Therapeutic reciprocity: A caring phenomenon

Fully realizing the power that caring can create in practice demands attention to those aspects of nurse–client relations that promote effective caring. The thesis of this article is that therapeutic reciprocity, as one phenomenon of caring, allows both the nurse and the client to benefit from their relationship in a mutually empowering manner. Through concept analysis it becomes evident that therapeutic reciprocity extends commitment to an ethic of caring from a morally correct position to a nourishing life force in professional nursing. The riches of caring are affirmed, and one path to their realization is illuminated.

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"GIVE AS MUCH as you receive, and all is for the best."[1(p207)] Equity theorists McClintock et al[1] cite this Maori proverb to propose a view of human behavior for social psychology. Nurses seeking to actualize an ethic of caring in their practice may also find considerable food for thought in these words of folk wisdom. As a concept recurrently surfacing in the nursing literature,[2–9] reciprocity deserves further examination of its therapeutic properties. Through a review of existing literature and an explication of its attributes, antecedents, consequences, and empirical referents,[10] a conceptual analysis of therapeutic reciprocity affirms the value of caring to the nursing profession ascribed by many nurse theorists.[2,11–13] In operationalizing a definition of therapeutic reciprocity, a caring phenomenon is articulated, and future directions for all facets of the nursing profession are implied. Exploring the mean-

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ing of therapeutic reciprocity therefore uncovers a path to caring that extends it from a morally correct position to a nourishing life force in professional nursing.

REVIEW OF EXISTING LITERATURE

Reciprocity has been defined as a mutual action or relation, a mutual exchange, an action or relation given in return, or feeling in return.[14] In an analysis of justice, Eckhoff[15] proposes that reciprocation is a give and take between two parties, in which one transfer of resources is conditioned by the other. In indebtedness theory, the desire of a person to reciprocate is viewed as a wish to reduce indebtedness in relation to another for a variety of underlying reasons.[16] For equity theorists, the motivation to reciprocate is influenced by one's perceptions of the fairness of a given situation,[1] and lack of opportunity to reciprocate is seen to be a potential barrier to effective seeking and use of help.[17]

In the nursing literature many researchers and scholars have addressed reciprocity in their work. In Rogers' coined term of reciprocity as a homeodynamic principle, assumptions of wholeness and openness are made, and the "relationship between human and environmental fields is one of constant mutual interaction and mutual change."[3(p10)] While Rogers has more recently discontinued this term in the belief that it was not understood,[18] her newer principle of integrality and her description of "knowing participation"[19(p4)] delineate similar postulates. Fry[4] and Noddings[5] both recognize the importance of mutuality and reciprocity in the nurse–client relationship, and Watson's[2] conceptualization of transpersonal caring describes a therapeutically reciprocal process. Thorne and Robinson[6] propose a model of health care relationships that advocates reciprocal versus absolute trust, and the therapeutic values of mutual learning and mutual self-disclosure in nurse–client relations are explored by Yuen[7] and Young[8] respectively. Gadow calls for a caring ideal in which "mutuality becomes the moral foundation of nursing."[9(p43)] Variations on a theme of therapeutic reciprocity have thus held nursing's attention over a significant span of time.

ATTRIBUTES OF THERAPEUTIC RECIPROCITY

From all these perspectives on reciprocity, a common theme of mutual exchange emerges. Whether examined in the more tangible forms of gift giving[20,21] and mutual accommodation of personal space[22] or the less quantifiable instances of mutual self-disclosure,[8] exchange of humor, and efforts to enlist client participation in decisions about their care, a mutual process appears to be occurring. Furthermore, to the extent that this mutual process has a shared meaning for the participants, reciprocal effects reflecting the content of the shared meaning are evidenced by the parties involved. For example, where personal space is violated, avoidance behaviors surface[23]; conversely, where per-

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sonal thoughts and feelings are appropriately disclosed to one another in the nurse–client encounter, trust and empathy are promoted.[8] Reciprocity as an entity is therefore neither inherently positive nor negative in nature. Rather, where authentic reciprocity exists, equal and unidirectional outcomes of either a beneficial or detrimental character are manifested by all the involved parties. In assuming therapeutic value, however, reciprocity becomes positive in its effects for both the nurse and client.

This equal and unidirectional nature of reciprocity has significant implications for the nurse–client relationship. Benner and Wrubel[11] point out the danger of nursing from an emotional distance in their discussion of the role of caring in developing effective coping skills. These theorists assert that rather than augmenting one's ability to cope with stressful nursing situations, such emotional numbing alienates the nurse from the humanity of the client and from that of the nurse as well. They propose that where the nurse and client are able to remain open to the feelings generated by the meanings of a particular situation, valuable information for coping with the inevitable stresses of help seeking is gained, and the humanity of both the nurse and the client is affirmed. This analysis of caring is particularly relevant to Callahan's[24] view of ethical decision making, in which emotions and reason are seen as "mutually correcting resources in moral reflection."[24(p9)] Therapeutic reciprocity may thus be posited to enhance the genuine exchange of feelings, thoughts, and experiences that appear to be central to decision making, both for the client and the nurse.

From this view of nurse–client relations, actions designed to "cut the cost" of caring extract a price of a different kind, and the equal and unidirectional aspects of reciprocity determine the extent of loss for all parties concerned. To the extent that vital information about their shared situation is not exchanged between the nurse and client, effective approaches to care are diminished. Decisions are made with incomplete knowledge and blunted emotions, and the outcomes of the experience for both client and nurse range from less than optimal to identifiably harmful.

Where the reciprocity is therapeutic, however, the authentic exchange occurring transforms the "costs of care" into shared experiences that produce positive growth for both nurse and client. Participation in care is truly "knowing,"[19(p4)] as the parties involved develop open access to both their own humanity and that of each other. Insights that freely flow between the nurse and client guide the decision-making process to those outcomes that are best suited to the unique individuals concerned. Reciprocity is therefore not constituted by the care given but rather manifests itself in the shared meanings between nurse and client that their encounter creates. Where those shared meanings are positive ones, genuine caring has occurred, and the reciprocity created generates therapeutic outcomes for both the nurse and client.

From the commonalities of mutuality, exchange, openness, shared meanings, and risking the cost of caring that appear to characterize therapeutic reciprocity, a shared control of the nurse–client relationship is implied. The collaboration, negotiation, and client participation in care referred to by Thorne and Robinson[6] in their recommendations for trust in health care relationships become difficult to envision in an interaction that is not therapeutically reciprocal.

Shared control, in turn, dictates a probabilistic as opposed to causal view of outcomes in nurse–client encounters, as exemplified by Benner and Wrubel's[11] concept of "situated possibilities."[11(p124)] Therapeutic reciprocity thus assumes a tentative nature, where ongoing "epistemic feedback"[25(p138)] guides and alters future behavior accordingly. Outcomes are therefore not predetermined but rather are monitored and tempered by the ongoing knowledge attained by both nurse and client in their reciprocally therapeutic exchange.

For the nurse, this knowledge is acquired by skilled efforts to understand the perspective of the other,[26] and therefore therapeutic reciprocity describes an exchange between nurse and client that is referenced both subjectively and objectively by personal and empirical data respectively. At the expert level of practice, this "knowing" of a particular client's perspective, with its attendant grasp of whole situations, may be occurring in what has been described as an intuitive manner.[11,27,28] The knowledge received and acted on by the nurse cannot necessarily be broken down into analytic principles, and arbitrary categories of data are subsumed by a more powerful perception of the overall meaning of the situation.[27]

Similarly, in asking clients why their thoughts, feelings, and reactions in a specific situation occurred as they did, a response that lends itself to rational analysis is frequently not forthcoming. The phenomenon of intuition thus provides an explanation for both nurses' and clients' behaviors in this context, where actions are at least partially informed by personal knowledge received in a whole, irreducible form. It may also explain the finding in Pyles and Stern's[29] work that critical care nurses considered clients' intuitions as significant data in their clinical decisions. In understanding the value of their own intuitive judgment, they were able to acknowledge reciprocally the worth of their clients' experiences of intuitive knowing. This suggests that in the therapeutically reciprocal nurse–client relationship, mutual learning is taking place. Equally, therapeutic reciprocity verifies the importance of nursing research that explores shared understandings between nurses and their clients[30,31] and provides theoretic basis for further investigations of a similarly dyadic nature.

A final implication of shared control in therapeutic reciprocity is the empowering nature of mutual responsibility for the nurse–client relationship. Neither the client nor the nurse holds sole accountability for the outcome of the encounter; through the mutual exchange of meaningful personal perspectives, the "power to be and to become"[32(p198)] through relation to others is facilitated. The client gains efficacy in coping with the concerns underlying help seeking, and the nurse experiences efficacy in the provision of care that genuinely helps. A mutual effort in which each party brings to the situation what they are authentically able to give creates meanings that change the outcome for the better.[11] Instances of hospice clients who, in an environment that accepts rather than suppresses the meanings of dying, "appear to have risen above their own condition and to have seen a larger picture"[33(p116)] may be illustrations of this aspect of therapeutic reciprocity.

Therapeutic reciprocity as discussed above therefore pertains to a phenomenon that is a mutual exchange of meaningful thoughts, feelings, and behavior; is probabilistic, collaborative, instructive, and empowering; and is subjectively and objectively referenced by personal and empirical data in

a dyadic manner. In view of the broad scope of these attributes, any given clinical example must be stressed as illustrating only one variation on a theme with infinite possibilities. With this proviso, the following model case is offered as one that illustrates the concept of therapeutic reciprocity.

The nurse who contacted Julie 8 weeks after her abortion received a guarded response to her initial greeting. "I'm fine, I'm OK," she said in a flat and distant voice. As the nurse questioned Julie more specifically, information about Julie's experiences since the abortion began to take shape. Julie expressed that while she still felt that the abortion was the only alternative, she could not resolve the decision because she was convinced that "had I been married to someone not like my husband, it would have been OK, and I probably would have had this baby." Her husband could not understand why she felt upset. "He thinks it's over and done with, time to put it behind us. I just can't carry on in the same way I used to." The nurse ventured that after the traumatic birth of their second child, she found that she and her husband coped very differently and that their inability to understand each other's behavior affected every part of their life together for a long time. Did Julie feel that what she and her husband were experiencing had any similarities to that? A flood of feelings poured out as Julie said, "Yes, that's it, that's what I mean." He wanted to resume their former sexual pattern, which "used to be good," but she said, "I just can't feel anything that way right now." She stated that she accepted and loved her husband despite her disappointment in him, but she also expressed great anger and resentment toward him and indicated that for her, their marriage was "at an all-time low." She asked the nurse some questions about how she and her husband eventually came to terms with their experience, and they exchanged humorous observations on the mysteries of life, family, and relationships. Julie concluded that marital counseling would be worthwhile and thanked the nurse "for telling me such personal things about yourself. It really helped me see what's happening to us." The nurse thanked Julie for trusting her with such important and intimate parts of her life, and they exchanged a warm parting.

Through a combination of several sources of information, including silences as well as tones of voice, reported thoughts and feelings, and the questions, disclosures, and humor they shared, the meaning of the abortion and its aftermath was illuminated for both Julie and the nurse. Mutual trust, respect, and recognition of the human quality of life and relationships were affirmed, and the client chose a course of action to begin to address her present concerns. Both the client and nurse experienced efficacy in their roles in the help-seeking situation, and while no specific outcome was guaranteed, the possibility for healthier relations and family functioning seemed more probable following the encounter than at its outset. The nurse developed further skills in appropriate disclosure and use of humor as a clinician, and the client learned that exploring her thoughts and feelings in a trusting relationship could help her identify both concerns and courses of action. Through the insights that their mutual exchange created, therapeutic reciprocity was in evidence.

ANTECEDENTS, CONSEQUENCES, AND ALTERNATIVE CASES

On the basis of the attributes of therapeutic reciprocity discussed and illustrated above, several antecedents and consequences can be inferred that shed light on the insufficien-

cies of various alternative cases. The absence of therapeutic reciprocity becomes more easily apparent when these essential conditions and outcomes are identified.

Antecedents

The four antecedents of therapeutic reciprocity are proposed to be as follows:

1. Therapeutic reciprocity could conceivably arise in any situation in which at least two people are interacting with each other. In a nursing context, a nurse and client with whom to exchange one or more meaningful thoughts, feelings, and behavior must be in relation with one another. Where the client cannot fulfill at least one of these criteria, family or friends may be viewed as clients by proxy. Where neither the client nor a proxy can relate to the nurse, it is more difficult to envision how therapeutic reciprocity would proceed. It is perhaps possible through the imagination of the nurse in light of whatever history of the client, projections about the client, and beliefs about existence the nurse entertains.
2. Interfering factors in the environment, such as noise, lack of privacy or time, and language and cultural differences, to name but a few, must be less potent than the meaning of the exchange occurring between the nurse and client. The balance of power between interfering factors and meaningful exchange is greatly influenced by the degree to which the next antecedent is present.
3. The nurse's skills in facilitating reciprocation must exceed the interfering factors in the environment. Accordingly, the greater the expertise of the nurse in overcoming environmental obstacles to exchanging meaningful messages with the client, the greater the likelihood of therapeutic reciprocity occurring. At any level of practice, these skills may be intuitively rather than logically deployed, and beneficial outcomes may occur. However, in the expert nurse, intuitive initiation of reciprocity will be augmented by the refined ability to recognize both the indications and avenues for the process to occur. As with all skills, then, "practice wisdom" allows the expert nurse to generate reciprocity that most creatively addresses the situation at hand.
4. The nurse must participate in the relationship from the philosophic premises that human existence has multiple meanings; that some personal meanings can be shared; that participation in the relationship is shared; that outcomes are multiple, probable, and amenable to change; that human interaction produces mutual learning; and that knowledge is attainable by personal and intuitive as well as rational and empirical means.

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Consequences

Consequences of therapeutic reciprocity are logical outcomes of the mutual and positive nature of the process.

- The nurse and client arrive at shared meanings about the client's experience that enhance their mutual understanding and instruct their approach to the situation.
- The nurse and client share control of and responsibility for the outcomes of their relationship.
- The nurse and the client gain trust, both in their own ability to relate effectively in the help-seeking situation and in each other as fellow human beings.
- The nurse and client are empowered to cope more effectively with the help-seeking situation, and the probability of positive outcomes for both parties is increased.

Alternative cases

Clinical examples of borderline, related, contrary, and illegitimate cases serve to separate therapeutic reciprocity from other interactive phenomena that may be similar or dissimilar in character. In each of the situations below, one or more of the attributes assigned to therapeutic reciprocity is absent. While in some instances therapeutic events may be occurring, they are not of a directly reciprocal nature.

Borderline case

John explained his involvement in the brain injury support group in the following manner. "I remember the nurse who stood by me even when I wanted to call it quits. It wasn't so much the things she did for me. It was the faith she showed in me. She told me I could do it, I could find a way. I didn't believe her at first. But when she didn't give up on me, I started to change. I realized she was right. I *could* do it! I just want to be able to show that same faith to someone here, to help them see that they can find a way too. Believing in them is a way of believing in myself, too."

For this client, the opportunity to directly reciprocate caregiving that held special meaning for him was not feasible. He found it instructive, meaningful, and empowering to be able to give in turn some measure of the significant caring he felt he had received from the nurse during his rehabilitation. A borderline, or indirect, instance of therapeutic reciprocity appeared to be occurring.

Related case

Moira found the nurse caring for her child to be remarkably warm and caring. One night as they talked of Moira's fears, guilt, and difficulties in coping with her daughter's chronic illness, Moira found herself confiding thoughts and feelings of a very intimate nature in great detail. She cried, laughed, and looked at her plight from all angles, marveling at the ability of this nurse to grasp what she was feeling. Later, as she sat with her daughter through another diagnostic procedure, she began to feel embarrassed about her discussion with the nurse. She realized that she knew virtually nothing personal about the nurse and felt naked and exposed in comparison. She wished that she could take back some of the things she had said and never felt quite as comfortable with the nurse again.

In this encounter, the nurse's empathic skills encouraged the client to express many

of her most private thoughts and feelings in the midst of a crisis situation. One appropriate self-disclosure on the nurse's part or even simply thanking the client for sharing such important information with her may have been all that was required to "equalize" the client's uncomfortable sense of a one-way giving of personal knowledge, and a one-way taking of listening.[8,34] Empathy, then, may be one means of initiating therapeutic reciprocity, but it cannot be considered a substitute for genuinely mutual exchange.

Contrary case

A woman rescued from a tenement fire with severe burns and smoke inhalation was resuscitated and maintained in the intensive care unit on very aggressive medical and surgical treatment. She never regained consciousness and had no locatable family or friends. As days wore on into weeks with no progress in her condition, nurses avoided caring for her and voiced grave conflict over the continuing array of procedures performed on this woman. They felt depleted and exhausted after a shift with her and took other more physically demanding assignments whenever they could, claiming that these other clients needed them more. An initially lively dialogue between the nurses and physicians regarding her care became a stony silence, and many staff commented that the atmosphere in the woman's room "hits you like a wall, right at the door."

Significantly the other clients who demanded greater physical effort from the nursing staff were seen as more rewarding to care for because the client was either improving, a family member or friend was involved, or the other staff were more willing to discuss the case. With all of these other clients, then, some form of direct or indirect reciprocity was evident. With the woman in question, no viable route to therapeutic reciprocity appeared to exist. A custodial rather than reciprocal relationship appeared to be in operation.

Illegitimate case

In the film "What do you see, nurse?,"[35] an elderly woman is followed in her attempts to achieve meaningful communication with her nurse. In one vignette, the woman is wincing visibly as the nurse, standing behind her and combing her hair, asks with unconvincing concern, "Am I hurting you dear?" The woman, seeing a possible inroad to real conversation, looks up at the nurse with a bright smile, denies discomfort, and tries to begin talking with the nurse. The nurse allows a few words from the woman before she proceeds to repossess the dialogue, apparently interpreting the woman's brief smile as approval for what is occurring. The vignette closes with the nurse asking rhetorical and superficial questions from behind the woman as she continues to yank the comb through tangled hair and the woman's eyes become shiny with moisture.

Certainly mutual exchange is occurring in this situation, and the interaction is instructive. But what is being taught? The nurse is learning that her approach is acceptable when it really is not, and the client is learning that the way to gain the nurse's attention is to conceal what she is really feeling. Nontherapeutic reciprocity is actually taking place.

EMPIRICAL REFERENTS AND AN OPERATIONAL DEFINITION

Because empirical referents of therapeutic reciprocity are dyadic in nature, validation

by both the nurse and client is required if the inherent mutuality of the concept is to be adequately acknowledged. As measurable events, the referents proposed range from more to less concrete phenomena, and a variety of research methodologies are probably required to obtain the most representative examples of therapeutic reciprocity. The four referents suggested for consideration follow.

1. Clients and nurses could be observed and analyzed for reciprocal accommodation of personal space and other nonverbal behaviors via Kirlian photography,[11,36] videotaping, and reported experiences of encounters by both nurses and clients.
2. Clients and nurses could be jointly assessed for evidence of mutual disclosure,[37] shared humor, shared perceptions of priority concerns and outcomes,[30,31] shared understandings of health messages taught and received, and shared use of intuition in assessing the meaning of situations, including sense of salience.[38]
3. Shared language versus unshared terminology between clients and nurses could be compared and analyzed for both explicit content and implicit values.
4. Knowledge, attitudes, and feelings of both clients and nurses regarding specific concerns could be explored for areas of agreement and disagreement.

Although not defined as investigations of therapeutic reciprocity, the studies cited with these referents facilitate explication of this concept. Given the broad possibilities for exchange between nurses and clients, further descriptive and correlational studies to expand our knowledge of both referents and their relationships with other phenomena of interest to nursing are recommended. It is expected that as this area of nursing research increases, additional referents and relationships that validate the presence of therapeutic reciprocity will be uncovered.

In the context of the foregoing discussion, an operational definition of this concept for nursing can be proposed: *Therapeutic reciprocity is a mutual, collaborative, probabilistic, instructive, and empowering exchange of feelings, thoughts, and behaviors between nurse and client for the purpose of enhancing the human outcomes of the relationship for all parties concerned.* This definition is acknowledged as an initial attempt, and it is hoped that therapeutic reciprocity will receive the further attention and refinement required to fully realize all the potential meanings that it holds for nursing. The insights and criticisms of others are a vital step in the continued exploration and operationalization of any concept.[10]

Even in its infancy, however, this definition of therapeutic reciprocity provides suggested directions for the nursing profession. In identifying and describing this phenomenon of caring, researchers can advance the human base of knowledge on which nursing science relies. Theorists can postulate the relationships between nurses and clients that constitute therapeutic reciprocity, and educators can endeavor to use learning strategies that best develop the human skills involved. Most importantly, practitioners and clients alike can benefit from that which we give to and teach each other. Nurses can validate the therapeutic significance of these reciprocal experiences in their work and more eloquently argue for resources that promote these encounters.

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In a short story by Goyen, the intensity of a relationship between a nurse and client is described as "this mysterious double action, this marvelous reciprocity, the way we human beings work upon each other."[39(p252)] Perhaps if nurses can truly acknowledge that "the essence of health care is still 'something that happens between people,'"[40(p43)] the power of caring can be extended through a recognition of therapeutic reciprocity's nurturing role. Nurses can affirm and assist clients' work,[41] appreciate their agendas,[42] and establish the collaborative nurse–client relationship described in the literature.[43-45] The nursing profession can risk the cost of caring to the mutual enrichment of clients and nurses.

REFERENCES

1. McClintock CJ, Kramer RM, Keil LJ. Equity and social change in relationships. In: Berkowitz L, ed. *Advances in Experimental Social Psychology*. Toronto, Canada: Academic Press; 1984; 17.
2. Watson MJ. New dimensions of human caring theory. *Nurs Sci Q*. 1988;1:175–181.
3. Rogers ME. *An Introduction to the Theoretical Basis of Nursing*. Philadelphia, Pa: FA Davis; 1970.
4. Fry ST. The ethic of caring: can it survive in nursing? *Nurs Outlook*. 1988;36(1);48.
5. Noddings N. *Caring: A Feminine Approach to Ethics and Moral Education*. Los Angeles, Calif: University of California Press; 1984.
6. Thorne SE, Robinson CA. Reciprocal trust in health care relationships. *J Adv Nurs*. 1988;13:782–789.
7. Yuen FKH. The nurse–client relationship: a mutual learning experience. *J Adv Nurs*. 1986;11:529–533.
8. Young JC. Rationale for clinician self-disclosure and research agenda. *Image J Nurs Scholar*. 1988;20(4):196–199.
9. Gadow SA. Nurse and patient: the caring relationship. In: Bishop AH, Scuder JR Jr, eds. *Caring, Curing, Coping. Nurse, Physician, Patient Relationships*. Tuscaloosa, Ala: The University of Alabama Press; 1985.
10. Walker LO, Avant KC. *Strategies for Theory Construction in Nursing*. East Norwalk, Conn: Appleton-Century-Crofts; 1988.
11. Benner P, Wrubel J. *The Primacy of Caring. Stress and Coping in Health and Illness*. Toronto, Canada: Addison-Wesley; 1988.
12. Leininger MM, ed. *Care: The Essence of Nursing and Health*. Thorofare, NJ: Charles B. Slack; 1984.
13. Carper BA. The ethics of caring. *ANS*. 1979;1(3):11–19.
14. Hanks P, ed. *Collins Dictionary of the English Language*. Oxford, England: William Collins Sons; 1979.
15. Eckhoff TE. *Justice: Its Determinants in Social Interaction*. Rotterdam, The Netherlands: Rotterdam University Press; 1974.
16. Greenberg MS. A theory of indebtedness. In: Gergen KJ, Greenberg MS, Willis RH, eds. *Social Exchange. Advances in Theory and Research*. New York, NY: Plenum Press; 1980.
17. Nadler A. Personal characteristics and help-seeking. In: DePaulo BM, Nadler A, Fisher JD, eds. *New Directions in Helping. Help-seeking*. Toronto, Canada: Academic Press; 1983;2:303–340.
18. Rogers ME. Presentation at the International Nurse Theorist Conference (cassette recording). Edmonton, Alberta, Canada: University of Alberta Faculty of Nursing; 1984.
19. Rogers ME. Rogerian practice perspectives. *Rogerian Nursing Science News*. 1988;1:4–8.
20. Morse J. Reciprocity for care: Gift giving and the patient–nurse relationship. *Can J Nurs Res*. 1989;21(1):33–45.
21. Gordy HE. Gift-giving in the nurse–patient relationship. *Am J Nurs* 1978;78:1027–1028.
22. Meisenhelder JB. Boundaries of personal space. *Image J Nurs Scholar*. 1982;14(1):16–19.
23. Minkley BB. Space and place in patient care. *Am J Nurs*. 1968;68:510–516.
24. Callahan S. The role of emotion in ethical decision making. *Hastings Center Rep*. 1988;18:9–14.
25. LeShan L, Margenau H. *Einstein's Space and Van Gogh's Sky. Physical Reality and Beyond*. New York, NY: Macmillan; 1982.
26. Kasch CR, Dine J. Person-centered communication and social perspective taking. *West J Nurs Res*. 1988;10:317–326.
27. Field PA. The impact of nursing theory on the clinical decision making process. *J Adv Nurs*. 1987;12:1–9.

28. Kidd P, Morrison PF. The progression of knowledge in nursing: A search for meaning. *Image J Nurs Scholar.* 1988;20(4):222–224.
29. Pyles SH, Stem PH. Discovery of nursing Gestalt in critical care nursing: The importance of the gray gorilla syndrome. *Image J Nurs Scholar.* 1983;15(1):51–57.
30. Roberts CS. Identifying the real patient problems. *Nurs Clin North Am.* 1982;17:481–489.
31. Kovner CT. Nurse–patient agreement and outcomes after surgery. *West J Nurs Res.* 1989;11:7–16.
32. Phenix PH. *Realms of Meaning.* New York, NY: McGraw-Hill; 1964.
33. Steeves RH, Kahn DL. Experience of meaning in suffering. *Image J Nurs Scholar.* 1987;19(3):114–117.
34. Quinlan DM, Janis IL. Unfavorable effects of high levels of self-disclosure. In: Janis IL, ed. *Counseling on Personal Decisions: Theory and Research on Short-Term Helping Relationships.* New Haven, Conn: Yale University Press; 1982.
35. *What Do You See, Nurse?* [videotape, call # CM-505]. Edmonton, Alberta, Canada: John W. Scott Health Sciences A-V Library, University of Alberta; 1980.
36. Clarke PN. Theoretical and measurement issues in the study of field phenomena. *ANS.* 1986;9(1):29–39.
37. Young JC. *The effect of nurse–practitioner self-disclosure on the self-disclosing behavior of college students in a college health setting.* Rochester, NY: University of Rochester; 1988. Dissertation.
38. Benner P, Tanner C. Clinical judgement: how expert nurses use intuition. *Am J Nurs.* 1987;87:23–31.
39. Goyen W. The enchanted nurse. In: *The Collected Stories of William Goyen.* Garden City, NY: Doubleday; 1975:240–254.
40. Drew N. Exclusion and confirmation: a phenomenology of patients' experiences with caregivers. *Image J Nurs Scholar.* 1986;18(2):39–43.
41. Strauss A. *Chronic Illness and the Quality of Life.* Toronto, Canada: Mosby; 1984.
42. Molde S. Understanding patients' agendas. *Image J Nurs Scholar.* 1986;18(4):145–148.
43. Kasch CR. Establishing a collaborative nurse–patient relationship: a distinct focus of nursing action in primary care. *Image J Nurs Scholar.* 1986;18(2):44–47.
44. Stanitis MA, Ryan J. Noncompliance. An unacceptable diagnosis? *Am J Nurs.* 1982;82:941–942.
45. Moughton M. The patient: a partner in the health care process. *Nurs Clin North Am.* 1982;17:467–479.