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An introspective study of the influence of death in a nurse-patient relationship

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AN INTROSPECTIVE STUDY
OF THE INFLUENCE OF DEATH IN
A NURSE-PATIENT RELATIONSHIP

by

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Bachelor of Science Degree, New York University, 1958

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First Reader:

Second Reader:

To

Those who supported and assisted me during the writing of this study, and especially, Lillian R. Goodman and Lilyan T. Weymouth.

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Chapter One

INTRODUCTION

Statement of the Problem

In this study the nurse describes an emotional interrelationship with a patient which was intensified by the death of the patient's mother. The nurse's own attitudes and life values were brought closer to her as a result of the experience. In the description of the interaction and concomitant events, the focus is on the need for deeper understanding of self as to meanings in death. Did the limitations set by the nurse's emotional reaction in this situation prevent her from coping with the problem?

Justification of the Problem

The patient referred to is hospitalized in a large mental hospital where the nurse was assigned to field work as part of the requirements in a Master of Science in nursing program. The patient was chosen in order to develop a nurse-patient relationship. Although he was very withdrawn and quite inaccessible to observable contact at the time, the nurse felt that she wanted to initiate a plan for intensive nursing care.

Soon after the nurse started to make regular visits to the patient she discovered that his mother was ill and had not been able to visit for several weeks. At the end of the semester it was reported that the mother had died. However, it was

discovered that her death did not occur until months later. The nurse had been attempting to work out the grief reaction with her patient and the situation became one of extreme frustration when the realness of the death became more perceptible.

Upon the request of an authority figure on the ward, the nurse had told the patient of his mother's death following the original report. She reacted with anger and guilt at this point, when she felt the responsibility for the action. Moreover, following the eventuating circumstances of the mother's actual death, the nurse became submerged with hostility. These feelings were expressed rather covertly in a pattern of withdrawal. She continued to visit the patient throughout the summer; only as a visitor, however. During the last semester of the nursing program some of these feelings were resolved.

The ability of the nurse to empathize with her patient seemed closely related to the level of her ability to cope with the loss of the mother. As he seemed to grow to accept the loss, she became less anxious; consequently, she felt freer to explore the situation. Her feelings and attitudes had been inculcated by the cultural stereotype of death as a sudden end to life, not as an a priori determinant in life. In her experience it had meant a cutting off, as it were, from communication with loved ones at various levels in their existence. Religious and ethical considerations of the living became subordinate to her denial of death and her preoccupation with

guilt as a result of having told the patient of the death of his mother. Reflection enabled the nurse to see that this current experience had reactivated an episode in her own life. While attempting to comfort and support the patient she was working out personal feelings.

The nurse became interested in the problem as she realized the extent of her involvement in it. Attempts to discuss the situation with others only increased her proportion of discomfort. An abysmal gulf was found to exist between the philosophical considerations as compared with the nursing suggestions. It subsequently evolved that an introspective study of death, as experienced in the process of one long-term nurse-patient relationship, would yield elements of personal and professional value; would possibly signify meaning for other nurses.

Scope and Limitations

A nurse practitioner utilizes her own experience in a situation to study one particular dimension of a nurse-patient relationship. Generalizations do not seem practical on the basis of a one-to-one relationship and the intangibles of intra and interpersonal relationships present acknowledged variables. Furthermore, feelings about death cannot be completely resolved; nor can the nuances of this phenomenon be completely explored. An exploration is limited by the self, by one's emotional responses; however, it can indicate the need for further relevent concepts in nursing.

Definition of Terms

The following terms lend meaning to the relationship in its continuum and are, therefore, given the specific definition which the nurse accepted for the purpose of this study.

Introspection:
An observation and analysis of one's feelings and reactions; a look at oneself; a subjective evaluation of one's thoughts involving a span of time.

Hope:
A feeling of desire accompanied by anticipation or expectation; a need to see events moving along positively with a concurrent denial of threat.

Hostility:
Guilt and fear resulting in unfriendly, antagonistic behavior; a moving against others due to one's reaction to death.

Aloneness:
Isolation and avoidance; lack of confidence that others understand one's predicament.

Resolution:
Arrival at a decision; solution to a problem; end of contemplation with renewed ability to participate.

Preview of the Methodology

In exploring the problem of her own involvement in the death of her patient's mother, the nurse devised a plan whereby her own experience could be tested in the light of philosophical reflection and scientific theory. The pertinent nursing literature was a point of departure in the development of her ideas. The findings were then analyzed from the point of view of immediacy, that is, in terms of the meaning of the events as they occurred through an introspective process in which new ideas were substituted. Correlation with the disciplines of philosophy and science became more meaningful as the experience grew. Hence, references to these disciplines are made at the appropriate points in the text of the data.

Using the data accumulated in her diary the nurse arranged the material in four descriptive phases of the relationship. The phases are hope, hostility, aloneness, and resolution; based on her conception of her own emotional development. Selected excerpts from the diary are used to illustrate critical episodes in the designated phases.

Sequence of Presentation

In Chapter Two the frame of reference used in developing the study will be traced. Chapter Three will be a description of the method of approach to the problem and of planning a solution. Chapter Four will be an assemblage of the data in narrative form with excerpts. (As previously mentioned in Preview of Methodology there will be references to pertinent literature in Chapter Four.) Chapter Five will include the summary, conclusions and recommendations.

Chapter Two

THEORETICAL FRAMEWORK OF THE STUDY

Review of Nursing Literature

Nursing literature has run the gamut of the 'shoulds' in describing the approach the nurse uses in dealing with death and grief. It can be noted, though, that the various solutions suggested by nurses follow, somewhat, the curve of thinking that is characteristic of the change from the merely descriptive to the increasingly dynamic.

Despite this more dynamic trend, however, the certainty of death as the ultimate reality in the human condition does not alter the nature of its imperativeness as a problem in nursing.

In 1938 Kasley[1] described the area of giving understanding care and emotional tranquility to the dying patient as the appreciation of *his* mental and emotional needs. More recently Wolff,[2] Norris,[3] Folck and Nie,[4] have written on the necessity of understanding the sociological, philosophical

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[1] Kasley, Virginia, "As Life Ebbs," *The American Journal of Nursing*, 48: 170-173, March 1948 (Reprint).

[2] Wolff, Ilse, "Should The Patient Know The Truth?" *The American Journal of Nursing*, 55: 546-548, May, 1955.

[3] Norris, Catherine, M., "The Nurse And The Dying Patient," *The American Journal of Nursing*, 55: 1214-1217, October, 1955.

[4] Folck, Marilyn and Nie, Phyllis, "Nursing Students Learn to Face Death," *Nursing Outlook*, 7: 510-513, September, 1959.

and emotional aspects which influence a nurse's attitudes and ideas in the care of a dying patient.

Byron[5] discusses the nurse's responsibility to the acutely ill patient who is grief stricken. She suggests that nurses need to explore their own feelings and behavior, in relation to their patients and the people with whom they work, in stress situations.

Among the most thought-provoking articles is a case study written by a student nurse in which she describes her experience with a dying patient. She concludes that the presence and understanding of the nurse helps to assuage the apprehension of the critically ill patient.[6]

A corollary can be drawn between these writings in terms of the loneliness with which nurses are confronted within themselves and with their patients, when the stress of death is met.

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[5] Byron, Edna, "About Barbara Nalley," Nursing Outlook, 7: 482, August, 1959.

[6] Ristau, Ruth, "The Loneliness of Death," The American Journal of Nursing, 58: 1283-1284, September, 1958.

In discussing the nurse as a participant-observer in a nurse-patient relationship, Peplau[7] says:

> "While professional purposes, ethical ideals, technological hypotheses, and a diagnosis of the patient's disease are held to be important to the development of sound nursing practice, nurses--like other human beings--act on the basis of the meaning of the events to them, that is, on the basis of their immediate interpretation of the climate and the performances that transpire in a particular relationship."

Having given much consideration to the subject of stress in her thesis, Weymouth[8] proposes:

> "The encouragement of all nurses to study the sources of stress they freely verbalize: One small item that carries stress would be contagious if shared with the other nurses and the disciplines involved in a particular situation..."

Portnoy[9] found in a nurse-patient relationship that:

> "The difficulties resulting from close relationships with patients have long been recognized by nurses in the traditional warnings against becoming 'involved' with patients. Experience has taught all of us that emotional involvement means commitment and often disappointment and pain. It can be emotionally rewarding and fulfilling, but is often a source of depletion and anguish as well. Yet it is possible that one of the keys to the therapeutic effectiveness of the nurse-

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7 Peplau, Hildegard E., Interpersonal Relations in Nursing, pp. 283-284.

8 Weymouth, Lilyan T., "A Study of Stress in the Head Nurse Role," p. 98. Unpublished Master's thesis, Boston University, Boston: 1952.

9 Portnoy, Frances, "The Nurse and the Patient: An Introspective Study of the Emotions and Behavior of the Nurse," p. 124. Unpublished Master's thesis, Boston University, Boston: 1957.

> patient relationship lies within the
> degree of emotional commitment of the
> nurse to the individual patient."

These latter considerations impel one to speculate on an almost ethereal but weightily important question for nursing: the matter of involvement and ensuing stress. It can be equated with the ponderous words of the child in these lines from A Death In The Family:

> "Sleep, softly smiling, draws me unto her;
> and those receive me, who quietly treat me,
> as one familiar and well-beloved in that home;
> but will not, oh, will not, not now, not ever;
> but will not ever tell me who I am."[10]

The antithetical quality of one person's commitment to another may be an indefinable essence in nursing.

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10 Agee, James, A Death In The Family, p. 8.

Bases of the Hypothesis

In the search for a tool or method of insight into her beliefs about death, following a rather traumatic experience with her patient, the nurse believed that sound evaluation of the ideology of death's phenomenon involved tracing origins of individual ideas in science and art forms. This posed the possibility of an eventually more enlightened attitude on the subject, which could then release her somewhat from the hindrances of extreme grief and fear in subsequent identifications with patients.

Statement of the Hypothesis

Was this nurse-patient experience of value in terms of the intense emotional involvement with its partial resolution?

The nurse believes that it did enable her to gain more understanding; then, through the process of introspection it was possible for her to guide the patient through a difficult period in his existence.

Chapter Three

METHODOLOGY

The nurse and the patient in the context of the ward situation in a large mental hospital constitute the sample in this study. The selection of the patient was a matter of human choice; the patient showed interest in the nurse and this influenced her decision.

When the relationship was established, that is, the patient was informed of the purpose of this particular type of relationship with a nurse, the nurse visited him in the ward for approximately two hours every week during the first semester. The second semester visits were increased to six, and sometimes eight, hours a week. During the summer vacation period, the nurse chose to continue visiting the patient, which she did on visiting day, for about one hour. In the final or third semester the visits averaged two every week, lasting two hours.

The relationship was unstructured in that it was geared to meet the needs of two human beings. Whenever the nurse planned to visit the patient, she informed him in advance. If he seemed unable to tolerate the nurse (as seemed evident on one occasion), she shortened the visit.

A diary was used to record the observations in this nurse-patient relationship. The recording was done immediately

following the visit to the patient. The nurse attempted to design her recordings in a way that would convey feeling as well as activity. In the beginning, she recorded detailed information about the patient in the ward setting; his appearance, affect, speech pattern, activities, and the general environmental background. As the relationship took on more meaning; when the nurse and the patient understood more about each other; and as the emotional effect of the crisis emerged, the nurse began to get more content of her own feelings into the recordings. She found that by recording the conversations between her and the patient that the feeling tones were there in the diary; that they could be recalled and classified for purposes of study. The four phases of emotional feeling that were evoked were thus formulated.

In the analysis of this introspective study involving one patient, the nurse found that her attitude changed according to the demands of the close relationship. With new information arising at random, preconceptions about the format of a final study were often made obsolete. It became clear to the nurse that an hypothesis would evolve with the development of insight into the problem.

The choice of an introspective study of participant-observation in this nurse-patient relationship was made in order to:

1. Formulate a problem:
   The nurse did not know what was going to happen; the exact nature of the problem was not in awareness.

2. Develop an hypothesis:
   More material is needed on the subject of nurse involvement in nurse-patient relationships; an experience much as this evoked an hypothesis.

3. Derive value for herself and possibly for nursing:
   This was part of a larger learning experience and it was a discovery for the nurse; the undetermined problem converged into a central idea or focus.

Chapter Four

PROLOGUE

The events leading to my choice of a patient in the nurse-patient relationship indicate to me how indecisive I was about launching into an experience which would pose personal threats. Choice of a woman or a man patient would depend upon how I felt about the original meeting with the person. I would be meeting my own needs first of all. My own feelings were carefully considered in assuming responsibility for the care of a 'chronically' ill schizophrenic patient.

Ultimately, the patient chose me. I was easily swayed when the patient by whom I was seated, asked me where I was from. The interest he demonstrated relieved me of the responsibility of attempting a relationship which might not have reciprocal meaning. I was sitting in the day room that afternoon and had just finished playing ping pong with one of the men. During the game there had been sexual overtures from other patients to which I had had difficulty in responding. We had sat down on a bench where Mort was. He took this opportunity to open up the relationship in an unpredictable manner by saying, "Where are you from?"

I decided that the problem of 'finding a patient' had been solved. But I waited another week before I definitely

decided to initiate plans and announce them to Mort. Another nurse had suggested a patient for me on one of the other wards in the same building. After all, patients are usually assigned to nurses and I felt somewhat obligated to the other patient and the nurse. As I thought it over, however, I felt comfortable in my choice of Mort; even if he had precipitated the arrangement.

The following week I told Mort I wanted to visit him regularly after having explained my status and purpose as a student nurse doing field work. His reply was, "I don't care." Realizing his difficulty in making a decision, but also recognizing no particular resistance in the response, I accepted it as affirmation and acceptance.

It is apparent to me that in avoiding the overtly seductive male patients I took refuge in Mort, a patient who was devoid of affect and almost mute. Perhaps I could be the mother to the patient who would not demand much from me.

On the subsequent visits I learned that Mort was frequently incontinent, never brushed his teeth, and usually spilled food on the front of his clothing while eating. These things provided me with opportunities for planning care. They made me feel comfortable in that I could assume a useful and familiar role.

One day when I entered the day room, Mort was playing ping pong with another patient. The latter had always expressed much concern for me and consequently drew attention to himself. The two patients acknowledged me as I approached them and Mort's companion asked me if I wanted to play with Mort. Mort then repeated the question to me and so it was arranged for the first time that we related in a social medium. Our relationship was gaining impetus through the efforts of another patient. The ping pong game with Mort was non-competitive and rather leisurely. He hit the ball mildly with a stiff posture, missing the ball frequently because his stance was inflexible and his feet remained fixed.

Other activities to which Mort was less amenable, whenever I suggested them, were movies and walks. He was quite adamant in his refusal. One day he showed me the library door. Thinking that he wanted to go in there, I unlocked the door and stepped in. He followed rather slowly, hesitantly. When I asked him to sit down, he seemed very frightened, then sullen and unresponsive. He was finding it very hard to get close to me. I recalled that the games we had played in the day room had been quite congenial and relaxing, that other people had always been with us. When I realized what I had done by imposing this intimacy upon him, I felt uncomfortable too.

Gradually I was seeing my own feelings being evoked by Mort's responses and behavior. The unbrushed teeth and untidiness were being replaced in importance by my own need to understand more about my reactions. It had become apparent that Mort would do something about his appearance if he were motivated. A few praiseful remarks had already brought about a change in his physical appearance. By now I was concentrating on the deeper meanings in the relationship.

It was the end of November when some of the staff members started discussing Mort's mother's illness. Mort never mentioned his mother and did not contribute anything when her name was brought up. According to comments from other patients' visitors (who knew Mort and his mother) and reports from the ward staff, the mother was chronically ill. I hoped she would return to him soon.

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The nurse considers it a privilege to address patients by their first names. In the clinical content of this study she uses the first name basis only to convey, in words, the intimacy of the relationship. She refers to herself in the first person.

HOPE

The focus on Mort's sick mother seemed to bring him more attention, or was it the presence of the new nurse which caused others to look upon him differently? Certainly ill health can open up new vistas for us all. With Mort it was the building supervisor's* offer of a job, sweeping the library floor, which he accepted and performed obediently for a short time. It was also the additional contacts with people, who for the purposes of offering sympathy and encouragement, were developing different kinds of speaking relationships with him. His fellow patients looked at him curiously and were unable to put thoughts into words. I observed Mort and thought about his mother.

Communications were sketchy. The image of the mother largely took the form of fantasy. The known facts that I culled included: "She's small and wiry--she brings him food and crams it into him"; "she's all he has, poor thing." Quite a fantasy was built on this foundation. But, no matter how bad a mother, I thought, she must come back soon. In dealing with Mort I never failed to ask, in some fashion, about his mother. The following is an example:

* References to supervisor, except for this and similar instances, will apply to the nurse who supervised this nurse-patient relationship.

THE EVENT

Patient's Response	Nurse's Response
Mort was sitting in the day room.	I came to visit. He responded when I greeted him.
	I had learned in an interview with the building supervisor that there was no news of Mort's mother. The supervisor had spoken anxiously and seemed to feel guilty for not having a more complete report on the situation. She said she was going to 'look into the situation' to see if the mother remained ill or had died.
	After sitting quietly for a few minutes I suggested playing ping pong.
"All right."	
	As we walked across the room I asked Mort if he'd heard from his mother lately.
"No, no news from home." He walked decisively with me to the table and we started to play. He hit the ball harder than usual.	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I feel the need to know if Mort's mother is coming soon. I want her to share the responsibility for Mort. I think I can handle the situation temporarily, however. I have not sought supervision in our relationship.	My own needs restricted the awareness that Mort was probably resenting my concern for his mother.
I think Mort is a bit more outgoing. I am anxious because he is unable to talk and let me know if I am helping.	There was a strong identification with a past experience with death. It seemed that this death must be avoided, if possible. The need was to fend off repressed feelings that were always aroused in me in connection with chronic illness.

The Christmas season was approaching. I wondered if I should give Mort a gift. Although I wanted to, I thought he might not accept it. Previously I had always looked upon the Christian holidays as opportunities to demonstrate affection and compassion to everyone. Yet in this situation I felt cautious and preoccupied. I wanted to discuss a gift with Mort's mother, whom I knew intuitively, I could not see. The idea of visiting her never developed--it would have been traumatic to me if it had, I think.

When one of my classmates suggested making candy for all the patients on the two wards that we visited, it seemed to be a perfect solution to the gift problem. An anonymous, token gift could be handed to Mort. A more appropriate gift would have been a pair of warm gloves or a scarf; the overt giving of a gift would have forced me into a commitment for which I was unprepared, however.

The following week when I visited, Mort seemed less friendly. He looked comfortable to me. Yet as I sat next to him I felt like an intruder into a strange world. Some of the other patients were stretched out, napping on the park-like benches, taking advantage of the additional space left due to the absence of patients out on activities. The room was quiet; when I spoke to Mort and received an apathetic answer, I suddenly felt the urge to get him out of there. He followed me to the lounge obediently but unenthusiastically.

Although the pressure was off me, Mort did not seem very happy at being uprooted from his fantasy. As the recreational director announced 'movies', I said rather carelessly: "Do you want to go?" I received the same reply from Mort. Then, I made the decision more firm, saying: "Yes, let's go." Mort excused himself to go to the bathroom then hurried back to accompany me to the basement recreation area. As we sat close together on the hard seats in the stuffy room viewing the movie, I realized that he was growing up; he was no longer incontinent.

Mort and I had never been outside the building. It had occurred to me that going for a walk would be a refreshing change from the ward environment; yet, I had ambivalent feelings about this. Being self-directed could mean becoming bogged down in routines _or_ it could involve attempting innovations where the ends could not be envisaged. Mort was unable to decide his course of action; in some ways I had strengthened his repetitive pattern of responses through my own need to depend upon an authority for direction. However, one day I went to Mort with the firm suggestion: "I'm going to find a coat for you to wear so we can go for a walk." He made no protest. The arrangements were made with the building supervisor and the head nurse. (Mort apparently had not been out since summer.) A coat was selected for him. He seemed eager to get it on; its shabbiness seemed not to affect him.

I grabbed my coat and as we started for the door, he said: "I don't know where to go." Realizing what a drastic step this must be for Mort, I tried to reassure him: "We won't walk too far; I know the way; we won't get lost." He seemed to enjoy the short walk on cold, crunchy ground covered with snow. When we arrived back in the building he handed me the borrowed coat, saying: "Thank you."

When movies were announced that day it was Mort who suggested to me: "Are you going to the movies?" I answered: "I'd like to go with you."

This was the last visit before the Christmas vacation and I told Mort it would be two weeks before I would come again. He looked straight ahead and did not reply. Telling him I would not be back for more than the usual length of time made me feel uneasy. Separations were often difficult for me, since they represented different kinds of loss. I felt, at the time, that I was neglecting Mort. It was uncertain, however, who was bothered more by this interruption in the relationship.

When I returned to the ward after the vacation, I found it cold and empty. Mort was discovered in the library, hunched forward in his coat. Someone had broken the porch door and plans for repair were in process. I spoke to all the patients--Mort looked up but did not speak. When I

centered my attention on him, he remained quiet. We went to the lounge to sit and talk. My eagerness for some kind of recognition was unrewarded. I asked if he had had any visitors, if he had been out walking. He replied monotonously: "No, I never have visitors" and "No, I don't go out;" then added: "It's wintertime." I offered him a package of lifesavers; he took one and handed the package back. Another patient, passing by, asked for one and took the package. Mort and I played Dominoes for a while. Although it had always seemed to be a very childish game, it was a refuge today. We were both bored after a while and the oblong, black, wooden pieces were replaced in the box. Eventually Mort turned, looked at me, and said: "You should have a jacket on--it's cold around here." While saying goodbye, later, Mort extended his hand. This indicated to me that the child was quite grown up and that perhaps I should grow too. I needed reinforcement.

For the remainder of the first semester I continued to feel more positive about my role. I thought there was a change in Mort in that he showed more aggressiveness at times. This made it easier for me to accept the fact that his mother was critically ill; perhaps Mort could continue to grow so that he would not need a mother.

Activities with Mort now included the competitiveness of Checkers. I became less anxious about the long silences

when we sat together. What Mort said was attended to more carefully. The tone of his voice in "It's cold outside" repeated frequently, told me that he was not too interested in changing his comfortable pattern of existence. Going for a walk meant venturing into the unknown. For the time being I felt comfortable indoors. It was very cold. It did not bother me to tell him that I would be away for two weeks at intersession. I needed the time to contemplate changes.

HOSTILITY

The first day of the new semester the building supervisor asked me how I felt about telling Mort that his mother had died. The message had been communicated by telephone during my absence; she and the doctor had decided to wait until my return to decide to tell Mort. Three weeks had elapsed since the death. I had a compulsion to tell Mort immediately. The anticipation of the past weeks suddenly materialized into a reality which created considerable guilt in me.

I went to the ward, greeted Mort, and sat down beside him. When another patient asked me to play ping pong, I welcomed the opportunity to delay the task of telling Mort. After asking Mort if he would excuse me, I played the game for a few minutes. Then I went over to Mort and asked him to go for a walk with me...

THE EVENT

Patient's Response	Nurse's Response
Mort put his coat on. He had no hat or gloves but said nothing.	As we walked down the street I thought of what I would say to him. Finally: "Have you heard anything from home lately?"
"No."	"Well, I did this afternoon, Mort; Mrs. A. told me that your mother is dead."
Looked straight ahead. Tears came to his eyes--he made no move to wipe them away.	
	"Mort, Dr. Z. and Mrs. A. asked me to tell you because I have a closer relationship with you than they do."
He said in his usual tone: "No, she's sick but getting better--she didn't come because it's cold."	
	"I'm telling you the truth, Mort."
He was willing to stop at the snack bar but was noncommittal. He used the tissues I offered; putting the used pieces in his pocket.	
	"This is hard for you to accept...I will continue to visit you, Mort; I hope I can help."
	Back in the building I asked if he was going to the movie.
"Yes." He excused himself to go to the bathroom and returned hurriedly.	
	I went with him to the stairway. I explained that I would return the following week.
He looked up alertly and said: "All right, goodbye."	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I can't tell him comfortably, any place; yet, I need to take him away from the building; it will be more confidential.	It was like trying to run away from a situation. Finally the mother no longer loomed as a threat to my independent planning for Mort. I had more responsibility for him and I did not want to accept it.
Now I need to act more independently in the interest of Mort. There is no one to replace his mother.	
	I was angry at Mort because I thought he denied the death. I did not know where to turn and was angry at <u>all</u> authority figures; I felt that they had not supported me, had not helped me withstand stress.
	I felt stuck with an insurmountable problem and a mute patient.
I feel very sad and guilty.	Death left me with a feeling of incompleteness, hopelessness.

Mort was hunched up in his coat when I walked into the day room. I thought he looked forlorn, sitting there. The feelings of guilt and sadness settled down upon me. I had decided that I must work through some of my feelings. My own discomfort demanded an outlet, could not be relieved anywhere else at the moment.

I asked him how he was and expressed the hope that he had found it easier to think about the loss of his mother. He responded with the same words of denial he had used that day I had told him his mother was dead. This was extremely frustrating to me. My own desire to talk about this problem overshadowed the recognition of his denial, based on his regressed condition and the symbiotic relationship he had experienced with his mother. My will to action was diametrically opposed to his resistance.

I tried to lay my own feelings aside by concentrating on ways to divert Mort's attention into social channels. Other patients, who were interested in the relationship, presented constant possibilities for setting up new situations. As other patients took a look at what was going on, I drew them into conversations or included them in games. Mort was always consulted and he always complied. He could not initiate plans nor could he disagree with them. For me it was a rather superficial game we were playing. It proved to be an unsatisfactory solution to the denial of feelings.

I asked the head nurse if she would mention something about the death to Mort because it was evident to me that he might think I was lying to him. No one else in the environment was acknowledging it verbally. I wanted the head nurse's cooperation in sharing responsibility for supporting Mort. If only people would talk to him about it, I would feel more comfortable, less guilty. Although the head nurse listened sympathetically, I thought she did not understand my dilemma. It seemed difficult to think and act simultaneously in a situation where the guilt that I felt appeared inappropriate (as I saw it) in the eyes of the others.

I was not able to come back for a week because I was ill. During this time I was becoming aware of even more anger and it was being directed at the entire ward staff. I noticed this after attending a ward meeting upon my return to the ward...

THE EVENT

Nurse's Response	Staff Member's Response
I was annoyed when I noticed another nurse flicking ashes from her cigarette onto the floor and wondered why ash trays were not provided.	The conversation in this meeting flowed mainly between the head nurse and the doctor, although there were students and attendants present. Some of them stood because of limited space. They talked in general terms about the ward.
I asked the group if they had noticed any change in Mort since he had been told of his mother's death.	An attendant admitted he did not know Mort's mother had died.
	The head nurse said that Mort denied it when she had offered a sympathetic comment.
I said that I felt guilty after telling Mort and thought they should mention acknowledgement to him in order to make it seem more valid. I added that as an outside agent I did not feel it was appropriate for me to do this alone; Mort had not attended the funeral; it might be realistically difficult for him to accept the death.	
	The doctor said that he felt it was sufficient that Mort had been told and that the head nurse had spoken to him about it. Also, he added that a certain amount of denial is always expressed by the majority of people when a death occurs in a family. Mort as a psychotic patient could be expected to react in a certain childish way; his behavior could be considered appropriate. In time, he pointed out, Mort will probably accept it.
I mentioned the kind of communication I have offered Mort, such as, "It has been difficult since your mother died; how do you feel about it now?"	He agreed that this type of reinforcement of the truth would be of value to Mort.

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I feel angry at everyone; why did I accept this responsibility? I did not really want to? Now it is my problem and I feel no one can help.	I was not really too concerned about what I had done to Mort. I was too concerned about my own intense feelings. The mother's death was a relief in one way; I might be able to replace her and try to improve an emotional experience for Mort.
What is this doing to Mort?	But I felt guilty over her death. Actually I used this situation to test my attitudes toward another death which I felt was unnecessary. I had retained the hostility I had felt toward the 'causative factors' in it.
	Any authorities in this new situation would become the focus of my hostile impulses, and my own action served my need to express guilt.
	I was too emotionally involved at the time to ask key people for support.
If I could interest the personnel in talking about my problem perhaps we could share it and I could expend more energy on the present and future instead of dwelling on an accomplished fact.	My moral principles entered into the situation. I needed to discover how the guilt and fear, in which I was enmeshed, were related to what I really believed about death.
I wonder what Mort thinks--maybe he doesn't believe me.	
What is to become of this relationship?	

I became more silent; I started looking around at the external factors in order to attempt a better understanding of Mort. Mort's record might be a source of helpful information...I went to the library and read it. Afterwards it seemed that I had not learned anything new; there were no clues to steps in the task ahead. The didactic information included the fact of twelve years of hospitalization. Perhaps it would be better to focus upon a day to day existence with Mort, to develop a more realistic attitude toward a therapeutic end. Actually I was parrying the point of whether I needed supervision; and, underlying this, could I accept it? I was approaching the end of my resources and finally I welcomed the opportunity to ask for help.

My supervisor listened carefully as I elaborated on my relationship with Mort. The particular emphasis was on the episode of the death. She reinforced the doctor's belief that Mort would accept the death, in time, on a conscious level. In addition, she thought that Mort might become freer as a result of the undeniable fact that the maternal bond had been broken. Then he could probably begin to branch out socially. She suggested using the opportunity to help Mort develop contacts with patients and others. In concluding, that day, her feeling was that my experience, traumatic as it had been, might be an advantageous element. But it was very difficult at that time for me to believe that anyone could empathize

with my feelings.

Mort remained consistently impassive. He conveyed interest and alertness when I visited. I thought I could detect this much in him, as he looked about selectively with his all-seeing and luminous eyes. Occasionally he was able to express some interest in me as a person by remarking, with some feeling: "You are early today." Usually, however, our conversations were devoid of reaction. There were some statements to which he could not reply. Questions that would require him to evaluate himself, for example, "What do you think of this" or "Why do you do that?" elicited very little. If I commented that an attendant was kind or friendly, his contribution might extend to: "He is an attendant."

I looked casually around the ward situation to seek some solution for the external cause of his isolation. When I watched the patients file into the cafeteria for meals, I noticed that Mort invariably stood at the end of the line. He was one of the first to complete a meal; he never talked or looked around when he ate. In trying to work out a method of social interaction for Mort I found myself becoming involved and interested in the activities of other patients. By becoming a member of groups I had opportunities to view him from a different perspective. If he was engaged in

activity when I arrived on the ward, I did not seek him out nor did I purposely reject him. When I participated in group activities, I did so only if he could be included (if he were free to do so). The relationships which I developed with other patients in this way gave me a better look at my own behavior. Having become so emotionally involved with Mort had blocked my view of our interpersonal process. I was rejecting him in what I considered an acceptable manner. Although my visits were more frequent, the focus of them on Mort was less.

I would get to the ward by nine in the morning, while the patients were involved in their household or personal chores. As they returned to the day room, where I sat waiting, they greeted me individually. This activity aroused a lot of feeling among the men. Only one patient could tell me directly that I had no right to impose myself and my feminine activities on them--they who had been deprived of normal and important sexual expression for years. Although my insistence on attention was yielding results, I realized then, that favorable interaction is a reciprocal process; that in commiting myself I should be prepared to meet the needs that were consequently expressed.

I was sitting with Mort in the lounge in the afternoon of the day when this particular reaction had been most obvious. A patient rushed over, saying: "Yes, it was you!

I saw you out walking." I smiled and spoke. He continued to talk then broke off suddenly, saying embarrassedly: "Why pick on me to talk to?" I said: "I think friendliness is a good thing..." Then he stomped out of the room. Another patient interpreted it this way--"Sometimes people can't take it when you are nice to them. I think he knows he made a mistake."

I was offering friendship and love in a superficial manner to gain something for myself, and the responses from the patients told me that I was being insincere.

When I was ready to leave, I told Mort the day of our next visit. He said: "You don't bother me." I felt reassured. But when I discussed this with my supervisor she indicated the possibility that Mort was protecting himself from closeness.

In my continued search for a clearer understanding of my relationship with Mort, I seized upon every opportunity to peruse the problem. The head nurse told me that Mort would not take pills; his medicine had to be put in solution. And, he would take the solution only with persuasion. He had become angry and combative once when a nurse attempted to substitute a hypodermic for the oral medicine. Since then, there had been reluctance to offer him any kind of medication.

I found that Mort became adamantly negative when any attempt was made to force physical attention on him. Sometimes he refused to take a shower. One of the attendants

told me that it was often necessary to lift him into the shower, and also, to shave him. He never brushed his teeth, either, it had been consistently reported. A dentist had told him, when he was fourteen, that he need not come back for treatment. This was interpreted, by Mort, as meaning that no further attention need be paid to teeth. The order given by the dentist had been followed by the inability to will any other action. Mr. F., the attendant, said: "It's a wonder you have any teeth, Mort." But remarks like this apparently did little to change Mort's opinion. His sculptored facade did not change, either, as he reiterated the challenge, "I don't need to brush my teeth."

The difficulties encountered in offering physical care to Mort were indicative of his inability to feel emotionally. Yet I could not grasp the implications at the time. He was, however, developing some ability to show interest and warmth. Occasionally he put some of his thoughts into words and was able to make such an overture as, "Did you get home all right yesterday?" He also asked me if the suit I wore belonged to me. But I was concentrating on his poverty and could not see his newly acquired ability to communicate curiosity. He was obviously accepting our close relationship and was developing more social skill.

In my supervisory conferences my main theme was the anxiety about the death. I was showing a lot of anger. All of the more superficial elements of discussion were inevitably channeled into my own inability to face the fact of the death. The following excerpt is an illustration:

T H E E V E N T	
Nurse's Response	Supervisor's Response
I had been discussing Mort's general condition...	
"He won't brush his teeth or shower, voluntarily. Bathing before other men may be embarrassing or threatening to him. I can't discover why he won't brush his teeth."	
	"I should think some arrangement could be made, whereby he could bathe in more private surroundings--even if it means taking him to another building."
"And--he still denies his mother's death--he told me that another patient's visitor said his mother would be back in warm weather. I'm checking with the staff as to the validity of this."	
	"Yes, he may be getting this from a friend of his mother who can't talk about death."
"Or, she--if it's true, may not know he's been told."	

THE INTROSPECTIVE PROCESS	
Immediate Reaction	Continuing Reflections
I'm trying to view the total situation. Two months ago I was not concerned about the physical aspects so much. I thought they would rectify themselves, as more basic needs were met. Now I've reverted to them in order to accomplish something.	I was searching for basic answers for myself. It was less of an effort, at that time, to emphasize the observable facts; the abstractions were on-going and less impressionable at any given time.
This is a very disturbing element; how can I ever ferret out the truth?	I did not make any attempt to check the 'truth' of anything then. It had to be thought through, over a period of time.

I found myself drifting back to a stricter one-to-one relationship with Mort. The doubtful element introduced by the visitor, who indicated Mort's mother was not dead, caused me to discuss it again with him...

THE EVENT

Patient's Response	Nurse's Response
	I entered the day room at two in the afternoon after attending a meeting.
"Hello, I didn't know you were coming."	I mentioned the meeting but did not explain it. Then I said: "Would you like to come outside to talk? It's so noisy here with the radio on."
Same.	"Let's go into the corridor."
"All right." He got up and followed me.	We sat on a bench.
He looked straight ahead at the opposite wall--his arms folded.	I turned to face him..."We haven't sat out here in a long time...you know I come to the hospital to see you; even though I do talk to other patients."
"You don't bother me."	"I'm visiting you as a nurse, and as a friend. I want to help you. Do you feel that it is helpful to talk to me?"
"I can't think of anything to say."	"Things have happened since I started coming to see you last fall...Your mother died..."
"No, she's not dead; she'll come later."	"Do you think I've lied to you about this?"
"Who told you to tell me?"	"Mrs. A. and Dr. Z."
"I don't know." He lifted his arms slowly, despairingly.	"Is someone telling you she is alive?"
He mentioned two women visitors.	"They do not know about her death..."
"I don't know." (first evidence of doubt.)	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I should have told Mort more about what I had been doing today; he apparently knew I was in the building for some time, before coming to visit him.	I was not utilizing the time, I did spend with Mort, to the best advantage. I felt uncomfortable with this thought. Meeting with him was a reminder of my seeming lack of accomplishment.
I recall some previous greetings from Mort, that have been more indicative of positive feelings. Days like this are discouraging.	I was very unhappy; Mort must have been affected by my lack of enthusiasm.
This could have forced Mort into a protective attitude; my low tone of voice could not have been very inspiring.	I was looking for reassurance.
I'm trying to help him accept a controversial issue (he has heard two versions); yet, I know he is psychologically unable to reason this thing out.	My frustration was increasing.

Following discussions like this one with Mort aroused more feelings within me. I assumed a protective and maternal responsibility, camouflaging an attitude of hostility.

We were sitting in the corridor one visiting day as a visitor joined us. She spoke to Mort, whom she knew, and asked me who I was. Armed with the fact that I was a nurse-visitor she poured out feelings about her family and ill son with much animation. Then, realizing that she was doing all the talking, she looked at Mort and asked about his mother. He said she'd be back soon. Compulsively, I said: "Mrs. T. has died." I had ignored Mort's comment. The visitor said, with distress, "Oh, she had a bad heart." Mort, meanwhile, was repeating his statement that she'd be back. The visitor was, by now, directing all of her conversation to me. She said that Mort looked well and she asked me about his condition. I referred her to Mort for an answer. He responded evasively.

After the visitor had left us I felt apologetic toward Mort and excused my behavior by saying that the visitor apparently had not heard of the death of his mother. He remained silent. Walking back toward the day room we discussed possible activity. I thought we needed diversion after the thought-provoking incident with the visitor and suggested a game of ping pong. Mort declined. He said that he played Casino only; probably, in order to show me that he could make decisions, too. He knew I couldn't play Casino well, since

I had asked him to teach me the previous week. If I wanted to play, that day, it would be on his terms. I accepted. I was angry at Mort and unable to discuss it with him. The anger could be acted out only in a competitive game. Playing the mother role was merely to emphasize to myself that the real mother was dead. At the same time her death represented a conflict to me.

The ward meeting was going to be held the next morning. I went to the ward and Mort greeted me enthusiastically. The other patients were moving the furniture in preparation for the meeting with the doctor. I sat down beside Mort, feeling rather unsure of my position. I asked him if he wanted me to stay. His reply was the standard "You don't bother me." We sat quietly and waited. When the meeting finally started, the patients were unresponsive. They had been told to speak on 'general topics' and not 'personal problems'. Mort suddenly spoke up saying: "How much longer do I have to take liquids three times a day?" The other patients laughed at this. The doctor asked him to repeat the question; when it was repeated, the doctor did not answer him. The silence continued for a while, followed by a few references to ward activities. The meeting was called to a close; the doctor and head nurse arose to go to the office. I asked Mort if he wanted me to make an appointment for him with the doctor. He did not reply. Since I had decided that I wanted to meet with the doctor, I stood up and faced Mort.

THE EVENT

Doctor's Response	Nurse's Response
	I excused myself; told Mort I was going to meet with the doctor and head nurse. I walked into the office and sat down with them.
The doctor was saying that he wished patients could speak up at the meetings and asked nursing personnel to encourage them.	
	I said: "Mort asked you a question and received no answer."
He said he had not understood the question Mort had posed during the meeting.	
	I told him it concerned Mort's medication. I added that Mort rarely spoke spontaneously; that the limitations as to content of material to be discussed put a serious limit on communication with such a withdrawn patient.
He said that there were disadvantages to group meetings.	
	I continued my onslaught by adding that patients must become very discouraged having to wait so long for meetings to get under way. (The doctor had been twenty-five minutes late.)
No response.	
	As meeting came to a close, the head nurse asked the doctor if he would speak to Mort.
He stopped to see Mort, briefly, as he passed through the day room on his way out.	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
My maternal feelings toward Mort forced me to take issue with the doctor for not fulfilling Mort's request.	I took this opportunity to air my feelings about the doctor's authority. If I had not felt the need to conform, perhaps I could have sought the help I needed, at that time.
The doctor is very anxious, too. He needs support also.	
A rare opportunity has been missed; the doctor's evaluation of Mort's question would perhaps help me in seeking a course of action.	
	The guilt I felt was out of proportion with the event; I should have been able to express an opinion in the interest of patient care with much more ease. Yet, I used a nursing problem to sponsor my own emotional needs.
The doctor was not responding to me because I was acting unreasonably. He had an enormous patient responsibility, and I was well aware of it.	
	I had made him become defensive, particularly as the head nurse had chosen to use the opportunity to make another request of him (to see my patient).
	I wanted to bring others, in the ward situation, in to protect my relationship with Mort; but I was too hostile to do this effectively.

Later when I saw the doctor in the building supervisor's office I asked him for an appointment. He asked me to leave a note with dates and time I was available. He also wanted to know what I wished to talk about. I thought he was telling me he was too busy to take up the topic he had chosen to ignore in the previous discussion. Although I did meet with him I was unable to discuss the resentment I had felt since February, when he had shifted the responsibility for telling Mort about his mother's death. We talked about Mort as a group member, and no new elements were brought up. It was rather pleasant conversation which never got beyond the brink of common knowledge. The doctor and I were reacting to our own resistances. He had set the limits when he agreed to give me an appointment and I did not have the courage to break through them.

Spring was coming. The patients were getting out of the building more often and life was burgeoning once more. Mort went on several field trips; also, he was invited to join a soft ball team that was being formed. Frequently, when I went to the hospital he would be participating in outdoor games or walking on the grounds. When he returned to the ward and found me waiting, he would become apologetic and say: "I told them Miss P. was coming." Although he was powerless to change the direction of his life, there were indications, such as this one, that he was ambivalent in its regard. Staying to wait for

me was less compelling than his words implied. I wondered about my ability to control any appreciable changes that might occur in our relationship. When Mort showed any tendency to develop, I withdrew into a more superficial sphere of attention--often with the focus on physical aspects of his care. The situation often took on the characteristics of a stalemate.

One day in mid-April I told Mort I would be visiting him on Saturday that week. I had not done this previously, but my school schedule had necessitated this change. He took an active part in discussing this with me. It was a two-party arrangement this time. The following illustrates Mort's volubility when the situation had motivated him:

THE EVENT

Patient's Response	Nurse's Response
	"I can't come on Friday; I have to work on a school project. I will be here Saturday morning."
"I go to services on Friday."	"Yes, I know you do."
"I never do anything on Saturday."	"You don't want me to come on Saturday?"
Same.	"I want to come to see you."
Same plus: "You don't bother me."	"I will be here Saturday morning."
"Are you going home now?"	"I'm going to class, then home." I smiled.
"Goodbye." He smiled.	
******	******
	Saturday morning I arrived at ten-thirty.
He leaned forward, but did not seem enthusiastic. He said: "Hello."	"Hello." I smiled. "Can't we move over there so we can sit together?" I glanced over at seats on the other side of the room.
As we walked over there he said: "It's Saturday."	"Yes."
"This morning I ate a bag of matzos."	"Oh, it is holiday time."
Same.	An attendant sitting near us asked: "Is he supposed to eat today?" I looked curiously at Mort, asking him: "When do you fast?"
Same response, then he added: "Passover ends April 28th."	Not knowing how to instruct Mort regarding Passover, and yet, believing that matzos would be approved, I said: "I will bring more matzos."
Silence for about five minutes then: "What would you do?"	"What do you mean?"

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
Mort wants me to know he attends religious services.	He was saying that Friday services are the beginning of his Sabbath. He expected me to know this.
	When he said he did nothing on Saturday he was emphasizing his orthodoxy. My response indicated that I did not fully recognize the importance of his religion.
He does not continue to reject me. His response, "You don't bother me" tells me that visiting on Saturday is no problem.	I was forcing him into submission, as his mother had probably done all his life.
Is he testing me to see if he can trust me when he asks if I'm going home?	It was very important to explain my activities to him. He reflected on these things more than I did. I'd been too busy thinking about the ultimate value of this relationship.

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Immediate Reaction	Continuing Reflections
He feels uncomfortable with me here today. There are fewer activities on Saturdays. Other patients are eager to know why I am here.	He was conscientiously observing his Sabbath and, he was not used to visitors.
He thinks he has eaten during a fasting period.	His mother had, undoubtedly, always been available for direction during holidays. He expected more from me. I had set myself up as the mother on a few occasions--and now, I was failing in an important area: feeding.
He is very concerned and, able to verbalize it.	
Mr. F. expects me to know about religious needs.	
Mort keeps asking for advice, then intimates that he really knows the holiday dates. He wants confirmation.	
	I felt compelled to give him something (matzos) because I felt that I had failed in being supportive.

T H E   E V E N T

Patient's Response	Nurse's Response
"If you'd eaten a bag of matzos..."	"I'd probably feel uncomfortable and might refuse to eat lunch." I knew he had refused breakfast.
"I'm not taking medicines." He said this with determination, then he added: "Do you know when Passover starts?	
	"I will find out before I leave, Mort."
He sat still when lunch was announced; then, he finally noted: "H. has not gone into the cafeteria."	
	I was unsuccessful in gaining information about Passover. I asked the charge attendant if he would check. However, I accepted Mort's decision not to eat.
	I told the charge attendant that Mort was not going to eat because of uncertainty about the fasting period. I also told him that Mort was apparently being guided by the activities of another patient; that he might, eventually, work the problem out for himself.
	Mr. F. said: "Oh, H. has gone into the cafeteria."
Mort walked toward the cafeteria readily, when he heard Mr. F's remark. Then, he stopped slowly, saying to me: "Are you going home?"	
	"Yes, I'm going there now. I have no classes on Saturday."
"Goodbye," he said: "You'll be here Monday?"	
	"Yes, I am coming Monday; good-bye." I smiled and left.

T H E I N T R O S P E C T I V E P R O C E S S	
Immediate Reaction	Continuing Reflections
I am concerned about the physical feeling of a bag of matzos.	It was easier than delving into the deeper meaning of my lack of control in the face of Mort's conflict. At best he could not make a simple decision.
He is deciding one thing-- he is refusing medicines.	This was the beginning of firm conviction.
I should know when Passover starts.	I should have been able to get the information. I was responsible to Mort; he had asked me, but, I depended upon others and never did get a valid report. I was reacting to the earlier experience of feeling like a scapegoat, by refusing to become one.
Mort has resorted to the authority of another patient.	
He seems anxious for me to go home; I wonder what is happening?	This was an important point in the relationship. It was clear that Mort had a definite need for support, yet, I could not act in accordance with it. I was hampered by my own feelings again.

On Monday I brought the matzos but left them in the office on the way to the ward. As I approached Mort, our eyes met. He said: "Hello, you're early." We sat together on a bench for a few silent minutes. Another patient was lying down on the other side of me on the bench. (He had moved there after I sat down.) He kept inching his way closer to me, so that his head was touching me. I moved away. I asked Mort to move over so that the other patient would have more room. But the man kept moving closer. I tried to ignore it but finally it was too much and I said to Mort: "I brought the matzos; they are in the office; let's go and get them." He agreed. I felt as though something had been left unsaid as I glanced down at the patient lying on the bench. "Must not he realize that I am staying very close to Mort?" As I walked away I also had the feeling that he yearned for some of this attention for himself.

When I handed the matzos to Mort he asked: "Do you know when Passover is?" Previously he had asked about the beginning and the end, now the question was less time-oriented. He seemed to be seeking information about my interest in his religion. "It starts Wednesday at sundown," I answered. I asked him, then, if the attendant had told him. His reply was: "He said it was this week." It occurred to me that my circuitous questioning on Saturday had not inspired the staff to investigate the Jewish patients' religious needs. (In reality,

Mort was behaving in his usual way: by conforming to the rationale of his distorted intellect. The other Jewish patients were seemingly unaffected by this lack of knowledge on the part of the ward staff. They had been to the services Friday afternoon with Mort. Mort's problem was an individual one based on the lack of firm, strong direction during this festival of ethnic importance. He was asking for the help his mother had always given without question. It was a crucial situation for him without her.)

He wanted to know when he should eat the matzos. I said: "Whenever you like; why not eat some with your lunch; perhaps you can keep the box in the office." He murmured without expressing the idea. I hoped that I had conveyed the idea that he should keep some in reserve; not eat them all at once.

The next day when I saw Mort he was reading the financial page of the previous day's newspaper. He said: "What does this mean?" pointing to an obvious typographical error in figures which distorted the meaning of the statement considerably. The patient sitting next to Mort broke in with: "I told you--it's a misprint." But Mort repeated the question. He could not accept a simple answer; it would mean accepting a decision he had made, and this was too threatening. This seemed similar to his inability to decide whether or not to eat at Passover; a decision would, perhaps, indicate acceptance of his mother's death. If he allowed himself to make a deci-

sion without her guidance it would be much too frightening, a new experience.

Disposing of the old newspaper was difficult, also, for Mort. He would ask: "What shall I do with it?" When I said: "Throw it away," and added, "Where is the waste basket?" he was still confused; yet, when I went with him to the waste basket, he could act reasonably sure of himself.

It could have been expected that Mort would not be able to perform the rituals of Passover, and he did not. He ate no food for eight days after Passover started. After some urging I gave up and when I visited, we sat together quietly. One day during this extreme fast I said: "It must be awful to be so hungry and, yet, unable to eat." A few minutes later he asked me for a 'big glass of water'. Occasionally he made the excuse that only kosher food would suffice. The head nurse brought special dishes and served the food on them; that, too, was refused. I could not decide to bring food into Mort; I was sure it would be refused. I also clung to the idea that I must not act too much like his mother by jamming things into him. His anger toward me was becoming noticeably strong.

THE EVENT

Patient's Response	Nurse's Response
	I walked into the day room; said 'hello' to everyone; then, walked over to Mort and, smilingly, greeted him.
He smiled, rather fleetingly, then said: "You came late."	It was later than I usually visited because I'd waited to ride with a classmate--I told him this.
Same	I smiled; asked him to come and sit in the corridor with me.
He followed me to a bench.	It was still daylight, but the corridor was darker than the other rooms. I asked him if he minded the dimly lit room.
"No, this is all right." His expression denoted patience.	Patients walking through, stopped to say hello. Those who did not speak stood and watched or asked for matches.
He looked at the wall with no change in facial expression. Occasionally he glanced at one of the other patients.	One patient asked several questions about my personal life, and, without waiting for answers led into a discussion of his loneliness; his aspirations as a man. I listened, without commenting, for a few moments, then told him he was interrupting my conversation with Mort. He laughed at this, apparently because there was no 'conversation' between Mort and I.
	To Mort, I said: "He has problems and wants to talk about them, but I am here to see you."
No response. He seemed disinterested.	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I wondered what the patients were thinking about--they were all so quiet.	I was visiting Mort more frequently, and at odd hours, in an attempt to make restitution for the Passover incident.
I had not stated an exact hour I planned to visit today. This did not seem to be the reason for his reaction to my visit, however. Despite this hunch, I could not enlarge on the possibilities.	The end of the semester was nearing. I wanted, very much, to feel some definite change in the relationship, and it seemed clear that I was not able to consider my part in it.
I wanted to get him away from the group in order to see him privately.	There were few locations in the building that could be considered 'private'. The corridor was not a quiet place; particularly in the evening, as the ward doors were left open during this period. I was very ambivalent about my contacts with Mort, yet felt compelled to confront both of us with these contacts.
I should have been firmer with the intruding patients.	Mort needed to be convinced of my sincerity. I was showing undue interest in the other patients because I could not face being alone with him. I had much guilt, at that time. There seemed to be no end to it. The incidents of the death and Passover were preying on me. Extra visits like this one were not helping to solve my problem.
The silence was unbearable.	

THE EVENT

Patient's Response	Nurse's Response
	There were no nurses on duty; I was the only woman in the huge building of men. I suggested going for a walk.
"It's too late."	I later suggested a game of cards and received the same reply.
He looked at me but did not return the smile as we said goodbye.	We sat in silence for a long period, and then it was time for me to go.
******	******
	The next time I visited he was sitting but he stood erectly as I walked toward him. Everything seemed chaotic; the day room was being painted; everyone was participating.
He did not smile at me as I greeted him.	The noise of the excitement in the day room prevented me from hearing his responses; I suggested going elsewhere.
He trudged along with me. As he sat on the bench he assumed a bent, resigned posture. He looked at the floor, crossed his legs and held his arms rigidly. Then he said: "You are early."	I said: "I usually come at this time on Thursday," then I asked him how he was.
"I can't think of anything to say."	"We haven't been saying much lately. I have the feeling that you are angry at me. I can accept this --you have feelings; I'm glad you can show them. I'd like to talk about them, and perhaps help. The past two weeks have been difficult. There were things about Passover that I was unaware of..."
His eyes blinked; he said nothing.	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I was expecting him to depart from a well-established routine (leaving the building after supper). I was aware of my own discomfort, that is, the ends I had in mind were vague and, without a more definite purpose for visiting him evenings, I was left with the pressure of my own insecurity.	I was trying to rid myself of the mother role, having experienced a bad performance. I wanted, immediately, to revert to a more detached, but friendly, relationship with Mort. My uncertainty as to what I meant to him was in discord with his fixed perception of me. 'Too late' might have meant 'You can't help'.
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He was becoming less accessible, more negative.	He was showing more feeling than he had at any other point in the relationship. I was the focus of a large residue of anger.
I took him away from an important group task.	He was angry and wanted me to know it; it was impossible for him to indicate it verbally. I felt the anger--it was frightening. He must have had the urge to strike out.
I thought I could help him release feelings by expressing an accepting attitude.	His control was admirable; despite my testing he remained adamant. It must have been a painful experience for him.

Mort could not enlighten me on the ritual of Passover nor could he impart to me his feelings at the time. After the holidays were over he became submerged in negativism toward me and avoided direct contact with me for several visits. Any suggestion or simple statement that I offered was refused or ignored. When we sat together he neither looked or moved toward me. I was completely shunned. He was, however, friendly toward other nurses and the attendants. This complete rejection of me was irritating, particularly when I observed his appropriate manner with the others. I tried to show calm concern and unflagging interest; I felt impatient, however. His punishment of me was contributing to the assuagement of my own guilt feelings for treating him as I had.

I had decided not to terminate my relationship with Mort and to continue to visit him regularly throughout the summer vacation period. It was too difficult for me to leave him. I felt that I had aroused Mort to a point of activity which deserved a less abrupt completion. It was during this extremely unresponsive period that I told him of my plans. School would be over in a few weeks and I wanted to prepare him for the change in routine. I also wanted to impress upon him the fact that I really cared about him. (I was specifically concerned about my own feelings in this regard, as well.) He listened carefully when I told him but he did not indicate

acceptance or rejection of my projected plans.

My supervisor suggested that the over-all picture of my relationship with Mort in the previous weeks represented final resolution of the loss of the mother and acceptance of her death. The anger which he felt toward me might be helpful to him in becoming independent of her. If he could endure this period and retain the relationship with me, he might become successful in relating with other people. This was helpful to me in that I no longer felt that it had been a completely negative event in either Mort's or my life. The support it offered enabled me to think more positively about future planning.

Mort no longer seemed angry and we were able to resume a more favorable concern for one another. It was May. The weather was warm and we usually went walking on the grounds. We would sometimes sit on a bench and watch the children play ball. One day I asked Mort if he had ever been on a picnic. He was rather vague in answering, and so I told him about such outdoor activities. The idea seemed amusing to him, especially the part about sitting under a tree and eating. At this time I was intrigued with his ability to laugh or smile when food was mentioned. I believed that I could offer it to him now and that he would accept. One of my classmates suggested a picnic for her patient and Mort. I concurred and we planned to have one.

Mort refused to eat anything at the picnic. However, he was amenable to the other activities in which we engaged, while traversing the large park prior to our noonday meal. His resistance to eating seemed to be related to the anxiety and displeasure he had experienced during Passover. He had been angry at me and could not resolve, yet, those feelings.

As I was to continue seeing him through the summer, I felt that this area of our relationship was one on which I could concentrate in the months to come.

ALONENESS

> The power of memories and expectations
> is such that for most human beings the
> past and the future are not as real but
> more real than the present. The present
> cannot be lived happily unless the past
> has been "cleared up" and the future is
> bright with promise.
>
> -Alan Watts, THE WISDOM OF INSECURITY

The purpose of my visiting during the summer is described as a self-satisfying process in view of my unresolved feelings of guilt. I needed to reduce this guilt, to reconcile my self with my felt demands of the nursing role. But I chose a scheduled visiting day and frequently wore a uniform; I could be identified either as a nurse or a visitor. As I watched the other visitors come and go, I felt protective of Mort. When I brought food for him, he accepted it readily. He had fully accepted the fact that his mother would not come any-more; I was certain. As we sat on the lawn one day, an elderly woman walked laboriously toward the entrance to the building. Mort said: "No one comes from home anymore." I told him I would visit him every Wednesday afternoon during the summer.

Later that afternoon as I stopped in the office prior to leaving, an attendant had a message for me.

T H E E V E N T

Attendant's Response	Nurse's Response
He greeted me, smilingly and then reported: "I read of Mrs. T's death in the obituary column a few days ago."	
	"Oh, no!" I paused...
	"Do you think that Mort knows? Has anyone told him?"
Still smiling, he answered: "I don't know; he rarely has visitors, I understand."	
	I laughed; said goodbye, and left to go home after thanking the attendant for telling me the news.

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
He is sympathetic; he also, feels some frustration.	Staff members were concerned about my predicament.
I had no desire to pursue this incident any further.	I felt no responsibility for speaking to Mort about this.
I can't imagine any continuity of purpose in this experience.	I was worried about his trust in me.
	I needed to get away from there to ponder the situation and find my place in it.

I was curious to know if Mort knew about this turn of events. When I stopped in the office on my next visit, I discovered that he had been visited by his cousin. She, I could only assume, had been there to tell him that his mother had died, just recently. Mort was rather quiet that day. He greeted me lethargically and seemed hesitant to accept the cookies I brought to him. He placed the bag on the bench beside him and showed no interest in them or me. Another patient attempted to get Mort into a conversation. Finally he said, looking at nothing in particular, "She can't think of anything to say." He must have sensed my preoccupation. At this time I felt very limited, more angry and guilty. We sat quietly on the bench and watched other patients and their visitors.

On subsequent visits I made no attempts to test Mort's reaction to the incorrect communication of the death of his mother; that is, I did not mention it. I was satisfied that his cousin had visited. This indicated that the family was assuming some responsibility for him and I was willing to remain silent. I had reached an impasse and lacked motivation to act. I was not able to check the obituary notice, although I felt that some corroboration was needed.

Mort became increasingly more inaccessible to verbal contact. He reached an extreme degree of inactivity in the middle of the summer. One day as I walked toward him, I received no recognition; contact between us had been cut off...

THE EVENT

Patient's Response	Nurse's Response
He was standing rigidly, holding a bag at his side. His face was expressionless and he looked fixedly into space.	I said hello and tried to get his attention with a warm smile.
He did not respond; he stared stonily.	
	I spoke encouragingly, asking him to come and sit with me.
No response, stance unchanged.	
	I asked him if he had had visitors, meanwhile looking at the bag he held.
He moved the bag away slightly --glanced at me momentarily with no change in facies.	
	As his eyes met mine I felt only cold antagonism.
He took a few very slow, rigid steps away from me.	
	I waited for about a half hour, hoping he could respond in some other way before I left.
	It was suppertime and I said goodbye and then, "I'll be back next week."
He looked in my direction as I glanced back at him on my way out the door.	

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I am alarmed at his inability to move or speak. He looks tired, as though he has been standing there for a long time.	I was not as concerned about Mort as I had been previously. I wondered what I had accomplished; I felt insecure; I was very discouraged.
I know it is food in the bag; I can smell it. He is denying me any privileges because I have not inspired his confidence.	I felt a little angry because he would not tell me where the bag came from. Then I decided that he needed food; giving to him should be a human and natural gesture. It seemed too late to change at this late stage; he had pointed this out to me the evening I visited.
I feel inadequate and frustrated. Mort has reached the peak of his negativism.	I was frightened--he really wanted to strike me.
This is the first time he has ever walked away from me.	
He is as alert as always and certainly interested in seeing me leave.	

Mort was reported to have struck a patient who tried to take the bag away from him that evening. He had been angry enough to strike me, I was certain. It was easier for him to demonstrate his feelings by displaying aggression toward another patient.

I could only sit back and watch events now. The idea of consulting my supervisor was considered and discarded. I resented the visits to Mort and I stayed for shorter periods. It became a methodical procedure. Every time I went I took some food to him; it took the place of other things I could not offer.

There were no planned meetings with the ward personnel. I came and went as a visitor soliciting no information. My contacts with Mort did not seem significant. I was easily irritated by his behavior; my intervention was superficial and punitive, rather than therapeutic.

During this phase of aloneness I chose to retreat from meaningful involvement. Instead, I concentrated on the value of the experience. I wanted to bring order out of the chaos and to provide some basis for the value of the components in this nurse-patient relationship. To do this I needed to trace the idea of my fear and hostility back to the point of a common element in derivation. I would attempt to clarify the meaning of my conduct by reasoning it out.

I was aware that human death was the common element which

had held the central focus in my experience with Mort. Death had always been an overwhelming concept for me, so overwhelming to me that I had never developed any new ideas about coping with its manifestations. I had easily identified with Mort when his mother died, thus placing myself in an extremely uncertain and traumatic position.

In addressing myself to the task of clarifying my thoughts I subjected them to a reflective process. By integrating my experience with scientific fact and philosophical valuation, I could, perhaps, alter my behavior pattern; I did not want to perpetuate it. I wanted to develop a more therapeutic relationship with Mort; perhaps I could, even at this late stage.

The framework for reflection started with the temper of thought generated by the facts of science, regarding the means by which men handle the problem of grief and death. Freud[1] described what happens psychically when grief is experienced. The shock of the reality of death takes so much energy that little is left for the normal patterns of living. The affection for the lost person requires redirection and is a gradual process in time. It is normal to grieve. However, if the process is protracted, and the pattern becomes static, new relationships probably will not become significant. Identification with the lost one can take extreme forms.

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[1] Freud, Sigmund, "Mourning and Melancholia", Collected Papers, pp. 152-170.

Freud[2] described the difference between normal and pathological reactions chiefly lying in the ability to test reality. In this nurse-patient relationship Mort, the regressed patient, could not be expected to face the reality of the situation. This created more anxiety in me because I could not cope with the fact of death, a repetitive process in my past experience.

Lindemann's[3] elaboration on the 'grief syndrome' involves psychological symptoms characterized by strong preoccupation with feelings of guilt, self accusation and negligence in relation to the deceased. These symptoms may or may not appear immediately after a crisis. This latter point was meaningful in this relationship in light of the apparent resistance or denial by Mort of the fact of his mother's death. It seemed that I, however, was experiencing a delayed reaction to grief.

In attempting to uncover the necessity for the psyche to avoid death, Wahl[4] has stated that death is a glaring exception to man's ability to control his environment. It is concluded to be a fictitious experience; magic is employed in handling it as witnessed by use of the elaborate euphemisms 'passed away' or 'departed', also, the attempts by morticians to preserve bodies. These defenses used so persistently as an escape from this

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[2] Freud, op. cit., p. 167.

[3] Lindemann, Erich, "Symptomology and Management of Acute Grief", American Journal of Psychiatry, 101: 141-148, September, 1944.

[4] Wahl, C. W., "The Fear of Death," Bulletin of the Menninger Clinic, 22: 214-223.

fundamental reality are psychologically costly, he adds. An investigation of the problem is necessary, urges Wahl, in order to get beyond the thinking stage of primitive ancestry.[5]

In writing of the obstacles to evolving a thanatology, Eissler[6] says:

> "Death is almost viewed as a phenomenon of deficit caused by dysfunction although it is the necessary and logical conclusion of an episode. Apparently modern man cannot integrate into his unconscious the idea of natural death, thus every death carries with it the implication of force."

My own inability to accept death as final and conclusive had contributed to the similarity in my attitude each time I was faced with it. The more meaningful the relationship, the more intense had been the reaction.

As I read, further expansion and integration of my thoughts arose; I became influenced by the ideas of a poet and some of the philosophers on the subject of death.

Socrates[7] said: "Be of good cheer then...and say that you are burying my body only..." in expressing the pursuit of wisdom, as the key to a serene attitude toward death. Wisdom and its accompanying search for the truth had constituted the good life according to Socrates.[8] He accepted death as a

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[5] Wahl, C. W., op. cit., p. 222.

[6] Eissler, Kurt, The Psychiatrist and The Dying Patient, p. 42.

[7] Edman, Irwin, ed., The Philosophy of Plato, p. 186.

[8] Edman, Irwin, op. cit., pp. 116-123.

logical necessity; he died comforting his friends.

Centuries later Voltaire,[9] in attempting to solve problems, reasoned always to emerge with skepticism. On his dying day he said to a friend, "I have left off dying to come and see you." He feared death having lived in a disquieting age of intolerance and calamity. Death, to him, offered no solace; his reasoning did not permit unqualified faith.

These diverse ideas led me to think more clearly on my own views, having been influenced more greatly by concern for the physical realities of disease and destruction than by the irreversibility of life. Had I not chosen psychiatry as the area of concentration in nursing to supplant the more overt demonstrations of human decline? The emphasis on the intangibles in the care of the mentally ill may have contributed to the dissipation of my guilt feelings after caring for physically ill patients, destined to die.

Following Socrates and Voltaire in time, and with reflection on their views, Durant[10] has spoken coherently of the point of view held by our modern society regarding death. In discussing man's search for the answer he says:

> "The fear of death is the beginning of philosophy, and the final cause of religion. The average man cannot reconcile himself to death; and therefore he makes innumerable philosophies and theologies; the prevalence of a belief in immortality is a token of the awful fear of death."

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[9] Durant, Will, _The Story of Philosophy_, p. 241.

[10] Ibid., p. 328.

Faith or reason, I believe, has to be tested on the ground of experience. An inability to withstand an experience of stress calls for a reevaluation of dormant values, concepts and skills. Strengths and weaknesses which previously were only vaguely recognized, may be revealed. Those appropriate attributes may then become more effectively integrated and sustained.

Tennyson[11] used the medium of poetry to work through a grief reaction. He lived at a point in history when scientific discovery cast an aura of skepticism over long established religious tenets. Compensation of the grief was made difficult because of the thoughts stirring him to the irreconcilability of God and nature. The disrupted human relationship could not be duplicated, and a long period of emotional preoccupation ensued. He finally resolved the conflict and gave it this expression:

> "I hold it true, whate'er befall;
> I feel it, when I sorrow most,
> "t'is better to have loved and lost
> Than never to have loved at all."

The ripples of thought now encompassed humanity. In my mind individual death could be viewed in the vast continuum as a logical necessity. The feelings of sorrow and compassion would always be an indispensable complement to the human experience, however.

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[11] Rolfe, William J., "In Memoriam A. H. H.," The Poetic and Dramatic Works of Alfred Lord Tennyson, p. 180.

As the summer vacation period drew to a close I began to feel more comfortable about my visits to Mort. Our relationship seemed more friendly. He was sitting on the porch waiting for me each time I arrived, and we invariably greeted each other with a smile. I could feel at last an unhampered sense of warmth for him; I truly enjoyed the Wednesday afternoon visits and no longer needed to use language excessively to grapple with the reality of the moment. It was easier to communicate with Mort; or, at least he was responding to the quiescence of my mood.

RESOLUTION

I had for some time wanted to take Mort out to eat in a restaurant. One reason for this was to assuage my feelings of having neglected him during Passover. I was certain, by now, that I could take him away from the hospital and return him without threatening either his security or my own.

The relationship was near its completion, and, at that time, I needed to test my ability to relinquish him. My supervisor approved of my plan and reiterated a previous suggestion to leave the hospital carefully, when taking Mort away from it. It had been years since he had left it, until this summer.

The building supervisor was pleased and arranged for appropriate clothing for Mort. When I approached him about such an activity he was hesitant about making such a grave decision but seemed to like the idea. I told him when to expect me the following week. I arrived that day and found him ready and waiting.

THE EVENT	
Patient's Response	Nurse's Response
He walked toward me, saying: "She gave me new clothes."	"You look nice, Mort. I'm glad you decided to come."
	I told the head nurse that we were on our way.
We walked toward the door. Mort was a bit hesitant and looked uncomfortable in the strange clothing.	
	I glanced at him with a feeling of encouragement. We walked through the door.
As we started to walk toward the gate he said: "Aren't you going to drive the car?"	
	I was surprised and said, spontaneously: "We can go in the car."
He was quiet as we drove along, but noticed the driving procedure carefully. In the restaurant he asked for his preference in food, without hesitation. He ate slower than usual, noticed other people, and responded when I spoke. As he finished he said: "I'm finished eating."	
	We left the restaurant and took a short walk. I bought some fruit and shared it with him. Then we returned to the hospital.

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I'm pleased that Mrs. A. and Miss B. are sharing this activity with me.	I was instigating a new pattern in Mort's life. I needed to proceed carefully. In a short time I would be gone, but he would remain.
I am uncomfortable, yet I feel it is important for Mort to become more able to make decisions.	Immediately after saying 'we can go in the car' I realized that there must be a deeper meaning in this for Mort. I was not fully aware of his need for limitation on his own control in this situation. This was not an appropriate time to give in to his needs for independence.
I think of him as an adult <u>and</u> as a child.	He needed to depend upon me; yet, closer observation revealed that part of him could make decisions and assume responsibility. I had to become more alert to his varied needs.

We returned to the ward as the other patients were completing the evening meal. Mort said repeatedly: "I've already eaten." As I left him he looked at me with a slight smile, saying: "Thank you."

The next time I visited he seemed quite pleased to see me. He was sitting with his coat on and arose as I approached. When I suggested going for a walk he responded immediately. He took the initiative as to which direction we would take when we started out. A few moments later he asked: "How did you get out here today?" I told him I had come in my car. Then I immediately felt the repercussion of the trip in the car to the restaurant. I said: "I know that you want to go for a ride, Mort, but it will not be possible--it would require special permission." He answered in a rather disappointed tone: "That's all right." He remarked later that it was a long walk. We sat down on a bench for a while before returning to the ward, then played ping pong. An attendant walked through the day room and, looking at Mort said: "He is a good volley ball player, too." Mort was very pleased at the praise and continued to hit the ball methodically. He responded to things of the moment.

Mort's conception of time seemed to be closely related to present events. He could derive satisfaction from activities which were pleasantly stimulating at the time. Also, he could respond to reason; for example, he had accepted my explanation about the ride in the car. At the same time, I realized that

the purpose served by such a time-oriented thinking process was an overwhelming one. It behooved me to become most alert to my responses to Mort. I wanted to uphold any feelings of security and satisfaction that he might possess.

October came and with it, the realization for me, that I would be leaving soon. I was attempting to be a participant with Mort, in activities which would be on-going for him. Sometimes these activities involved group games or attending group meetings. It was warm enough to take long walks and to stop sometimes for soda or ice cream. Other times, we merely sat in the day room, in communion with the other patients; that is, as part of a group, without uttering a sound.

I felt very close to Mort and occasionally I experienced a feeling of sadness at the anticipation of separation from him. Moreover, there were feelings of satisfaction when I was with him, and I tried to make the most of my visits.

One day at a ward meeting the doctor announced that Miss B., the head nurse, was going to leave after three years in her position. There was much acting out at that meeting. One patient became sexually aroused and paced to and fro in front of us. Mort and I remained quiet. He showed no recognition. Although I wanted to comfort the patient, I felt the purpose could be served best by remaining quietly seated. Eventually, an attendant showed the distraught patient to a seat. After the meeting, and its discussion of the departing nurse, Mort

repeatedly said: "Miss B. is leaving." It had been clearly demonstrated that Mort and the other patient were reacting to the situation in their own individual ways.

As I thought of this episode I was reminded of the day when I first came to the ward and was so threatened by the sexual advances of several patients. The outcome had been my choice of Mort because of his inaffectual demeanor. It seemed that I could now look at the meaning of these different behavior patterns with more equanimity.

Although Mort and I were having a rather serene relationship, there remained one task which I needed to accomplish to remove a trace of discomfort. I had never been able to tell him that I regretted the chaotic experience his mother's death had caused. I did not expect him to understand my concern in this; I wanted to convey my appreciation of his feelings...

T H E   E V E N T

Patient's Response	Nurse's Response
	"Mort, I've wondered how you feel toward me since I told you that your mother died in January and her death did not occur until June."
"I don't know about anything."	"You must have some feelings about this--I was asked to tell you in February; we all believed it to be true; then later, the report was found to be an error." "I felt badly about you losing your mother; I could not discuss it with you."
Same	"I'm sure this experience has been very upsetting to you. I can also understand how difficult it is for you to talk about it. But, I hope you will be able to--perhaps it would make both of us feel better."
Silence.	We walked back to the building and went into the library and sat down.
"I can't think of anything to say."	"I know it is difficult." I reached for a magazine and held it so he could see, as I turned the pages.
We scanned the magazine, together.	"Have you had any visitors lately?"
"Yes, Sunday a woman came."	"Oh, a woman..."
"She's married."	"Do you mean your cousin?"
"Yes, she came with her husband."	"Is she the cousin who came, during the summer, to tell you that your mother died?"
"Yes."	"What did you talk about?"
"We didn't talk about anything; she brought me candy and fruit."	We sat quietly until it was time for me to go.

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I am testing to see if he will respond differently.	I was not anxious. I was merely interested in revealing my feelings to him. It was of less importance to get words from him.
I want to show interest in him, empathically. Also, I want, once more, to state the facts in a calm manner.	I was revealing the facts in a manner which would have been impossible previously--I could be objective about the stress of death.
I am not expecting an answer. Possibly my spontaneous confession will have some meaning for him.	I realized that Mort could not respond to deep feelings. I could be satisfied with my own ability to show warmth.
He is thinking about my comments and feelings.	I did not need to pursue this any further.
Perhaps he will supply the corroboration I've sought.	I had waited until now to show intellectual curiosity. Previously I had done nothing constructive to gain the information.
I recall a woman's visit, in June.	
Does he think my security is threatened? He probably wants me to know the kind of relationship he has with her.	Did he want me to know that he was not interested in other women? He could not discuss her husband's part in the visit. Women are probably more significant to him.
Mort has finally admitted verbally that his mother is dead.	Will he ever be able to do this more coherently?
His mother used to bring him candy and fruit.	This woman, his cousin, can also fit into the mother role, and perhaps very satisfactorily.

Talks with members of the staff on the ward disclosed that my impending departure from the situation was being considered in terms of planning nursing care for Mort. The new head nurse and one of the attendants were particularly interested in developing a closer relationship with him. They asked me such questions as "What do you talk about when you visit," or "give us suggestions as to how we can make this transition period easier for him." I thought that they were expressing anxiety over the possible inability to carry on in the wake of an intensive nurse-patient relationship; and also that they were expressing their own needs to learn more about interpersonal relationships. In verbalizing their feelings of responsibility for Mort, I thought there was negation of any conception of rivalry with me, which would in turn affect the care of their patients. I felt that we had been relating in a meaningful way, as a group, as well as with Mort, my individual patient. As we discussed the situation, I felt more certain that we had shared an experience.

Mort seemed to be experiencing a feeling of freedom. He transmitted this to me more overtly on the occasions of our last walks on the hospital grounds. Since it was the middle of November, it occurred to me that I must instigate plans for separation. I did not say anything to him until we had worked out the question of going through the gate; a problem which arose frequently during this phase. Whenever we went walking Mort chose to go in the direction of one of the two main hospital gates. He would say, inevitably, as in the following illustration:

T H E E V E N T

Patient's Response	Nurse's Response
"We are at the gate.	
	"Yes, Mort, but we can't go through the gate."
Silence.	
	When we returned to the building he remained silent. I said: "Would you like to go down to the square for supper next Wednesday?"
"Would we go in the car?"	
	"No, we would walk."
"I don't know."	
	"Well, you can think about it. I'll ask Mrs. A. for permission and clothes."
************	
	The following week I arrived as planned.
He was rather unconcerned but acquiesced when I suggested that we leave. As we walked toward the gate he said: "Where are we going?"	
	"We might take a walk and then return to the ward if you do not want to eat supper away from the hospital."
"I don't know."	
	"Let's go to --- for supper and then go back to the ward."
"Yes--", repeating my statement.	
	After we left the restaurant we started back, walking the few blocks to the hospital.
As we entered the gate he said: "That was a long walk."	
	"Yes, but we are almost there."

THE INTROSPECTIVE PROCESS

Immediate Reaction	Continuing Reflections
I've already told him that we need special permission to leave the hospital. Maybe he thinks I won't set any limits, but I must. On the other hand I want to take him through the gate.	I was very ambivalent about separation.
I have to offer something.	I needed to test my ability, still further, to handle this situation.
I am so anxious to make up for the disappointment I thought he felt at the gate.	Although I had reversed my decision about leaving the hospital, I did not feel guilty about it. I thought it would work out; I had more confidence.

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Immediate Reaction	Continuing Reflections
I wonder why he asked this question. We have gone out before and he has seemed less dubious.	I had created a crucial question in his mind. I was vacillating from dependency to independency; separation for me meant leaving school and reestablishing relationships in several areas.
I wonder if it is too late to be firm.	I gave him an opportunity to stay if he seemed too upset about going, yet I firmly outlined the plans for the trip.
I think this trip should be a short one.	I had decided that this was the last time I would subject Mort to more reality than he could absorb.

On subsequent walks on the hospital grounds Mort made such remarks as, "We will go as far as the gate." Apparently he felt secure in the fact that we both knew how far we could go.

It was time for me to suggest that in four weeks I would be leaving. I did so one afternoon by carefully explaining to Mort that the time was coming when school would be over; and that I would be returning to work; that we would not see each other anymore. He thought a few moments then asked: "When is school over?" I told him the date that I would make my last visit. As I looked at him I thought I could detect sadness behind the marble-like facade; within myself I felt sadness tempered with a deep need to support both of us.

When the final day arrived I spent the afternoon with Mort. Another very depressed patient wanted to share our visit so we invited him to play cards with us for a while. Then I asked him to leave, explaining that Mort and I were visiting for the last time.

The dread of leaving Mort was made less poignant by his own calm facility. As he had welcomed me so matter-of-factly, by asking: "Where are you from?" we parted with these words from him: "Goodbye, Miss P., I hope we will meet again sometime."

CHAPTER FIVE

SUMMARY

The emotional interrelationship described in this study can be noted to have moved from the phase of hoping that the nurse, her patient, and his mother could develop more positive qualities. Next came a phase of extreme hostility during which the nurse, because of her own inability to view death as an a priori determined event, felt that she had failed in supporting the patient. Following this was the development, through an introspective process, of a more positive attitude toward the entire experience. The phase of resolution brought about acceptance and deeper self-understanding in the nurse which resulted in a more meaningful relationship with the patient.

Such an experience called forth the need to look beyond professional concepts and skills toward scientific explanations and philosophical reflections for a critical evaluation of values and beliefs attendant upon the phenomenon of death. Following earnest consideration of this rather eclectic path, the nurse returned to the nursing role with many of the doubts and anxieties brushed aside.

CONCLUSIONS

The nurse believes that the data, high-lighted by significant excerpts therein, attest to the accuracy of her assumption; namely, that her emotional reactions to the stress situation deriving from the death of her patient's mother greatly determined the course of this nurse-patient relationship. With a more acute awareness of her own reactions, she was able to move closer to the patient and focus on the immediate problems; the past and the future could be set aside in deference to the realness of the present.

RECOMMENDATIONS

As a result of the vicissitudes inherent in this study of a nurse-patient relationship, certain recommendations are indicated. They are suggested from the point of view of the uniqueness of an individual nurse's emotional involvement in a problem concerning her patient.

It is suggested that nurses probe the indefinable essence in nursing by:

1. Introspectively studying their own attitudes and beliefs regarding human needs.
2. Attempting through achieved insights to understand and experience with patients the effects of stress.
3. Recognizing that the same intangibles exist in all areas of nursing. In particular, problems relating to death become elements superimposed upon any nursing process.
4. Writing effectively of their own feelings and appreciations in order to fill in the hiatus between the means and ends--the science and the art--in nursing.

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APPENDIX

The patient's illness was first recognized as a serious problem when he was eighteen years of age. Although he had not completed high school, he was considered an intelligent youngster. While selling newspapers on a street corner one day it was brought to the attention of a police officer that he was in a stuporous condition. He was taken to a general hospital, then transferred to a mental hospital, from which he was discharged to home two years later. At the age of twenty-nine, while hospitalized for a kidney complication, he jumped from a window, sustaining a fractured clavicle and other injuries. His mother, at this time, realized that she could not cope with him at home and he was again admitted to a mental hospital. He was anorexic, mute, negativistic, immobile, and masturbated freely. The kidney complication continued to be a problem; because of great difficulty in urinating, he was placed on catheter drainage for a while. Eventually, he had a cystotomy for the removal of stones.

The symbiotic relationship with his mother continued despite her demanding manner and insistence on forcing food into the patient when she visited him. She was very punitive; a characteristic remark was: "I've given my life to him; why is he sick?" Her husband left her after the patient's second hospitalization (to go home to his mother).

Her visits were curtailed in September, 1957, when she became more punitive and scolded him consistently for not conforming to her needs. After joining The Mother's Club at the hospital, she seemed to respond favorably, recognizing some of the deleterious features of her attitudes toward the patient.

When first admitted (second hospitalization), he received a course of electro-convulsive shock treatments to which he responded initially, then regressed to the former condition. He has had numerous infections; has received injuries at the hands of other patients, which have required treatment and medication. Since the cystotomy, he has had at least one cystoscopy.

In the more recent past the patient has had no serious physical problems. He has been on one of the ataractic drugs for about two years. Particular adjunctive therapies play no part in his treatment. He has been in the state hospital for thirteen years.