistic meaning is rooted in a "prelingusitic and prepredicative encounter with the world" (Zahavi, 2003, p. 29). Merleau-Ponty (1968) would emphasise this further (Murray & Holmes, 2013). This does not just mean prior to language acquisition, but also that "perceptual acquaintance with the world is a permanent condition and source of linguistic meaning" (Zahavi, 2003, p. 29). Husserl is saying that "sense and the sensuous" cannot be separated, that conceptual thinking and perception are intimately linked, but perception comes first (Zahavi, 2003, p.29). Signitive (linguistic)

givenness is ‘empty’ in that it is removed from this ‘sensuous’ encounter, while perception gives the object in its fullness (Zahavi, 2003, p. 31 after Husserl, 1984, p. 600). ‘Empty’ or ‘full’ can be regarded as absence or presence of the intended object. Perceptual fullness however is still a self-presentation of the object’s being rather than the thing-in-itself (Zahavi, 2003, pp. 30-31).

For Husserl every intentional experience, or act, has a *quality* to it, and a *matter* to it. Quality is what is meant by aspects such as hoping, desiring, fearing, judging, remembering, and so on; matter is what this quality is directed towards, for example, a maths problem, a cat, a table. In *Logical Investigations*, the matter of the act also designates the meaning of the act (Zahavi, 2003, p. 22), in that it contains an ‘interpretative sense’ (*Auffassungssinn*) (Moran, 2000, p. 116). There is an element of interpretation involved here from the outset. In later works (*Ideas I*), Husserl will distinguish between meaning (*Bedeutung*) and sense (*Sinn*); the former referring to linguistic meaning, and the latter to a more comprehensive concept of meaning that includes prepredicative and perceptual meaning (Moran, 2000, p. 117; Zahavi, 2003, p. 149). Merleau-Ponty will focus on the latter in *Phenomenology of Perception*, and the former in his later works, *The Visible and Invisible*, and *On Vision*, where he recognised how language interweaved with perceptual experience (Shaw, 2014). This concept of meaning (*Sinn*) emerged as crucial for this research, as will be discussed in Chapter 6 (Phenomenology).

Coming to understand this difference took time in this research, involving struggling with how ‘meaning’ at this pre-predicative level perhaps cannot be understood as either an interpretation nor a description, but something that simply *is*: that is ‘constituted’ both pre-linguistically and linguistically, interwoven more like a *gestalt* that remains fixed (see Boston Change Process Study Group, 2008). In this way, I would argue that ‘constitution’ is ontological and is neither an interpretation nor a description but a ‘finding oneself in the

world.' Merleau-Ponty's 'being-in-the-world' emphasises this sensual linking of the world and the subject, especially in operative intentionality, where givenness is like a *gestalt* given to perception, whose "very form is the appearance of the world" (Merleau-Ponty, 2014, p. 62). Merleau-Ponty showed the effects of operative intentionality through an examination of the case of Schneider, a German soldier injured in World War One. What Schneider lacked was a tacit relation to his 'body schema' (a holistic unity in which the body moves and functions as a whole in the world). At this stage for Merleau-Ponty this schema does not depend on representation in that nothing mediates between moving and deciding to move: "the relations between my decision and my body are magical ones" (Merleau-Ponty, 2014, p. 97/123). Merleau-Ponty develops this much further by seeing that embodiment cannot be separated from engagement with the world. For example, when Schneider is asked to draw a sketch, he has to verbally describe and interpret to himself the elements of the sketch. But:

> For the normal person, the object is "speaking" and meaningful, the arrangement of colours immediately "means" something, whereas for the patient the signification must be brought in from elsewhere through a genuine act of interpretation (Merleau-Ponty, 2014, p. 133/164).

This 'genuine act of interpretation' is the reflective intentionality that Husserl usually refers to, in that something is posited in words (Freeman, 1993). This is the intentionality that Giorgi (2009) refers to in his method, and as can be now seen it refers to something that is not tacitly embodied, that does not grasp the 'internal' relation of the subject to his world. This appears to be of major importance for research method.

In contrast, Merleau-Ponty emphasises operative intentionality as revealing a *gestalt* in perception which has to do with the immanent aspect of the 'meaning' of the world – the 'internal' relation between the subject and the world which cannot be broken down into 'sense data' or indeed, 'linguistic data.' The 'meaning' that is referred to in this operative

intentionality is one that reveals meaningful relations of the parts to the whole that are inseparable (Shaw, 2014, p. 51).

Gestalt phenomena demonstrate how such 'meaning' is revealed as a whole in perception. For example, the Necker cube (Figure 1) demonstrates how perception reveals different aspects 'passively,' assigning meaning to these according to how each aspect is disclosed.

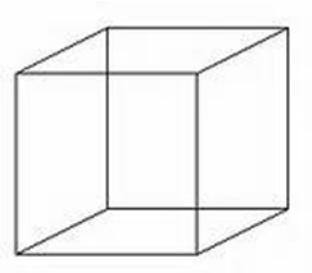


Figure 1 Necker cube (Shaw, 2014)

"Each part announces more than it contains, and thus this elementary perception is already charged with a *sense*" (Merleau-Ponty, 2014, p. 4/25-26). The 'sense' (*sens*) spoken of here refers to a multiplicity of meanings that the word 'sense' can refer to, also in English, and directionality is included in French meanings. This kind of sense as a *Gestalt* is in opposition to the approaches (for example, in Hume) that see sense as a kind of stream of individual data points, or as a material that is given form through 'categories' of the mind (as in Kant) (Shaw, 2014) This can also be extended to language, by analogy, whose meaning takes up a different aspect if it is removed from its situated 'game,' in a community of practice, involving the tacit, the gestural and the embodied (see Theory, Chapter 2, Section 2.4). Merleau-Ponty regards the *gestalt* as being due to how the human subject is 'geared into' the world (Merleau-Ponty, 2014, xxxiv/20).

In the example of the Necker cube, two options present themselves to consciousness, two options are 'given' in perception, giving a 'meaning' of a cube with a lower front face or an upper front face. How the phenomenon of language affects such a disclosure of meaning -

something ‘given’ in intuition in Husserl’s terms - in a conversation between two people, in an interview, in a therapeutic dialogue, or in any intersubjective relation, could be considered to be like ‘finding’ a *gestalt*, something that takes shape. This appears to be the direction that Merleau-Ponty was moving in before his untimely death (Shaw, 2014). It is interesting to note that Wittgenstein was of the same view, that the patterns that Gestalt psychology revealed were “precisely a *meaning* that I see” (Wittgenstein, 1980, §869 in Braver, 2014, p. 143). Braver (2014, p. 143) notes that Wittgenstein spent much of his final years on this kind of analysis, and what is particularly striking is how the noticing of an aspect in perception ‘dawns’ as a result of possibly seeing it in other ways (Wittgenstein, 1982, p. 169 in Braver, 2014, p.143), while simultaneously “a concept forces itself on one. (This is what you must not forget)” (Wittgenstein, 2009, p. 215, § 191), and he did not believe this ‘seeing-as’ was an interpretation in terms of thinking about something (Wittgenstein, 2001, p. 174 in Braver, 2014, p. 143). It is interesting to note that this is the same problem as how anything becomes ‘constituted,’ and how language influences ‘meanings’ such that they are so much ‘before’ the thinking of interpretation that they appear as if they simply *are*.

This taking shape may be much like a ‘repeat’ of what is already found in sedimented language, like the Apostle repeats a doctrine, or like a cliché repeats something that belongs to someone else and is thus “empty” of vitality (de Botton, 1997, p. 106). But there is also the possibility that something other than this will ‘dawn through’ that has more to do with the embodied subject speaking and to be responsive and open to such an experience, I argue, depends entirely on the researcher being able to ‘allow’ this ‘field of experience’ between the researcher and the other person. This also links, again, to ‘openness’ and the therapeutic (Theory, Chapter 2, Section 2.2.2). This kind of allowing of ‘meaning’ then may be more like an art form - a practice - than a science which can be taught methodically, and I would argue that it may involve ‘resisting’ meaning, or not imposing meaning, when with another person.

> Operative intentionality is the one that provides the text that our various forms of knowledge attempt to translate into precise language. The relation to the world, such as it tirelessly announces itself within us, is not something that analysis might clarify: philosophy can simply place it before our eyes and invite us to take notice (Merleau-Ponty, 2014, p. xxxii/18).

What seems important here also is how Merleau-Ponty was working on language as being intimately intertwined with the world and the subject (Shaw, 2014). In this research, it will be argued that it appears, drawing on the later Merleau-Ponty, that meaning which includes linguistic meaning, can be found as a *gestalt*, which 'functions' in operative intentionality. While perception reveals the world as a gestalt (a meaning), it appears perhaps that linguistic meaning too is a gestalt, revealed in a gestalt of language, which may, or may not be, open to dynamic change. What I mean to imply here is that perception, the non-intentional, the intentional of 'act intentionality,' and operative intentionality, are intimately interweaved with language such that meaning reveals itself like a gestalt. This is already implicitly indicated by Merleau-Ponty in *Phenomenology of Perception* where he describes the 'intentional arc' that inextricably links the subject to the world:

> The life of consciousness - the epistemic life, the life of desire, or perceptual life - is underpinned by an "intentional arc" that projects around us our past, our future, our human milieu, our physical situation, our ideological situation, and our moral situation, or rather, that ensures we are situated in all of these relationships. This intentional arc creates the unity of the senses, the unity of the senses with intelligence, and the unity of sensitivity and motricity (Merleau-Ponty, 2014, p. 137/170).

3.6 Speaking and spoken speech, and linguistic meaning as gestalt

This section will explore how linguistic meaning - in light of the current research - may also arise as a gestalt, a pattern of relationships in which the whole cannot be broken down into constituent parts. The aim here is to throw light on the problem of the 'experience of truth' in which the same experience, linguistic and perceptual, can be understood

differently by different people. Coming to understand what another 'means' - what experience he is trying to speak of - it is proposed here depends on being open to a new pattern, or gestalt, of meaning. It is proposed that this openness depends on tacit knowledge, intuition, and an operative intentionality which also includes language, as well as 'act intentionality' (more active, judging, reflecting, recalling, imagining and so on; Freeman, 1993). In the experience of trying to understand someone else then something 'dawns through' as a perceptual and linguistic gestalt.

It appears also that this experience cannot be separated from empathy as 'self-alienating,' which implies that if the meaning of another's experience appears clear then there may be something of my own 'constituting subjectivity' at work which has alienated the other through 'constituting' him within my own constellation of 'meanings,' unless we are both talking in clichés perhaps. In this way, it seems to be that what emerges in a perceptual and linguistic pattern or gestalt will always 'have something to do with me' and the only way to do justice to the other is to 'not know.' Meaning emerges like a gestalt that 'speaks to me,' like a pattern that I notice, that draws me to it to 'see' it. This gestalt of meaning is something then that the researcher is also involved in: I draw the other's meaning through my own 'constituting subjectivity'; whatever 'dawns through' is something that 'dawns through to me and through me,' as a pattern that speaks to me. But crucially I have already been spoken for.

In *Phenomenology of Perception*, Merleau-Ponty (2014, p. 202/238) distinguishes between spoken and speaking speech. Speaking speech is a creative act of novel thought and spoken speech reflects conventional significations of one's language (Shaw, 2014, p. 104). He indicates this tension in his view on what constitutes 'thought' in *Phenomenology of Perception*:

> Thought is nothing "inner," nor does it exist outside the world and outside of words. What tricks us here, what makes us believe in a thought that could exist for itself prior to

> expression, are the already constituted and already expressed thoughts that we can silently recall to ourselves and by which we give ourselves the illusion of an inner life. But in fact, this supposed silence is buzzing with words – this inner life is an inner language (Merleau-Ponty, 2014, pp. 188-9/223).

Spoken speech "enjoys the use of available significations like that of an acquired fortune", whereas speaking speech shows a "meaningful intention in a nascent state" (Merleau-Ponty, 2014, p. 202/238). Therefore, to 'think for oneself' may often be nothing but a repeat of what has already been thought in a reservoir of language.

> We live in a world where speech is already *instituted*. We possess in ourselves already formed significations for all these banal words. They only give rise in us to second-order thoughts, which are then in turn translated into other words that require no genuine effort of expression from us, and that will demand no effort of comprehension from our listeners. The linguistic and intersubjective world no longer causes us any wonder, we no longer distinguish it from the world itself, and we reflect within a world already spoken and speaking (Merleau-Ponty, 2014, p. 189/224).

In contrast to spoken speech, speaking speech involves the transformation of something originary, something embodied, transforming a "certain silence into speech" (Merleau-Ponty, 2014, p. 189/224). He illustrates this through several examples: the child who learns to speak, the novelist, and the lover who discovers his emotions (Shaw, 2014, p. 105). Because this speaking speech emerges from a kind of embodied silence, it 'shows' something that spoken speech cannot:

"…it is the body that shows, that speaks" (Merleau-Ponty, 2014, p. 203/239).

To disarticulate 'thought' - as with Descartes - from this embodiment is to become lost in spoken speech, to think of the self as an idea:

"…myself as an idea, that is not, strictly speaking, my own" (Merleau-Ponty, 2014, p. 422/462).

It is not ‘my own’ because it has been given through language, intersubjectivity, and tradition, perhaps like a credo. In contrast, speaking speech then gives rise to something that “cannot be thought, but must rather be revealed” (Merleau-Ponty, 2014, p. 426/466). How speaking may give rise to this revelation appears mysterious.

The relation between acquired significations of spoken speech and the creative act of speaking speech is not fully accounted for in the *Phenomenology of Perception* because speaking speech must draw on what is already spoken to express that which is embodied and significant for the individual, and it appears that Merleau-Ponty was attempting to address this relation in his later works (Shaw, 2014).

For Merleau-Ponty, in *The Primacy of Perception*, the speaking subject “lives in his language” (Merleau-Ponty, 1964, p. 87/152). Speaking speech comes through in the voice and reflects the operative intentionality in the subject’s ‘gearing into’ the world. In developing these concepts Merleau-Ponty was influenced by Saussurian linguistics which distinguishes between *la langue* (language as a system of signs governed by rules) and *la parole*, that is, language as spoken by the individual subject (Shaw, 2014, p. 116). This current research has found few published texts on the relation between language and perception, outside of psychoanalysis and cognitive science (for example, Boston Change Process Study Group, 2008; Zahavi, 2012). It is worth noting Graziano’s (2000) concluding comments from his unusual book on operational language (influenced by Sartre),

> “…a life can encyst itself so securely within a maze of words, and operational habits, that can become for it an impenetrable matrix, and a shell, that it can prevent itself from happening: from operating response-ably... with the lives of others” (p. 449).

Perhaps those people who do not ‘insist’ (‘encyst’) so much, who are uncertain and open to others, are those who are most therapeutic (see Theory Chapter, Section 3.5.2).

Shaw's (2014) conclusions are that Merleau-Ponty's late work on language and the sensible world (ie perception) are concordant with a *non-foundationalist* understanding of knowledge, that the 'thing itself' cannot be revealed through a phenomenological reduction because language is always already at work, and we are always already situated in the world so that we cannot find an 'objective' or 'transcendent' view. This implies that "meaning, *at every level*, is not imparted to the world in a deliberate act" (Shaw, 2014, p. 160). It can be inferred then that meaning 'emerges' and it appears that this occurs perhaps *like* how a gestalt appears in perception. Dahlberg (2006) in her discussion of 'the essence of essences' in phenomenology, notes how a pattern of meanings emerges through active phenomenological work (presumably free imaginative variation and the reduction). But then this pattern of meaning is watched, "as a figure against other meanings as background", and it may become background again, with a new "tentative meaning" emerging as foreground:

> "In one moment, an explicit tentative meaning is a figure, in the next the same part of the text and its meaning is part of the background" (Dahlberg, 2006, p. 14).

What appears most significant here is how meaning may be disclosed as a gestalt, a pattern of significances that reflect how the participant has lived her life, embodied, and experienced herself, "overrun with words":

> "The meaning is not on the phrase like the butter on the bread, like a second layer of "psychic reality" spread over the sound; it is the totality of what is said, the integral of all the differentiations of the verbal chain; it is given with the words for those who have ears to hear. And conversely, "the whole landscape is overrun with words"" (Merleau-Ponty, 1968, p. 155).

It appears to me that this "integral of all the differentiations of the verbal chain" is a pattern, something that emerges as a meaning that is perceived as whole. Since "the whole landscape is over-run with words" (Merleau-Ponty, 1968, p. 155), it appears that operative intentionality may be infused with language, not broken from it, which connects with

Wittgenstein's assertion that meaning emerges from use which is rooted in a form of life, but this meaning may 'force itself' on us (this chapter, Section 3.5.5). As Husserl noted, meaning cannot be 'torn' from the living context (this chapter, Section 3.5.4). In an interview then, what may come through (if allowed to do so) is the meaning that the participant presents in his whole speech and embodied presence, and how this interacts with that meaning which the researcher also reveals as an embodied presence in himself, and much of this may remain hidden, and unknown, in the tacit and implicit senses.

3.7 Sedimented horizons of experience

What has already been anticipated in this chapter, especially in reference to constituting subjectivity and givenness, is Husserl's concept of the horizon to all perception. Husserl summarises this as:

> "There belongs to every genuine perception its reference from the "genuinely perceived" sides of the object of perception to the sides "also meant" – not yet perceived but anticipated" (Husserl, 1991a, p. 82 in Moran, 2000, p. 162).

The horizon "maps out a set of expectations" linked to already experienced events (Moran, 2000, p. 162). Husserl recognised that one's experience and understanding of the world had a 'genesis,' developed from an overlapping and sedimented series of horizons of the past, present and future, such that one's subjectivity, constrained by these, also constitutes the same lived world (Moran, 2000).

The concepts of perception of temporal objects (for example, music, or speech), as primal giveness involving "protention" and "retention" give a rationale for sedimentation. Protention is an anticipation of what is about to come already based on the primal givenness of a moment and the retention of that moment (Zahavi, 2003, p. 83-84). The latter is not like 'recollection' which is thematic, nor the former like 'expectation' as it too is thematic. Protention and retention are implicit and unthematic and form part of a single 'moment' of

givenness, yet it can be seen that such a moment therefore has a 'width' to it. These processes build, over time, horizons of experience which become sedimented (Davidon & Cosgrove, 2003; Sousa, 2014; Stern, 2004).

While for Husserl, the 'width' of the present moment is a 'structure' of consciousness, it also indicates that there is something 'implicit' happening in the moment that influences how experience may be grasped. To understand an experience that is 'built in' to being present to the other then may be beyond reflection - and therefore beyond method. This can be linked also to the 'anonymous' transcendental ego, that is, that consciousness which resists all reflection but rather 'acts'.

> "When I say 'I,' I grasp myself in a simple reflection. But this self-experience is like every experience, and in particular, every perception a mere directing myself towards something that was already there for me, that was already conscious, but not thematically experienced, nor noticed" (Husserl, 1973, pp. 492-493 cited in Zahavi, 2003, p.89).

3.8 Plato's Ideas and Husserl's transcendental subjectivity as imaginary

It is tempting to imagine that the 'ground' which Husserl is searching for is an imaginary one, an effect of appearance in the sense that Zizek (2014) elaborated for Plato's Ideas. An essence then would be an appearance of one, but nevertheless an appearance that may have purchase ontologically and epistemologically, and is 'felt' or embodied, as well as generating research. Jameson (2006, p. 378) has posited that phenomenology is "a marker of the presence of the Imaginary," a something that ensures "the temporal nature of truth." What only needs to be taken from this - that is, one does not need to become Lacanian to use this idea - is that appearances are stabilising and reassuring, and 'built in' to the subjectivity that constitutes the reality around us. It is perhaps this kind of stabilising experience, emerging in *credos*, that give a sense that something has a timeless presence that can be described. A kind

of stabilising experience like this might encourage someone to try to transpose Franciscan spirituality into a life as a mental health nurse.

In summary, this chapter has outlined the reasoning and experience behind the choice of phenomenology as a methodology. It has outlined how, in my view, epistemology and ontology are interdependent. A broad outline of phenomenology has been drawn to locate the research methodology against a philosophical background, especially with reference to Plato, Descartes and scepticism, in order to highlight what Husserl was attempting to achieve in deriving transcendental structures of consciousness. A further detailed exposition of some of Husserl's concepts relevant to the research has been developed, including reference especially to the epoché, the reduction, constituting subjectivity and intersubjectivity, empathy and intentionality.

In doing so it has explored how knowledge, or knowing, is only foundational in the sense that it is intersubjectively and subjectively influenced, and may appear as an 'experience of truth.' This experience can lead to an idealisation of Truth, Knowledge, Science and so on, in a quasi-Platonic search for essences, if it does not take into account the effects of how language and culture gain purchase on subjectivity. This is linked to meaning, which, it is argued, appears as a *gestalt* influenced by sedimented language and culture, and has been explored through the work of Merleau-Ponty. Meaning which occurs to one, say in an interview, or in an interaction that is meant to be therapeutic, may be nothing but a meaning that 'forces itself' upon one as in a gestalt (see this chapter, Section 3.5.5.) so that the other person - and perhaps both of us - are 'made captive' in the one who is 'accepting' such meaning. We may also become captivated by *credos* emerging from such a milieu such that they come to be seen as 'truth' when they may be more to do with an 'experience of truth.' To be 'open' to the other then, which I have indicated may be what is therapeutic about some

mental health nurses (and therapeutic generally) (Theory, Chapter 2, Section 2.7), would involve perhaps ‘resisting’ or ‘suspending’ this meaning indefinitely. In this way, a ‘system’ of meaning never closes, although, as noted, some may need to close any such ‘system’ through anxiety (this chapter, Section 3.4.3). The points made in this chapter will be revisited in a discussion of Giorgi’s method in Chapter 4, with the intention of indicating the remit and limitations of Giorgi’s method.

4 Method

4. Introduction

The Methodology chapter has explored how, following aspects of Husserl's and Merleau-Ponty's work, that what is being researched in this study is an 'experience of truth,' and the 'primal givenness' of this experience is intertwined with constituting subjectivity and intersubjectivity, regarding how the world has been 'disclosed' to the individual person in and throughout his life through others, language and tradition. The Methodology chapter has indicated how researching this experience may be made more difficult due to how an intentionality that permeates meaning may reveal its 'activity' in a captivating gestalt. An 'experience' that strikes a person then like a 'truth' can captivate him, or her, which shuts down other ways of allowing others to be. In contrast to this 'shutting down,' it has been suggested in the Theory chapter that a kind of 'openness' to the other person may be therapeutic in the sense that he, or she, is 'allowed' to be, and this links with an aspect of empathy which is 'self-alienating.' Keeping in mind these considerations, the intention of the method in this research is to describe "that which shows itself and actually appears" (Zahavi, 2003, p. 52), without adding to or taking from it, in mental health nurses' responses to the research question. The focus of the research question is on what mental health nurses know, and do, that is therapeutic and how have they learned to be therapeutic. Giorgi (1970; 1983; 1989; 1993; 1997; 2000; 2006; 2009; 2012; 2014 a; b) makes the claim that 'that which shows itself and actually appears' can be described through an empirical method without interpretation, and his method will be examined in this chapter. What emerges from such a descriptive procedure will be discussed, as well as how Giorgi's method consequently delimits research findings. Although Giorgi's method derives from a reading of Husserl, and Merleau-Ponty, it principally utilises the Husserlian concepts of epoché, the reduction, and free imaginative variation (Giorgi, 2014). The Methodology chapter has looked at the

philosophical context from which these concepts emerge, and examined the wider field of Husserl's project. This was important to situate the strengths and limitations of Giorgi's method as will be discussed in this chapter. The chapter is organised so that firstly, an assumption about context in psychology is problematised. Secondly, an overview of Giorgi's empirical method is outlined, with reference to why it has been chosen as a research method, why a method might be phenomenological at all, and Giorgi's considerations on description versus interpretation, meaning and the empirical. Thirdly, the method of research is outlined. Finally, ethical considerations are discussed.

4.2 An assumption about context in psychology

In his introduction to existential-phenomenological psychology, von Eckartsberg (1998, p. 14) states a principle which he notes largely goes unnoticed and taken for granted in mainstream psychology, including phenomenological psychology, which is that "as we all do in everyday life, identically named experiences refer basically to the same reality in various subjects." This has been called an 'axiom' by van Kaam (1966, p. 32), which refers to all psychology. Von Eckartsberg (1998, p. 15) notices the tension between language and experience, in that we can say what we experience but always "live more than we can say." Despite this, he and others, including Giorgi, depend on the assumption that "people in a shared cultural and linguistic community name and identify their experience in a consistent and shared manner" (von Eckartsberg, 1998, p. 15). What this points to is that phenomenological psychological research methods 'name and identify' from within a 'community' with agreed, perhaps tacitly agreed, normalised sets of meanings. This applies whether the method is hermeneutic or descriptive; the former 'defers' meaning in a never-ending movement linked to being (Braver, 2014), the latter looks for 'unprejudiced' meaning in context (von Eckartsberg, 1998). This means Giorgi's method is delimited by such a shared 'cultural community.' He shows this in several references to the "critical other" he is trying

to satisfy, that appears as the scientific community, or his peers in psychology (Giorgi, 2009, p. 96; p. 134). In this sense, he also refers to intersubjectivity in the analysis (with reference to meaning units being transformed into psychological language):

> The researcher is reading the participant's description, but within the reduction he or she awakens the phenomenal characteristics of the description, which in turn makes the sense of the described experience more available. This is not as individualistic as it sounds. First of all, the researcher is in a research attitude, which means that an intersubjective attitude is adopted. The researcher is not responding as an individual but as a member of a community whose criticism he or she is well aware will pursue the analysis. That is why one can say that in all of these solitary analyses, the critical other is sitting on the shoulder of the analyser (Giorgi, 2009, p. 133-134).

Channelling the psychological descriptions into a form that can be accepted by a community in order to gain recognition may therefore delimit the findings, so that what cannot be spoken of for that community remains excluded. In contrast, the view which has been traced in this research, is in which language, embodiment and culture intersect in such a way that meaning, and being alive, for a person is idiosyncratic such that 'being oneself' goes beyond the fact that 'we live more than we can say' and into the realm of a multiplicity of ways of finding and being oneself in the world with others. There will always be something about us that escapes the 'community' of shared understanding. This is complex, as, it appears we are 'subject to' culture, language and embodiment, yet somehow 'escape' culture and language also.

4.3 An overview of Giorgi's empirical method

Giorgi's method draws on certain aspects of Husserl's phenomenology to attempt to derive, using scientific method, essential meaning structures (Giorgi, 1997). Giorgi was a founding figure in adapting Husserl's phenomenology towards an empirical science in psychology (Valle, 1998; Wertz, 2005). There are several mainstream methods which draw principally on Husserl's phenomenology (Moustakas, 1994; Valle, 1998). For this research,

Van Kamm's method was rejected because it was an early, ground-breaking method developed to attend to a large number of participants, and included quantitative procedures such as analysis of the frequency of statements in the data (Moustakas, 1994; Valle, 1998). The method proposed by Colaizzi (1973; 1978) was considered, but a difficulty here was that an interpretative reading of the 'data' is required in order to arrive at a fundamental structure, which also involves interpreting implicit aspects with reference to the researcher and the participants (Dowling, 2007; von Eckartsberg, 1998). Colaizzi differentiates a fundamental description, linked to a readily accessible reflective, reportable appearance, from a fundamental structure, linked to a pre-reflective aspect of a participant's experience. The former is an explicit experience, and for Colaizzi is phenomenal. The latter has an implicit character, and is revealed through an interpretive reading of the participant's presentation and language, and for Colaizzi is phenomenological (von Eckartsberg, 1998). Colaizzi's approach is Heideggerian in its underpinning philosophy, such that "knowledge is always and necessarily contingent, constantly in tension, awaiting further though never completed fulfilment" (Colaizzi, 1973, pp. 98-99 cited in von Eckartsberg, 1998, p. 36; see also Giorgi, 2006), so the implicit meanings in fundamental structures are presumably still subject to these hermeneutic conditions. However, what has been argued in this research is that there is something that gives 'purchase' to meaning which 'captivates' us, and it is this that becomes susceptible to description rather than interpretation. Therefore, participants' descriptions are coming from something embodied that has purchase, 'captivating,' as opposed to being like a text that might be interpreted hermeneutically. For this reason, Colaizzi's method was rejected, although the approach is clearly fruitful and of value. Giorgi (2006) notes that Colaizzi's final step of having the participants check the analysis is theoretically unsound, as they would be checking from the natural attitude, whereas the analysis was carried out in the phenomenological attitude. Giorgi (2006) also adds that replication of a phenomenological

analysis can only be carried out from another analysis in the phenomenological attitude. It is interesting to note that Colaizzi's focus on implicit meaning may also be an implicit attempt to reveal operative intentionality, in order to get 'outside' of 'anonymous consciousness', and embodiment (see Chapter 3, Section 3.5.2). Von Eckartsberg (1998, p.35) summarises this succinctly in more ordinary terms: "Can one ever be present and privy to the pre-reflective dimensions of one's experience?"

Giorgi's (1970; 1997; 2009; 2014) descriptive phenomenological method has been chosen for this research for three reasons. Firstly, the descriptive phenomenological method is part of a strong tradition in psychological research (Giorgi & Giorgi, 2003) and claims to separate empirically what is essential to a phenomenon or subject of inquiry (Hein & Austin, 2001; Rennie, Watson & Monteiro, 2002; Wertz, 2005). Secondly, its potential to capture a present moment, regarding in particular what is given in perception so that what is given can be viewed as a description rather than an interpretation. Thirdly, its claim to isolate essential meanings in a transcribed text, derived from recordings of interviews, in an empirical, scientific way. Some of the "liveliness" of the interview dialogue is evoked "imaginatively" in the transcribed text (Giorgi, 2009, p. 126), while at the same time the description is not meant to go beyond the 'given' (Giorgi, 2009, p. 127).

It is important to note that, for Giorgi (1997; 2009), scientific knowledge has a distinct validity, because it is systematic, methodical, general, and critical. Science for Giorgi is a "cultural institution" concerned with ascertaining the "most valid" knowledge of phenomena (Giorgi, 1997, p. 246). 'Systematic' knowledge is regulated by "laws, concepts, or meanings" - that is, patterned - as opposed to "chaotic or random" knowledge (Giorgi, 1997, p. 246). The methodical requirement of such knowledge relates to how it has been gained through a method "accessible to a community of scholars" (Giorgi, 1997, P. 46). 'General' means that such knowledge, although it may not be universal, has applications beyond the research

situation (Giorgi, 1997, p. 246). Englander (2012, p. 17) notes that 'general' here also refers to the knowledge resulting from the research, as opposed to the process of finding participants. Also, 'critical' refers to the activity of the researcher rather than the participants, as well as referring to the critical scrutiny of a research community (Giorgi, 1997; Englander, 2012; 2016). A critique of aspects of this view of scientific knowledge will be discussed in the Phenomenology and Discussion chapters (Chapters 6 and 7 respectively).

What is appealing about Giorgi's method is that it attempts to give a faithful description that is theory-free, and so not interpretative in the broadest sense (Giorgi, 2014). Intuitively this seems possible, but there is a complex of ideas that would indicate that it is not, most importantly from Husserl's own view of constituting subjectivity and intersubjectivity, such that we are always caught up in the views of others, as well as empathy, such that we are alienated from others. What has been argued throughout this research project is that there is something embodied that is not open to interpretation, that can be described effectively, rather than being subject to a sliding interpretation (since interpretation always leads on to another interpretation in the hermeneutic circle). This may be linked to Plato's idea of Ideas, and Zizek's (2014) interpretation of these as an appearance 'on the surface' that gives a sense of stability and constancy. But the embodied effects of such an 'ideality' imply that there is something stable that is susceptible to description rather than interpretation. In fact, Zizek (2014) may view his interpretation as nothing but a description. Giorgi's (2009) view is not centred on embodiment but rather on how language can give a faithful sense of what the research participant is trying to communicate. By choosing this method of research, it is implied that the phenomena that the research participant conveys in the interview can be 'given' faithfully in the consciousness of the researcher, so that what is written about it is a description rather than an interpretation. But this depends on the ability of the researcher to enter into the phenomenological attitude (Finlay, 2008), that is, maintain the process of the

epoché and the psychological reduction (Giorgi, 2014). Staying in the reduction is the work of the researcher and not the research participant (Giorgi, 2014). This means the researcher has to be able to be open to the other person in a radical way, such that he comes to be alert to the activity of his own intentionality. This appears to present an impossibility because what is being asked is to address a 'transcendental problem' through a psychological procedure, although Merleau-Ponty (2014, p. xxvii/14) implies there is some room for this happening through his use of the metaphor of loosening "the intentional threads" in order to let those thread "appear". It might be helpful to consider that Husserl's, and Edith Stein's, view of empathy as 'self-alienating' (Zahavi, 2003) indicates the kind of attitude the researcher might take up, so that something of the 'between' of the participant's subjectivity-world intentionality, and the 'between' of the researcher-participant intersubjectivity, may be intuited (see Methodology, Chapter3, Section 3.4.2).

Giorgi (2009, p. xii) set out originally to find a method for qualitative psychological research based on phenomenology. It is interesting to note that perhaps phenomenological psychologists and philosophers may not have developed a method for good reasons, that is, that phenomenology as a practice was primarily about cultivating an attitude. For example, Inkpin (2016, p. 6) views phenomenological 'method' as simply describing "accurately how things appear or manifest themselves." This is not at odds with a view of science as observational, which is the basis for natural sciences such as geology, zoology and botany, which are founded on field work. The current research comes from a praxis that has developed over years of working as a therapist phenomenologically, cultivating the phenomenological attitude involved, which is an attitude of radical openness to 'what is there'; as discussed, this involves suspending the 'natural attitude', but this takes practise, and can be "painstaking" in its "demand for awareness" (Merleau-Ponty 2014, p. xxxv/22). It has been argued here also that this involves a long process of coming to know oneself: I cannot attempt to put in

parentheses my beliefs, biases and prejudices without knowing what these are. In developing a method, Giorgi was trying to make a place for phenomenology in science viewed as method, in psychology as a human science (Giorgi, 2009).

Giorgi's (2009) method especially focuses on Husserl's concepts of the epoché and the reduction in a psychological way, as well as the process of imaginative variation to describe the essence of the research participant's meanings in the data. He appears not to have engaged with the implications of constituting subjectivity and intersubjectivity, as well as Husserl's view of empathy as involving otherness and Merleau-Ponty's views on embodiment. In light of the methodological considerations already discussed, what Giorgi's method appears to be aimed at is the 'experience of truth' of the research participant as revealed in the consciousness of the researcher. As indicated such an experience may be both epistemological and ontological for the research participant, that is, embodied and lived.

Empathic understanding has been discussed in relation to Walker's (1994 a; b; 1995) comparison of Jaspers and Husserl, and more recently, Zahavi's (2001; 2003; 2014) analyses of empathy in the phenomenological tradition (see Methodology, Chapter 3, Section 3.5.2.1). It is argued here that Giorgi's method of analysis is one that depends on a view of phenomenology as empathic understanding as understood by Jaspers (1912), following his teacher, Max Weber (Walker, 1994 b; 1995), and developed by Spiegelberg (1964; 1986; 1995 cited in Giorgi, 2009). In so doing some questions are opened up as to the nature of how Giorgi's method attempts to address the complexity of understanding the other. By responding to these questions, an outline of what the method actually does, and what it cannot do, will be explored and discussed.

> For me, philosophy, as an idea, remains universal, and in a radical sense, 'rigorous' science. As such it is science built on an ultimate foundation, or, what comes down to the same thing, a science based on ultimate self-responsibility, in which, hence, nothing held to be obvious, either predicatively or pre-predicatively, can pass, unquestioned, as a basis for

> knowledge. It is, I emphasize, an *idea*, which, as the further meditative interpretation will show, is to be realized only by way of relative and temporary validities and in an infinite historical process – but in this way it is, in fact, realizable (Husserl, 1989, p. 406 in Applebaum, 2012, pp. 36-37).

In defending Giorgi's empirical method, Applebaum (2012) uses this passage to highlight that scientific method based on Husserl's phenomenology will yield knowledge that is perspectival and contextual, and involves a self-responsibility on the part of the researcher to understand in depth what kind of knowledge is being generated. This is one reason why it is important for the researcher to understand his own 'natural attitude' in that it entails a self-responsibility to have an in-depth idea of what is understood as knowledge. This self-understanding is not just to prevent 'distortion' to the data analysis epistemologically, but also to stay open to the 'other person' in research, including the research participant, and everyone else involved in the research project. Getting close to the radical implications of intentionality, requires this kind of radical openness (Dahlberg & Dahlberg, 2003). Applebaum (2012) is arguing that Giorgi is aware of this need.

4.4 How Giorgi sees his method as phenomenological and descriptive

In defending his method against critics who believe it is a distortion of phenomenology (Paley, 1997), or that it is in fact a hermeneutic method (Rennie, 2012), Giorgi (2000; 2014) has explicated in detail the connections between his method and Husserl's phenomenology. Giorgi (2000) emphasises that his method is not a philosophical one and therefore is not attempting transcendental reduction, is not trying to analyse consciousness, but analyses descriptions from others and is not at its core interpretative. In theory, there is only a qualitative difference between an interpretation of 'a present moment' - of something that presents itself - and a description of the same if both are undertaken within phenomenology as all biases and prejudices are bracketed insofar as possible (Giorgi, 2014).

This can be seen, for example, in Giorgi (2014), where the view is that the reduction makes description mandatory (unavoidable). That is, the reduction, if successful, means there is no interpretation: If I have removed all my biases and assumptions successfully, then I am in a position where what I see is a description. Heidegger and Merleau-Ponty thought this kind of reduction was impossible (Moran, 2000).

Rennie (2012) has given strong arguments to indicate that all qualitative research in psychology is hermeneutic, including Giorgi's descriptive method. Giorgi's (2014) response to this accusation is thorough and detailed, insisting that the move in his method from Life-world phenomena to psychological language is interpretive in one specific sense only, but that the core of the method is descriptive. The argument between Rennie (2012) and Giorgi (2014) appears to show that description and interpretation are concepts with 'family likenesses'. Giorgi (2014) spends some time exploring the differences between description and interpretation and insists on their difference. Description is a predication, denoting that "a linguistic expression accurately delineates the non-linguistic state of affairs to which it refers"; interpretation, on the other hand, "always implies that something is not entirely clear" (Giorgi, 2014, p. 544). Giorgi (2014) believes then that 'states of affairs' can become clear through a radical and active entering into the epoché and reduction (Dahlberg & Dahlberg, 2003).

Giorgi (2014) maintains that description is a discreet and separate entity to interpretation; the latter involves 'theory', that is, views and beliefs in the broadest sense, being applied to experience, and therefore distorts in some way. Drawing on Ricoeur (1971), Giorgi (2014) is of the view that hermeneutics at its core involves a 'personal commitment' and therefore an imposing of a theory in its broadest sense upon the 'data' – 'If I make something 'my own' then this is what I have done':

> If we follow the paradigm of the dialectic between explanation and understanding to its end, we must say that the meaningful patterns which a depth interpretation wants to grasp cannot be understood without a kind of personal commitment similar to that of the reader who grasps the depth semantics of the text and makes it his "own" (Ricoeur, 1971, p. 561 cited in Giorgi, 2014, p. 548).

Following Husserl, Giorgi (2014) believes that phenomena can be described just as they present themselves - as presenting to consciousness, not necessarily existing - and that this presentation can be described faithfully in all its givenness without being distorted by any theoretical attitudes or beliefs. What is presented to consciousness - viewed as the participant's data - is described, and Giorgi (2014, p. 546) uses different verbs to give a sense of the effort involved in what happens in this process of description: for example, 'draws out, imagines, clarifies, and highlights.' Part of this "nitty-gritty" of analysis involves imaginative variation (Giorgi, 2014, p. 546). In my view, this aspect of the analysis appears as the point where constituting subjectivity especially comes into play, and if the findings of the research are to be repeated - repeatability of results being a characteristic which Giorgi indicates validates the method as scientific (Giorgi, 2009, p. 83) - then this may have more to do with the researcher using 'sedimented' language to describe phenomena (see Chapter 3, Section 3.4.2). Giorgi appears to be aware of this but sets such concerns aside, indicating that his method does in fact yield scientific results nevertheless, which, although they cannot describe "every aspect of a lived-through event", are "adequate" (Giorgi, 2009, p. 125). Citing Merleau-Ponty (1964, p. 46), he demonstrates that he is aware that expression and experience do not simply coincide:

> "In already acquired expressions there is a direct meaning which corresponds point for point to figures, forms and established words… But the meaning of expressions which are in the process of being accomplished cannot be of this sort; it is a lateral or

oblique meaning which runs between words" (Merleau-Ponty, 1964, p. 46 cited in Giorgi, 2009, p. 125).

Despite this, for Giorgi, the words of the participant reveal something that is 'adequate', enough to reveal new knowledge of the phenomenon being explored (Giorgi, 2009, p.125). As can be seen, the difference between interpretation and description is one that haunts the method. An example may illustrate this. Participant 9 makes the simple statement that she does not think about the therapeutic much:

> I suppose weird because a lot of the stuff I do I just do it and don't really think about it... so, it's a bit weird I'll probably miss loads and loads and loads off because I just do it without thinking about it... and I'll probably go and do something and I will go, oh I could have said that... (lines 397-399).

In the transformed meaning unit, an effort is made to stay descriptive, situated in the language of the participant, and not to state what perhaps is glaring out of the text, that there is tacit knowledge involved, because this may involve interpretation.

> It is weird talking about what she does that is therapeutic because a lot of what she does she does not think about a lot. She thinks she will probably miss out a lot in talking about it because she just does it without thinking. She will probably think later that she should have spoken about other things also (Participant 9, Transformed Meaning Unit 30 - Meaning Unit, lines 395-401)

There is a difference here which is part of the activity of the reduction, separating what appears more explicitly as an interpretation - even if such an interpretation appears correct - from the tacit, or 'constituting' activity of the researcher. The former can be seen more easily, while the latter usually cannot emerge at all, or may do so to some extent with some difficulty, perhaps through being open to the 'critical other'. For this reason, the difference between interpretation and description haunts the method. It is interesting to note that openness to the other is a critical finding in this research, so that not only can this be therapeutic but it also may reflect what 'good research' might involve. The decision to stay

descriptive then results in the sentence, 'She does not think about what is therapeutic much,' which summarises this theme in her general synthesis.

Giorgi (2000) addresses whether description of the experiences of others can be viewed as phenomenological (cf. Paley, 1997). Giorgi (2000) drew on Spiegelberg (1964; 1982) for precedent, who took issue with Jaspers' claim that describing the 'psychopathology' of others was 'phenomenological', and therefore took up the challenge of addressing how such experiences like categorising psychopathology could be said to be phenomenological. The difficulty being addressed here is how empathy is possible. Jaspers saw his work as employing a 'descriptive psychology', mistakenly drawing on the early Husserl, specifically in *Logical Investigations* (Walker, 1994a; b; 1995).

Spiegelberg (1995 in Giorgi, 2000) believed that a researcher could be phenomenological by 'vicarious experiencing', which involved "imaginative self-transposal" and "co-operative encounter" or "co-operative exploration" (Giorgi, 2000, pp. 4-5 citing Spiegelberg, 1995, pp. 35-53). In imaginative self-transposal there is a "shuttling back and forth" between the researcher's "understanding self and that of the other who is to be understood" - there is a tension "between constructing the other" and avoiding "imaginative license" (Spiegelberg, 1982, pp. 49-50 cited in Giorgi, 2000, p. 4). Something about the other in the world is communicated to the researcher through the participant's speech and behaviour (Giorgi, 2000, p. 5); Giorgi (2000) alludes to Husserl's (1964) concept of subjective constitution, and Edith Stein's (1989) work on empathy here, but does not note that Husserl saw empathy as 'self-alienating', or examine the full implications of constituting subjectivity (see Methodology, Chapter 3, Sections 3.5.2). Indeed, phenomenology can be thought of as "not-empathy" (Walker, 1995, p. 255).

'Co-operative encounter' is an exploration, likened to the transference relationship in psychoanalysis, and the researcher experiences the participant's experiences "only through"

the latter (Spiegelberg, 1982, pp. 50-51 cited in Giorgi, 2000, p. 5). Giorgi (2000) strongly agrees that the research relationship (that between the researcher and participant) is like a therapeutic relationship, and appears to follow Spielberg's reference to a psychoanalytic one. He is saying that something of the other can be known through a therapeutic-like process of research, involving empathy and imagination. This is his first point, in defending the move from philosophical phenomenology to a scientific phenomenology. Regarding the therapeutic relationship, he does not appear to acknowledge that different 'therapies' will engage differently with the other in therapy, so there is an implicit assumption that the 'therapeutic relationship' is somehow a uniform concept. For example, to name just three 'therapies', Lacanian psychoanalysts do not see their practice as a therapy (Parker, 2008), Kleinian analysts interpret the transference according to a rigid theory (Malan, 1993), and person-centred counsellors will focus on providing the 'necessary and sufficient conditions' required for personal development (Rogers, 1962). Each of these forms of 'therapy' involve numerous assumptions as to what it is to be a subject, a human being, or a person, and what is empathy.

Scientific scholarship has its own style, which Giorgi (2000, p. 5) says he also experienced as a "critical other" (the wider scientific community) which demanded he did not address only his own experience as the phenomenological philosopher would, but explore the experiences of others. He came to believe that he could practise phenomenologically while exploring the experience of others through the following argument (Giorgi, 2000, p. 5):

1. "Individuals who are research subjects describe situated experiences of interest to the researcher from the perspective of the natural attitude."
2. "The researcher analyses the description from within the phenomenological reduction and specifically for its psychological (or nursing) meaning." He is saying here that there is a phenomenal field of meaning that applies to separate areas of interest (nursing, psychology, etc.) For example, if I am a geologist and I want to know what kinds of

rocks were on the moon, I would not ask the astronaut how he felt on the moon but what he saw. This appears to imply that a different language game is to be applied to the 'data' depending on the area of research.

3. As the researcher is in the attitude of the reduction, he makes no claim as to the existence of the phenomenon that appears, but only that it appears faithfully in the consciousness of the research participant as it was reported by her.
4. The focus being on the "human science meaning, rather than on the facts as such" indicates that the "the intentional objects and the signitive or fulfilling acts are given in linguistic experience" (as much as they would have been in direct experience). He assumes here that *meaning* can be given full expression in words ('fulfilled' in Husserl's terms). As has been noted (Chapter 3, Section 3.5 and 3.4.4), signitive intentions are fulfilled by categorial intuitions, and it is to this correlation that Giorgi is referring. However, there is the basic assumption on Giorgi's part, that the language being used belongs to a linguistic community in which meanings are already known (van Kaam, 1966). Therefore, the meanings involved already refer to a set of meanings (tacit or explicit) in circulation in a linguistic community. Giorgi does not dispute that the results of his analysis are always contextual (Giorgi, 2000).

Giorgi is aware that meaning arrives as part of a 'figure-ground' as in a gestalt (Giorgi, 2009, p. 125) so that descriptions will always fall short of expressing this phenomenon. He is more interested in meaning as defined by the words of the research participant. Again, what this appears to do to the words used by the participant is to make them mirror an already received view of a phenomenon, something that is already to do with 'spoken speech' rather than speaking, in Merleau-Ponty, or sedimented language in Husserl. Giorgi is aware that linguistic description cannot express a lived-through experience fully. Citing Merleau-Ponty's *Signs* (1964, p. 46 in Giorgi, 2009, p. 125), "acquired expressions" have a "direct meaning" in "established words" but "the meaning of expressions which are in the process of being accomplished" have an "oblique meaning which runs between words". The direct

meaning that Merleau-Ponty is referring to here appears to be what he would later call 'spoken speech'. The relationship between speaking and spoken is ambivalent, as discussed (Chapter 3, Section 3.6), where meaning may emerge as a gestalt against a ground of tacit and embodied knowledge. Giorgi's claim is that descriptions can be adequate enough however to convey new knowledge drawn from this figure ground (Giorgi, 2009, p.125). Implicit meanings can also emerge for Giorgi (2009, p. 134) against a contextual ground, which may be articulated if possible.

4.5 Meaning in perspective

Giorgi (2014, p. 542) has indicated that he prefers the descriptive method of research over the hermeneutic method because it is, in his view, "more faithful to the data", that is, what the research participant has said or indicated. As discussed in the Methodology chapter, it appears that the hermeneutic method imposes a theory (in the broadest sense) upon the data, and this has distorting effects (Giorgi, 2014). The only aspect of his method which Giorgi concedes as interpretative is the overall positing of the 'lifeworld' data in *psychological terms*, but the actual core of the data analysis is descriptive (Giorgi, 2014). It would appear that for Giorgi (2014) a description is a faithful representation of what the research participant *meant* and this can be 'given' to the researcher such that he only needs to describe it just as it is given (possibly attainable if he can stay in the epoché and reduction).

Giorgi is aware that the process is complex (Applebaum, 2012). A major difficulty with Giorgi's method - or any 'method' that involves 'meaning' - is that Husserl's view of intentionality does not refer to meaning in the ordinary sense. Intentionality refers to how the subject's consciousness 'constitutes' the objects in the world (things, states of affairs and so on) and this is not only the activity of a self-reflecting, autonomous consciousness (standing back reflecting on the world) but is also the activity of an 'anonymous' consciousness, pre-reflective and 'constituting'. How then can we catch a glimpse of the anonymous

consciousness of the research participant as it constitutes the world without our own anonymous consciousness getting in the way?

The careful description that Giorgi's method attends to is not one that addresses this anonymous, constituting consciousness, but one which tries to describe faithfully the language the research participant uses in reference to meaning. What Giorgi's method provides is an account of what meanings appear but appear in a process of speaking and interaction between two people, where one is trying to remove his own meanings from the conversation.

It appears that 'living in our descriptions' is an important concept to note here; that it is important to develop an attitude that questions our firm 'beliefs' ('beliefs beyond beliefs') about the world (see Methodology, Chapter 3, Section 3.5.4). An interpretation can become a description if it is embodied enough to be 'beyond interpretation' - that is, if it is 'constituted' rigidly, perhaps in the Husserlian sense. In this way, what is taken for granted as how the world is, how others are, and how oneself is, *are* beyond discussion. This would be the opposite to a radical openness that the reduction implies, and indeed to the 'openness' that has been identified as therapeutic in the Theory chapter.

4.6 Giorgi's move from transcendental to empirical

Giorgi and Giorgi (2003) indicate that in order for Husserl's method to be described as scientific, as opposed to philosophical, it has to be modified, in that the researcher now adopts an attitude of scientific phenomenological reduction with a psychological perspective. This is not the transcendental reduction of the philosophical method, but rather a psychological reduction whereby what is experienced is understood to be an experience given to the person experiencing the object but no existential status is given to the phenomenon.

> "To be taken as a phenomenon means that everything that is noticed with respect to the given is taken to be worthy precisely as a presence in the manner it is present, but one does

> not have to say that the given *is* the way it presents itself to be…This aspect of the reduction is devised to help overcome the natural human bias of stating that things *are* the way we experience them to be without critical evaluation" (Giorgi & Giorgi, 2003, p. 249).

The difference between transcendental phenomenology and empirical phenomenological phenomenology is clear when one considers that, as noted above, what Husserl means by 'things' are what "words may be found to signify when their significations are correctly intuited by the right kind of *Anschaaung*" (Macquarrie & Robinson, 1962, p.50), where an *Anschaaung* is "an intuition immediately given in experience" (Smith & Woodruff Smith, 1995, p.86). For Husserl these 'things' refer to the meaning-intending structures of consciousness (Moran, 2000, p. 93), while for Giorgi (2009) they refer to coincidence between words and a given intuition within the psychological reduction (not the transcendental reduction). However, as discussed in the Methodology chapter, there may be a blurring between the transcendental and the empirical, as both are rooted in intersubjectivity (Chapter 3, Section 3.5.2.1).

A scientific analysis obtains descriptions of experiences from others as opposed to oneself. This is largely in response to traditional scientific practice and its accepted ideas of validity (Giorgi, 1997; Giorgi, 2009), something towards which Husserl took issue, who thought of science as more to do with a playful curiosity (Husserl Archiv B 1 32 Nr. 17 translated by Moran, 2000, p. 183; see Chapter 3, Section 3.3.1). Giorgi's version of science can be traced back to Galileo and Descartes, where something is being measured in the world (in the former) and then analysed through a deductive procedural process (in the latter). Giorgi (2000, p. 5) speaks of having to engage with the problem of how to reconcile philosophical (phenomenological) practice, in which the first-person perspective is paramount, with the demands of the scientific community in order to arrive at a "scientific phenomenological practice." Strictly speaking, from the phenomenological perspective, the researcher is meant to analyse his or her own stream of consciousness (Giorgi & Giorgi 2003). Giorgi (2000, p.

5) notes that scientific research has a "certain style, one that turns towards the world or others as the basis for its interrogations" and that if he had persisted with the phenomenological, first-person stance, then he would have had to defend himself against the accusation that his research would be "in the service" of his own personal theory.

Giorgi came to believe that meaningful psychological results, mediated through the consciousness of each participant, are all present to the consciousness of the researcher and this fulfils the phenomenological requirement (Giorgi, 2000; Giorgi & Giorgi, 2003). There is an emphasis on signitive giveness, or linguistic meaning, as the data is written words, but Giorgi (2000, p. 5) insists these are not just 'marks on a page' but are worked with imaginatively in the data analysis to attempt to be true to the participant's experience. There appears to be something missing here in Giorgi's method in that Husserl gave precedence to perceptual givenness (Zahavi, 2003, p. 28). In what way can Giorgi's method do justice to givenness that is non-linguistic if it focuses on transcriptions? Words that convey linguistic meaning, or signitive intentions, are modes of givenness of being (Zahavi, 2003, p. 30-31) so in this sense something of the 'being' of a situation is being given in Giorgi's analysis. Giorgi (2009, p. 134) appears to recognise this when he indicates that an "implicit psychological meaning" can be intuited as a "background presence" in a description. But as indicated it would appear to be a mode of givenness that has been filtered reflecting a linguistic community of 'psychological language.'

Giorgi (2000) draws on this connection to make claims that the researcher can know what the participant means through signitive fulfilment or intuition: by you saying something I know what you mean. This appears to draw on the van Kaam (1966) 'axiom' in psychology that there is a common language which we can rely on for meanings that are consistent. Giorgi (2009, p. 133) states that in order to fulfil the phenomenological requirement "the intentional object of the researcher's experience" is being discerned, and presumably that this variation

is faithful to the participant's situation in the world also. In addition, the researcher bears in mind the intersubjective requirement of his descriptions. Therefore, the results of the data analysis will reflect what the researcher has already found to be in the world, or at best, this reflection will coincide with what the participant's speech appears to mean about the participant's situation in the world assuming the participant is already part of the situation of the researcher. It cannot escape notice here that the speaking speech of the subject is given less relevance in Giorgi than the spoken speech of the subject.

Giorgi (2014) emphasises that what is given in the data is not to be analysed in a way that imposes theory, or any kind of view, and maintains that this is possible. Giorgi's view of theory is in line with my own 'natural attitude' regarding theory in that theory imposes a way of thinking about the other that is potentially violent to the other person, but we are always caught up in 'theory' to an extent.

4.7 Giorgi's empirical descriptive method

Giorgi's method, developed over many years (for example, Giorgi, 1970; 1997; 2009; 2014), comprises eight steps or stages, listed here:

1. Interviewing (data collection)
2. Transcription of each interview
3. Division of each transcription into meaning units
4. Transformation of each meaning unit into psychological language
5. Synthesis of transformed meaning units into general or situated structures, or themes, with key constituents
6. Synthesis of themes into a general synthesis, or structure, for each participant
7. General synthesis, or structure, comprising all the general syntheses of all participants, along with identification of key themes, or constituents, across all the participants.
8. These key themes, and their constituents, facilitate an understanding of the variations in the interview data.

These steps will be elaborated in this section, illustrated with actual data from this research. Note that 'stage 5' is a transitional move from transformed meaning units to the general synthesis. Giorgi sometimes gives examples of this movement (Giorgi & Giorgi, 2003) but the transition is so complex, involving imaginative free variation, and the reduction, that it is difficult to illustrate. An attempt has been made in this research through listing themes which emerge, and an attempt has been made to preserve the situated character of the participant's words, or meaning of those, as much as possible. The final step, Giorgi's "poststructural analysis", involves a return to the data from each structure, or synthesis, to facilitate an understanding of the variations on themes in the data, "reducing myriad details to their essential components" (Giorgi & Giorgi, 2003, p. 256). The 'life-world' language of the participants can be viewed again through the essentialising lens of the structure for all participants, to understand the data in a "systematic and methodical way" (Giorgi & Giorgi, p.255). In this way, "the ultimate outcome of phenomenological scientific analyses is not just the "essential structure" but rather the structure in relation to the varied manifestations of an essential identity" (Giorgi, 1997, p. 242; Giorgi & Giorgi, 2003). It was found in this research that this final step was one which was integral to the arrival at a synthesis, and it is hard to see how this would not be so in every case, since the syntheses emerge from the data (and not the other way around).

4.7.1 Two principles

Giorgi (2009, p. 69) sees two principles from Husserl which he considers key with respect to a phenomenological approach to science. The first is the 'principle of principles' which is that the 'givenness' of phenomena can be trusted within limits, so that

> "…every originary presentive intuition is a legitimising source of cognition, that everything originarily (so to speak, in its 'personal' actuality) offered to us in 'intuition' is to be accepted

> simply as what it is presented as being, but also only within the limits in which it is presented there" (Husserl, 1983, p. 44 in Giorgi, 2009, p. 69).

As Giorgi (2009) puts it,

> "Husserl is respectful and trusting with respect to experience. It is not the case that experience cannot be illusory, it is just that illusions and others sorts of error are also corrected by experience" (p. 69).

The second principle is that of imaginative free variation. The use of imaginative free variation within the attitude of the phenomenological reduction, aims to result in the emergence of the essential psychological characteristics of the phenomenon under study, without which, or beyond which, the phenomenon would 'collapse' (Giorgi & Giorgi, 2003, p. 246). Imaginative free variation is a key move in Giorgi's method and is present throughout the process. In terms of the phenomenological reduction, Husserl gives the example of looking for the essence of an act of perception (Moran, 2000, p. 154):

> Starting from this table perception as an example, we vary the perceptual object, table, with a completely free optionalness, yet in such a manner that we keep perception fixed as perception of something, no matter what. Perhaps we begin by fictionally changing the shape or the colour of the object quite arbitrarily… In other words: Abstaining from acceptance of its being, we change the fact of this perception into a pure possibility, one among other quite "optional" pure possibilities – but possibilities that are possible perceptions. We so to speak, shift the actual perception into the realm of non-actualities, the realm of the as-if (Husserl, 1991a, p. 104 cited in Moran, 2000, p. 154-155).

In this way, contingent and essential characteristics of a phenomenon are derived, by varying the characteristics imaginatively. If the 'meaning', or 'meaningfulness', of a phenomenon collapses when an aspect is removed imaginatively then this aspect may be an essential characteristic (Giorgi, 2009, p. 69). It is important to note that practising imaginative free variation is a process that occurs throughout the analysis of the transcribed interview, and happens within the attitude of the epoché and the reduction.

Imaginative free variation, or eidetic variation (see Andrews, 1985; Levin, 1968), highlights the complexity of the kind of decisions that the researcher must make in defining what is and is not essential to a phenomenon. It would appear that the kind of process involved here is analogous to the complex decision-making employed in responding to an encounter, as well as being open, and being able to be open, to viewing the situation differently, as discussed in the Theory chapter. Some of the complexity here is also indicated by Moran's (2000, p. 155) comment, that "it is one thing to intuit an essence and quite another to express that intuition in words." This may link to tacit knowledge, in that one can have an intuition - in the perceptive sense of Husserl - and be unable to formulate this in words ('signitively fulfilled'). Some of this complexity will be illustrated below (Section 4.7.4), and discussed further in the Phenomenology chapter (Chapter 6).

4.7.2 Sampling and sample

The choice of participants in a phenomenological study centres around those whose "lives involve a revelatory relationship with the subject matter under investigation" (Wertz, 2005, p. 171). The sample aims at 'representativeness' with respect to the subject of research (Englander, 2012, p. 18). Participants are those who are likely to be in a situation to elucidate the overall phenomenological focus of 'What is it like?' with respect to the research question (Englander, 2012, p. 18; Giorgi, 2009). However, the findings from a sample of people, who ostensibly may know something of the phenomenon the researcher is exploring, may not be representative of what the researcher already knows about the subject, and this only emerges during the latter stages of the analysis (Englander, 2012, p. 19). In other words, the findings may transcend what is already known of the subject of research (Englander, 2012, p. 19). Englander (2012) makes these points because the focus in a phenomenological method with respect to 'representativeness' is the phenomenon itself, rather than a population, as may be the case in quantitative methods. While it is obvious that the participants will have something

to say about the research question, sampling in phenomenological research is based on a "depth strategy" rather than a "sampling strategy" (Giorgi, 2009, p. 198). Morse (1994) recommends that phenomenological research focussed on determining the invariant, or essential structures of a phenomenon include around six participants. However, the size of a sample in phenomenological research is not always predictable from the outset of the study (Denscombe, 1998). In addition, the logistics in interviewing participants, and the time involved in transcription and data analysis, limits the number of participants that can be involved (Englander, 2012).

The researcher set out to interview qualified mental health nurses working in NHS adult in-patient mental health settings and NHS adult community mental health settings. The study was approved ethically by the NHS Trust involved, after which permission was granted by the appropriate ward and team managers to approach mental health nursing staff regarding the study. Participants in the study are those who responded to global emails, with the research question information sheet attached, sent to mental health nursing staff on two acute mental health adult wards and two community mental health teams. There were 10 participants in total, nine interviews lasting from 55 to 70 minutes, and one lasting 46 minutes. Those who responded were clearly interested in the study, and so findings may perhaps represent the context of those mental health nurses who place a particular value on their practice being therapeutic. Seven of these worked as community mental health nurses across two separate teams, and three worked on in-patient acute wards.

4.7.3 Interview procedure

Descriptions of experience were gathered by means of recorded interviews, which are the main data collection tool in qualitative human science research (Englander, 2012). Before the interview each participant had read an information sheet summarising the research project, and this is also summarised verbally before the interview. Each participant also signed the

information sheet agreeing to participate (Appendix 2). The interviews for this research were digitally recorded, and the interviews carried out in different quiet office locations on NHS Trust sites which were amenable for the participants.

Englander (2012) notes that Kvale (1994, and 2009 with Brinkmann) provides the most extensive commentary on how to conduct an interview in general qualitative methodology. However, as Giorgi (2009) observes, there is nothing published with reference to phenomenological interview criteria. Englander (2012) means to remedy this to an extent by clarifying some difficulties. In particular, Englander (2012) draws attention to the source of the research question, as it will be this which needs to inform a philosophically consistent research method, including the approach to the interview. What stands out as most relevant for this research is the need to remain in the phenomenological attitude of describing 'what is' as opposed to interpretation, since it is being claimed that something can be known from phenomenological experience that can be described (Giorgi, 2009), that holds true as an 'experience of truth', for example. In the interview the interviewee describes his or her experience of the topic the researcher is investigating in as detailed a manner as possible. The participant is speaking from the natural attitude, while the researcher is within the attitude of the epoché and reduction (Giorgi, 2000).

Prompts and questions endeavour to open up a space where the participant can find his or her own voice on the topics that arise, while at the same time the researcher tries to maintain the activity involved in the epoché and reduction. As Giorgi (1997, p. 247) notes: "The phenomenological approach is "discovery oriented," and in order to discover meanings in the data, one needs an attitude open enough to let unexpected meanings emerge." This applies as much to the attitude of the researcher in the interview as to his attitude during transcription and analysis of descriptions.

An approach to questioning that reflects back what the participant said may be more amenable to staying with the phenomenological attitude throughout the interview (Findlay, 2008). Interviewing phenomenologically, it is acceptable to direct the participant to the focus of the study if he or she has strayed away from this, but unacceptable to lead the participant (towards a view of one's own, for example) (Englander, 2012; Giorgi, 2009, p. 124). What is paramount for the researcher is to attempt to stay in the epoché and reduction throughout the interview, withholding judgement in responses, and suspending assumptions about what the participant may mean, attempting to draw out more detailed descriptions of phenomena being described if they appeared to be relevant to the research question. The emphasis is on description and it is important to be aware of any drift towards interpretation (Giorgi, 2009). This is a demanding activity, similar to what happens in the analysis of the transcriptions but perhaps more complex because it involves an embodied relation between two subjects, as opposed to a subject-object relation in the natural sciences (Englander, 2012, p. 34). It was an activity with which the researcher had some familiarity through practising therapeutically from a phenomenological perspective in his work as a therapist for some years now. However, a balance has to be struck between developing a rapport with the participants and directing them towards the focus of the research (Giorgi, 2009).

In this research in some cases, it was clear that the participant was trying to figure out what the researcher wanted from them, and there was a tension between whether this attitude may represent something of what the participant felt was therapeutic - to put the other first - or to do with something else. In one case, the participant said she had been "thrown a curve ball" because she did not realise that the interest was in her own experience and thoughts regarding the research question, and the copious notes she had prepared from text books and journals were not the focus. In this case, it seemed important for her to be allowed to have space to speak about these notes also, and it came across in the interview, reflecting her

studious approach to the interview, that she wanted to 'get it right' for others, and was able to be open to the experience that her own ideas may be 'wrong.'

4.7.4 Transcription and analysis of the data

The data from each interview is then transcribed. This is a time-consuming process, but allows a thorough immersion in the data as it may involve repeatedly listening to different aspects in order to catch the exact words used, along with tone of voice, embodied effects, and implicit meanings that emerge from a background to the words being spoken. The method requires that the focus is on the words spoken, although there is room for implicit meaning to also be registered (Giorgi, 2009). One then reads the entire transcription of the interview as a whole because the phenomenological perspective is holistic. There is a positioning of the data in the mind of the researcher as a whole body, rather than a fragmented collection (Giorgi, 2009).

Meaning units are then demarcated, based on where meaning appears to change. This step is largely to make the data manageable. All researchers would not have to have identical meaning units for the procedure to be valid as this is an intermediary stage of the method (Giorgi & Giorgi, 2003). Meaning units "are constituted by the attitudes and activity of the researcher" (Giorgi, 1997, p. 246). Often, several separate themes may be found in one meaning unit, so it is not a question of finding a consistent meaning in each unit.

The researcher then analyses each meaning unit through free imaginative variation to derive invariant or essential descriptions within each meaning unit. This follows the following procedure: The researcher transforms the initial meaning units into psychological language through free imaginative variation. This involves the researcher "interrogating each meaning unit to discover how to express in a more satisfactory way the psychological implications of the lifeworld description" (Giorgi, 2009, p. 131). It is interesting to note that Giorgi is aware

that “the phenomenological psychological attitude of the researcher” is to an extent constitutive of the findings in this procedure (Giorgi, 2009, p. 131). Psychological meanings are “teased out” of the participants’ descriptions and the process of imaginative variation is lengthy and complex but cannot be fully shown. Descriptions are revisited over again until invariant psychological meanings emerge (Giorgi, 2009, p. 132). The psychological phenomenological reduction at work here is a partial reduction for Giorgi, as what is being reduced - through imaginative free variation - are the objects of consciousness and not the acts, such that these objects are the participant’s descriptions linked to his or her “worldly subjectivity” (Giorgi, 2009, p. 135). Giorgi is interested in what can be discerned of the “intentional activities of individual subjectivity” in relation to each participant as revealed through each description (Giorgi, 2009, p. 135). The meanings researched in this project are those related to the therapeutic and learning in mental health nursing, and the language employed in this step was focused on staying as true as possible to the participant’s words, or ‘situated,’ but in the third person. There is an assumption then that the reader will see the descriptions as reflecting the ordinary language of the mental health nursing milieu, and not for example, a language game from psychoanalysis, or cognitive psychology.

For example, as can be seen from the table below, Participant 3 is wondering about an aspect of what she finds to be therapeutic, and this meaning unit is embedded in an overall fragment of conversation about tender loving care. She has just criticised the Crisis Team for not caring but then has backtracked, as their job is to assess and manage risk. While the word, ‘care,’ is not in this meaning unit, it is implicit in the context of what is therapeutic being linked to care (‘the Crisis Team did not care’). What is striking also here is how she wonders whether empathy is always helpful, and whether the therapeutic is a personal value rather than a universal factor. These aspects are not quite explicit, nor quite implicit either, but it is like she is ‘feeling’ her way towards discovering something. Indeed, her wondering and

questioning indicate an openness to learning that is implicit here while made more explicitly clear elsewhere. ‘Openness’ is therefore emerging as a key constituent for her.

Meaning Unit 6 (Lines 133-148 of Transcript)	**Transformed Meaning Unit 6 (TMU6)**
P3: Yeah, but I suppose that's where the therapeutic thing comes in, but it's just that's my personal values then isn’t it? R: Yeah P3: Thinking about it… R: And what happens there? Yeah… it is your personal values. P3: How I, I suppose I've always treated people how I would want to be treated, so if I was in their position… Is it over-empathetic, I don't know? I don't know… R: I don't know either… So it's as if the other person, if you were in their position what would you want? P3: Yeah and what would they need… and	She feels that to have the personal value of caring is therapeutic. She sees this caring as treating people the way she would like to be treated, but is concerned she may be being over-empathetic.

There is a balance between over-contextualising a participant’s experience and the use of “theory-laden terms” to diminish the relevance of this experience (Giorgi & Giorgi, 2003, p. 253). This process attempts to distinguish which parts of the transformed data are essential to the phenomenon under study and which are not (Giorgi, 1997). The researcher is seeking the essence or structure of the phenomenon but because of the nature of the data this is always context-bound so that what one arrives at in the research in terms of findings is always in the context of the field being researched and of the data sampled (Giorgi & Giorgi, 2003; Wertz, 2005). Giorgi (2014) concedes that this part of the analysis is interpretative because it is imposing a psychological language upon the description, however he still maintains that the imposition of psychological language remains true to the original description. Such ‘psychological language’ refers to a broad understanding that reflects an “atheoretical psychological attitude such as is often assumed by practising clinicians and therapists every

day" as opposed to, for example, the specialist language of psychoanalysis, and other therapies (Giorgi, 2009, p. 135). Giorgi's (2009; 2014) views on this transformation into psychological language are ambiguous as he admits that there is no agreement yet as to what 'psychological language' means since psychology is not yet "authentically established" as it has not yet been "theoretically unified" as a science, in his view (Giorgi, 2009, pp. 134-135). Indeed, on this subject he argues that psychology is "the study or science of subjectivity" (Giorgi, 2013, p. 250), which would imply that 'psychological' language belongs to the whole field of what it is to be human. Extrapolating from Malebranche (1638-1715), following (Gurwitsch, 1966), Giorgi (2013) posits that such a 'study' as psychology addresses error, strangeness, what deviates from norms, or the "difference between the lived and the known", and that aligning psychology with a 'natural' science' such as physics is a mistake rooted in Cartesian methodology (Giorgi, 2013, p. 254; Giorgi, 1993). The term 'study' sits more congruently with my view on subjectivity. In view of this ambiguity as to what 'psychological language' may be, Von Erckartsberg (1998, p. 41) has been followed here, who states that a transformed meaning unit is a "third person summary statement" of the dominant meanings in that meaning unit. This appears congruent with Giorgi's views as outlined above.

In the next step, the researcher again applies free imaginative variation, this time to the transformed meaning units to arrive at what is an essential structure of the phenomenon under study: "One carefully describes the most invariant connected meaning belonging to the experience, and that is the general structure" (Giorgi & Giorgi, 2003, p. 253). This process involves determining which elements of the transformed meaning units are essential to the phenomenon under study and which are not (Giorgi, 1997). This step was carried out by placing the transformed meaning units into themes, making the arrival at a general synthesis for that participant more manageable, and the process more transparent. As Giorgi (1997) has noted, some themes may be redundant in that they do not refer to the phenomenon under

study, but nevertheless these themes are allowed to emerge, although are excluded from the findings. Several transformed meaning units may refer to the same theme running through the data. These themes can be termed situated structures, which represent the essential description in the concrete terms of the data; or general structures, which are removed from the concrete terms of the data, and can be trans-situational, that is, they can apply across different aspects of the same theme (Von Erckartsberg, 1998). These themes are specifically outlined in this research, in order to show how the key constituents in each converge into final themes in the general structure of each participant. The flow of the key constituents as they converge or diverge into themes is illustrated below, but note that the process over multiple participants involves repeated immersion in the data and cannot be illustrated fully (Giorgi & Giorgi, 2003, p. 255).

For example, Figure 2 (below) illustrates the synthesis of three transformed meaning units for Participant 3 contributing to the partial development of Theme 1 (Figure 3). Apart from the three transformed meaning units listed here, five other transformed meaning units also link with this Theme 1 (as indicated in brackets).

Figure 2 Transformed Meaning Unit synthesis Participant 3

P3 Transformed Meaning Units	**P3 General/situated structure or Theme**
TMU2: Her patients were all on the Care Program Approach who had serious mental illnesses and felt abandoned because services had not been in touch. Mental health services had an 18-month waiting list just for assessments. TMU3: At first, P3 thought she was going to cure her patients through tender loving care, and through helping them manage their illness and associated problems. But she sees this hope of curing them as naïve now. She began to feel helpless and sometimes depressed that there were so many people asking her to talk with them, sharing their problems with her. She felt she had to be available for each person as she was often the only person in their world who actually cared enough to sit and listen to them. She did not want to feel she was letting them down by not being available and she thought of this as counter-transference. She feels she is put on a pedestal by her	Th1 P3 can feel sad and helpless because people are not cured, including by tender loving care. They still want time with her nevertheless and she can instil realistic hope (TMU2, TMU3, TMU5, TMU11, TMU18, TM20, TMU35, TMU38)

patients, as their Community Psychiatric Nurse, and her anxiety is about wanting to do her job properly for them and to be helpful. She does not think she is emotionally involved with her patients.

TMU35:

P3 personally wonders whether a lot of medication is effective because she sees it does not work for many people, especially regarding anti-depressants. She is unsure about how much is placebo effect. She thinks medication gives psychiatrists something to hold on to that is practical.

Figure 3 P3 Theme1: Illustrative changes in free imaginative variation and reduction

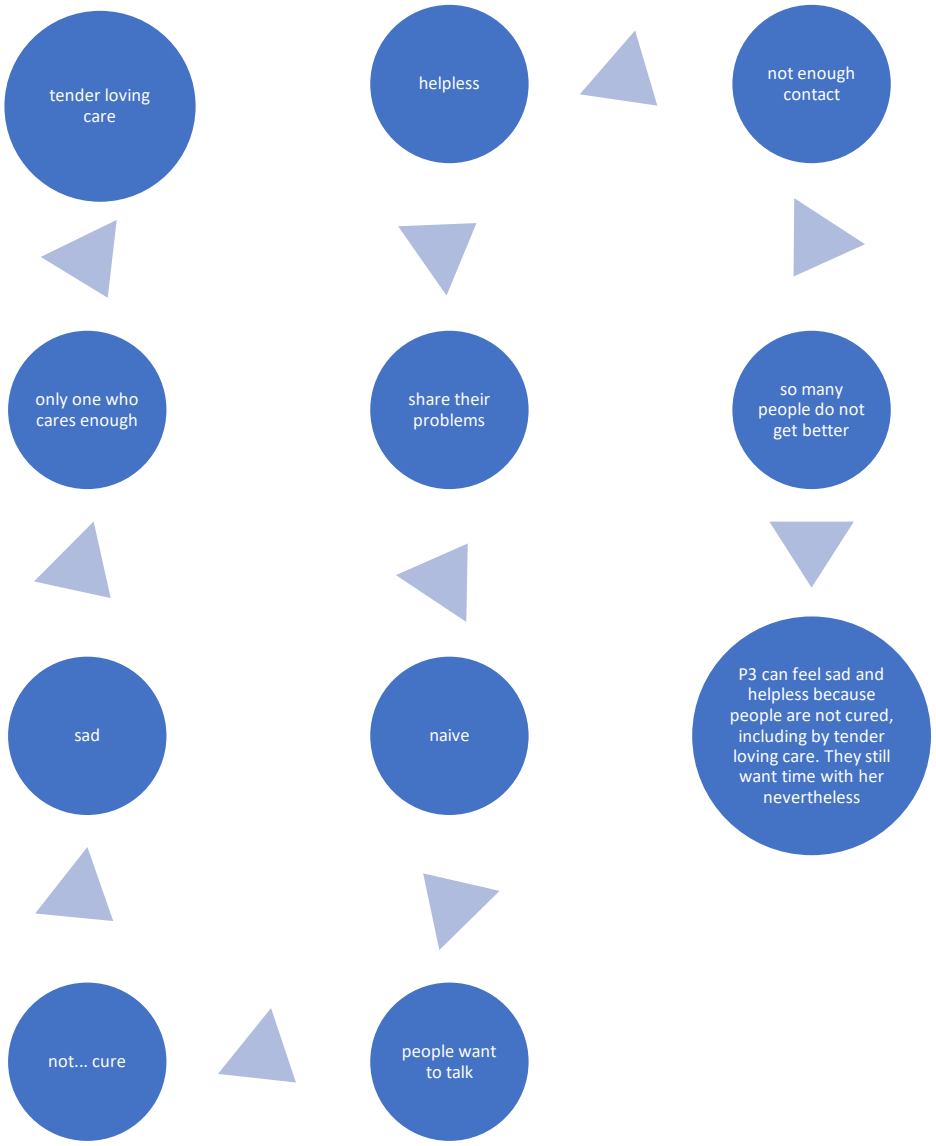
Patients felt abandoned by the community mental health team due to lack of contact (TMU2)

It is naïve to think that tender loving care is enough to cure people (TMU3)

She can feel helpless and depressed as so many people do not get better (TMU3, TMU35)

People want to talk to her and share their problems with her (TMU3)

She is often the only one who cares enough to sit and listen (TMU3) *P3 can feel sad and helpless because people are not cured, including by tender loving care. They still want time with her nevertheless* (Theme 1, partial)



Without needing to explore this topic here, as it will be addressed in the Findings chapter, it can be seen that it is problematic to separate themes from what appears to be an integrated activity of this mental health nurse. The sense she has of her 'patients feeling abandoned' she addresses by giving them time, so that in this theme, 'time' subsumes 'abandonment'. What is essential to the therapeutic aspect of her work, without which the meaning of what she is conveying might collapse, is 'time.' The factor of 'hope' is integral and tacit to her activity and comes through from other transformed meaning units. The

example given is intended to illustrate the process of arriving at a theme, and 'hope' has not yet been included. The arrows in Figure 3 are skewed to indicate the to-ing and fro-ing interchange of deciding what is essential

The following example illustrates the development of the general synthesis for Participant 3.

Figure 4 Development of general synthesis Participant 3

P3 General synthesis

Spending prolonged time with people is therapeutic because she becomes personally involved, genuinely listens and is interested, feels for, is open to, and learns from, the other as an equal, and is cautious about identifying herself with the other or giving advice. She shows understanding and makes her commitment to the person explicit. Being able to feel and tolerate emotional distress is part of being therapeutic.

She has learned from being open to patients and colleagues, and her own reading. No formal training was offered in university on how to be therapeutic outside the medical model of cure. Being caring and compassionate cannot be taught, and are more like personal qualities.

Her work is split between applying models of care to do with risk management and the medical cure (encouraging compliance with medication, the recovery model and the Care Program Approach, and NICE guidelines), and spending time with patients, which is like a 'prescription of humanity'. The split in her work causes her distress as she feels responsible across both aspects.

P3 General/Situated structures or Themes

Th1: P3 can feel sad and helpless because people are not cured, including by tender loving care. They still want time with her nevertheless and she can instil realistic hope (TMU2, TMU3, TMU5, TMU11, TMU18, TM20, TMU35, TMU38)

Th2: Because of her role, she feels she must not disappoint anyone who relies on her, and she commits herself to them so they know she keeps them in mind (TMU3, TMU4, TMU7, TMU44, TMU45, TMU46)

Th3: She is not emotionally involved with patients although she feels wanted and needed (TMU3, TMU17)

Th3i She appears emotionally involved, either through the personal importance of being a professional nurse, and/or a personal sense that no-one should be abandoned (TMU2, TMU3, TMU17)

Th4: High caseloads create imbalance between required documentation and time with patients, causing her physical distress (TMU20, TMU21, TMU22)

Th5: She works using what she has learned from practice and she teaches students by showing (TMU1, TMU2, TMU31, TMU49)

Th6: Developing a therapeutic alliance is expected but no training was given on this in university. She learns from the person as an equal by being open to them, using humour and being friendly (TMU1, TMU15, TMU18, TMU34, TMU49, TMU50)

Th7: Responsibility involves overseeing medication, referring to others, and documenting risk, as well as spending time with a patient (TMU5, TMU13, TMU15, MU16, TMU26, TMU34, TMU36)

Th8: Treating others how she would like to be treated is itself caring as therapeutic, but it might be too personal (TMU6)

Th8i: It is therapeutic to not identify too much with someone (TMU6i)

Th9: P3 feels a responsibility to the other person and gives too much, as she may be for that person an only friend, a best friend, confidante and sounding board (TMU8, TMU13, TMU17, TMU38)

Th10: Nurses listen. Actively listening and the person speaking with trust is therapeutic somehow (TMU9, TMU17, TMU25, TMU27)

Th11: She does not show that it is tiring to be non-directive and available, and thankless as it is expected (TMU10, TMU17, TMU44)

Th12: She shows solidarity with people and offers understanding (TMU11, MU20)

Th13: She becomes part of a person's life in a close, personal way, and she enjoys this aspect as it is therapeutic (TMU12, TMU14)

Th14: Part of her role is to transfer received advice and guidelines about illnesses to patients (TMU12,

Th15: She involves colleagues in the person's care, also to feel less alone and learn (TMU15, TMU50)

Th16: Talking and being with patients is like a prescription of humanity in a medicalised and model-driven environment (TMU16, MU20, TMU36, TMU37)

Th17: There is a tension between intimate trust and professional assessment, which affects her emotionally (TMU19, TMU20, TMU33)

Th18: She feels privileged that people confide in her because she is a nurse (TMU23, TMU24, TMU25, TMU29, TMU32)

Th19: A lot of nurses are caring and compassionate (TMU28)

Th20i: She may not see her personal experience as being worth knowing (TMU30i)

Th21: She values formal training (TMU31, TMU33)

Th22: She explains her role to patients to delimit expectations as she is anxious they expect so much (TMU33)

Th23: She is unsure about the efficacy of medication (TMU35)

Th24: Psychiatry is not always only the medical model, although prescribing medication can make psychiatrists feel effective (TMU35, TMU46)

Th25: Reducing time with the patient increases relapse rate (TMU39)

Th26: Ethical ideas show themselves with experience (TMU40)

Th27: Models of care can structure planning and relieve anxiety about explaining her practice to authority (TMU38, TMU41)

Th28: Her training had no modules on mental illness. She read about it herself, and learning from others on placements (TMU42, TMU43)

Th29: She gauges a student's suitability based on genuine interest in the patient (TMU 47)

Th30: Important topics to know are care planning, risk, medications and depo injections (TMU 48)

This general synthesis has two elements which have to do with what is therapeutic, and how this is learned, which are directly relevant to the research question. A third element has been included also, as it has to do with a major theme that emerges across all participants, namely the tension in nursing between risk management, along with care coordination and the medical aspect, and being therapeutic. It is felt that to not indicate this tension would be to misrepresent the context of the therapeutic in mental health nursing and so it is included.

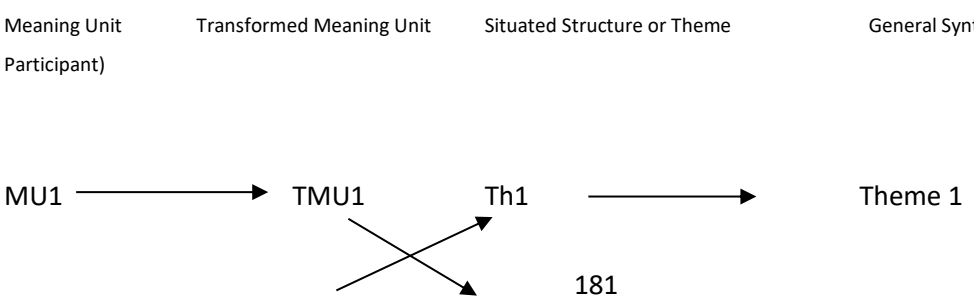
Synthesising thirty themes into three short paragraphs indicates how this process of arriving at a general synthesis is complex, as it also requires staying in the epoché and the reduction, using imaginative free variation. On reading through the themes within the phenomenological attitude, however, certain aspects begin to repeat and emerge, such as 'spending time', 'being open', and 'learning from'. As well as this, certain aspects which appear significant, for example, 'instilling hope' (in Theme 1) have been subsumed into a

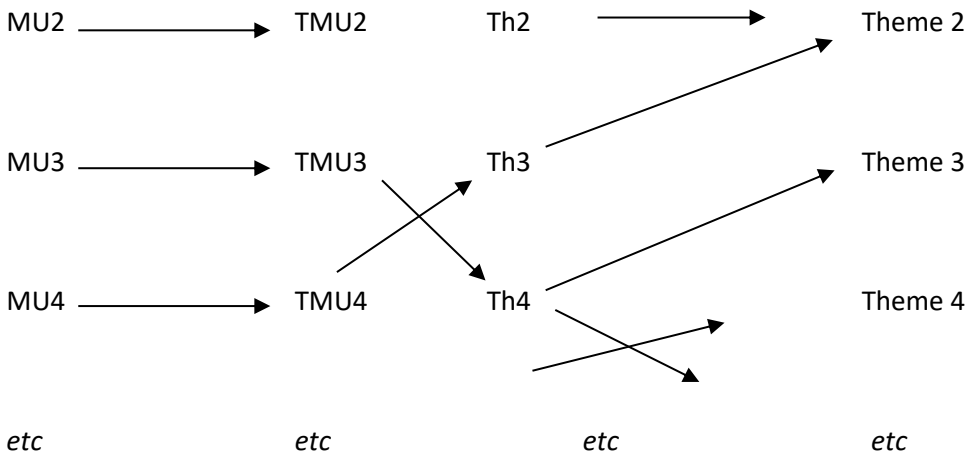
deeper meaning, for example, 'commitment' in the general synthesis. This particular decision was made through returning to the original transcript, and noticing that hope is given through explicit commitments to the person, where Participant 3 said, for example, "you're not on your own" (Line 171), she has "got their back", (Line 504), and (speaking of herself) "you just keep being there… because that's all you've got left" (Line 602) - this indicates that perhaps commitment instils hope and so is more essential to the therapeutic. Characteristic features, or key constituents, of the phenomenon being investigated, emerge in this process of arriving at a synthesis of the data - key constituents are the main elements that form structures, or themes, in the synthesis (Giorgi & Giorgi, 2003, p. 256). 'Commitment' is an example of a key constituent for Participant 3 here.

The diagram below illustrates the movement of the analysis for one participant. Themes 1, 2, 3, and so on, of the General Synthesis for this participant are essentially 'sentences' which are parts of a description which Giorgi (2009) calls the 'structure' of the phenomenon being researched. Note the more one-to-one correspondence between meaning units and transformed meaning units, while transformed meaning units can refer to one, or multiple themes, developing in the intermediary stage of forming the themes in the general synthesis. The themes under the heading of 'general/situated structure or themes' are variants on what will become the themes in the general synthesis. For example, themes 2 and 3 here combine to form theme 2 in the final general synthesis for this participant.

Figure 5 Illustrative diagram of the analysis for one participant

Individual Synthesis





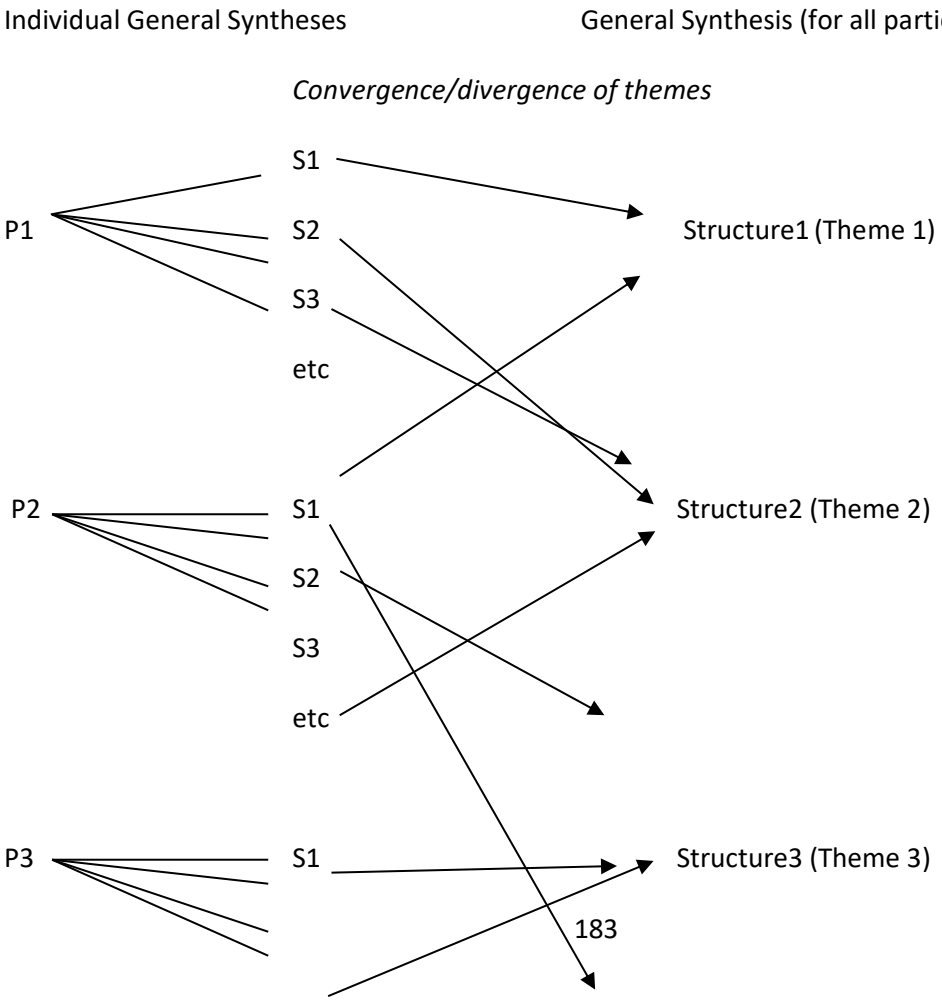
The arrival at a "structure", or general synthesis, that comprises all the data from the participants, is a question of "efficiency or convenience" rather than "theoretical necessity" (Giorgi, 2009, p.103). Giorgi (2009, pp. 103-104) discusses how one general synthesis to include the syntheses of all participants is possible, but depends on the "variability" in the data, and whether it is needed is basically a "judgement call on the part of the researcher". Giorgi (2009, p. 154) notes that "integrating results across participants is by generalizing" although this may not be possible if the "concrete descriptions are highly varied." Along with this, a "heightened articulation" of each meaning unit is required, and is a creative, intuitive process that does not involve condensation into labels. The researcher's experience and intuitive activity is paramount in this process (Giorgi, 2009, p. 154). In this research, overarching key themes, or structures, have been identified at this stage.

Giorgi and Giorgi (2003) show how themes for two participants converge, which are then summarised as key constituents. In this research, it was felt that each participant required an individual synthesis in order for the findings to be represented adequately (Giorgi, 1997; Giorgi, 2009). It was considered that in order to do justice to each participant, and to keep the data in its "biographical integrity" (Von Erckartsberg, 1998, p. 39), a synthesis for each participant was necessary, as well as an arrival at a general synthesis for all participants. The arrival at a general synthesis for one participant, through the reduction, is a lengthy process,

and involves re-checking the themes identified in the original data in order to identify what each phenomenon is, as well as how it is being revealed here in any particular instance (Von Erckartsberg, 1998; see Figure 4).

It was considered helpful in this research group, because of variability in findings, to follow this process across individual syntheses to arrive at a general synthesis for all participants to show where the findings both converge in consistently occurring themes, and diverge in other themes. This process involved cross-checking again the transformed meaning units and themes, or structures, for variations from one participant's analysis to the next (Giorgi & Giorgi, 2003; Giorgi, 2009). The final general synthesis, addressing all the data, was thus split into two parts, the first comprising where the data converges for all participants, and the second being where the data shows variation across participants. Arrival at a general synthesis for all the data is illustrated in Figure 6.

Figure 6 Illustration of structure of General Synthesis



S2

S3

Figure 7 shows an example to illustrate this development (from Participants 4 and 5):

Figure 7 Example of development of General Synthesis

	TMU12	Th13	P3 General synthesis (constituent of)	(constituents)
I'm on first name terms with your dog and cat, you know… (laughs) … things like that… and then you just start having these quite general conversations because… you end up having to get to that point where it isn't just well, I'm going to talk to you about something you know about now, you've done that part, now it's just staying with you… P3 lines 300-303 MU12 (fragment)	When P3 first qualified, she kept her work close to what she had learned in training, following NICE guidelines, and giving practical advice about symptoms, including educating the person about their illness, recognising individual symptoms and relapse signs**. During this process, she comes to know the patient on a personal level, knowing the family, and pets, and she becomes part of their life**.	**She becomes part of a person's life in a close, personal way**, and she enjoys this aspect as it is therapeutic (**TMU12**, TMU14)	…**she becomes personally involved**…	…being with… …getting to know… …personal aspects…
	TMU14	Th9	P4 General Synthesis (constituent of) **Getting to know a person… and may include family.**	
I would try to get a family member and then if they didn't have any family member I would get a support worker to go but you've also got... activities so you're looking at what they're doing in their life... are they sitting at home all day I'm not being washed or dressed did they used to like things P4 lines 185-188 MU14 (fragment)	She finds this information by spending time with the patient, at home if they are not risky, or in the office. **She would try to get a family member** or support worker to help with attending appointments if necessary. She would suggest activities - **especially if they are depressed, not getting washed and dressed and out of the house** - they used to like, such as knitting, or woodwork,	**Practical work help bonds the relationship and contains a wide variety of aspects, from encouraging people to get dressed**, to health checks, risk assessments, and financial matters. She talks to the person at length and over time about these aspects (TMU9, TMU12, TMU14, TMU15)		

	perhaps go to men-in-sheds.			
Meaning Unit	Transformed Meaning Unit	Themes (general and situated structures)	Individual General Synthesis	General Synthesis

What is happening here is that Participant 3 notices that she starts to 'get to know' a person by being with them, firstly through her role, and then something else starts to happen. She is involved in the everyday of a person's life. Participant 4 notices something similar, that through her care plan she becomes involved in discussing with a family member, perhaps, how to get someone out of bed. In both cases, there is a sense of getting to know, personal involvement, and through being with the person, and family, as opposed to, for example, reading case notes or devising theories. Both meaning units converge on the constituents, 'being with' and 'getting to know', while there is perhaps a more idiosyncratic element to 'personal involvement' and 'family', and so these come under the constituent, 'personal aspect'. All of these are preserved in the General Synthesis (for all participants). For example, 'getting to know' as a constituent, comes under the key theme of 'Therapeutic activity is 'being with' clients over time.'

In summary, within the activity of the epoché and reduction along with imaginative free variation throughout, there is a movement from the raw data, or the speech of the participant as transcribed, to meaning units which are then transformed into 'psychological language,' although in this case language more aligned to the therapeutic milieu of mental health nursing. Common themes are then identified across these transformed units to arrive at a number of themes, which are then synthesised into a general synthesis for each participant, and these in turn into a general synthesis for all participants. Key themes, or structures, emerge in developing the general synthesis for all participants, which overarch a number of sub-themes or key constituents.

4.8 Ethical considerations

No major ethical problems were found in the planning and development of this study. The NHS Trust ethical committee, and the University ethics committee, had no objections to the study, given that ethical guidelines had been followed to address risk and protect confidentiality as far as possible. Every effort was made to protect confidentiality through eliding any references to client or staff names, as well as places. If particular situations were described which may have made a client, or staff member, identifiable, then some of the material was elided or altered, without altering the general meaning of what was being researched. If information arose during an interview which was upsetting for the participant, there was an understanding that he, or she, could have time to speak privately to the researcher in a therapeutic capacity; if this was not sufficient, a plan of action would be agreed, for example, to refer on for individual counselling, psychotherapy, or psychological support if necessary. Before each interview, participants signed a consent form, agreeing to participate, and agreeing to allow the interview material to be used for publication. Copies of a sample consent form, information sheet, and ethical approval letters are provided in Appendix 2.

To summarise this chapter, Giorgi's descriptive phenomenological method of psychological research, rooted in Husserlian phenomenology, has been described, including details of the steps involved in the data analysis and examples. These steps involve finding suitable participants, and within the phenomenological attitude, interviewing, transcribing the interviews, and undertaking the analysis of these transcribed descriptions. The descriptions from transcripts are transformed from meaning units, to third person summary statements, into themes and then to general, essential descriptions which intend to give the invariant characteristics of the phenomenon being researched. Key constituents of the data are then outlined. Certain crucial aspects of the method have been problematised, including

psychological context and language, what may constitute description and interpretation, the importance of Giorgi's view of empathic understanding to the method, and how the method meets the demands of a scientific scholarship. In addition, ethical, participant and sampling considerations have been outlined.

5 Findings

5.1 Introduction

This chapter describes the findings from the interviews and how these emerged through the stages of Giorgi's (2009) analysis. The research addresses the question, "What is the need, if any, for therapeutic education in mental health nursing?" The focus is on what mental health nurses know, and do, that is therapeutic and how have they learned to be therapeutic. The Methodology chapter has shown, following Husserl that what is being researched is an 'experience of truth' and the 'primal givenness' (Husserl, 1970a, ¶ 51 in Welton, 1999, p.21; see Methodology, Chapter 3, Section 3.5.3) of this experience is intertwined with constituting subjectivity, and intersubjectivity; how the world has been 'disclosed' to the individual person in and throughout his life. It has been explored how this 'disclosure' may occur as a meaning, or gestalt, following Merleau-Ponty (1968; Methodology, Chapter 3, Section 3.6). As Husserl (1970a, ¶ 51 in Welton, 1999, p.21) has noted, two people may live the same situation but register it differently as 'truth' in their experience, so what is being researched here is not some Ideal truth, as in a mathematical equation, but how 'truthfulness' *appears* to a person. As has been discussed, this is also in relation to how Husserl (1973 in Zahavi, 2003) views the claims of scientific method as accessing 'Truth' as being nothing but a tradition in which experience is no longer trusted (Methodology, Chapter 3, Section 3.5.2.2). But yet experience can be trusted, and as Giorgi (2009, p. 69; see Method, Chapter 4, Section 4.7.1) puts it, "Husserl is respectful and trusting with respect to experience".

As I see this, Husserl is critical of scientific method setting up its own 'criterion of truth' (after Sextus Empiricus; Westphal, 2003, p. 38; see Methodology, Chapter 3, Section 3.4.4). Coming to understand one's experience then, appears to be about a dialogue that may

not have an end-point, and suspending one's assumptions, more in the spirit of a Montaigne than a Descartes, as we can become so 'captive' to ideas and concepts that they 'appear' like a Truth (see Zizek's (2014) critique of 'Truth'; Methodology, Chapter 3, Section 3.4.3). The intention of the method in this research is to describe the appearance of experience, "that which shows itself and actually appears" (Zahavi, 2003, p. 52), without adding to or taking from it. Giorgi (1970; 2014) makes the claim that this can be done through an empirical method without interpretation.

The findings in this chapter are a result of the application of Giorgi's method (after Giorgi, 1970; Giorgi, 1997; Giorgi & Giorgi, 2003; Giorgi, 2009; Giorgi, 2012; Giorgi, 2014). In the analysis, within the activity of the epoché and reduction along with imaginative free variation throughout, there is a movement from the raw data, or the speech of the participant as transcribed, to meaning units which are then transformed into 'psychological language,' although in this case language more aligned to the therapeutic milieu of mental health nursing. Common themes are then identified across these transformed units to arrive at a number of themes, which are then synthesised into a general synthesis for each participant, and these in turn into a general synthesis for all the data. As part of this process, key constituents are identified.

Each transcript is first split into meaning units. Then the use of free imaginative variation, within the attitude of the phenomenological reduction, aims to result in the emergence of the essential psychological characteristics of the phenomenon under study, without which, or beyond which, the phenomenon would 'collapse' (Giorgi & Giorgi 2003: 246). As a result, transformed meaning units and themes emerged that began to delineate a structure relevant to the question. A single individual synthesis for each research participant was necessary, as well as a general synthesis to include all the participants. Thus, an attempt

is made to preserve the variations in the data of each participant, as well as biographical integrity, through individual syntheses (Von Eckartsberg, 1998).

The interview transcript, as well as the stages of analysis, from meaning units to transformed meaning units, and transformed meaning units to themes, for Participant 3 are presented in Appendix 3, along with her general synthesis. Participant 3 was chosen as she seemed to embody most of the themes discussed in the findings, and it was particularly clear how she embodied the 'being with' aspect of the therapeutic which is at the heart of the findings both with respect to the therapeutic and learning. As discussed in the Method chapter, findings in the empirical phenomenological method are contextual, so no universality is claimed (Giorgi, 2009). The findings are presented with reference to the general synthesis for all participants, and examples of key constituents are traced from the original interview data, meaning units, to transformed meaning units, and themes. The findings are presented through key themes, or structures, along with the key constituents in that theme, in order to link with variations in the data, since "the ultimate outcome of phenomenological scientific analyses is not just the "essential structure" but rather the structure in relation to the varied manifestations of an essential identity" (Giorgi, 1997, p. 242; Giorgi & Giorgi, 2003).

The chapter is organised so that, firstly, there is an introduction to the general synthesis for all participants. The general synthesis for each participant is presented in table form in Appendix 4. Secondly, themes relevant to the research question, subsumed under the headings of key themes from the general synthesis for all participants, are presented with links to the original interview transcripts with an accompanying discussion, which is an essential part of presenting the findings. Five key themes, or structures, related to the research question have been identified, which address key constituents and variations across the data. These themes are, firstly, that therapeutic activity is subordinate to administrative and medical activities, secondly, therapeutic activity is 'being with' clients over time through idiosyncratic

ways, which, thirdly, depends on innate personality characteristics; fourthly, learning is through practice and openness with others, including patients, and finally, learning is facilitated by a therapeutic environment. Within each key theme, examples of particular constituents, such as empathy, are discussed, including variations in the findings, as well as links to other themes, in order to keep in touch with the whole context in question.

5.2 Introduction to the general syntheses for each participant

The variety of themes across the interviews made it necessary to have a single synthesis for each participant and these are presented in Appendix 4. It seems significant that the interviews with some participants seemed to 'flow,' so that what was discussed appeared in line with variations on my own position in many ways, while also being revelatory, in particular with regard to 'something about' the participants. For example, sincere personal commitment to the other person, seemed to emanate from the person of the mental health nurse in some instances, such as Participant 3. With others, for example, with Participant 10, the way in which the other person was spoken of seemed incongruent with respect to the participant's way of being. This will be discussed under the aspect of 'being with' in this chapter. The variety of views on what the therapeutic may be, and how it is learned, was striking, and reflected the wide variety of discussions in the literature. A basic, overarching finding indicated that as long as mental health nurses perform their administrative and medical duties, then if they wish to try to be therapeutic in the remaining, or interleaving time, how they do this is largely left up to their own judgement, and so they practice in idiosyncratic ways. They can practise therapeutically in their own ways. What is remarkable is that each mental health nurse reported that their practice was therapeutic, and their descriptions generally appeared congruent with this, while at the same time they often clearly worked in a multiplicity of different, and sometimes opposing, ways. This may indicate something to do

with being a human being rather than any fatal incoherence of thought, so in this way, idiosyncratic and individual ways of being therapeutic are part of the synthesis.

The method of analysis is aimed at elucidating what essential structures, or themes, may run through these ways without losing touch with the context and variations across themes. The key themes which have been identified relating to the therapeutic are about ways of being with another person, and the various personality characteristics mentioned cannot be removed from the context of this 'being with.' None of these ways of 'being with' were overly influenced by theoretical models (while there was some influence) and have been learned mainly through observing others and responding to the other person, as opposed to practising under the view of a formal, academic environment following particular schools of thought. 'Being with' is also a way of learning about how to be therapeutic. The clear implication is that mental health nurses are therapeutic based on how they have learned to be with others throughout their lives, and during their training this may be developed, or affected otherwise, by other nurses, colleagues, and patients. The implication is that mental health nurse training ought to focus on what is therapeutic about 'being with' others, but it appears that the therapeutic is not what mental health nursing is about primarily.

There was a clear dissonance between how the mental health nurses in this study (all but one) had to practice, through administrative and medical demands, and how they wished to practice, through being with others therapeutically, which caused some distress. From this study, it appears that mental health nurses are being prepared in university, and on placement, to be 'administrators' of the medical model of psychiatric care, while on a personal level nurses wish to spend time with patients in order to be therapeutic in their own ways. Most of the participants expressed an uneasiness about the focus on the dominant administrative and medical duties, while one said she would leave the profession if she could as a result (Participant 5), and another mentioned that her colleagues were leaving 'in droves' because

of the situation, adding that she herself would leave if her remit was so narrowed that she could no longer care for patients by being with them (Participant 7). Even the apparently progressive recovery model of care, which aims to challenge stigma, emphasise a person's strengths, and promote independence, in practice appears to have been subsumed under the medical model (assess, treat, discharge), which was noted especially by Participants 5 and 9.

Because of the amount of data involved, key themes from the general synthesis for all participants will be presented and discussed, and illustrated through key constituents, such as empathy, as well as from vignettes that show the interlinking of themes and their constituents between participants. In this way, a picture will be drawn of the findings without it being an exhaustive one. This is to illustrate context to an extent, and is in line with Giorgi's (1997, p. 242) method, in which, "once the structure has been delineated, one has to go back to the raw data and render intelligible the clusters of variations that are also contained in the data." As noted in the Method chapter (Chapter 4, Section 4.7), attention to variations have already given rise to the themes emerging from the data. The structure delineated here then relates to each individual participant's general synthesis, containing a number of structures, or themes, and to the general synthesis for all participants, containing a number of structures, or themes.

Aspects of each synthesis will be discussed in this chapter. If all the individual syntheses were to be presented visually, the constituents of each synthesis would overlap to varying extents, but with other aspects, of no less significance, 'outlying' these. One 'outlier' would be the need for a safe, reflective environment to promote openness and learning about what is therapeutic, which was introduced only by Participant 4, yet it seems of vital importance. She was a very experienced nurse, semi-retired, yet she showed a similar 'openness to learning from the other' to Participant 9, a newly qualified nurse. 'Openness to learning from the other,' then, seemed to be a personal characteristic, which could further develop in the right circumstances perhaps. 'Openness' came across in other ways, for

example, Participant 4 was the only one who mentioned that she needed to feel she was doing good and helping people, while adding, with humour, that it was said all nurses were damaged in some way (Transformed Meaning Unit 52). Similarly, and with a disarming openness, Participant 3 said that in this "thankless" job, what she receives is to "feel wanted and needed" (Transformed Meaning Unit 17). This openness itself invoked a sense of 'trusting' in her.

5.3 Key themes of the general synthesis for all participants

The key themes from the general synthesis are presented and discussed in this section, along with the key constituents of these, for example, empathy, and openness to learning from the other. These key themes, or structures, need to be thought of as being in relation to each other (Giorgi, 1997), and will be linked to individual syntheses and variations across themes. Five key themes, or constituents, related to the research question have been identified, which address key constituents and variations across the data. These themes are, that therapeutic activity is subordinate to administrative and medical activities, therapeutic activity is 'being with' clients over time through idiosyncratic ways, and depends on innate personality characteristics; learning is through practice and openness with others, including patients, and learning is facilitated by a therapeutic environment.

5.3.1 Overview

It is significant that none of the participants identified the therapeutic with the medical model in itself, and spoke in terms of the therapeutic having to do with being with people in various ways. Medication was seen as being a cure in certain cases, if used idiosyncratically, that is, tailored to suit a person's individuality (Participants 7 and 10). For all participants, it was seen as potentially stabilising for a person in order to enable therapeutic work. Reflecting the current emphasis in psychiatric care on recovery, the analogy of the 'broken leg' - that mental health problems can be managed in the same way as a broken leg, and follow similar

medical pathways (assess the condition, treat the condition, then discharge) - was given by several participants, and used to signify opposing opinions (Participants 5 and 7). For example, Participant 5 was dismayed at this analogy which her service managers advocated, and although she thought medication was essential to certain people, and helped remove distressing symptoms, those people who were then discharged as 'cured', or 'recovered,' could be seen in her home town shuffling along the streets, unemployed and friendless (Transformed Meaning Unit 31). She saw a major part of her work as being with those people in some way to improve their lives, and removing this aspect of her role - in her view, the therapeutic aspect - was distressing for her, making her want to leave the profession. Participant 7 was more optimistic about the 'broken leg' analogy of recovery, but was of the view that medication was not enough, and that some people would never be 'out of the system' (Transformed Meaning Unit 11).

Participant 6 said he had thought carefully about the research question, saying that the therapeutic was hard to define, but whatever it was, it was being side-lined by the focus on risk management. He was glad to be leaving mental health nursing, as it was so repetitive (Transformed Meaning Unit 43), and was glad to be changing career to a more medical role. He was the only participant who did not particularly want to 'be with' patients over time as it encouraged dependency, for him, although he regarded the therapeutic as something to do with how a person was treated respectfully in a relationship. He thought it was important for someone to be 'resilient' to life's general problems, just as everyone had to be, and he encouraged this, for example, by not calling to see someone if they phoned him. His comments, transformed below, in one instance (TMU7), appears to sum up the dominant recovery model of psychiatric care, with which he was aligned.

Figure 8 Transformed Meaning Unit reflecting Recovery Model Participant 6

> Risk can go up and down, and people can come to rely on him as he knows them very well, but he would tend to focus more on risk. With some people, there is a danger that they can become too dependent on the community psychiatric nurse. Following the recovery model, the focus is to promote individual skills and strengths in order to develop resilience to everyday problems (P6 Transformed Meaning Unit 7).

However, he spent some time in his interview talking about a nurse consultant who had inspired him once, because he treated patients like equals, and created such an environment that often patients would come back to 'hang out' after they were discharged. There was a sense here that those patients were acknowledged, recognised and given a sense of belonging perhaps, in an environment that was creative and playful. When probed a little in the interview as to why he thought dependency was such a bad thing, he noticed he began to "fiddle" with things, and he wondered whether it was some personal 'oddness' of his that he did not want anyone depending on him. He seemed closed to exploring this any further.

> R: Do you not want them to feel something there or is it like...? Are you trying to protect them from something? Because you said that a couple of times that you could get moved [away]...
> P6: It might be about protecting me...
> R: Protecting yourself?
> P6: Yes maybe... (long pause) … It's just how I've always been I suppose... perhaps I've an odd personality, I don't know... I'm fiddling with things now (laughs) …

What emerges is that the central role of mental health nursing is to ensure that key documentation (for example, to do with care plans and risk assessments) is up-to-date, and that psychiatric care is safe and managed (including restraining and/or secluding a person if necessary), along with administering medication and assisting in procedures such as electro-convulsive therapy (including forcibly if necessary). The significance of the nurse's uniform, only recently re-introduced on in-patient units after an absence of years, perhaps indicates the commitment to the medical model of recovery. The uniform is seen as a means of establishing a professional boundary by some of the in-patient mental health nurses in this study, indicating their alignment with a certain medical aspect (Participants 9 and 10), although all in-patient nurses in the study were ambiguous regarding its effects. The uniform was seen as

narrowing the relationship with the patient to a primarily medical one (Participant 8). Once this central role is taken into account, there is very little time left for what some participants view as what mental health nursing is in itself, that is, therapeutic practice (Participant 8), or caring (Participant 5).

The therapeutic aspect is a non-essential side-line to the main role, yet most participants were personally involved in this side-line and it appeared to be the reason they were mental health nurses. Links that were made with respect to why they were mental health nurses varied, from being spiritually 'called' (Participants 8 and 10), to having always been caring (Participants 3 and 10), to perhaps being damaged and hence the need to 'do good' (Participant 4), to needing to feel wanted (Participant 3), to gaining something therapeutic from being with others (Participant 7), and linked to an unwell parent in childhood (Participants 2 and 5). More implicit links were also present, including parents not caring in childhood (Participant 1), and to perhaps needing to 'connect' with others (Participant 8). Every participant spoke in terms of the therapeutic as 'being with' the patient in some form, including listening, talking and getting to know the other person, through idiosyncratic ways, and this has been defined as a key theme. The personal involvement of the mental health nurse might be summarised as 'I will be with you in ways that I find to be therapeutic,' and these ways stem from idiosyncratic learning experiences throughout life, as well as mental health nursing practice, 'which have impacted on me.' The 'experience of truth' of the mental health nurse is that these ways are therapeutic, and have been tested through trial and error as well as observing other mental health nurses. These therapeutic ways are linked to personal characteristics of the mental health nurse which imbue this 'being with'. These personal characteristics have been defined as a key theme, and it is important to view them as living ways of being in context, that have to do with the person of the mental health nurse and his, or her, responsiveness to the other person. These characteristics are sometimes explicitly

mentioned as ‘words spoken,’ and at other times emerged implicitly. ‘Being with’ is sometimes also spoken of at times in terms of the relationship, that something in the relationship itself is healing (Participant 5).

The key theme regarding learning was that it took place through practice with others, and this learning may have taken place since childhood. This theme was found in each participant’s interview except for participant 6. A theme closely linked to it, but mentioned explicitly only by Participant 4, defines another key aspect of learning, which is that it takes place in a therapeutic environment. This was implied in various ways with other participants. Both of these aspects indicate that learning in mental health nursing is especially vulnerable to other nurses and the environment of practice settings which they create. For example, Participant 2 spoke of working on a dementia ward in her training, many years ago, and the environment of fostering respect, and dignity, and treating each person as an individual, was strikingly ‘new,’ and still resonates with her (she is semi-retired). But it could also be imagined that the therapeutic ways of a mental health nurse could become impaired in an adverse environment.

5.3.2 Key Theme 1

Therapeutic activity is subordinate to administrative and medical duties

This theme was spoken of in the context of not having time to be with clients. It is included in the final analysis because it sets the scene, or is the background, for the rest of the research findings. The explicit and implicit meaning is that the role of mental health nursing is to provide the administrative and medical framework for the medical cure. For example, Participant 5 enjoys the medical side to an extent, seeing it as providing stability, and relief from distressing symptoms, for some patients:

> … I mean my area has always been with the clinic and Lithium clinic and the Lithium patients... (P5 MU 23-24 lines 207-222)

Also, the use of medication to attempt a cure was viewed by most as something that should be idiosyncratic, that is, considered on an individual basis. For example, Participant 7 (Theme 10), explains to a patient that medication is different to what is therapeutic about mental health nursing:

> **we work hand in hand with medicine… but medicine isn't just the answer, is it?** You know our medications are good but my message to my patients is that medication just isn't the answer we've got no magic pill that's going to go poof and everything's going to go back to normal what we have to do is **find ways** for you… to make things better… (P7 MU18 extract 324-343)

It is this 'finding ways' which is subordinate to the administrative and medical side, and which is expressed in different ways by participants. However, for each participant, in different ways and to varying degrees, this administrative and medical role, which one participant described as "soul destroying" (Participant 8, MU13) undermined therapeutic activity because it took priority and so much time, causing distress for most. The rest of what follows in mental health nursing then is subordinate to this role. Extracts from Participants 5, 6 and 8 demonstrate the kind of meaning unit that has informed this theme in the general synthesis, from 'short, sharp interventions,' to 'risk management trumps everything', to 'make it look like a business is running smoothly':

Figure 9 Administrative and medical dominance of roles

> Yeah… they want it to be... they're trying to make it more... **short sharp interventions** and I don't think that works with the type of clients we're talking about... because they've got a long-term mental illness that's going to be there... [gap]... and they're going to need help, support, to manage these problems for a long time... [gap]…yes... I find that really hard I find it so hard that I almost want to give up nursing if there was an option to give up nursing I probably would right now (P5 MU26 extract 234-251)

> With regard to therapeutic... you mean I mean I think when I looked at what you're proposing some of the things that stuck in my mind is the worry that... **risk management trumps everything else**, doesn't it? (P6 MU2 extract 15-22)

> the time that should really really matter doesn't get picked up because obviously the CQC or whatever don't look at that... then you look at all the stuff that hasn't been done then you look at what the ward looks like on paper… [gap]… it's soul destroying… [gap]…I would say soul

> destroying... it's not what I came into nursing I came into nursing to make a difference... not to **make it look like a business is running smoothly**... (P8 MU13 extract 196-210)

A confluence of variations on the theme may be demonstrated in a number of meaning units. For example, Theme 4 for Participant 3 is linked below with its relevant meaning units (Figure 10). She experiences the demands of the administrative and medical roles, along with high caseloads, as clashing directly with her sense of how she wants to be there for the person, often in intractable situations for patients (repeated suicidal thoughts, for example), and gets a "knot in her stomach" because she cannot concentrate fully, or give her time properly, due to other pressures. It is interesting to note that if she did not 'care' she would not be feeling this anxiety, and that she conveyed a sense of reassurance, commitment and security in the interview (to me). The experience of 'reassurance' made her words feel congruent when she spoke of commitment to the other person, and later on, bringing something of herself to the person, which I defined as 'humanity' as she had used the word 'humanise' regarding her role in the medical approach, which would indicate she had a positive view of this humanity:

> You're trying not to medicalise people, are you? You're trying to humanise them, in a medical environment… because, you know, their identity becomes a mental illness… … and you're reminding them I don't see you as just a schizophrenic or a manic depressive… (P3 Meaning Unit 16 (411-461)

Such terms as 'humanity' have to be held in the context of the whole synthesis and the interview. Note that each meaning unit is not fully exhausted by Theme 4, and is relevant to other themes also.

Figure 10 High caseloads impair time with patients Participant 3 (Theme 4)

High caseloads create imbalance between required documentation and time with patients, causing her physical distress (TMU20, TMU21, TMU22)

P3 Meaning Unit 20 extract (563-622)

P3: It's horrible knowing that there's people who are struggling, and as I said before, **your role is to try make them feel better**. **These can be chronic, chronic… issues**

…

P3: For a long time... and then you get to a point where **you try and problem solve** and you try and maybe change medication… because that might cause nightmares. Or you might try lift their mood, and moods become chronic…

…

P3: X---… who was having the nightmares and the suicidal thoughts… and two and a half years later you get to the point where **you don't give false hope, you just say, 'Right, well this is how it is then right now.**'

P3 Meaning Unit 21 extract (623-699)

P3: But then when **you get big caseloads… you start to compromise** your admin time or your training time because I suppose again it's down to your personal way of working… you prioritise what you're there to do… then that person… an increasing number of people still deserve that service…

…

P3: I don't know if it's quality but you try and give them what you perceive is the best you can give them, you know, that's… if you've been given that responsibility to work with that person… **And then you start to feel really stressed**…

…

P3: I think it's just, you know, you start to squeeze people in… and try and see 7 people in a day… **and then you get a knot in your stomach** because you might get the phone ringing and you don't want to answer it but you have to and you haven't got time for that…

P3 Meaning Unit 22 extract (700-726)

R: So, that sounds like something to do with your value, your own values, that you know if the phone is ringing somebody is ringing you… You don't want to let them down…

…

P3: Yeah… I mean, obviously, you get great, great days, maybe weeks, and you think I'm getting on top of it, but it doesn't take much to get really… **just needs a few people in crisis… Or…. And then you're back to chasing yourself again**…

…

P3: And it's that old familiar feeling, I'll get sorted… and then you have your own hope just like your patients do, you'll have your own hope that you'll get organised and get on top of it all…

5.3.3 Key Themes 2 and 3

Key themes 2 and 3 relate to 'being with,' and personality characteristics, respectively. The phenomena to which these key constituents refer are intimately linked in practice, and it is perhaps artificial to separate them; however, separating them is what the

method does as they reflect the descriptive way the participants use these terms as if they were separate to their person.

5.3.3.1 Key Theme 2

Therapeutic activity is 'being with' clients over time

As already noted, this theme was consistently present, with many variations; even for Participant 6, who saw the main role of mental health nursing as facilitating the medical as therapeutic cure. Participant 8 saw being with the person as what mental health nursing was in itself as a discipline, "…to me it is all about that interaction and having that rapport with someone... and building on that kind of relationship with that person…" (P8 MU14 line 217).

'Being with' involves a whole complex of ways of being, along with characteristics, and significantly this takes place according to the idiosyncratic views, capacities, and character of the mental health nurse. There is the view, sometimes explicitly spoken, that 'if I don't suit the person, then one of the other nurses will' - indicating that what is therapeutic is seen as idiosyncratic, based on the person of the nurse and the person of the patient. In the research method, these ways of 'being with' comprise 'listening to,' 'talking with' and 'getting to know,' the person, although always in relation to the wider context of other themes. Before illustrating this key theme and its relations as part of the whole synthesis, some examples of how this is expressed across different participants are listed below, as well as a confluence of key constituents from one participant. Examples of key constituents are 'closeness,' 'making them feel important,' 'she gets on with me and accepts me,' and 'talking about their innermost thoughts and feelings'.

Figure 11 Examples of key constituents of 'being with'

Yeah but I think because you've developed **closeness** in a weird way, not in a personal way… [gap]…Or… you know, it's understood that I can talk to you about my personal problems within our appointment time, however, you've got a closeness where you're

> allowed into their world and you know about their abuse, all the relationship problems, or… the dark things that they think… or the suicidal thoughts they have that have don't tell anybody… or the nightmares… and that's really personal… (P3 MU19 extract 536-561)
>
> well I know... for me it involves a lot of listening and a lot of conversation... talking a lot of listening and stuff and sometimes that in itself works... …do you know what I mean... when I speak to someone giving me an idea of who they are where they come from their life story... kind of building on that... developing on that really **making them feel important**... (P8 MU2 extract lines 16-22)
>
> No, I don't think I have, no. It's not CBT it's not... no, no, it's nothing at all… it's just… (long pause) … Perhaps it's both of us - **she gets on with me and accepts me**… …I suppose over the years we have discussed other things, you know, like my dog. I suppose she knows a little bit about me… Because… yeah, and X, she isn't someone who you'd be doing, setting the CBT. She's got chronic schizophrenia really… she'd tell you where to shove it… (P2 MU7-8 extract lines 77-95)
>
> You know with nurses you've got to have some time to build up a therapeutic relationship… you know they've got to trust you because they're **talking about their innermost thoughts and feelings**… things that you know you we wouldn't want to divulge really… (P7 MU5 extract lines 82-100)

A confluence of meaning units with key constituents relevant to 'being with' are outlined below for Participant 3. This theme, which is included in Participant 3's general synthesis, as 'prescription of humanity,' comes from her description of how she manages when medication 'fails' (although it gives the doctor a way to "feel helpful"). "Talking to that person and giving them that time" becomes the 'prescription' that she can make; other factors also come into play here, regarding how she is as a person, how she commits herself, no matter what the struggle may be: "… you just keep being there… because that's all you've got left…". Her 'being there' however, involves a sense of reassurance and commitment, so that she will try all avenues to help, along with something to do with her own self.

Figure 12 Examples of 'being there' Participant 3

P3 Theme 16:

Being a community psychiatric nurse is more than just overseeing medication and risk. If it were not, then paperwork would always be up-to-date and nurses would not be so busy. Talking to the person, giving them time, is like a prescription of humanity in a medicalised environment. By visiting patients personally, P3 means to show them that she does not just see them as a psychiatric diagnosis.

P3 Meaning Unit 16 (411-461) P3 Meaning Unit 20 (563-622) P3 Meaning Unit 36 (994-1007)

P3: But, you know, if a CPN is just to oversee medication and to oversee risk, well then all that sitting with somebody for an hour every two weeks is not necessary, it could be a phone call, couldn't it?

…

P3: 'Are you alright? Everything ok? Meds ok? Any side-effects…? I'll ring again in a couple of weeks to check there's no changes.'

…

P3: It's more than that. It has to be, or else what's the point of all these visits?

…

P3: I think it has to be… to know that person… that therapeutic side… it has to be… **Because talking to that person and giving them that time… is the prescription in itself, I suppose, or that's what it feels your role has become**… I don't know.

…

P3: You're trying not to medicalise people, are you? **You're trying to humanise them, in a medical environment…** because, you know, their identity becomes a mental illness if they're seeing a mental health nurse and you're reminding them I don't see you as just a schizophrenic or a manic depressive…

P3: For a long time... and then you get to a point where you try and problem solve and you try and maybe change medication… because that might cause nightmares. Or you might try lift their mood, and moods become chronic…

…

P3: X---… who was having the nightmares and the suicidal thoughts… and two and a half years later you get to the point where you don't give false hope, you just say, 'Right, well this is how it is then right now.'

…

P3: yeah… I suppose I do**… you just keep being there… because that's all you've got left…** well, you know, well we've got a really strong rapport now and you can tell me that, so I can't make it go away but at least you can talk to me and we can have a coffee and… and I've understood…

…

P3: When you break it down it sounds difficult… you just do it because it's…

…

P3: It's what you have to do…

P3: And **to feel helpful because that's their area…** and has a nurse, ok, you've got all the talking, but the practical side of nursing is, **I can fill out your benefit form for you, we can go for a coffee, we can get out of the house, I can get you a support worker, or I can refer you to therapy… but that's not enough for you… let's review your medication and let's talk in that medical way and then you feel like this is normal, what's going on, because maybe a tablet will help as well…**

The variations across this theme, involving, getting to know, listening and talking, show the idiosyncratic ways in which mental health nurses are with others therapeutically. The themes of listening to, and talking with, were best exemplified in Participants 9, 3 and 4. Participant 9 in particular, appeared to have thought carefully about how she listened to others, and wished to 'make space' to enable the other to speak. This was remarkable as she was one of the youngest nurses, with the least experience, yet there was something about her that made the atmosphere of the interview 'open.' She said that conversations could be serious

or like a chat, and she revised her suggestions and ideas in response to how the patient responded, accepting if she was getting it wrong. She tried to be honest, but not in an invasive search for transparency. This gave the sense that she was open to learning from the other person, whether patient or colleague, and it came across in how she was in the interview. A whole range of themes are here which span her synthesis, and the general synthesis, emanating from the theme 'being with.' She is also aware that sometimes what she thinks has helped (has been therapeutic) may not have done, and she is open to thinking about this rather than being dismissive of the other person:

Figure 13 Example of openness to the other person Participant 9

There are times when a person has told her that talking has helped, but equally, with personality disorders, the person has self-harmed even though she thought the conversation had helped. Sometimes, the person with a personality disorder has said that the conversation has helped and then have done something like self-harming afterwards. This is difficult for her, as the team then feel they are not doing much to help and the behaviour escalates. Trying to understand why the person is in need of a certain kind of attention, but cannot communicate that well, is important (P9 TMU14)

Participant 3 also had a particular, noticeable, way of 'being with', which came across in the interview. As noted, strangely, what was 'given' in her company, during the interview, was a sense of safety or being reassured. She spoke about the importance of being genuinely interested, and listening carefully, being open and treating the other as an equal. There is something in common here with Participant 9, where she is willing to review her ideas and learn from the other. Participant 3 said she would become personally involved, and make commitments to the person that she would keep. She is neither optimistic about psychiatry, nor "tender loving care" (her words), as offering a cure for a person, and will do what she can by being with them:

Figure 14 Ways of 'being with' a person Participant 3

At first, P3 thought she was going to cure her patients through tender loving care, and through helping them manage their illness and associated problems. But she sees this hope of curing them as naïve now. She began to feel helpless and sometimes depressed that there were so many people asking her to talk with them, sharing their problems with her. She felt she had to be available for each person as **she was often the only person in their world who actually cared enough to sit and listen to them.** She did not want to feel she was letting them down by not being available… (P3 TMU3 extract)

Being a community psychiatric nurse is more than just overseeing medication and risk. If it were not, then paperwork would always be up-to-date and nurses would not be so busy. Talking to the person, giving them time, is **like a prescription of humanity in a medicalised environment.** By visiting patients personally, P3 means to show them that she does not just see them as a psychiatric diagnosis (P3 TMU16)

P3 treats her patients as equals. P3 **feels she is a sounding board, a best friend and confidante** to her patients. It is a thankless job because it is expected that she is this way. The feedback she gets is that she feels wanted and needed. Patients always say they feel better after talking to her. P3 believes it is cathartic for them (P3 TMU17)

This 'being with' however, appears to depend on the person of the mental health nurse, as well as including what he, or she, has been caught up in throughout life, and has been able to learn through this. For example, working in two similar situations in different settings, Participants 4 and 10 show markedly different ways of 'being with' a person while both understand what is happening to be therapeutic. Both recount different scenarios in which a patient is thinking seriously of strangling or hanging themselves, and respond through 'being with' but in different ways. Participant 4, akin to Participants 3 and 9, shows patience and a willingness to learn from the other, while Participant 10 shows impatience and a desire to uncover the 'real' problem 'underneath' for the patient. With Participant 4, the situation may be somehow resolved through speaking about what has triggered this event, or by being with the person and allowing them to talk as they wish:

Figure 15 Speaking and listening Participant 4

…I would try and get them to talk about how they are feeling why they are feeling like that, why are they feeling hopeless and helpless, what happened what's triggered them off to make them feel like

> that and then because you know that patient, you know, what would work in the beginning, you know, what would what has helped in the past like, and so you might be thinking that in your head but **you might just have to let them actually just talk and just be there with them you may not even have to say anything you may just have to let them talk to you** (P4 Meaning Unit 33 lines 409-415)

The transformed meaning unit reads:

> In the example of someone threatening to hang themselves, she would stay with the patient, and ask them to talk about how they were feeling, why are they hopeless and helpless. She would be interested in what triggered them to feel this way and how they had managed before when this happened. But she may also not ask anything, and just be there with them, allowing them to talk. It can be about listening, hearing and being there with somebody (P4 TMU33)

This example shows that there are other aspects also in play. There is a real sense that Participant 4 is thinking in complex ways, being responsive and open, making judgements as to what is the best way to respond for this person, which links with other themes in her interview and individual synthesis. From the tone of voice in her interview, as she recounts this, it is clear she is showing positive regard (perhaps from her person-centred counselling experience), as well as self-containment, genuineness and commitment (all constituents of the general synthesis). She has spoken about each of these factors also elsewhere in the interview. There is a sense that these characteristics are genuine and embodied in her way with others, including with me.

In contrast, Participant 10 responds in a different way to a patient (who was sexually abused by a neighbour) who wants to strangle herself. She firmly holds her paient's hands while sitting on the floor of her room, and after a while, asking her 'what is this really about,' at which the patient, after some time, breaks down in tears, sobbing about the death of her father. This cathartic expression leads the patient to not 'dissociate', which is another way she has of coping with the trauma of other losses. After some time, sobbing, she tells the mental health nurse that she never cries. Participant 10 sees this as a breakthrough for the person, which it certainly appears to be. She spent two hours with her sitting on the floor of

her room. However, there is an incongruence in the way this account is related, as what triggered the event was the news that the person's pet rabbit had died, and Participant 10 recounts:

> …and I'm holding her hands and trying to stop her doing anything and she started to cry and she started to talk - first of all about the rabbit and after a bit I thought this is nothing to do with the rabbit this is not about a fucking rat! - you know what I mean? …there's something else, so I said to her, "What's this really about?" (Meaning Unit extract lines 699-722)

How Participant 10 recounted this gave the impression that the rabbit did not matter, and what really mattered was getting to something 'underneath' (another theme in her individual synthesis). As she recounted this, it felt as if her attitude was not therapeutic yet her actions had been. It appeared that she felt that the therapeutic depended on full empathy, fully understanding someone in this case, and so for this reason, it could not be about the rabbit as she had no time for the pet, calling it a 'rat.' She appears to view the connecting to unexpressed feelings, and connecting with a 'hidden' experience, as cathartic, and therapeutic, yet she seems somehow out of touch with herself and the other person.

At the same time, perhaps there was something about how she was willing to stay with the person in distress, holding her hands to prevent her harming herself, sitting on the floor for two hours, and wanting to be of help, that made a difference. In this way, her actions have also been placed under 'idiosyncratic and personal ways,' and 'something in the relationship is therapeutic, through the healing of past trauma'. It is interesting to note that a key theme for another interviewee, Participant 5, was that a mental health nurse had to 'want to be of help,' so that even if they were in a learning process, and misguided in their efforts, that somehow a genuineness would come through in their efforts which was therapeutic.

As can be seen from these two examples, 'being with' may involve contrasting attitudes, and beliefs about what is therapeutic, as well as embodied ways of being with the other person. As such, it appears to be highly personal and idiosyncratic, as to what is

therapeutic about 'being with' a person. A range of examples of this include the following: Participant 10 prays with a fellow patient who finds this therapeutic; Participant 1 gives a woman a manicure, based on how she feels when she sees her own hairdresser; Participant 2 goes for a coffee with a woman she has known for years; Participant 5 listens patiently to a person recounting the same problems which have repeated over many years in different guises; Participant 9 and Participant 8 find time to sit with a patient on a busy ward. These perhaps 'ordinary' activities are motivated by a certain thoughtfulness to be available to the other person, and emerge in idiosyncratic ways which appear to suit the moment. One implication is that a lot of this depends on tacit knowledge through life experiences, tacit ways of having learned through practice, and 'being with.' When questioned about whether she is using skills with a particular person, Participant 2 says she is just getting on with someone:

> No, I don't think I have, no. It's not CBT it's not... no, no, it's nothing at all… it's just… (long pause) … Perhaps it's both of us - she gets on with me and accepts me…. [gap]…**I suppose over the years we have discussed other things, you know, like my dog. I suppose she knows a little bit about me…** (P2, MU7 extract lines 86-92)

As discussed, there is something here about reciprocity that is implicit. Again, with Participant 2, a relationship has developed over time with another client, and she engages with her in quite 'ordinary', or idiosyncratic, and playful ways (illustrated in Figure 16).

Figure 16 Ordinary and playful ways Participant 2 Theme 1

Being therapeutic does not require educational skills, as it can be to do with listening, talking, being playful and genuine, giving someone time, and getting to know somebody (TMU1, TMU2, TMU3, **TMU4**, TMU5, TMU8, TMU22, TMU23, TMU26, TMU27, TMU35, TMU55)

P2 **MU4** (lines 48-59)

R: So what helped then with you? Is it because you knew her for 8 years? Is there something there about the relationship with her…?

P2: Probably… because I have known her for 8 years and… you know and if I ever see her outside Y I always go and have a chat with her…
R: **What's the chat? What's in the chat?**
P2: **Nothing much… (she laughs)**
R: Like what?
P2: **Well she usually says something like, 'you look gorgeous,' she's a real character…** she's a real character… and it's not like her to be prodding and… so I think we need to make sure she's getting her meds now.
R: So do you say things back to her, then?
P2: **Yes, I'll say back, 'Oh you look pretty gorgeous too.'**
R: And what else do you talk about then?
P2: **Her family, her brother, just general general…**

This personal touch, and friendly way of being with a person, is similar to how Participant 3 talks about spending time with someone. If she prescribes anything, it is perhaps this time spent 'being with' the other person:

> I think it has to be… to know that person… that therapeutic side… it has to be… **Because talking to that person and giving them that time… is the prescription in itself, I suppose,** or that's what it feels your role has become… I don't know (MU16 extract 436-438)

In a similar vein, Participant 1 (Theme 1) may work with women by doing their nails, and the whole context of this, which also involves touch, is therapeutic. This meaning unit, as a transformed meaning unit, becomes one aspect of Theme 1. Meaning Unit 2 touched on several aspects of the relationship and here what is being traced is the importance of touch, and sensory experience being shared (while other aspects also combined to form Theme 1). Participant 1 has learned from being with her hairdresser that this kind of interaction is therapeutic. How this aspect becomes part of her general synthesis is illustrated in Figure 17. Key constituents that can be seen as part of the synthesis are 'transparency…by checking', and 'sharing sensory experiences' (surprisingly, she emphasised using her "senses" with a person).

Figure 17 Therapeutic use of self - Participant 1 (Theme 1)

The therapeutic use of self includes body language, **sharing sensory experiences** with other females and offering practical activities such as a manicure, often combined together. It also includes **checking carefully** with the other person what has been helpful (TMU1, **TMU2**, TMU10, TMU11, TMU37, TMU45, TMU47, TMU49, TMU50)

Transformed Meaning Unit 2

Manicures and hand massage activities are therapeutic, only with women, and develop trust, allowing the other person to talk and interact, which is therapeutic. P1 checks with a person first if they would like a manicure. P1 finds talking with her own hairdresser therapeutic, sharing her private concerns with her; she feels the same therapeutic effect happens between her and her patients when she does a manicure. It also conveys a sense of belonging and familial support. She also can assess the other person's levels of anxiety.

P1 **Meaning Unit 2** extract lines 71-85

P1: **I sort of identify different things which are important to those people which I can talk about** so emm if I noticed that a lady does actually use nail varnish, or she has particularly nice nails, whatever, or she doesn't… you know, we get chatting about that… **then I can say I'll tell you for next time I'll bring me nail polish with me** and you know we can do your nails and what you think of that?... and straight away they go, oh no, no, I don't bother with anything like that then I know I'm going down the wrong track, but generally you'll find once you've got that trust with someone they're quite happy…

R: And is there something therapeutic about that?

P1: Absolutely

Perhaps the most flamboyant of all the participants, Participant 7 was confident about speaking about how being with patients made her "feel alive", and as such, being with patients was therapeutic for her (Figure 18). This reciprocity appears to indicate something indefinable about the therapeutic aspects of being with another person, and was an implicit theme throughout all the interviews.

Figure 18 Reciprocity of the therapeutic Participant 7

She loves nursing because of the patients. **The challenges and the range of feelings she gets working with people makes her feel alive.** She feels honoured and privileged at times to be part of people's lives, that people let her into their lives for her to help improve things for them (P7 TMU13, MU13, lines 256-265)

the feelings that you get the emotions the good and the bad it makes me feel alive (P7 MU13, line 261)

In what ways learning was occurring and to what it was addressed in the mental health nurse and the patient was idiosyncratic. Participant 7 said at the start of the interview that she had been depressed for some time after her mother died, that she was unable to leave her house and had never experienced anything like such anxiety. She said that she shared this with some of her depressed clients sometimes to show they could recover too. However, later in the interview, as she was speaking about having had a very caring mother in the context of how she had learned to be therapeutic, I asked her if perhaps she was being like her mother to her clients. Her voice became sharp and aggressive momentarily.

> R: So, are you a bit like your mum with your patients?
> P7: What do you mean? [sharply]
> R: I mean you have had a very good mum and it sounds like you've picked up stuff from her, you've learnt from her...
> P7: Yeah, I think subconsciously I have...
> R: Are you are you doing the same with your patients then, are you being like a very good mum...?
> P7: Oh no, not like a good mum, I'm certainly not like that
> R: ok
> P7: Because I think sometimes they hate me...
>
> She does not think she is like her mother with her patients as her patients sometimes hate her (Transformed Meaning Unit 7).

The transformed meaning unit here is a description whereas the possible meaning of her sharpness, that she perhaps had difficult, or aggressive, feelings towards her mother, is an interpretation. Yet such an interpretation would have been worth exploring for her. This fragment gave a sense that there was something 'closed off' for her about being available to others, and it crossed my mind that perhaps this was why she had a bubbly approach with patients, where she 'got things done', which was not especially reflective. I wondered whether Peplau's (1988) sense of the nurse learning from the patient, and the therapeutic being reciprocal, may be hampered by this 'closed' feeling.

5.7.3.2 Key Theme 3

Therapeutic activity is linked to innate personality characteristics

These characteristics were spoken about explicitly, or were sometimes implicit. This section will present some examples of these characteristics and how they emerged from the interview data through the method. To varying degrees, they are repeatedly referred to by participants, and sometimes imply a tacit understanding and with varying meanings. For these reasons, it is felt that is it useful to discuss them in context, which will overlap with other findings, as they emerge in context. The following characteristics were found across all participants: being enabling, genuineness, respectfulness, reliability, responsiveness to the other person, being reflective, accepting, caring, compassionate, attentive and empathic. In addition, other characteristics that participants found to facilitate being therapeutic were: tact, affection and inclusiveness, resilience, self-containment, openness to learning from the other person, self-confidence, commitment, equality, individuality, and being able to tolerate in others, and feel in oneself, physical and emotional distress. These characteristics are interwoven with the 'being with' of the mental health nurse.

A striking factor was the view that these characteristics are all innate, or have been developed in childhood under individual circumstances, and although cannot be taught, they can be 'brought out', or developed further through practice. Due to lack of space, only some of these characteristics will be discussed here in detail, through examples, of how these are integral to the person of the mental health nurse, as well as some incongruence as to how they are spoken about and conveyed.

Participant 1 divides competencies, which can be 'brought out,' from skills which can be learned (P1 MU13 lines 263-276) (Figure 19). Competencies are innate, but may have been stunted in childhood.

Figure 19 Competencies versus skills Participant 1

P1: …when I'm having conversations with people now, so I think that sort of… those competencies if you like as opposed to… **they have to be in you and they're brought out, I think.**

R: You mean they were in you already before you were in X----?

P1: Yes, because -

R: And someone just brought them out?

P1: Yeah. Cos you've got, I think competency and skill are two different things. **Skill for me is something that you can learn but a competency is something that you have in you.**

R: You have in you?

P1: Yes. Yeah.

R: How does it get in there?

P1: Ehh, I think it's just… I don't know...! **But I think how does anyone's personality get in there really?**

Immediately after this, she goes on to say how the researcher's personality is that of a "shrinking violet" (implying this was caused by some kind of damage in childhood):

> P1: Yeah. So, you've got somebody who's… **Let's face it, you're a shrinking violet**, but I believe but then… You see I believe, this is what I believe, that everybody… when they're born, has the ability to develop and communicate and hone their skills and I believe that the only reason that that doesn't happen with people is because they're stopped from doing it…
>
> R: Right… by who? By what?
>
> P1: By the parents, by society, by… **You know, there but for the grace of God**… there are a lot of… you know, instances, you know, when you think about what and how…

Although this was an accurate insight, her delivery of it was somehow misguided, in that it seemed to be coming from somewhere 'hurt' to do with 'faulty communication from a parental figure' perhaps. It is clear that my 'constituting subjectivity' is at work here in describing her response in this way, and it is an interpretation. Nevertheless, it is 'given' phenomenologically. A later topic in the interview seemed to align with this 'givenness' (MU39: 594-603, extract 602-603):

> P1: In that emm… I suppose from an early age it was quite accepting that **I would have to look elsewhere… for support and love, I suppose**… to from perhaps… my own father and mother… [gap]… In that, and that was given most definitely by my maternal grandmother

This also comes through in her insistent speech, and way of being, which was like a kind of vulnerable objection to something. She spoke about how her problematic family had made her resilient, yet it came to mind that by being 'resilient' she may be 'blocking' something which would actually make her vulnerable. The meaning of 'resilience' is immediately put under question here, yet she saw it as a positive characteristic. The transformed meaning units try to stay with the descriptive aspect, and focus on 'developing stunted competencies', and the characteristic of resilience which she felt was therapeutic, as opposed to the possible characteristics of being somehow 'needy' and overly caught up in herself in her views. In arriving at the research findings, a judgement has been made as to what is interpretative and what is not, so that an aspect of what the researcher's constituting subjectivity 'found', has been taken out of the findings. The transformed meaning units therefore have dropped the sense of 'she is coming from somewhere hurt' in the 'between' of her words, to arrive at:

> P1 sees part of her therapeutic work as **drawing out competencies and developing skills** in the other person, including the ability to communicate well, **which have been blocked or stunted** due to family and societal circumstances (Meaning Unit 14: 277-286 to Transformed Meaning Unit 14)
>
> Alcoholism in her family made her **resilient** in the sense that she realised **she could not look to her parents for love and support**, and needed to look elsewhere (Meaning Unit 39: lines 594-603 to Transformed Meaning Unit 39)

It is interesting to note that after this interview, she asked if she could come and talk occasionally about difficult patients. I readily agreed but she never followed through even though I approached her twice in the weeks afterwards to make time for her. The competencies she spoke about were resilience and the ability to challenge others, while elsewhere she also saw herself as being independent of psychiatry in her therapeutic practice, and was self-taught a lot through her own reading. The picture emerging tentatively in the interview was that she did not find it easy to ask for help from others and it seemed reinforced by her later reluctance to meet, perhaps with a figure who represented a neglectful parent.

These aspects, viewed as interpretative, were not included in her synthesis. Yet they indicate how a certain form of therapeutic education might be helpful for her, where she could learn to look safely at some of these possible difficulties.

Caring is perhaps synonymous with nursing in general, and all participants spoke about it as being essential to mental health nursing. It is here outlined in some of its varying meanings in this study, as mentioned above, with respect to how idiosyncratically the idea of caring is conceived. All participants felt caring was an innate characteristic, although Participant 1 believed one could be caring without being therapeutic. What she meant by this was that she could 'do her duty' as a mental health nurse, in providing information, or administering medication, even following the 6 C's (Cummings & Bennett, 2012), but without actually being able to be therapeutic with that person. In this case, she was referring to an alcoholic, and she had no wish to be available for him, due to her childhood. Caring for her was separate to being therapeutic.

For Participant 5, caring was what was therapeutic about mental health nursing and did not involve skills, such as cognitive behavioural therapy. Participant 5 described how her ability to care developed through her mother being unwell as a child (P5 MU17-18 extract lines 142-166) (Figure 20).

Figure 20 The influence of childhood Participant 5

P5: to be honest with you **I think I remember now why I went into nursing what made me...** because my **mum was very ill all through my childhood** and a lot of my... carers that came in some were brilliant… again… but we had some pretty miserable ones… that as well… and I remember as a teenager **watching them treat her and I didn't think it was good enough** you know and I think that's made me want to be a nurse that I can go with and maybe do something a bit better and I think yeah … [gap]…

P5: yeah… I think that shaped for me a lot how people should be cared for... and... I think what I'm trying to say is that **I don't think that can be learnt on a course** or... … or a textbook... ... I think that comes from...

At the same time, it took some time for her to start to speak this way in the interview. Her voice was faltering for some time, as if she was waiting for me to show her what I wanted so that she could try to 'care' for me by providing it. I wondered about this to myself in the interview, until finally I told her that I was interested in what *she* thought more than anything. Caring then for her might be about 'putting the other first'. Her voice changed after this and she said how she always 'spoke up' for patients, and would defend their wishes, despite being under pressure to conform to what a psychiatric team thought was best. In this case, she referred to preventing a woman being given electro-convulsive treatment by strongly representing her in a meeting. Indeed, the tone of her voice changed when she touched on this, opening up to show a self-assuredness that up till then had been hidden.

> She thinks being an advocate is a really important part of the mental health nurse's role. In a few Care Program Approach meetings, she has made herself unpopular with the consultant by stating that if a patient does not want a treatment they should not be having it (P5 TMU47, MU47: 485-489)

This becomes in the reduction and free imaginative variation, 'She is an advocate for people who are not heard' in her general synthesis. There seems to be something here about her mother not being heard, not being cared for properly when she was a child also perhaps, as her voice carried a new conviction when she spoke about it.

As discussed above, Participant 2 links the motivation she has to be a mental health nurse with her father, which was touching for her in the interview (P2 MU14 extract lines 189-204) (Figure 21).

Figure 21 The influence of childhood - Participant 2

> P2: …but I think that **the thought my dad could have been there**… that's what I want to do… and I think I've always tried to do… **I've always felt I want to be as if it was my dad**… anyone that I knew having treatment I wanted to… hopefully give what I would want them to get… and that I think I've always based…

She connects this with how impressed she was in her training on an elderly ward when a senior nurse allowed patients to get out of bed at their own pace, or have breakfast in bed, treating them as individuals with respect and dignity (P2 MU13 lines 163-187):

> P2: Yeah. Dignity, and you know if you've been in hospital all your life 6 years or whatever, you do want a lie in, don't you? So 9 o'clock, I thought that was a lovely way of doing it… and there was no pressure on to have everyone up and dressed, you know, what will be will be… so that was nice and… [gap] **… Dignity…**

From Participant 2, Meaning Unit 14 has contributed to the theme of 'affection' while Meaning Unit 13 has contributed towards that of 'respectfulness' in the general synthesis for all participants. These have contributed towards Theme 10 and Theme 11 for Participant 2 (Figure 22).

Figure 22 Respect and affection Participant 2

P2 Th10	P2 Th11
Caring to respect a person's dignity is therapeutic (TMU12, **TMU13**, *TMU15i*, TMU34, TMU36)	Treating a person like someone she loved is therapeutic (**TMU14**, TMU16, TMU17)

In the subsequent meaning unit (Figure 23), she is not sure of the effects of her father on her decision to be a nurse, and she says there is also something innate in her that wants to care.

Figure 23 Wanting to care may be innate Participant 2

She is not sure whether mental health nursing is linked to her father. It struck her later on that he had died so young and so suddenly. He was the senior engineer at XY and within 6 months of stopping work he died. The onset of his illness was very sudden. It is shocking to think about it and how many years she has outlived him. She had not thought that perhaps being a nurse comes from all those years before. But she thinks that that is how one is also. She has always thought that if someone were in hospital she would want [others to care] (P2 TMU15)

These transformed meaning units have been reduced to ‘treating a person like someone she loved is therapeutic’, while there may be perhaps more to this, as indicated above, to do with complex feelings towards her father. For her then, caring was about affection, although she also saw that sometimes it was not enough in order to be therapeutic, when speaking about a client who tried her patience. What she meant was that being therapeutic sometimes had to involve thinking through an approach with somebody, which the psychologist had helped her do, as well as being a parent, and some training she had completed (Figure 24). In this instance, she meant keeping a consistent ‘boundary’ (her word) with a particular person who was derogatory towards her.

Figure 24 Thinking through with others Participant 2

She completed some degree modules in personality disorder at university, which taught her skills such as keeping boundaries. She already had some idea because as a parent, boundaries also create security for the child. The psychologist and P2 were keeping boundaries with the patient. Before there were psychologists on the team, she would not have known about it as much. People with personality disorder only came into the service after the Mental Health Act, as before that they were excluded. In her nurse training, she had not learned about personality disorder. She is not sure if it is a skill or not, but she thinks she got on well with this patient (P2 TMU40, MU 40 lines 617-639)

In all cases, being therapeutic had to do with enabling others, and this was emphasised to varying degrees by different mental health nurses. The variations in this characteristic was shown across Participants 4, 5 and 6. Participant 5 wanted to have a longer term, caring relationship because she felt her patients needed this, while Participant 6 was somewhat personally averse to any kind of dependency being developed. Participant 4 was somewhere in between these poles, feeling she should be ‘caring without disabling’ (Figure 25).

Figure 25 Enabling others - Participant 4 (Theme 8)

Being caring, compassionate and enabling is therapeutic (**TMU9**, TMU45, TMU46)

P4: I think it's just you've got to show that you are you are caring and enabling rather than being caring and over the top if you know what I mean it's difficult to explain… [gap]…**you've got to make sure I think that you don't disable the person …** [gap]…and by seeing what their strengths are you can work with them so they feel empowered …[gap]…rather than… you sort of doing everything for them… [gap]…so it's about getting that relationship whereby **you are enabling them to fulfil their potential** rather than everything you can't do for them… (P4 **MU9** extract lines 92-108)

Participant 3 shows resilience, in her case, the ability to 'stay with' someone in distress, and self-containment in the following extract, while also indicating she is committed to the person, as noted above (P3 MU20 extract 563-622). Self-containment here is about 'being able to feel and tolerate emotional distress, including her own.'

> yeah… I suppose I do… **you just keep being there… because that's all you've got left…** well, you know, well we've got a really strong rapport now and you can tell me that, so I can't make it go away but at least you can talk to me and we can have a coffee and… and I've understood…

Commitment to the other person, for Participant 3, is illustrated in Figure 26.

Figure 26 Theme 2 Commitment to the other person Participant 3

Theme 2

Because of her role, she feels she must not disappoint anyone who relies on her, and she commits herself to them so they know she keeps them in mind (TMU3, TMU4, **TMU7**, TMU44, TMU45, TMU46)

Transformed Meaning Unit 7

When P3 first meets a patient, she tells them what she can offer them, explaining her role and that of the community mental health team. **She makes unsaid promises to the patient. She explains that the patient is not alone now, that she will be there for the patient until things settle down, someone the patient can call on.** She knows she is making commitments to the person that she will keep (**TMU7**)

Meaning Unit 7

P3: Well, I think as a cpn… it's different now which is another thing… when I have been doing the community nursing the first few sessions you can see there's a pattern every time, you get to know each other so you start off the first few sessions you put your stall out - this is what I can do for you - you make sort of unsaid promises don't you?

…

P3: Yeah, we're going to, you know, this is what I do, this is my role, this is what the team does. You might have met them in hospital so someone's coming now, come to see you when you leave hospital… **you're not on your own - somebody's going to be here**, aren't they?

….

P3: To help them to… **until you feel better until you settle down… I'll be your named nurse, someone you can call (P3 MU7 extract lines 149-189)**

In Figure 27, Participant 9 listens in a way that facilitates the other to speak, by being attentive and responsive to the person, opening up a space to speak.

Figure 27 Listening and being open - Participant 9 (Theme 17)

Listening, and allowing the other person to speak, is essential to being therapeutic (**TMU17**, TMU18)

P9: Yeah quite often she asked she'd asked for certain nurses... so... I was doing something right if she asked for me when she needed to talk...

R: What do you think you were doing right?

P9: I think in that case it was listening... because she did struggle to talk to people she had X... so it was... I think it was the listening in that case... **I don't I don't think everyone like sits quietly for a while like if someone is not talking they'll say something in the gap**... often not saying anything to someone will then say something and fill the gap in for you...

She demonstrates openness to the other person, genuineness, and treating the patient as an equal, developing trust, in an ordinary way (Figure 28).

Figure 28 Developing trust and openness Participant 9

P9 Transformed Meaning Unit 26 (**TMU26**)

She will say she has got something wrong and ask what she can do in the future to help. She does not see the point in being any other way, that is, closed off. She has to build a level of trust and cannot do this unless she is completely honest.

P9: yeah **if I'm wrong I'll say I got that wrong I'm sorry**... what can I do in the future to help rather than saying the wrong thing… [gap]…yeah well... **I don't see the point in... in being closed off** about stuff like that... [gap]…because you've got to build up a level of trust and you're not going to build a level of trust if you're not a 100% honest... (extract from Meaning Unit 26 - **MU26**)

The characteristic of 'openness to learning from the other person', is something that Participant 4 shows in different and contrasting settings. For example, she speaks about learning from students in an everyday setting: "I think that you can learn a lot from students... it was a teaching ward that I ran…" (P4 MU49 extract). She also learns from patients in extreme distress (Figure 29).

Figure 29 Learning from others - Participant 4

P4: Yes I think I have... I mean... I mean... you've got somebody sitting with a rope in front of you saying that you know you're in the house and they wanted to die and you know perhaps you've done quite a lot of work with them and they're still doing that… [gap]…what do I do there and then? **I think I would try and get them to talk about how they are feeling why they are feeling like that, why are they feeling hopeless and helpless**, what happened what's triggered them off to make them feel like that and then because you know that patient you know what would work in the beginning you know what would what has helped in the past like and so you might be thinking that in your head **but you might just have to let them actually just talk and just be there with them you may not even have to say anything you may just have to let them talk to you**

What is also shown in this extract from Participant 4 is that other factors are in play, such as how she has already 'got to know' this person, as well as being able to 'allow the expression of feelings,' and 'being able to tolerate in others, and feel in oneself, physical and emotional distress' (see General Synthesis). These are all themes also found elsewhere in her interview (Themes 2, 3, 6, 10, 19, 20, 25).

Empathy is understood by all participants as being important to being therapeutic, but it is conceived of as being about a transparent understanding of the other person with most participants, while it is treated with caution by others, where it is more about recognising difference. For Participant 1, empathy has to do with acknowledging difference:

Figure 30 Empathy as difference Participant 1

To try and empathize… and…[gap]… And try to accept that… that what… It's like culture… isn't it? It's accepting that there are **people that are different and have different lives from us** (P1 MU18 lines extract 332-347)

For Participant 3, she is wary of empathising in a way that makes assumptions that the other person is like her:

Figure 31 Empathy and assumptions Participant 3

> Yeah, but I suppose that's where the therapeutic thing comes in, but it's just that's my personal values then isn't it? …[gap]…Thinking about it… [gap]… How I, I suppose I've always treated people how I would want to be treated, so if I was in their position… **Is it over-empathetic, I don't know?** I don't know… (P3 Theme 8, MU6 lines extract 133-148).

In contrast, Participant 8 looks for empathy as transparent understanding, based on his own experience. He is anxious to 'identify' the person's real problem. This seemed linked to his own story, where he said he struggled to 'identify' what kind of life he wanted to live, and stumbled upon it by becoming depressed and working as a health care assistant. For this reason, he is more comfortable working with patients with depression than other diagnoses. His own experience gives a sense that he can truly know where someone is coming from, what they are feeling, and this makes him feel he can be more therapeutic (Figure 32).

Figure 32 Empathy as transparent understanding Participant 8

when a patient says to me ohh … you know my job's not happy with me or my mother is not talking to me or this person is... I can understand actually these could be some of the reasons why... **I can identify with actually you know**... I kind of say it to the person obviously not kind of say it about my depression ... it's not you it's the illness…you know and just remember the symptoms you get with depression so **I can kind of relate a lot more to the experience I have had**... (P8 MU27 extract lines 476-495)

> as nurses… **it's having a genuine genuine empathy for people...** [gap]… that whole feeling of I know where you are I can empathize **I can understand where you're coming from... of your mind** (P8 Theme 6, MU9 extract lines 119-140)

> to work with people, **know how to identify with people you need to feel that sadness for people sometimes as well you need to feel someone's pain feel what actually is someone's the stress** … [gap]… not take it home with you… you need to have some kind of truly got what that person is coming from (P8 Theme 6, MU41 extract lines728-743)

He struggles to work with people with diagnoses which he cannot 'identify' with:

and then on the other end of the spectrum if I'm honest with myself you've got a lot of people like personality disorders and stuff... people you know like that kind of find it more difficult to work with or relate with... (P8 MU26 extract lines 448-475)

Participant 10 qualifies 'full' empathy, saying she has at least some sense of what the other person is going through based on her own experience:

Figure 33 Empathy qualified - Participant 10

All **I'm telling you is I've been through all that, you know**, I've had mental health problems myself so I do know, a lot of the time, **I do know at least a portion of what they're feeling** (P10 MU12 lines 228-229)

She thinks that because she has been through mental health problems herself that she at least knows to some extent what a person is feeling (P10 TMU12 extract)

Having had mental health problems oneself enables empathy as understanding, at least to some extent (General Synthesis)

As can be seen in this section, it is difficult to separate characteristics as if they could be thought of as something to be found in a dictionary or thesaurus, or looked up in a manual, to understand their full meaning. However, some have been listed here to give a sense of how the method tends to isolate these as 'key constituents,' although Giorgi (2009) is aware there is a figure-ground aspect. It was a struggle to write this section, as meaning is always situated in a form of life (Heaton, 2010, p. 155), as discussed in the theory chapter, and so, listing characteristics was like removing them from the 'form of life' in which they made a particular, idiosyncratic sense. It was decided to stay with the struggle to demonstrate the difficulty of isolating elements from a meaning situated in a life.

5.7.4 Key Theme 4

Learning is through practice with others

Education in nursing has become a university-based discipline in an attempt to improve the status of nurses, however, the academic requirements to enter a nursing course are far less than those for medicine or psychology. This emerged explicitly on two occasions,

but was implicit throughout in that the medical and administrative aspects of the work took precedence (Key theme 1).

Participant 9 mentioned she did not get the grades to be a medical doctor or psychologist, and was interested in the brain (transformed meaning units 2, and 3), so it was as if mental health nursing was her last chance to work in the field of the 'brain'. Yet she showed an ability to 'make room' for the other person, which came across immediately as therapeutic in some way in her interview, which in the method was reduced to the characteristic of 'being open', and 'listening'. In fact, some months previously, a major distressing incident, a suicide, occurred soon after she was replaced as the main nurse for a fragile patient with whom she had engaged therapeutically for months. This 'administrative' decision, due to staffing shortages, may have been contributory to the incident perhaps. This mental health nurse was particularly affected by the event and depended on a lot of support from her colleagues - a therapeutic environment perhaps - to recover. It appeared that the subordination of her therapeutic relationship to the administrative and medical framework may have caused the fatal and tragic consequence for the patient. In all participants, there was mention of the university-based courses being geared towards recovery, that is, the medical and administrative view of recovery as the removal or management of symptoms and encouragement of independent living.

The second occasion where the implications of the standard of education emerged explicitly was towards the end of Participant 4's interview. She mentioned, without any apparent chagrin, that nursing knowledge is "side-lined" because they are not as well educated as doctors. This fact of academic achievement delineates power and pay structures in the working environment of mental health nurses. It indicates that the learning involved in mental health nursing is already seen as subordinate to another kind of learning, which is a finding of this research also. Nevertheless, this 'subordinated' learning is regarded as vital to the

practice of mental health nursing for each participant, often being the main reason they entered the discipline.

The problem here for mental health nursing education with respect to the therapeutic, is that it is left very much to chance as to whether the right therapeutic environment, created by the right therapeutic mental health nurses, are in place. There is an implication that the psychiatric nursing system is geared towards provision of the 'right kind of people', those with characteristics that satisfy the requirements of the 6 C's, for example, in order to service the medical model. There is little difference then, in principle, between current mental health nursing and the attendants of old who were chosen based on character rather than academic or critical ability or leanings (see for example, Nolan, 1993).

Only one interviewee, Participant 1, was critical of university training. Her argument was that high grades could be achieved through 'regurgitation' of material taught, and linked to this, she was disappointed there was no room for critical thinking. She was also the only participant who was critical of the 6 C's. The three mental health nurses whose original training had been over eighteen years ago noted there once had been an emphasis on humanistic skills (Participants 2, 4 and 6), while one of these regarded such skills as too 'soft' for acute psychiatric nursing, for which skills in de-escalation and cognitive behavioural therapy were more practical (Participant 6). Yet, Participant 6 viewed the therapeutic as linked to engaging in a complex of person-centred, flexible, playful and supportive ways, largely based on the attitude and charisma of a nurse consultant with whom he once worked (Theme 12). Perhaps what can be seen here is the contrast between psychiatric, medical care, as cure and containment, with therapeutic mental health nursing aligned towards the 'art' of healing. Participant 6 learned through being in the environment that this nurse consultant created a therapeutic way and environment with others, and the experience remained with him, but which he did not take up in his practice, preferring the medical model.

What this section outlines is that mental health nurses appear to learn about the therapeutic from other nurses in practice, which places the onus on those nurses who 'teach' through practice, informally, and tacitly, as they go about their work. What goes into practice can be drawn from a number of sources, including everyday life, childhood experiences, ideas from various training courses, and ideas that come to a nurse while with the patient. Each participant spoke about learning from other nurses as their main way of learning about the therapeutic. This would indicate that the therapeutic environment created by other nurses, and/or their example in practice, is crucial to therapeutic learning. Learning in this way is a consistent theme, where practice can be with mentors in practice settings, other nurses, and to a lesser extent, with patients. Being open to this kind of learning was also a key characteristic that emerged more in some participants than others. If learning in this way depends so much on practice, it has major implications for the future of the therapeutic aspects of mental health nursing.

For example, the following extract from Participant 4 (Figure 34) indicates how characteristics, and skills, have been developed through training and practice, which are also linked to making a right judgement, or complex decision-making (P4 Theme 17, from Transformed Meaning Units, 27, 28, 34, 36):

Figure 34 Complex decision-making - Participant 4

Theme 17

Judging what is appropriate for each person is based on the relationship and what happens in the moment (TMU27, TMU28, TMU34, TMU36)

P4 MU27 (354-367)	P4 MU28 (368-372)	P4 MU34 (419-427)	P4 MU36 (438-454)
P4: and **knowing what you can and can't do I think as well is important** because you know sometimes	P4: it means **you're not closed to anything**	P4 you've **got to be very present in the moment** because... what you gather from that information of **how they**	P4 **you're making a judgement all the time but you're**

somebody might have had horrific sexual abuse in the past but they may have had quite a lot of counselling for that and they're living with that well it would be not good this then you come in and you start going over that again yeah... so what **about knowing your client knowing what can be helpful and what can't be helpful**… [gap]… I've done quite a lot of sexual abuse counselling in the past mainly in the day hospital… [gap]… structured counselling with proper supervision… [gap]…person centred… [gap]…

really. I think the experiences you have as you go through nursing means you're not closed… the things that people feel ok to open up and tell you things and then it's what you do with that knowledge and that's where the skill comes in... **and it's knowing when to intervene when not to..**

are then will depend on how you are going to react um... you'd know whether this was common behaviour you know whether this was common behaviour you know your… your patient because there would be times then when you would think right there's something a bit different about their behaviour today so today I think that their impulsivity would be high you know it's higher than normal

looking for things that would alert you to things being different because you know… [gap]… she has this severe severe personality disorder emotionally unstable personality disorder and it would be about an… you don't take risks but **you have to know you have to know what is an acceptable risks and that's the difficulty that's when you have to make sure you have discussed this with the patient with all the staff with all the team,** so you're your approach to that person is consistent, is boundaried… that **you want the best for that person to enable that person to reduce their distress but you have to make a judgement there**

In this theme, Participant 4 indicates there are skills which she has learned through a counselling course, linked to knowing what to do (MU27), while there are also capacities such as being 'not closed' (that is, openness to learning from the other) (MU28) linked to practice in mental health nursing (and perhaps counselling). There is a sense here that 'openness to learning from the other person' is something she has developed, and this is reinforced by her comments in MU36, indicating how previously she has asked the patient and the team about risks, while bearing in mind that she wants to enable this person also. She is open enough, able to say she needs help, and confident enough to do this, with a range of colleagues. This appears key to learning. Her comments are perhaps crucial.

> It is not too difficult for P4 to be open about her concerns, as she accepts constructive criticism, and would welcome suggestions as to other approaches. But she thinks others

might struggle with saying they are vulnerable, that they are not sure if they are getting it right (P4 TMU 39 MU39: 474-481)

The characteristic of being attentive is shown in how Participant 4 is present to the person (MU34). There is also an implicit meaning across these examples that Participant 4 is working from a wealth of tacit knowledge (*Theme 17i*). These themes, as is evident, are all relevant to 'being with' the person also.

5.7.5 Key Theme 5

Learning is facilitated through a therapeutic environment

This key theme is closely linked to the above, key theme 4. However, it differs in that it specifically highlights the need for an environment in which the mental health nurse may come to know herself safely. What encourages learning to be therapeutic is a safe, self-reflective environment of therapeutic reciprocity with colleagues. As noted above, Participant 4 was the only one who explicitly spoke about how being open was facilitated by a reflective, structured therapeutic environment. In this kind of environment, she felt valued, which in turn allowed her to be able to speak more clearly about her concerns, and to show others that she may not know what to do. She needed a safe environment to enable this. This facilitated her own openness with colleagues and patients.

In summary and conclusion, this chapter has presented the findings of the empirical analysis according to Giorgi's (2009) method. An overview of the general syntheses of each participant has been presented. Key themes of the general synthesis have been discussed, also in reference to each participant. Being therapeutic is to do with the person of the mental health nurse, and characteristics that nurses speak about which they see as therapeutic, or appear therapeutic, cannot be removed from the situated context, of learning, and of the embodied

aspect of being with others. Two notable features of the ability to learn to be therapeutic emerged: Firstly, that the capacity to be therapeutic is innate, or learned in childhood, in such a way that it cannot be taught, although it can be 'brought out' through practice. Secondly, that learning to 'bring out' the therapeutic is facilitated through practice with others who are therapeutic, and in a safe environment, which allows openness about vulnerabilities and receiving constructive feedback from others. The dependency on the environment created by other mental health nurses, and individuals, to 'bring out' the latent therapeutic abilities in others, makes the learning environment vulnerable to the kind of mental health nurses occupying it. A concluding remark is that the findings presented here are from a method, which claims to be phenomenological. However, phenomenology, as can be seen from the Methodology chapter (Chapter 3), is a way of being that is open to the 'things themselves', which method seems to constrict. For this reason, a phenomenology of responses to the research question will be presented in the following chapter, to put under question method, and open up further what may be revealed in the responses to the research question.

6 Phenomenology

6.1 Introduction

This chapter is an attempt to allow the 'things themselves' to emerge through a phenomenology with respect to the research question. The approach here is phenomenological in the Husserlian sense in that what is 'trusted' is the researcher's own consciousness, or experience (Zahavi, 2003). As indicated in the Methodology chapter (Chapter 3, Section 3.5.3), two people may "… have the same sensations but are differently affected in their feelings," and this implies that "inner evidence is nothing but the "experience" of truth" (Husserl, 1970a, § 51 in Welton, 1999, p.21). At the same time, for Husserl, the "nature of meaning, truth and reality" depends on understanding subjectivity, which is intrinsically linked to "that which shows itself and actually appears" (Zahavi, 2003, p. 52). There is a tension then between the 'experience of truth' and the 'facticity' of the reality disclosed in that experience (Zahavi, 2003; see Methodology, Chapter 3, Section 3.5.2). Consequently, this phenomenology attempts to 'lead back' (*reducere*) from this experience of truth, in order to throw light on what is happening in the consciousness of the researcher in arriving at meanings, the 'things themselves', through interviews. What is disclosed in this *reducere* (leading back) are findings that appear as phenomenological, underlying the empirical 'talk'. The reduction has allowed an emergence of the "conditions of the possibility for appearance" (Zahavi, 2003, p. 94) of these findings. As a result, the differences between the empirical and the phenomenological seemed to clarify during this phenomenology (which includes the 'creative process' in Appendix 5), and it seemed the study had been re-found in a certain 'truthfulness' of my own experience. This kind of phenomenology attempts to address how responses to the research question are not only spoken, but are also implicit, as meanings emerge obliquely, and sometimes 'shown' in a whole pattern that emerged (Merleau-Ponty, 1968; 2014).

Two principle (and unexpected) findings have emerged from this phenomenology which seemed to underlie the responses to the research question. Firstly, that there is an irreducible tension between the 'I' and the 'not I'. Secondly, that meaning has both 'sensual' and 'given' aspects. These two findings, shown tacitly and explicitly, inhabit this chapter, as well as in retrospect, the entire study from its inception in a 'feeling' of abjection. These findings reflect considerations in the Methodology chapter (Chapter 3), and link with the idea of openness in the Theory chapter (Chapter 2), however, they now appear through a certain attempt at 'truthfulness' (of the researcher) as opposed to outlining 'clever arguments' in those chapters. Wittgenstein's (1998) distinction, highlighted in the Methodology chapter (Section 3.5.3), appears now in a clearer light.

> "One *cannot* speak the truth; if one has not yet conquered oneself. One *cannot* speak it – but not because, one is still not clever enough" (Wittgenstein, 1998, p. 41 in Heaton, 2010, p. 32 original italics).

What is happening here then is that, in this phenomenology, there has been a disclosure (and restoration) of the relation between the 'I' and the 'not I', both internally and externally (to me), which are joined like two sides of the same coin. The same can be said for the sensual and the given 'sides' of meaning. This emerged through a certain 'truthfulness'. Coming to see these two findings in one's own truthfulness is crucial, as opposed to in theory. The importance of truthfulness (in Wittgenstein's (1998)) sense has become itself a finding of the phenomenology, although it was alluded to in the Theory chapter (Chapter 2, Section 2.5), and perhaps gives a sense of how being open allows something to 'unfold' in a learning.

The organisation of this chapter is rooted in these two findings, which re-inform at times a reflection on methodological and theoretical considerations, but permeated now through the unfolding aspect of truthfulness. The two findings are inter-related and have

emerged from the 'creative process' of the phenomenology (see Appendix 5). In this chapter, the relation between the 'I' and the 'not I' is discussed first. Following this, the chapter is like catching three different aspects of both of these findings as if they have been held up to the light, each aspect like a different pattern in the same kaleidoscope. The aspects seen are reflections on, firstly, meaning as empirical and phenomenological, secondly, experience and deductive rationalisation, and thirdly, scientific language and the sensual. Meaning as sensual and given is then discussed. Finally, implications for the research question are summarised.

6.2 A phenomenology in the tradition of Husserl and Merleau-Ponty

In relation to the research question, meanings have emerged between the interviewer and the interviewee. The interviews, in each line written and each sentence spoken, uneasy shifting in seats, anxious and peaceful silences, invoked images, recollections, and words, in which meanings seemed to come and go, sometimes the most fleeting one seeming to be the most important. Meanings seemed to shift, moving in and out of perspective, and changing, and perhaps then stabilising (see Appendix 5). Some of this has been thought of as a landscape "overrun with words" in the metaphor from Merleau-Ponty (1968, p. 155), as this seemed an appropriate way of describing patterns that emerged, and also fits Husserl's view of "givenness" arriving in profiles (or horizons) (Husserl, 1982, p. 94 cited in Zahavi, 2003, p. 16; see Methodology, Chapter 3, Section 3.5).

What emerges comes into the consciousness of the researcher, and this 'experience of truth' is then put under question, in the reduction, to 'allow' something else to be disclosed. It is worth noting that the experience of the interviews 'showed' that the sensual is in the breath, air and life-force of the landscape of each interview. Like the sap beneath the bark it seemed to ebb and flow, and finding its way into the breeze moving through the leaves. It was present as not only the background but also coming into relief at times as sexual, or also an affectionate look, a recognition of something like a wild thought, smiled at, something wildly

alive (that might even kill). Openness seemed to be linked with this too, as it allowed a wildness to be. Meanings have been 'allowed' to be disclosed in an uncertain, ambiguous relation between the I and the other. Some meanings persist, and some emerge fleetingly like a glimpse of a wild animal in a landscape.

The phenomenology of responses to the research question came to be seen as nothing but this attention to a relation and an allowing of whatever words are there to describe a landscape in which a wild creature (perhaps both shy and savage) may come near, to watch, or be curious, mistaking the other perhaps for a block of colour, or mistaking the other for a reflection of itself in a pool. This 'allowing' may be the revelation in phenomenological 'seeing', and each section in this chapter reflects this. The hunched figure by the doorway is allowed to be, and slowly it may become a coat on the chair as something 'dawns through' in a "perspectival" way (Zahavi, 2003, p. 15). Something reveals itself in its own time in a relation. In the recognition, something happens that seems to change us. There is something restoring in the relation established again between this I and this otherness 'outside', which is found also in the relation of openness with oneself and the other in the 'I.' But it seems that this uncertain relation can become obscured, or is completely elided, in the reality of violence and aggression.

6.2.1 Openness to another person

Some considerations from the Methodology chapter are revisited briefly here, principally in relation to the reduction. For Husserl, "[w]e should let the originary giving intuition be the source of all knowledge" (Zahavi, 2003, p. 45, after Husserl, 1982, § 24). Yet, he is also particularly clear that we rely on the other person to 'know' anything at all.

> All Objectivity, in this sense, is related back constitutionally to what does not belong to the Ego-proper, to the other-than-my-Ego's-own in the form, 'someone else' - that is to say: the non-Ego in the form, another-Ego (Husserl, 1969, p. 248 cited in Zahavi, 2003, p. 115).

For Husserl, this is an *a priori* constitutive relation between intersubjectivity and subjectivity (Zahavi, 2003). This 'relational aspect' has been linked in this study with an 'anonymous subjectivity' (Husserl, 1981/1927 (19, II, 8) in McCormick & Elliston, 1981, cited in Welton, 1999, pp. 329-330) which is transcendental in that it 'functions' in a pre-reflective way, which Husserl also spoke of in the Bernau manuscripts (1917-1918) (Zahavi, 2003) as well as *Formal and Transcendental Logic* (Welton, 1999; see Methodology, Chapter 3, Section 3.5). Merleau-Ponty's (2014, p. xxxii/18) idea of operative intentionality is rooted in this (Husserl's) idea of a 'functioning intentionality'. In addition, what seems particularly important is how empathy may be to do with "self-alienation" for Husserl (1970b, p. 189 in Zahavi, 2003, p. 124; see Methodology, Chapter 3, Section 3.5.2.1).

If meaning then arrives like a gestalt, then it may be that what is found is a "modification of myself" (Moran, 2000, p. 177), and in order to be open to something of the other's meaning one may need to allow a certain 'alienation' to take place, through the reduction perhaps, while also, as has been argued in the Theory chapter, a certain openness. The reduction and openness may be linked perhaps. The picture is complex because it appears that meaning has already been intersubjectively disclosed (constituted) in oneself, and at the same time there is an operative intentionality tacitly 'allowing' experience in a certain way so it is difficult, or possibly impossible, to gain distance from meanings that 'force themselves.' Combining these aspects then, it can be seen how the interplay between this 'I' and 'an other I' can be so clumsy when trying to catch a meaning. This interplay seems to imply that in the field of meaning between people, the full extent of what is really going on cannot be said. It has been argued here that by suspending judgement, and allowing the other in an openness to her, to him, and resisting meaning, something may 'emerge' like the wild creature that emerges in a landscape. In a sense, it is a strange uncertainty which distinguishes the phenomenology outlined here (see Appendix 5 also). There is no rushing after causal or

explanatory links, but rather an attentive waiting that 'allows' things to take a shape, without grasping at these. It is often unclear what is going on in this 'allowing', but something has emerged in this analysis (that seems to insist) that has to do with 'me and the other person' (which appears to point towards a hidden ontological relation). This 'allowing' appears to link with openness.

To 'use' a lens like a method would be to imagine being able to step back from this 'co-constitutive' relation while forgetting being always within it, just as Husserl (1960 in Zahavi, 2003) notes how he is only an 'I' in relation to another (see Methodology, Chapter 3, Section 3.5.2.1). What this implies is that the experiencing 'I' cannot be separated out from the 'analysis' of the interviews because of an entanglement in an ambiguous, oscillating relationship of uncertainty inherent to being open to the other. It seems that it is quite usual to turn away from this relation between the 'I' and the 'not I', and for example, to impose a particular language on a meaning. It is crucial that 'knowing' this in theory, is different to its painful realisation with another, and perhaps it takes time with another, or others, who are 'open' to come to realise this. In this 'painfulness' a certain 'truthfulness' comes to be as one's own truth emerges. It is also painful for this openness not to be allowed. In waiting and listening, what is revealed is an ambiguous relation between the 'I' and the 'not I'. This relation seems to be of enormous significance.

For example, it seems impossible to remove the 'I' from these thoughts in referring to what the other is saying, what is being heard, and what 'dawns through' in the interviews. In starting to 'notice', or think, there is a flood of recollections, and images, along with words which seem to, as Merleau-Ponty (1968) sees, 'overrun the landscape'. There seems to be a certain 'truth' in Husserl's thought that there is a "reduction of all unities of sense to me myself and my sense-having and sense-bestowing subjectivity with all its capabilities" (Husserl, 1973, p. 366 cited in Zahavi, 2003, p. 46). Removing the 'I' appears impossible. In

other words, the reduction cannot be complete, which perhaps Husserl did not seem to fully realise (Moran, 2000; Zahavi, 2003). It is interesting to note that scientific method (without using this terminology) makes the assumption that the reduction can be complete (in terms of subjectivity being removed from an analysis).

In the tradition of Husserl and Merleau-Ponty, the reduction 'leads back' in that it *veers towards* revealing the world and one's relation in it as if for the first time, and in this sense, it may be child-like. Perhaps children may be more able to see the strangeness of the world before they have become educated, or entrained into a dogma which acts like a prism through which the world is understood, no matter how perverse. But it is not that a child would see the world 'as it is' either. It is only in this sense that the reduction in Husserlian phenomenology changes experience; reality remains the same, so that things "lose[s] nothing of their being" (Husserl, 1970b, p. 152 cited in Zahavi, 2003, p. 46; see Methodology, Chapter 3, Section 3.5.1). But it is argued that seeing the world in this 'magnified' way, and returning to it, would appear to change the person. It opens onto a certain loneliness, and there is a certain ""wonder" before the world" (after Eugene Fink (1970, p. 109) in Merleau-Ponty, 2014, p. xxvii/14). There is a kind of homelessness here coupled with a strange belonging as everything is so transient. Perhaps there needs to be a certain trust to allow this way of seeing to be spoken of, as it seems so private and perhaps even illusionary. There appears to be a dialectic between others trusting in that experience of trust and trusting in others' experience of that experience. Is this not what Husserl may have meant also by a co-constituting "foreign subjectivity" (Husserl, 1959, p. 495 cited in Zahavi, 2003, p. 115)? This trust allowed the creative process of the phenomenology to be less restrictive, more open, compared to an empiricism.

An example regarding Participant 1 may show this relation to an extent perhaps. She would close her eyes at times, and it felt like she did not want me to be there, that she could

not trust in my experience of her, and I was caught in a meaning of hers that was not mine (but neither did I know anything about it). In trying to 'get out of her way', to relinquish my own meanings about her, to open a space for her to speak, it seemed all the more that she needed to close her eyes (see Appendix 5). She would not trust in my experience of her. To close down on this relation between the 'I' and the 'not I' seemed to be harmful to her. She could not allow herself to be found in a relation to this other (me, in this case, who perhaps represented an 'other I' both 'internal' and external to her), and it seemed important that I say nothing of this to her, to allow her to 'off centre' me. This experience of being with her seemed to be of more importance than anything empirical she said.

In this way, it appeared that the relation to the other becomes so important in phenomenology because in finding the 'I' everywhere one finds the other in oneself, and this then has to be taken seriously (because surely the world is not only *mine*), and suddenly it appears clearly that there is a relation to something other, someone other, who cannot be ignored, not because of some power relation, but because this 'other' is centred in me, off-centring the 'I' at its very centre. Participant 1 'off centred' me and she too was off centred by me, but perhaps I knew more about it than she did and thus did not try to impose a meaning on her. The relation is both obstructing and holding in place in a kind of clumsy recognition. The clumsiness seems important, because it shows there is no schooling and no method. This paradoxical and ambiguous 'relation' is there, throwing the 'I' off-centre. This can be so hidden that it has only been possible to sense in a kind of raw vulnerability in a kind of relation with the other person (which may not be relational but perhaps ontological). Participant 1 seemed not to allow an acknowledgement of this (through anxiety perhaps; see Appendix 5).

As can be seen, this uneasy relation can be fraught with paradox, uncertainty, ambiguity, aggression, and anxiety. It is not easy. It is no wonder that it is easier to polarise, pretend the relation does not exist, annihilate otherness (an other I), to remove the 'tension'

so that the other person does not put the 'I' under question. This relation appears to be a phenomenological fact as opposed to an empirical one.

Having read through, and listened to, the interviews over again, perhaps what comes through as therapeutic may be in the re-establishing of this ambiguous relation with the other person. The openness to the other in oneself is restored through another. Logically, the other can be god but phenomenologically it must be another person (because one finds the 'not I' in oneself). Perhaps this is why it was important to turn to Brother David in the Franciscans, as there was a welcoming openness that did not impose itself. It seems easy to keep forgetting, and missing out on, this relation. The 'I' at one's centre which is 'not-I' is a relation which creates an uncertainty which is like an invitation. The 'not-I' is a relation, or opening out, to the other which is constitutive of the 'I' in a paradoxical relationship. The closure of this paradoxical relationship seems to arrive at dogma and violence. It is not surprising that when the 'internal' relation with the other, 'not I', is reduced to a logical one with a god (or a theory, an idea), it results in saints, martyrs and fanatics. Participant 10 seemed to be approaching this logical relation, while Participant 8 had a redeeming kindness (see Appendix 5). Merleau-Ponty (1968; 2014) seems to have given a language to this relation which evokes the experience of the world in its sensuality, as well as how meaning may arrive as a gestalt (which meaning it has been argued here needs to be resisted, or suspended in uncertainty).

6.2.2 Meaning as empirical and as phenomenological

This section reflects the struggle to differentiate between an empirical analysis and a phenomenology of the interviews. Giorgi (2009) promotes the idea that arrival at a 'structure' or essential, stable meaning in a description comes through an intuitive process of free imaginative variation (see Method, Chapter 4, Section 4.5). However, the problem with free imaginative variation is that it seems impossible to intuitively vary an experience until there

is arrival at a structure of meaning that is stable without it being a rationalisation. Giorgi (2009, p. 154 italics added) provides the rationalisation, as the "intent… is to describe carefully the intuitive *psychological* senses that present themselves to the consciousness of the researcher." The psychological senses then are the rationalisation, and as a result what appears is something that is filtering the language into an already known terminology.

It seems clear that even if we focus less on the psychological and more on the mental health nursing meanings (or any empirical field of study) the principal of rationalisation remains the same. This has been discussed in the Methodology chapter, with reference to Merleau-Ponty's (2014) distinction between spoken and speaking speech (see Chapter 3, Section 3.6), where the latter transforms a "certain silence into speech" (Merleau-Ponty, 2014, p. 189/224). Giorgi's (2009) method appears to mainly address the former, 'spoken' speech, so that a way of 'seeing' the world is just repeated (see Method, Chapter 4, Section 4.6). Nevertheless, Giorgi (2009, p. 125) regards the findings through his method as "adequate," although he is aware that a "lateral or oblique meaning which runs between words" (Merleau-Ponty, 1964, p. 46) is missed out. In addition, it appears that 'meaning' here is not just what comes obliquely between the lines but is also something that belongs to a sensual landscape (Merleau-Ponty, 1968; 2014). Even given these limitations, when does the empirical analysis stop? When we have run out of psychological words to describe the phenomenon? If a researcher knew more psychological concepts, theories and empirical findings, would this mean her findings were simply just more psychological? It could be that the more the researcher is 'expert' empirically, the more there is 'closure' through rationalisation. Merleau-Ponty (1964, p. 46) would say, at what point are meanings "accomplished." Can they ever be accomplished, in any way, whether empirically or phenomenologically? It seems not, as this 'accomplishment' has to do with the sensual and language, which will be discussed further (Section 6.2.5).

The "creative process" which Giorgi (2009, p. 154) acknowledges, in order to "get the right expression," is curtailed by the filter of psychological language in which that 'rightness' is expressed. Because the method is empirical, that is, rationalised to a psychological way (in this case) of 'expressing' something, it constricts the words that can be used. Empiricism also gives the idea that there is 'data' to be analysed, as in for example, how Hume saw the senses as 'receiving' data (Copleston, 1963; see Methodology, Chapter 3, Section 3.4.4). The 'data' is 'decoded' in some way, for example, through a method. This can be put under question by thinking of how Husserl (1970a, §34 cited in Welton, 1999, p. 367) speaks of 'givenness' as "an immediate presence, or, in memory, remembered as the thing in itself", or how Merleau-Ponty, (2014, p. 62) speaks of 'meaning' appearing like a gestalt whose "very form is the appearance of the world". The 'data' cannot exist as discrete units to be analysed (see Gill, 2000). This will be discussed further here, as feeling that we 'know' someone, that we 'know what someone means', opens up questions about empathy.

Empathy as analogy constricts language even more, resulting in findings that are 'like me' (or 'mine'). In this way, findings may become what is 'already known' and 'like me', or a "phenomenological modification of myself" (Moran, 2000, p. 177; see Methodology, Chapter 3, Section 3.5.2.1). This point appears to be crucial. It is argued here that this constriction shows that Giorgi's (2009) method, or any method, cannot be viewed as phenomenological. But only because it is a constriction (through a narrow view of language and empathy). Empathy as analogy is important at times. For example, coming to see a certain healing kindness in Participant 8 depended on empathy as analogy (Appendix 5). But this kind of empathy is not the whole picture.

Crucially, what is also allowed in the phenomenological is empathy as self-alienation ('not mine'). It appears that we can only allow self-alienation by allowing 'not understanding' to have a place in the landscape, 'to not know.' Empirically, this might be 'forced', for

example, in betrayal (by a close friend) perhaps, and trying to then understand this - a 'meaning' is 'forced' that seemed inconceivable (see Wittgenstein, 2009, § 191; see Methodology, Chapter 3, Section 3.5.5).

Thinking about Participant 5 might show some of the 'creative process' to which Giorgi (2009) refers, but in a way which 'opens up' the language that can be used so that something of the phenomenological can be let through, with less 'curtailing' into an empirical view. She had looked after her ill mother to an extent as a child. It 'felt' like there was something not being understood in her interview (as it did in all the interviews) (see Appendix 5). Just being with this idea, as if it were a cup sitting on the table, another 'thing' in the landscape, without looking at it, or actively trying to puzzle it out like a mathematical problem, seemed helpful. But it could just as easily not have been helpful. There is no 'method'. For some obscure reason, in those few moments, without any 'analytic' effort but with a different effort of 'allowing', of a 'not knowing', something 'showed itself' in the landscape. Under a heavy sky, rain soaked flower beds turned into bed-ridden mother not in some chain of association or logical deductive process. Linguists (for example, Hawkes, 1977), and some psychoanalysts (for example, Lacan, 1977), might say there is assonance in the words ridden/sodden, and metaphor in the word 'bed', which cause associations; however, although this may also be the case, this appears to not give due emphasis to the sensual relation in words. There is a meaning in the heaviness of the grey clouds, the weight of something, the insistent scent of the garden that seemed to come through in the turn sensed in the season changing from autumn to winter, the smell itself of the air, the soaked ground, and the slow laboured movement of the clouds, the flowers seeming burdened and vulnerable but deep rooted and resistant to something, almost defiant. Something conveys a burden. Something insistent in the colours and the rain was in between her words, that went beneath the complaint that she no longer had time for patients. Seeds seemed to be sown around a

bed-ridden mother, life-giving and overburdening, a burden taken on unresentfully in kindness, and a sapling having grown strong had now become a weary shelter for others. It seemed that she needed someone to cut something back, and open up a space for her instead. The burden may have been kindness itself, how branches break under the weight of their own fruit.

All of what is sensual is involved here in informing, or forming perhaps, the word associations that emerge in a meaning. The process seemed to be more like in some way a subconscious transformation of the image, like a gestalt 'happens'. The process was perhaps like the thoughtless way a child learns while playing - things are tried out, without thinking, in a creative 'trying out' till something fits or works but not in any pre-thought logical, deductive way. There seem to be no rules. As Tomasello (1992) says in relation to language learning in children, "There is individuality and concreteness everywhere, signs of broad-based rules nowhere" (Tomasello, 1992, pp. 264-265 in Heaton, 2010, p. 106; see Theory, Chapter 2, Section 2.6.1). Something 'happens'. Experience 'corrects' experience, as Giorgi (2009, p. 69) would say. There is nothing logical about it in terms of deductive rationalisation. The rationalisation seems to come later through a need to know, a need to take control and 'know' - which may be a way of talking about method - of something that appears ineluctably unknowable. Method seems to speak of how 'knowing' happens in a presumptuous way as if it is not mysterious. The imagery of the overburdened tree seems to be about something to do with empathy as a whole impression but the sensual here belongs to me. There appears to be something ineluctable about whether the imagery speaks about her or not, although it speaks to me. This uncertainty, in a sensual relation, seems vital to allow, as opposed to closing down through an experience.

6.2.3 Experience and deductive rationalisation

The "creative process" to which Giorgi (2009, p. 154) refers may appear to be an intuitive knowing (Applebaum, 2012), but such an assumption seems to mislead, because it links 'intuition' with somehow something not clever, not logical, not capable of analytic reasoning, something for the simple or "naïve" (for example, Shtulman & Harrington, 2016, p. 119; see Theory, Chapter 2, Section 2.6.1). The creative process appears however, to be instead an open, mysterious activity involved in learning itself in which imagery 'explains' experience 'overrun with words' (Merleau-Ponty, 1968). Giorgi (2009) seems to know this but it appears that he will not fully trust his experience, even though he says experience can be trusted,

> Husserl is respectful and trusting with respect to experience. It is not the case that experience cannot be illusory, it is just that illusions and other sorts of error are also corrected by experience (Giorgi, 2009, p. 69).

This disjunction in Giorgi's (2009) approach may be because if experience is really trusted then 'coming to know' something, in a meaning, may be shown to not be methodical after all, and therefore not scientific in terms of how his community defines scientific. Trusting his experience might exclude him. Experience from the 'creative process' of the phenomenology (Appendix 5) appears to show rather that meanings come like hallucinations or visions, like dreams appearing out of nowhere, and they need to be left alone rather than rationalised after the event. This is a Husserlian way of thinking, linked to the epoché and the reduction (see Methodology, Chapter 3, Section 3.5.1). Here is Husserl (1982, p. 51-62 in Welton, 1999, p. 61), in *Ideas 1*, describing something of perception in the natural attitude,

> "Determining presentations, obscure at first, then becoming alive, haul something out for me; a chain of such quasi-memories is linked together".

Trusting experience allows something to be described with the words that present themselves, and left alone. But the next time we look, the whole landscape might have

changed. This is a disturbing thought, especially if we are wondering whether someone loves us, for example; or perhaps if we need some kind of prestigious recognition. The words of Participant 10 come to mind, "I'll box it, hammer it down" (line 464) (see Phenomenology, Chapter 6, Section 6.3). An image of pinned butterflies might fit this, and the professional skims through with his expert eye to see which type you are. The illusion of certainty in this kind of 'cataloguing' may, for some, assuage the anxiety-provoking experience of uncertainty. The difficulty of openness, which has been theorised as being linked to the therapeutic (Theory, Chapter 2, Section 2.3.1), may come more sharply into focus on meeting such a certainty of attitude. Openness catches something in the chest, rather than catching something in a net.

What the example from Participant 5 seems to indicate is that meaning is not a message typed out in words, it is not revealed in a chain of signifiers, but is rather about how the sensual 'explains' the words. Meaning seems to come through a dialect of feeling that 'appears' like a gestalt. Phenomenology seems to invoke this kind of revelation in experience. The disclosure (to me) of the sense of 'burden' with Participant 5 may be a way of thinking of the epoché and the reduction, in that

> "…the epoché… is the way of uncovering judgements about correlation, of uncovering the reduction of… my sense-having and sense-bestowing subjectivity…" (Husserl, 1973, p. 366 cited in Zahavi, 2003, p. 46).

This could also be thought of in terms of the later Heidegger, regarding 'letting beings be' (*Gelassenheit*) (Heidegger, 1930, p. 129-130, in Polt, 1999, p. 127), so that they show themselves through an attentive involvement - "In order to let the rain show itself to me… it has to make enough of a difference to me, that I properly notice it" (Polt, 1999, pp. 128-129). This sounds like Participant 5 saying, "people can tell who cares and is interested" (line 96). She may have been saying that it takes an 'attentive and proper involvement' (Polt, 1999, p. 128) to be therapeutic. The 'proper' here could perhaps refer to being 'open'. She also appears

close to Merleau-Ponty, for whom philosophy (phenomenology) 'invites us to take notice' of others,

> "The relation to the world, such as it tirelessly announces itself within us, is not something that analysis might clarify: philosophy can simply place it before our eyes and invite us to take notice" (Merleau-Ponty, 2014, p. xxxii/18).

If meaning 'explains' itself in a dialect of feeling, it appears to have its own rhythm, 'feel', sounds (words) and imagery, that 'speak' and may captivate. It appears that meaning is more than the "integral of all the differentiations of the verbal chain" (Merleau-Ponty, 1968, p. 155). Husserl was aware that "sense and the sensuous" cannot be separated (Zahavi, 2003, p.29). Husserl's later view of meaning (*Sinn*) included the linguistic, pre-predicative and perceptual (Zahavi, 2003, p. 149 after Husserl, 1982, p. 285) and this is what Merleau-Ponty was developing (Moran, 2000).

For Participant 2, for example, something was happening about her father. It was difficult (if not impossible) to disentangle this from something to do with my own father. In Irish, "*Tá sé go h-ána fuar agus fliuch*", was his catch phrase on wintry days on the way anywhere. It meant, 'It's very cold and wet.' But the Irish words (the sounds) held an exhilarating energy caught up in his look, a certain humorous invitation mixed up with an anxious, maybe even vicious, distance. But with those Irish sounds comes a flood of the sensual, where rain, green and copper leaf-littered footpaths, soaked leather shoes, the smell of jam sandwiches and milk, are just fragments. A strange sense was felt of being part of something beloved, but ephemeral, even though his glossy black hair seemed like it would be eternal. Something like, 'A boy loves his father, no matter what' comes through the Irish words like the insistent breeze finds its way through the rain. Coming to see a grief for Participant 2 seemed to have to come through this fragmented, sensual gauze of memory.

In something like this way, meaning seems to be like a dialect of feeling that 'appears'. The words are "not on the phrase like the butter on the bread" (Merleau-Ponty, 1968, p. 155; see Methodology, Chapter 3, Section 3.6) but are sounds belonging to a sensual landscape. It comes to mind whether this 'sensuality' is illusionary, which it may well be as the picture is surely always incomplete, a piece of the fabric of memory. But this fragmentation, and illusory 'sense', does not take away from the experience of implicating meaning in an insistent 'memory' of the other, and which gives sense to another's words. In this memory, the 'I' is revealed as rooted in an intersubjectivity (for example, a son, a father, and the whole "halo" (Husserl, 1977, p. 62 cited in Moran, 2000, p. 153) of other people and images) which gives 'sense' to the experience of the 'not-I' (this other person, Participant 2). Acknowledging this may allow uncertainty to have a place, for an epoché and reduction - 'leading back' so it can be seen that 'this may belong to me, not her' - creating openness, to allow the other a space where meanings are not imposed.

The fragment of Irish above is not part of a network of differences that make up a language (Hawkes, 1977), because the mother tongue is English. The Irish words were never part of a mother tongue. They are just sounds, a scrap of fabric, and part of a long-gone landscape that insists still in the sensual. What appears to be most important for this study is that they 'show' a fragment of something, a meaning, that is essentially *private and unfolding.* It seems from this that it cannot really be spoken of, how a credo, an identity, gets imprinted in the sensual impact and flowers into a meaning. The scraps of that landscape either may, or may not, have anything to do with Participant 2, although it felt like they had. It also felt that to ask her a question about a grief would be to begin a rationalisation, or alienation, from something (and this seemed almost inevitable). Staying in the uncertain 'may/may not' seems to have something to do with openness. Perhaps, if the imagery has something to do with Participant 2, then it is like empathy as analogy, but if it has not then it is like empathy as

self-alienation. To try to stay in the place in between these two seems important as it would imply an openness. A space is being opened up in which the other may come to see herself more clearly perhaps, find her own 'truthfulness'. But the person who allows the open space may know nothing about what happens therapeutically for that other person.

It appears then that meaning 'must not' be removed from the whole 'sense' of this other person before me, beside me, who is a sensual living being, who invokes a 'sensual' response in me "overrun with words" (Merleau-Ponty, 1968, p. 155). If the possibility of feeling the loss in a grief had been closed down, then the gauze of memory and imagery (as opposed to imagination) in which the words of Participant 2 were caught may have been a different one, a grief perhaps unnoticed. And also, that enigmatic phrase, 'she accepts me', which came later, may not have caught something else. To be accepted seemed important, to belong, and there were sounds of Irish and cold winter days. There seems to be the beginning of a credo - of loyalty - here in the look of a father. It seems like something that cannot be stepped back from, because there may be no other footing before that footing. To separate this meaning from the sensual may be impossible, and shows a stark contrast to meaning 'given' through a 'sedimented' horizon of experience (Husserl, 1991a, p. 82 in Moran, 2000, p. 162) which "maps out a set of expectations" (Moran, 2000, p. 162), or similarly, spoken speech (Merleau-Ponty, 2014, p. 189/224) which "only give[s] rise in us to second-order thoughts" (see Methodology, Chapter 3, Section 3.6). Perhaps the sensual meaning is the only one that really matters therapeutically.

If she had been interviewed by someone else, would she have spoken of other things? The sensual world revealed in the entanglement of thought, memory, illusion and all the 'senses' revealed *this*, in this moment, but as 'something belonging to me', a "constituting subjectivity" (Zahavi, 2003, p. 89) which may try to impose something that has nothing to do with her. With another person, or on another day, it felt like it might reveal something else,

or nothing at all. Some other creature would emerge from the phenomenological landscape. The illusionary aspects of 'knowing' appear vital here. Literally vital, in that they return the words to something of their original life-giving place in the world of others, and reveal themselves as ultimately 'not mine' in that they belong in a landscape of others (but still private). The sensual 'meaning' in the words of the other person can be no more comprehended than the Irish words above can be to someone who 'knows' no Irish. To think of meaning as only 'the word' seems to indeed inflict a 'cut' (cf. Lacan, 1988, p. 2; see Introduction, Chapter 1, Section 1.3); to inflict a cut between the intellect and the sensual, to separate "sense and the sensuous" (Zahavi, 2003, p. 29). A cut like this is a false separation, a denial of some form, a turning away from what makes the blood flow to the tips of our fingers. To inflict such a cut seems to be to inflict indifference itself.

It seems at least two points can be made from these considerations. Firstly, the imposition of 'scientific language' appears to involve a move away from the sensual. Secondly, meaning, in terms of the therapeutic, appears to be ultimately sensual (and private). Both of these points appear interlinked and have implications for learning and being therapeutic. Meaning as private might be shown with respect to how participants in this study struggled to say what was therapeutic, which perhaps could be rephrased as the struggle to say something that is essentially private that happens between people, and neither of them (in the case of two) may know anything about what has happened. How could Participant 2 have known anything of the imagery and the sensual she invoked as she spoke of her father? And conversely, what of *her* imagery, some hint of which was perhaps revealed in the flickering vulnerability in her eyes? How could either of us have known anything of the sensual landscape of the other? A vital aspect of what appears to make this kind of interaction therapeutic seems to be openness, so that another person's 'meaning' is not closed off, or channelled into 'mine.'

6.2.4 Scientific language and the sensual

As discussed in the Method chapter (Section 4.2), von Eckartsberg (1998, p. 14) notes "as we all do in everyday life, identically named experiences refer basically to the same reality in various subjects." Van Kaam (1966, p. 32) has called this an unnoticed "axiom" in psychology. Stubbornly, this appears to remain the case in much of the 'scientific' literature in psychology. Taking Bentall's (2004) work as an example of this scientific approach to language, he writes as if there is a shared reality which is the 'correct' one, and he is writing from it 'using' words as if they are 'butter to be spread' (Merleau-Ponty, 1968). The main title of Bentall's (2004) book, *Madness Explained*, perhaps reflects a kind of persistent 'narcissism,' under the guise of scientific method. Madness has been explained. Using an endless series of tables, charts and findings from empirical studies, he puts psychiatry under question, drawing on "concepts from psychology and the neurosciences" (Bentall, 2004, p. 494). But nowhere does he put himself, those concepts, and his own words, under question. In this 'science' it is as if its method is a "simple return to universal reason", and there is a refusal to take seriously that "reflection… [is]… a creative operation that itself participates in the facticity of the unreflected" (Merleau-Ponty, 2014 p. 62/88).

An image of Narcissus gazing at his own reflection perhaps depicts the narrowed approach to understanding exemplified in Bentall's (2004) book. It is as if there is a certainty in this kind of 'knowing' that excludes all other kinds, for example, from philosophy, physics, phenomenology, art and poetry. This 'narrowing' is also found in the roots of the psychiatric tradition, for example, in Jaspers (1912), who tried to divide "intuitive content" from "conceptual form" (Walker, 1994a, p. 259; see Methodology, Chapter 3, Section 3.4.2).

Husserl (1970b) was critical of this substitution of the scientific method for experience (its origin mainly attributed to Galileo),

> "the surreptitious substitution of the mathematically substructed world of idealities for the only real world, the one that is actually given through perception, that is ever experienced and experienceable" (Husserl, 1970b, §9 (H) cited in Welton, 1999, p. 353).

It appears that Bentall (2004) (to take his work as an exemplar of this) is behaving like "the usual theorist," behaving as if there is "a single mental process *torn* from the concrete, essentially unitary, context of subjective mental living" (Husserl, 1969 §59 cited in Welton, 1999, p. 262 italics added), that process now his own, which he shares with his community, of 'scientific method.'

It is interesting to note that Husserl (1960, p. 107) links intersubjectivity to "endless openness," and it appears scientific method instead 'closes down' how anything can be validly known. The 'scientific' way of speaking about reality is dominant now (Rose, 1985; 1999). Kahnemann (2011, p. 41), for example, speaks of "cognitive load" as if this gives some kind of scientific rigour to 'thinking' as opposed to day dreaming. A well-meaning, but vain, novice in the Franciscans comes to mind, who complained once that his 'prayer load' was a struggle. It seemed to pass him by that if he were looking for the gentle god he imagined, that no special language would be required. The vanity seems to be in the attempt to possess an exclusive key to a special knowledge. The way to recognition seems to involve carrying a load of some kind in both cases. Giorgi (2009) is firmly in this tradition of the scientific, although he feels marginalised within it (Giorgi, 2002). The sense that something 'objective' can be shown in psychological language could also be understood in terms of a kind of 'operative intentionality' (Merleau-Ponty, 2014, p. xxxii) at work that makes a person insensitive to the tacit assumptions and moves being made. The scientific approach appears to have literally lost its senses.

Husserl (1969, pp. 26-47 in Welton, 1999, p. 235) sees the sciences in this empirical tradition as "so-called sciences" which are "cultural formations, going by that name." For Husserl (*ibid*) reason aims at "genuineness" but this is "what is "missed" in obscurity or

confusion" in the cultural formation of science. Trying to read scientific works in this cultural tradition can 'feel' like something is 'not genuine', and it is no wonder that some people, including it appears most of the mental health nurses interviewed, are put off from achieving in this field, especially if they interact 'intuitively', tacitly, or are sensitive to the sensual, private aspect of meaning. This kind of scientific language might leave somebody like this feeling quite 'dead' and perhaps feeling stupid. It may be that mental health nurses need more encouragement to slow down, and take seriously the sensual in their experience of being with others. There appeared to be something of a lack of confidence in most of the participants, in one sense linked to believing their 'scientific' understanding of 'therapies' was not developed, so that other understandings took a relegated place. And in another sense, the lack of confidence seemed linked to trusting in another person to 'draw out' what they already knew (as Socrates did with the slave boy). There was a mix of frustration, resignation, and acceptance of a certain position, which appeared, in different responses, perhaps to be the position of 'servant' (Bjorklund, 2004).

6.2.5 Meaning as sensual and meaning as given

What seems to be emerging here, is that there is meaning that is 'sensual,' which is approached (by another) asymptotically, so that 'contact', so important to those who work in 'relational depth' (for example, Wiggins, Elliott and Cooper (2012)), is never actually made (except in the invasive imagination). The 'contact' that is made may be more about the recognition that contact is not made (something which perhaps belongs to the tacit because if it is made explicit it is an attempt to 'make contact'), so that there is a feeling of openness, of a wide space between us where I could throw you a ball maybe.

There may be a tacit, playful recognition that another's world of sensual meaning, the only meaning that perhaps really matters, is ultimately private. It appears that this meaning has its place, from which it grew and in which it remains rooted, in a specific sensual home.

To speak about meaning as if it comes from another place (for example, the idea I may have of someone else) is to uproot and displace it, to make it alien. This alienation appears to be what scientific language, as sub-section of 'spoken' language, does when it is applied to experience. The meaning we agree on is an imposed one through language in 'sedimented' horizons, 'spoken' for, or 'given'. We agree to agree to get along, and in so doing it seems we are alienated from the sensual in this agreement. This is perhaps why Kierkegaard (1938, §53 in Grimley, 1973, p. 15; see Methodology, Chapter 3, Section 3.5.2) wanted to shoot himself, as he sensed that he was alienated even in the recognition from others. The fanatic clings on to this 'spoken' word, the dogma, and belief that it is 'real.' This kind of meaning might be called 'given.' This kind of distinction seems close to Merleau-Ponty's (2014) one between 'speaking and spoken' speech. Although, perhaps the silence in a landscape may need to remain silent.

The difference in meaning, between 'sensual' and 'given', appears to be what phenomenology shows here. It seems also that to discover the difference is something that cannot be taught, even though it may be 'spoken' in a text, or a talk. It seems that it instead has to be 'found' in the difficult, anxious relation with another, and oneself (the 'I' and the 'not I'). What comes to mind here is how the slave boy discovered a knowledge he did not know he had through 'giving birth' to it through the help of Socrates (the midwife) (Plato, 1970, § 85a-c; see Methodology, Chapter 3, Section 3.4.4). It appears that there is a kind of operative intentionality here, 'allowing' an experience to reveal itself in a particular way, in this way, in this moment, but it can alter in time. The experience of the 'conditions of the possibility for appearance' (Zahavi, 2003) seems to involve a fragmented fabric of memory which 'shows' how something comes to feel 'known', or comes to feel like an 'experience of truth' (Methodology, Chapter 3, Section 3.5.3).

The recognition needed perhaps can only be communicated tacitly, so I can breathe without having to explain myself (because I cannot explain myself in such a shifting, sensual landscape). In the feeling of openness that comes, there is a kind of tacit recognition, the gift of that recognition, that I can 'play'. Different 'things' emerge this way - sensual meanings. For example, in football, when someone 'has your back', it allows you to play more freely, knowing that any mistakes will be covered by a 'friend', another. Suddenly, Participant 3's comment that she had "got their back" (line 504) seems to link to not just 'being there' but to 'providing a place in which to be playful'. The recognition that this playful space is needed, seems to return, the way you might catch a ball, which is not necessarily thrown lightly. What is communicated is the image of a fragment of sensual meaning through the alienating spoken word. The fragment of an image is conveyed through the spoken word which is itself alienated from the sensual meaning. Violence instead, seems to be the attempt to close the gap between this 'I' and this 'not-I', to 'make contact', or define the path of the ball, and thereby harm something playful, to 'close out' something that must be left alone, because it does 'not belong' to me, is 'not mine'. The meanings involved with Participant 3 begin to shift, for example; there is a playfulness at work now which was not noticed until months later, and which I recall in her expression and smile.

This changes the understanding of the feeling of the abject as perhaps being more about being 'pinned', caught, 'known', captured in a frame of reference that harms the soul as it is 'not mine', like being trapped in someone else's idea. In this case, the idea of psychiatry. It is not such a surprise then that mental health nursing also invoked feelings of anger. This 'changing of the understanding' seems to be what the phenomenological opens onto, in that it opens out into an "endless openness" (Husserl, 1960, p. 107 in reference to intersubjectivity) which cannot be defined.

6.3 Implications of the phenomenology

It seems important to note that the phenomenology informing this chapter (also see Appendix 5) has at times felt like an illusionary experience of some kind. To disentangle the 'self' (or the 'I') from the other's ways and talk seems impossible. However, in the effort to disentangle there seems to be a kind of disintegration of something, like a gauze breaking up perhaps, through which a different light can then shine through. Things forgotten, or lost, forgotten that they have been lost, are somehow found again, like old photographs in a drawer, and some living image shows itself like a dream. The 'things themselves' show their colours and detail like the wing of a dull bird may suddenly shimmer a petrol blue in the light. There seems to be a completely unpredictable blossoming of imagery and the senses. Words tumble through these images like wild birds screeching and harassing each other. They belong in this landscape and no other. This dream-like scenario must mean something. It perhaps has to do with how being open to another person, in the effort and ability to do so, allows the unexpected to show itself in a kind of therapeutic flowering. The burdens of all the meanings imposed on this person are perhaps removed, or at least lessened. And perhaps in so doing, the burdens of our own meanings are lessened. Something silenced can speak for itself. There appears to be also a finding of one's own "truthfulness" (Wittgenstein, 1998, p. 41 in Heaton, 2010, p. 32) in this engagement which is therapeutic in itself. An understanding of truthfulness then is like a finding in itself, which seems to point towards something, an "endless openness" (Husserl, 1960, p. 107) towards understanding (as sensual and given). The importance of others who are 'open' to this, to invoke a learning, seems to be 'ontologically' necessary. I cannot come to know any of this without another person who is open to it, and to me. Is this perhaps not another way of speaking of the hermeneutic circle (see Methodology, Chapter 3, Section 3.3)?

What is also emerging here is that the struggle to differentiate between the empirical and phenomenological may lead back to a simple distinction relating to language. The phenomenological appears to be in 'allowing' language to speak freely of the sensual, and the imagery that comes to be in consciousness. It 'opens up' language. In this 'allowing', attempts to be methodical, methodological, theoretical, 'data driven' and observational, are undermined by a sensual 'givenness' of words (sounds) which flow freely from a context rather than being "torn" (Husserl, 1969, §59 cited in Welton, 1999, p. 262) from it. The freedom to allow this 'opening up' is a sensual one, which appears to be therapeutic in itself. This 'freedom' appears to 'belong' to a person - as an openness - and perhaps may be nurtured and brought out in someone too. It can be crushed by violence.

As noted in Section 6.1, the disclosure of openness (to a permanent uncertainty) in the relation between the I and the not-I, and the difference between sensual and given meaning, appear to be the only true phenomenological responses to the research question which emerged from the interviews. But the unfolding and transforming sense of 'truthfulness' permeates these findings and this also appears phenomenological. This is the phenomenological in the sense of how Husserl intended, as it appears to transcend (or ontologically underpin) every other response. Stemming from this, a number of other responses appear which at times seem to blur the phenomenological and empirical, sometimes as a kind of photographic negative (see Appendix 5). What appear to be significant aspects of these responses will be discussed here.

Putting the self under question in relation to the other person appears to be of major importance, and this would appear to link with challenging the accepted practises, beliefs and traditions of psychiatry, the standard treatment. This may be linked to coming to know how a person may not be therapeutic even if he thinks he may be, or to not glossing over the anxiety in meeting the other, through allowing one's own self to be put under question as

opposed to closing down the other. Exploration of one's self-understanding in relation to others is closely linked to this questioning, but is related to coming to know how a person may be therapeutic without actually knowing it. This might be about allowing the tacit to somehow emerge in relationships. There may be an interplay between putting under question and exploration, that involves an openness.

A difficulty here appears to be linked to how openness can be taught, or learned, as it appears it is like an innate way of being that needs to be cultivated. The problem seems to return to a kind of clumsy movement in the ontological relation noted above, between the I and not-I, which is like a kind of orbit (that does not close itself in a circle) whose path constantly slightly shifts and breaks. What closes itself in a circle appears to be like a dogma repeating, forcing itself like a gestalt. We seem to know when this happens in being with another. We somehow know when we have been closed out. Learning from the other and openness appear to be interwoven. Empirically, most of the participants specifically mentioned that caring has to be 'genuine' and this appears to point towards this ontological relation of being open to learning from the other. The difficulty is that some people think they are genuine when they may not be, which indicates a closure of the circle. It may be impossible to 'break in' to this closed way of being perhaps.

Some of the participants, if not all perhaps, appeared to have been drawn to mental health nursing through some form of 'injury' to themselves, something in the relation to others was going on tacitly which appeared therapeutic in some but pathological in others. Coming to know more about this unawareness appeared to be of major importance, as it appeared to guide how each participant acted in the relation to the other person. This kind of 'coming to know' seems to be also about the effects of the burden of kindness for some.

Drawing these reflections together, it appears then that there is an urgent need for a space for mental health nurses to learn about these aspects in play in their everyday way of

being with others. This would facilitate a coming to understand, and speaking in, one's own truthfulness, which seems crucial for the therapeutic. A safe environment of openness, a forum to speak safely, amongst others who can allow an openness to the other would seem to be of enormous benefit. What appears also as missing were critical ideas, other ways of perceiving the person apart from mainstream psychiatric and psychological beliefs. There seemed to be a certain lack of ideas that might challenge received ones of how being therapeutic can be thought about, while there was also a wealth of tacit understanding. It is not that these other ideas would be replacements, but would provide other words to put psychiatry and psychology under question, to open up spaces for other ways of being to be thought about and allowed. New ideas might also allow mental health nurses to find more confidence in the wealth of tacit knowledge many already appeared to show, and challenge those who were closed to at least hesitate.

In summary, this chapter has attempted a phenomenology in the tradition of Husserl and Merleau-Ponty. This attempt showed a certain 'truthfulness' permeated the experience of coming to show what meanings emerge in response to the research question, which appears to be a tacit finding. Two main phenomenological findings relate to how there is a fundamental relation between the 'I' and the 'not I' (this other person), which calls each one into question. This relation is reflected in, and revealed through, meaning as sensual and given, which emerged through an 'opening up' of language in the phenomenological. These two findings have been explored under different aspects, namely, openness to another person, meaning as empirical and as phenomenological, experience and deductive rationalisation, scientific language and the sensual, and meaning as sensual and given. Finally, implications of the phenomenology have been outlined, in particular with respect to openness, truthfulness, and learning.

7 Discussion and Conclusion

7.1 Introduction

This chapter discusses and concludes the study, indicating also areas for further research. The chapter first provides an overview of the study, and then divides into six areas of discussion, each one overlapping and informing the others. The first area addresses the source of this study, as the experience of abjection. The second addresses how a person may come to be therapeutic, as the course of this study seems to show how understanding continually evolves and changes over time, but only in an environment of openness (to oneself and others). Coming to know about oneself in one's own 'truthfulness' seems to be of importance here, with respect to coming to be therapeutic. There has been a circularity to the progress of this study, in which captivating ideas, thoughts, and experiences, have been changed through openness, in what seems to be an un-ending process of learning. Some thoughts on this 'circularity' seem to be worth drawing together here. The third section addresses the relation to an 'other' person. This has appeared throughout the study in different forms, and especially seems to be signalled by uncertainty. The other person calls our certainties into question, if we are open. The fourth section addresses the difference between meaning as sensual and meaning as given, which appears of central importance to research on the therapeutic, and being therapeutic. While this difference was already implied through other aspects of the study, such as Husserl's distinction between *Bedeutung* and *Sinn* (Zahavi, 2003, p. 149), it only came to be clarified through the phenomenology. The fifth section addresses the empirical findings, regarding these as 'signposts' indicating something of where a journey may start or diverge, but little of that experience. A final section discusses aspects of the study which have not been emphasised, but are important. These are related to how we

do come to understand others, which is implicit throughout the study (in the activity of writing, for example).

7.2 Overview

This study set out to explore what it is that some mental health nurses know and do in their practice that is therapeutic, and how have they learned this. The origin of the study is in a feeling of abjection in working as a mental health nurse. Some of this feeling was linked to being in a discipline whose activity was clearly at times therapeutic, but this practice was not acknowledged as a treatment, or considered as such. Coming to understand something about this lack of recognition felt important, and it was also felt that this exploration may throw light on what may be therapeutic generally. The therapeutic as the art of healing seemed more important than the therapeutic as cure, and this directed the literature review towards the 'personal process' strand in mental health nursing. This way of practising is in contrast to the 'contain and fix' strand, which belongs to a practice that applies a cure that is already spoken for, the medical psychiatric one, imposing a 'given' meaning on a person. The personal process strand seemed to hold the potential to open up other ways of being with people, which seemed to be clearly happening in mental health nursing but which were difficult to define or speak about.

Emerging out of the literature in mental health nursing, and the wider literature on the therapeutic, it appeared that therapeutic mental health nurses spent a lot of their time speaking with, and being with, others who were in mental distress. The kinds of distress could often be extreme, where meaning may have collapsed, and at times the nurse's own sense of self and identity may be threatened. At first, this extreme distress was theorised in terms of the psychoanalytic notion of abjection (Kristeva, 1982), and it seemed that mental health nursing itself was an abject discipline. Abjection linked to my own experience of working as a mental

health nurse. In this milieu, speaking with, and being with, another seemed to be about an openness to the other person. Speaking was linked to an oral tradition, in which speech involves a whole, embodied experience, in opposition to writing which is a technical achievement and may narrow expression (Heaton, 2010). Speaking with others (and mental health nurses speaking with others) seemed to involve a certain search for "truthfulness" (after Wittgenstein, 1998, p. 41 in Heaton, 2010, p. 32). Being with another person seemed to involve ordinary activities, at times also personal care, and there appeared in this ordinariness the sense of an encounter with another person. Ways of being therapeutic in this encounter were explored in terms of tacit knowledge, emotional labour and intuition. Yet, what seemed to characterise both speaking with and being with others was a certain openness that was difficult to express. An example from being a Franciscan seemed to show how being welcomed and accepted, in a certain kindness, was a great relief, and more important than understanding ideas, dogma or credos of any kind. There was a sense of healing in this 'welcome' which involved an openness. Trying to research such an experience of healing (which did not lend itself easily to words) through a method seemed daunting.

The Methodology (Chapter 3) approached researching such an experience from two directions, one aimed at addressing the method chosen (Giorgi's (2009) method), and the other at how we may become captive in an idea, dogma, or theory, a credo, which closes down openness. In this sense, the Methodology looks backwards to the Theory chapter, and forwards to the Method chapter. Husserl's view that we can trust experience (Giorgi, 2009) seemed fundamentally important, as it was the transposition of the meaning of being a Franciscan onto the work of being a mental health nurse that gave rise to a feeling of abjection. This feeling, at first, had no 'truthful' way of being understood as I did not trust my experience, and stayed instead with the separated out 'ideal' meaning of being Franciscan (what can be seen now as a separated 'given' meaning). Experience would have opened a

way to seeing something important if I had trusted it. It is only now it can be spoken of in a certain truthfulness. The Methodology therefore looks at ways of thinking about how we become captivated in meanings, which seem to repeat, or insist. The focus on operative intentionality (Merleau-Ponty, 2014, p. 453/492) seemed to show a way into thinking about how we may make assumptions tacitly, which undermined the more conscious act intentionality, which mainly occupies Husserl (Zahavi, 2003), that may be going on in any empirical method, such as Giorgi's (2009). It appears that Giorgi (2009) is captivated in a meaning, one in which his scientific community has imposed (although he feels marginalised within it (Giorgi, 2002)). What appears to offer a way out of such captivation seems to be about trusting experience, our own embodied feeling about something, and crucially, allowing ourselves to be in relation to another (or others) who may be thoughtful enough to invoke a *genuine* curiosity about ourselves and others. This then began to link with openness, because the other person invites a relation to which he or she is open. Crucially again, perhaps interlinked with this openness, is the opening up of language, so that speech can come freely, and words that present themselves can be appreciated rather than channelled into a credo. Husserl's insistence that the "originary giving intuition" (Zahavi, 2003, p. 45, after Husserl, 1982, § 24) says something important about ourselves and reality, and Merleau-Ponty's (1968, p. 155) imagery of words 'overrunning' a landscape, seemed to say something here about words needing to be freed to show something of the 'truthfulness' of experience.

Seeing this clearly took some time. Giorgi's (2009) method seemed to restrict language, so that words were channelled and tamed into an idea that already pre-existed, and so, it seemed that whatever findings were found would belong to an already found understanding. It is not any great wonder then that the empirical findings tend to align themselves to already spoken ideas about the subject, as indeed, the talk of the mental health nurses did also. Findings would be 'dead' in a sense, if taken as 'given' meanings. This

seemed to coincide with Paley's (1997; 2002) criticism of research in nursing, which often uses Giorgi's (1970; 2009) method, as simply resulting in findings that could just as easily be read from a thesaurus. Yet, Giorgi's (2009) method is widely accepted as applying a scientific methodology to research. It seems now that perhaps the greatest strength of his method was an incidental one, both in giving time in the interviews to mental health nurses whose voices are never heard, and in the careful attendance to the words used which is part of the descriptive approach. The findings from the method show that the mental health nurses interviewed work therapeutically in various ways, idiosyncratically often, through being open, speaking with, and being with, although in the service of psychiatry, and they have learned mainly from life experience and practice. These points were already apparent from the literature. What could not be shown in his method was what was actually going on through free imaginative variation, and the reduction, because there was an obscure 'creative process' (Giorgi, 2009, p. 154) at work. This seems to indicate that what could not be shown was what was going on in the consciousness of the researcher, or what was 'felt' in the 'originary giving intuitions' throughout each interview, and afterwards on listening, and thinking about each.

Some attempt has been made in the Phenomenology (Chapter 6) to show some of this creative process, and what emerges here is something different. There was a surprising sense of the 'things themselves' being presented from a landscape, with whatever words happened to present themselves. What emerged from this was that being with certain people felt like being called into a relation, in which there was a freedom, or openness, which also put me under question. Along with this, there began to come clearly a sense that meaning was sensual, and it was this sensuality of meaning that restores us to something healing and enlivening. The given meanings of words tended to become separated from this sensual meaning, a separation that came very clearly into focus as violent and damaging to one's being. For example, I had torn the sensual meaning of being a Franciscan and tried to impose

it onto mental health nursing, and this made me feel abject. Such a tearing of the sensual from the given was 'a-bjectifying.' Coming to know this has been a coming to be in my own 'truthfulness', whose light then shines back across the study and finds its reflections in fragments of ideas and the struggle to speak.

This coming to know, and coming to be, would have been impossible without the 'caring about' and 'thinking with' of others. This seems to say that what is therapeutic about mental health nurses has nothing to do with 'mental' or 'health' or 'nurses' but all to do with being open to another person, in a 'caring about' and 'thoughtful' way. In this way, there may be an 'opening up' of language in its sensual meaning for the other person in her own truthfulness. In the Phenomenology (Chapter 6), this therapeutic way has been thought of as involving recognition of an irreducible relation between the 'I' and the 'not I', and how meaning belongs in a sensual landscape. How such a way of being with others can be learned appears to be about it being nurtured through being with people who are already like this.

7.3 Abjection and healing

The inspiration for this study was an experience of feeling abject, which seemed linked to mental health nurses not being recognised as therapeutic (Introduction, Chapter 1, Section 1.1). Coming to understand this experience has taken the time of this whole study, and is still emerging. An emerging understanding is that the source of this experience has to do with a sensual 'belonging' to a psychical landscape rooted in a real, intersubjective landscape. This perhaps re-states what Husserl meant in his intuition that our subjectivity 'knows' something of the 'facticity' of the world (Zahavi, 2003). There has been a struggle to find how this sensual 'home' was lost, which at the same time, seemed to 'show itself' in an obscure way from the outset. The sensual home is of course my own. Yet it seems such an understanding, and coming to have such an understanding, has relevance to others also, not

least because it depended on others being open to me. Jumping too quickly into explanations (and theory) only distanced, or covered over, what was emerging from an obscurity in experience. There was a 'givenness' to something which was obscure, and this was clarified through a dialogue with others, an openness to what was 'not mine,' itself reflecting something to do with a response to the research question (without any need for interviews or even participants).

Openness, in dialogue with others, and oneself, also 'allowed through' a healing in relation to others. For this reason, certain senses of 'salve' seemed to represent something of this healing, in terms of a welcome also. Healing seemed to become like a restoration of a meaning that had been 'torn' (Husserl, 1969, §59 in Welton, 1999, p. 262) from its context. There seems to be a kind of unction here that restores the place of the given meaning with the sensual. The salve is like an ointment repairing what has been torn from its living landscape, restoring it to its place, at first intuited in a vague way. There is also the sound of the Latin word, *salve*, which speaks of a welcome and a recognition. Perhaps we must be able to be this way if we are to be therapeutic. This perhaps seems to be what therapeutic mental health nurses do, a restoration of a sensual meaning that belongs to the other person, in a kind of welcome and recognition. The words of the patient here now seem to reflect this.

> "…the nurse gave me a bath with many words of comfort, like a child, after I felt neglected for weeks in my psychotic state" (Ruhl, 1998, p. 227 in Teising, 2000, p. 451).

It could be imagined now that the nurse's actions here have nothing at all to do with being patronising, or providing 'personal care', and all to do with recognition (of the 'I' and 'not I') and the allowing of a restoration of a sensual meaning to this person. The 'given' meaning (of psychosis) means something to the patient, but the openness of the nurse ameliorates its effects, returning the 'words of comfort' tacitly to a sensual meaning (perhaps to do with being a child once) that restores. In an unfolding understanding, it seems now that

this kind of restorative relation was what Brother David was allowing for me also, without either of us knowing it, and perhaps it was reciprocal (see Theory, Chapter 2, Section 2.5).

As noted in the Introduction (Chapter 1, Section 1.4), Cutcliffe, Santos, Kozel, Taylor and Lees (2015) found that the in-patient psychiatric setting is often "devoid of warm therapeutic relationships, respectful interactions, information or choice about treatment and any kind of formal/informal 'talk therapy.'" They follow this by saying that the 'care' environment instead is dominated by "coercion, disinterest, inhumane practices, custodial and controlling practitioners, and a gross overuse of pharmacological 'treatments'" (Cutcliffe, et al., 2015, p. 375). Rather than a restoration of a sensual meaning through a relation here, there is an imposition of a given meaning, that of psychiatric 'ideas,' or indeed, any 'ideas', which might be termed the 'disinterest of ideas'. For example, it is as if in the 'science' of psychiatry, and psychology, being able to sit with someone having tea and biscuits, in a personally warm and open environment, cannot be seen as therapeutic because it has no prestige in the 'scientific' view of 'treatment'. Yet, it can be seen that in an environment of interest and warmth, this other person can perhaps begin to feel his own relation to others in the only way that seems to matter, the sensual one. Most of the mental health nurses interviewed in this study appeared to 'know' this tacitly, and in different ways expressed something of it in an empirical way, which are outlined in the Findings chapter (Chapter 5; see Appendix 3). The mental health nurse being open to the other person seems crucial here.

7.4 Coming to be therapeutic

In this study, there has been an attempt to clarify what is happening with respect to how meaning arrives in empirical research and phenomenologically, and how a person may come to be therapeutic (not only in mental health nursing). The course of this study seems to show how understanding changes over time, but only in an environment of openness to oneself and others. How things may come to be understood differently brings Heidegger's

(1962, pp. 192-195 [151-153]) idea of the hermeneutic circle to mind, in which there is "hidden a positive possibility of the most primordial kind of knowing." A number of different ways of understanding things, which have emerged in this study, through a new 'givenness' of something, shows that in the return to an "originary giving intuition" (Zahavi, 2003, p. 45 - after §24 of Husserl's *Ideas I*) of something, the starting point has shifted. The circle does not seem to close (start from where it began) if there is openness.

For example, the struggle in the Theory chapter to articulate differences between speech and writing (Heaton, 2010) opened a path to Merleau-Ponty's difference between speaking and spoken speech, which then 'returned' to Husserl's distinction between *Bedeutung* and *Sinn* (Zahavi, 2003). It felt like a discovery to 'feel' the difference between what has been distinguished as sensual and given meaning in the phenomenology, as if finding a rare fossil for the first time for oneself and then noticing that others had come this way before. It is like Wittgenstein's distinction about being 'truthful' only if we have come by the way of our own 'truthfulness' (Heaton, 2010, p. 32; see Methodology, Chapter 3, Section 3.5.3). This way of 'discovering' seems to have repeated throughout the study in different aspects. This appears to have been more like an 'unfolding of patterns' from a sensual landscape than a rational, deductive process, although it is not that reason and deduction are not important. It appears that one's own truthfulness involves entering into, and taking seriously, one's own sensual landscape in which words are living things (imbued with sensual and linguistic 'sense').

A point made at the start of this study was regarding how certain theories, credos, and beliefs never seem to change, but repeat inexorably, so a person may *not* be "constantly compelled to face the possibility of disclosing an even more primordial and more universal horizon from which we may draw the answer to the question, 'What is "Being"?'" (Heidegger, 1962, § 49/26-27; Polt, 1999, p. 41; see Introduction, Chapter 1, Section 1.3).

The ‘unfolding of patterns’ seems to be blocked for some people, or with respect to certain aspects of a person. This has been explored in the Methodology chapter (Section 3.5.5) as to do with being ‘captivated’ in something like a gestalt, an “intentional arc” (Merleau-Ponty, 2014, p. 137/170), or similarly, a picture in which a “concept forces itself on one” (Wittgenstein, 2009, p. 215, § 191). It appears that some can extricate themselves from this captivity, and some cannot (as shown by the interminable repeat of dogma, credos and senses of identity). It does not seem possible, for example, to ‘shed’ the identity in relation to my father, the sensual meaning melded into the words “*Tá sé go h-ána fuar agus fliuch*” (see Phenomenology, Chapter 6, Section 6.2.2).

A movement ‘out of captivity’ towards a certain freedom then links back to the Theory chapter, where it seemed that openness to an ‘other’ person, and another meaning that was ‘not mine’ could be learned perhaps while it also seemed innate. A question here is whether openness can be learned, or nurtured, only if it is already innate. How do we come to know we are not open? And how do we come to care to be open? How could these questions be researched? It seems that learning appears to involve a ‘painful’ openness to an ‘other’ person, in which we are called into question, and this is a reciprocal movement of asymmetry. The asymmetrical relation has been thought of here after Husserl’s view of “foreign subjectivity” (Husserl, 1959, p. 495 in Zahavi, 2003, p. 115) linked to empathy as “self-alienation” (Husserl, 1970b, p. 189 in Zahavi, 2003, p. 124); although empathy exists in other forms also (see Methodology, Chapter 3, Section 3.5.2.1).

Drawing these two aspects together, that the meaning of one’s own truthfulness belongs in a sensual landscape, and that the other person is ‘known’ (at least to some extent) through a self-alienation, points towards something mysterious happening in becoming therapeutic. It can be imagined that a whole field of meaning exists for another person of which I have no inkling, but in which that person will find her own ‘truthfulness’ somehow

in relation to me being there as 'open' to her. This field of meaning has been shown to some extent in the phenomenology (Chapter 6; see appendix 5 also). Both coming to be therapeutic, and being healed in some significant way, then appears to involve coming to be in one's own truthfulness. How can truthfulness of something that is essentially alien (to the 'I') be researched? And why does it seem necessary for another to facilitate truthfulness, of which that other may know nothing? These questions appear to indicate areas for future research.

7.5 The relation to an other

The methodology especially attempted to explore the relation between a self and an other person in coming to understand anything, through aspects of Husserlian phenomenology in particular. Questions arose as to why it was necessary for someone else to be there to facilitate what is therapeutic. Husserl's way of writing can seem arid at times, his thinking is intricate, and at times almost impenetrable, bordering on solipsistic (Sousa, 2014), but the question of the other person (intersubjectivity) occupied him all his life (Zahavi, 2003). It is worth remembering that his initial studies were an attempt to refute psychology as being the bedrock of human knowing, and as a result perhaps, he seems to circle round and through what psychology may be in much of his writings (Zahavi, 2003). However, on reflection, on reading Merleau-Ponty (2014), and Husserl's privileging of the "giveness" of experience (Husserl, 1970a §51 in Welton, 1999, p. 21), something about language came to mind in a vague way. This vagueness clarified during the phenomenology, so that what it seemed Husserl's phenomenology was about was something quite simple, in that it was a way of speaking. Speech seemed to be 'opened up' through taking seriously what Husserl was saying, that, put simply, experience can be trusted (Giorgi, 2009), or in Husserl's terms, "let the originary giving intuition be the source of all knowledge" (Zahavi, 2003, p. 45, after Husserl, 1982, §24). In the phenomenology (Chapter 6; Appendix 5), it was apparent that the 'originary giving intuition' was a dream-like landscape, where there was a confusion about

what imagery was important and what was not, and ultimately, it seemed that meaning that counted therapeutically was sensual (and private). This will be discussed further in the following section (Section 7.6). This kind of 'private life' of meaning seemed to indicate that we do not know each other, except through fragments of 'spoken' speech which seem to be 'pointers' (see Section 7.7 below). Yet what is also clear is that we need others, to be with, to be in relation to, and to put us under question. This 'needing others' (also to be healed) appears to be an existential fact.

Phenomenologically, what appeared clearly, was that the 'other person' (the not-I) called into question one's own meanings, and attempts to understand these same meanings as an imposition on that other person. The necessity of an 'other' to understand oneself seemed to concur with Husserl's (1960, p. 125 in Zahavi, 2003, p. 116-117) idea that we are 'co-constituted' through a "transcendental intersubjectivity". It may be that this kind of relation is signalled, 'signposted', by simple statements in the interviews like "she accepts me" (Participant 2), or "just keep being there" (Participant 3). These statements seem loaded with ambiguity, tacit understanding and feeling. The ambiguity, tacit dimension, and feeling, along with uncertainty of meaning, 'showed' that there was a relation of uncertainty between an 'I' and an 'other' as opposed to seeing the other as a thing, an idea, or an already accounted for version of oneself. This has been explored through empathy especially, one aspect of which appears to involve openness to self-alienation. Such an openness links to restoration of openness, paradoxically, perhaps indicating that being open to an 'other' (another person) is innate. It appears to be the case that 'being with' (as a main theme in the empirical findings) simply reflects how this being in relation calls the person back into an openness to others.

This is a question perhaps for further research, as to how we become, or are, open to others. 'Spoken' language (Merleau-Ponty, 2014) is misleading here, and it feels like we could go around in circles forever trapped within its limits, if it were not for the sensual which

breaks through it. Sensual meaning 'shows' that there is another dimension to meaning which eludes us, is essentially private, but which continuously unfolds as we allow it a place (see Phenomenology, Chapter 6, Section 6.2.3). Key theme 2 of the empirical findings (see Chapter 5, Section 5.3.3.1), seems to reflect this empirical constraint, in that 'being with' a person is reflected in many ways, yet something of the relation between this 'I' and an 'other I' which emerges in the phenomenology remains hidden.

7.6 Meaning as sensual and meaning as given

In the phenomenology, (Chapter 6), being open to meaning in the relation between 'me and this other person' opened up the senses of meaning as 'given' and 'sensual' through a creative process. This creative process seems not unlike the process Giorgi (2009) speaks of, but he does not seem to take it seriously enough because it gets restricted through his method into empirical meanings, 'spoken' speech (Merleau-Ponty, 2014), or 'given' meanings. The meanings become 'given', separated from the 'sensual' aspect, and there is no acknowledgement of the seriousness of the failure of the 'given' word (or 'spoken' one) to "accomplish" a meaning (Merleau-Ponty, 1964, p. 46). The difficulty with a theoretical approach, or an idea, is that it may become an imposition of a way of seeing oneself, so that the sensual meaning is separated from the given. Heidegger (1985, § 6, p. 56 in Moran, 2000, p. 234) perhaps sums this up in his observation that, "We do not say what we see, but rather the reverse, we see what one says about the matter." The 'given' overwhelms the 'sensual'.

Those mental health nurses who appeared most therapeutic in this study appeared not to impose a meaning on the person, which seems to open up a space where the other's meanings can begin to emerge and be spoken (where possible). In this open space, of uncertainty, and no imposition, perhaps there is room for a restoration of the sensual meanings

for a person, and it may be that this is what therapeutic mental health nurses do. Through not imposing a meaning, but opening up a space for the other person to be, perhaps the burden of that person's 'given' meanings may be lifted.

Meanings 'appear', linked to a sensual landscape, belonging to it, the way the sea defines the coastline and the coastline defines how the sea's waves will break. The sea, the breaking waves, and the coastline change and shift in relation with each other. In another metaphor, the 'meaning' of the words in a landscape are like screeching wild birds, clamouring through the trees. But if those 'words' (sounds) are taken only in their 'given' meaning it is like removing the wild birds to a reserve, an aviary, in which they sit speechless and in mourning (the sensual landscape to which they belong having been removed). This seems to be what the imposition of a credo, or an idea, does to another person, it separates the meaning from the sensual landscape and the person is left (possibly speechless) in an alien world, alienated from himself. Separation of the given meaning of a 'word' from its sensual (private and unfolding) meaning is violent but appears to happen all the time. It appears that this separation is 'a-bjectifying'. For example, when Participant 1 called me a "shrinking violet" it appeared that a meaning had been imposed from which there was no escape (see Findings, Chapter 5, Section 5.7.3.2).

The picture is more complex, in that the sensual landscape may also have 'savage creatures' in it, as indicated in the Phenomenology (Chapter 6, Section 6.2). This complexity can be shown through returning to the Theory chapter, regarding openness to an uncertain encounter, in Hem and Heggen's (2003) study (Chapter 2, Section 2.4.3). Here, the mental health nurse is trying to be therapeutic through communicating with the other person, in her view, helping him to understand his vulnerability as a child. However, his responses are sometimes violently verbally aggressive. It seems that he is bordering on physical violence

with her, and her colleagues warn her to gain some distance from him. But through a "stubborn empathy" she keeps trying to communicate with him, so that there will be "understanding and contact" (Hem & Heggen, 2004, p. 104). It seems that a difficulty here may be that she is not taking into account that her empathy (as analogy to her own experience, for example) may be misguided. She may be making assumptions about his 'sensual landscape', perhaps finding her own landscape in his in a kind of mirror image, rather than allowing empathy as 'self-alienation.' It could be that he finds her attempts to get to know him unbearable, being trapped perhaps in her idea of him (as a vulnerable boy), and his aggressive language should be read as a warning.

Her certainty appears to be problematic, and the lack of exploration of a tacit dimension to what is happening seems to be a failing perhaps, because there appears to be a lot going on that cannot be spoken about as it is unknown, belonging to a landscape whose sensual meanings are 'private.' The tacit dimension here may be summed up by Hem and Heggen's (2003, p. 104) comment that she is expected to be "both intimate and distanced". This seems to concur with the phenomenology in which there is an uncertain relation between the 'I' and the 'not I', which needs to be allowed, and acknowledged tacitly, so that the other person has space to breathe. We appear to be linked to the other in a relation which is asymmetrical and uncertain in terms of trying to define, or 'know,' the other, reflecting the aspect of empathy as "self-alienation" (Husserl, 1970b, p. 189 in Zahavi, 2003, p. 124). The asymmetry between self-experience and other-experience appears to be a "necessary and persisting existential fact" (Zahavi & Rochat, 2015, p. 544), but one which we seem to repeatedly lose sight of in different ways.

This asymmetry also appears to be reflected in meaning as sensual, whose meaning appears to come to be known by the other asymptotically, never making 'contact', as it were,

with some ‘full’ experience of knowing the other (see Phenomenology, Chapter 6, Section 6.2.5). Even one’s own sensual landscape unfolds and its meaning seems to open out onto an “endless openness” (Husserl, 1960, p. 107 in reference to intersubjectivity), revealed in and through a shifting, sensual gauze of memory.

7.7 Empirical findings and the phenomenology

What seems to repeat, inexorably, like Wittgenstein’s picture (2009, ¶115) is how mental health nursing is in captivity to the psychiatric way of thinking about people. A certain degree of ‘self-alienation’ (on my part) seems to be present in trying to understand why mental health nurses work in this scenario. And looking into this world now seems ‘self-alienating’. This captivity in psychiatry especially became apparent in the empirical findings and how the language ‘spoken’ was imbued with psychiatric beliefs, but also frustration with not being able to have more time with people. It is indeed as if mental health nurses are servants to psychiatry (Bjorklund, 2004), and what they do therapeutically in other ways is side-lined, seen as superfluous, and they can be left to their own devices as it does not really matter. The empirical findings reflect this situation, with the main focus of activity on facilitating medical psychiatric care, alongside another, subordinate activity of being with clients in various ways.

Working with others therapeutically, in idiosyncratic ways, seemed to reflect beliefs held by those interviewed, but also had to do with the evolving resolution of personal difficulties from childhood. In the latter case, it was as if being a mental health nurse was a way of ‘working through’ unconsciously active difficulties in relation to ‘an other person’ (or others). The ‘working through’ may have been then reciprocal in ‘being with’ others (patients). There seemed to be no consistent acknowledgement of this in the literature apart

from Peplau's (1988) emphasis on the nurse coming to understand why she wanted to care. Peplau's (1988) kind of thinking has now been replaced by 'evidence-based' nursing (Watson, 2012), dominated by the 'contain and fix' strand of thinking (Eckers, Dawson & Bailey, 2013; Ellis; Gournay, 2001).

In the decreasing lack of emphasis on 'personal process' in mental health nursing, it is not surprising that in-patient settings are dominated by indifference (Cutcliffe, Santos, Kozel, Taylor & Lees, 2015). Yet, this study has shown that individual mental health nurses are therapeutic (both in in-patient and community settings), but this depends on the person of the nurse. The struggle to say what it is that is therapeutic, apart from 'being with' in various forms, seems important phenomenologically. The struggle seems to reflect not only a lack of training in ideas about the therapeutic (so that there would be given words to speak about it), but more importantly perhaps, points to something ontological in the relation between people which is potentially therapeutic (linked to openness). This ontological relation seemed to be most clear in the phenomenology. 'Training' might simply do to mental health nurses what the empirical does to language, constrain and limit it to 'given' meanings, and therefore, may constrain and limit the person in relation to the nurse to the same meanings. It seems that a therapeutic education in mental health nursing ought instead to aim for the mental health nurse to come to be in her own 'truthfulness.'

Empirical findings seem to be like signposts that point towards sensual meaning but do not show it. The findings from the phenomenology show the sensual more clearly. The relation between the empirical findings and the phenomenology seem to show that being therapeutic has to do with a person finding his own meanings, in 'truthfulness', in a landscape of given and sensual meanings, and having the openness to the other to facilitate this. Openness to an 'other person' seems necessary to facilitate such a 'truthfulness' and this

openness appears to be reciprocal. What the empirical findings seem to show is that they are confined by a way of speaking, which may, or may not, reflect a way of being in the person. The phenomenological appears to 'open up' language, so that the differences between sensual and given meaning appear, and the words reflecting the 'things themselves' may be expressed in a more evocative, playful, and perhaps poetical way. It seems that the way to one's own 'truthfulness' lies in this 'opened up' language so that words are allowed to 'speak' from a landscape that is sensual. The phenomenological takes seriously the questioning of experience - for example, 'What is it like for me to try to understand this person? What is actually going on for me when I am trying to understand what they mean?' - rather than fall too easily into the captivity of ideas and beliefs.

Giorgi (2009) appeals to method in order to be able to present to the other's consciousness (the critical other as a community) a form of common language (a certain empirical language), so that 'what is going on in the researcher's consciousness' can be checked and critiqued by that community. By default, this constrains the language used. In a sense what Giorgi's (2009) method reflects is a way people speak in the 'natural attitude' of a discipline, believing they are being more accurate, more scientific, more informed perhaps. This also seemed to appear everywhere in the empirical findings, with reference to the 'technical' ('spoken' or 'given') language of psychiatry and psychology being ubiquitous. But there was something else going on which the empirical findings could not access (similarly by default). For example, the struggle for each participant to speak about what 'being with' meant appeared to expose a certain failure of 'spoken' speech, or 'given' meaning in language. Participant 8, for example, spoke about what was therapeutic in mental health nursing as "… all about that interaction and having that rapport with someone... and building on that kind of relationship with that person…" (P8 MU14 line 217). But he struggled to speak about this much further, as if the words did not come easily, or could not

be found in those he had been given or through which he felt he could speak. It seemed that he needed a place to find his own truthfulness in this struggle for words, and also to come to understand more clearly the ambiguity in words like 'rapport', and 'relationship'. In his general synthesis, this struggle is spoken of as 'the therapeutic is hard to express' (see Appendix 3), and so, this empirical finding seems to stand like a signpost showing that another journey is needed. It seems from the phenomenology that this journey is towards coming to allow the uncertain relation with the other person who calls us into question, and one's own truthfulness through that relation.

With respect to the effects of empirical findings, Giorgi's (2009) lack of insight into the tacit assumptions he makes about language appears to be critical. It is as if there is an operative intentionality at work for him (and others) which elides the possibility that meanings are simply being repeated in an already constrained way. It is worth returning to Merleau-Ponty's (2014) description of operative intentionality here.

> We uncovered, beneath act or thetic intentionality - and in fact as its very condition of possibility – an operative intentionality already at work prior to every thesis and every judgement; we discovered a "*Logos* of the aesthetic world," [after Husserl in *Formal and Transcendental Logic*, p. 292] or a "hidden art in the depths of the human soul," [after Kant in *Critique of Pure Reason*, A141/B180] and that, like every art, only *knows itself in its results* (Merleau-Ponty, 2014, p. 453/492 italics added).

Giorgi's (2009) method (and perhaps all empirical methods) seems to 'know itself in its results' and so, the circle is closed, closing out openness to another person. With respect to Giorgi (2009) empirical method, there seems to be a 'logos' or 'hidden art' that appears to be a tacit way of making assumptions which is not easily accessible to consciousness (see Freeman, 1993). It is not that the phenomenology is immune to this 'hidden art' but it

acknowledges it and tries to allow its 'functioning' to show itself. Another way of saying this is the 'always already' aspect here (see Methodology, Chapter 3, Section 3.5.4):

> "… the researcher is always, already in an intentional relationship with the phenomenon under investigation… therefore, the researcher can never decide to invoke intentionality nor escape it; the researcher can only try to make fleeting sense of it as he or she reflects on it" (Vagle, 2009, p. 586).

The implications of operative intentionality have been discussed in some detail in the Methodology (Chapter 3, Section 3.5.4), the main one being that findings in research may always have something to do with the researcher's 'beliefs' or credos, functioning to inform the findings in a tacit way which cannot be explicated. Operative intentionality has been thought of as one way in which a meaning may 'force' itself, like a gestalt, so that we feel it is a 'truth' of some kind (after Wittgenstein, 2009, p. 215, § 191). The effect of something like operative intentionality may be one way of thinking about why van Kaam's 'axiom' (1966, p. 32) - "identically named experiences refer basically to the same reality in various subjects" (von Eckartsberg (1998, p. 14) - is so persistent.

The phenomenology appears to have shown, perhaps, some of this kind of pre-reflective intentionality in coming to 'find' meanings. Now, looking again at operative intentionality, it appears that my focus on it was a way into allowing experience to be taken seriously, to trusting the 'truthfulness' of my own experience, through another's experience. The focus on operative intentionality showed a way towards something that I knew nothing about, or perhaps sensed something tacitly, until experience began to be trusted. Again, in a circular movement (that does not close), there is a return to something that came before but now in a new light, a trust in the "originary giving intuition" (Zahavi, 2003, p. 45, after Husserl, 1982, § 24). And again, this seems to show that in coming to know anything

worthwhile that the journey is through one's own "truthfulness" (after Wittgenstein, 1998, p. 41 in Heaton, 2010, p. 32), even if others are (it seems without fail) needed to show the way.

The intersubjectivity involved here becomes clearer, in that understanding depends on others, and then a certain confidence in one's own experience develops from this, but there is a constant return to others. We belong in an intersubjectivity. This seems to signal, again, what Husserl saw as 'co-constituting intersubjectivity' (Husserl, 1960, p. 125 in Zahavi, 2003, p. 116-117). In effect, we depend on each other, but also, we can become trapped in another's idea, and another may trap us in that idea. The importance of the asymmetrical relationship between the 'I' and the 'not I' becomes clearer if this 'entrapment' is kept in mind. Making this relationship symmetrical would result in us all being copies, eventually, 'of the same story in a newspaper' (Zahavi, 2003, p. 116, alluding to Wittgenstein's (2009, §265) example).

In being caught up in a credo (the same story in a newspaper), then we think we can describe the world accurately in our words, without realising that the words have already been provided by the credo. It seems that 'knowing' this is different to coming to know it in one's own 'truthfulness'. It seems to be that 'truthfulness' is what is most important, rather than a repeat of words that define the search for that truthfulness. In the phenomenology, what seemed to be opened up was a trusting in whatever words came to speak of an experience, so that language becomes more fluid, open, and the sensual aspect reveals itself more clearly. It appears that this is what mental health nurses who are open to others (and themselves) may show, and offer, to others. This kind of openness is like an invitation for the other person to simply speak of their experience and come to know it in a more truthful way.

7.8 Understanding the other person

This section addresses what has been implicit throughout the study, which is that we *can* come to understand the other and meaning can be communicated in a reliable way. This has been addressed explicitly, but not at great length, in terms of empathy as a 'whole' experience of the other, empathy as analogy, and the 'sedimented' meanings in spoken speech (see Methodology, Chapter 3, Section 3.5.2). Differentiating empathy as self-alienation was important to address the problem of how we can become captivated in ideas, and theories, about another person, without seeing this captivation as it is like a meaning has been 'forced' on us (without knowing it has been forced). Although we may come to understand another's meaning, at least to an extent, it appears that it is likely to 'close down' a person if we assume we know, if we do not preserve a certain openness towards something that we know nothing about.

This kind of openness was noticed in some of the mental health nurses interviewed for this study, and it was clear there was no need for an empirical method of research to 'find' this. It was clear and obvious, but the question arises on whether it is only clear and obvious to someone who is open already to this openness. This 'noticing' may be what Husserl calls 'personalistic,' and for him is more fundamental than a 'scientific' attitude. In the former, the other is given as whole, and he may be talking, laughing or dancing, so that I see him as an expressive unity (Zahavi, 2014, p. 128, after Husserl, 1952, p. 228; 235; see Methodology, Chapter 3, Section 3.5.2.1). This form of empathy communicates something of the other that we can trust, but it is important to bear in mind that the 'whole' picture may not be apparent, as we perceive in profiles, which we then 'fill' through 'assumptions'. We 'intend' the other person as a whole through an intentional consciousness of absent profiles (Zahavi, 2014, p. 128). The absent profiles are not 'deduced' or inferred rationally; they are 'filled' by intentionality, which can be seen as a special kind of interpretation or 'meaning-intending'

(Husserl, 1962, p. 183 in Zahavi, 2014, p. 129). This is why operative intentionality is such a crucial concept, as it is a form of intentionality that informs the more 'conscious' way we intend meanings, and understanding this then calls our judgements into question (as noted above, Section 7.7).

But nevertheless, it is clear that we come to know and understand what another means, although we may not 'know' the whole picture. It also seems to be a great relief when someone comes to 'know' us in some way, and we might feel we belong or are accepted by another (as for example, being with Brother David showed). 'Spoken' speech seems to convey directions, like signposts pointing towards a landscape but never being able to convey that landscape. It seems that Giorgi's (2009) method draws out the meanings of 'spoken' speech more than anything, translating these into psychological terminology which is like a specialist section of 'spoken' speech. The way the method does this also seems to only serve a need to be seen as scientifically methodical, rather than any special way of revealing something hidden or disguised. The reduction in Giorgi's (2009) method is a psychological one, in that it tries to attend to what is essential in a psychological meaning (while the researcher attempts to suspend his assumptions about that meaning). The phenomenology was also immersed in spoken speech, but such speech became instead like a way of both indicating and disguising, so that something else was needed for implicit meanings that came through. The 'something else' seemed to be the phenomenological reduction, in the sense of coming to see how the researcher's imagery and 'sense-making' was like a gauze of memory through which the experience of the other was 'seen'. Ultimately, this led to uncertainty about the meanings in play for the other person, and this seemed to lead into openness towards that person then.

In contrast, Giorgi's (2009) method may make us think that we know something about the person's meanings which can be pinned down and repeated. They *can* be pinned down

and repeated only in the sense that 'spoken' speech acts like a reservoir of agreed meanings, just as Husserl (1973) noted that only 'normal' people define what is normal and that then becomes 'sedimented' into a tradition (Zahavi, 2003, p. 134; Husserl, 1973, p. 162; see Methodology, Chapter 3, Section 3.5.5.2). For example, a psychiatrist might say of a patient who comes to see him, "He is sad because he's depressed", whereas the patient may be sad because the doctor will not see him in any other light. The reservoir of spoken speech 'speaks' for him (defining him as depressed) and the psychiatrist (who is spoken for). In this sense, we 'know' someone through spoken speech (both the patient and the doctor here), but as can be seen, the words only indicate something (for example, he says he is sad), including possibly a closure to the other person (the doctor is closed). Someone in the phenomenological reduction might allow a thought such as, "Is he sad because I am trapping him in sadness?" This kind of speech seems more to be 'speaking' (after Merleau-Ponty (2014, p. 202/238); see Methodology, Chapter 3, Section 3.6) now and opens up other 'profiles' (to follow Husserl's way of writing), showing that the phenomenological opens up a space for another in which he may find his own 'truthfulness' in what seems to be an "endless openness" (Husserl, 1960, p. 107).

Concluding this study is difficult because it is like there is no 'closure' to it, as if in keeping with the main argument for 'openness' as healing. Concluding seems to involve a certain loss, while also seeing things as if for the "first time" (Heidegger, 1962, p. 362/315). There is the coming to know of loss of a life's journey in one sense, in which credos fall away, of coming to know the impossibility of trying to be Franciscan through the framework of mental health nursing, and what is left is being a person in the 'endless openness' of intersubjectivity. It appears that this 'coming to know' has to be in one's own truthfulness, and it seems there are no easy ways through to this because we are caught up in credos, ideas, endless ways of being (including vanity). What seems to persist as meaning something, that

placed no demands, and offered a patient openness, is Brother David's welcome. The pot of tea, the hand pouring milk, a space at a table for someone, a tacit allowing of the other, also to speak, speaks of something healing that reminds me of some of the mental health nurses in this study who are therapeutic. The sensual landscape here seems impossible to convey.

What was surprising was the unexpectedness of the findings that emerged from the phenomenology of the therapeutic, called here the phenomenology (Chapter 6). In a way, this surprise reflected the phenomenological approach taken from the start, trying not to grasp at ideas too vehemently, and allowing something to 'speak', but staying with the anxiety that perhaps nothing would. It was surprising that I came to be able to speak also. It came to appear in a kind of truthfulness that not 'allowing' the other person was violent in some way, closing the other's meanings into versions of oneself, or given meanings. This violence can be reciprocal and seems to silence us. We might not allow the other person to heal us. The phenomenology seemed to show more about what the empirical findings had only indicated, from the empirical method, that 'being with' another person was somehow healing if the person was open to the other in a reciprocity. Being open to another without grasping at ideas, seemed to open a space where the other could come to be recognised as she was, also in a sensual landscape that could not be understood. This paradoxical asymmetry in the relation between one person and another seems to be crucial, and appears to open out onto other worlds, sensual landscapes belonging to 'an other', of which we know nothing.

Appendix 1 Public, statutory and professional expectations

A.1 There is agreement between public perceptions of nursing, the government, and the Nursing and Midwifery Council, that nursing is a practise-based discipline involving humanistic values, where the nurse puts the patient first. The main expectations of the public are that nurses should care, and put the needs and interests of the patient first (Francis, 2013).

Following a first inquiry in 2010, in February 2013, the Mid Staffordshire NHS Foundation Trust Public Inquiry reported to the Secretary of State for Health in the Francis Report. In March 2013, the government's initial response to the Francis Report included the proposal that NHS-funded student nurses should spend up to one year working "on the frontline" as health care assistants or support workers, before they could receive funding for their degree, in order to ensure that people who become nurses "have the right values and understand their role" (www.gov.uk/government/speeches/the-government-s-response-to-the-francis-report). This response goes beyond the corresponding Francis Report recommendation (number 187) that student nurses spend at least three months working on the direct care of patients under the supervision of a registered nurse, and reflects public perceptions that nursing should be about basic caring contact with patients.

In response to such poor care highlighted in Mid Stafford and elsewhere, in December 2012, the Chief Nursing Officer for England, Jane Cummings, and the Director of Nursing, Viv Bennett, published *Compassion in Practice*. This put forward a strategy (to be run over three years) for nurses, midwives and care staff to deliver high quality, compassionate care, and achieve excellent health and wellbeing outcomes. The strategy was developed in consultation with over nine thousand nurses, midwives, care staff, patients and others, which asked for feedback on Cummings and Bennet's idea of organising practice around the "values and behaviours" of care, compassion, competence, communication, courage and commitment: the 6Cs. They found there was widespread support for their vision and strategy, especially amongst frontline staff. The 6Cs are to be embedded throughout all career pathways, including training, education and recruitment, organisational culture and appraisal and development of staff.

Compassion in Practice (Cummings & Bennett, 2012) provides the following definitions:

- Care: "helps the individual person and the whole community"; people expect care to be right for them, throughout their life.

- Compassion: is how care is given through relationships based on empathy, respect and dignity; it is "intelligent kindness" and is essential to how people perceive their care.
- Competence: all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
- Communication: central to successful caring relationships; listening is part of this, and essential for "no decision about me without me."
- Courage: enables the nurse to do the right thing, to speak up about concerns, to innovate and to embrace new ways of working.
- Commitment: a commitment needs to be made to improve the care and experience of patients and populations.

The values and behaviours indicated here appear to be transparent and clear to the understanding of others. For example, to care may mean to give someone a glass of water when they are thirsty (this example refers to a common failure to care in the Francis Report), and nobody would disagree with this. Providing someone with a glass of water may also provide a means for the therapeutic in other ways, perhaps for that person to speak for the first time after a trauma, or a means of approaching the abject. There is more complexity to the nurse-patient relationship, in which the meanings and implications of commitment to strategies like the 6Cs are not so clear. This is noted by the Nursing and Midwifery Council (2010: R5.6.2) in terms of meeting the "complex needs of people", but again there is an assumption that there is transparency with regard to 'need'. The inadequacy of language to circumscribe the roles and attitudes of the nurse again point to something outside of language with which nursing engages and contains. This may be implicit in the UK government's initial response to the Francis Report in the recommendation that students should spend up to one year working 'on the frontline' as health care assistants.

These initiatives indicate that nursing is a public role, whose activities are defined, in part at least, by normative ideas (visions and strategies) imposed upon the discipline, also from within the discipline itself. It is interesting to note that this places nursing in a peculiar position with respect to the currently dominant evidence-based paradigm in healthcare, in that reports or opinions from respected authorities (the least reliable level of evidence) takes precedence over other evidence (see Muir-Gray 1997). McCrae (2011) has noted that nursing

is subject to such directives because of a lack of theory underpinning practice. Edwards and Liaschenko (1998) have noted that because nursing is a pragmatic discipline it has no need for theory. As noted above, the lack of theory may also be a necessary aspect of nursing because of its closeness to the abject.

A.2 Therapeutic knowledge in standards of education and competence

The information in this section is drawn from the Nursing and Midwifery Council website. The mission of the Nursing and Midwifery Council is to safeguard the health and wellbeing of the public as required by the *Nursing and Midwifery Order 2001*. One way of achieving this is to set standards of education, training and conduct. Nursing education and practise must also be consistent with *The Code: Professional standards of practice and behaviour for nurses and midwives* (Nursing and Midwifery Council, 2015). Degree level education has been required of all nurses since September 2013. The current standards for pre-registration nursing education have been in place since 2010, updating and strengthening the 2004 standards (Nursing and Midwifery Council, 2013, p. 10) in response to the initial *Francis Independent Inquiry* report (2010) into care provided by Mid Staffordshire NHS Foundation Trust (January 2005 – March 2009). These new standards emphasise the importance of care and compassion, as well as focusing on safeguarding the public, "so that nurses of the future are fit for practice… and are able to meet the needs of patients and the public safely and effectively with compassion" (Nursing and Midwifery Council circular 01/2010). These are also consistent with those recommendations of the final *Francis Report* (2013) which addressed nurse training and education (currently under review).

For the Nursing and Midwifery Council caring is both an art and a science, requiring compassion, and competence in acquiring scientific and technical knowledge, as well as holding humanitarian professional values (Nursing and Midwifery Council September 2010). Fields of practice in nursing are divided into adult, mental health, learning disabilities and children's nursing. For each field the Nursing and Midwifery Council defines learning outcomes for pre-registration nurses in terms of skills. In the Council's Standards for Education, minimum requirements are set out.

Introduced in 2008 (Nursing and Midwifery Council circular 07/2007), five Essential Skills Clusters are defined, and individual educational institutions are allowed to develop their own ways of delivering these. The clusters provide a guide for theory and practice learning

outcomes, tested using valid and reliable assessment methods. Any curriculum "must reflect the application of ethical, professional and legal frameworks… must be evidence-based and reflect the very latest knowledge, practice, research and technical requirements" (www.nmc-uk.org). Programmes must be approximately fifty percent theory (2300 hours) and fifty percent practice (2300 hours). Students should also have a range of opportunities to learn in practice with, and from, other health and social care professionals.

Essential content of education programmes must include the following:

- Theories of nursing and theories of nursing practice
- Research methods and use of evidence
- Professional codes, ethics, law and humanities
- Communication and healthcare informatics
- Life sciences (including anatomy and physiology)
- Pharmacology and medicines management
- Social, health and behavioural sciences
- Principles of national and international health policy, including public health
- Principles of supervision, leadership and management
- Principles of organisational structures, systems and processes
- Causes of common health conditions and the interaction between physical and mental health and illness
- Best practice
- Healthcare technology
- Essential first aid and incident management

The emphasis here is on medical and pharmacological knowledge, and understanding organisational and legal frameworks and technology.

This content should underpin the following key aspects of practice, enabling the nurse to "meet the essential and immediate needs of all people" and the "complex needs of people in their chosen field" (Nursing and Midwifery Council 2010: R5.6.2):

- Communication, compassion and dignity
- Emotional support
- Equality, diversity, inclusiveness and rights
- Identity, appearance and self-worth
- Autonomy, independence and self-care

- Public health and promoting health and wellbeing
- Maintaining a safe environment
- Eating, drinking, nutrition and hydration
- Comfort and sleep
- Moving and positioning
- Continence promotion and bowel and bladder care
- Skin health and wound management
- Infection prevention and control
- Clinical observation, assessment, critical thinking and decision-making
- Symptom management, such as anxiety, anger, thirst, pain and breathlessness
- Risk management
- Medicines management
- Information management
- Supervising, leading, managing and promoting best practice

'Meeting the needs of others' is the key theme in these key aspects of practice, and there is an assumption again that these needs are transparent. There is an emphasis on the activities of daily living (after Roper, Logan and Tierney, 1980). The therapeutic effects of communication and nurse-patient interactions are given less emphasis.

A.3 Essential Skills Clusters and Standards for Competence

Since 2010, the Essential Skill Clusters form guidance within the standards for pre-registration education. It is interesting to note that these lay out a framework which is likely to come into conflict with the actual interpersonal interaction in the moment which may involve some other 'skill, behaviour or attitude', or something else, to those defined.

The five Essential Skill Clusters are:

1. Care, compassion and communication.
2. Organisational aspects of care.
3. Infection prevention and control.
4. Nutrition and fluid management.
5. Medicines management.

The first cluster is most relevant for the current study and is summarised below:

<u>Essential Skill Cluster: care, compassion and communication</u>

There is an emphasis on providing collaborative care, person-centred and empowering to the patient; showing respect for diversity and difference; being warm, sensitive and compassionate, with appropriate use of touch, and the use of active listening skills.

The Standards for Competence set out the context of the skills and attitudes the student must acquire to qualify at degree level. 'Competence' is a holistic concept and may refer to *a combination of knowledge, skills and attitudes* required to practise safely and effectively without direct supervision (The Nursing and Midwifery Council adapted this definition from the Queensland Nursing Council 2009). At times the term, 'behaviour' is used instead of 'attitude'. The term 'competencies' replaces 'proficiencies' (although it is not explained why). Acquiring competencies lies at the heart of nursing education. The definition of competencies is fluid in that the qualifier 'may refer' is used, purposefully, perhaps to indicate the complex nature of practising competently as a nurse.

Competencies cover four domains:

1. Professional values.
2. Communication and interpersonal skills.
3. Nursing practice and decision making.
4. Leadership, management and team working.

The context in which the competencies are acquired depends upon the particular field of nursing. Each domain has a generic and field specific component reflecting the commonalities and differences of the four fields of nursing. All nurses are required to apply knowledge and skills based on the best available evidence indicative of safe nursing practice, and these are integrated into the competencies.

Domain 1: Professional values

The standard for competence in this domain for mental health nursing is:

"Mental health nurses must work with people of all ages using values-based mental health frameworks. They must use different methods of engaging people, and work in a way that promotes positive relationships focused on social inclusion, human rights, and recovery, that is, a person's ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying" (Nursing and Midwifery Council 2010).

Domain 2: Communication and interpersonal skills

The standard for competence in this domain for mental health nursing:

"Mental health nurses must practise in a way that focuses on the therapeutic use of self. They must draw on a range of methods of engaging with people of all ages experiencing mental health problems, and those important to them, to develop and maintain therapeutic relationships. They must work alongside people, using a range of interpersonal approaches and skills to help them explore and make sense of their experience that promotes recovery" (Nursing and Midwifery Council 2010).

Domain 3: Nursing practice and decision making

The standard for competency for mental health nursing is:

"Mental health nurses must draw on a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions to provide person-centred support and care across all ages, in a way that supports self-determination and aids recovery. They must also promote improvements in physical and mental health and wellbeing and provide direct care to meet both the essential and complex physical and mental health needs of people with mental health problems" (Nursing and Midwifery Council 2010).

Domain 4: Leadership, management and team working

The standard for competency for mental health nursing is:

"Mental health nurses must contribute to the leadership, management and design of mental health services. They must work with service users, carers, other professionals and agencies to shape further services, aid recovery and challenge discrimination and inequality" (Nursing and Midwifery Council, 2010).

A.4 Influence of values and nursing models in the Standards for Education and Competence

What appears here is that mental health nursing is a practise that involves close interpersonal interactions with patients, but also within a context of public expectations and managerial roles. The interweaving of 'personal process' and 'contain and fix' approaches is clear here. Some values appear to be prescriptive, based on what the public wants and traditional expectations within nursing:

- That nurses should have the 'appropriate attitude' although it is not defined what this may be.
- Emphasis on legal frameworks, such as human rights and dignity; including medico-legal concepts such as consent, which guide practice.
- The idea that transparent communication is possible.

The influence of nursing models in these standards is not explicitly indicated, but can be derived along the following themes, valued as being therapeutic:

- *Empowerment and choice* – reflecting Parse's (1981) focus on existential themes, after Sarte, such as freedom.
- *Difference, and the individual as autonomous* – reflecting another existential theme, found in Barker's Tidal Model (1998), which focuses on recovery and valuing the person's own words and story.
- *Developing insight into one's own values, self-awareness, and understanding of how one's own interactions affect relationships* – reflecting Peplau's (1952; 1988) psychodynamic theory of interpersonal relations in nursing; the nurse, in order to be therapeutic, must be able to allow herself to be affected and changed through her interactions with others.
- *Meaning seeking* – this is an existential theme developed by M. E. Rogers (1970), Parse (1981 and Barker (1998).
- *Kindness, touch, and caring relationships* – themes especially developed by Watson (2012), where love is a transpersonal phenomenon especially relevant to nursing.
- *Person-centred approach and achievement of goals* – This places the patient centre-stage, and in part reflects the influence of humanistic psychology on nursing (after Carl Rogers).
- *The activities of daily living* – this is a dominant theme in the standards and directly reflects the influence of the Roper, Logan and Tierney (1980) model of nursing, centred on activities of daily living, including physical, emotional and spiritual needs.

A.5 Summary

What appears in the standards of education and competence is that there is something intangible about mental health nursing practice that can be learned but is difficult or impossible to define. This may be due to the difficulty in moving from frameworks of values

to what happens in the actual encounter with another person. McCrae (2011, p. 224) notes that nursing models are regarded by many nurses as “unrealistic dogma” and as “diversions from intuitive care.” In the standards and the literature there is an indication that nurses are guided by an intuitive humanistic ethos tuned by training and experience (McCrae 2011). There is a need then to open up a space where mental health nurses can speak of the encounter with the other person, and approach a way of articulating this

Appendix 2: Ethical Approval and Sample Information and Consent Forms

The research for this project was submitted for ethics consideration under the reference PSYC 13/074 and was approved under the procedures of the University of Roehampton's Ethics Committee on 4th May 2016 (see attached form).

NHS approval was received 12th February 2013 (see attached form).

University of Roehampton
Grove House
Froebel College
Roehampton Lane
London SW15 5PJ

Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London
SW15 4JD

4th May 2016.

To Whom it May Concern,

Project Title: **The nature of therapeutic knowledge with particular reference to mental health nursing**
Researcher: **Anthony McSherry**
Reference: **PSYC 13/ 074**
Department: **Psychology**

On behalf of the University of Roehampton Ethics Committee I am pleased to confirm that, under the procedures agreed by the University of Roehampton Ethics Committee, the Department of Life Sciences has approved the above ethics application and confirmed that all conditions for approval of this project have been met.

We do not require anything further in relation to this application.

Yours faithfully,

Professor Garry Marvin
Ethics Committee Chair

University of Roehampton London

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project:

What is the need, if any, for therapeutic education in mental health nursing? An empirical phenomenological study of mental health nurses' responses to this question.

Brief Description of Research Project:

This research aims to identify whether mental health nurses need an education (basic and ongoing) that substantially supports and develops their own therapeutic potential with others. This is about helping nurses to improve their interpersonal relationships as well as improving the quality of their own work for themselves and others. Extensive reporting in the literature shows that mental health nurses are highly valued by patients, and that the therapeutic relationship is the core focus of the profession. This research aims to examine these views and show how nurses can be supported in this focus of their work. Data will be collected through interviews with mental health nurses interested in the topic. Each interview will be recorded and last about 1 hour or so. Interviews will take place on CWP Trust premises convenient to the participant. Confidentiality in the interview will be upheld unless of course there are issues of serious harm to self or others apparent. If the participant wishes to discuss any issues arising from the interview process, this can be arranged between the researcher and the participant. Further or alternative support can be arranged through another therapist or health professional if necessary also.

Investigator Contact Details:

Name	Anthony McSherry
Department	Psychology
University address	Roehampton University, London
Postcode	SW15 5PU
Email	tony.mcsherry@cwp.nhs.uk
Telephone	0151-3577500 or 07581562003

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw, or drop out of the research at any time. If I do decide to withdraw I agree that any

transcription deriving from my interview may still be used in an aggregate form (not an individual synthesis). I understand that the information I provide will be treated in confidence by the investigator and that my identity, and anyone I may mention in my interviews, will be protected in the publication of any findings.

Name ……

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Head of Department Contact Details:

Name	Dr Diane Bray
University Address:	Department of Psychology (Head of Department) Whitelands College, Holybourne Avenue London SW15 4JD
Email:	D.Bray@roehampton.ac.uk |
Telephone:	020 8392 3627

Director of Studies Contact Details:

Name	Professor Del Loewenthal
University Address	Research Centre for Therapeutic Education Whitelands College, Holybourne Avenue London SW15 4JD
Email	d.loewenthal@roehampton.ac.uk
Telephone	020 8392 3615

Supervisor Contact Details:

Name	Dr Julia Cayne
University Address	Research Centre for Therapeutic Education Whitelands College, Holybourne Avenue London SW15 4JD
Email	j.cayne@roehampton.ac.uk
Telephone	0208 392 5788

University of Roehampton London

RESEARCH INFORMATION SHEET

What is the need, if any, for therapeutic education in mental health nursing?

You are being invited to take part in a M.Phil/PhD in Psychotherapy research project being carried out through Roehampton University, London. Before you decide it is important for you to understand why the research is being done and what it will involve. **Please take time to read the following information carefully and discuss it with others if you wish.** Ask me anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the research?

I would like to interview a range of Mental Health Nurses to describe their perceptions of whether or not mental health nursing education ought to have a therapeutic focus. Mental Health Nurses are highly valued by patients, yet nurses struggle to describe what it is that they do that is effectively therapeutic. For example, there are few nurses (sometimes none, and no nurse academics) on NICE Guideline Development Groups and Review Panels for common mental disorders. The research aims at finding out if, and how, therapeutic education for mental health nurses might improve the effectiveness of nursing, both for the wellbeing of patients, nurses and services. Therapeutic education would involve practical engagement in theoretical and empirical understanding of what is therapeutic, that is, what is beneficial or healing to another person.

Do I have to take part?

You do not have to take part if you do not wish to do so. If you do decide to take part you will be contacted by the researcher and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

At the interview, I will invite you to speak about whether nursing education should have a focus on what can be considered to be therapeutic. I will try to allow you to speak as much as possible rather than be guided by my own ideas. The interview should take approximately one hour.

What happens to the information I give at the interview?

The interview will be tape recorded so that the interviewer can listen to you without the need to take notes. It will last about 1 hour. Following the interview, the information will be typed up from the tape. Your personal details and any names of people or places mentioned will remain confidential, as they will not be included in the written account. The tapes will then be destroyed. The written accounts will then be collated and written up as part of a psychotherapy M.Phil/PhD research study.

What will happen to the results of the research?

The results will contribute to a PhD, and may in part be published in article form in journals or published as part of a book.

Who is funding the research?

The research is self-funded by the researcher.

Contact for further information

Tony McSherry 0151-4888399 tony.mcsherry@cwp.nhs.uk

Thank you for reading this information leaflet and considering taking part.

Version 2 18th January 2013

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Research Office
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ

Tel: 01244 650559
Email: phil.elliott@cwp.nhs.uk

Standardised Process for Electronic Approval of Research

12th February, 2013

Tony McSherry RMN
Psychotherapist UKCP
Cherrybank Resource Centre
85 Wellington Road
Ellesmere Port
CH65 0BY

Dear Tony,

Re: NHS Permission for Research

Project Title: What is the need, if any, for therapeutic education in mental health nursing? An empirical phenomenological study of mental health nurses' responses to this question.
Unique SPEAR Identifier: 1205
Sponsor: University of Roehampton, London

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. **Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed**.

Please take the time to read the attached conditions for NHS permission. Please contact the Research Office should you require any further information. You will need this letter as proof of NHS permission.

NHS permission for the above research has been granted on the basis described in your university application form and supporting documentation.

The documents reviewed were:

- University ethics form
- Participant information sheet and consent form
- Protocol

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee (where appropriate).

May I wish you every success with your research.

Yours sincerely,

Phil Elliott

Dr Phil Elliott
Senior Research Facilitator on Behalf of:

PP Dr Pat Mottram
Research and Effectiveness Manager

Enc: Approval Conditions Leaflet

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Study Title: **What is the need, if any, for therapeutic education in mental health nursing? An empirical phenomenological study of mental health nurses' responses to this question.**

Conditions for NHS Permission Reply Slip

In order for your NHS permission to be valid, please return this form to the address below to confirm that you have read and understood the conditions of NHS permission to conduct research.

1. I confirm that I have read and understand my duties and responsibilities as part of the conditions for permission to conduct research at this site.
2. I understand that I must submit the following information to the Trust's R&D department:
    - Recruitment figures on a monthly basis
    - New researcher details prior to them commencing on the research project
    - Any amendments submitted to the Ethics Committee
    - Changes to the status of the research project
    - Any urgent safety measure incorporated
    - Untoward Incidents and Unexpected Events within 24 hours of their occurrence
    - A final summary report
    - A copy of the Ethics letter confirming receipt of the End of Study Declaration
3. I understand I must complete and return in a timely manner any audit forms sent to me by the Trust.
4. I understand that I must gain permission from the Trust in order to publish or place information of the current research into the public domain.

Signed…… Tony McSherry ……

PRINT NAME…… Anthony McSherry ……

Date…… 12/02/13 ……

Estimated Start date to commence research at this Trust …… 01/05/2016 ……

At which site will you approach first? …… Chester ……

Expected recruitment target at this Trust? …… 10 participants ……

Please return to:
Phil Elliott
Senior Research Facilitator
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ

Appendix 3: Participant 3 interview transcript and full analysis

R: Now that's recording now...we can kind of just forget about it really....
so really the question, this study is about, the title of the study is what is the need if, any, for therapeutic education in mental health nursing. So, I suppose, I would like your view what it is that you do that is therapeutic in your opinion and what kind of… um… learning have you had, have you learnt to be therapeutic, and really take it from there… So, any thoughts about it?

P3: Well, since qualifying I've only ever really done Community Nursing…

R: When did you qualify?

P3: I qualified in 2010 and I got a job in a CMHT in Manchester so it's a new area cos I trained in Chester, and I walked into the team and I was given a caseload of 35 and they had not been seen for 8 months… so I was literally told: Go out, introduce yourself… They needed all new care plans and everything… so I suppose I'd never had any training at uni… You don't have sessions or lessons about the therapeutic alliance or rapport, or…

R: What kind of training would you have had at uni that would have helped…

P3: I think it was just your placements… the actual practice placements… seeing, you know that the two community placements just seeing how they worked really, I suppose and…

R: Was it being in practice with other nurses while you were training? Is that what you mean by practice placements?

P3: Yeah practice placement… because I did a placement at X--- with the team I was working for as a first year and I had a mentor, and then I did crisis team, was a transition in my last placement for 12 weeks… that wasn't a care coordinating but it was going in and seeing different people who were in crisis and trying to be helpful… So I suppose it's not said but it's implicit rather than explicit isn't it that you have got to try and get a rapport with this person so they can trust you so you can be helpful to them.

R: So, what happened that you got 35 people all of a sudden…? None of them have been seen for 8 months…

P3: No, not for eight months.

R: And suddenly you have to do something therapeutic with them or…

P3: They felt abandoned... they were struggling, you know, so… they were CPA patients who had serious mental illness…

R: Who did they feel abandoned by?

P3: The fact that they were left than they were promised that somebody would get in touch… because the team there was so busy, and the waiting lists for people just for assessment was 18 months, it was just a different way that it is over this side of the County, I suppose, and it was knocking on someone's door…

R: What was that like?

P3: As in being a newly qualified nurse?

R: Yeah.

P3: I was determined to be a help to them… I suppose I was naive because I thought I'm going to cure them…

R: You want to cure them…

P3: I want to come in and I'm going to care plan them, I'm going to cure them, they're going to get all the TLC they need, to know that they can manage their illness, and they can manage all the problems that go alongside it and things will get sorted out… and it was that absolutely naivety… but I think that's where your nursing comes in you want to be caring, you want to be compassionate, you want to help people.

R: Yeah

P3: So… (laughs)…

R: So, like curing them would what? Curing them would be…?

P3: Well, they come in, you talk to them and they would have all the woes in the world and you don't… I used to feel and I still do, but I suppose, helpless is the right word… I'd probably be walking out feeling depressed because they'd ring you going, "I need to see you, I'm in crisis, something's happened", so you become this really important figure in their life.

R: How would you respond to something like that? Say, what would you do if someone rang you like that… and you'd seen them and walked out feeling a bit helpless and then they rang you, is that what you mean?

P3: Yeah, or even if it was just… I suppose that's just the nature of the beast, isn't it? You're dealing with a lot of people have got depression and a lot of problems… you might be the only person in their life that actually cares enough to sit and listen to their problems for an hour once every week or every two weeks… so if you're that person you don't want to feel that you are letting them down because, I suppose… Is it counter transference in a way, isn't it? Really, you're thinking about… they… you get… I… I wouldn't say I'm emotionally involved, I'm not that nurse that goes home and loses sleep about it although I know nurses that do that, they care that much, don't they - I couldn't sleep last night - I suppose that's a risk thing, but I suppose my anxiety would be, I want to know that I have been helpful, that I'm doing my job for that person, because they're looking for me, to me - you are my cpn - I have a cpn - so you get caught on this pedestal in a weird way… so there's a power thing going on…

R: Right

P3: Really they've got the power

R: Why have they got the power? In what way…?

P3: Because they're relying on you…

R: …so you have to respond, you feel like you have to respond?

P3: Yeah

R: You said something about TLC, that you're going to give this person so much TLC that you're going to cure them…

P3: Yeah… and that's the naivety, absolutely naïve…

R: That was your naïve approach at the start? Why do you say it's naïve...? And what is TLC?

P3: Tender loving care… you know I say… it's just that you know, in the sense that, I used to see a lot of nurses going in, especially in the crisis team - I understand why because they're super-busy and they sit there for 5 minutes and then you are uh uh, uh uh, uh uh, and then they go, ok. But if I go for an hour and a half they get an hour and a half

R: So, they'd sit there for five minutes with the patient and then just go.

P3: They could do. And then it's…kind of like, you write a note and there's no thought afterwards and it's hard, and you know… that's their role I suppose they do assessments they manage and then they move on. They don't have to take that… they don't feel that responsibility…

R: But you would be thinking that wasn't right somehow, here as a student?

P3: Yeah

R: So, you tried to put something else into place that gives the person time.

P3: Yeah, but I suppose that's where the therapeutic thing comes in, but it's just that's my personal values then isn't it?

R: Yeah

P3: Thinking about it…

R: And what happens there? Yeah… it is your personal values.

P3: How I, I suppose I've always treated people how I would want to be treated, so if I was in their position… Is it over-empathetic, I don't know? I don't know…

R: I don't know either… So it's as if the other person, if you were in their position what would you want?

P3: Yeah and what would they need… and

R: One of the things you've said is time… you'd actually spend time with them, like you would spend an hour or an hour and a half, whatever that time was allocated you would give it to them.

P3: Yeah

R: And what would happen in that hour, say?

P3: Well, I think as a cpn… it's different now which is another thing… when I have been doing the Community Nursing the first few sessions you can see there's a pattern every time, you get to know each other so you start off the first few sessions you put your stall out - this is what I can do for you - you make sort of unsaid promises don't you?

R: Do you?

P3: Care plan, your risks…

R: Yes, what's your stall? Sorry, care plan, yeah…

P3: Yeah, we're going to, you know, this is what I do, this is my role, this is what the team does. You might have met them in hospital so someone's coming now, come to see you when you leave hospital… you're not on your own - somebody's going to be here, aren't they?

R: Right

P3: To help them to… until you feel better until you settle down… I'll be your name nurse, someone you can call.

R: And would you say that? You're not on your own.

P3: Yes. I used to say that. But then I'm making massive promises that I would never ever not want to not keep.

R: You're saying you used to say that?

P3: I probably still would.

R: You probably still would.

P3: Yes, because that's how I work…

R: Yeah

P3: I know a lot of nurses work differently and I remember as a student one of the nurses said… "Don't over-give because you'll give too much and then you can't take it back… emm… Let them do it"… which is … which is the recovery model and you try and work towards that… but… as I've got more experienced I do work towards that, and it's very hard

because when you deal with people who've got personality problems, who are very depressed, who are very unmotivated… because you're trying to work to a care plan you do to take responsibility even though you're not supposed to… Your name's attached to it then, the benefits, they're phoning you up

R: And how do you… emm… what's it like taking responsibility? What are you taking responsibility for there?

P3: It could be I can't fill this form out, or, I'm in loads of debt… you know, it depends on whatever is going on or they're in crisis… or you know you'd sit and talk to them because they've had a relationship breakdown… So, you're talking to them just as… not as a nurse, are you? Because it's a personal… it's not about the mental illness now… They're coming to you, they're having a normative emotional reaction but… they still want you there to stroke their hand, don't they?

R: Yeah

P3: Because you… you get to know each other so well…

R: To stroke their hand… Do you mean that actually?

P3: Figuratively

R: Figuratively, so it's like a metaphor… so there's something… What's in that… like, to stroke their hand? How do you do that, you know, without actually doing it, or would you do it sometimes? Would you stroke someone's hand?

P3: No.

R: So how do you do it? What is the stroking their hand bit?

P3: It… it's… down to active listening… so even though they will take… they'll do the… well, it's like a therapist in a way, isn't it? They'll do 90% of the talking… but you're trying to guide them to…

R: Yeah

P3: … come to some kind of realisation… But there's no training in there… it's just trying to be supportive because for all… for all I've always been there for somebody, I've never ever told anybody what to do, ever…

R: Okay… And are you actively trying to guide them towards some realisation or are you going with the flow of what's happening?

P3: Probably a bit of both.

R: A bit of both?

P3: Yeah, 'cos in my head I'll be thinking I'd love to tell you what I think but you can't because it's your professional head isn't it? So professionally you're there as a nurse and

you're there to listen to them and to hear what they decide, but I suppose you question things and you look up the pros and the cons all the time… so you help them to sort talk through a list of positives and negatives… I suppose of the decisions they're making.
R: And what's that like to do that?

P3: It can be frustrating… It can be really tiring especially if you've worked with somebody for years…

R: Yeah

P3: … and they're still talking about the same things…

R: Right… (both laugh) …

P3: So, that going back to, I'm going to cure you, you're not curing anybody, are you? You're just trying to help people get through their lives and… you end up saying, you have like rote things like: 'this is just the human condition', 'life's really hard'…

R: Yeah

P3: Because they're looking at you like 'this is too hard for me', but, it's hard for everybody, isn't it?

R: Yeah

P3: But what makes it more difficult is if they've got an SMI, I suppose…

R: And what made it… when did you move from that, you're saying, you're calling it kind of naïve, I'm going to cure you, to the other part what you're saying, well actually I'm going to give you them the pros and cons of, and I'll just stay with them? I think you're saying you're just kind of, that you'll stay with their process… When did you make that shift…? Or did you make a shift?

P3: I think I must have done because when I first started, when I first qualified and started doing it… even though we use your life experience, your insecurity of making sure you're doing your job properly will be quite textbook, you know…

R: And what's that?

P3: This is what depression is, you were looking at your biological symptoms are you eating, are you sleeping, you know, are you looking after yourself? What can I do…? And I still go back to what can I do practically so I feel like I'm helping you?

R: Okay. And what's the textbook?

P3: Just like what your NICE guidelines would say…

R: From your training?

P3: From your training.

R: Yeah

P3: And then as that, as that moves on you feel, ‘ok, I have educated you about your illness’, and now I'm learning to know your relapse signs, or your early warning signs, or you know… the medication you’re on, I don't need to refer to it because we just know each other, you know I know.

R: Yeah

P3: You know I know about your benefits, about your family, I’ve met your family

R: Yeah

P3: I'm on first name terms with your dog and cat, you know… (laughs) … things like that… and then you just start having these quite general conversations because… you end up having to get to that point where it isn't just well, I'm going to talk to you about something you know about now, you've done that part, now it's just staying with you…

R: Is a bit like you enter into their life or something? Because you know the names of their pets and things. Is it like you’re getting into their life in some way?

P3: Yeah… yeah, it's quite a privilege really, isn’t it? Where you become, you started off as a stranger, and then suddenly you become actually a key figure… And there are particular people who are very good at going, ‘ok, I get the service and you're not part of my life, you’re just an aspect of it, and I come in and it's very nice to have you to talk to but I get on with life’. And then you've got your patients who… you're very central to it…

R: Yeah

P3: You know, there’s a lady who at X, who… she did that ice bucket challenge… Now, we're not friends on Facebook, but she showed me the Facebook page and she nominated me… because I was her only friend…

R: All right

P3: You know… Or she'd ring and go, ‘Oh, you seem sad today, are you okay, you seem really stressed’ - so she was worrying about me and I had to reassure her, ‘no, no, no, I'm absolutely fine…’

R: And what was it like being her only friend?

P3: It was a responsibility…

R: Were you actually her only friend?

P3: Yeah, pretty much. Well, until she got another friend but it was all very… but… because she was another service user within that, it's still within mental health so their identity is mental health.

R: Yeah … and it was a responsibility, was it? In what way?

P3: To, to always be there.

R: Ok… (long pause)

P3: Because you can't walk away… you can't be too busy when they ring up… even if you're in the middle of something you have to drop everything and take that call, and it could be, you know, that they might be just bored or lonely and they'll find a reason to ring you
… or to come in and see me, and you have to go down don't you … (smiles) ….

R: Yeah… you can't walk away… It's an interesting relationship, isn't it? Are there any… are there any qualities about you as a person, do you think, that help that happen? Or like that, say, a mental health nurse needs to help that happen?

P3: I think… for me… maybe because I have tried without meaning to, or maybe with meaning to, trying to build up this really strong therapeutic alliance… I created then, not a dependency because I'm always working towards independence and wellness and recovery, but I've created a close relationship to… because I feel that's part of my role, that they can trust me that they can rely on me and I can be helpful.

R: I get a sense that you believe in that as well?

P3: Yeah

R: You know, that trust and reliability and being there are important, you know… That that's something you believe. This is something that you've learned not from a textbook, it sounds like to me.

P3: No… that's why I became a nurse not a social worker.

R: Right… Why?

P3: Because it's not about the paperwork and you going, 'right, let's look at your care plan'. I know that's where I start off from, that's the business side, and then you get… you're a part of the person's life.

R: Yeah. Is that what speaks to you most about nursing?

P3: Yeah

R: That's what you didn't do social work…

P3: Yeah

(long pause)

R: And the kind of qualities you might need to do that, the qualities you have, what would you say they are? Are there any qualities? What are they? I… they must be there, they sound in there… (laughs) …
P3: I just wing it.

R: You wing it.

P3: You wing it. You don't know what's happening, every day is different, you don't know what problems people are going to have. And you've got your own little toolbox. You go like, 'someone's in crisis, you've got your medication, you've got the crisis team, you can bring an outpatients appointment forward, or if someone's really risky, a professionals meeting… Or they've really got massive psychological issues – Tony, well you know I've referred here and I feel really good now because I've got someone else, I can say, 'Look, I've got, I can do something for you'…' then I'm passing a little bit of that to somebody else and then you know that's building up their tool boxes, isn't it?

R: Yeah

P3: But, you know, if a CPN is just to oversee medication and to oversee risk, well then all that sitting with somebody for an hour every two weeks is not necessary, it could be a phone call, couldn't it?

R: Yeah

P3: 'Are you alright? Everything ok? Meds ok? Any side-effects…? I'll ring again in a couple of weeks to check there's no changes.'

R: Yeah

P3: It's more than that. It has to be, or else what's the point of all these visits?

R: Yeah… If community nursing was like that would you do it? If that's what it was?

P3: Well, you dream of it, don't you? Because then you're not so busy! And your paperwork would be brilliant… but… why do we create so much work for ourselves?

R: Yeah

P3: Because we do.

R: But you're saying that there's something else involved in that visit, that hourly visit…

P3: I think it has to be… to know that person… that therapeutic side… it has to be… Because talking to that person and giving them that time… is the prescription in itself, I suppose, or that's what it feels your role has become… I don't know.

R: Does it feel like a prescription, like as if your prescribing something?

P3: Yeah, my role as part of your… 'cos what makes… Yeah…that, that… that's creating a role for me and for that person.

R: Yeah… and who's doing the prescribing there? You know like… Is that what you meant by prescription?
P3: yeah, I suppose

R: That it's almost like a part… a part of what? …. The care, or medical care or something? Would you see it as medical care or as separate, isn't it? I can see you're saying 'no'….

(both laugh) …

R: What is it?

P3: You're trying not to medicalise people, are you? You're trying to humanise them, in a medical environment… because, you know, their identity becomes a mental illness if they're seeing a mental health nurse and you're reminding them I don't see you as just a schizophrenic or a manic depressive…

R: Okay, you're not…

P3: … I see you as a whole, I'm talking to you as a peer… on a level… I don't know.

R: It sounds like the people you've been looking after appreciate that…You know, that that speaks to them. Is that what you're saying as well?

P3: Oh, it's a thankless job… I know that but… your feedback is your wanted and you feel needed… and… your time with them… they'll always say 'I feel so much better after talking to you', it's cathartic, isn't it?

R: So, do you mean it's thankless?

P3: It's thankless in the fact that I think it's become expected, that's what you're there to do.

R: Okay, right.

P3: So, not that they're not grateful for it… but you don't do it going, 'well, say thank you now', you don't expect that, it's just become that's what your role's become now, someone to listen to, you're their sounding board, you're their best friend, you're they're confidante. Because it is confidence.

R: What's that like for you to be in that role when seems a bit thankless and it's almost expected…?

P3: You get used to it?

R: You get used to it.

P3: Yeah, it's just that's part of the job in itself, isn't it?

R: And what's in the little bit of 'getting used to' - Is there a kind of, you know, it sounds like you're saying when you get used to something that initially you're not used to it, you

know. So, is there something there that, you know… Is it getting used to not having, not being thanked?

P3: I think it's getting used to knowing that even though you've spent a really good hour with somebody thinking that you got somewhere, tomorrow you might get a phone call and you're back to square one again… (laughs a lot) …

R: Right… that's just accepting that…

P3: It's accepting… that for all your motivational, you know, talking… and, you know, you're gee-ing them up and you've got their back

R: Yeah

P3: It might… just… people are going to do what they want to do at the end of the day, you know…

R: You sound very encouraging like, you're gee-ing them up, and you've got their back and your motivating them… but then you think it might just all collapse the next day. Is that it?

P3: Yeah, but I accept that. I don't take it personally. I have to… you know, I, I… I always say I am a hardened optimist…

R: Okay

P3: Because you'll ring me up again with the same thing and it's like we'd not had that conversation before and I remind them of things we said, and things we discussed before, but 'right let's start all over again, let's gee you up, let's motivate you, let's get you feeling ok, so you can get off the phone and not feel so depressed and hopeless, because I've reminded you it isn't…' because that's what they rang me for… Why else?

R: Well, there's something about, emm, is there… Why else would they ring you, is that what you mean?

P3: yes

R: I don't know… Why? Maybe is there something else…? I've got your back, there's a lot in that, isn't there? What does that mean? I mean to you, like? It sounds like… just getting back to the idea of being therapeutic, it sounds like all these things that you're mentioning are what it means, kind of makeup what's therapeutic about nursing, about mental health nursing, and there's like, you know, like 'I've got your back'…

P3: Yeah

R: Sounds like…

P3: Well, you know, there's, there's a conflict, isn't there? From all of that I've become somebody you can talk to and trust, you get poorly I might be the one who has to trigger a mental health act assessment against you, and I'm sitting with you and the police are stood either side of us, and I'm telling you the doctor's coming and you're going to go to hospital

now and you've lost insight so it's a section… and then I'm going to come and visit you on the ward and go, 'right,' you know, and we're going to have a tribunal, you're going to read all these things that you don't get and then when you get out we'll carry on as we used to… so…

R: So, there might be a part there where they don't trust you, and if they lose that insight, if they become really unwell…

P3: Yeah but I think because you've developed closeness in a weird way, not in a personal way, if I walked past that person in the street out of hours I know you just go, 'Hi, are you all right?' - always acknowledge each other, you might even have a quick chat, but it's not like let's go and have a coffee and you tell me your problems… The divide is there, it's definitely kept… professional… Or… you know, it's understood that I can talk to you about my personal problems within our appointment time, however, you've got a closeness where you're allowed into their world and you know about their abuse, all the relationship problems, or… the dark things that they think… or the suicidal thoughts they have that have don't tell anybody… or the nightmares… and that's really personal…

R: Yeah… and these are the kind of things they would say to you in your conversations in the hour?

P3: Yeah

R: What's it like listening to things like that? I mean how do you help them? What's it like listening to things like that? - the dark things.

P3: It's sad … it's sad.

R: Yeah

P3: It's horrible knowing that there's people who are struggling, and as I said before, your role is to try make them feel better. These can be chronic, chronic… issues

R: These are going on for a long time

P3: For a long time... and then you get to a point where you try and problem solve and you try and maybe change medication… because that might cause nightmares. Or you might try lift their mood, and moods become chronic…

R: Yeah

P3: L---… who was having the nightmares and the suicidal thoughts… and two and a half years later you get to the point where you don't give false hope, you just say, 'Right, well this is how it is then right now.'

R: Yeah and what effect does that have on you? Does it affect you? Apart from making you sad…

P3: Yeah

R: Does it do something else to you?

P3: I think you start to feel a bit of helplessness, I suppose.
R: Right… and how do you manage that?

P3: I don't know… I don't know…

R: Do you stay with?

P3: yeah… I suppose I do… you just keep being there… because that's all you've got left… well, you know, well we've got a really strong rapport now and you can tell me that, so I can't make it go away but at least you can talk to me and we can have a coffee and… and I've understood…

R: So, you might be sitting there feeling a bit sad and helpless… but you are still… you're just still there…

P3: Yeah.

R: That sounds difficult, you know… to do that… Have you thought about it before?

P3: No.

R: Does it sound difficult now, or is it just… like…

P3: When you break it down it sounds difficult… you just do it because it's…

R: Because it's what? It's just…

P3: It's what you have to do…

R: Right

(long pause)

P3: But then when you get big caseloads… you start to compromise your admin time or your training time because I suppose again it's down to your personal way of working… you prioritise what you're there to do… then that person… an increasing number of people still deserve that service…

R: That kind of quality… of being with them…

P3: I don't know if it's quality but you try and give them what you perceive is the best you can give them, you know, that's… if you've been given that responsibility to work with that person… And then you start to feel really stressed…

R: Do you?

P3: Yeah

R: What's stressful about it?

P3: I think it's just, you know, you start to squeeze people in… and try and see 7 people in a day… and then you get a knot in your stomach because you might get the phone ringing and you don't want to answer it but you have to and you haven't got time for that…

R: Yeah

P3: And then, where do you do your paperwork… So, you start to… (laughs) …

R: So, what makes it so…? When you say squeeze people in you, you would be giving them that kind of attention, like, that you've been talking about…

P3: Yes

R: And you might squeeze in 7 people a day and you get stressed, you get a knot in your stomach… What's causing the knot there? I can imagine but what do you think it might be?

P3: Because I'm giving them 60% concentration… and I'm looking at them and I'm going through all the process and I know them well and I'm saying all the right things and the other half of my brain is thinking… and looking at the clock… I need to, I need to start to wind things up, you know… Is there anything I've made promises to do? I need to lock that in my head, right I said I'm going to do that… I'm going to make sure that's done, so you start thinking of your next step… whilst you're still trying to give them, that person, the quality time they've been waiting maybe a week for, or two weeks for, or 3 weeks for…

R: So, if you make promises you keep them, you kind of lock it into your head that you've made a promise

P3: Yeah

R: You're not scribbling stuff down on a bit of paper, it's kind of gone into your mind…

P3: Or I will, I'll have a little to do list, I'll just write this down, because if I've written it down it's going to happen and I won't forget… You know, and if I know I'm running behind I'm going to do it today because you don't want to let people down, it's about I will do this, I will put a half hour aside so I can do that for you then, we've made an understanding and you know it's, it'll be done… I suppose that, that's the communication part of it, I suppose…

R: And is the stress, ehhh, the knot in your stomach… that's caused by compromising, is it? Or is it just seeing too many people?

P3: I think it's um… I think it's not compromising… not saying I'm too busy… it's a rare thing that I'd ever say that to somebody…

R: That you're too busy?

P3: Mmm.

R: You'd always pick up the phone.

P3: Always, yeah.

R: Why do you do that?

P3: Because I don't want to let somebody down.

R: Okay

P3: Yeah

R: So, that sounds like something to do with your value, your own values, that you know if the phone is ringing somebody is ringing you… You don't want to let them down…

P3: Yeah

R: So, you are kind of sacrificing a bit of yourself there, aren't you? Or you're putting yourself under stress.

P3: Yeah… I mean, obviously, you get great, great days, maybe weeks, and you think I'm getting on top of it, but it doesn't take much to get really… just needs a few people in crisis… Or…. And then you're back to chasing yourself again…

R: Yeah.

P3: And it's that old familiar feeling, I'll get sorted… and then you have your own hope just like your patients do, you'll have your own hope that you'll get organised and get on top of it all…

R: Yeah.

P3: But it's been nice because in this current role, it's assessment in custody suite, and in the courts, so I've walked into this job… very aware that we are a secondary service to the criminal justice process, that's coming first…

R: Right

P3: But it's been lovely because… For one, I've had the time that I never got I was at X---… to actually sit and talk to somebody and formulate a plan and then actually on the same day do the referrals… and do all the safeguarding… you know… sit there ringing around and checking everything is done and ok… and doing you're really thorough assessment that you know is on Carenotes now, so everything's there for that person if they ever need it, or for whatever is going on with them.. But even though there in that, the cells… they could be bleeding and all sorts… when they know that you're a mental health nurse and they're in that interview room talking… they forget all of that, they're talking to you as a nurse, they're looking to you as a nurse not as a police officer or a detention officer…

R: So, do they look at you differently?

P3: Yeah
R: How do they look at you?

P3: Some of them go, 'I've been here before I'm not interested everybody just lets you down', well, you know, if you want to talk let's see what we can do… no promises… and some… for the most part they want to talk and they forget what they, where they are…

R: Why they're there.

P3: Yeah. They're just talking about their problems, and the history and their background and the abuse, so much abuse…

R: What kind of abuse?

P3: Sexual… we see 90% men, in custody… it's about 90% men… And it's about 60% drug and alcohol, and within all of that most of them have got, emm, yeah, have had abuse... background…

R: And they suddenly start telling you this? And this might be the first time you've met them?

P3: First time you've met them, and the amount of times I've heard, 'I've never told anybody this'…

R: Right

P3: But they've never accessed services before. So, you come and go, 'I'm not here for the police, I'm here to see how you are.'

R: So, somehow you being a nurse… this facilitates that?

P3: Yeah. And they see the NHS lanyard, so they believe that you are a nurse… and you reassure him that you there and it's confidential… and you're here to support them and to see if… they're suicidal, if they've got depression, and you check notes and Primary Care and they're not known, and what's going on… and you do a thorough assessment with them… and that is therapeutic, that's therapeutic.

R: How is it therapeutic?

P3: Because they're off-loading and the amount of, you know, they're crying, and they're telling you all these really personal things and you… you haven't done anything to help but to listen and at the end of it they'll go, 'Oh, I feel better… I feel better for talking to you… thanks for listening…' Well, you know, I'd go, well, here's a plan…'… 'Thank you!' So even that half hour, or hour, and plus the other four hours of paperwork that you don't see… Is.. it's really meaningful…

R: And is there something about you, do you think, that they would open up to, more say than someone else?

P3: I don't know. No. I think it's just the assessment process. I think it's just sitting there and giving someone an opportunity.
R: But knowing firstly that you're a nurse, you think changes things… you're not a policewoman, and you're not, I don't know who else would be seeing them?

P3: The solicitor

R: You're not a solicitor, you're not a policewoman.

P3: Yeah, the investigating officer… yeah… yeah… I definitely, I definitely say because I'm a nurse you get that privilege…

R: Okay… So it feels like a privilege…?

P3: Yeah.

R: When they tell you all of these things… Does it affect you? If they tell you… you know, maybe, bad things or upsetting things, does it affect you?

P3: Yeah, it does, when you think about it… You know, you're looking at this broken person who's had a broken life… because something terrible happened to them that was out of their control… you know, there's so much homelessness going on, you want, you want to help them… you want to know that… that you can get them… I don't know you could just go on and on, couldn't you? Because the care coordinator kicks in, you start doing an holistic plan… and really all you can do is see what the outcomes are and, you know, we're lucky we've got support workers, so we can make some promises, if you're not going to prison the support worker can take you to housing and help you with that, and she'll take you to your Primary Care appointment that I'm going to set up for you… whatever it is… So you can start to make a few little promises, 'you know what, I can help'… So it still goes back to that nursing thing…

R: yeah

P3: And it takes it away from the criminal justice, criminal justice then becomes secondary within that interview although it's still a primary thing…

R: Where were we? Oh yes, so… I can see you've written down a lot of stuff there. Is there anything there that you wanted to talk about that seems important to talk about? Can I ask you one question though? You are doing a lot of listening in those assessments and people are opening up to you… Where have you learned… in your training, or anywhere else… about how to listen… or how to… you know, that active listening you're talking about? Have you learned that anywhere, has anyone taught you it?

P3: No. I think it's just… what CPNs do, what nurses do…

R: So, it's like… so you may have learnt from watching other nurses doing it, or you've learned from your life maybe?

P3: Yeah… yeah… I think you learn from your life.

R: Yeah… (long pause) …
P3: It's their time, isn't it?

R: And was there anything, say… I suppose you've learned from your life… but, do you think you need a certain kind of life to learn from? Or is it just…?

P3: I just think… I just think a lot of nurses, you know, are just caring… that's what drew them into that profession.

R: Ok… so it's caring…

P3: And it sounds cliché, doesn't it? Compassion and caring… but that's what drives, I think, that is the underpinning… of a lot of the work that we do…

R: And where is that caring coming from? That idea, that activity of caring?

P3: I don't know…

R: Is it just part of you? Or is it?

P3: Yeah, maybe… I suppose it would be part of you, yeah, it has to be, doesn't it? I think you can't fake it, you've got to be genuine… you can't fake that 2, 3, 4, 10 years with somebody, could you? You've got to, you've got to mean it, or someone would see right through you.

R: Yeah. So, it's just something that's there?

P3: Yeah.

R: Because they're suddenly opening up to you, these people, they're not opening up to the policeman or the solicitor.

P3: Yeah, yeah…

R: Suddenly, they're there, they're opening up to you.

P3: Yeah

R: I suppose you're doing something, are you? There's something about you…

P3: Mmmm…

R: So, was there stuff that you'd written… that seems important? Is any of this chiming with what you've written down already?

P3: Yeah, a couple of things… yeah… I think I was just putting… I didn't know it would be about me! I was just saying generally the things, you know…

R: No, it's about you…

P3: You've kind of curve-balled me there… (laughs) …

R: Have I…?

(both laugh)

R: I suppose… yeah, it, yeah, there is another part of it, like when I asked have you learned anywhere… Like I don't know, have you done a course on active listening or something? Or, or, a course on person-centred counselling or something? Have you done anything like that?

P3: No.

R: Ok… Isn't that interesting?

P3: I have to, I have to say to the people I work with I'm not a trained counsellor… because even though you're doing all this pros and cons and you're listening and you're sharing your ideas, you have to remind them I'm just talking to you without any background training…

R: Are these the people in the custody suite now or as a CPN?

P3: As a CPN. The assessment process is such a different aspect of nursing… But I still think it's therapeutic in itself…

R: Yeah, yeah… I'm sure it is…

P3: Yeah.

R: And emm, so you say that as a CPN to your patients as well like?

P3: Yeah

R: I don't have, I'm not a trained counsellor…

P3: I think you have to remind them…

R: Why do you say that?

P3: Because they'll turn up, because they'll ring, because they look to you for the answers, they expect you to have the answers, and I suppose you've been given this job or responsibility, or perceived responsibility… it's you in the Coroners Courts so there is a responsibility there… It's you whose writing notes about this person, directing the care… You know, it could be your letter of recommendation that gets the benefits or wipes the debts off… So, there is a responsibility, isn't there?

R: Yeah

P3: Or something… so if they're coming to you, and you have to kind of remind them… of the boundaries within that role, so they'll take that as well, it's good counsel to talk to you, but it's not… it's not… therapeutic or a psychotherapy or a psychological approach you've

got this, is just between me and you, I'm just you know, your named nurse, I'm overseeing your care plan… And it becomes more than that! So, you have to keep reminding yourself maybe… (laughs) …

R: So, how does it become more than that? What's happening there, in the 'more than that'?

P3: Yeah, it's, it's because you've had to develop the therapeutic alliance with that person, so you can work with them.

R: Ok.

P3: Yeah, so, they can trust you… so you can… emm… if they, if they don't get on with you and they think you don't care, they're not going to believe you when you talk to them and say, well, you really need to take that medication that's making you fat or tired, or zonked out… or… they'll just stop taking it… Whereas maybe if they trust you, they'll go, 'I don't want to take this, and I'll go, let's look at something else.'

R: Yeah… How, how would you find that if someone, say, didn't want to take their medication? And because of that reason, say, it was zonking them out or making them really overweight or something…

P3: Well, they're the kind of questions I check… I ask, and it's so hard for somebody to lie to you. If you ask them direct…

R: Yeah

P3: And I'll go and check, 'let me have a look at your blister pack'…

R: Right

P3: So, it still… so, you're still maintaining your professionalism, aren't you? You're still expecting an honesty.

R: And what's the link there with medicine and psychiatry, you know, because you're doing something about medication there, aren't you? What's the relationship would you say between nursing and psychiatry there?

P3: I think… I think for medication, and this is again a personal value, and I don't say this to people I work with, but I wonder how therapeutic a lot of medications are… just because I see it not working for so many people…

R: Yeah

P3: Particularly anti-depressants… but the placebo effect of that is something… and I think it's something for psychiatry to hold on to when somebody's going, 'it's not working, oh well, we'll try something else or we'll increase the dose,' so that person walks away saying, 'ok you've done something practical'…

R: So, it gives psychiatry something to…

P3: It gives psychiatry something…

R: Something to do?

P3: And to feel helpful because that's their area… and has a nurse, ok, you've got all the talking, but the practical side of nursing is, I can fill out your benefit form for you, we can go for a coffee, we can get out of the house, I can get you a support worker, or I can refer you to therapy… but that's not enough for you… let's review your medication and let's talk in that medical way and then you feel like this is normal, what's going on, because maybe a tablet will help as well…

R: You're doing a huge amount of things there, aren't you? A lot of things you're doing… and, and… … Sorry, was there anything you'd written there that you wanted to talk about? That you, that we haven't brought up…

P3: No, no, I think we've kind of covered that really, saying about how it's holistic, which is what I was just saying, it's more than just…

R: yeah

P3: I don't know…

R: When you say holistic, what do you mean, that it…?

P3: Yeah, it's the medical side of it - there's your illness - and there's the human side, there's your… And it is, it's the care plan approach, isn't it?

R: Yeah

P3: And then there's the recovery… model… We're talking models but you're trying to apply those structures to help you structure how you can work with that person…

R: And if you have someone, say, someone you've got who's been moved from… CPA standard and they won't be having you anymore, say… What would that be like?

P3: It's… it's really difficult to regrade somebody… you work closely with… and it's great when they're really well and they're really, really well, you know, 'this is wonderful, I don't have to see you anymore, isn't this great'… But 99% of the time they're not happy about it because they've got very used to having you in their lives, even if it is once every two weeks… It's hard to reduce your visits never mind regrade somebody…

R: Yeah. So, what might happen… might… umm… yeah… So, would they ring you, say? Say they are regraded and they are on standard now and there are no arranged visits, will they come to see you?

P3: I had a lady who used to come and see me all the time… (laughs)…

R: Right

P3: Just to keep me up-to-date with what was going on in her life…

R: And what would you do?

P3: Well, I'd just go and have a chat…

R: So, you just went with it.

P3: Yeah, I just went with it… There's no appointment made, 'I'll come and see you again and let you know I'm getting on' and things like that, you know… What can you do? That's somebody who… who wants to tell you something, who truly thinks that you… well, you do… you truly do care that they're okay and what's going on… so, it's ok… But there's a lot of people who have been regraded who end up back on CPA… because they might have been stable for years and then they relapse… and is that because someone's not checking on the blister pack, you know, as part of an hour conversation checking their taking their medication, let's check how your mood is, not slipping too much, you can nip things in the bud without realising that you've done that…

R: Or might it be because they're not getting the visits, you know… they're not getting that one to one time you were talking about…?

P3: Possibly, yeah… it's something that's missing…

R: Going for a coffee with them and things like that…

P3: Yeah…

(long pause)

R: Have you thought about stuff like that? How that might make someone unwell?

P3: I think that's why there is a reluctance to regrade people.

R: Ah right, so you have, it's kind of automatic that you…

P3: Yeah, it's more than they're just going to be a bit sulky... Are they going to be alright without you?

R: Yeah.

(long pause)

P3: And it's unwritten thing, you can't quantify that, you just know, don't you…?

R: Yeah. If they're going to be okay without you or not… and it's hard to judge, I suppose.

P3: Yeah.

R: So, you must mean a lot to them, you must be doing a lot, you know? If you are thinking that… That they might relapse if they're not with you, or if you don't see them.

P3: Mmmm

R: It's interesting that you said that you got no… um… You know, you didn't have any kind of training in your own training… about say, like, skills, say like, I don't know, CBT skills or anything like that, or person centred counselling skills… that you didn't have anything like that…

P3: No, I mean we had… at uni… we did kind of modules on ethics…

R: Yeah

P3: And it's weird because the more I'm doing my continued learning now, the more I realise, the more I think about… sort of… paternalistic and beneficence… and autonomy… you can see why that's applicable and it really is… you know, as a student nurse when you've got assignments to do I don't think you really put that into…

R: Yeah

P3: You can't equate that into practice, I suppose… But, yeah…

(long pause)

P3: There was all these modules that we were doing… and you're at placement, you're doing 6 weeks and alongside that, okay, you've got an assignment that you just want to pass…

R: right, yeah.

P3: So, bits sink in, little bits, like you remember Maslow, and then you look at you care plan and go, 'Oh that's from Maslow'… and you're thinking…

R: Hierarchy of needs

P3: There's your basics so you can see that's where your care plan's coming in, and you do a session on risk, but then the rest you've got… to pad out yourself thinking about historic risk, all of those things… You get an underpinning theory… you can only equate that with experience into practice… and now when you're doing assessments with risky people… that one session's not going to cut it… when you're risk managing or risk formulating and… what you're writing down is actually… you could be telling a coroner, couldn't you…

R: Yes, that's right… But… yeah…

P3: Yeah, so things were touched on but they were only touched on… I mean we never had a session on what schizophrenia is, and what hallucinations were… in all my mental health training, there wasn't any sessions at all on what mental illnesses were… because you were expected to go and read that yourself, that's your reading…

R: Right

P3: So, it was on specific topics like public health, ethics, physical health…

R: Yeah, so did you just do that reading yourself?

P3: Yeah

R: Right… Where did you read?

P3: Anywhere… and I'd use… I suppose using the placements is where a lot of the learning came because you'd get to see it… and then you'd read about it and you'd see it, and you then apply it, and then if you're working with somebody with illnesses… you know… I feel confident now and it is with experience not with reading a book ,to know if someone's got an adjustment disorder… or if they're really depressed… but that only comes with…

R: With…?

P3: With experience… with experience, with seeing it, and being able to balance that against your knowledge and your experience…

R: Going back to those 35 patients you started off with… They hadn't been seen in 8 months… that was like the learning curve, wasn't it?

P3: Yeah… massive…

R: And the thing about the TLC…. Has that been… is that still there?

P3: Yeah, yeah.

R: It's still there… But the expectation isn't as… It sounds important…

P3: Yeah… yeah

R: I just get a sense that there's more as well… I get a sense from talking to you that maybe there's more about being therapeutic… um… that you somehow know… and it's kind of… I don't know, do you make people feel safe? It's just something about making them feel… you said, 'I've got your back'… and there was another one… something about, 'I won't let you down' or something… at the start…

P3: You're not alone…

R: Yeah… It's quite a powerful thing to say… to actually say that to somebody, isn't it? It's quite…

P3: Yeah, but they're not… and you, you actually say it, don't you? 'I know you're going to be dealing with this but you've got somebody you can talk to you now, who's going to share it with you, who's going to try and make you feel better…

R: And that's down to you personally, isn't it?

P3: Yeah… I do and I know I'd never go back on it.

R: And you will pick up the phone… that's what gets you stressed…

P3: (laughs) But it's my stress they wouldn't know.

R: It's like you're making a decision to do that…?

P3: Yeah.

R: Yeah.

P3: But you're dealing with people risk, aren't you?

R: And that's not coming from an ethics module you've done…? That's coming from you, isn't it?

P3: Yeah,,, No, that has… Yeah, that's coming from me…

R: And also you're awareness of risk, maybe?

P3: Yeah. I think emm, I read, I read a… an article… I've got it somewhere, I'm going to have to dig it out for you… about people who are suicidal and a lot of suicide… could be prevented because… if that person knew that… they were held in mind, and it doesn't have to be family or friends… If you've got a therapeutic relationship with them and, and… the fact that they know you think of them can keep them… evidence-based… can keep somebody safe…

R: That sounds really good… Is that an article?

P3: Yes, it's an article…

R: It makes sense.

P3: So, that was powerful for me.

R: When did you read that?

P3: When I was in Manchester… one of the psychiatrists gave it to me.

R: Is that when you first started working there?

P3: Yeah… it was always so… It's always been there… If you bear somebody in mind, you know… your relationship just can be just as powerful if it can keep somebody safe from killing themselves… as much as… the family or the friends, well that must mean something.

R: Yeah. And did that speak to you, that sounds like it spoke to you though, something that was already there… possibly?

P3: Possibly… yeah… possibly.

R: Ok… we're coming to the end… Is there anything that you'd like to say? Anything that has crossed your mind, you know? No matter how weird or bizarre or odd…that, you know, about the therapeutic and mental health nursing, you know… Or maybe something I haven't asked? How do you learn to be a mental health nurse? How would it be taught? How could someone teach you to get to where you are now?
P3: I think it's because I mentor students… I spend a lot of time talking to them about all the textbook stuff, so. But I'm also passively just say… saying 'show that you're interested', you don't know learn that… You know, I've got students who are like this … (looks around)… you're wondering 'are you paying attention to this person', you're in their house and they're telling you things… show that you're interested… You know…so, it's little things like that that you are trying to impart to somebody… so, that, that's nursing too…

R: And when you show you're interested, I get a sense you actually are interested.

P3: Yeah…

R: You're not pretending you're interested.

P3: No. I'll be upset if that student's not...

R: Yeah… And the textbook stuff.... What's that that you're teaching them? Is that risk?

P3: Risk, care planning, medication, depots, all that… all the bread and butter stuff…

R: How to do those things?

P3: Yeah and then it's actually… that you can't read in a book… you're going to knock on that person's door and go and sit in their house and talk to them now… and you'll quite easily fill an hour just by letting them talk and having a conversation with them… and humour… I use humour a lot.

R: Yes, you do… you laugh a lot…

P3: Yeah… I always make a joke… and I get a laugh out of them…

R: Will you?

P3: Try and keep it so it's…

R: What does that do?

P3: I think it's friendly… it's familiar, isn't it? So, you're not bringing it – 'Yes, I'm listening to you' - it's just, it's breaking the barriers down.

R: Yeah. So, it's like a friendliness… and ordinary kind of friendliness…?

P3: An ordinary… yes… keep this an ordinary thing…

R: It sounds difficult to teach, doesn't it? How would you teach that? In a way, I suppose through the practice… What you say to your… the students you're mentoring, you'd say, like 'show that you're interested'.

P3: Yeah. You could teach by showing, yeah, by example. You want to be a good example, don't you? Because they're looking to you like rabbits in the headlights… Am I going to be able to do this? And I suppose it's reassurance that you are just talking to another human being, don't be scared, just get to know them, and get them to feel comfortable with you, and the rest will come… Wing it!

R: Wing it! Wing it I suppose means taking a risk, does it? Kind of like, wing it… what?

P3: I think it's just the perennial 'am I still really a nurse' - just winging the job every day, so I've got so much to learn, still trying to be, you know, do the job as best as you can… and I'm constantly learning… and constantly striving…

R: Yeah.

P3: I'm learning from other nurses all the time… I'm listening to how they talk to people… looking at their notes and how they write things… and you know, 'Oh, I like that' and I lock that in, and it's something else for me… so I'm constantly learning…

P3: Yeah…ok… Well, thank you very much… and I'm very grateful for the interview… We'll end there.

P3 Transformed Meaning Units	General/Situated structure or Theme
TMU1: lines 1-32 P3 has been qualified for 6 years and has worked only in community mental health nursing. In her first job, she was given a caseload of 35 who all needed new care plans and had not been seen for 8 months. She based her work on what she had learned in placements in her training. It is implicit that a therapeutic alliance or rapport is developed with each patient but there was no formal training given for this in university.	Th1 P3 can feel sad and helpless because people are not cured, including by tender loving care. They still want time with her nevertheless and she can instil realistic hope (TMU2, TMU3, TMU5, TMU11, TMU18, TM20, TMU35, TMU38)
TMU2: lines 33-55 Her patients were all on the Care Program Approach who had serious mental illnesses and felt abandoned because services had not been in touch. Mental health services had an 18-month waiting list just for assessments.	Th2 Because of her role, she feels she must not disappoint anyone who relies on her, and she commits herself to them so they know she keeps them in mind (TMU3, TMU4, TMU7, TMU44, TMU45, TMU46)
TMU3: lines 56-91 At first, P3 thought she was going to cure her patients through tender loving care, and through helping them manage their illness and associated problems. But she sees this hope of curing them as naïve now. She began to feel helpless and sometimes depressed that there were so many people asking her to talk with them, sharing their problems with her. She felt she had to be available for each person as she was often the only person in their world who actually cared enough to sit and listen to them. She did not want to feel she was letting them down by not being available and she thought of this as counter-transference. She feels she is put on a pedestal by her patients, as their Community Psychiatric Nurse, and her anxiety is about wanting to do her job properly for them	Th3 She is not emotionally involved with patients although she feels wanted and needed (TMU3, TMU17) *Th3i She appears emotionally involved, either through the personal importance of being a professional nurse, and/or a personal sense that no-one should be abandoned* (TMU2, TMU3, TMU17) Th4 High caseloads create imbalance between required documentation and time with patients, causing her physical distress (TMU20, TMU21, TMU22) Th5 She works using what she has learned from practice and she teaches students by showing (TMU1, TMU2, TMU31, TMU49)

and to be helpful. She does not think she is emotionally involved with her patients.

TMU4: lines 92-104

Patients have power over her because they rely on her and she feels she has to respond to them.

TMU5: lines 105-132

P3 used to think that the Crisis Team were not therapeutic because they spent so little time with a patient. The role of the Crisis Team was to assess and move on, and she thought that they did not feel a responsibility towards the patient. As a result, she was determined to give her patients more time and tender loving care as she felt this would make them better. She believes now that this was absolutely naïve of her.

TMU6: lines 133-148

She feels that to have the personal value of caring is therapeutic. She sees this caring as treating people the way she would like to be treated, but is concerned she may be being over-empathetic.

TMU7: lines 149-189

When P3 first meets a patient, she tells them what she can offer them, explaining her role and that of the community mental health team. She makes unsaid promises to the patient. She explains that the patient is not alone now, that she will be there for the patient until things settle down, someone the patient can call on. She knows she is making commitments to the person that she will keep.

Th6

Developing a therapeutic alliance is expected but no training was given on this in university. She learns from the person as an equal by being open to them, using humour and being friendly (TMU1, TMU15, TMU18, TMU34, TMU49, TMU50)

Th7

Responsibility involves overseeing medication, referring to others, and documenting risk, as well as spending time with a patient (TMU5, TMU13, TMU15, MU16, TMU26, TMU34, TMU36)

Th8

Treating others how she would like to be treated is itself caring as therapeutic, but it might be too personal (TMU6)

Th8i

It is therapeutic to not identify too much with someone (TMU6i)

Th9

P3 feels a responsibility to the other person and gives too much, as she may be for that person an only friend, a best friend, confidante and sounding board (TMU8, TMU13, TMU17, TMU38)

Th10

Nurses listen. Actively listening and the person speaking with trust is therapeutic somehow (TMU9, TMU17, TMU25, TMU27)

Th11

She does not show that it is tiring to be non-directive and available, and thankless as it is expected (TMU10, TMU17, TMU44)

TMU8: lines 190-211

As a student nurse, a qualified nurse advised her not to give too much, as what is given cannot be taken back; that it was better to encourage the patient to do things for themselves and this is the Recovery Model of care. But P3 finds she gives too much because she feels responsibility for the other person. She can take responsibility for a broad range of problems, from filling in forms to talking about relationship breakdowns.

TMU9: lines 212-244

Through active listening it is like she is stroking the patient's hand. She is also guiding them to a realisation of some kind as well as listening. She says she has never told a person what to do.

TMU9i: P3 feels *she is guiding the person to some realisation but is not sure how.*

TMU10: lines 245-259

P3 wants to tell the person what she thinks and to advise them, but she feels as a professional it is her role to allow them to make their own decisions. She encourages them to look at the pros and cons of potential decisions. This can be very frustrating and tiring, especially if it has been this way for years with some people.

TMU11: lines 260-278

P3 believes that she is not curing anybody, and that she is just helping people get through their lives. She finds herself repeating stock phrases to patients, that life is hard and this is the human condition, when they say life is too difficult for them, in order to show solidarity. Severe and enduring mental illness can make it more difficult for some patients.

TMU12: lines 279-314

Th12

She shows solidarity with people and offers understanding (TMU11, MU20)

Th13

She becomes part of a person's life in a close, personal way, and she enjoys this aspect as it is therapeutic (TMU12, TMU14)

Th14

Part of her role is to transfer received advice and guidelines about illnesses to patients (TMU12,

Th15

She involves colleagues in the person's care, also to feel less alone and learn (TMU15, TMU50)

Th16

Talking and being with patients is like a prescription of humanity in a medicalised and model-driven environment (TMU16, MU20, TMU36, TMU37)

Th17

There is a tension between intimate trust and professional assessment, which affects her emotionally (TMU19, TMU20, TMU33)

Th18

She feels privileged that people confide in her because she is a nurse (TMU23, TMU24, TMU25, TMU29, TMU32)

Th19

A lot of nurses are caring and compassionate (TMU28)

Th20i

When P3 first qualified, she kept her work close to what she had learned in training, following NICE guidelines, and giving practical advice about symptoms, including educating the person about their illness, recognising individual symptoms and relapse signs. During this process, she comes to know the patient on a personal level, knowing the family, and pets, and she becomes part of their life.

TMU13: lines 315-357

P3 sees it as a privilege to become such a central part of someone's life. Some patients treat it as part of a professional role, but for others P3 is their only friend. Being an only friend is a responsibility, because it means being available as much as possible, even if at inconvenient times.

TMU14: lines 358-388

P3 intentionally builds a close relationship, or therapeutic alliance, so that the person can trust her and rely on her. She views this as part of her role, while also believing in its value personally, as it facilitates independence, recovery and wellness. She became a nurse, and not a social worker, because mental health nursing has the element of becoming part of the person's life as opposed to paperwork.

TMU15: lines 389-410

In response to a question about qualities needed to be a mental health nurse, P3 indicates a readiness to adapt and learn, in the term 'wing it.' P3 never knows what is going to happen each day. She has a set of strategies, or toolbox, comprising the crisis team, emergency doctor's appointment, a professionals' meeting, or a referral to psychology. Involving others helps her feel less alone with the patient's problems, and can help the patient build strategies also.

She may not see her personal experience as being worth knowing (TMU30i)

Th21

She values formal training (TMU31, TMU33)

Th22

She explains her role to patients to delimit expectations as she is anxious they expect so much (TMU33)

Th23

She is unsure about the efficacy of medication (TMU35)

Th24

Psychiatry is not always only the medical model, although prescribing medication can make psychiatrists feel effective (TMU35, TMU46)

Th25

Reducing time with the patient increases relapse rate (TMU39)

Th26

Ethical ideas show themselves with experience (TMU40)

Th27

Models of care can structure planning and relieve anxiety about explaining her practice to authority (TMU38, TMU41)

Th28

Her training had no modules on mental illness. She read about it herself, and learning from others on placements (TMU42, TMU43)

Th29

TMU16: lines 411-461

Being a community psychiatric nurse is more than just overseeing medication and risk. If it were not, then paperwork would always be up-to-date and nurses would not be so busy. Talking to the person, giving them time, is like a prescription of humanity in a medicalised environment. By visiting patients personally, P3 means to show them that she does not just see them as a psychiatric diagnosis.

TMU17: lines 462-482

P3 treats her patients as equals. P3 feels she is a sounding board, a best friend and confidante to her patients. It is a thankless job because it is expected that she is this way. The feedback she gets is that she feels wanted and needed. Patients always say they feel better after talking to her. P3 believes it is cathartic for them.

TMU18: lines 483-535

P3 says she is a hardened optimist, and does not take it personally if her patients seem to improve after an hour with them and then they return to where they started. She has got used to patients phoning her with the same problems that had seemed to be resolved. She tries to get people to feel better again, through motivating them and encouraging them to see that situations are not hopeless, and she believes this is why they contact her.

TMU19: lines 536-562

There is a conflict in P3's role as, despite building trust, she may have to ask for a Mental Health Act assessment if the patient becomes too unwell. She feels close to her patients in a strange way. There is an understanding they would not go for coffee together if they met in the street. At the same time, patients and P3 can be personally close because the patient may have shared distressing personal details of

She gauges a student's suitability based on genuine interest in the patient (TMU 47)

Th30

Important topics to know are care planning, risk, medications and depo injections (TMU 48)

his/her life with her, such as sexual abuse, nightmares, relationship problems and suicidal thoughts.

TMU20: lines 563-622

When patients share distressing personal details, it makes her feel sad. She can feel helpless when someone's problems never seem to change. She does not want give false hope and the patient with a good therapeutic rapport will know she cannot make the problems go away. She stays with the patient, offering understanding and accompaniment, and being there for them.

TMU21: lines 623-699

With big caseloads, P3 can compromise on her paperwork and training time in order to see people. She feels they deserve the best service possible and she will rarely say she is too busy to see someone. She does not want to let anyone down. She can also try to see too many people, causing her stress which she feels as a knot in her stomach. Seeing a lot of clients, she may start to give each person only 60% attention and is over-aware of time. She makes a list of promises she makes to each patient and fulfils these.

TMU22: lines 700-726

Sometimes she is not too busy and she can get all her paperwork done. But it just takes a few people in crisis to fall behind again.

TMU23: lines 727-743

While working in psychiatric assessment services, she had time to formulate plans and make the appropriate referrals, and updating notes. When people who are awaiting trial realise she is a mental health nurse, they speak

differently to her than they would to a social worker or police officer.

TMU24: lines 744-774

Some of these people on remand do not want to talk in her assessments, but most of them want to talk because she is a nurse. Most of them are males and have been sexually abused. It is the first time they may have spoken about it to anyone. They speak to her because she is a nurse.

TMU25: lines 775-805

It is therapeutic to do an assessment because it may be the first time someone has spoken about really personal things. Listening is therapeutic. Being a nurse gives her the privilege of someone confiding in her.

TMU26: lines 806-825

She is affected by assessing distressed people so that she wants to help them. She begins to care coordinate and put a plan in place if the person is not going to prison. She hopes to be able to make some promises to people about how she can help, such as arranging appointments and allocating a support worker.

TMU27: lines 826-845

P3 has not had any training on how to listen, and has learned from her life how to listen. In her opinion this is what nurses do. She sees the time with her as the other person's time.

TMU28: lines 846-865

A lot of nurses are caring and compassionate and this is what draws them into the profession.

TMU29: lines 866-881

People confided in P3 rather than a solicitor or police officer.

TMU30: lines 882-893

P3 had written notes for the interview but was unprepared for the interview being about her.

TMU31: lines 894-908

P3 has not been on any training courses regarding therapies, and she tells her patients that she is not a trained counsellor.

TMU32: lines 909-917

An assessment is an aspect of mental health nursing and is therapeutic in itself.

TMU33: lines 918-942

P3 reminds her patients that she is not a trained therapist, that she is a nurse and care coordinator and what the boundaries of her role are. She is anxious that what she writes in notes, and what plans she makes, she may have to explain to a coroner's court. Yet she sees that being a mental health nurse with her patients becomes more than an overseer of a care plan.

TMU34: lines 943-971

In order to work with patients, she has to develop a therapeutic alliance and be honest with them. This will encourage them to be more open with her and tell her about concerns regarding medication. She also expects honesty but will check medication to see that it has been taken.

TMU35: lines 972-994

P3 personally wonders whether a lot of medication is effective because she sees it does not work for many people, especially regarding anti-depressants. She is unsure about how much is placebo effect. She thinks medication gives psychiatrists something to hold on to that is practical.

TMU36: lines 995-1008

Mental health nursing is holistic. Apart from talking to the patient, filling out forms, getting out of the house and going for a coffee, a mental health nurse also has to talk in a medical way, reviewing medication, normalising taking medication, because that might be helpful also.

TMU37: lines 1009-1024

Mental health nursing is holistic because it addresses the medical and the human, which the care plan approach encompasses. This includes the recovery model. These models and ideas help P3 structure how she works with the person.

TMU38: lines 1025-1050

It is difficult to change the level of care given, to take someone off Care Program Approach level, because people get used to having P3 in their lives. It is difficult to reduce visits also even if they remain on Care Program Approach level. One woman continued to come to see P3 to have a chat, to update her on her life, because she felt P3 really cared about her.

TMU39: lines 1051-1089

A lot of people who are regraded have a relapse, despite having been stable for years, and have to return to Care Program Approach level after a while. P3 wonders whether this is because nobody has been checking that they take their medication and their mood has changed. She is

unsure whether it is due to the absence of a care coordinator. There is a reluctance to regrade people because of the risk of relapse.

TMU40: lines 1090-1110

There were no modules on therapeutic skills in university, although there was a helpful module on ethics. She relates better now to the content of this module after being in practice for some years, especially to paternalism, beneficence and autonomy.

TMU41: lines 1111-1129

Some ideas from university made sense in practice, for example, Maslow's hierarchy of needs. But the module on risk was not enough. In practice, managing and formulating risk depends on historic risks, and personal judgement that she might have to explain to a coroner.

TMU42: lines 1130-1145

In university, she never had a session or module on what schizophrenia, hallucinations and mental illnesses were. It was expected that they would read about this themselves. Some specific topics were public health, ethics, and physical health.

TMU43: lines 1146-1155

She read about mental illnesses from any sources she could. In placements P3 got to see mental illness and in time came to be confident, for example, in distinguishing adjustment disorder and depression.

TMU44: lines 1156-1193

P3 can become stressed by committing to being there for a person but she does not allow her patients to see that she is stressed.

TMU45: lines 1194-1221

P3 was strongly influenced by an evidence-based article she read that said if a person is suicidal and knows they are being kept in mind by someone in a therapeutic relationship that it lowers the risk of that person committing suicide.

TMU46: lines 1222-1237

A psychiatrist gave her the article on keeping someone in mind. It means a lot to P3 that the therapeutic relationship can be just as powerful as that of family and friends.

TMU47: lines 1238-1256

P3 is a mentor to students and spends a lot of time talking about textbook topics. However, it is important that students are interested in their patients and this cannot be learned. P3 tries to impart to students that they need to show an interest in their patients. P3 does not pretend she is interested, as she actually is interested, but she will be upset if her student actually is not interested.

TMU48: lines 1257-1263

Textbook topics include risk, care planning, medication and depo injections.

TMU49: lines 1264-1284

P3 also shows the practice of going to someone's house, talking to the person and having a conversation, letting the person talk. An hour can quite easily pass this way. She also uses humour and friendliness, to break barriers down and become familiar in an ordinary way.

TMU50: lines 1285-1309

P3 teaches her students by showing them and leading by example. Students can be frightened and anxious when meeting patients. When they visit patients, P3 shows that they are just talking to another human being and encourages the students not to be scared and to feel comfortable. She encourages them to be open to learning from the situation, just as she is open to learning every day. P3 learns from other nurses all the time, how they talk to people, write notes, and so on and she keeps what appeals to her.

P3 General/Situated structures or Themes

Th1

P3 can feel sad and helpless because people are not cured, including by tender loving care. They still want time with her nevertheless and she can instil realistic hope (TMU2, TMU3, TMU5, TMU11, TMU18, TM20, TMU35, TMU38)

Th2

Because of her role, she feels she must not disappoint anyone who relies on her, and she commits herself to them so they know she keeps them in mind (TMU3, TMU4, TMU7, TMU44, TMU45, TMU46)

Th3

She is not emotionally involved with patients although she feels wanted and needed (TMU3, TMU17)

Th3i She appears emotionally involved, either through the personal importance of being a professional nurse, and/or a personal sense that no-one should be abandoned (TMU2, TMU3, TMU17)

Th4

High caseloads create imbalance between required documentation and time with patients, causing her physical distress (TMU20, TMU21, TMU22)

Th5

She works using what she has learned from practice and she teaches students by showing (TMU1, TMU2, TMU31, TMU49)

Th6

Developing a therapeutic alliance is expected but no training was given on this in university. She learns from the person as an equal

P3 General synthesis

Spending prolonged time with people is therapeutic because she becomes personally involved, genuinely listens and is interested, feels for, is open to, and learns from, the other as an equal, and is cautious about identifying herself with the other or giving advice. She shows understanding and makes her commitment to the person explicit. Being able to feel and tolerate emotional distress is part of being therapeutic.

She has learned from being open to patients and colleagues, and her own reading. No formal training was offered in university on how to be therapeutic outside the medical model of cure. Being caring and compassionate cannot be taught, and are more like personal qualities.

Her work is split between applying models of care to do with risk management and the medical cure (encouraging compliance with medication, the recovery model and the Care Program Approach, and NICE guidelines), and spending time with patients, which is like a ‘prescription of humanity’. The split in her work causes her

by being open to them, using humour and being friendly (TMU1, TMU15, TMU18, TMU34, TMU49, TMU50)

distress as she feels responsible across both aspects.

Th7

Responsibility involves overseeing medication, referring to others, and documenting risk, as well as spending time with a patient (TMU5, TMU13, TMU15, MU16, TMU26, TMU34, TMU36)

Th8

Treating others how she would like to be treated is itself caring as therapeutic, but it might be too personal (TMU6)

Th8i

It is therapeutic to not identify too much with someone (TMU6i)

Th9

P3 feels a responsibility to the other person and gives too much, as she may be for that person an only friend, a best friend, confidante and sounding board (TMU8, TMU13, TMU17, TMU38)

Th10

Nurses listen. Actively listening and the person speaking with trust is therapeutic somehow (TMU9, TMU17, TMU25, TMU27)

Th11

She does not show that it is tiring to be non-directive and available, and thankless as it is expected (TMU10, TMU17, TMU44)

Th12

She shows solidarity with people and offers understanding (TMU11, MU20)

Th13

She becomes part of a person's life in a close, personal way, and she enjoys this aspect as it is therapeutic (TMU12, TMU14)

Th14

Part of her role is to transfer received advice and guidelines about illnesses to patients (TMU12)

Th15

She involves colleagues in the person's care, also to feel less alone and learn (TMU15, TMU50)

Th16

Talking and being with patients is like a prescription of humanity in a medicalised and model-driven environment (TMU16, TMU20, TMU36, TMU37)

Th17

There is a tension between intimate trust and professional assessment, which affects her emotionally (TMU19, TMU20, TMU33)

Th18

She feels privileged that people confide in her because she is a nurse (TMU23, TMU24, TMU25, TMU29, TMU32)

Th19

A lot of nurses are caring and compassionate (TMU28)

Th20i

She may not see her personal experience as being worth knowing (TMU30i)

Th21

She values formal training (TMU31, TMU33)

Th22

She explains her role to patients to delimit expectations as she is anxious they expect so much (TMU33)

Th23

She is unsure about the efficacy of medication (TMU35)

Th24

Psychiatry is not always only the medical model, although prescribing medication can make psychiatrists feel effective (TMU35, TMU46)

Th25

Reducing time with the patient increases relapse rate (TMU39)

Th26

Ethical ideas show themselves with experience (TMU40)

Th27

Models of care can structure planning and relieve anxiety about explaining her practice to authority (TMU38, TMU41)

Th28

Her training had no modules on mental illness. She read about it herself, and learning from others on placements (TMU42, TMU43)

Th29

She gauges a student's suitability based on genuine interest in the patient (TMU 47)

Th30

Important topics to know are care planning, risk, medications and depo injections (TMU 48)

Appendix 4 Individual syntheses and General Synthesis

P10 General Synthesis

Administrative work, such as risk assessments, and medical work, prevents her having therapeutic time with patients. Medication helps people get better. Nurses are like a communication channel between patients and doctors, and have a more holistic view. The therapeutic is different for different people, and getting to know someone in a relationship is important to it. She will try out different ways with others, and may be gentle or assertive. She feels that getting a person to speak about what is hidden about their problem is therapeutic. She wants a person to get better, and tries to prevent them from having disturbing feelings. It is frustrating when they will not talk about their underlying problems because it prevents her helping them to get better. Listening is important. Empathy, meaning understanding someone to an extent, is central to being therapeutic, and it cannot be taught from books. Empathy is learned from life experiences, including feeling depressed, and she can feel that her experience is really the same as that of another person. Compassion is a therapeutic quality which is like feeling sorry for someone. Like her own experience, it is therapeutic for the person to feel understood, listened to, and cared about. Being clear and honest with someone is therapeutic. She has learned about being therapeutic with others through observing other nurses. She believes she has a calling from God to be a mental health nurse, which gives her confidence, and she may pray with Christian patients. Having some cognitive behavioural therapy herself has helped her be therapeutic.

P9 General synthesis

Mental health nursing is split into two main activities, concerned with interacting with patients, and administrative and medical duties. Talking with, and listening, is the main therapeutic activity of mental health nurses, but does not take priority over administrative duties. Talking is like a conversation and can be serious or more informally friendly like a chat. She is responsive in the conversation, placing the discerned needs of the patient first, making space for the patient to speak. She is open to learning from the patient, revising her suggestions and ideas, sensitive to what she may be missing, and getting it wrong. She may speak for the patient if necessary. Medication is therapeutic in a different way to talking. The nurse's uniform is a barrier to therapeutic communication. She is not sure how she has learned to listen. She has always been caring since she was a child. Confidence is important and she has grown in confidence through university and practice. She wanted to be a doctor or psychologist. Learning has been from practice, through trial and error. In university, communication skills, and treating the person as an individual was encouraged. Her work sometimes involves exposure to extreme distress and she relies on colleagues and others in this case to be therapeutic to her. She does not think about what is therapeutic much.

P8 General Synthesis

Mental health nursing is divided into a dominant administrative and medical aspect, and a minor therapeutic aspect. Medication is an essential aspect of getting better. The therapeutic aspect is difficult to express, although is real mental health nursing, involving spending time getting to know patients in an idiosyncratic relationship. University learning is about administrative and medical proficiencies rather than the therapeutic. Learning to be therapeutic is about practice and watching others. Factors which are therapeutic are genuine empathy, which is fully understanding someone, encouraging insight and hope. Helping the person identify themselves and their problems is therapeutic, not defining themselves through the diagnosis but as a person. A mental health nurse needs to be caring to be therapeutic, and this cannot be taught. Caring is looking after, supporting, nurturing, and has to do with one's nature, perhaps linked to life experiences, including being depressed. The therapeutic being a minor aspect is 'soul-destroying', as the therapeutic gives him a sense of accomplishment and meaning, linked to his spirituality.

P7 General Synthesis

Being therapeutic is what mental health nursing in itself is, and takes time, getting to know a person as an equal, involving trust, genuineness, and complex, sometimes tacit, creative decision-making regarding self-disclosure, guidance, and speaking the truth, while respecting the person's wishes and difference. The therapeutic is reciprocal as she receives something from patients since they make her feel alive, and privileged. Being therapeutic requires qualities that are innate, including compassion, which are perhaps learned from others as a child. She tries to make people happy and selectively withholds emotions. She learns from colleagues. In her training, there was focus on psychosocial interventions but not on personal qualities. The administrative and medical aspects of nursing, such as documenting risk, and managing Lithium, Clozapine and depo clinics is not therapeutic. The medical and administrative aspects of nursing are demanding and draining, not the therapeutic nursing aspects. However, the medical model of recovery is therapeutic when followed idiosyncratically. Tacit knowledge informs therapeutic decision-making.

P6 General Synthesis

The therapeutic in mental health nursing is about doing the right thing but is hard to define. It involves having the time to spend with others, treating others well, being genuine, respectful and reliable. It develops in an inclusive environment of interacting responsively, playfully, imaginatively and flexibly. Promoting independence, trust and resilience is therapeutic. Being a Community Psychiatric Nurse is repetitive. The 6 C's are what nursing is really about. Risk management takes precedence over therapeutic work. His focus in practice is on the medical model, promoting recovery and the

therapeutic as cure. Practical training in managing critical situations helped him more than humanistic skills. Perhaps being in dependent relationships is difficult for him.

P5 General Synthesis

The therapeutic is about caring, which has nothing to do with skills. It involves being with the patient over time, interacting in an ordinary way, while being inclusive and respectful, which allows them to trust, be open, and to speak. Something in the relationship itself is healing, which may be idiosyncratic, sometimes linked to social isolation. She is an advocate for people who are not heard. The mental health nurse must genuinely want to be caring, compassionate, empathic, and genuinely want to listen and be actively interested even though sometimes clients are emotionally draining. These are personal capacities, acquired through life experience, including childhood, and practice rather than taught courses. Care coordinating duties, the medical model, and the recovery model, reduce therapeutic time and erode caring from mental health nursing. Medication may provide the stability for the therapeutic to take place.

P4 General Synthesis

The relationship with the mental health nurse is therapeutic. It takes time to build this relationship as it involves demonstrating a self-contained genuine interest, respect, trust, positive regard and being attentive. Those with mental illness require this relationship over time rather than a focus on cognitive techniques. Getting to know a person is often interlinked with administrative, medical and everyday practicalities, and may include family. She prefers an individual rather than general approach to each person. Being caring, compassionate and enabling is therapeutic. She does not share her own difficulties with patients. Mental health nursing can be emotionally and physically draining. Training in humanistic and behavioural psychological approaches has encouraged her to teach skills and coping strategies. She has learned to be therapeutic through the trial and error of practice. She makes therapeutic decisions based on the relationship and the moment. Being reflectively open, linked with being open to learning from the patient, and colleagues, is essential to being therapeutic. Being open was facilitated by years of working in a reflective, structured therapeutic environment where she felt valued. Being challenging is therapeutic and takes courage and tact. The 6 C's are a fitting summary of what it takes to be a good nurse. Nurses may be damaged in some way to do their work. Nursing knowledge is side-lined because doctors are better educated.

P3 General synthesis

Spending prolonged time with people is therapeutic because she becomes personally involved, genuinely listens and is interested, feels for, is open to, and learns from, the other as an equal, and is cautious about identifying herself with the other or giving advice. She shows understanding and makes her commitment to the person explicit. Being able to feel and tolerate emotional distress is part of

being therapeutic. She has learned from being open to patients and colleagues, and her own reading. No formal training was offered in university on how to be therapeutic outside the medical model of cure. Being caring and compassionate cannot be taught, and are more like personal qualities. Her work is split between applying models of care to do with risk management and the medical cure (encouraging compliance with medication, the recovery model and the Care Program Approach, and NICE guidelines), and spending time with patients, which is like a 'prescription of humanity'. The split in her work causes her distress as she feels responsible across both aspects.

P2 General Synthesis

Being therapeutic is about getting to know a person, spending time, listening, talking, being playful and genuine. This involves patience, trust, mutual acceptance and affection, and respecting a person's dignity. But being caring is not enough sometimes to be therapeutic. Acknowledging individuality is therapeutic. Treating a person like someone she loved is therapeutic. Learning to be therapeutic came through observing others, and being open to others, including patients. Some skills could be learned through educational modules, while therapeutic qualities could not and are linked to childhood. Administrative and medical duties can be a vehicle for being therapeutic.

P1 General synthesis

Being therapeutic involves something of the self, acknowledging the other as an individual with unique characteristics, and encouraging the person to develop skills and competencies that have been stunted in childhood. Empathy is accepting that the other person is different. Transparency is encouraged by checking what is helpful with the other person. Changing current anxieties is part of being therapeutic, through creative ideas of her own and behavioural principles. Sharing sensory experiences is therapeutic, including using touch, because it builds trust and facilitates talking about difficulties and cathartic expression of feelings. Skills learned from training courses are helpful in engaging others in order to become therapeutic. One can care, as it is a formal approach, without being therapeutic. She learned about being therapeutic from mentors and other nurses on placements. Competencies are innate rather than learned or taught. Adverse childhood experiences have given her the competencies of resilience and being able to challenge others. Practising therapeutically, she feels independent of psychiatry, but medically she is not as she administers medication and checks compliance. Representing the person, and educating them about mental illness, encourages a therapeutic rapport. University training did not encourage critical or original thinking, which resulted in her reading around her subject a lot to teach herself.

General Synthesis (all participants)

Mental health nurses work in two separate, sometimes closely intertwined strands, one dominant, involving administrative and medical duties, the other involving being with clients. The forum for the therapeutic activity of mental nursing to take place is any opportunity of being with clients, and this can be practised as they wish. However, the vital importance of time spent with the person means that administrative and medical duties undermine such activity. Medication can provide the stability for therapeutic activity, and can also be curative at times through removing distressing symptoms. Administrative and medical pressures support a model of recovery that minimises therapeutic time spent with mental health nurses. Mental health nursing therapeutic knowledge may be side-lined because doctors have a better education. There is an absence of a cohering knowledge base for therapeutic mental health nursing outside of psychiatric care, with little mention of the 6 C's (care, compassion, competence, communication, courage, commitment).

Mental health nurses regard being with clients as their main therapeutic activity. Being with clients with mental health problems involves spending time with, talking with, listening to, and getting to know, a person, crucially, over time. For some participants, being with clients is mental health nursing in itself. Something about being personally involved in the relationship itself is healing, perhaps idiosyncratically, involving tact, affection and inclusiveness, which may facilitate the client in speaking and being open. The relationship can encourage development that has been stunted in childhood, sometimes through developing transparency between the nurse and the patient, and allowing cathartic expression of feelings. What is therapeutic is hard to define for some and caring is not enough. For some nurses, being therapeutic is mainly about caring, which has little to do with skills. However, for one participant, caring may not be therapeutic as it can just be a duty, for example, in following the 6 C's. Being therapeutic can involve complex decision-making, linked to the moment and the relationship. Being therapeutic can be about being creative, playful, and sharing parts of one's life, and may be reciprocal. It can involve ordinariness, sharing activities and touch. Spiritual beliefs may motivate and inform therapeutic interactions.

Characteristics required in being therapeutic are innate, personal capacities, or have been developed through life experience, including in childhood. These characteristics are to do with being enabling for the other person, and showing genuineness, respectfulness, reliability, and responsiveness, as well as being reflective, accepting, caring, compassionate, attentive and empathic. Other characteristics the mental health nurse may have, or need to develop, are resilience, self-containment, openness to learning from the other person and self-confidence. Sometimes, an explicit commitment is made to the person to 'be there' for them. Equality and individuality are sometimes recognised. Some mental health nurses are cautious about empathy and giving advice. Empathy can be acknowledging that the other person is different. Personal experience of going through one's own mental health problems may enable empathy as understanding, at least to some extent, and sometimes fully. Being able to tolerate in others, and feel in oneself, physical and emotional distress, is part of being therapeutic.

Learning has been mainly through life experience and practice, including observing other mental health nurses, trial and error, and reading about specific topics. What encourages learning to be therapeutic is a safe, self-reflective environment of therapeutic reciprocity with colleagues. Learning involves being open to others, including patients.

Regarding taught aspects of training, both humanistic, and behavioural, therapeutic approaches have been helpful to teach skills. Taught skills require being therapeutic in the first instance to be helpful. Humanistic therapeutic approaches may not be helpful on some acute wards however, due to the chaotic environment. In training, skills taught through experiential course work are more important for being therapeutic than administrative and medical course work, although the latter dominates.

Appendix 5 Examples of the creative process in the phenomenology

Meanings emerge implicitly, as well as in sharp focus, and the following outline will try to give a sense of this changing landscape. It seemed important to write here about some things rather than others and the reasons for this seem impossible to find. Not everything could be written about due to space and time. The following is a presentation of a phenomenology for each participant, in no particular order apart from the first one whose considerations set the scene.

Participant 6

What invoked an old feeling of abjection was the interminable language and power of psychiatry which was overwhelmingly present throughout. This seemed to have most force with Participant 6, who will be presented first. He seemed to show the choice that every mental health nurse had to make, as to whether to submit to the ideas of psychiatry or to leave that career. He chose the former. He had found a certain recognition of his intellect (talking about a lecturer, "probably a bit like me, he knew everything" (Line 695)), in finally embracing the medical paradigm which he may as well "buy into" (Line 722). He was fearful that his promotion to the equivalent of a junior doctor might make him aloof, yet this seemed to fit with how he was anxious about dependency in relationships. He had learned from experience in mental health settings "to not let people become too dependent" (Line 70). "Risk management trumps everything else" (Line 17), so that there was "no time to work in a meaningful therapeutic manner" (Line 136), by which he meant having time to talk to people in a Rogerian way. But it seemed also that neither would he take a meaningful risk for somebody else. He whispered that he worked in a more "holistic" way than the other doctors who essentially stuck to an "algorithm" (Line 629), but 'holism' for him was providing a leaflet on community activities. There was a certain despair in being with him. Through experience, he had learned that the key to being therapeutic was "to be nice to people…

respectful" (Line 279). When he spoke of how some of the nurses had spoken "scathingly" of him as having become "a little doctor" (Line 312), he added that he "had to use a bit of old emotional intelligence" (Lines 320-321). It was if the allusion to a 'mechanism' of emotional intelligence protected him from saying that he felt hurt, so the message was that there was indeed an aloof, all-seeing person inside him who knew what to do. Yet it was clear this was not the case.

He had given up on mental health nursing, not only because it was like a "milk round" (line 569). Mental health nurses needed training in de-escalation, anger management and risk assessment rather than therapeutic models (such as Rogers) and being respectful to people was the core of being therapeutic. He had also learned that being trusting and respectful was therapeutic from the charismatic leadership of a nurse consultant who worked this way. Yet he spoke about trust from a place where he appeared to have cut off from that uncertain relation, which was also a dependent relation, with the other, or (as may be more often than not) restricted it to a certain few. It could be imagined that a despairing patient might walk out from an appointment (with a leaflet) and jump off a bridge. It then became clearer why he may be so concerned with risk management. It seemed hateful to summarise him as a nice man, respectful, but closed to how the other might disturb his person and put him under question. He was far more than this, but he had taken on the persona of psychiatry. The technicalities of anger management were clearly important for the work of mental health nursing, but in terms of the therapeutic as healing what appeared through him as most significant (in a kind of photographic negative) was putting one's own self under question in relation to the other, something he seemed to not want to do.

Participant 4

Participant 4 seemed to have 'given up' in some way to the medical model also, although she was open to others ("I think that you can learn a lot from students" (line 588)).

But it was as if she knew her remit and would go no further. She showed a patient ability to stay with a person in distress, which she regarded as therapeutic, but then it emerged she was likely to guide that person towards a psychiatric view of recovery. This way of working within a psychiatric system was not so surprising. She seemed tired. It was tiring to read over again her interview, as if in and between the words was being felt years of some labour, not in her name but in the name of psychiatric care - "mainly I feel tired when I get home because I feel work gets the best of me" (Lines 606-607). She was sure of her place in that place and it was hard to find her now. The disturbing question came to mind as to whether all credos worked through turning the person into a host. What she appeared to need was what she had learned from years ago, which was an environment in which new ideas could be thought about and challenged by others, which she also at times translated into her work with patients - "I would try and get them to talk about how they are feeling, why they are feeling like that, why are they feeling hopeless and helpless" (Lines 409-410). Without her seeming to notice, this dialogue was losing out in a tension with her commitment to a psychiatric model of the mind, which she presumed so much about that she had lost sight of it being an idea - "if you've got a good diagnosis of a patient and you have a good pharmacologist they wouldn't have to see probably the psychiatrist that often" (lines 627-628). It seemed important that a therapeutic education would not be about a preparation to host a credo (that exploited her good will).

Participant 2

As participant 2 spoke, there was something fragile (but not weak) about her; something of an uncertain young girl flickered in her eyes, perhaps because she was upset about something that happened that morning just before the interview. When she touched on how she came into nursing, her speech was full of pauses, stops and starts, the beginnings of sentences taken up and then abandoned. It was unclear which way to go, yet this uncertainty itself seemed important. It opened a space between us that allowed silences to be. In this space

she spoke about how her father had died suddenly when she was aged 10, of early onset dementia, and during his short illness was offered a bed in the local psychiatric hospital as his condition was deemed to be psychiatric. She had felt a stigma that he would be admitted to a psychiatric hospital and felt bad about feeling this way. She came across as not having ever understood why she became a mental health nurse, but it appeared to have something to do with her father being cared for, or not being cared for, by someone. There was an intense sense of sadness, of an untold grief, something that had still to be articulated, or perhaps never would or could be. Without knowing about it much, it seemed somewhere there was a regret for 'not being there' to a father, not being able to stop him dying, and for her a feeling of stigma that he was going to be in a psychiatric hospital, perhaps ashamed of him, and intermingled with this, unspeakable loss. There was an entangled grief here perhaps. There was also warmth between us. There was a sense that she needed to be minded, or taken care of (just at that moment), and it may have been that this was happening with some of her vulnerable patients, that somehow a vulnerability touched them - only those who were capable of being touched - and this made them feel important to someone again, so that they could show affection and care towards someone. She spoke especially about a woman she knew for years, who had been abused as a child, and had grown up to be a kind of vigilante. It seemed there may be something reciprocally therapeutic between them, both in some way 'minding' each other. She had retired recently but came back to work part-time as she missed her patients and her colleagues.

It was easy to imagine the flickering vulnerability and sensibility in her eyes may have touched her client, who had been so viciously abused as a child, and perhaps some kind of communication, or recognition at this level was healing. She seemed unaware of this. It may also have come through tacitly in her words, when wondering what it was that helped between them:

> no, no, it's nothing at all… it's just… (long pause) … Perhaps it's both of us - she gets on with me and accepts me… (P2 MU7-8 extract lines 77-95)

This had a disarming sense of 'truth' about it, that what is therapeutic depends on how the other person accepts, and gets on with, another, as opposed to accepting some 'therapy' that will be imposed. There seemed to be a lot that was 'unthought' in this phrase also. There appeared a tacit understanding that she was 'in relation' in some important way which was indefinable. It seemed as if she had never really thought about her own ways of being therapeutic, and as she spoke she said it may be like what was going on in the interview, that there was room to speak and there was a genuine interest in what she had to say (a space which she also created). But she seemed quite accepting of not knowing what it was, and this seemed important. Although she learned from example, especially with respect to how others' dignity should be respected, she also was certain that she did not know as much as the psychologist, for example, in working with personality disorders. She did not appear to value her own way of 'working' with her clients, and some of her clients had this diagnosis (including the one she had spoken so warmly about). Perhaps a validation of her own way of being therapeutic was needed through ideas that would help her find words. It also seemed important that there should be a safe place to speak, not only of a 'flickering vulnerability', but also for an uncertain, insecure intelligence to show itself.

Participant 3

A few weeks after Participant 3's interview, a memory came back out of nowhere. As a very young boy, in the almost-dark listening to the indistinct words of my mother and sisters by the fire in the next room, it seemed they were talking about mysteries. There is a comfort in the sound as if somehow all will be well, and the atmosphere of the interview with Participant 3 is the same. This may be an example of how subjectivity constitutes (discloses) a meaning which had already been constituted (disclosed) through an intersubjectivity, and

the meaning, ‘all will be well,’ appeared like a gestalt in a complex, living, multiply patterned landscape ‘overrun with words.’ She would say to patients, “you’re not on your own” (line 171), that she had “got their back” (line 504), that these were sometimes unspoken promises she was making, and “I know I'd never go back on it” (line 1187). Her words seemed to be revealing something of her being, which appeared to have to do with an ‘openness’ to those who had been injured, which would “soften[s] and brighten[s] the face of the world” (Brooke, 1993, p. 158). It appeared that to have someone like her being available to someone who was in a distressed state, indicating with her words, actions and person that she would “…just keep being there…” (Meaning Unit 20), would involve something of the art of healing. There was a critically thoughtful hard work going on also. She said that through experience she saw it was “naïve” (Line 110) to think that “tender loving care” (Line 115) was enough, and was critical of nurses who showed “no[t] thought afterwards” (Line 122). Her openness to others included then an ability and desire to learn. This appeared important, as it seemed to show being therapeutic involved a way of being (an openness to others) which included an ‘ability’ and willingness to be open to something different from one’s own experience. It was the opposite to dogma. It seemed clear that these two aspects were interwoven.

Participant 7

With Participant 7, ‘Rings on her fingers and bells on her toes’ came immediately into mind. In the *Oxford Dictionary of Nursery Rhymes* (Opie & Opie, 1997, pp. 65-67) it goes like this,

> Ride a cock horse to Banbury Cross,
> To see a fine lady upon a white horse;
> With rings on her fingers and bells on her toes,
> She shall have music wherever she goes.

Her enthusiasm and colour would draw someone along, and it was easy to miss something. A kind of vibrant energy seemed to distract from something else, which did not register until much later although the nursery rhyme seemed to 'speak' it immediately. Mental health nursing for her was a "proactive keeping people on a journey" (line 207). Maybe there would be no time to stop. She also worked for herself as an Aesthetic Nurse, doing "Botox and fillers… I like to make people feel good aesthetically" and it seemed as if 'keeping things on the surface was important.' She did not "want [patients] to see [her] true emotions… sometimes the happiness, yeah, because we have achieved something there…" (Lines 301-302). It felt like she might 'gee up!' someone who was in despair rather than stay with their situation and allow something different to develop, although there was also the possibility that some people might need to be 'gee-ed up!' She made several references to "training the brain" (line 304) and how some people "don't have a logical, rational mind" due to "part of the brain not developing" (lines 500-502).

It seemed as if something had been passed over, something turned away from in her relationships with others through being too logical ("still my positive self, I'm very logical" (Lines 287-288)). This may have been indicated in the difficulty that was there regarding her relationship with her mother, where she referred sharply to not hating her (see Findings, Chapter 5, Section 5.3.3.1), and later how her mother was "very sharp and logical" (Lines 643-644). It was as if 'functioning again,' through this sharp logic, was more important than learning through a more complicated view. She was forgiving, of patients at least, as for example when she re-established the relationship with the patient who humiliated her in a packed reception area ("Look at you, with your charity shop cardigan and bad skin! Who do you think you are?!" (Line 746)). It appeared that what would have been important for her was slowing down, which might help her see herself, and others, differently, as how she was

seemed like a way to distract from something else. How she viewed rationality and logic, and spoke of the brain but not the mind, seemed to fit into this cover-up.

Participant 9

Participant 9 was qualified a year. She did not like writing essays, but enjoyed classes and placements. Talking is the main therapeutic thing in mental health. A certain openness was reflected in this way of speaking, which it felt may expose her also so that she would be affected by the other person (and it would be dangerous for her if that person was violent). She understated her own struggles, and gave the sense she was containing of those of others. Some months previously, a patient who she had been very close to had killed herself soon after she had been transferred to the care of another nurse and it had affected her badly. This only came out at the end of the interview. From the start however, a certain 'strangeness' was there that seemed linked to how she emanated something 'open to the other' from her person. In the avalanche of memories she invoked, thoughts of being forgotten, overlooked, looked down upon, keeping a low profile, unable to speak, came into mind. Something about feeling flawed and stupid, and finding one's voice against some oppression spoke in the atmosphere of the interview. Her presence around someone who was 'shut down' or 'crushed' would have been therapeutic, allowing something not quite destroyed to recover. Thoughts like this appeared as simply as patterns in a drawing.

In the struggle to stay in the reduction, to not try to empathise too much and 'get out of her way' (as it felt what was being found was an avalanche of memories that were not hers), the more it appeared that she would somehow allow others to be. What seemed to be happening was that, in being with her, thoughts seemed freed up, and she 'allowed' this to happen (without apparently knowing it). The only thing she noticed was that she did not fill in the gaps in conversations so that the other person had space to speak. But she seemed to be doing this through her own self as opposed to implementing it like a technical strategy or

‘communication skill.’ It was easy to understand how the patient on the ward who had struggled to communicate had been able to speak with her. The disturbing thought insisted that that space being taken from her may have contributed to her death soon after being transferred. There seemed to have been a crucial opening up for that struggling person which had been closed down by the clumsy administration of the ward, not noticing that the ‘treatment’ was already taking place. Participant 9 had not noticed either that this relation may have been the ‘treatment’ (or at least a significant element of it), and she did not object strongly enough to the transfer, not having the awareness or confidence to do so. It seemed a therapeutic education would have been somewhere around facilitating an understanding of her own self in relation to others, and learning ideas in order to be more confident about being critical of the ‘standard treatment.’

Participant 8

Participant 8 wanted to “truly relate” (line 530) to patients as this was therapeutic, and linked to his Christian beliefs which he said defined him. He wanted the other person to know that “someone is here who actually cares about them” (line 22). He said he had “always… failed and stuff” (line 605) and had a kind of mini-breakdown and gave up his previous career as a chef. While getting back on his feet, he started working as a health care assistant. He came to realise through this that “working very closely with people” (line 63) was what he wanted to do. It gave him meaning, and it felt like he was “making them feel important” (line 19), as well as “contributing to their greater good” (line 686). He got “positive feelings… from looking after someone in a crisis” (line 648). What he did therapeutically was “difficult to put into words” (line 215) and he was better with people who had been through depressing experiences like he had because “I can identify more with these” (line 455). He could not work with people who were manipulative. He mainly learned to be therapeutic through his own life experiences. The therapeutic aspects of mental health nursing were “talking and

listening" which "all flows naturally" (line 410), and "if you don't have a nursing caring nature you can't learn it" (line 332). This meaningful and therapeutic work was undermined by the overburdening administrative duties involved in mental health nursing, which was "soul-destroying" (line 207).

It took some time for all of these words to sink in, so that they were not just platitudes. It seemed a struggle to allow him to have his faith. The 'soul-destroying' comment resonated somewhere, and it came to mind that perhaps his soul had been almost destroyed through trying to work in a career for 'material things' - "you can't take your nice watch with you, it just turns to dust" (line 679) - and now it was almost being destroyed again through becoming an administrator of a psychiatric system. It was a struggle for this to come across clearly, perhaps because there was a tension between one faith dissolved and one very alive. It was difficult to view him as not being naïve and lost, until somehow, months later, when struggling to get past what seemed like the platitudes of spiritual conviction, there emerged the memory of a feeling of warmth that might come with finding meaning, and belonging, in one's life at last. This was empathy as an analogy. It opened out a different understanding, so that amongst the naivety there could circulate a certain sweet kindness, that perhaps others would also feel. And it seemed so clear that to someone who was injured and distressed this kindness would be healing. For a fleeting moment Brother David was spilling out biscuits from the golden tin that shone like a chalice. But this offering had to be allowed. The other person had to allow something to happen, just as something had to happen in the 'analysis' to see it. This may have been why he did not work with manipulative people, as the implicit aggression might 'destroy' his soul.

It appeared that being caring could not be taught and this seemed to offer a predicament regarding education. He called the interview a "kind of reflective account" of himself "as a person" (line 702), and he had rarely had this kind of conversation. It seemed

crucially important to have some kind of space to reflect with another (or others), as it gave room for perhaps new understandings to emerge regarding the meanings involved in choosing to work as a mental health nurse.

Participant 10

Certain lines from the interview with Participant 10 were unforgiving. The forceful way of speaking words such as, "I'll box it, hammer it down" (line 464), "Oh, spit it out!" (line 548), "thrust pills down their throats" (line 310), "It's better to get it out in the open" (line 333), and "this is not about a fucking rat" (line 712), seemed driven from some dangerous unknown. She did not see the danger of the conviction in her voice. She meant well. She had been qualified for 4 years and came into nursing late. God had called her to be a mental health nurse - "me and him have an understanding" (line 636) - and until she received other instructions as to "where he wants me" (line 637) she would stay in this work. There was a sense that 'true' empathy existed in a real relationship between two people, as mirrored in her relationship with god, and it was important to get to that place with someone no matter what. The relationship with god was so important that it seemed other relationships must have failed. There was a certain echo of a far-off empathy in wanting to reach out to her. The relation with god seemed to be the way for her to make sense of intolerable anxieties. But everything depended perhaps on how she perceived the 'god-me' dyad. The off-hand manner in which she said that she learned from others - "Where else am I going to learn? ...You can't teach empathy with a book!" (lines 216-220) - seemed to hide something that might be linked to such anxieties.

It was difficult to write this way, or at all, about her as it seemed that she could easily have been dismissed, and maybe this was why her guiding relationship in life was with a god rather than another human being. There seemed to be a tentative relationship with others developing through learning from observing others. She admired the ward manager because

she had a way of being with others that was calming and people listened to her. It seemed important that Participant 10 would come to understand her own anxieties in being with others as part of her training, as she was too caught up in trying to get to the 'real' problem with people, ignoring the journey someone might be on. She seemed to be caught up in putting an idea first, rather than the person in front of her. Her training appeared to have failed her in coming to understand something crucial about herself.

Participant 1

"I'm grateful for you talking" was the line addressed to her (line 1) before any thoughts found their mark. It simply 'showed itself' that Participant 1 needed to be appreciated. This impression may have been something to do with a surface confidence at times rippled by a certain tremor in her voice and how she closed her eyes momentarily as if not to see something. The meanings in the interview seemed to lap back on each other in time, so that later, talking about a patient, the sense of denial in how she said (line 433) "I don't expect… any acknowledgement" confirmed the original impression. It seemed confusing as to which meanings belonged to whom but it appeared there were returns to images, ideas and symbols that spoke about her. In the middle of the interview she spoke about her alcoholic parents who were unavailable, un-interested and this seemed like a crystal ball in the pub hall to fling its colours indifferently onto every surface. Her grandmother had rescued her by stepping in, and they would play "role play" games and read stories out loud together (line 621). She knew a lot about communication skills, which she had learned on training courses in her previous career with a bank - active listening, open and closed questioning, mirroring, body language. Experience of life had made her critical of empathy and psychiatry. But what seemed to throw its light into every shadow was how she closed her eyes sometimes as if to block out something, even though she said it was important "to make some sort of bond and open up lines of communication" (line 14). What was therapeutic for her was the tactile, the

sensory, the reassuring touch, that someone was present, and certain words, like thoughts perhaps as well, could be "shelved" (line 185). She said she had learned about being therapeutic also through "shadowing" her mentor (line 541). Her speech often shot across like stones skimming on a glassy surface. But when the throw was not so good, the glass broke and something foundered.

Referring to a client who had "intrusive thoughts" (line 161) … like 'rape me' and 'cunt' and 'turd'… they're all really horrible" (line 162), she suggested to her that "she could perhaps make them into a bit of a comedy" (line 166). She and her client had linked the thoughts to sexual abuse, although they had decided to focus on the effects of the abuse, which had been to make her feel "worthless and stupid" (line 206), because she did not want to "open a box of worms" (line 247). It seemed so accurate, speaking about her nurse training, when she said "all this nonsense we learnt" (line 495). It seemed that her training had failed her, consigned her to the shadows, to playing games, and what she needed was someone to help her step out of there. But like a wounded creature, it would be difficult for her to trust the other's word or the hand held out to help.

Participant 5

Participant 5 seemed to have a clarity about her that was blocked by the interview at first. Trying to isolate what was therapeutic got in her way, until when asked about 'qualities' she said, "I hate all these things" (line 71). When she followed with, "I think it's really important to listen…," and not to "cut them off in the middle" (line 79), it was like a gentle reminder about interviewing although this did not seem to be her intention. There was a tacit slant to her words. The effort to find out something was just closing her down. Perhaps to be kind, she listed things like listening, not being dismissive, empathy, caring, "getting to know [how] they feel about their life from their perspective" (line 89). The meanings in the remark regarding 'hating all these things' returned more clearly after a while, and it seemed to show

that these ‘skills’ or ‘elements’ of being therapeutic did not matter much at all if considered as something that anyone can be taught, because “people can tell who cares and is interested” (line 96). The meaning appeared obliquely, like a ray of light might catch an unexpected colour, that a person either is, or is not, therapeutic. Being therapeutic had to do with actually caring and being interested in another. She declared she had “absolutely not!” (line 98) learned anything from courses on the therapeutic. Instead, she learned from watching others and being with others, “bad examples taught me as much as seeing good examples” (line 140). This had started early as her mother was ill for most of her childhood and needed nursing care at home. She knew that the difference between ‘good’ and bad’ was down to her “interpretation” (line 122). It seemed that somehow her interpretations would be trustworthy and she evoked a kind of calm trust. But she was also unsure of herself, asking “Is that the wrong answer?” (line 100) immediately after her declaration. There appeared to be a need to have something affirming reflected back, yet her lack of confidence helped open up a space also to wonder about things. Others might see it as weakness of some kind. But the lack of confidence seemed to indicate that she needed to develop more trust in her own experience, not to dominate another but to open a more freed dialogue.

What came to mind was an underlying ‘clarity,’ and when she said, “We need to listen to what *they* feel their needs are” (line 11), she was showing this also to this other person in the interview. What she said and what she did rang true. She was used to putting the other person first, and this work seemed to neither come from, nor leave, any bitter edge or hurt. But she was unhappy that she did not have much time any more to spend with patients, because of the focus now on “care plans and their goal to recovery” (lines 17-18) which had to include referrals to courses in the Recovery College, day services, and voluntary work. What came to mind was that she wanted to walk alongside those who had been forgotten or discarded, “encouraging them, empowering them” (line 30) but this had been replaced by a

paper exercise. Her own laboured walk seemed to say something about a burden yet the tone that rang true in her voice seemed flawless. A few days later, it rained heavily overnight and the garden was drenched in rain. Something insistent was in how the heavy grey skies overhung the colours of the garden in a kind of struggle. The rain gave life but could also drown. Something insistent in the colours and the rain was in between her words, that went beneath the complaint that she no longer had time for patients. Seeds seemed to be sown around a bed-ridden mother, life-giving and overburdening, a burden taken on unresentfully in kindness, and a sapling having grown strong had now become a weary shelter for others. It seemed that she needed someone to cut something back, and open up a space for her instead. The burden may have been kindness itself, how branches break under the weight of their own fruit.

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*Note: Where applicable, Husserl's works are referenced showing the volume of the critical edition of his works, *Husserliana* (a work in progress), to which the accompanying English translation corresponds (if present), following Moran (2000), Welton (1999) and Zahavi (2003). Dates refer to the English translation where applicable.