

# 1 The Therapeutic Use of Self in Nursing

*Dawn Freshwater*

The nature and/or the existence of the 'self' is a topic that is well rehearsed in the literature surrounding healthcare. Indeed the notion of what constitutes the self is a subject that has interested poets, artists and philosophers alike. Writers have described theories of self in philosophical terms (Satre, 1956), theories of self in psychological terms (Laing, 1961; Freud, 1963; Lacan, 1966), in spiritual and transpersonal terms (Rowan, 2001; Wilber, 1981), in biological terms (Ginsburg, 1984), modernist terms (Giddens, 1990) and more recently post modernist terms. Postmodern versions of the self challenge both the permanence and indeed the presence of a self at all, that is in the sense usually proposed (Fee, 2000; Flax, 1990; Gergen, 1991; 1997). Whilst definitions of the self derived from these varying theoretical perspectives are diverse, there is also some convergence. This chapter explores some of these definitions, reflecting upon the meaning of the self in the therapeutic alliance both for the nurse and the patient. Introducing the concepts of the self, self-awareness, self-efficacy, self-esteem and the therapeutic use of self, this introductory chapter aims to signpost the basic ideas under consideration with subsequent chapters.

Recent debates divide the theories of the self into two types, those of ego & bundle theories (Gallagher & Shear, 1999). Ego theories (in some way the most natural way to think about the self) believe in a persistent self. A self that is the subject of experiences and whose existence 'explains the sense of unity and continuity of experience' (Blackmore, 2001: 525). This equates with the dominant modernist viewpoint which will be outlined in more detail shortly. Bundle theories deny any such thing. As Blackmore points out, 'The apparent unity is just a collection of ever changing experiences tied together by such relationships as a physical body and a memory' (2001: 525). This perspective can be likened to the postmodernist perspective of the self which it would seem is becoming ever more inescapable.

## **The self**

Consideration of the nature of the self is deeply bound up with questions about consciousness, about which the scope of this book does not allow an

in-depth exploration. Hence whilst the fathomless abyss of consciousness and unconsciousness, reality and subjectivity are fundamental to any exploration regarding the nature of the self, the subsequent discussion will be limited to points of contextual relevance. In addition, there may be a number of contradictory standpoints presented simultaneously within this chapter; I do not apologise for this, rather I encourage the reader to tease out these inherent contradictions in the understanding that the self is in fact a contradictory being, if indeed a self does exist. The reader is encouraged to pursue further writings as indicated in order to expand the ongoing conversation pertaining to the nature of the self.

It has been argued that the concept of a self possessed by a person is a product of both personal reflection and social interaction. Priest's defines the self as 'an individual that is conscious of the individual that it is while at the same time being conscious that it is the individual it is conscious of' (1991:163). The experiencing self as described by Bohart (1993) and Maddi (1989) is essentially anti-reductionist in nature. Life is apprehended through experiencing, which involves an interplay of thought and feeling, without either of these concepts being conceived of as polar opposites (Bohart, 1993). Humanistic psychologists, however, describe the self as conceived of separate entities. Rogers (1991), for example, speaks of the organismic self and the self-concept. The organismic self is that aspect of the self which is essentially the 'real' inner life of the person and is present from birth. The organismic self consists of the basic force that regulates the individual's physiological and psychological growth; growth and maturity are seen as the central aims of this aspect of the self (Hough, 1994; Rogers, 1991). Therefore the focus of the organismic self is essentially internal. This view of the self purported by humanistic psychology has recently been challenged by social constructivism, deconstruction and postmodernism. All of these theories say in their own way that there is no 'real' self as defined in the sense usually proposed by humanistic and modernist theories.

As some authors have observed, the dominant modernist view specifies that the self is a 'finite, rational, self-motivated and predictable entity which displayed consistency with itself and across contexts and time' (Gottschalk, 2000: 21). Hence from a modernist perspective the self can be either healthy or pathological; it could also be observed, diagnosed and indeed improved. Postmodern theory, however, challenges this assumption, positing that the self is a conversational resource, that is to say, it is a story we tell to others and ourselves. Androutsopoulou, for example, states that from the narrative and social constructivist viewpoint the self:

... equals to a continuous construction of a self-narrative, aiming to secure a sense of historical continuity, directionality and coherence among what often appear to be loosely connected 'selves' that may seem to act differently depending on the circumstances. (2001: 282)

Thus the 'solid and stable modern self loses its' footing and becomes fluid, liminal and protean *selfhood*' (Gottschalk, 2000: 21, original italics). Postmodern theories then move beyond the concept of a stable and static self, rendering it obsolete, to the notion of the self as a continuous process, constituted through multiple and often contradictory relationships. Thus the self as postmodern selfhood is

iterative, interactive and interdependent. This has obvious implications in the context of a book which focuses on the therapeutic use of the self in work which is largely relationship based; namely that of nursing.

### **The self as a concept and self-concept**

The very conception of a self is conceived of as a by-product of the relationship between power and knowledge; it is inseparable from language games, from mass media and ideologies, and as Gergen (2000) comments loses its sense of substance in the ongoing construction and dissolution encountered within everyday relationships. He says of the self 'increasingly we find no "there" there' (2000: 100). Hence self-identity becomes a reflexively organised endeavour constructed through intrapersonal and interpersonal dialogue (Freshwater & Robertson, 2002). Nevertheless, there are a multitude of theories and an ever-increasing amount of literature being written concerning the self and its various aspects. One such aspect is that of the self-concept.

According to Burns the self-concept is 'forged out of the influences exerted on the individual from outside, particularly from people who are significant others' (1982: 9). This definition is in accord with the humanistic school of psychology, which views the self-concept as the individual's perception of himself, based on life experience and the way he sees himself reflected in the attitudes of others (Rogers, 1991).

According to this theory, the self-concept is acquired very early on in life and is continually reinforced by ongoing communications with significant others throughout life. As the self develops it needs to feel loved and accepted and as a result the organismic self (or the 'real' self) is neglected in favour of the self-concept. This is a point that Maslow (1970) illustrates in his hierarchy of needs (See Figure 1.1).

These ideas are not dissimilar to the theories of self developed by Carl Jung (1960). The self-concept can be likened to Jung's idea of the persona, with the psyche sitting closely to the organismic self. For Jung the self was buried in the

Need for  
Self-actualization  
(Am I myself?)  
Recognition needs  
(Am I successful/repected?)  
Belonging needs  
(Am I loved, do I belong?)  
Safety Needs  
(Am I safe/comfortable?)  
Physiological needs  
(Will I survive?)

**Figure 1.1 Maslow's hierarchy of human needs (1970)**

unconscious and full of creative potential. Jung believed that the aim of the psyche was towards individuation, that is the growth of an individual towards becoming aware of all aspects of their personality, leading to a better balance between their internal and external worlds and a subsequent integration of opposites. Through the process of socialisation, the self is repressed and thwarted; a persona (or mask) is developed as the individual becomes absorbed in enacting roles. Thus the individual becomes alienated from who they are and who they might become. Self-alienation, in this sense, meaning that in which the 'subject is no longer the author of the ongoing narrative of his self' (Dawson, 1998:164), implying a loss of control over the self.

The focus of the self-concept is predominantly external. Rogers (1991) believed that the tendency of the organismic self was towards harmony and integration of discomfort arising as a result of inconsistency in ideas and feelings between the organismic self (the inner) and the self-concept (the outer). Burns (1982) contends that the self-concept has three roles, one of which is that of maintaining consistency, the other two being determining how experiences are interpreted and providing a set of expectancies. Where consistency is not maintained, a degree of dissonance is experienced (Festinger, 1957) and the discomfort that this causes is likely to motivate the individual to take action towards harmony and comfort, at any cost. It is often the awareness of discomfort with self that motivates the individual to engage in reflection. Such reflection, when undertaken in relation to nursing practice, often leads to the practitioner examining the contradictions between their espoused theories (desired practice) and their theories in action (actual practice) (Arygris and Schon, 1974).

### **Self-concept in nursing**

The self is an important concept in nursing as in any therapeutic alliance, for often when patients are physically ill or psychologically distressed 'the most striking and consistent feature reported is a changed self-concept' (Dawson, 1998: 164). The goal of any therapeutic alliance (and incidentally emancipatory and transformatory learning, a topic that is considered in more detail in Part II of this book) is to facilitate the emergence of the authentic self (Friere 1972; Hall, 1986). In his recent work refining the humanistic approach to human inquiry, John Rowan (2001) writes of the authentic self (which he also refers to as the true self, the real self and the Centaur). The authentic self, he determines, lies beyond self-images, self-concepts and sub-personalities; requires that the individuals take responsibility for being themselves and for being 'fully human' (2001: 115). In this sense Rowan aligns the authentic self with the mystical self and draws heavily on the existentialist traditions and the work of Ken Wilber (1996; 1997). So, for Rowan and others the real or authentic self, when fully autonomous, can assume responsibility for being-in-the-world (Heidegger, 1972).

There is a Hasidic tale that illustrates Rowan's point beautifully:

Before his death, Rabbi Zusya said 'In the coming world, they will not ask me "Why were you not Moses?" They will ask me "Why were you not Zusya?"

Rogers also captures the centrality of this point when reflecting on the work of Kierkegaard, whom he says:

... pictured the dilemma of the individual more than a century ago, with keen psychological insight. He points out that the most common despair is to be in despair at not choosing, or willing, to be one's self; but that the deepest form of despair is to choose to 'be another than himself'. On the other hand 'to will to be that self which one truly is, is indeed the opposite of despair', and this choice is the deepest responsibility of man. (1961: 110)

From this vantage point the role of the nurse in caring can be seen to be to transcend the self-concept, the persona (or what Winnicott (1971) might term the false self) in order to give voice to the organismic self, authentic self and to encourage, through a therapeutic alliance, the emergence of the authentic self of the patient (Rogers, 1991). This process necessitates a great deal of self-awareness and self-consciousness, a subject that will be touched on briefly in the following section. However, this is probably a good point at which to introduce some scepticism in relation to the idea of a self-concept and an organismic real self. As I mentioned at an earlier juncture, postmodern theories question the whole idea of a real self; from this particular stance there is no such thing as 'being authentic (true to oneself) or autonomous (taking charge of one's life) or self actualisation (being all that one has in oneself to be) (Rowan, 2001: 120). Rowan, however, works hard to reinstate the real self in his latest work on action research and the reader is pointed to this for an interesting and in-depth analysis (and indeed defence) of the idea of a real self (Rowan, 2001). Discussions on the real self, self-concept and authentic self cannot take place in isolation from Freud's (1963) theories of the ego. In an earlier paper I attempted to highlight the impossibility of the human ego to perceive unity or wholeness, saying that 'Immediately I call myself "I", I cut myself off from everything that is "not I"' (Freshwater, 1999a: 136). Consciousness, splitting and dissecting experiences into pairs of opposites as it does, forces us to encounter the dualistic (and indeed pluralistic) nature of the self. It is to the idea of consciousness and the self that I now turn my attention, linking this to the theory of reflection and the notion of intentional action.

### **Self-consciousness and awareness of the 'I'**

The practice of reflection is a central skill in developing an awareness of the self. The 'I' being self-conscious disappears in repetitive doing and is only found again when reflected upon (Spinelli, 1989). The process of repetition of routine

tasks and focus on 'doing' (something that tends to dominate nursing, see Menzies, 1970) leads to a loss of 'I' or the self. Reflection on self is proposed as helping the practitioner to reform their identity through being in relation with themselves, the patient and others, instead of having an identity that is forged by their surroundings. Without reflection the practitioner may not be aware of the loss of self, which often manifests itself in somatic and psychological symptoms such as burn-out, disconnectedness and a sense of meaninglessness. Furthermore, practice, which is not reflected on either after the event or reflexively during the event, is not necessarily intentional practice.

According to Burks the concept of intentional action 'is especially relevant for those whose goal it is to change or maintain behaviour.' She goes on to say that 'In many nursing situations the intent of the nurse is to influence the action or behaviour of the client' (2001: 668). But not all action in nursing is intentional, in that it does not necessarily include mental processing neither of the intent nor of the conscious deliberative plan. This is to say that it does not always include an awareness of the (aspect of the) self that is practising. Bandura (1991) proposes that self-regulation and self-influence are the motivating factors in purposeful human action and whilst self-regulation is a multifaceted phenomenon, significant components of effective self-regulation include self-observation and monitoring of self-efficacy. Reflective practice provides such an opportunity for critically reflexive observations of self as practitioner and person, placing the self as central agent in the dynamic process of creative, autonomous and accountable practice. As Burks comments, 'intentional action originates from an actor's desires and wishes, it is influenced by motivation, emotional state, and the concept of self as the active agent' (2001: 669). Nursing theorist Peplau argued for ideas similar to this in 1952 when she asserted that 'Self insight operates as an essential tool and as a check in all nurse-patient relationships that are meant to be therapeutic' (1952:12).

Knowing and recognising self through self-awareness and self-consciousness then can be seen to be fundamental to the development of a caring alliance which is to be therapeutic. As Boykin comments, 'The importance of knowing self as caring cannot be overemphasised as one can only understand in another what is understood in oneself' (1998: 44).

## **Self-recognition**

Most human beings are born into a culture in which the mirror is a significant artefact (Miller, 1998). In such a culture the act of self-inspection is spontaneous and recurrent. But how do we succeed in recognising our own reflection if we do not know what we look like until we look in the mirror, how can we tell that the reflected face is ours? Miller posits that the individual 'in recognising everything else that appears in the mirror as a duplicate of what we can see around us, we might deduce the identity of our own reflection by a process of elimination since it would be the one item appearing in the mirror for which there were no counterpart

in the immediate environment' (1998: 135). He goes on to comment that a much more significant clue regarding the identity of the image in the mirror is that 'its behaviour is perfectly synchronised with our own' (1998: 135).

But where is the optimum place for the development of self-awareness and even self-regard, for such needs are often linked to the negative attributes of vanity, self-absorption and narcissism. Narcissus, the most (in)famous example of an individual to be annihilated by reflective self-absorption, has been depicted as someone who fell in love with himself and as a result suffered a fatal outcome. But as Ovid asserts in *Metamorphoses*, Narcissus fell for his own self-reflection without recognizing that he was looking at himself.

If psychotherapeutic practice and developmental theories are to be believed, then one of the most effective arenas for discovering the self is in a therapeutic relationship; that is, a relationship that facilitates such discovery in a safe and contained manner. Being with other people allows the individual to become aware of themselves through a variety of different experiences, including as Taylor (1998) suggests, through self-likeness. Self-likeness is when people see themselves mirrored in other people. Taylor advocates that in nursing 'self-likeness creates the potential for patients and nurses to understand the humanness of themselves on others, sharing an affinity as humans together bonded by the commonality of their ordinary human existence' (1998: 70).

Coming to know self as human through reflection is a complex and often confusing, if not demanding, call for nurses not least because pride, vanity and self-intoxication seem to come hard for those in the caring professions (as for other sectors of contemporary society), where it is not safe to speak of let alone enjoy self-love (Watson, 1998). Much of the research examining self-esteem in nursing and the caring professions concludes that contextual factors conspire to diminish the self-esteem and subsequently the efficacy (and therapeutic potential) of the nurse resulting in self-doubting, submissive and often disillusioned practitioners (see for example Chapters 3, 5 and 9 in this book) (Freshwater, 2000).

### **Self-esteem, self-efficacy and self-regard**

Self-esteem is commonly defined as the evaluative aspect of the self; it is a popular concept in the professional discourse surrounding the self and is often linked to the notion of self-regard. Whilst social psychologists usually relate self-esteem to the evaluative aspect of self-regard, other writers put forward self-esteem as a derivative of the affective dimension of the self, for example, whether one feels good or bad about oneself. It is also linked to self-knowledge, thus 'Reflexivity prompts an emotional response to self, and that is the fundamental reality to which self-esteem refers' (Hewitt et al., 2000: 170). Hewitt et al. endorse this association further stating that 'Self esteem (and its associated terms of reference) thus provides a label the person may attach to feelings aroused when he or she sees the self reflected in the social mirror' (2000: 171).

It appears that self-esteem resonates strongly in a culture that emphasises the centrality of the individual and that has a long tradition of discourse about the 'power of positive thinking' to help the person overcome obstacles, find success and enjoy happiness' (Hewitt et al., 2000: 171). Little wonder, then, that social theorists emphasise the connection between self-esteem and self-efficacy. Bandura (1986), for example, suggests that self-efficacy is related to levels and experience of self-confidence and self-concept, all of which are fundamental to the experience of self-esteem.

It is posited that is a 'good thing' for therapists, counsellors and healthcare workers, including nurses, to be self-aware in order to maximise their effectiveness when working with their clients (Bond & Holland, 1998; Boykin, 1998; Briant & Freshwater, 1998; Casement, 1985; Freshwater, 1998a; Higgs & Titchen, 2001). It has also been contested that in order to begin to understand and help other people, therapists, nurses and carers need to be aware of themselves. It is argued here that self-awareness does not only benefit relations with clients, but is crucial to the health and well being, and subsequently the self-esteem and therapeutic efficiency, of the practitioner.

There is much talk about the therapeutic use of self in the psychological literature (Casement, 1985; Sedgwick, 1994). As mentioned earlier, emphasis is placed on the necessity for the therapist to act with intention when acting in a therapeutic way, suggesting that a degree of self-awareness is required (Casement, 1985). As Jung (1960) proclaimed, 'the therapist must at all times keep watch over himself ... over the way he is reacting to his patients' (1960: 33). This is not to deny the therapeutic value of natural spontaneous emotional displays for clients, but one must have a 'self' available and be aware of that self in order to use it therapeutically.

Reflective practice is a way of viewing and participating in the unfolding drama of the self in becoming; the practitioner can watch themselves being invented as a therapeutic practitioner, engaging in intentional and deliberative practice, whilst at the same time be aware that they are inventing themselves. Hence 'Through the unfolding experience of reflection the nurse is looking backwards to the future, she is becoming whilst being', recognising his or herself as a dynamic and worthy being whose presence makes a difference (Freshwater, 1998b: 16). So, what has all this to do with therapeutic nursing and to ask a now familiar plea, what does it mean for the patient at the receiving end of the nursing (as if the practitioner is somehow not also the receiver)?

### **Therapeutic use of self**

Originating in the field of psychotherapy, the concept of the therapeutic use of self is widespread throughout healthcare literature; little, however, has been documented regarding the experience of the therapeutic effect of nursing. Ersser (1998) points out that the concept of therapeutic use of self in nursing has been



influenced by those nurse practitioners with a psychotherapeutic interest (see for example Peplau, 1952; Hall, 1969; and Travelbee, 1971).

As Ersser notes, and as alluded to previously in this chapter, emphasis is given to the importance of the nurse acting with intention when aiming to be therapeutic. Travelbee, for example, defines therapeutic use of self as 'When a nurse uses self therapeutically she consciously makes use of her personality and knowledge in order to effect a change in the ill person. This change is considered therapeutic when it alleviates the individual's stress' (1971: 19).

Ersser's (1997) own study challenges this notion, arguing that the therapeutic potential of the nurse's presentational actions may be 'communicated to the patient with or without intention' (1998: 56). Concluding that there is still a need to examine the nature of therapeutic nursing, Ersser calls for a re-examination of what he calls the 'received concept' of therapeutic use of self, one which allows for and values the nurses' 'natural, spontaneous emotional display for patients which is not intentionally purposeful' (1998: 56). One might question this call, for whilst some natural and spontaneous actions may not appear to be purposeful (see Winnicott's analysis of play, for example, 1971), there may still be intentionality which is not yet known. Other writers too argue that all human action is undertaken to achieve a purpose or to execute an intention (Ewing & Smith, 2001; Langford, 1973). This is to say that 'all human actions, including nursing actions, reflect ideas, models, or some kind of theoretical notion of purpose and intention and how these purposes and intentions can be executed' (Freshwater, 1999b: 29). The exploration of these alternative vantage points form the beginnings of a response to Ersser's challenge to revisit the therapeutic use of self in nursing; this text provides a forum for debate regarding contemporary issues related to the concept of therapeutic use of self and indeed contemporary developments in therapeutic nursing in healthcare.

## **Therapeutic nursing?**

McMahon (1998) identifies a number of characteristics that may affect the practitioner's ability to nurse therapeutically. Drawing on the work of Muetzel's (1988) models of activities and factors affecting the therapeutic nurse-patient relationship, McMahon validates the mutually beneficial relationship that is therapeutic nursing, emphasising the role of self-awareness and evaluation to achieve the same. Muetzel argues that the ability of the nurse to partake in a therapeutic relationship is dependent upon the nurse having developed as a person, both personally and professionally. Butler (1995) concurs, saying 'The qualities of the personal self within the professional are the key to excellence' and that 'professional development is radically centred in development of self' on 'personal being and becoming' and the 'understanding of individual human agency in the realm of practical actions' (1995: 153). Drawing upon Labone (1994), Ewing and Smith argue that 'In our development as practitioners we must continue to reconcile our ideal professional self and our actual professional self' (cited in

Higgs & Titchen, 2001: 25), indicating that the prevailing perception of a lack of integration with regards to the self persists. This perhaps affirms the postmodern view that the self is not only fragmented but consists only of fragments tied together which can be integrated through the current self-narrative.

On the point of integration Field and Fitzgerald (1998) indicate the need for therapeutic nursing to be both integral to everyday practice, explicitly, in which it forms the foundation for all nursing, and discreetly, whereby specific therapeutic skills are practised within the context of a therapeutic alliance.

### **Self as worker – the professional self**

It was suggested earlier that knowing self is a frequently unmet challenge by nurses, who usually have an inclination to focus on the behaviour and potentials of others finding it difficult to focus on them'selves'. Although paradoxically it is the focus on other that very often brings self-appraisal; this is one of the rewards of doing the work. However, it has also been pointed out that the self (in modernist terms) develops a persona, a self-concept with which it faces the world. For some nursing authors this represents the schism between the professional self and the personal self, or what Taylor (1998) refers to as 'the ordinary self'. She suggests that:

...some nurses may choose to hide behind their professional masks and talk in high falsetto pitch to mimic the 'soapie' representations of a 'real' nurse. Acting out the role of a nurse may also serve to protect the hapless practitioner from the everyday battle-front of clinical work, where emotional knocks and bruises may be the norm.' (p. 74).

She goes on to say that in the uncertain context of professional practice 'a façade may act as armour to protect nurses from the daily drama of human suffering. In this sense, nurses are patients of sorts, in that they also suffer because of the illness experiences of the people for whom they care' (Taylor, 1998: 74).

So it would seem that, for the nurse, the professional self is defined in relation to others (namely patients) as it is for the client (namely the nurse). When discussing the self in relation to others, the word 'personality' is often used, and whilst it is not something that can be expanded upon here, it is important to note that the concept of a personality is of direct concern to this book (most notably Chapters 4, Part II and Chapter 9) in that it is closely linked to the issue of relationship.

The word 'personality' is used to describe the way people are perceived in relation to others. Their personality is the thing that distinguishes them from others. One might question if there are certain types of personality that are attracted to therapeutic work, or indeed does the personality attract the work? Perhaps, as Kolb explains, there is an interplay: 'Environments tend to change personal characteristics to fit them' (the process of socialisation perhaps linked to the earlier discussion regarding self-esteem and self-regard), however 'people tend to select themselves into environments that are constant with their personal

characteristics' (1984: 143). What does seem important here is the level of self-awareness involved in making the decision to work with the selves of others and inherent in this decision is the level of conscious self-choice and perception of (internal) locus of control (as opposed to unconscious needs, perceived external locus of control) (Rotter, 1966).

The idea of a professional self is also directly linked to the theory of locus of control. As Rotter (1966) points out, work performance is closely aligned with the worker's locus of control; that is, whether nurses perceive outcomes as controlled by themselves or by external factors, this is obviously an important concept for practitioners when viewed in terms of the parallel processes with their patients, whom also will be negotiating power and control in the management of their health needs. Perception of control is important to the self and all individuals, whatever their walk of life. Rotter (1966) maintained that certain individuals believe that there is a strong link between what they do and what happens to them (originators of behaviour), while others deny or minimize this link and explain events on the basis of fate, luck or chance (non originators). Hence when individuals perceive the event to be dependent on their behaviour, they have an internal locus of control. If, on the other hand, they believe that they do not have any control over events and attribute success or failure to outside forces, they have an external locus of control. This also has implications for the patient who comes to the therapeutic alliance in search of some new learning which will re-instill in them a sense of self-control and self-reliance. Part I of this book provides examples of practitioners who are negotiating their way through the healthcare system, learning about themselves both as professionals and as powerful, self-determining human beings.

### **Self as learner – the developing self**

Factors such as self-awareness and locus of control play a crucial part in the nurse and patient being open to new learning and expanding consciousness (and in turn self-awareness). As already revealed, Jung's (1971) opinion of the self-mooted reveal several different aspects to the personality, which strive to become integrated. He included in these, attitudes towards the outer world and ways of perceiving the world. Jung (1971) indicated four predominant ways of perceiving the world: thinking, feeling, intuition and sensing. In addition, individuals approach the world from either a predominantly extrovert or introvert manner. Although it should be noted that Jung maintained that a person's psyche contains all of these aspects, but in their development identify with a preferred way of translating information. Scales have been devised to measure the extent to which an individual has a preference for ways of relating to the world (Myers, 1980; Jung, 1971). Similarly, it is debated that individuals have a preferred style of learning (Kolb, 1984). It could therefore be argued that not only are different theoretical perspectives of the self required, but that the differing approaches to therapeutic use of self that are derived from the varying theoretical constructs are necessary in order to meet the diverse needs of the learning self.

These are significant considerations for the learning and teaching process as Field and Fitzgerald so poignantly articulate: 'The obvious corollary of therapeutic nursing is the development of practice-led curricula' (1998: 100), which concentrates upon the learner and 'the practitioner becoming responsible for and capable of controlling his or her own learning and practice' (1998: 101). Therefore, student-centred philosophies of education that include self-evaluation, student autonomy and education as life-long self-directed processes need to be fully embraced as part of the development of the therapeutic practitioner. Part II of this book outlines examples of student-centred philosophies that are not only firmly embedded within the nursing curricula, but are lived in everyday teaching practice in creative and therapeutic ways.

### **Self as researcher**

It was posited earlier that the modernist conception of the self meant that it could be observed, diagnosed and improved. This rather objective language promotes a view of self-observation as if the self were being observed in an objectified manner by an (external) other, as opposed to a subjective investigation of oneself in dialogue and conversation with others (including oneself). For all the postmodern criticisms of humanistic psychology, it has promoted a view of research which involves treating research participants as human, and as was indicated earlier, humanness is deemed by some authors to be a fundamental component of therapeutic nursing (Taylor, 1998). As such the researcher personally is also human and does not hide behind roles; taking reflexivity seriously, the self as researcher does not exclude themselves from the research process, rather they see themselves as co-participants in the research endeavour.

This approach to research is not novel, although nursing still struggles to adapt to such radical perceptions of research in its drive towards evidence-based practice. What might be more novel is the idea that the process of the research itself might be the therapeutic, that is to say that the research itself is the therapy. Bentz and Shapiro (1998) applaud the cotemporary development in therapeutic research stating that 'the cotemporary situation in inquiry and research is one that is conducive to an integration of personal and philosophical self-reflection and also requires it' (p. 34). They go on to say that in their work with students 'we have observed over and over again the way in which the process of carrying out a research project seems to promote psychological and even spiritual development and transformation' (Bentz & Shapiro, 1998: 34).

This type of practitioner-based enquiry is called transformation because the people involved change; this includes all participants. But what makes reflexive inquiry transformational is the pattern of data collection, which is collaborative; in this sense the researcher is transformed from observer to participant. Engaging in reflexive research then means that all those involved are participants in the research endeavour, deconstructing the narratives that are created by and about

self and about the therapeutic alliance. Part III of this book identifies ways in which practitioner-based research might transform and influence practice, and indeed self.

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