THE ESSENTIAL STRUCTURE OF A CARING INTERACTION: A PHENOMENOLOGICAL STUDY

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INTRODUCTION

The words" care" and "caring" are prevalent throughout nursing literature. There is consistent confirmation that caring is vital and, in fact, the very essence of nursing (Bendall, 1977; Leininger, 1977; Rule, 1978; Watson, 1979). Although constructs and essential ingredients have been posited that are present in caring (Leininger, 1977; Mayeroff, 1971), very little research has been done to substantiate what constitutes the essential structure of a caring nurse-client interaction from the perspective of the client.

In this age of super technology, as related especially to health care, more and more of the nurse's time and energy are devoted to working with nonhuman objects. The ultimate result of this increase in technological functioning is that the client as a human being may be left out of the nursing picture and may experience the depersonalization and dehumanization that results. In relating caring to hospice nursing, Donovan (1979) stated that technology per se is not to be disparaged. Only when the tools of technology are used without personal

attention is technology dehumanizing. "If depersonalization accompanies the use of machines, procedures, and services, the responsibility rests with us. We have failed, not the machines" (p. 23).

The use of the term "caring" has become a cliche. Slogans abound in nursing advertisements, articles, and textbooks that proclaim nurses as "caring and competent," "caring and sharing," "we care a bundle," the "final step in caring," and "to care is human." Yet, books, articles in magazines, and newspapers proclaim the lack of caring that is evident in the health care system today (Howard & Strauss, 1975). In an article written by a consumer, Rockefeller stated, "What the public wants is an entire health care team to give the patient the feeling that they care, that they are involved in him as a human being" (1963, p. 580). The following comment was made by a hospital official after tabulation of a survey of former patients: "expectations were different from what we expected--we were thinking about medical care; they want someone warm and caring" (Dunlop, 1982, p. 36). Former patients themselves reflect similar comments:

> What I need and value most is someone concerned enough to smile, to listen . . . to let him know not only that he still exists, but that he's important . . . I just know that the most important thing to the patient is that the nurse cares . . . (they) made it very clear to me

> that the hospital was there to treat patients, not people. (Chaney, 1975, pp. 24, 37, 38)

One poignant example was a letter written to the Washington Post in March 1977 by a mother whose 17-year-old daughter was tragically killed in an automobile accident. In an open letter to health professionals, writing of her experiences in the emergency room after the accident, the mother wrote

> Please search yourselves for resources to deal helpfully with others like us. Seek ways to make the few moments available for deeply troubled persons times of healing rather than destruction. Plan ways of staffing your facilities with people who are full of heart and wise in the administration of compassion. We need caring so desperately. (cited in Reilly, 1978, p. v)

This lack of caring on the part of nurses as perceived by clients, patients, and their families, and the dearth of research as to what constitutes a caring interaction, demonstrates a need for an understanding and identification of the essential structure of such an interaction.

Problem of Study

The problem of this study was stated: From the perspective of the client, what is the essential structure of a caring nurse-client interaction?

Prior to 1982, the limited research available regarding caring interactions has concentrated almost exclusively on empirical indicators of nurse caring behaviors as defined and categorized from the nurse's perspective (Amacher, 1973; Henry, 1976; McCorkel, 1974). To objectively study only empirical indicators of caring from the nurse's perspective would not get at the essential structure of the caring interaction as experienced by the client. In the final analysis, to describe caring interaction as indicated only from the nurse's point of view may not be at all congruent with the client's experience. It is only when the client defines the essential structure of the caring interaction for nurses that progress can be made to provide clients with the quality of nursing care that can be identified and labeled as caring.

Leininger (1977), a leading nurse-anthropologist, stated "Nurses could well study caring behaviors, values, and outcomes for the next two decades and not tap the full possibilities" (p. 4). The goal of the research should be to "learn more about the nature and process of caring, and to determine which caring behaviors are universal and which are non-universal" (Leininger, 1977, p. 14).

The purpose of this study was to research the phenomenon of caring by obtaining from clients' verbal descriptions their preceptions of caring and noncaring interactions with nurses. The essential structure of a caring interaction was extracted from these descriptions by phenomenological analysis.

Justification of the Problem

Flaskerud, Halloran, Janken, Lund, and Zetterland (1979) stated the problems patients and clients encounter in interactions with the health care system and nurses in particular.

> In a system where parts are emphasized instead of wholes, where cure is the focus instead of care, where processing the patient through the system takes on assembly line dimensions, nurses have neither the incentive nor the inclination to become involved with patient care in a concerned (caring), expressive, and physically present way. Apart from performing necessary tasks, interactions between nurses and patients are uninvolved and often dehumanizing. (p. 161)

The whole technical revolution in medicine has tended to increase the trend toward impersonal treatment. As Wexler (1976) observed, this technical revolution has "created an array of tools with which to do things to people, thus resulting in less and less time to do things with people" (p. 276). Studies show, however, that more

time has not solved the problem. New, Nite, and Callahan (1959) found that when the nursing staff was increased, patients did not perceive any increase in quality of care. Aydelotte and Tener (Note 1) showed that increased time available for patient care was spent by the nurses in procrastination and on personal activities.

Howard and Strauss (1975), in describing depersonalization, wrote of the tendency to treat people as things ("thinging") whereby people are viewed as objects of action rather than as subjects. Also, in dealing with things, there is a connotation of an absence of feeling; things lack the capacity for subjective experience. Thus, patients and clients are perceived as "insensitive objects, objects that psychologically, at least, do not exist at all" (Howard & Strauss, 1975, p. 60).

Research by Duff and Hollingshead (1968) and Dumas and Leonard (1963) demonstrated that nursing care generally lacks intensive nurse-patient interaction. In these studies the nurses' behavior indicated nurses as "not knowing" or "being interested" in the patient. That patients and clients desire such an interaction was demonstrated in a study of physician-patient interaction (Dimatteo, Prince, & Tranta, 1979). Patients' perceptions

of the caring, concern, warmth, and positive feeling of their physicians was found to strongly influence their desire to continue their relationship.

A need for intensive care nurses to concentrate some of their skills in the area of developing a trusting relationhip with patients was demonstrated by Williams (1978). Relatives of patients in intensive care perceived nurses as fulfilling the technical-professional role well but not the caring role. Perrine (1971), a 20-year-old paraplegic, described how some of his needs were met and some unmet during his frequent periods of hospitalization. He stated his needs could have been met by the nurses if they had established a trusting relationship with him and "really listened" to him. "Nurses didn't know anything about my situation and furthermore, didn't care! I needed someone to trust, someone who was credible and understood and cared about me" (Perine, 1971, p. 2131). Besides patients, families also are conscious of dehumanization. The following, from an Ann Landers' column, was written by a relative of a patient in a hospital. "Time after time I have been made to feel like a nuisance, something to be avoided or ignored like a piece of equipment left in the hallway." He wondered why nurses have so little

compassion. "We don't ask much--just a little smile and a few words" (1981, p. E-7).

Menninger (1975) noted that most discussions of health care quality address only the objective technical aspects of such care. He stated that medical literature has made occasional apologies for the omission of measuring in some way the subjective "caring" aspect of treatment by getting feedback from patients. Cochrane (Note 2), in his presentation before the Institute of Medicine, emphasized that the quality of care was a poignant, personally experienced feeling of being cared for. Peabody stated the need for caring most clearly in 1927, "the secret of the care of the patient is in caring for the patient" (p. 877).

Pelligrino (1974) suggested it was possible to investigate the inherent dehumanizing tendencies in today's patterns of patient care by incorporating the practice of genuine caring in each individual transaction. Nurses especially must balance the technical and routine tasks with the interhuman interactions. The nurse's caring presence is an essential component in this relationship. Naugel (1973) touched on this when she concluded

> How easily gadgetry and labels substitute for a human being .. . I know that only when someone

> listens, only when someone touches, can the body and spirit be restored. If no one cares, then both the body and the spirit of man are shriveled into nothingness. (p. 1981)

To study caring in this light can best be done using an existential phenomenological approach.

Philosophical Existential Perspectives

In the 1960s, nurses began writing about the relevancy of existentialism as a philosophy applicable to nursing; specifically the philosophies of Marcel and Buber (Ferlic, 1968; Vaillot, 1966). These philosophies are particularly well-suited for application to the phenomenomen of caring. Although there is a wide variation in the interpretations of existentialism, all interpretations stress the worth of the individual and the potential for change. Man is not, but is forever becoming. The notion of growth is implicit in existentialism.

Existential Themes of Martin Buber

Buber is generally considered to be the most influential Jewish philosopher of the 20th century. His most notable contribution is his book I and Thou (1958). Despite the fact that his expression has become a cliche, the notion has had wide influence in not only theology but

social sciences and education. Buber stated that in the beginning there is relation. The "self," or the "I," of each person comes into being in one or another of two primary relations--the I-it or the I-thou. He contends that what really determines the being of a man is the way he relates to the being and events of the world. It is the nature of the relationship that constitutes the person. Livingston (1971) defined I-it as

> The usual way of relating ourselves to other beings is by experiencing and using them, i.e., we observe a thing, examine it, and test it. Our relationship is essentially objective and instrumental . . . it is the typical way we relate to things and persons in general, although in an unconscious way. (p. 350)

Buber (1958) acknowledged that the I-it relationship is necessary for human life and progress so that we can understand and order the world. Yet the I-it relation is not the primary human relationship. This is found only in the relation of the I-thou. According to Buber, the I-it relation is experiencing, and experiencing takes place within the person and not between persons. It is a purely subjective process, lacking any mutuality, and marked by the subject-object dichotomy. Buber stated that no man can know another simply as he knows objects. Real

knowledge of another person requires openness, participation, and empathy. Buber stated, "The primary word of I-Thou can be spoken only with the whole being. . . . I become through my relation to the Thou; as I become I, I can say Thou. All living is meeting" (p. 40). I-thou involves a real encounter and genuine mutuality. Man cannot live continuously in a world of I-thou's. He can live securely in a world of I-it but "He who lives with it alone is not a man" (p. 50).

Buber (1958) contended that what has happened is that the proper balance of I-it and I-thou has been disturbed by the increase in I-it relations. Man has decreased his power to enter into genuine relationships as evidenced by the depersonalization in contemporary society.

> In our age the I-it relation, gigantically swollen, has usurped, practically uncontested, the mastery and the rule. The I of this relation, an I that possesses all, succeeds with all, this I that is unable to say Thou, unable to meet a being essentially, is the lord of the hour. (Buber, 1958, p. 56)

Friedman (1978), one of Buber's translators, stated this idea as it pertains to caring. "The very role of caring gets in the way of caring because the one cared for no longer appears as a person on the same level as the one who cared" (p. 3).

Existential Themes of Gabriel Marcel

Like Buber, Marcel (1971) saw a first level of participation that is characteried by experiencing and utilizing. This is comparable to Bubler's I-it relationship. Marcel's position was that man must be awakened out of this first level of participation into that of genuine personal encounter. What has occurred in the modern world is loss of this participation. Human relations and tasks have been reduced to the status of problems to be treated and resolved as objective things. Neither participant can be objectified.

Marcel (1971) distinguished between the kind of reflection appropriate for the sciences and that which is appropriate to reflect on human relations. The distinction is between a problem and a mystery. A problem is something to be solved by certain techniques, and an objective study of a problem will achieve a definite result. Yet, these methods are not applicable for situations where the feelings of the persons in the situation are crucial to understanding the real problem. Questions such as love, death, and caring are examples of what he calls a mystery.

Marcel's (1971) themes of presence and availability are particularly pertinent as a framework for a caring

relationship. The crux of his feelings on these themes can best be understood by the following quotes from Philosophy of Existence (1971).

> When I say that a being is granted to me as a presence . . . this means that I am unable to treat him as if he were merely placed in front of me; between him and me there arises a relationship which surpasses my awareness of him; he is not only before me, he is also with me. (p. 24)

> It is an undeniable fact . . . there are some people who reveal themselves as "present"--that is to say, at our disposal--when we are in pain or need to confide in someone, while there are other people who do not give this feeling, however great is their good will. . . . The most attentive listener may give me the impression of not being present; he gives me nothing, he cannot make room for me in himself, whatever the material favors he is prepared to grant me. The truth is there is a way of listening which is a way of giving, and another way which is a way of refusing. . . . Presence is something which reveals itself immediately and unmistakable in a look, a smile, an intonation, or a handshake. (pp. 25-26)

> The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resources. For the one I am a presence; for the other I am an object. (p. 26)

Marcel always identified existence with participation. One's own personal experience arises in communication with that of other persons. The more one's existence takes on the character of including others, the fuller that

existence becomes. Marcel termed this interdependence of man "intersubjectivity." In this world of intersubjectivity, knowledge comes from participation, by "taking part in the lives of others" (Heinemann, 1958).

Paterson amd Zderad's (1976) "lived dialogue" is exactly this intersubjective relating of two people. The I and the thou are thus in a "lived dialogue." These nursing theorists defined lived dialogue as a "form of existential intersubjective relating expressed in being with and doing with the other who is regarded as a presence (as opposed to an object)" (pp. 34-35).

Existential Perspectives of Caring

A diffentiation must be explicit between "caring" and taking care of." Nursing literature abounds with information on the latter. To take care of someone physically could very easily be done in an I-it relationship. Nursing interpersonal relationships of this type exist in every setting, i.e., the person in a coma, the "gallbladder" in Room 125, "a 24-year-old male appendectomy." Nurses today are accustomed to dealing with people as nonpeople. This mode of interaction, however, is usually interpreted by the client as noncaring. To be involved in an existential caring relationship means the establishment

of an I-thou relationship that takes place in the present but is also tied in with both the past and future of those involved in the relationship. Thus, caring in the nursing realm should take place on an interpersonal level of equality that recognizes and enhances each person's dignity, worth, and humanness.

Gadow (1980) advocated an existential philosophy that "unifies and enhances the experience of the individuals involved rather than devaluing and alienating" (p. 80). Her proposal of existential advocacy as the essence of nursing pointed to the nurse's participation, the give and take, the dialogue with the patient in determining the unique meaning for the patient. The nurse helps the patient clarify values and reach decisions that the patient truly desires. For Gadow, professional involvement meant directing the whole of oneself toward another's need. It is a "participation of the entire self, using every dimension of the person as a resource in the professional relation" (p. 90).

Gulino (1982) further expanded the theme of an existential approach to nursing care. She suggested that nursing has ignored this approach because it does not submit to familiar patterns of knowing. Carper (1978)

wrote of the "self-conscious reluctance . . . to include those aspects of knowing in nursing that are not the result of empirical research" (p. 16). Gulino (1982) postulated that an exposure to existential ideas will help the nurse view the client holistically and to enlarge and diversify the perspectives through which he she orders his or her understanding.

Phenomenological Approach to the Problem

The derivation of the word phenomenology is from the Greek phainomen (an "appearance") and logos ("reason, hence a reasoned inquiry"). Phenomenology is, therefore, a reasoned inquiry which discovers the inherent essences of appearances. An appearance is anything of which one is conscious. "Anything at all which appears to be consciousness is a legitimate area of philosophical investigation. Historically, Cartesian dualism led to a shift in emphasis away from conscious experience to objective realities. As a result, consciousness was treated as an empirical phenomenon to be investigated by the quantitative methods of natural science (Stewart & Mickunas, 1974, p. 4). Husserl, considered to be the founder of phenomenology, contended that none of the

rigorous sciences can lead toward an understanding of man's real experience in the world.

The phenomenological approach is, therefore, primarily an attempt to understand empirical matters from the perspective of those persons being studied. It is fundamentally different from empirical methods because the phenomenologists feel that the phenomena of the social sciences are not qualitatively continuous with those of the natural sciences and, therefore, need different methods to study reality. Bruyn (1966) stated "phenomenology serves as the rationale behind efforts to understand individuals by entering into their field of perception in order to see life as these individuals see it" (p. 90). To identify and study the empirical indicators of caring would not get at the heart or essential structure of a caring interaction. In order to ascertain the essential structure of a caring interaction, it will be desirable to learn from the client his perceptions of the caring interactions that take place between the nurse and client. Davis (1978) recommended support of the phenomenological approach in nursing research because nursing is primarily a social and interpersonal act between the nurse and patient. In this approach, preconceptions are "bracketed"

or "suspended" by the researcher. Therefore, he does not enter into the situation that he has defined according to his preconception prior to understanding the situation as it is defined by those experiencing it. The phenomenologist seeks to understand the experience of those being studied and does not impose an a priori hypothesis on these experiences.

Sociologists who use the phenomenological approach express the view that the data of social research are always "somebody's data." To Znaniecki (1934), the essential character of these data were the "humanistic coefficient." "The way to obtain inductive knowledge of human activity would be to use consistently the humanistic coefficient in dealing with it and take it as it appears to the agent himself" (p. 192). Douglas (1970) suggested the way to study the phenomenon of everyday life was on their own terms and to make use of methods of observation and analysis that retain the integrity of the phenomena. This means that to be meaningful, the phenomena needs to be studied as experienced in everyday life and not as set up experimentally.

Psychologists became divided as to what research orientation would best serve their interests for studying

human behavior. While the majority adhere to the behavioristic natural science methodology developed to predict and control, a number have opted for another approach, that of phenomenology. Omery (1983) listed three reasons why most psychologists pursued a more definite and structured methodology.

> 1) Psychology, like nursing, experiences direct competition with medicine, a science that uses natural scientific research methods effectively.
> 2) The development of the definitive methodology seems to have been an attempt to increase the legitimacy of the method, since psychology was already established within an academic setting where the natural scientific method dominated.
> 3) Possibly it was due to the sensitivity of psychology because so much of its original knowledge was rooted in philosophy. (p. 55)

Therefore, phenomenological psychologists wish to establish an empirical human science in an attempt to transcend a dilemma as stated by Bonner as (1965)

> a position between the investigation of unimportant problems by means of rigorous formal techniques, or important problems by means of inadequate methodologies--but dealing with problems that are significant for humans in a scientific way. (p. 99)

Valle and King (1978) stated that phenomenologically oriented psychology research seeks to answer two related questions: What is the phenomenon that is experienced and lived and how does it show itself? May (cited in Valle &

King, 1978) defined existential-phenomenology as meaning "ideally to take the human being as he exists, a living, acting, feeling, thinking phenomenon, at this moment in an organic relationship to us" (p. viii). Existentialism seeks not only to understand mankind in concrete lived situations and the lived moments but also man's responses to these moments. The natural science methods can investigate the observable physical aspects while phenomenology is a method which allows us to better understand phenomena as we actually live them out and experience them.

> Existential-phenomenology seeks to explicate the essential structure, or form of both human experience and human behaviors as revealed through essentially descriptive techniques including disciplined reflections. (Valle & King, 1978, p. 7)

The phenomenologist seeks to understand the phenomena and is not concerned with explaining, predicting, or controlling them. Description through disciplined reflection, therefore, replaces the experimental method while structure replaces the usual cause-effect relationship. Structure in the existential-phenomenological context is the commonality among instances of the "what" of a particular phenomenon. Regardless of a phenomenon's particular variations, the same phenomenon is seen as

> having the same essential meaning when it is perceived over time in many different situations. . . . Only after seeing different reflections and varied appearances on repeated occasions does the constant unchanging structure become known to us. (Valle & King, 1978, p. 15)

As Giorgi (1970) stated, "One of its (structure's) values for us is that it is precisely structure that is the reality that one responds to at the phenomenal level" (p. 179). Colaizzi (1973) supported the importance of the phenomenological description when he stated

> Without thereby first disclosing the foundations of a phenomenon, no progress whatsoever can be made concerning it, not even a first faltering step can be taken towards it, by science or by any other kind of cognition. (p. 28)

Hodges (1944) stated that in the description of the total reaction of the whole person to a situation confronting him, every reaction includes elements of three main types.

1. cognitive--based on or capable of being reduced to empirical factual knowledge
2. affective--relating to, arising from, or influencing feelings or emotions
3. conative--an inclination to act purposefully. (p. 42)

> The relations among the three elements in experience are called the "structure" of the mind. This structural system is not discovered by inference or hypothesis, but is actually experienced or "given in lived experience." (p. 44)

There is not one phenomenological methodology but rather a variety of methods which all hold to the primacy of the subjective experience. A few examples of recent studies serve to illustrate the similar yet variable phenomenological methodologies being employed to study questions of human experience.

A phenomenological approach was used to discover the fundamental structure of aggression in middle adolescence (Munn, 1982). The experiences of 10 adolescents were analyzed. The three essential constituents and their components were combined to form a fundamental structure of aggression. More closely related to caring was a phenomenological study on healing in psychotherapy (Heckler, 1982). Therapists were interviewed, and the data analyzed using a phenomenological methodology which reduced the data to its most essential structure and description. A "healing episode" was a moment or series of moments in which a client experienced either an insight, an emotional catharsis, or feelings of well-being. One of the conclusions offered was that the client's healing experiences were also healing for the therapist. In studying self-esteem, Myruk (1982) chose an existential-phenomenological methodology because such

experiences only occur in the actual living of one's life and cannot be appropriately manipulated in an experimental situation. The data from the interviews were analyzed for regularities and then universal themes. Colaizzi's method of analysis was used to phenomenologically analyze male executives' work experiences with female executives (Simon-Kiecher, 1982). Patterns of common themes emerged from this analysis.

Wetzler (1982) conducted an investigation which he labeled an "empirical-phenomenological study." Six individuals described their experiences of becoming and being relaxed. Their written descriptions were further elaborated by tape-recorded interviews. After a qualitative analysis, the research synthesized a general structural description of the process to become and be relaxed. A phenomenological methodology was used to research the question of "What is it to be fat" (Rolfson, 1982). This method was used to ground the research and therapeutic assumptions in the experience of people who see themselves as being fat. A six-step process was utilized to explicate a phenomenological description of being fat as a category of human experience. A major conclusion of the study was that a theory which treats

obesity without reference to its place in the lived-world of the fat person is likely to exacerbate the problem.

Several examples are available from current nursing research. A phenomenological evaluation of family and child perspectives was designed to develop a picture of family functioning and perspectives (Duffy, 1982). Families and children were interviewed about their thoughts, feelings, and actions regarding illness when the child was the patient. Interviews using open-ended questions were tape recorded, transcribed, and analyzed for individual verbalization rates, individual family content, and group family and child content. In a study on professional/client interactions, videotaped playbacks of face-to-face interactions were used in order to stimulate the participants' recall of the interaction (Miller, 1982). The investigator used it as a means of assessing how people "track" with (perceive) each other and the degree of similarity in their responses. "At ease" types of feelings were determined to be the best single predictor of satisfaction. A preliminary phenomenological investigation was undertaken on the lived experience of "being truly committed" (Rugh, 1979). In a similar manner, Stanley (1978) used an adaptation of van Kaam's

six-step process to explicate the necessary and sufficient components of the lived experience of "hope."

The researcher using the phenomenological approach must approach the subject with a minimum number of expectations, reduce any preconceptions, and go into the situation to be studied with as open a mind as possible. Davis (1978) considered the phenomenological approach to nursing research as being appropriate because this is the approach nurses are familiar with in their clinical preparation. This approach "emphasized observations, interviews, interaction, and interpersonal relations in an attempt to understand the patients' definition of the situation" (p. 194). Durfee (1976) stated that phenomenologists begin by pointing to something unthematized, preobjective, preconceptual, something experienced and lived but not explicitely known.

> Phenomenology first formulates, explicates, "lifts out," renders in structures and discriminating description, aspects "implicitly known" to us, but not known explicitly until formulated. (p. 254)

Norris (1975), in studying restlessness using a descriptive phenomenological approach, asked the question "How can nurses do research and teach nursing when there are no adequate definitions or descriptions of the

phenomena of nursing?" (p. 103). Field (1981) took a phenomenological approach in studying what is meant to give an injection. She stated there is a dichotomy "between the objectified other to whom I give the injection and the experiencing other who expresses his feelings and emotions" (p. 294). Although she was not researching caring per se, she made the following observations.

> If the other does not feel pain from my act, my view of myself as a caring, nurturing being is reflected in his words and actions. . . . If the other responds by saying he is hurt or by struggling or crying out, I am rejected as a caring person. (p. 294)

Recently, Oiler (1982) expanded the idea of phenomenology being appropriate for nursing research.

> The nursing profession emphasizing a reverence for clients' experiences is concerned with the quality of life and the quality of the nurse-patient relationship. . . . Phenomenology does not want to replace scientific inquiry but it is an alternative method. (p. 178)

Nursing supports the holistic approach to man, yet in the research approach, nursing advocates the scientific-behavioristic point of view. Man is capable of being broken down into his component parts which are objectively identifiable and observable (Carter, 1978). In this process, the subjective and unobservable part of man is lost, and thus, one is afforded an incomplete and

inadequate view of man. In writing regarding nursing's scientific quest, Watson (1981) stated that nursing research's methodology incorporates reductionism, quantifiability, objectivity, and operationalism. Henderson (1982) stated that the nursing process as now interpreted in nursing is associated with the scientific problem-solving process. The nurse's function has become focused on an analytical, objective process. With the concentration on scientific knowledge in practice, research, and education, both Watson (1981) and Henderson (1982) suggested that nursing has been divorced from the subjective and the intuitive.

Munhall (1982) asked the interesting question regarding nursing philosophy and nursing research: Are they in opposition or apposition? Munhall's comparison of the stated beliefs used in nursing philosophies and the expressions used in the scientific method revealed that the two do not have congruency. Griffin (1980), writing in the Journal of Advanced Nursing, stated that philosophy has much to offer nursing. She made the point that nursing "borrows" knowledge from other sciences for its practice, education, and research theory but does not borrow from philosophy in the same way. Griffin's

contention was that many issues facing nursing today are of a philosophical nature and that nursing knowledge is being impoverished by total concentration on objectivity and exactness of the scientific method. Her position is that philosophy is an example of nonscientific knowledge whose study is fundamental to understanding the area of human experience--nursing.

Schlotfeldt in 1960 and Carper (1978), McKay (1977), Silva (1977), and Stevens (1978) in the 70s suggested that philosophical methods of introspection and reflection should be considered as legitimate methods for inquiry in nursing. "It's important to count and measure what is countable and measureable, but the most important values in human life are not reproducible in the laboratory" (Zbilut, 1977, p. 67). Curtin (1979), in advancing a philosophical foundation for nursing, stated that nursing should be distinguished <u>not</u> by its care functions but rather by its philosophy of care. She stated that the end and purpose of nursing is "not a scientific end but a moral end" (p. 2). Donaldson (1983) made a plea for nursing not to abandon the humanities. She suggested that nursing's almost exclusive pursuit of scientific knowledge is a "misguided attempt to elevate our status, making it

scientific and rigorous without subjective contamination" (p. 40). She further suggested that nursing is bound to the humanities and should formally recognize the bond because "without the humanistic perspective of nursing, the uniqueness and justification of the nursing discipline becomes lost" (p. 42). It is desirable to study caring from an existential/philosophical and phenomenological perspective in order to analyze the essential structure of client/nurse caring interactions from the client's perspective.

Assumptions

Phenomenological analysis requires the researcher to state his assumptions regarding the phenomenon under investigtion and then "bracket" or "suspend" these preconceptions in order to fully understand the experience of the subject and not impose an *a priori* hypothesis on the experience. McCarthy (1980) stated that

> nurse-client interactions have the same chameleonic qualities as do any of the performing arts . . . and are as inaccessible to measurement as any whole and wholly human act can be. (p. 723).

While no performance can be "exactly the same as another," it is assumed that there is an essential

structure of a caring interaction that can be extracted from the client's verbal description of this experience.

Regardless of the superficial circumstances of time and space, it is the assumption of the researcher that there is an essential structure to the interaction that is consistent in every interaction described by the client as a caring interaction. This essential structure or core of the interaction can be identified by the absence of this quality in those interactions described as noncaring nurse-client interactions.

Definition of Terms

For the purposes of this study, the following terms were defined.

1. Essential structure of a caring nurse-client interaction--description of the answer to the question of "What is essential for the experience to be described by the client as being a caring interaction?" Caring and noncaring interactions are not defined by the researcher but by the client in his verbal description.

2. Nurse--a registered nurse; however, it is presumed that some of the descriptions may be a "nurse" who may not be a registered nurse. Nonetheless, it is a

person who the client has identified as being a member of the "nurse" category.

3. Client--anyone over the age of 18 who has had a prior interaction with a nurse, who was not hospitaalized at the time of the interview, and was not personally known to the researcher prior to the interview.

4. Interaction--any mutual or reciprocal action or influence between the client and nurse.

Summary

While caring is generally considered by both clients and nurses as a desirable feature of nurse-client interactions, very little research has been done to substantiate what constitutes a caring interaction. Most of the previous research attempted a description of the phenomenon from an empirical investigation of caring nurse behaviors as classified by nurses themselves.

This study investigated the following question: From the perspective of the client, what is the essential structure of a caring nurse-client interaction? The existential perspectives of Buber (1958) and Marcel (1971) form the philosophical background for a phenomenological analysis of clients' descriptions of caring and noncaring nurse-client interactions. From a phenomenological

analysis of these descriptions emerged the essential structure of a caring interaction.

CHAPTER 2

REVIEW OF LITERATURE

Watson (1979) called caring the essence of nursing and listed 10 carative factors as primary mechanisms in caring for another human being. In the cross-cultural studies, Leininger (1977) posited 17 major constructs that are present in caring. Engel (1980) posited confirmation and validation as being the essential components of caring that she considered to be professional nursing. She defined confirmation as the "acceptance of a person's definition of himself" (p. 4) and validation as "the acknowledgement that one has received the message which the sender transmitted and from the sender's perspective if it is true" (p. 55). Nursing to Engel is a "profession of caring when the nurse confirms and validates the client" (p. 56). Mayeroff (1971) described the eight essential ingredients of caring. Fromme (1956) listed caring as one of his four components of love. Rogers (1969) equated love and caring. He stated, "I find it enriching when I can truly prize and care or love another" (p. 233).

The helping professions' literature emphasized the growth promoting aspects of caring (Carkhuff, 1969; Combs, Avila, & Purkey, 1978; Gazda et al., 1977). Some writers (Bowers & Door, 1962; Combs & Soper, 1963; Moustakas, 1981; Noddings, 1981) related caring specifically to the teaching profession. Bowers and Door (1962) stated, "A teacher must care and be able to enter honestly into relationships with others" (p. 311). Moustakas (1981) stated that "by cherishing and holding the child in absolute esteem the teacher is establishing a climate that promotes growth" (p. 13). Noddings (1981) emphasized that in the teaching relationship,

> When we care, we are touched by the other and expect to touch him. We enter into a relation with the student, but that relation need not be one of interference and control. (p. 145)

Mayeroff (1971) identified what he considered to be eight essential ingredients of caring. Although stated differently, they encompass all the attributes that other writers include in their longer lists. Knowing and knowledge are considered to be related but are two different elements. Knowledge of the person is necessary but consists of information about facts and figures. Knowing, on the other hand, is a much broader implication of understanding the other person, his powers,

limitations, and needs. Without this aspect of knowing, knowledge alone would lead to "taking care of," not "caring." Alternating rhythms are important in order to be able to maintain and modify behavior according to variations in circumstances or perspective. Patience is required in order to allow the caring person to follow the lead of the person needing caring. Honesty is essential for the relationship to grow and is implicit in an I-thou relationship as contrasted to an I-it relationship. Trust must be present for the caring person in the form of trusting their own and others' abilities and judgements. Humility is necessary for the giver to realize that he does not know all the answers and that he can learn from the person needing caring. Hope is implicit in the developmental caring process in order that the person will grow as a result of the caring. Courage has the further element of risk and responsibility for the unknown or where a person's caring will lead.

Recent books and articles by nurses (Blattner, 1981; Carper, 1979; Chinn, 1979) on the ethics of caring delineate Mayeroff's (1971) eight components as the basis for caring. In his book On Caring, Mayeroff made the basic assumption that "to care for another person, in

the most significant sense, is to help him grow and actualize himself" (p. 1). Gaylin (1976), coming from a maternal-infant attachment background, stated that if we have not been cared for by others, we will not be able to care for ourselves or others. To be cared for is essential for the capacity to be caring. Research to verify whether, in fact, the essentials as outlined by Mayeroff are perceived by the client as being present in the caring relationship has not been undertaken from this phenomenological perspective.

For McNally (1977), to care means to be "present to each other" (p. 49). She posits this presence to be a healing presence because they (the carer) accepts you on your own terms, i.e., when they listen, they "really listen" to you, and when they speak, they "really speak" to you. vanKaam (1959) wrote to a nursing audience specifically regarding the patient's feelings of really being understood. His existential-phenomenologically based research revealed that patients felt that they were really understood by nurses whose "views, feelings, and behavior . . . manifest consistently genuine interest and care" (p. 1710). His analysis was that the nurse's interest had to be perceived as genuine and honest, not

feigned because "patients in their intensified sensitivity" distinguish sharply between genuine and pretended interest and care. Hyde (1977, Part VI), stated that nurses can be life-giving by caring for others. She emphasized that caring--the human contact, dialogue, really listening, spending time, and meeting--are all part of healing.

Spiegel and Backhart (1980), in their book Curing and Caring, used utilization, satisfaction, and compliance as measurements of caring. Ort, Ford, and Liske (1964) obtained descriptions of doctor-patient relationships from physicians' and medical students' descriptions. These descriptions indicated six categories of satisfaction and four of dissatisfaction. Numerous studies cited complaints with the health care system. Korsh, Gozzi, and Francis (1968) listed lack of warmth and friendliness, failure to understand their worries, inadequate explanations of illness, and confusing medical terms as principle causes of dissatisfaction. Korsch and Negrete (1982) observed that less than 5% of the physicians' conversations were friendly and personal in nature. Bellin and Geiger (1972) reported that 31% of the clients complained that the doctor failed to explain what was the

matter. In a recent survey comissioned by the Texas Medical Association ("Study Shows," 1983), patients indicated that in considering a physician, they considered "a physician's manner of discussing problems, up-to-dateness, reputation, and a warm and caring attitude" (p. 21).

Thus, concern has been cited as a characteristic that patients look for in their doctors. Nevertheless, McDermott (1977) insisted that the ability to adequately measure aspects other than technical skill was a problem.

Linn (1975) addressed the question of what professionals and their students maintain is important in the care and cure of sick people. He discovered significant differences between the physicians/medical students and nursing faculty/nursing students as to their care-cure orientations and attitudes. As predicted, the medical personel were more cure oriented, and the nursing personnel more care oriented. No effort was made to assess the patients' perceptions of the relative importance of a care or a cure orientation.

Henry (1976) assigned certain values to care components which she delineated, then distributed questionnaires to the patient population for a response. Findings

revealed that carrying out nursing procedures, giving information, making herself available and accessible, being patient, friendly, kind, considerate, and "doing extra things" were perceived by patients as indicators of caring. Amacher (1973) associated the notion of touch as caring with the notion of tenderness. McCorkle (1974) conducted an investigation of the effects of touch on seriously-ill patients. She concluded that not only did touch promote physiologic changes but also conveyed to the patient that he is not alone, that the nurse is there and has time to listen. Rubel (1976), in a publication on nursing process, equated caring with nursing. From her point of view, caring means getting involved, and getting involved can increase one's vulnerability. Caring can mean pain for the ones involved. Caring, in her opinion, involves sharing and also means love. Nelson (1978) discussed caring and explicated existential themes from the writings of Buber and Marcel and the relationship of these themes to nurse-patient encounters.

Medicine and nusing are not the only professions to be concerned with the caring relationship. Noddings (1981), writing in the Journal of Curriculum Theorizing, claimed that

> There are three aspects of a caring relationship. . . . There is engrossment, (a first-person aspect) in which the consciousness of the one-caring is focused on the cared-for. This engrossment induces a displacement of motivational focus from the one-caring to the cared-for. There is an attitude of the one-caring which is received by and reflected in the cared for (a second-person aspect). This attitude conveys the regard for the one-caring to the cared-for; its reception in the cared-for completes the caring. . . . One may properly claim to care for another if the first-person conditions are met, but that the relation itself cannot be called "caring" unless the caring is completed in the cared-for. Finally, there is usually some observable action (a third-person aspect) in behalf of the cared-for. (p. 139)

Hyde (1977), in a series on self-care and caring, stated the reciprocity of caring as "caring is an art which requires the actions of carers and also the action of the one being cared for" (p. 4). In 1980, the American Association of Occupational Therapists held a conference which had as its theme "Caring Is the Key." At this conference, Yerxa (1980) posited that society has moved from humanism to scientism and is dominated by technique. "Scientism refers to a prejudiced belief in a science that applies habits of thought mechanically and uncritically to fields different from those in which they have been formed" (p. 529). Technical thinking involves valuing objectively and viewing mankind as separate from the environment. Technique seems in control of our

destiny as it gains in complexity and power. In such a society dominated by technique, individuals experience a sort of desolation and sense of alienation. Gilfoyle (1980) proposed caring as the art of therapy which involves "an internal receiving the client, not an external giving of the therapist" (p. 520). King (1980), in discussing the philosophical climate for caring, stated that the philosophical basis does not have to be the same for everyone, but "it is important that caring be grounded in a personal philosophy of some depth" (p. 523).

Two recent nursing studies (Brown, 1982; Larson, 1982) incorporated both the patient/client's perceptions of nurse-caring behaviors as well as those of the nurse's perceptions of nurse-caring behaviors. In the Larson (1982) study, oncology patients and nurses had significantly different perceptions of the importance of 19 of the 50 previously identified nurse-caring behaviors. In the Brown (1982) study, 50 subjects described an incident in which they felt "cared for and about" by a nurse. The two major aspects that were described were (a) "what the nurse does," and (b) "how the nurse does." Brown stated that the study provided empirical evidence

that supports the strongly-held belief in nursing that nursing care is made up of both "being" and "doing."

A recent study (Ford, 1982) established caring behavior categories listed by three subsamples of professional nurses as to how they modeled nursing-caring behaviors. Listening was the only category listed by all three subsamples. Ray's (1981) participant observation study of caring within an institutional culture developed a classification system founded on 1,362 caring responses of 192 participants. She stated that ideal modes of caring were replaced by a bureaucratic model which produces professional conflict for the majority of nurses.

Summary

Although most professionals and nonprofessionals involved in the helping professions state a valued need for caring, little research has been carried out to substantiate in fact what caring really is. There is a rather widely accepted view that caring is growth-producing, valuable, and difficult to research. One of the biggest deterrents to researching caring seems to be the lack of value placed on research conducted in other than the scientific method, translated as the method

traditionally utilized in the natural sciences. Recent phenomenological research within the fields of sociology and psychology would support phenomenological analysis as a valuable and viable methodology.

Within the nursing profession itself, there are a number of nurses who are actively supporting and beginning to conduct phenomenologically-oriented research. These nurse researchers do not advocate abolishing the scientific quantifiable research methodology but only stress that legitimate descriptive qualitative methodologies must be accepted and employed in order to properly research a number of concepts and questions important to quality nursing care.

Jacobsen (1981) pointed out that many descriptive methods are capable of exploiting data in ways that simple p-values never can. Downs (1982) stated that too many studies are being done which are methodologically impeccable but devoid of substantive content. She pleaded editorially in Nursing Research for more carefully executed exploratory studies.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A phenomenological approach was utilized for this descriptive study. The purpose of a descriptive factor searching study is to "devise and invent labels that taken together will usefully characterize the important aspects of a given situation" (Diers, 1979, p. 101). Helmstadter (1970) stated that the primary purpose of the descriptive approach is "painting a picture" of some situation rather than studying cause-and-effect relationships. Since a factor-searching study is at the first level of inquiry (factor-searching isolating theory), there is no hypotheses to be tested. Diers (1979) stated regarding the factor-searching study, "the method is to begin with as open a view as possible of the situation . . . rather than pre-conceived ideas of" (p. 107). This open view parallels the phenomenological approach outlined by Davis (1978).

> He must approach his subject with a minimal number of structured expectations as to how an object should be described . . . he must reduce his preconceptions to a minimum so that he will be able to receive an object as it is given to his consciousness. No hypothesis direct him as to what he should find in his investigation; rather, he goes into the situation to be studied

> with as open a mind as possible. . . . The phenomenologist assumes that there is something in the nature of human experience beyond sheer reason or sensory observation, which produces knowledge. (p. 194)

Davis suggested that the phenomenological approach more perfectly fits the clinical research approach to studying interpersonal relationships.

Crawford, Dufault, and Rudy (1979) stated that in theory development, nursing should first seek out the relevant questions and then find the appropriate answers. In the July 1982 Advances in Nursing Science, Ellis stated that premature occupation with formal scientific process may be handicapping nursing in studying the areas of understanding human perception, feelings, and responses.

Setting

The setting for the study was a city of 65,000 population located in the Southwestern United States. The physical location for the interviews was in clients' homes or places of business.

Population and Sample Size

The population for this study was nonhospitalized adults over 18 years of age who have had prior interactions with a registered nurse and were able to

verbally communicate their experiences and feelings regarding these interactions. The sample was 10 individuals who met the stated criteria and agreed to be inteviewed and tape-recorded. These 10 subjects were selected from the general population and were not known to the investigator prior to the interview. Names of adults who met the criteria were solicited by the investigator from students, faculty, and staff of a two-year upper division university located in the Southwestern United States. Five male names and five female names were selected at random from the pool of names and were contacted by the investigator regarding their willingness to participate in the study.

The sample size was small because of the time involved in transcribing and analyzing the large amount of data from each subject. Also, each subject's verbal description was a complete description of the nurse-client interaction and as such described the essential structure of that interaction.

Protection of Human Subjects

Application was approved by the Human Rights Review Committee of Texas Woman's University for permission to conduct the study (Appendix A). Each subject was given

Form A (Appendix B) for his/her written consent. After he/she agreed to participate in the study, he/she was asked to sign Form C (Appendix C) giving written permission to have his description tape-recorded.

Data Collection

The subject was approached and asked if he/she would like to participate in a research project involving tape-recording their description of a caring and a noncaring interaction with a registered nurse. Written consent (Appendix B) was obtained and a second signature recorded on the permission form to tape record the description (Appendix C). Demographic data of age, sex, marital status, education, and occupation were recorded on the tape just prior to obtaining the verbal recording. The client was informed that he did not have to complete the recording and he could stop at any point he so chose.

The following verbal instructions were given to the subject:

> Describe a personal interaction you had with a registered nurse who you felt was caring.
>
> Try to describe how you felt in that interaction.
>
> Describe a personal interaction you had with a registered nurse who you felt was noncaring.

> Try to describe how you felt during that interaction.
>
> Please do not stop until you feel that you have discussed your feelings as completely as possible.

A description of the interaction was recorded. At any appropriate time questions were asked in order to clarify what the client was relating. Of special significance were his feelings regarding the interaction and what meaning it appeared to have for him. When the client had described his feelings and the total interaction and no further clarification was required, the recording was considered complete.

Pilot Study

A pilot study was conducted in 1981 using a sample of 10 subjects. The five men and five women were nonhospitalized adults who met the criteria of being over 18 years of age, having had previous interactions with registered nurses, and who agreed to tape record their experiences and feelings. The selection of the subjects was from a list of names, the majority of whom were unknown to the investigator. This pool of names was suggested to the investigator by the faculty, staff, and students at a 2-year upper division university in the Southwestern United States.

The subjects were interviewed and asked to describe a caring and noncaring interaction with a nurse and what they experienced and how they felt during these interactions. The tape-recorded interviews were transcribed and analyzed phenomenologically to reduce the data to its most essential structure and description. The subjects' descriptions were read and reflected upon until the themes and ideas could be condensed, while still retaining the original idea. The analysis consisted of the following steps.

1. Each experience was read to acquire a feel for it.

2. Significant statements were extracted from all of the descriptions and duplicate statements eliminated.

3. Meanings were formulated from the statements.

4. Clusters of themes were organized from the aggregate of formulated meanings--these themes were common to all descriptions.

The three themes that clustered out were (a) the attitudinal approach of the nurse, (b) the behavioral approach of the nurse, and (c) the meaning generated by the client.

Treatment of Data

The raw data as recorded were transcribed verbatim for each subject. These transcriptions were subjected to phenomenological analysis using a methodology as developed by Colaizzi (1978). The procedural steps used were as follows.

1. Read all of the subject's descriptions in order to acquire a feeling for them.

2. Return to each protocol and extract from them phrases or sentences that directly pertain to the investigated phenomenon, known as extracting significant statements. Several descriptions may contain the same or nearly the same statements, thus repetitions can be eliminated.

3. Spell out the meaning of each significant statement, known as formulating meanings. This is a difficult step, and while moving from what the subjects say to what they mean, the meanings arrived at must never sever the connection with the original description. The formulations must discover and illuminate those meanings hidden in the various contexts and horizons of the phenomenon which are present in the original descriptions.

4. Repeat the process for each description and organize the aggregate formulated meanings into clusters of themes. The attempt here is to allow for the emergence of themes which are common to all of the subjects' descriptions.

a. Refer these clusters of themes back to the original descriptions in order to validate them. Ask whether there is anything in the original that is not accounted for in the cluster of themes and whether the cluster proposes anything which is not in the original. If either of the above are true, a re-examination is necessary.

b. At this point, discrepancies may be noted among and/or between the various clusters; some themes may flatly contradict other ones or may appear to be totally unrelated to other ones. The researcher must rely upon his tolerance for ambiguity; he must proceed with the solid conviction that what is logically inexplicable may be existentially real and valid.

5. The results of everything so far are integrated into an exhaustive description of phenomenon.

6. The exhaustive description of the phenomenon is as unequivocal a statement of its essential or fundamental structure as possible.

7. a. The descriptions of the noncaring interactions are analyzed using the same process as with the caring descriptions. A validation of the final description of the essential structure of a caring interaction will be undertaken by contrasting it to the exhaustive description of a noncaring interaction.

b. A final validating step will be achieved by returning to the subjects and asking the subjects if the description as formulated validates their original experience.

CHAPTER 4

ANALYSIS OF DATA

In this chapter, the results of data analysis are reported. A description of the sample is followed by presentation of the data relating to the research question. Data relating to the research question are analyzed, and the chapter concludes with a summary of the findings of the study.

Description of the Sample

The sample of the study was composed of 10 nonhospitalized adults over 18 years of age who had experienced prior interactions with a registered nurse and who were able to verbally communicate their experiences and feelings regarding these interactions. The sample consisted of 10 individuals selected from the general population who were not personally acquainted with the investigator prior to the interview. The names of the five men and five women were selected from a list of names submitted by faculty, staff, and students of a 2-year upper division university located in the Southwestern United States. The first 10 people contacted all met the criteria of age and verbal ability and agreed to be

interviewed for the study. The demographic data regarding age, ethnicity, occupation, and educational level are presented in Table 1.

Table 1

Demographic Data of Sample

Subject	Age	Race	Occupation	Educational Level
Female				
1	32	White	Traffic coordinator	Master's
2	21	Black	Student	Associate of Arts
3	32	White	Secretary	High school
4	28	White	Housewife	High school
5	56	White	Housewife	Bachelor's
Male				
1	32	White	Engineer	Bachelor's
2	50	White	Social worker	Master's
3	63	Black	Janitor	High school
4	34	White	Railroad worker	High school
5	50	White	College teacher	Master's

Findings

The research question was stated as follows: From the perspective of the client, what is the essential structure of a caring nurse-client interaction? Taped interviews of the 10 subjects were transcribed and the significant statements extracted from these transcriptions became the raw data for analysis (Appendix D). Duplicate statements were eliminated, and the remaining significant statements are presented in Tables 2, 3, 4, and 5. The statements of male and female subjects are divided as well as those statements pertaining to caring and noncaring interactions.

Meanings were formulated from the significant statements. These meanings were arrived at by reading, rereading, and reflecting upon the significant statements in the original transcriptions to get the meaning of the client's statement in the original context. These formulated meanings are presented in Tables 6 and 7.

The aggregate of formulated meanings was organized into clusters of themes. These clusters represent themes that emerged from and were common to all of the subjects' descriptions. These clusters are presented in Table 8. These clusters were referred back to the original

Table 2

Female Significant Statements--Caring Interactions

	Statement
1.	listened well--really listened
2.	emphathetic
3.	understanding regarding my fears
4.	supportive of my concerns
5.	there to talk to
6	talked to me about things other than illness
7.	made me feel like a normal person
8.	interested in me as a person and an individual
9.	sat down on the side of my bed
10.	held my hand
11.	asked me questions
12.	looked me directly in my face
13.	verbalized some of her own insecurities
14.	let me know it was all right to be scared
15.	came back several times to see if I was comfortable
16.	felt secure with her being there
17.	felt more relaxed
18.	felt peace of mind
19.	didn't feel I was some thing on display
20.	felt I was human
21.	mild mannered--quiet--gentle
22.	really concerned
23.	compassionate
24.	she knew something was bothering me
25.	nurse explained
26.	I was very relieved
27.	I felt well taken care of
28.	motherly
29.	called to see if I needed anything
30.	talked "nice"
31.	tried to give me hope
32.	she knew what she was doing
33.	concerned with family also
34.	I felt very warm towards her
35.	I wanted to do something for her
36.	I was comfortable with her
37.	understood patient and family as individuals
38.	paid attention to me
39	paid attention to what I said

Table 3

Male Significant Statements--Caring Interactions

	Statement
1.	nurse was there
2.	holding my hand and mopping my brow
3.	make me comfortable
4.	trying to comfort me
5.	nurse would come when I rang
6	come voluntarily
7.	sat down
8.	talk to you
9.	really listen
10.	feel like it's my daughter taking care of me
11.	go out of her waay
12.	constantly came back to see if she could help
13.	she looked after me all the time
14.	made me feel good
15.	interested in you as a person
16.	give me what I needed first--then do the nursing
17.	explain to me
18.	ask if I needed anything
19.	spent time with you
20.	pleasant
21.	kind
22.	felt you were in good hands
23.	soft attitude
24.	compassionate
25.	really concerned about you feeling good

Table 4

Female Significant Statements--Noncaring Interactions

	Statement
1.	I felt as though my hands were being slapped
2.	rules more important than people
3.	it was an arbitrary, capricious power thing with her
4.	she looked at the equipment instead of me
5.	always appeared to be in a hurry--always in a rush

Table 4--Continued

	Statement
6	didn't have time to talk
7.	didn't want to talk
8.	she wasn't interested in what I had to say
9.	she was there to perform her duties and then go home
10.	she didn't get close--stood at a distance
11.	felt as though I had a contagious illness that would rub off
12.	wouldn't look at me directly in the eye
13.	she was so snappy
14.	defensive
15.	wasn't interested in the person as a whole
16.	I was not at ease
17.	I was uncomfortable
18.	I became depressed
19.	I felt I had to keep my mouth shut
20.	super efficient attitude
21.	nothing seemed to bother her
22.	seemed to feel she was really tough
23.	she made me more tense
24.	she showed she was frustrated
25.	she made me frustrated and scared
26.	I was upset
27.	unable to figure out what was going on
28.	she didn't care what she said
29.	I was almost a "basket case"
30.	I was fidgeting
31.	buzz and she would not come
32.	she'd say "yes-yes" and not come
33.	she did not explain--"just sign"
34.	frightened me to death
35.	acted like she had a job to do
36.	didn't pay any attention when I told her--because I was older
37.	made me feel angry
38.	no confidence in her
39	afraid
40.	prancing around when the doctor was there
41.	left equipment on my bed and left the room
42.	told me to get up and take care of myself
43.	I was scared and weak
44.	she would not come back to help
45.	I fainted

Table 4--Continued

	Statement
46.	I cried
47.	I didn't want her to touch me
48.	she was too busy talking to the other nurses to talk to me
49.	she did not know what she was doing
50.	I was not treated as a person
51.	was as though I was a nobody
52.	didn't want to go back to that hospital
53.	couldn't "care less"
54.	acted like clockwork

Table 5

Male Significant Statements--Noncaring Interactions

	Statement
1.	did not pay attention to what you needed
2.	just came in to do what she had to do
3.	she didn't have "no pity--no mercy"
4.	she just wasn't soft
5.	talk to you a very short time
6	seemed it was just a "rum dum affair" (nursing)
7.	give you a quick answer and go about her business
8.	won't tell you what she's doing
9.	give you a simple answer as though you couldn't possibly understand
10.	act like it was an everyday job
11.	do a job--look at you like an object
12.	watch you like you're a ten-year-old
13.	raise and shake her finger at me
14.	felt like a child being scolded
15.	not come in the room
16.	element of human contact lacking
17.	efficient--but no human element
18.	rang bell and would not come
19.	not supply any information
20.	bathed me as though she was doing it to a dog
21.	it's insulting

Table 5--Continued

Statement
22. strapped me to the bed--never talked to me and walked out
23. spoke loud and slow as though I'd lost my marbles
24. could "care less" about how I was suffering
25. very rough--like striking out at me
26. no personal awareness of my comfort
27. sound of her voice was cold--unconcerned
28. felt helpless
29. washing me as though I was a toy
30. I was of no value to her

Table 6

Formulated Meanings of Significant Statements--
Caring Interactions

Statement
Female
1. Nurse really listened to what the client said, responding to the individual's uniqueness.
2. Nurse was perceptive and supportive of client's stated and unstated concerns.
3. Nurse's physical presence of sitting, talking, direct eye contact, holding hands, and being self-disclosing made client feel free to talk.
4. Caring interactions (encompassing behaviors and attitudes) made the clients feel like valued human beings and not like inanimate objects or things on display.
5. Nurse's voluntary and unsolicited return to the client was highly indicative of a caring attitude.

Table 6--Continued

Statement
6. Individualized concern for the client made the client feel comfortable, secure, at peace, and relaxed.
7. The soft, gentle voice and mannerism impressed the client as caring and nonthreatening and nondegrading.
8. The security felt by the client when in a caring interaction invokes feelings of being well taken care of by a family member.
9. Caring encounters evoked warm feelings in the client of wanting to do something reciprocal for the nurse.
Male
1. Nurse's physical presence of sitting, talking, and holding hands, made client feel nurse was truly concerned with him as a valued individual.
2. Nurse's voluntary and unsolicited return to client was seen by the client as highly indicative of caring.
3. Nurse's caring made him feel comfortable, relaxed, secure, in good hands, as though he was being taken care of by a family member.
4. Attention by the nurse to comfort and needs of the client before doing nursing "tasks" was interpreted by the client as caring.
5. A kind, soft, pleasant, gentle voice attitude impressed the client as being caring and nondegrading.

Table 7

Formulated Meanings of Significant Statements--
Noncaring Interactions

Statement
Female
1. The nurse's actions of always being in a hurry, without taking time to really talk or listen are indicative to the client of the nurse's lack of interest in him as an individual.
2. The nurse's attitude of lack of interest in him as a person is interpreted by the client as the nurse viewing nursing as only a "job."
3. The nurse's physical actions and manner of speaking that belittle and degrade are seen by the client as noncaring.
4. The physical behaviors exhibited by the nurse of being cold, tough, super-efficient, rigidly following rules, avoiding eye contact, not offering explanations, and seeing only parts of the client, result in the client feeling frustrated, scared, depressed, angry, afraid, and upset.
Male
1. The nurse who does not pay any attention to the client's needs but views nursing only as a job is perceived by the client as noncaring.
2. The physical absence or only short superficial appearance of the nurse is interpreted by the client that the nurse does not consider him to be of any importance as a human being.
3. The cold voice and rough physical actions of the nurse are interpreted by the client that he is being treated as a nonhuman subject or as an inanimate object.

Table 7--Continued

Statement
4. The verbal and physical communication from a nurse which makes the client feel like a bad child is insulting and degrading and makes the client feel helpless and frustrated.

Table 8

Clusters of Common Themes

Theme		Statement
Caring		
Nurse's Existential Presence	1.	For the nurse, her physical and mental presence are available for the client's use.
	2.	For the client, the nurse's presence is available not only when he calls for it but also when he needs the nurse's presence but does not solicit it.
Client's Uniqueness	1.	The nurse recognizes the client's uniqueness by really listening and responding to him as a valued individual.
	2.	The client perceives he is treated by the nurse as a human being of value.
Consequences	1.	The nurse's individualized concern for the client results in the client feeling comfortable, secure, at peace, and relaxed.

Table 8--Continued

Theme		Statement
Noncaring		
Nurse's Presence	1.	For the nurse, her physical presence is to get the "job" done.
	2.	For the client, the physical presence is available briefly or not at all even when solicited.
Client's Uniqueness	1.	The nurse does not recognize the client's uniqueness because she does not "really listen" and appears "too busy" to pay attention to the client as an individual.
	2.	The client is devalued as a unique individual by actions of the nurse which degrade and belittle.
Consequences	1.	The nurse's lack of concern for the client results in the client feeling frustrated, scared, depressed, angry, afraid, and upset.

descriptions in order to validate them. Each description was examined to see if there was anything in the original that was not accounted for in the cluster of themes and whether the cluster proposed something that was not in the original.

An exhaustive descriptive of the phenomenon was produced by the integration of the results of the analysis. The description of the caring interaction is a statement of its essential structure. The exhaustive

description of a caring interaction is presented in Table 9.

Table 9

Exhaustive Description of a Caring Nurse-Client Interaction

In a caring interaction, the nurse's existential presence is perceived by the client as more than just a physical presence. There is the aspect of the nurse giving of herself to the client. This giving of herself may be in response to the client's request, but it is more often a voluntary effort and is unsolicited by the client. The nurse's willingness to give of herself to the client is primarily perceived by the client as an attitude and behavior of sitting down and really listening and responding to the unique concerns of the individual as a person of value. The relaxation, comfort, and security that the client experiences both physically and mentally is an immediate and direct result of the client's stated and unstated needs being heard and responded to by the nurse.

An exhaustive description of a noncaring interaction was produced by integration of the results of analysis of the noncaring data. The exhaustive description of a noncaring interaction is presented in Table 10.

Table 10

Exhaustive Description of a Noncaring Nurse-Client Interaction

The nurse's presence with the client is perceived by the client as a minimal presence of the nurse being only physically present. The nurse is viewed as being there only because it is her job and not to assist the client or answer his needs. Any response by the nurse is done with a minimal amount of energy expenditure and bound by the rules. The client perceives the nurse who does not respond to his requests for assistance as being noncaring. Therefore, an interaction which never happened is labeled as a noncaring interaction. The nurse is too busy and hurried to spend time with the client, and, therefore, she does not sit down and really listen to the client's individual concerns. The client is further devalued as a unique person because he is scolded, treated as a child, or seemingly as a nonhuman being or object. Because of the devaluing and lack of concern, the client's needs are not sufficiently met and the client has negative feelings, i.e., frustrated, scared, depressed, angry, afraid, and upset.

A final validation was undertaken by returning to eight of the subjects (two were unavailable) and asking them if the description formulated validated their original experiences. The eight subjects contacted stated that the description they read of the caring and noncaring interactions contained the essence of their experience. Four of the subjects stated they had not really thought of their experience in the terminology of the nurse's presence as used by the investigator. However, they further stated that the words they used in their original interviews had the same essential meaning as the terminology used by the investigator.

Summary of the Findings

This chapter presented a description of the study sample and an analysis of the data extracted from the transcribed descriptions of caring and noncaring nurse-client interactions. The steps of the analysis were presented, culminating in the exhaustive descriptions of a caring and noncaring interaction.

CHAPTER 5

SUMMARY OF THE STUDY

The results of the investigation are discussed as they contribute insight into the client's perceptions of the essential structure of caring interactions with nurses. The findings of this study are considered in relation to the philosophical insights of Buber (1956) and Marcel (1971). Current research studies on the phenomenon of caring are examined in conjunction with the findings of this study. Conclusions, implications, and recommendations for further study are given.

Summary

The specific research question was: From the perspective of the client, what is the essential structure of a caring nurse-client interaction? Since the research question was based on client perceptions, the phenomenological analysis of transcribed client interviews was an appropriate methodology for this study. The six-step method of analysis, as described by Colaizzi (1978), was followed. Each step of the analysis was guided by two concerns: (a) to characterize the essential meaning of what the client's description reveals about the nature of

a caring interaction and (b) to remain as faithful as possible to the client's original characterization. The additional data regarding noncaring interactions were also collected, analyzed, and contrasted to the description of the caring interaction.

The phenomenological analytical process by which findings were arrived at was a reflective activity. This activity is similar, if not identical, to that which is used in everyday life. None of the subjects asked what was meant by caring or noncaring. Each subject already understood what was involved in a caring and noncaring interaction. In other words, each subject in order to explicitly realize and describe the caring and noncaring interaction had to be already living an understanding of the meaning of caring and noncaring.

This study sought to understand the client's way of being in a situation as it was actually lived and experienced by the client in interaction with a nurse. The essential structure of a caring interaction was allowed to show itself and speak for itself. It was not translated or defined by external criteria. The research remained faithful to the being-in-the-situation of all human phenomenon.

Discussion of Findings

The phenomenological analysis resulted in the following description of the essential structure of a caring nurse-client interaction.

> In a caring interaction the nurse's existential presence is perceived by the client as more than just a physical presence. There is the aspect of the nurse giving of herself to the client. This giving of herself may be in response to the client's request, but it is more often a voluntary effort and unsolicited by the client. The nurse's giving to the client is seen primarily by the client as an attitude and behavior of sitting down and really listening and responding to the unique concerns of the individual as a person of value. The relaxation, comfort, and security that the client experiences both physically and mentally is an immediate and direct result of the client's stated and unstated needs being heard and responded to by the nurse.

The use of the word presence brings to mind several aspects, i.e., that of being physically present and mentally present and of being willingly and unwillingly present. As Nelson(1978) observed, "It can be safely concluded that the decision to make oneself present is rooted in the will" (p. 154). Just because a nurse is present physically, there is no guarantee that the individual is also present mentally. The nurse's existential presence means that not only is the nurse present physically and mentally but that she is voluntarily or willingly and consciously present.

For Marcel (1971), existential presence is found in his theme of availability (disponibilite). A quote of Marcel's statement on availability is appropriate for reflection.

> It is an undeniable fact, though hard to describe in intelligible terms, that there are some people who reveal themselves as present--that is to say, at our disposal--when we are in pain or in need to confide in someone, while there are other people who do not give us this feeling, however great is their good will. . . . The most attentive and most conscientious listener may give me the impression of not being present; he gives me nothing, he cannot make room for me in himself, whatever the material favors he is prepared to grant me. The truth is that there is a way of giving, and another way of listening which is the way of refusing oneself; the material gift, the visible action, do not necessarily witness to presence . . . presence is something which reveals itself

> immediately and unmistakably in a look, a smile, an intonation, or a handshake. (p. 25)

The client's consistent use of the term "really listening" is closely related to the notion of presence as described by Marcel. The willingness of the nurse in a caring interaction to give of herself voluntarily and without solicitation from the client is akin to what Marcel described as availability.

For Marcel (1971), the first level of participation is the level of experiencing and utilizing. In modern society, man's experiences at this first level of participation and human relations have thus been reduced to problems to be treated and resolved objectively. Marcel (1971) made a distinction between problem and mystery. In noncaring interactions, the nurse views the client as a problem and another task to be accomplished and crossed off the problem list. According to Marcel, a problem is something to be solved by certain techniques and an objective study of the problem will achieve a definite result. Objective problem-solving techniques may not be appropriate when dealing with a client and his or her personal concerns. Marcel would label the interaction between a client and nurse as a mystery, thus requiring involvement at the second level of participation--the I-thou level.

Marcel's (1971) term of intersubjectivity is an appropriate label for the caring interaction between the nurse and client. Marcel used intersubjectivity to describe the interdependence of man. Knowledge of each other comes from taking part in or participating in this intersubjectivity. In the noncaring interactions, characterized by brusqueness and noninvolvement, there is no intersubjectivity or knowledge gained by the nurse and client about each other. However, in the caring interactions, the participation is active on the part of both the client and nurse, and the nurse gains knowledge regarding the client and his concerns. The client also gains knowledge regarding the nurse and comes to appreciate what she is making available for him. In this intersubjective process, the client experiences warm feelings toward the nurse. Intersubectivity for Paterson and Zderad (1976) was defined as lived dialogue, "a form of existential intersubjective relating expressed in being and doing with the other who is regarded as a presence (as opposed to an object)" (pp. 34-35).

For Buber (1958), the initial phase of a relationship is in the realm of I-it. In noncaring interactions, the nurses look at clients as things to be manipulated

and controlled. The degrading remarks, which make the clients feel they are being treated like children, are used by the nurses to manipulate and control. The noncaring interactions are further characterized by the client being responded to as a nonhuman being or object.

> In our age, the I-it relation, gigantically swollen, has usurped, practically uncontested, the mystery and the rule. The I of this relation, an I that possesses all, succeeds with all, this I that is unable to say thou, unable to meet a being essentially, is the lord of the hour. (Buber, 1958, p. 56)

Buber's (1958) notion of "person making present" is similar to Marcel's (1971) theme of availability or presence. The nurse who does not hide behind the busy schedule, the uniform, and the equipment, makes herself open to participation. This second level of participation--the world of I-thou--is a world of genuine relation.

> When I step into an elemental relation to the other . . . that is when he becomes present to me. Hence I designate awareness in this special sense as "personal making present." (Buber, 1965, p. 205)

In caring interactions, the client appreciates being recognized by the nurse as a unique, thinking, feeling human being. Buber (1965) stated that "Every human being needs confirmation because man as man needs

it" (p. 71). In really listening to a client's stated and unstated needs, the nurse participates in his world and comes to appreciate and respond to him on the I-thou level of equality.

Buber (1965) posited three types of dialogue: (a) the monologue, (b) technical dialogue, and (c) genuine dialogue. Monologue occurs when two people engage in a conversation wherein each is speaking to himself and is not open or listening to the other. Technical dialogue is prompted by the need of objective understanding. Conversations that took place during noncaring interactions appear to be of the second and possibly the first type of dialogue. Genuine dialogue is all too rare, according to Buber (1965).

> There is genuine dialogue where each of the participants really has in mind the other or others in their present and particular being and turns to them with the intention of establishing a mutual relation between himself and them. (p. 19)

In caring interactions, genuine dialogue occurs between the nurse and client; the nurse being fully present, fully available, and fully capable of giving of herself.

The results of this study reinforce several finding in two recent studies on the phenomenon of caring. In

Brown's (1982) study, two major aspects emerged from questionnaire responses of the clients: (a) what the nurse does and (b) what the nurse is like. Availability and support of individuality and doing extra things were three of the categories. Verbal descriptions of care by patients revealed two major aspects: (a) what the nurse does and (b) how the nurse does. Two of the themes were found to be the nurse's reassuring presence and the nurse's recognition of individual needs. In another descriptive study, Ford (1982) found that among three groups of nurses (nurse educators, practicing nurses, and nonpracticing nurses), listening was listed by all three groups in describing caring behaviors. Two other categories that were identified were genuine concern for the well-being of another and giving of yourself.

van Kaam (1959) conducted existential phenomenological research on "the feeling of really being understood." Findings of the study of 365 subjects showed that the patient's feeling of being really understood depended on his being able to sense the nurse's understanding. The nurse had to show in her attitude and behavior that she understands the patient as a person, a fellow human being, not as an inanimate I-it object.

> Her interest has to be perceived as genuine and honest; it cannot be feigned. Patients in their intensified sensitivity distinguish sharply between genuine and pretended interest, caring, and trust. (van Kaam, 1959, p. 1710)

Consequences of the caring interaction are positive ones for the client who experiences feelings of security, comfort, relaxation and of being in good hands. van Kaam's research also revealed that the consequences of the client feeling really understood were that the client experienced a feeling of relief, being less frightened, and safe.

In the analysis, the formulated meanings from the significant statements of both male and female clients were integrated into the description of the essential structure of a caring interaction. However, it is noted in looking at the male and female significant statements that there appears to be subtle differences. Both sexes mentioned the unsolicited caring behaviors and that of being really listened to as being of major importance. However, males mentioned nurses' physical actions of comfort and reassurance, while females noted psychological support at a deeper or more intimate level than noted by the males. From rereading the original transcriptions, the investigator concluded that women expected this deeper

level of emotional support and felt very free to verbally report it. Men did not appear to state their concerns as forthrightly as the females and, thus, may not have either expected this from the nurse or may have just not verbally mentioned their desire for such support at a more intimate level.

Noddings (1981), a female, presented a phenomenological analysis of caring.

> Caring involves, for the one caring, a "feeling with" the other. This feeling with others involves receiving the other. . . . To be completed, it (caring) depends upon the receptivity of the cared for. . . . I look for something which tells me that you have regard for me, that you are not behaving perfunctorily or merely out of obligation. (pp. 141-142)

Pinar (1981), a male, responded to Noddings in an article on gender analysis. Pinar posited that "receiving the other is, classically and specifically heterosexually the woman's position" (p. 149). He suggested that caring is classically a woman's preoccupation, especially when it is described as receptivity, and that men may have reduced capacities to care. He further suggested that men repress subjectivity and insist on objectification of persons.

In the present study, all the nurses mentioned by the clients were female nurses. It is interesting to

speculate whether results of a similar study would be different if all of the sexes were reversed.

Conclusions and Implications

Findings of this study add credence to the limited research on caring. It is not only what the nurse *does* in the way of physical acts of assistance but what the nurse *is*. Being existentially present or available and showing genuine interest in the client as a valued individual by really listening is considered by clients to be one of the most important aspects of caring. These findings have implications in the areas of nursing education, nursing practice, nursing research, and in building and testing nursing theory.

Nursing Education

The findings of this study have implications for the inclusion and integration of existential philosophical thought into undergraduate nursing education. With some understanding of existential philosophical concepts, beginning students can begin to build their nursing practice on a meaningful philosophical base. If caring is valued as a base for nursing practice, then nursing educators have the responsibility to provide access to existential philosophical ways of thinking.

If caring is a valued attribute for nurses, then the demonstration of this attribute must be evident for nursing students to see in nursing educators. Caring behaviors and attitudes are not developed by exposure to theory alone. Presence, really listening, and respecting the uniqueness of the individual are all characteristics nurse educators must live so that students can know the receptivity of caring. Being on the receiving end of caring will make the doing end easier and more natural to accomplish.

Nursing Research

The findings of this study show that data can be gathered directly from individuals, analyzed, and the findings communicated so that the meanings for the person in the lived world are not distorted, reduced, or fragmented. Rather, the meanings are viewed holistically, as a part of that individual's whole experience. Quantitative data can provide information but cannot provide what it feels like to be in a caring or a noncaring interaction.

One consideration is that phenomenological research can never exhaust the investigated phenomenon. The results of phenomenological research are "the essence of

certainty to be established with reservations" (Merlau-Ponty, 1962, p. 396). Phenomenology tells what man is all about outside the boundaries of traditional science. The scientist's interest in manipulating variables to predict and control have the effect of permitting man to lose his unique identity. Traditional science thus tends to cancel out its value to individual man and society. The lived world is researchable and in ways that can be specified and shared with other researchers. Nursing will enhance its research possibilities if it can learn to treat the qualitative as such, rather than seeking its transformation into quantifiable measurements.

Nursing Practice

Considering the client as the center of his own universe, then what is going on in the client's environment is of utmost importance to him. The client's perceptions are not the same as those of other individuals. It is logical to assume that the best source of information about the client is the client himself. Situations should, therefore, be defined from the client's point of view.

In nursing, to view each client from his own unique individual point of view will entail the nurse being

existentially present. This will mean more than the physical presence and more than answering the stated questions and concerns. Existential presence in a caring interaction does not have to entail hours of time. It does mean that in interactions with clients, the nurse will truly be present in thought, word, and deed. If the existential mode of interaction became as habitual as the brisk, efficient, cliche, nonhuman type of interaction, clients would respond with the feelings of relaxation, comfort, and security. Although there is limited scientific research to validate the notion, feelings of relaxation, comfort, and security are generally supported as hastening and promoting clients' recovery and well-being.

Nursing Theory

"Theory must as usual, wait on practice" (Griffin, 1980, p. 265). While the statement has a certain validity, the findings of this study indicate that theory development is possible concurrently with utilization of the findings in education, research, and practice.

Rogers (1970) made several assumptions within the theory or model: (a) man is a unified whole possessing his own integrity and manifesting chracteristics that are

more than and different from the sum of his parts and (b) man and environment are continuously exchanging matter and energy. One of the unstated assumptions is that an observer cannot see the whole and the parts simultaneously (Rogers, 1970). Health, in Rogers' model, is when the client's pattern and organization of his energy field is in synchrony with the pattern and organization of the environmental energy field. Nursing, to Rogers, is the humanistic science that has as its aim to assist people in achieving their maximum health potential. Thus, within this framework, nursing attitudes and behaviors which assist in synchrony of pattern and organization of the client-nurse energy field would assist the client in achieving his maximum health potential.

Findings of this study indicate that the consequences of caring nurse-client interactions are a client who is relaxed, comfortable, and more secure--one whose energy field is in synchrony with the energy field of his environment. The nurse, by attitudes and actions, becomes the medium by which energy is channeled to the client. It is this giving or availability--an essential of a caring interaction--that is the medium of energy exchange flowing to the client. Although research in the area of

channeling energy is limited, Krieger (1979) did some preliminary investigations in her work on therapeutic touch. Through the process of centering oneself physically and psychologically (finding a reference for stability), the nurse is able by conscious effort to direct the universal or environmental energy to the client to repattern his own energy. There are numerous interactions recounted where this transfer of energy appears to have taken place (Krieger, 1979). If transfer of energy is demonstrable by the mechanism of therapeutic touch, it is possible to assume psychological energy transfer taking place within caring interactions between nurse and client.

Recommendations for Further Study

The findings of this investigation led to recommendations of further study in the following areas.

1. A phenomenological investigation of nurses' perceptions of caring and noncaring interactions with clients.

2. Further phenomenological investigation into differences between male and female clients' perceptions of caring interactions.

3. Phenomenological investigation of caring and noncaring interactions of male nurses and male clients.

4. Investigation of physiological measurements to record how caring interactions promote groth and hasten the healing process.

5. Phenomenological investigation of the assumption that synchrony of man-environment interchange leads to a higher level of wellness.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
Box 22939, TWU Station
RESEARCH AND GRANTS ADMINISTRATION
DENTON, TEXAS 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Doris Riemen Center: Denton

Address: Rt. 1, Box 449 Date: April 5, 1983

Big Sandy, TX 75755

Dear Ms. Riemen,

Your study entitled The Essential Structure of a Caring Interaction: a phenomenological study

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

____ Other:

_x_ No special provisions apply.

cc: Graduate School
Project Director
Director of School or
Chairman of Department

Sincerely,

Chairman, Human Subjects
Review Committee

at Denton

8/10/82

APPENDIX B

TEXAS WOMAN'S UNIVERSITY

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

_____ _____

Signature Date

_____ _____

Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____

Signature Date

_____

Position

_____ _____

Witness Date

APPENDIX C

TEXAS WOMAN'S UNIVERSITY

We, the undersigned, do hereby consent to the recording of our voices and/or images by Doris Riemen, acting on this date under the authority of the Texas Woman's University. We understand that the material recorded today may be made available for educational, informational, and/or research purposes; and we do hereby consent to such use.

We hereby release the Texas Woman's University and the undersigned part acting under the authority of the Texas Woman's University from any and all claims arising out of such making, recording, reproducing, publishing, transmitting, or exhibiting as is authorized by the Texas Woman's University.

SIGNATURE OF PARTICIPANTS

_____
Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

* * *

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____ _____
Authorized representative of the Texas Woman's University — Date

APPENDIX D

COMPLETE LIST OF SIGNIFICANT STATEMENTS--
CARING INTERACTIONS

Female

1. listened well--really listened
2. emphathetic
3. understanding regarding my fears
4. very supportive of my concerns
5. she was there to talk to
6 talked to me about things other than my illness
7. made me feel like a normal person--not a patient
8. really listened
9. interested in me as a person and an individual
10. sat down on the side of my bed
11. held my hand
12. asked me questions
13. looked me directly in my face
14. I could feel the empthy between the two of us
15. verbalized some of her own insecurities
16. let me know it was all right to be scared
17. came back several times to see if I was comfortable
18. felt security with her being there
19. felt more relaxed
20. felt peace of mind
21. didn't feel I was some thing on display
22. felt I was human
23. mild mannered--quiet
24. real gentle
25. felt she understood how scared I was
26. came in all the time to see if I was all right
27. really concerned
28. compassionate
29. she knew something was bothering me
30. sympathetic
31. paid attention to what I said
32. paid attention to me as an individual
33. nurse told me what they had done
34. I was very relieved
35. I felt well taken care of
36. nurse was motherly
37. I felt secure
38. she came in my room frequently
39. so concerned
40. called to see if I needed anything

41. talked nice--really listened to what I had to say
42. tried to give me hope
43. I felt good towards her
44. she knew what she was doing
45. concerned not only with patient--but family
46. understood what I was going through
47. I felt very warm towards her
48. I wanted to do something for her
49. could comfortably talk with her
50. understood patient and family as individuals

Male

51. nurse was there
52. holding my hand and mopping my brow
53. make me comfortable
54. trying to comfort me
55. nurse would come when I rang
56 come voluntarily
57. sat down
58. talked
59. really listened
60. making sure you are comfortable
61. feel like it's my daughter taking care of me
62. go out of her waay
63. constantly came back to see if she could help
64. she looked after me all the time
65. made me feel good
66. she listened to me
67. made me feel comfortable
68. she would talk to you
69. she would try and help with anything
70. get me whatever I needed first and then do the nursing
71. like taking time to listen to you
72. would carry on a conversation with you
73. interested in you as a person
74. sat with me
75. give more interest to you
76. explain to me
77. ask if I needed anything
78. spent time with you
79. pleasant
80. come in when I called
81. ask if you were all right
82. listened to me and what I had to say

83. kind
84. attentive to patient's comfort
85. felt you were in good hands
86. soft attitude
87. compassionate
88. come in to see you
89. concerned about you feeling good

COMPLETE LIST OF SIGNIFICANT STATEMENTS--

NONCARING INTERACTIONS

Female

1. I felt as though my hands were being slapped
2. rules are more important than people
3. it was an arbitrary, capricious power thing with her
4. looked at the equipment instead of looking at and listening to me
5. always appeared to be in a hurry--always in a rush
6 didn't have time to talk
7. didn't want to talk
8. her body language let me know she wasn't interested in what I had to say
9. she was there to perform her duties and then go home
10. she didn't get close--stood at a distance
11. felt as though I was contagious--my illness might rub off
12. wouldn't look at me directly in the eye
13. she was so snappy
14. defensive
15. wasn't interested in the person as a whole
16. I was not at ease
17. I was uncomfortable
18. I became depressed--not being able to talk
19. I felt I had to keep my mouth shut
20. super efficient attitude
21. always had to follow the rules
22. seemed to feel she was really tough
23. she made me more tense
24. always trying to rush
25. she showed she was frustrated
26. she made me frustrated and scared
27. I was upset
28. unable to figure out what was going on
29. she didn't care what she said
30. I was almost a "basket case"
31. I was fidgeting
32. buzz and she would not get there
33. she'd say "yes-yes" and then not come
34. she did not explain permit--"just sign"
35. frightened me to death
36. too much in a hurry

37. acted like she had a job to do
38. didn't pay any attention when I told her
39. didn't pay attention because I was older
40. made me feel angry
42. no confidence in her
42 afraid
43. prancing around when the doctor was there
44. would not answer bell for over 45 minutes
45. left equipment on my bed and left the room
46. told me to get up and take care of myself
47. I was scared and weak
48. she would not come back and help
49. I fainted
50. crying
51. I didn't want her to touch me
52. she was too busy talking to the other nurses to attend to me
53. she did not know what she was doing
54. I was not treated as a person
55. it s as though I was a nobody
56. didn't want to go back to that hospital
57. couldn't "care less"
58. so busy--act like clockwork
59. no time to stop for talking or listening.
60. have to get things done--go by the book

Male

61. did not pay attention to what you needed
62. just came in to do what she had to do
63. she didn't have no pity--no mercy
64. she just wasn't soft
65. talk to you a very short time
66 seemed it was just a "rum dum affair" (nursing)
67. give you a quick answer and go on with her business
68. won't tell you what she's doing
69. give you a simple answer as though you couldn't possibly understand
70. act like it was an everyday job (nursing)
71. do a job, and look at you like an object
72. watch you like you're a ten-year-old
73. raise and shake her finger at me
74. felt like a child being scolded
75. this is a job
76. not come in the room
77. element of human contact lacking

78. efficient--but no human element
79. rang bell and would not come
80. not supply any information
81. bathed me as though she was doing it to a dog
82. it's insulting
83. strapped me to the bed--never talked to me-- walked out
84. spoke loud and slow as though I'd lost my marbles
85. could care less about how I was suffering
86. very rough--like striking out at me
87. no personal awareness of my comfort
88. sound of her voice was cold and unconcerned
89. felt helpless
90. washing me as though I was a toy
91. I was of no value to her

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