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The Healing Power of Professional Invisibility

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"Critical reflection is an interesting and powerful thing. It can send us on an investigation which can change our lives by leading us to further discoveries about ourselves and others." Annette Street (1995:109).

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"... "care" sounded a strange word to use in the context of family and child health nursing - to me anyway. Caring for my clients doesn't sound right. I do "care about" them, of course, but am I "caring for" them? It makes it sound dependent - that they are dependent on me for care. I feel it's more of a "working with", not "caring for" role as a child health nurse. Yet if I am not caring for my clients then am I really practicing nursing?" (*Journal. 18-3-01*)

Introduction

As part of my Bachelor of Nursing Honours course, this unit called for me to use the process of critical reflection to explore, in depth, my practice in the area of family and child health nursing. Becoming a parent is a major life transition and a life crisis (Percival, 1994: 296). As part of the universal service available to all families with children, in this state, I work autonomously, in the community, with families of children from birth to school age. I support women and their families in this, sometimes overwhelming, parenting role. I struggle, however, to articulate the value and importance of this nursing. In this critical reflective process, I come to realise the intangible and invisible aspects of my practice relate to the concept of care.

I explore caring from a cultural and social background, revealing how caring and nursing has been devalued, and that I too have questioned its importance. I explore the caring nature of my practice. Developing a trusting relationship, where professional expertise is not highlighted, is shown to have powerful healing benefits. This reflective process brings me to a deeper understanding and awareness that what I do is at the heart of nursing. It is based on care. I dispel any doubts of the value and importance of caring and what I do.

Critical Reflection

Freire (in Street, 1992: 15) asserts reflection does not start with a search for answers but with a search for questions. Reflection is about uncovering the taken-for-granted assumptions of everyday practice. Taken-for-granted practices are by definition hidden and invisible to nurses (Parker and Gardner, 1991-1992: 3; Street, 1995: 2). So the quest is to search for those practices I do without thinking and explore these.

The process of critical reflection used can be described as four stages: *reconstructing* accounts of practice by recording, or journaling, thick descriptions; *deconstructing* or analysing and informing these experiences to uncover the issues and meanings present, as well as the historical and social factors shaping the setting; *confronting* these issues and factors in order to learn and question the underlying assumptions directing practice; and then *reconstructing* practice with critical thinking to how things can be done differently or how things will be different now (Street, 1991:29; Street, 1992: 16; Taylor, 2000: 197). Keeping a journal to record episodes of practice is the first step to reflecting on, and questioning practice. [1] Once the art of journaling was mastered (another story) the issues needed to be uncovered.

The issues: Making conscious the unconscious

Although assessing health and development are important aspects of the role, reading through my journaling accounts, I could see this was not what I valued the most. This was implied in the following journal extract, of my first interaction with a young family.

"I really felt like a stranger and a professional... This will take time to build a relationship with this family so I feel less like I am considered 'the professional up there'...I focused on the clinical aspects which was what my role was expected to be I think. I acted the part of the health nurse. This made it safe and easier for the parents to accept me....It will be interesting to see how this relationship develops." (*Journal: 13-7-01*)

I realised establishing a relationship and how I related with the family, were the more important aspects for me. However, in other journal accounts where I have come to know the family, I seemed to doubt the value of my work, or wonder what I was doing in the interactions. I did not see myself as playing a significant role. I felt quite comfortable with the family. I would "sit and listen", or "listen to the parents proudly talking about their baby." I always recorded weighing the baby. Sometimes I would fleetingly question what I was achieving. I did not appear to be doing anything significant or important.

However, when I looked through my journal again, trying to look in as an outsider, I could see patterns emerge. I found the episodes I was recording involved interactions with families in varying complex social situations. Issues included parents or children with disabilities, mental health issues, difficult relationships, depression, and poverty. All were very vulnerable people. Some were in crisis. Yet when I wrote of the interactions these issues were often not apparent. They were in the background or not mentioned at all. At the same time, I did not see myself taking a significant part in the interactions. It was all fairly normal to me. I was taking for granted the fact I can relate well with people who are very vulnerable, in complex social situations, and caring for young children. This is part of my job. But my difficulty articulating what I do, what my practice is, how I related to a mother, or why I behaved the way I did, or said the things I did, was associated with the intangible, almost invisible aspects of my role. I came to realise this large invisible part of my practice was related to the whole concept of caring in nursing.

It is caring which is integral to life and therefore to health. As I came to see, this intangible concept of caring has become so devalued, that I too doubted its significance and therefore my own truly caring, nursing practice. Benner (2000: 105) warns it is the apparent intangibility of caring that can lead to its dismissal. Clarke and Wheeler (1992: 1283) suggest that enhancing our understanding of the meaning of care will lead to our understanding nursing itself.

The Nature of Care in Family and Child Health Nursing

"Caring is nursing, and nursing is caring." states Leininger (quoted in Kyle, 1995: 506). Care is central to nursing (Benner, 1984: 171; Caelli, 2001: 26), but the concept of caring remains poorly defined (Gardner et al. 2001: 32; Kyle, 1995: 506). Perhaps this explains why, early in my journaling, I had recorded my disconcertion around the term "care" in relation to my work, as quoted at the beginning of this paper.

I had automatically thought of caring as the clinical, visible doing for behaviours and tasks of nursing. Kyle (1995: 507) points to the limiting effects of seeing caring as a set of activities and behaviours without seeing as equally important the expressive role involving relationship building and support. Benner (1984: 170) stresses the "...violence to caring..." when making such distinctions. She finds the expert nurse melds these roles. Duke and Cropp (1992: 40) have described caring as the unifying dimension of nursing and "Like the string in a necklace, it holds all the beads together. However in the same way that a string is often hidden, so is caring and, therefore, nursing." So why is this caring so hidden and undervalued? Why was I questioning the value and importance of my caring role? Street (1995: 2) emphasises the need to locate and challenge the culturally created myths in our lives, because of the effect they have on who we are and how we live our lives.

The social devaluing of women and caring

The devaluing of caring, and caring as women's business, becomes apparent when considering the cultural roots of care. Colliere (1986: 95) states "Care is at the very root of women's history, as it is around care that the main part of women's destiny is woven." In the past, the social value of women's care giving was recognised and held status. Their knowledge was valued and built on a body of empirical facts based on accurate and concrete observations and perspective (Colliere, 1986: 97-98). With the rise of academic medicine women's empirical knowledge was considered menial and unscientific. Care practices were progressively eroded (Colliere, 1986: 98). When nursing and then midwifery finally became medically institutionalised professions

"Any question about *what care means* ...was diminished.... nursing care practices became overwhelmed by treatment and procedures. Anything related to care became taken for granted, considered unworthy, requiring 'lower skills' and scanty knowledge, limited to routine procedures and 'know-how'.... everything dealing with care was never revealed as part of work. [Care became].... *Invisible work done by invisible women* ." (Colliere, 1986: 102-103).

Thus the devaluing of what is not observable and tangible and able to be described in a scientific manner. The caring components of nursing are now seen as the least sophisticated and subordinate to medical interventions (Pearson, 1991: 199). A recent study showed it was nurses' technological skills that were seen as important by patients, nurses and the hospital (Gardner et al., 2001: 38). Nursing in family and child health is not a highly technical area - a pair of electric scales is it! Family and child health nurses work mostly on their own, in isolation, in the community. The nurse and family work together in private. The work is unseen and virtually unknown. Comments from the public such as "What a nice job weighing babies" abound. The intangibility and invisibility of such caring was also reflected in my interactions with families, where I realised it was normal for me to have a low profile.

Professional invisibility in relationships

I found, from my journaling, developing a relationship was fundamental in my practice. It was also important I was not prominent in the interactions. This was revealed in recording the following journal extract.

“...I knew immediately that this four-week-old baby was not thriving. His face was drawn and he had a 'worried look' even when asleep. The health assessment confirmed he had not regained his birth weight. I knew then this was going to be difficult. The first time I meet this young teenage couple and there is something wrong. I said nothing about my concern as we sat and talked about how things were going, including the breastfeeding. All the time I was gauging the parents' response and level of understanding. I was hoping they would say something that could explain why he looked the way he did. They didn't. They were very proud and happy parents. ...They thought he was going fine, although he was “a bit skinny”...

I was finding this a very delicate and difficult situation. I did not know these young people. I needed to make them aware of the gravity of the situation without alarming them or making them doubt their ability as parents. I was able to say everything else was going well, but as they had noticed, he was a bit skinny. I pointed out he had gained weight since coming home from hospital but was not quite back to his birth weight, which has usually occurred by about the third week. This made them aware that he could gain more weight than he had, but did not alarm them too much, I hoped...

We talked of the possibility of waking the sleepy baby for more frequent feeding, and the benefits of this. The parents appeared happy with this. We arranged for me to home visit in three days to see how things were progressing. (*Journal. 19-3-01*)

I was very aware of my interaction with the young couple. I realised it was very important to me not to come across as the expert who knows everything and tells them what to do, or to convey the impression they know nothing, or are incompetent. My experience and knowledge in this area meant I recognised the problem and knew how it could be addressed. However, I did not want to impose my solutions onto this family. I was trying to give these parents, especially this shy young woman, a sense of control over the situation.

It would have been an easier option for me, to just tell them what to do. However, I recognise that all my knowledge and experience in this area does not make me the one with the answer. The danger in thinking I automatically know what is best in a situation raises the disabling potential I have as a professional (Illich, 1977:18). Imposing authoritative solutions, with the resultant loss of power to the mother, is disempowering, and has a debilitating effect on her well-being and her capacity as a mother and a woman. As Benner and Wrubel (2001: 173) state, "...authentic care seeks to care for the other in liberating, and nondominating ways." It is the relationship and the interpersonal process that I find so important to my nursing and caring, that I find has such therapeutic potential.

Healing potential of relationship

"Nursing is primarily a personal relationship between nurse and patient which fosters the well-being of the patient" state Bishop and Scudder (1990: 11). Caelli (2001: 26) found health-focused care to be undeniably caring in nature, and it involved the nurse engaging in rapport building to support the

other with consideration, respect and dignity. Jerome and Ferraro-McDuffie (1992: 153) use Peplau's 1952 theory to describe the therapeutic relationship as an "...interpersonal process that uses the nurse (as self) to move a patient to desire healing ...by providing information, empathy, non-directive listening, respect, and feedback as an actual treatment modality..." This describes well what I try to do. So it seems strange to read that viewing nursing as a potential therapy itself is considered unconventional (Ersser, 1991: 43). Yet "...fostering the well-being of clients...is the meaning of therapeutic." (Bishop and Scudder, 1996:127).

I realised the healing potential of my practice after reading again a journal entry where I had initially not seen my input as anything much. I had been regularly visiting Mary, her husband Tony, and their five young children, for over five years. Mary had little trust or respect for child health nurses or any authority that would tell her what to do. The family had little personal resources, and little support. By visiting this vulnerable family and focusing on developing the family's "...personal capability to take charge of their lives and make their own choices" Zerwek (1991:214), I was invited back and our relationship, based on respect for each other, gradually built up over many months.

I had recorded the following in my journal:

"...I could hear raised voices as I approached the back door.... Mary opened the door for me as she continued crying and yelling at, and about, her husband. (This was not going to be the quick visit I had planned.) Tears were streaming down her face. I hadn't seen her this upset in a long time. Thoughts of the stress of parenting a new baby again, or past depression coming back, crossed my mind. Mary cried to me the baby had thrush in her mouth and on her bottom. She needed to go to the doctor...and they had no way of getting there. She glanced pointedly at Tony, sitting silently in the lounge room. I knew the difficulties posed when a trip to the GP was needed. With no transport, it meant either trips in a bus or finding a taxi fare, which was usually difficult to find. I felt like putting my arm around her, but didn't. Mary did not show affection easily. ...I was able to tell Mary she could now get the ointment from the chemist without a prescription. Once she realised no trip to the doctor was required, Mary calmed down."

The account continues for several pages. Mary mentioned her breastfeeding problems associated with the thrush. She then went on to talk about how hard it was not having a break, she talked of their fear of fresh harassment from neighbours, of the eldest child's ongoing behaviour problems, and recognised she was picking on Tony more. I did not give her answers to anything, just listened. I concluded the journal entry:

"...By the end Tony and Mary were both talking and we were sharing a few laughs. As I was about to leave Mary said thanks and we exchanged a meaningful glance as we said goodbye." (*Journal. 3-5-01*)

Mary had developed a sense of trust in me. She did not feel she had to change her behaviour as she let me in her home. This situation was not something I had to fix-only Mary could. But I could seek to understand, and in understanding I could support her to realise her own ability to develop her own sense of control.

My just listening was a way of "being with" Mary. This term describes a caring presence that conveys an assurance of personal concern how she is does matter to me (Benner and Wrubel, 1989: 411; Bishop and Scudder, 1996: 41). As Swanson (1993: 355) explains, it is giving "...time, authentic presence, attentive listening and contingent reflective responses...to give simply of the

self...in such a way that the one cared for realizes the commitment, concern and personal attentiveness of the one caring." It was only on reflection I realised the meaning of the look that passed between Mary and myself.

What words cannot express

It was the glance that says all that words can't express. It was a look of thanks from her for what has happened, the acceptance and valuing of her as a person. The I understand look from me in response, the recognition of the privilege I have been granted in being allowed 'in' to help, to care.

There was an awareness of the underlying need for recognition of what and why Mary was feeling the way she was. By acknowledging her pain, her exhaustion, her situation that will change little at present, it made it more bearable. My belief in her, that she can cope, may have provided her a glimpse of hope. It was the accepting of that person the way she is no matter how she was feeling or acting. She is valued as the person she is, at her innermost spiritual level, the core of her humanness (Sellers and Haag, 1998: 338).

This is a privileged level of intimacy that has occurred in our nurse-client relationship. It is a mutual relationship of personal response. It is a personal "I-Thou" relationship as termed by Buber (in Bishop and Scudder, 1996: 45; Carper, 1978: 18). It promotes healing and well-being of the person's inner self. *It is nursing*. As Swanson (1993: 357) found "...nurse caring frequently consists of subtle, yet powerful, practices which are often virtually undisclosed to the casual observer, but are essential to the well-being of its recipient."

As a family and child health nurse, my practice is at the heart of caring. As an autonomous practitioner of nursing I have the privileged position of working with families at a major life transition period. Health is viewed in its broadest and deepest sense. I am working with women, men and their families promoting their health and well-being. This is a dynamic process that I do not control but can enhance. There are powerful healing benefits when working with vulnerable people in a low-key professional manner. It is not professional power that is important in caring, it is healing power.

Conclusion

This journey of reflection has been enlightening, and I have come to see what I do through a powerful new lens. My questioning of the value and importance of my practice and my difficulty in articulating this sent me on an exploration of caring. That intangible concept that is integral to life, and the basis of nursing. Entwined with women and nursing, its devaluing throughout history was explored. I came to see that the importance I placed in the personal interaction and relationship was well founded. Working in a low key, enabling manner, which did not emphasise my professional status, provided the best opportunity to enhance the well-being of the family I was working with. I came to see that as a family and child health nurse, I was at the heart of caring. My nursing had powerful healing potential.

What I do is caring, it is nursing and it is powerful healing. If I, as an experienced nurse, cannot learn to articulate the importance of what I do as the vital caring that it is, then caring and nursing will continue to be devalued and dismissed. I am fortunate to work in an area where I can practice

holistic health promoting nursing.

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[1] To ensure confidentiality, pseudonyms have been used in all journal extracts in this paper.