Caring for families: Double binds in neuroscience nursing

By Linda Yetman

Abstract
Despite the proliferation of literature related to nurse-family relationships, little is known about such relationships in acute care neuroscience environments. A grounded theory study illuminated the experiences of nurses caring for families of patients with acquired brain injuries in the context of acute care hospital environments. Nurses, working in pressure-cooker-like environments, tried to meet information and emotional needs of families. During data analysis, a communication pattern emerged that impacted on nurses’ experiences and relationships with families. This communication pattern, known as a double bind, contributed to a pattern of nursing that emerged and offers an explanation for the behaviours of the nurses in coping with family members. Nurses felt “damned if they did and damned if they didn’t.” To provide family-centred care, we need to fully understand the experiences of nurses caring for these families. This paper describes the concept of double bind and its application to neuroscience nursing.

Introduction
Copper Woman warned Hai Nai Yu that the world would change and times might come when Knowing would not be the same as Doing. And she told her that Trying would always be very important.

—Anne Cameron, Daughters of Copper Woman

Despite advances in technology and knowledge about patient treatment in the early phases of injury trajectory, the person with an acquired brain injury (ABI) faces an uncertain road of recovery. The emotional impact on the patient’s family remains significant as the patient progresses through various stages of physical, cognitive, emotional and psychological healing. This impact has been well documented in the literature (Baker, 1990; Brooks, 1991; Brooks, Campsie, Sympington, Beattie, McKinlay, 1986; Dikman, Machamer, Miller, Doctor, & Temkin, 2001; Florian, Katz, Lahav, 1989; Gervasio & Kreutzer, 1997; Knight, Devereux, & Godfrey, 1998; Kosciulek, 1999; Leatham, Heath, & Woolley, 1996; Lezak, 1988; Oddy, Humphrey, & Uttley, 1978; Warren, Wrigley, Yoels, & Fine, 1996; Zeigler, 1999). In addition, family needs and responses to the injury change throughout the recovery period (Junqué, Brunà, & Mataro, 1997). Given that nurses care for patients throughout the entire health care continuum, it is likely that many patients recovering from ABI and their families will encounter nurses on the path of recovery. However, little is known about the nature of relationships between nurses and families of ABI patients, especially in acute care clinical settings. In an effort to contribute to literature on staff nurse-family relationships, a grounded theory study aimed to explain how relationships between staff nurses and families of ABI patients develop and the contributing influences, from the nurses’ perspective, to the development of these relationships within the context of acute care clinical environments. The findings from this study have been published in another article (Yetman, 2008).

Nurses, working in pressure-cooker-like environments, tried to meet information and emotional needs of families. Nurses felt “damned if they did and damned if they didn’t,” and found themselves in double binds with families. Consequently, some nurses developed a way of practising in order to protect them and to cope with the double binds that surrounded them as they tried to care for family members. The purpose of this paper that builds on the previously published article is to

Le soin aux familles: double contrainte en soins infirmiers en sciences neurologiques

Résumé
Malgré la prolifération d’écrits sur la relation infirmière-famille, on en sait peu sur les relations dans un environnement de soins aigus en sciences neurologiques. Une théorie ancrée a guidé l’expérience d’infirmières soignant des familles de clients avec des traumatismes crâniens, dans le contexte d’un environnement de soins aigus en milieu hospitalier. Des infirmières qui travaillaient dans un environnement sous pression ont tenté de rencontrer les besoins émotionnels et d’information des familles. Durant l’analyse des données, une tendance de communication a émergé et offre une explication sur le coping des infirmières et de leurs comportements avec les membres de la famille. Les infirmières se sentaient dans une impasse « damned if they did and damned if they didn’t ». Nous avons besoin de bien comprendre l’expérience des infirmières qui soignent ces familles pour prodiguer un soin centré sur la famille. Cet article décrit le concept de double contrainte et son application en soins infirmiers en sciences neurologiques.
describe the theoretical application of double binds as it related to nurses’ experiences of caring for families in the author’s study. Individuals in a double bind, which is discussed in the theoretical and literature review, are basically in shaky, no-win situations.

Theoretical and research literature

Staff nurses and relationships with families

Many authors have studied nurse-family and nurse-patient relationships (Bell, 2000; Hainsworth, 1998; Johnson, 1995; Robinson, 1996; Robinson & Wright, 1995; Tapp, 2000; Ward-Griffin & McKeever, 2000; Wright & Leahey, 2000). Health care relationships have been identified as very powerful influences on patients and families who experience chronic illness (Robinson & Thorne, 1984). In a literature review conducted by Robinson about nurse-patient relationships, several themes emerged: (a) the centrality of this relationship to the practice of nursing, (b) the professional satisfaction derived by nurses from the relationship, as well as the patient’s satisfaction with care, (c) theoretical questions about how the nurse-patient relationship should be enacted in practice and how the nurse-patient relationship is actually enacted, (d) the paradoxical nature of the nurse-patient relationship, with its tension between closeness and distance, and (e) dominance of the professional perspective in research on the nurse-patient relationship, with relatively little attention to the family’s perspective. Robinson noted that authors conceptualized health care relationships as foundational to nurses’ interventions with families. How, then, does the relationship between a nurse and a family contribute to interventions by staff nurses?

Although clinical, theoretical, and research reports about relationships between nurses and families in various clinical settings have been published, little attention to the interactions between staff nurses and families of ABI patients in acute care is evident. While the nature of brain injury, family coping and adaptation, and the family’s overall response help to determine the patient’s recovery, so do staff nurses’ involvement and interventions with families. While there is substantive theory development in this setting (Duff, 2002), little within the published literature offers nurses guidance in caring for families during this phase of an ABI patient’s recovery. The essence of nursing practice is processes (Stern & Pyles, 1985). These processes include the relationships nurses build with their patients and families, and the reciprocity and experiences from both sides must be fully understood for family-centred care and quality patient care to exist. Therefore, discovering the challenges faced by nurses caring for families of ABI patients is required so that the nurses’ experience in these relationships can be understood as well.

Hainsworth (1998) used a phenomenological approach to study eight acute care nurses caring for three severely neurologically impaired patients. She gave few details about the patients’ family situations or their cultural backgrounds. Using a purposive sample and semi-structured interviews, she explored what the nurses experienced regarding patient care and how they interpreted their experiences. One theme that emerged was a “feeling of abuse by family members.” While this theme was not explored fully, given what we know from research about the emotional toll of ABI on families, there are many factors that have caused negative reactions of family members to the nurses.

Carson (1993), Robinson and Thorne (1984, 1988), and Thorne (1993), through their theoretical frameworks, provided some explanations of family experiences and processes that could apply to the ABI patient/family population, which nurses may use to establish therapeutic relationships with families. Carson developed a substantive grounded theory for family caregivers of patients with moderate to severe traumatic brain injury (TBI). Although this theory applies to family members who are direct caregivers and focuses on the community reintegration phase of recovery, community and hospital nurses could use this theory to understand the needs of families and to help to guide practice. Carson described three phases in community reintegration of a person recovering from TBI: centring on, fostering independence, and seeking stability. In the centring on process, the family puts all of their attention on the family member with TBI. The family begins this phase as soon as they hear about the injury. In the second phase, fostering independence, the family tries to allow their family member to assume responsibilities within the limits of any cognitive and physical problems. In the last phase, seeking stability, the family tries to bring normalcy into their lives, supporting the family member with the TBI and beginning to accept the family member’s limitations.

Robinson and Thorne (1984, 1988) identified three stages in the development of relationships between patients/families and health care providers in the context of chronic illness. Given the ABI patient’s compromised position, the uncertainty of recovery and the possibility of chronicity, Robinson and Thorne’s work may apply to ABI patients’ families. Robinson and Thorne labelled the stages as naïve trust, disenchantment, and guarded alliance. In the naïve trust stage, families place blind belief in health care providers, almost as if they are all-knowing gods who will provide the best care possible with the best possible outcomes. During the disenchantment stage, families (and patients) become aware that health care providers and the health care system may not or cannot deliver care that they believe will alleviate the individual’s pain or optimize functioning. In the guarded alliance stage, people align themselves with health care providers forming partnerships. However, they attempt to drive the partnership and direct most of the care.

Two noted research leaders in family nursing are Wright and Leahey. According to them: Health and illness, families, and nurses have each been studied as separate elements by a variety of disciplines. However, it is the reciprocity or relationships between the elements that are often new or startling to nurses. Therefore, it is our belief that nursing of families must focus on relationships, not on discrete elements. Fortunately, nursing is making strides in shifting toward a systematic understanding of families experiencing health problems (2000, p. 14).

While the notions of relationships and reciprocity within the staff nurse-ABI-family relationships need further research to reach a deeper understanding, some researchers offer ideas...
and concepts that can apply. According to Robinson and Wright (1995), the fit between nurse and family is important. As important is the relational context in which nursing interventions are offered. However, how can a nurse establish this fit within today's acute care environments, which have been called "the fast lane of health care" (Tapp, 2000, p. 29)? According to Wright and Leahy (2000), family nursing interventions include providing information to family members, offering emotional support, encouraging family members to support each other, and encouraging family respite. These interventions may be used as ways to meet family needs in the context of brain injury recovery. However, the relational context between staff nurse and family is complicated and complex and must be comprehended prior to delivery of "interventions".

Robinson's (1996) study explored both the process and outcomes of family-systems nursing interventions offered to families having difficulty managing a family member's chronic condition. She reported a startling finding in response to her question, "What did the nurse do that was helpful for you in the process?" In their answers, the families did not focus on what nurses call nursing interventions. Rather, they emphasized the importance of relationships. Robinson makes a critical observation: "At this point in the development of family nursing, these families offer an important reminder that relationships are not central to care, they are care" (p. 1). The nurses' behaviors became relational interventions that, in turn, enhanced nurse-family relationships, helping to make them therapeutic.

Robinson (1996) listed four therapeutic behaviors that families said made a difference in the relationships they had with nurses. First, the nurse was a curious listener. The nurse asked good questions and focused conversations on important issues. Second, the nurse was a compassionate stranger, a person who demonstrated genuine involvement in the relationship with the family, yet was able to remain at a distance from the family's suffering. Families identified this distance as important for the nurse to remain objective. Third, the nurse was a non-judgmental collaborator. This non-judgmental behavior was necessary for the nurse to help the families change, because the families revealed negative experiences and feelings of being blamed in past health care relationships. Therefore, the non-judgmental behavior of nurses allowed families to speak candidly. Last, the nurse mirrored family strengths, thus supporting families to draw on their own resources and to demonstrate resilience.

A number of studies have explored family needs from both families' and nurses' perspectives. These studies drew from a variety of patient populations: neurosurgical, neurological, coronary, medical-surgical, cardiovascular, thoracic, and telemetry step-down (Bijttebier, Vanoot, Delva, Ferninande, & Frans, 2001; Caplin & Sexton, 1988; Dockter, Black, Hovell, Engleberg, Armick, Neimier, et al., 1988; Forrester, Murphy, Price, & Monaghan, 1990; Fox & Jeffrey, 1997; Johnston, 1986; Jacono, Hicks, Antonioni, O'Brien, & Rasi, 1990; Kleinpell & Powers, 1992; Lynn-McHale & Bellinger, 1988; O'Malley, Favaloro, Anderson, Anderson, Siewe, Benson-Landau, et al., 1991; O'Neill Norris, & Grove, 1986; Prowse, 1984). All but two of the above studies examined family needs from both family and nurses' perspectives. Fox and Jeffrey, as well as O'Malley et al., studied family needs from nurses' perspectives only. Jacono et al. (1990) study settings included adult and neonatal intensive care units. Bijttebier, Vanoot, Delva, Ferninande, and Frans compared perceptions of family needs among relatives, physicians, and nurses. While a variety of measurements were used in these studies, variations do exist between family and nurse perspectives of family needs following a relative's injury. However, overall, the results of these studies suggest that nurses perceive with a good degree of accuracy the needs of family members: for information, to have questions answered honestly, to be assured of the best care, and to know that hospital personnel care about their relative.

Even though the research suggests that nurses understand the needs of families, the actual relationships are often tense, complicated and multifaceted. The complexity is attributed to a number of factors such as patient acuity, context of the clinical environment and resources. However, in this author's study, the double binds in which nurses found themselves were often a major contributing factor to the tension between family members and the nurses.

**Double binds**

"If you are in a double bind, you are in a very difficult situation, because you have problems that cannot be solved easily or without causing more problems" (Collins Dictionary of Idioms, 2002, p. 27). Double bind theory originated in the work of researchers Bateson, Jackson, Haley, and Weakland (1956), who studied communication with schizophrenic people. Rather than viewing schizophrenia as an intrapsychic disturbance (a thinking disorder) that secondarily affects a person's relationships with others and, in turn, theirs with the person, these researchers proposed that a sequence of interpersonal experiences induced (rather than caused) schizophrenic behavior. They postulated that essential characteristics must exist for such interpersonal experiences and called these characteristics a double bind, or an irresolvable communication sequence. Watzlawick, Bavelas, and Jackson (1967) furthered the initial research into the complexities of human communication while developing the concept of paradoxical communication. Watzlawick, Bavelas, and Jackson proposed that all behavior is communication—*it is impossible to not communicate*. "Activity or inactivity, words or silence all have message value: they influence others and these others, in turn, cannot not respond to these communications and are, thus, communicating" (p. 49).

While the initial work of Bateson, Jackson, Haley, and Weakland (1956) was later modified and expanded upon by Watzlawick, Bavelas, and Jackson (1967), other authors (Alexander, 1976; 1981; Krefting, 1990; Ringstrom, 2003; Zuk and Zuk, 1998) also acknowledged the necessary components of a double bind first described by Bateson et al. Alexander (1976) applied the double bind model to relationships between health care staff and chronically ill hemodialysis
patients, relationships she described as intense and permanent. Alexander suggested that double binds develop within complementary relationships in which the parties exchange different kinds of behaviour. These relationships are often hierarchical. For example, in health care, she asserted the complementary characteristics between caregiver and care receiver are healing and pain, giving and receiving, and comforting and complaining. Alexander identified three attitudes that many people with disabling conditions are expected to display: be normal, be independent, and be grateful. These expectations, however, are negated by disabilities that entail dependence on professionals, limitations on lifestyle, and possibly a negative attitude toward service providers. The contradiction between expected attitudes and reality represents a double bind.

It is through the work of Alexander (1976) and the later researchers that double binds were explored in this author’s grounded theory study. Throughout data collection and analysis, it became evident that nurses took a passive role in their interaction with family members and/or reacted to how family members related to them. While Alexander looked at double binds within the context of direct relationships between people, in the context of this author’s study, it is contended that nurses were caught in continuous double binds with family members, with peers, and with the organization. According to the nurses, they were expected to facilitate family-centred care without adequate supports to meet those expectations. The contradiction between what the organization expected (family-centred care) and what nurses could deliver represented the first double bind, which led to other double binds at the bedside.

**Double binds in neuroscience nursing**

The theoretical perspective of double bind theory is offered as an explanation of the struggles and challenges that surrounded the nurses who cared for family members of their ABI patients. And, in turn, these double binds had consequences for how some nurses practised in their clinical settings. In the context of the author’s study, nurses were caught in double binds as a result of trying to include families in their care. They tried to care for families, yet were unable to do so because of the competing demands of patients (related to patient acuity on the ward) and working in a chaotic environment – “a pressure cooker”. Drawing on Alexander’s (1976) work, in the interest of its specific application to the relationships between nurses and families in the context of this study, the six criteria necessary for a double bind are presented here, followed by its application to this study. According to Alexander, the double bind consists of the fulfilment of six criteria:

1. Two or more persons (A and B) are engaged in a predominantly complementary relationship that is ongoing.
2. Person A issues primary and explicit directives [also known as primary injunction] that contain an implicit threat to person B if they are not carried out.
3. Person A simultaneouslyqualifies the primary injunction with implicit secondary negating directives, e.g., “do not act as if I were threatening you,” “do what I tell you as if you wanted to do it” [known as secondary injunction].
4. A tertiary injunction must be operating to bind person B to the situation and relationship. Simple examples: a paraplegic may not terminate dependency on other people.
5. The ongoing relationship between A and B is patterned as described above and the paradoxes are recurrent and come to be expected.
6. Redundant paradox is finally learned. (p. 1353).

Applying the double bind to this study, the six criteria are fulfilled:

1. Nurses (B) are working in chaotic, pressure-cooker environments (A). Highly anxious families are a part of this environment.
2. Nurses (B) are requested by the organization (A) to include families in their care along with patient care. Exclusion of families results in a number of consequences, such as increasing family anxiety, increasing stress on nurses (result of families persisting to have their needs met), pressure from the organization to include families (sometimes the result of family complaints), and disillusionment and dissatisfaction of nurses with their work (lack of meaning for them).
3. The organization (A) conveys the message for nurses (B) to include families and to do so as if they wanted to include them (family-centred care).
4. Families are connected to patients, therefore, it is difficult for nurses not to communicate with them or terminate relationships with them. Nurses may try to ignore or avoid family members, however, they often suffer moral and ethical consequences in doing so.
5. The expectations from the organization continue. Nurses try to cope in whatever ways they can, and the situation is perpetuated.
6. Nurses develop patterns of practice and ways of relating to families reflective of disruptive communication, while trying to protect themselves and get through their shifts.

Double binds resulted in peer conflict and conflict between nurses and families in the author’s study. For example, negotiations to extend visiting hours created double binds for nurses. A nurse might discuss with a peer why certain family members were permitted to stay beyond visiting hours (trying to meet the needs of the family) knowing that this extension may put the peer in conflict with other nurses on that shift. So, that nurse granting the extension is “damned if she/he does, and damned if she/he does not.” The family will be happy to stay, but the nurse who helped them may later bear the brunt of peer conflict.

The family of an ABI patient is thrown into a state of high anxiety and uncertainty. This anxiety impacts on the nurse. Zuk and Zuk (1998) contended that a high degree of anxiety precipitated by a dilemma or conflict contributed to the process of a double bind. The following example, drawn from data in the study, illustrates how a double bind for a nurse and family might develop in the context of a chaotic acute care clinical environment:

1. The nurse becomes anxious and frustrated toward the family in response to their persistent demands for attention and for care of their relative, the ABI patient.
2. The nurse recognizes that, in order to be considered a “good” nurse (one who meets the needs of patients and families and creates therapeutic relationships) anxiety and frustration must be disguised.

3. The family may still recognize the nurse’s anxiety and frustration, but accepts it because of family members’ continued need for attention and care for the patient. However, family’s anxiety is increased.

4. Because the family is strongly connected to the patient, the nurse has no choice but to accept the family’s highly charged emotional state.

5. The nurse mirrors the family’s anxiety. Anxiety begets anxiety, resulting in negative consequences for the nurse, such as feeling exhausted, overwhelmed, discouraged, and dissatisfied with the care provided at the bedside.

Watzlawick, Bavelas, and Jacksons’ (1967) contention that consecutive double binds can damage people who experience them confirmed what Bateson, Jackson, Haley, and Weakland (1956) asserted: repeated double binds lead one to comprehend the world through learned, double-bind patterns of communication. These patterns of communication were evident throughout this study. Moreover, although all nurses seemed to have individual nursing styles, certain patterns of nursing practice became evident. Some nurses developed disruptive patterns of communication with respect to families. These patterns varied with the degree of the conflict experienced by nurses with family members, with peers, and internally. And, communication patterns within double binds reinforce them, creating a self-perpetuating cycle (Watzlawick, Bavelas, & Jackson, 1967).

Drawing on Alexander’s work, Krefting (1990) used the double bind model to interpret some of the puzzling behaviours noticed in traumatically head-injured persons. However, as Krefting so aptly stated, “The model cannot, however, explain all of the complexities of the world of the head injured; it is unlikely any single concept can” (1990, p. 859). Nor is it likely that the double bind model can explain all the complexities of relations between staff nurses and family members in the context of ABI patient recovery. Nonetheless, this model can provide insight into nursing practice with family members.

Nurses’ relations with families are often intense and hierarchical. Nurses and families exchange different kinds of behaviours. Families expect to have their emotional and information needs met by nurses 24 hours a day, seven days a week (given their shift work). According to the literature, families expect the best care possible for their relative, need to have their questions answered honestly, and want to be called at home with changes in the patient’s condition (Bernstein, 1990; Freichels, 1991; Leske, 1986; Price, Forrester, Murphy, & Monaghan, 1991; Rukholm, Bailey, Coutu-Wakulczyk, & Bailey, 1991). Nurses are aware of the important needs of family members of critically ill patients with brain injury (Forrester, Murphy, Price, & Monaghan, 1990; Hupcey, 1998; Jacono, Hicks, Antonioni, O’Brien, & Rasi, 1990; Kleinpell & Powers, 1992; Lynn-McHale & Bellinger, 1988; O’Neill Norris & Grove, 1986; O’Malley, Favaloro, Anderson, Anderson, Siewe, Benson-Landau, et al., 1991). However, nurses may be constrained in meeting these needs by (a) emotional fatigue, (b) not knowing the patient well because nurses work casual, part-time or are caring for the patient for the first time, (c) lack of knowledge about the illness, (d) perception that meeting family needs is another health care professional’s role, and (e) competing demands from other patients. Subsequently, the contradiction between what families expect and what nurses can deliver creates another double bind. Taken from study data, the development of this double bind is illustrated in the following sequence (offered as an example only):

1. A complementary relationship exists: The family is on the ward because their relative has been admitted to the hospital, often under catastrophic circumstances. The nurse invites the family to help with physical care (or family members demonstrate that they want to help). This invitation may be extended because the nurse needs help with care, or it may be an opportunity for the nurse to get to know the family. Boundaries of care activity are ill defined and depend on the individual nurse’s style of practice, which may differ between colleagues. Families become confused, anxious, and frustrated. Sometimes nurses’ needs (such as help with physical care) are not met by families, resulting in nurses’ anxiety, frustration, and sometimes withdrawal or minimal contact with family members.

2. The invitation to help with physical care is a situational message that nurses offer to family members while limiting their interaction with family members about patients’ physical care needs. However, family members sometimes expect that nurses will meet their emotional needs; nurses, at times, cannot offer this support.

3. Confusion over expectations occurs. Depending on the patient’s progress, increased anxiety in family members affects how much they can help nurses. Contradictory messages are exchanged. This situation leads to increased frustration in both family members and nurses.

4. Family members feel they cannot leave the bedside, needing to be there to alert the nurse if they perceive that the patient needs something. Nurses may want families to leave in order to rest or because they feel they are being watched by family members.

5. Distorted and disruptive communication patterns results between nurses and family members, as well as between nurses.

6. These patterns of disruptive communication become the patterns of relational nursing practices between nurses and family members.

The example of a double bind between nurses and families described above is illustrated in Figure 1.

Discussion

While double binds cannot solely explain the ways nurses relate to family members, they may contribute to an explanation about nurses’ behaviour towards families and, indeed, be difficult obstacles to overcome in the daily lives of nurses. During data interpretation of the author’s study, it became clear that nurses did, indeed, experience conflicts and double binds with family members, interrelated with peer conflict.
In her interviews of nurses and family members, Hupcey uncovered both positive and negative behaviours in each group. When she showed nurses which of their behaviours family members perceived negatively, the nurses identified with families. Hupcey’s work provided the nurses an opportunity to evaluate their practice with families.

In 1999, Hupcey examined how nurses and families interacted to increase or decrease family involvement in the ICU. In that study, she offered the perspectives of patients, their families, and nurses. She developed a model around a core category of looking out for the patient—looking out for themselves. In that model, the families look out for the patients while looking out for themselves, and the nurses look out for the patients while looking out for themselves. In the study conducted by the author, the nurses’ relationships with families were negatively impacted because of a variety of factors—some associated with the context of the environment in which they worked that, in turn, rendered them into feelings of being in double bind situations.

“How do nurses manage these double binds or conflicts?” became an emerging question during data collection and analysis in the author’s study. Eventually, a process of nursing defensively surfaced to answer this question and to manage conflicts associated with caring for family members of their patients. For a host of reasons, nursing defensively was how nurses made meaning of their work with families. First, they looked to families to see how family members would relate to them and then, reactively, created a relationship with families based on their perceptions of a family. Nurses felt a need to protect themselves for several reasons: (a) nurse-family, peer, and internal conflicts, and (b) the chaotic and unpredictable environment in which they worked.

Visible or not, caring for families may be a lot of work and taxing, and the nurses in the author’s study demonstrated the resulting strain. The context of the environment impacted on their ability to relate to families in therapeutic ways. In order to cope with the situation, these nurses nursed defensively. This pattern did not always agree, however, with some nurses’ individual nursing styles. When some nurses reached out to families, this intervention, at times, led to peer and then subsequent internal conflict. Despite these circumstances, nurses still tried to do the best they could to care for family members of their patients.

Double binds left the nurses feeling vulnerable not only to families and to each other, but to patients from whom they felt time was taken away when they tried to meet the needs of families. Subsequently, nurses felt they were not always delivering safe or quality patient care. In the end, they were left no choice other than to respond defensively in order to protect themselves (and to a degree, their patients).

Walker (1994) stated that caring resists representation because it “resides in the flesh and sinews of nurses” (p. 53). This idea was reinforced by Will (2001) who suggested, “The ‘core’ of nursing is nurses, who we are and what we bring to each and every encounter with other human beings” (p. 114). The search in this author’s study to understand the nature of
the deeply complicated relationships between nurses and families is incorporated in Will and Walker’s ideas. Will further stated: The idea that the essence of nursing resides in our flesh and sinews is a captivating one. It suggests that we must attend in a more mindful way to understanding nurses and their lives, and to exploring, in nursing education, practice, and research, how knowledge acquired in life experience contributes to nursing knowledge (p. 114).

The face of nursing is changing with the introduction and more frequent use of less skilled workers in patient care. This study revealed that the pursuit of nursing’s very ideals, connecting with others in healing and meaningful ways, is at risk of being lost in the chaos of today’s health care system. Furthermore, nurses are becoming fatigued in the wake of this chaos. They are adopting patterns of practice to protect themselves from the chaos that, unfortunately, excludes care of families much of the time.

Those who embrace the concept of family-centred care need to carefully examine how it is implemented in clinical settings. In addition, more and more responsibility is being placed on families in patient care (Grossman & Gottlieb, 1995; Ward-Griffin, 1999) and nurses are in a pivotal position to welcome families in a respectful and non-judgmental way. However, in closing, it seems that patients and families’ needs are usually placed first. Perhaps we need now to prioritize the needs of nurses so that true healing environments can be built for all.

About the author
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