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Understanding Empathic Engagement of a Fourth-Year Nursing Student Through Narrative Inquiry

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by

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Abstract

There has been substantial research on empathy and the components of empathy for nursing education and nursing practice (Alligood, 1992; 2007; Evans et al., 1998; Gagan, 1983; Kalisch, 1973; Kunyk & Olson, 2001; Morse et al., 1992; Ward, 2016; Ward et al., 2012) but very little research has addressed how students come to understand empathic engagement, a social phenomenon of human connection. Empathic engagement is a liminal relational experience, based on the principles of empathy and humanistic values that leads to a spatiotemporal phenomenon of human interconnectedness. Empathic engagement moves beyond feeling empathy for a person, beyond empathic concern and elements of cognitive empathy.

In this study, I explored explore how fourth-year nursing students come to understand and recognize empathic engagement in their work and how students make meaning from this unique phenomenon in nursing practice. This study used narrative inquiry by way of written and visual narratives, followed by a face-to-face semi-structured conversation between the participant and the researcher about the participant's experience. "Humans are storytelling organisms who, individually and socially, lead storied lives" (Connelly & Clandinin, 1990, p. 2). The use of narratives enabled participants to express his or her constructed and objective reality and to articulate "the temporality and liminality of human beings' interpretation of their lives" (Sandelowski, 1991, p. 161). Fulford (1999) notes, "stories are how we explain, how we teach, how we entertain ourselves, and how we often do all three at once" (p. 9). The outcomes of this study introduced four phases of empathic engagement and will add new knowledge to nursing curricula addressing humanistic values of nursing practice.

Keywords: empathy, empathic engagement, nursing students, nursing education, humanity, narrative inquiry

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Dedication

This dissertation is dedicated to my family. To my daughter, Jordyn: you have been an amazing support throughout these years. You listened to me even if you had no idea what I was talking about, you were there to give me a hug when I needed one, demonstrated patience as I took classes and wrote papers, and even provided me with words of encouragement when I lost my way. You are the greatest blessing in my life and I am lucky to be your mom.

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CHAPTER ONE: INTRODUCTION

When I was a bedside nurse working in the Intensive Care Unit (ICU), I had unique, and unexplainable, emotional days working with patients and families. ICU is an environment notorious for the care of acutely sick patients somewhere in-between life and death; warm bodies kept alive by the sound of ventilators moving air in and out of the patient's lungs, with intravenous lines delivering life-sustaining medication of antibiotics, fluids, and other drugs necessary to keep hearts beating. It may sound dramatic to those individuals who have never been to an ICU, but this description was a daily occurrence. Shalof (2013), a medical intensive care nurse from Toronto, indicated "the ICU made me a nurse less by its machines and technological advancements than by its people and their expertise" (p. 147). Like Shalof, the ICU made me a nurse in hidden ways; how I witnessed expert nurses not only care for the body of a patient but also for their soul, how I watched tears fall down the cheeks of the strongest nurses after they had broken every rib in the frail patient during the code and despite the teams efforts the patient still died, how I felt the exaltation when a patient turned a corner and was making urine without the use of a dialysis machine. The ICU is a unique environment of extreme emotional highs and lows and those who work in critical care are along for the ride.

There was something special that happened in those quiet rooms with patients and families that had less to do with tasks exhibited during day to day (or night to day) care of the very sick and more to do with the intimate connection's nurses make in those hours of stillness. I have come to understand and call these unique spaces of connection, empathic engagement. Let me explain further.

A Moment of Reflection about a Moment in Practice: *"How do I say good bye?"*

I recall a time when a wife sat at the bedside of her husband. It was winter and he had been shoveling snow from the driveway. He had suffered a massive heart attack, gone into cardiac arrest, and had lain alone in front of their house until the ambulance was called to take him to the hospital. He lay before her in the hospital bed, his eyes closed, unresponsive to voice, while connected to a heart monitor that displayed every beat on a screen and a ventilator that inflated his lungs with life. She knew that he was slipping away with each minute that passed. I reached my hand towards her hand then lowered my body to the floor and knelt beside her. We did not speak for a moment but remained quiet, acutely aware of the ventilator and the rhythmic sound of breath. She looked intently at him, wrinkled her brow, while she sat on a chair facing him from the foot of the bed and asked, "How do I say good bye?" I did not have the answer for her—an answer that would allow her to come to terms with the fact that he was dying. I said nothing. A tear rolled down her cheek and I handed her a tissue. She sighed, took a deep breath and continued, "What do I do without him? What do I do now?" In the silence, I let her unanswered questions fill the space of that hospital room. I knew then, as I do now, there was no answer to be found.

At the time of the incident relayed in that reflective note, I did not have the words for what this moment of intimate connection was with the patient's wife. She was losing her husband and there was not any type of drug or life-sustaining technology that could save him. The moment I reached for her hand was the moment I entered into a space of empathic engagement with the woman, uncertain of what would happen next. What would she say, what would I say, how would I respond? I cannot remember whether I made a conscious decision to

touch her, or it was an intuitive awareness that she needed human connection. In that moment of recognizing her uncertainty of the future, I sat with her and, I believe, gave her permission to express her thoughts safely in that hospital room.

During the years that I worked in the intensive care unit, there were many more moments such as the one described above. I found that those moments provided me with the purpose I was looking for when I became a critical care nurse. During breaks from the unit, colleagues and I would share similar stories with one another. It seemed apparent that sharing of the experiences connected each nurse who engaged in the conversation, drawing together a shared meaning of empathic engagement. My colleagues seemed to feel the way I did about each encounter. This practice of entering into a space of empathic engagement seemed necessary and became intuitive action in practice. I was acutely aware of the tenuous space between life and death that many critical care nurses come to work within, but in these spaces of empathic engagement, I was not separate from the patient or family, but just one human being present with another in times of grief, transition, and existential questioning. Throughout this dissertation, I share my own reflections of my own experiences, as a way of suggesting the importance of storied experience to my own learning about empathic engagement. As the reflection shared above illustrates, I offset these reflective interruptions — which connect me to my inquiry and to scholarly literature — and present them in italics. I also entitle each reflective segment differently, to help establish why I have included it.

Now, fast forward several years where I find myself teaching nursing students in academia the (he)art of what it means to be a nurse; lessons related to a deeper knowledge of the human body, how attending to the humanity of patients and families is not only a holistic practice but vital to tending to their spirit, and realizing the narratives of patients, clients, and

families are central in how nurses care for others. When I stopped working at the bedside and began as a nursing instructor, students would share similar moments of empathic engagement; through conversations of hospice care with a husband as he comes to understand the terminal diagnosis of his wife, the tender, yet brief touch of one final squeeze of a patient's hand before leaving the unit for surgery, the revelation of past regrets and missed opportunities in the silence of a hospital room. I was surprised to hear how spaces of empathic engagement emerged for students in acute care clinical environments and how eager they were to make meaning of these intimate moments of human connection that surpassed the tasks of practice. There was commonality between the stories from students and my own experiences of empathic engagement which prompted me to want to learn more. These personal student accounts led me to question further how students come to recognize these spaces of empathic engagement, how students make meaning from these in-between nuances of holistic practice, and how nursing students come to understand unique spaces of empathic engagement: How do participants recognize and move into spaces of empathic engagement? What can be learned from participants about spaces of empathic engagement? Will this knowledge contribute to nursing curriculum? So many questions.

What *is* Empathic Engagement, Anyways?

In order to understand the term empathic engagement, it is important to start with an understanding of the term empathy. Defining empathy is messy, and no consensus exists across scholarly disciplines in which the word is taken up, except for its etymology. What scholars agree on is that empathy is derived from the Greek roots, *em* and *pathos,* which translates as *feeling into* (Coulehan et al., 2001; Sinclair, Beamer, Hack et al., 2017) or *feeling with* (Hein & Singer, 2008; Post, Ng, Fischel et al., 2014). *Merriam-Webster Dictionary* defines empathy as

"the feeling that you understand and share another person's experiences and emotions and the ability to share someone else's feelings" ("Empathy," 2018). I have found definitions of empathy seem more complicated than the simple explanation offered by Merriam Webster Dictionary. This is where, I think, it all gets a little muddy. Empathy may be defined in multiple ways: the ability of one to share in the feelings of another person (Bernhardt & Singer, 2012), acknowledging the emotional state of another (Halpern, 2003), identifying or thinking along with the emotional state of another person (Hall, 1952), the capacity to enter into or join the experiences and feelings of another (Rogers, 1957), the ability to understand the thoughts and emotions of another person (Moscrop, 2001), and/or imagining how it feels to be in another person's situation, or thinking along with another person (Aring, 1958). Kunyk and Olson (2001) reviewed nursing literature between 1992 and 2000 to conceptualize empathy. They identified five conceptualizations of empathy: empathy as a human trait, empathy as a professional trait, empathy as a communication process, empathy as caring, and empathy as a special relationship. With so many uncertain definitions of empathy from multiple disciplines, I needed something to ground myself and for purposes in this study a clearer way to define empathy.

The areas of social psychology and neuropsychology have provided a foundation for the definition of empathy indicating that there are several multi-layered factors associated with what was once only thought of as an emotion. For the purposes of this study, these neural components of empathy are deeply rooted in what I have learned about empathic engagement. Researchers have identified two primary forms of empathy: affective empathy (Eres, Decety, Louise, & Molenberghs, 2015; Shamay-Tsoory, 2011) and cognitive empathy (Decety, 2011). Understanding empathic engagement can be understood by acknowledging the neural pathways associated with empathy.

Affective Elements of Empathy

Affective empathy is the first of the two principle forms of empathy whereby one person shares in the emotional states of others (Eres et al., 2015). One person bears witness to an emotional expression of another, then shares in that feeling (Shamay-Tsoory, 2011) because he or she connects with the emotional state of the other person (Bernhardt & Singer, 2012; Decety & Jackson, 2004). Eres et al. (2015), researchers from the areas of psychology and behavioral neuroscience, describe affective empathy as an "umbrella term" (p. 305) for other forms of feeling empathy, that recognizes a clear delineation from self and the other. It is the recognition of sameness or human interconnectedness. With affective empathy, there is a shared emotional meaning separate from any cognitive understanding (Decety, 2011).

A Moment of Reflection about a Moment in Practice: *"The Buddy Shift"*

It was January, 2001, my first official day as a staff nurse in the ICU. I had just graduated with my nursing degree six months before and this was my first "buddy shift". A buddy shift meant that I would not have my own patient assignment but I would assist another nurse while learning just exactly what I had gotten myself into. I had completed all the required course work prior to starting on the floor which included 6 weeks of specified class time learning cardiac rhythms, critical care medications, hemodynamic monitoring, and passed all the module exams. By any given account, I had the basic knowledge to take care of a simple ICU patient, but was I really ready to handle the emotional side of practice that was so foreign to me?

On that first day, I was sitting in the report room scared and anxious to get to know my nurse and patient for the day when I noticed there was a lot of action on the unit. Nurses were running past the doorway of the report room, towards a patient's room. Even though this was my

first day, I could tell that this type of action was not a positive rush but this was not the time to ask any questions. There was urgency with the steps of the nurses and doctors. Suddenly, an ethereal gut-wrenching female cry rang out throughout the hallways. I was stunned into silence. I had never heard anything like that before- what was going on and what was I walking into? A young patient has passed away in the night after several code blues had been called due to life-threatening events requiring advanced life support. The skilled ICU team could not save the patient, and family was at the bedside crying out in the anguish from the loss of life. In my 21 years I had never heard such pain and loss. I never saw the family, the patient, or even the actions of the team, but there was a palpable heaviness on the unit that day with the loss of the young patient.

That day was a reality check of the environment that I was stepping into. Once I crossed over the threshold of the ICU doorway, I was thrust into a cloud of emotions, many I had no direct experience or prescribed algorithmic script that best sensitively handle these experiences of families. The nurse class I had taken about loss and grief given the gravity of the situation. I empathized with the family as we all did that day.

The unintended loss of any patient in the ICU bubbles many emotions for nurses and health care staff. This patient was not supposed to die. That mother was not supposed to lose her child that night. Yet, despite advanced medical technology and expert knowledge of the ICU team, they could not save that patient. We all felt the mother's emotional pain, loss, and unabating grief. Affective empathy was one of the strongest emotional motivators that led me to the profession of nursing and all I could do was move forward in that shift as I walked into the next patient's room, "Good morning, my name is Kara, and I will be your nurse for the day."

Affective empathy starts in knowing details and characters of the story and connecting with those details. As a nurse, the last thing I would do on my shift would be to give report to the oncoming nurse. I would essentially tell a story about the patient; what were the events of their admission history or what brought them to the hospital, I would provide my assessment with thorough details of vital signs such as blood pressure, heart rate, ventilator settings, as well as a complete head to toe physical report, and lastly any important events that occurred for the patient that day such as tests, plans of care, intentions and goals. What happens during the time one nurse is giving report and the other nurse is receiving report, is the story that the recipient of the report creates in his or her head about the patient, even before entering the room. All that is missing is a visualization of the central character, the patient.

Pennebaker and Seagal (1999), psychologists from the University of Texas, indicate that "the act of constructing stories is a natural human process that helps individuals to understand their experiences and themselves" (p. 1243). Nurses create stories about their patients prior to entering the room, even if it is a subconscious act. At that moment, either affective empathy is present or not. The construction of each story as well as the affective emotion directed to the characters in the story, plays a significant role in how nurses create and strengthen the nurse-patient relationship.

Empathic Concern. Empathic concern, a concept taken from Batson and Coke's (1981) empathy-altruism hypothesis, is an extension of affective empathy and what prompts motivation to empathically take action. In this theory, Batson (1990, 2010) recognized people have an intrinsic need to help others, in turn receiving some benefit from that help as well, which often provides the motivating factor. Batson defined empathic concern as "other-oriented emotions elicited by and congruent with the perceived welfare of someone else. — [E]mpathic concern

includes feelings of sympathy, compassion, softheartedness, tenderness, sorrow, sadness, upset, distress, concern, and grief" (Batson, 2010, p. 11). Morse et al. (1992) identified empathic concern as the expression of emotions which motivates empathic action.

Empathic concern has more to do with "seeing how others react when someone else is distressed" (Goleman, 1995, p. 99). With an excerpt from Goleman's blog, he continues, "With this kind of empathy [empathic concern] we not only understand a person's predicament and feel with them, but are spontaneously moved to help, if needed" (http://www.danielgoleman.info/three-kinds-of-empathy-cognitive-emotional-compassionate/). Empathic concern follows affective elements of empathy but precedes the neural biophysical pathways associated with cognitive empathy.

Cognitive Elements of Empathy

The second principle form of empathy are cognitive elements. It is a "process of understanding another person's perspective" (Shamay-Tsoory, 2011, p. 21). Decety (2011), a social neuroscientist, proposed a model of neural pathways which include a bottom-up processing of affective sharing and top-down processing within the neural pathways of the brain that is linked to motivation, intentions, and self-regulation of actions leading to prosocial behavior. Decety has completed extensive neurobiophysical research that reviewed MRI scans of participants' brains during stimulation and discovered that there are different and shared pathways within the brain that affect the limbic system, known as the site of emotions, as well as other cortical pathways. Empathy is more than just a feeling that emerges from a person, but a manner by which to explain one's ability to "regulate and control emotions, thoughts, and behavior" (Decety, 2011, p. 102) associated with empathic action.

Cognitive elements of empathy can be further explained by the ability to understand the feelings of another person. This is where the brain of the perceiver acknowledges the experience of the other and consciously decides to act or to refrain from action. In 1978, Premack and Woodruff coined the term Theory of the Mind. In their seminal research, they discovered that chimpanzees have the ability to ascertain the process of intention behind actions and as well as the process of knowledge and belief. In the research, a chimpanzee watched an actor who was struggling to reach a banana. When the animal was shown pictures of solutions to the problem, the researchers found that chimpanzee would choose the solution 75% of the time. When the animal witnessed the actor struggling, the chimpanzee placed himself in the situation as the actor to solve the problem. Theory of Mind is also known as mentalizing. This is a human ability to represent other people's intents, desires and affect by drawing on the capacity to understand the other's thoughts, emotions, and beliefs (Hetu, Taschereau-Dumouchel, & Jackson, 2012; Shamay-Tsoory, 2011).

Latimer, a nursing researcher from the School of Nursing at Dalhousie University, and a team of researchers including Jackson, a leading psychologist who has conducted several studies with Decety on empathy, performed two studies with pediatric ICU nurses and other allied health care personnel to study their response to pediatric and adult pain. Understanding how repeated stimulation of the neural pathways may help to predict burnout and secondary trauma in the over-stimulated novice nurses entering the profession. The overall conclusion indicated that there was reduced activation of neural pathways to pain with a direct association to the number of years of work experience of the nurses (Latimer et al., 2017). Researchers discovered the less years of work experience had a negative correlation and placed this group of pediatric ICU nurses and increased risk for secondary trauma and burnout. Habituated exposure to situations

of patients with pain blunted responses in nurses working with adult pain as opposed to pediatric ICU nurses observing pediatric pain (Jackson et al., 2017). These interesting findings may contribute to the resilience of some ICU nurses, especially in relation to the high emotional demand necessary to work in this environment.

By identifying key neural mechanisms and overall significance to how the perceiver interprets, analyzes, and behaves in accordance with the stimuli, will help the reader to make sense of the data associated from this study and how stages of empathic engagement unfold. There is also a clear separation of self to other in relation to how one person perceives the mental state of another person, and then makes a decision to act. It remains multifactorial in how regions of the brain are activated. Developing insight into how the neural pathways of affective and cognitive empathy contribute to empathy may offer a broad foundation to understand elements of empathic engagement.

What do I mean when I refer to Empathic Engagement?

Empathic engagement is a liminal relational experience, based on the principles of empathy and humanistic values that leads to a spatiotemporal phenomenon of human interconnectedness. Humanistic values are further described as empathy, kindness, concern, sensitivity, caring, and compassion (Attree, 2001). Empathic engagement moves beyond feeling empathy for a person, beyond empathic concern and elements of cognitive empathy. There is a distinct point in the verbal and non-verbal dialogue of the patient, client, and family member when the nurse recognizes the other person needs more of their authentic emotional presence within the relational exchange, moving into a space of empathic engagement. Within this space of empathic engagement, it is a meeting of humanity, where the nurse connects to the sameness in the other. Between the nurse and the patient or family, there exists a space of in-between-ness

or liminality. According to Thomassen (2015), "liminality refers to moments or periods of transition during which the normal limits to thought, self-understanding and behavior are relaxed, opening the way to novelty and imagination, construction and destruction" (p. 1). It is an identifiable space of "in-between" and where the dynamic of empathic engagement emerges from the nurse-patient relationship.

In professional practice, the shift from a general feeling of affective empathy to self-awareness and action strengthens the trust within the nurse-patient relationship. It is within this shift from empathic *feeling* leading to empathic *engagement* that interested me and was at the heart of this study. There is limited nursing literature reflecting the complexity of the intersection of the nurse-patient-family dynamic and the existential human encounters that occur in nursing practice. To understand the juncture of empathic engagement, in the discussion chapter, I will expand on the concept of empathic engagement and introduce the four key stages of empathic engagement: 1. Laying the groundwork. 2. Leaping into uncertainty. 3. Liminal state of empathic engagement. 4. Lifting the veil. In this paper, I will present the findings of the study that explored the phenomenon of empathic engagement.

Context of the Study

When I reviewed nursing literature, there was no information on the topic of empathic engagement, despite a professional career that highlighted these key moments as both a nurse in the intensive care unit and an educator. It seemed that my colleagues from the ICU had developed skills that enabled moments of empathic engagement and even previous students had come to recognize that these spaces of engagement occurred, even if a name was missing from his or her articulation of the event. The impetus for this study was to understand how participants came to understand what is meant by spaces of empathic engagement and ultimately

how each participant found meaning for themselves and their practice. As Palmer and Zajonc (2010) conclude,

> A prerequisite for an enduring shift in meaning making is that we are able to place ourselves in the world of others. Empathic and imaginative knowing does exactly this; we repeatedly live others' lives, experience their joys and sorrows, their trials and success (p. 106).

In coming to this inquiry, I reflected upon many questions: Is this a phenomenon common in nursing practice? How do novice nurses make meaning from such experiences? How does story connect to experience and identify any commonalities or shared meaning of participants' perceptions?

Merriam, Caffarella, and Baumgartner (2007) explained that people create meaning through the constructing and sharing of stories, whether they are read, heard, or created through personal storytelling. I recognized myself in the stories of students—in their experiences of, emotions expressed, and reactions to the complexities of nursing practice and human suffering. This is why narratives and conversations became the central methodology for this study. As Connelly and Clandinin (1990) outlined, people lead "storied lives" (p. 2). My own stories were braided with the stories of my patients, and ultimately the stories of my students. I began to question how stories have a place in nursing education and if common or shared experiences could provide deeper understanding in complex situations.

The aim of this study was to develop an understanding of empathic engagement as a phenomenon, as it is learned and experienced by fourth-year nursing students, using the method of narrative storytelling. Drawing upon the work of Buber's (1970) "I-Thou" theory of human connection, van Gennep's (1960) concept of liminality and rites of passage, Dewey's (1938)

theory of experience, and Dirkx's (2008) role of emotion in human experience has provided a strong theoretical framework for the study. These concepts will be further explored in Chapter Two.

This paper will present data in a narrative manner on how participants engage with and make sense of personal experiences of connection, specifically identifying commonalities of empathic engagement through personal storytelling. My experiences as a nurse and educator are woven like a tapestry throughout to illustrate the commonalities with participants' stories. Clandinin and Connelly (1990), claim that because human beings are natural storytellers who live storied lives, narrative inquiry can provide a space "to study the way humans experience the world" (p. 2) and understand the intricacies of empathic engagement within the nurse-patient relationship.

Theoretical Framework

Key elements of this study will focus on relationships, empathic engagement, nursing practice, storytelling, experience, emotional learning, and the liminal phase of transformation. Building on existing philosophical and theoretical foundations has required that I read literature situated in several disciplines, including education, psychology, sociology, and nursing; therefore, the overall lens by which I interpreted the results of this study come from multiple disciplines. This study will be rooted in humanistic philosophy (Elias & Merriam, 2005), through a social constructionist paradigm (Berger & Luckmann, 1966; Gergen, 2011), and the ideas noted above.

The tenets of humanistic philosophy (Elias & Merriam, 2005), with a primary focus on existential humanism, places an individual at the center of relationships which attend to humanity, consciousness, perception, and meaning-making. Humanistic philosophy addresses the

individuality and potential for growth in relation to others. As Elias and Merriam (2005) suggest, humanistic philosophy is "one's responsibility to others and working for the good of humanity" (p. 121). This philosophy is applicable to the practice and act of caring for others in the nursing profession. Paterson and Zderad (1976) extends the humanistic philosophy to highlight humanistic nursing with foundations in Buber's existential thinking. These scholars describe humanistic nursing as a recognition of one's self in relation to another; two autonomous beings that are drawn together in relationship recognizing the complexity and nuances of the human condition. This philosophical underpinning is threaded throughout this study as it relates to intricateness of participant in relationship with patient/family/client/other as well as participant in relationship with me.

I approached this inquiry from a constructionist epistemological and ontological paradigm, in which knowledge and reality are seen as constructed as individuals ascribe meaning to their lived experience and through relationship with self and with others (Berger & Luckmann, 1966; Gergen; 2011; Guterman, 2013). Social constructionism is well suited for explaining the phenomenon of empathic engagement. Social constructionists believe that "knowledge and reality are constructed through discourse or conversation" and "focus on what's happening between people as they join together to create realities" (Sommers-Flanagan & Sommers-Flanagan, 2012, pp. 370-371). Berger and Luckmann's (1966) theory, the social construction of reality, identified that knowledge is linked to the "analysis of the social construction of reality" (p. 3). The construction of reality is a two-fold for participants of the study: first, the initial interaction in conversation with the patient will create a specific reality for the participant, and second, the face-to-face discussion with me, the researcher. A language now given to the experience assists with deriving meaning. Gergen (2011) identifies four internal mechanisms to

create new knowledge as constructed by the mind; mental discourse as originating from relationships, mental discourse functions in service or relationships, mental discourse is action within relationships, and discursive actions is embedded in traditions of co-action. Data revealed in the study participants found meaning through the social dialogue of relationships between nurse-patient or nurse-nurse and during conversation with me, the researcher. At the time of their experiences with empathic engagement, participants were aware that a new dimension to the nurse-patient relationship had been achieved, but was unable to articulate why the experience was meaningful. Based on results from the study, I was able to create a tangible definition of empathic engagement for nursing practice. Through the discussion chapter, I will clearly identify how participants constructed meaning from these experiences and identify what comprises their reality of empathic engagement through the four phases of empathic engagement. It is through relationship and a shared understanding of story plus dialogue where reality and meaning were constructed from the experience.

I draw upon Martin Buber's (1970) theory of human connection and humanistic philosophy, as the basis for relationships that may develop between a nurse and patient. According to Buber, people enter into relationships with others in two ways: "I-It" and "I-Thou." The I-It orientation is characterized by relationships that are centrally focused on individuals, seen as separate or distant from one another; in contrast, the I-Thou orientation sees people as related to one another, and a degree of wholeness develops as individuals exhibit vulnerability and authentically find subjective meaning to their relationship.

In nursing practice, the nurse-patient relationships may be either an "I-It" or an "I-Thou" orientation. Nurses are taking care of higher acuity patients with less focus on relational practice as it is fragmented by skills and tasks; therefore, overall, nursing practice tends to lean more

towards an "I-It" relationship. Ross (2002) acknowledges that "Buber called the essence of human relationship the sphere of the between, located not primarily in either partner but in the interchange, their intersubjective communion" (p. 409). The health-illness spectrum creates an unforeseen opportunity wherein nurses are present during intimate stages of people's healing and illness. Responsive relationships provide a framework where the "responsive use of self" (Smithbattle, Drake, & Diekemper, 1997, p. 79) comprised of three essential elements: respect, trust, and mutuality (Tarlier, 2004). The nurse's self-awareness of his or her ability to contribute to the health-illness spectrum of any patient or family is key to the development of relationship and opportunities for empathic engagement.

Josselson, Lieblich, and McAdams (2007) provide further elaboration of Buber's thoughts, proposing that I-Thou involves relationship with the world, relationship with another human being, and relationship with the self. It is within the existential spaces of human connection, or rather the dash between "I" and "Thou"—what constitutes the phenomenon of empathic engagement—that I was most curious to learn from this study, including how participants come to recognize this liminal space of relationship. Space is defined as an "in-between" juncture of relationship. As I have mentioned previously, experienced nurses intuitively learn to recognize when it is necessary to enter into spaces of empathic engagement and enhance the therapeutic relationship. The results of this study will provide new evidence for understanding the cognitive, emotional, spiritual and embodied process of how participants come to recognize the edge of entering into or choosing not to enter into empathic engagement. I offer an analogy to explain empathic engagement: Think of a person standing on the edge between two cliffs, with a swinging bridge connecting both sides. The person may choose to walk across the bridge or remain where he or she stands. It is in the process of crossing the bridge that

uncertainty is experienced. “On this bridge, we are in no hurry to cross over; in fact, such bridges lure us to linger” (Aoki, 1993, p. 255). The experience of empathic engagement alludes that both parties (in this case, the participant and the patient/family/client) sit in a space together, that may be uncomfortable and uncertain. It is in this uncertainty where the conversation has an opportunity to unfold, uniquely bonding through relationship, an emotional connection between participant and patient/family/client emerge.

Van Gennep’s **(**1960) concepts of liminality and rites of passage are inextricably situated within the concept of empathic engagement in three ways: when the nurse consciously and responsively empathically enters into relationship with the patient, during the cognitive and identity transition of a fourth-year nursing student, and at the time of reflection. Van Gennep (1960), a French anthropologist, proposed that “all societies have ‘rites of passage’ that characterize major life events (i.e., childbirth, adolescence, adulthood, marriage, and death)” (Kumagai & Naidu, 2015, p. 286). Van Gennep (1960) explains that in all rites of passage, there are three stages: a preliminal stage, where the individual separates from his or her former self; a liminal stage, in which the transition occurs; and a postliminal stage, in which knowledge developed during the transitory phase is incorporated into the new identify of self. The premise of my study was to recognize when and how students begin to understand when they have entered into (the liminal stage of) empathic engagement. I am not concerned about how the patient perceives the actions of the participant, but rather what each participant perceives as important elements of the transition. In adult education, “transformative learning is about making meaning of experiences and revising perspectives . . . . Storytelling is a way of making meaning of experiences” (Kroth & Cranton, 2014, p. 25). It was through story where the threads of meaning were revealed to participants and me.

Dewey's (1938) theory of experiential learning and Dirkx's (2008) role of emotion in human experience provide a disciplinary foundation for this study, grounding it in questions of how participants come to understand empathic engagement and connecting it to the field of adult education. First, Dewey (1938) proposed that collateral learning exists in all experiences; knowledge is constructed through experience. Benner, Sutphen, Leonard, and Day (2010) stated that clinical experiences enable the student nurse to initiate and identify with the habits of practice, starting with a controlled, stable environment and progressing to less predictable situations. Learning in context provides the student with referential content bridging theory and practice. Reflection on those experiences allowed the opportunity for adult learners to "step into" (Kumagai & Naidu, 2015, p. 285) recreating their actions via memory, what was communicated or not communicated to patients, colleagues, or families, and methods that may or may not have produced holistic outcomes for patients. At each stage of the study process, participants uncovered deeper meaning about self, individual practice, and what this new knowledge meant for each of them moving forward after the study completed.

Second, Dirkx (2008) identified that a challenge for adult educators is to help "learners understand and make sense of emotion-laden experiences" (p. 9). The role of the emotions of adult learners represents cognitive processing that enable learners to draw conclusions and internalize meaning from experiences (Dirkx, 2008). Clark and Dirkx (2008) claimed that, "the evolving emotion work also involves the development of a deeper sense of how acculturation within specific sociocultural contexts shape our emotions" (p. 93). Based on my own experience with empathic engagement and how previous students have shared their experiences with me, there is considerable emotional work at play. Students often do not know how to manage emotions that bubble to the surface with reflection or debriefing, as these can be morally

distressful. This study was complex with multiple layers of nuances identified in the data; the contextual differences between each participant as an individual, their unit of final focus or previous clinical context, as well as the variables necessary for empathic engagement to be present in relationships led to a comprehensive picture of empathic engagement. The results of this study and overall discussion is necessary for further research in this area and conversation, not only in nursing education but also for education in allied fields.

Merriam, Caffarella, and Baumgartner (2007) recognized that adults learn through embodied learning and that "we learn in an experience" (p. 192). The embodiment of the experience becomes identifiable, and meaning can be placed in that experience. In this study, the intention was for participants to become more aware of potential moments of empathic engagement and relive the experience through the unfolding of the narrative. It is through the restorying of the empathic engagement experience where participants had an opportunity to identify with transformative learning, leading to growth and new knowledge for future practice.

Research Problem

Despite the fact that there is no nursing literature that has researched this area of interaction between nurse and patient, there is the assumption that moments of empathic engagement are not necessary in practice. There is the assumption that empathy and spaces of empathic engagement may or may not exist in practice, as there is no documentation to demonstrate the existence of this phenomenon. Humanistic values such as empathy, kindness, concern, sensitivity, caring, and compassion, typically associated with nurses, are viewed as important characteristics of practice, often more important than technical skills of nursing (Attree, 2001). Nurse-patient relationships are central to the health-illness spectrum, but what if a new area of relationship, such as learning from spaces of empathic engagement, is missing

from that conversation. Significant nursing literature proposes the need for students and nurses to be empathetic or to display empathic qualities while in practice (Kahriman et al., 2016; Richardson, Percy, & Hughes, 2015; Rogers, 1986; Wilkes, Cowin, Johnson, & Zheng, 2014; Williams, Boyle, & Fielder, 2015; Williams & Stickley, 2010; Wiseman, 1996, 2007); however, little is known about students' experiences of empathic engagement and how they come to understand those experiences. This study focused on the gap in existing nursing literature with a specific focus related to the experiences of senior-level nursing students.

Given that different scholars define empathy differently, this poses complications both for education and curriculum. A lack of consensus from the literature leaves educators with limited resources to incorporate consistent humanistic content within nursing curriculum. This leaves a high probability that educators assume that students are aware of humanistic values such as empathy, compassion, and sympathy, and avoid the conversation altogether.

There is considerable nursing literature that supports the importance of relationship and positive outcomes for the patients in the health-illness spectrum. Relational engagement between a patient and nurse, combined with humanistic values of empathy, appears to be where the science of nursing and the (he)art of nursing practice intersect. Hartrick Doane (2002) identifies conscious participation in relationship with another as necessary for "the process of being in relation with and inquiring into human life" (p. 402). Actively being situated in the moment, and recognizing emotional cues and physiological responses, play a large part in the degree of relationship between a nurse and patient or family. Nursing literature continues to cite the importance of empathy for therapeutic relationships and notes the importance of empathy in therapeutic communication leading to positive outcomes (Benner, Sutphen, Leonard & Day, 2010; Charon, 2001; Peplau, 2004; Richardson, Percy, & Hughes, 2015; Williams & Stickley,

2010). Limited evidence exists that addresses both relational engagement and humanistic values. The intention of this study, will initiate discussion about the powerful and significant impact of empathic engagement in the development of professional nursing identity, relationships between the nurse and patient, client, or family, and finally, how empathic engagement is under-examined in adult learning related to professional programs, nursing education, literature, and curriculum.

Purpose and Research Questions

The purpose of this study was to explore how participants, fourth-year undergraduate nursing students, come to experience and understand empathic engagement. This study will expand on previous scholarship related to the cognitive, affective, spiritual, and embodied domains of empathy and adult learning and approaches to teaching empathy, and has implications for the scholarship of professional, especially nursing, education, pedagogy, and curriculum

Nursing, is one of many socially constructed professions. Students learn from other nurses who share grand narratives of experiences in both theoretical and clinical environments. Students self-identify with peers as well as senior practitioners in these stories, thereby imagining themselves as practitioners and becoming part of a hermeneutic circle. As I will explain further in the methodology chapter, the process of narrative inquiry allowed the participants in my study to construct meaning from their own stories and relate their stories to the humanistic imperative of nursing practice. Crotty (1998) wrote, “Actual meaning emerges only when consciousness engages with them” (p. 43). Through the purposeful construction of their own individual stories and through one-on-one conversation, I was able to interpret specific themes from the data.

I have developed the following guiding question for this study: How do participants—nursing students in their final preceptored term of an undergraduate program—come to understand, encounter, and respond to empathic engagement in their work?

From that question, I have developed three sub-questions:

1. How do participants identify spaces of empathic engagement in their developing nursing practice?
2. How do participants make sense of empathic engagement as crucial to their lives and their work?
3. How do participants respond to the experience of empathic engagement on their own and with peers?

Rationale and Significance

This outcomes from this study should build on previously executed research to expand nursing episteme from the ideology of empathy to a construct necessary in nursing practice. It will add new knowledge of what can be learned from the phenomenon of empathic engagement between a nursing *student* and patient or family.

Nursing curriculum is intended to prepare nursing students to meet the rigor of nursing practice and entry to practice competencies as outlined by provincial and national regulatory nursing authorities. Kleiman (2007) claims that nursing curricula are centered on the fundamentals of nursing practice: medical-surgical/mental health nursing, anatomy and physiology, and courses that emphasize illness, systems, organs, and pathology. This approach meets the outcomes and expectations of new graduates but lacks the humanistic imperative assumed to be inherent for practitioners to care for others. Exploring the lived experience of participants as they come to understand those experiences may provide opportunities to develop

nursing curriculum and an deepen knowledge of how students address humanity in nursing education.

As the researcher, I located commonalities and transferability of meaning between the narratives. Through these unique and special experiences, what can be learned from the narrative will inform nursing educators as to the impact of experience and add to the discussion of teaching empathy. Dewey (1938) identified that, in all experiences, collateral learning occurs. People learn not just subject matter; in this situation, participants learn to recognize when they enter into a space of empathic engagement, and through the process of internalizing the experience, how the experience affects them. Through the four phases of empathic engagement, there were clear and distinct elements associated with moving into these spaces and where the phenomenon of empathic engagement emerged.

This intention of this study is to initiate future discussions about spaces of empathic engagement and address how researchers and educators come to understand and associate the meaning of empathic engagement, within and beyond nursing education. This study addressed the perspective of the participant only, not the patient or family; therefore, an extension of this study could represent both perspectives and identify whether and how the patient recognizes when spaces of empathic engagement occur. In the future, this study could be extended into other practice disciplines such as social work, education, and even medicine to identify how spaces of empathic engagement emerge within different professional contexts. In each of these professions, students must connect with others in order to create positive experiences for patients and families. This study is seminal work which will provide reference and foundation to other research to inform epistemology.

Researcher Assumptions

As an educator and registered nurse, I am acutely aware of the impact that experiences such as empathic engagement can have on participants and nurses; however, I am also cognizant of my role in this study and made efforts to balance my role as interpreter of participants' narratives with participants' experiences and accounts of empathic engagement. I could not fully separate myself from beliefs and biases emerging from my knowledge of the profession or from my own experience. One advantage of that reality was my interpretation of the specifics of participants' narratives as well as the one-on-one conversations between participants and me elicited more compelling data than if another researcher with little experience as a nurse or as someone who could relate with participant's experiences conducted the study. I was able to draw from the participants, through a shared understanding of the experience of empathic engagement, unique and specific details that may not have been obtained.

Summary

One of the most significant relationships that exists in the health-illness spectrum is that which occurs between a patient and nurse. Participants will have unique perspectives, different from those of an experienced nurse because he or she has already developed a comfort with the fundamental skills of practice while continuing to develop an acute awareness of the impact he or she may have with a patient. By drawing from Buber and van Gennep's work, learning from this study in how participants have come to recognize spaces of empathic engagement will help educators understand the lived experience of these exchanges, how participants constructed meaning through the written narrative as well as through dialogue, and finally how participants began to recognize empathic engagement.

The subsequent chapters of this dissertation will provide a map of what is already understood about empathic engagement as evidenced by the literature review in Chapter Two, situate the reader in the methodology of narrative inquiry in Chapter Three, present a narrative portrait of each participant as well as their personal experiences with empathic engagement in Chapter Four, inform results of the study through the four phases of empathic engagement in Chapter Five, provide discussion of these results for nursing education, adult learning, nursing literature and curriculum, and conclude with how new epistemology will impact nursing as well as other professional disciplines of service in Chapter Six.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides an extensive review of nursing literature and research related to empathy, nursing education, nursing students, and the correlation with empathic engagement. Although nursing literature supports empathy as an important humanistic value for nursing practice as well as providing models to enhance interpersonal relationships between the nurse and patient, little research has addressed what might be learned from and about the experience of empathic engagement. By learning more about these experiences, especially among nursing participants who were nearing the end of their undergraduate programs and preparing to enter professional practice, nursing educators now have new episteme to incorporate pedagogies and curricular opportunities to address and foster empathic engagement in nursing education. In this chapter, I will discuss key points from the literature which addresses (a) the empathy enigma, (b) the neural pathways of empathy, (c) illustrations of empathy in nursing literature, (d) what is known about empathic engagement, (e) and finally, if empathic engagement is known by another term.

Individual and combined searches were undertaken using empathy, empathic engagement, nursing education, nursing student, and nursing practice. The resulting literature was read and topics themed to ensure all areas could be linked together in the review of the literature related to areas of nursing education and practice. Data sources used include CINAHL, Canadian Health Research, PUBMED, Google Scholar, and ERIC to review literature from nursing and education disciplines.

The Empathy Enigma

Two years ago, I read a research article by Ward, Cody, Schall, and Hojat (2012). Despite a strong correlation between patient outcomes and empathy, these authors identified a

statistically significant reduction in empathy among third and fourth-year nursing students, a phenomenon they referred to as the "empathy enigma." They examined changes in empathy of nursing students over one year and found a significant reduction of empathy in students who had more clinical encounters with patients. Their study highlighted the need for nursing educators to create curricula that fostered and developed empathy in nursing students. Although research pertaining to empathy had previously been documented, Ward et al.'s (2011) research produced significant results for nursing education. The researchers questioned nursing curriculum pertaining to empathy as well as the type of nursing student entering professional practice: students who meet all requirements of a baccalaureate program, yet self-identified with less empathy towards others. This begets the question what type of new nurses are transitioning into practice with less empathy towards those that need it most?

Berg, Majdan, Berg, Veloski, and Hojat (2011) looked at a comparison of medical students' self-reported empathy with simulated patients' assessments of the students' empathy. The results indicated there was a decrease in empathy in medical students as self-reported, comparable to the perceptions of simulated patients but not statistically significant enough to warrant changes in curriculum. As a follow up study, Ward (2016) focused on whether there was a decline in self-reported empathy with the introduction of standardized actors in a simulated learning environment. Ward (2016) discovered that the results were comparable between nursing students to that of Berg et al.'s (2011) work related to medical students. Ward (2016) began the discussion of addressing humanistic values valued in nursing education.

These findings proposed that more research is needed in nursing education to focus on the decline of empathy in nursing students, despite overwhelming consensus that empathy is a trait needed for nursing practice (Benner, Sutphen, Leonard, & Day, 2010; Kleiman, 2007;

Wilkes, Cowin, Johnson, & Zheng, 2014). If Ward (2016) and Berg et al. (2011) identified that medical and nursing students self-report a decline in empathy, then what other determinations may be made about empathy, based on the literature?

The Neural Pathways of Empathy

Neuroimaging studies have shown that specific areas of the brain are associated with empathy. Neural pathways of empathy are associated with the interconnectedness of the limbic system, the insula, as well as the anterior cingulate cortical regions of the brain. Within the center of the brain is the limbic system where the hippocampus, thalamus, hypothalamus, substantia nigra, and amygdala are situated. The limbic system mediates emotion and long-term memory through connections in the pre-frontal cortex. “Its principal effects are associated with behavioral responses, reactions to emotion, motivation, mood, biological rhythms, and sense of smell” (Butterfield, 2019, p. 446). “The anterior insula (AI) is a hidden area between the temporal and frontal lobes. It processes sensory and emotional information and routes the information to other areas of the brain” (Butterfield, 2019, p. 444). Craig (2002, 2009) identifies that the anterior cingulate cortex (ACC) region forms motivation and action- related responses. To successfully understand the intricate nuances of empathy, it is important to understand the neural processes involved with memory, emotion, processing of sensory information, and motivation.

Neural imaging shows specific regions of the brain are activated in response to affective and cognitive empathy. The AI region appears to be more activated in response to emotional and painful situations (Eres et al., 2015) whereas the ACC forms the intrinsic desire for motivation and action. The AI receives input and plays a critical role in the subjective awareness of emotional states (Craig, 2002). It is through the AI individuals begin emotional processing. As

Decety (2011) states, “the perception of an emotion in another individual activates in the observer, the neural mechanisms that are responsible for the generation of similar emotion” (pp. 97-98). The ACC and the AI are interconnected with the amygdala and hypothalamus of the limbic system. This matrix of neural pathways provides an explanation of how the regions of the brain receive stimuli, process emotional response, differentiate between self-other, identify where motivation originates, leading to a neurobiological underpinning for empathy and empathic engagement.

Illustrations of Empathy in Nursing Literature

Clinical Empathy

Nursing literature continues to cite the importance of empathy for therapeutic relationships and improved patient outcomes (Charon, 2001; Richardson, Percy & Hughes, 2015; Williams & Stickley, 2010). A lack of empathy has been shown to have negative effects for the nurse and ultimately for patient care (Attree, 2001; Williams & Stickley, 2010), leading to a lack of trust within the therapeutic relationship. Relationships are central to the health-illness spectrum, and empathy is a significant addition to the relationship (Alligood, 1992).

Considerable debate exists as to how empathy or an empathic approach may be demonstrated to the patient. For nursing practice, Davies (2014) proposes four methods to improve an empathic nursing approach: (a) be more self-aware to understand his or her limitations of values, beliefs, and judgments, (b) practice effective listening so the patient feels that he or she is being heard and understood, (c) reflect feelings back that lead to mutual respect and understanding between the nurse and the patient, and (d) exert positive non-verbal behavior such as smiling, leaning forward, and head nodding to what the patient is expressing (p. 200-201). While Morse et al. (1992) asserts that empathic approach has more to do with the four

components of empathy: moral, emotive, behavior, and cognitive. These nursing scholars state: (a) the *moral* component is recognition of the otherness similar to Buber's (1970) theory, necessary for therapeutic relationships, (b) the *emotive* component which recognizes and shares another person's emotional state, (c) the *cognitive* component of empathy is based on the intellectual ability to understand the patient or client's perspective, and (d) the *behavioral* component of empathy includes the ability to mirror the other person's response through non-verbal communication such as nodding.

Careful consideration of nursing literature identified empathy in the practice setting as an extension of what is known from psychotherapy and rooted in Rogerian theory. Thorne (1991), counsellor from the United Kingdom and a previous colleague of Rogers, affirms the importance of reiterating what the client or patient says as a form of empathic understanding. Stickley and Freshwater (2008), nursing scholars from the United Kingdom, identify that a physical presence is necessary to convey understanding for patient care. Nursing scholars are careful to maintain the uniqueness of nursing practice; therefore, drawing from other disciplines requires mindful attention about whether the application of empathic approaches can be used for nursing, such as through the work of Stickley and Freshwater.

Empathy in Nursing Education

An extensive review of the nursing literature indicates that for several decades, scholars in nursing education have researched empathy. As early as 1968, Ludemann, a mental health nurse, addressed the need for empathy in nursing practice and therapeutic relationships. Through her role as a clinical nurse specialist, Ludemann (1968) identified the importance of empathy in nursing practice by recognizing the patient's emotions while remaining both subjective and objective in the care of the patient, so that therapeutic relationships with patients could benefit

from this deeper understanding. Finally, Ludemann questioned if empathy could be taught in nursing education programs.

During the time Ludemann's article was published, the conventional manner of nursing practice was to provide objective care of a patient, or only attend to physiological needs, with less subjective involvement by the nurse within that care, remaining distant from the emotional context of nursing practice. The historical significance of Ludemann's concept of empathic care was introduced before key nursing theorists whose work concentrated on relationships and improving patient outcomes (Peplau, 1991; Rogers, 1971; Watson, 2008). Rogers' (1971) theory of the science of unitary human beings has been credited with influencing the practice of holistic nursing that integrates mind, body, and spirituality. Peplau (1991) identified the significance of the nurse/patient relational complexity, arguing that patients develop an identity and trust through relationships with the nurse. Watson (2008) introduced the theory of caring, which embeds the relational caring for self and others through authentic presence. Ludemann's (1968) simple approach to empathy in practice led to theoretical development. Discussions of the conceptual work related to empathy in nursing education have excelled since these early introductions into nursing scholarship. Nursing scholars recognized early that in order to impact nursing practice, it was necessary to address whether empathy could be taught in nursing education.

In nursing education literature, programs of empathy have been developed to impact the humanistic aspect of nursing practice (Cunico et al., 2012). Drawing from Paterson and Zderad's (1976) theory of humanist nursing, Kleinman (2007) introduced a humanistic teaching model at a university in New York City. The program integrated humanist with existential understanding of the patient, recognized as "contributing to the dignity, happiness, and well-being of persons with

whom we interact" (p. 210), and addressed the existential concepts of being present with a patient. It was a way to develop empathic relationships, find individual meaning when caring for a patient, integrate humanity into the context of patient care, and develop greater awareness of the impact students have on their patients, as well as to recognize the patient as more than the physiological aspects of illness.

At a pediatric unit in an Iranian hospital, an empathy-training program for nurses was introduced (Kahriman et al., 2016) in response to previous studies that reported low empathic skills in nurses. In this study, nurses initially self-identified their own level of empathy based on the empathic skill scale (ESS), then divided into two groups; nurses from Group 1 were provided with empathy training through group and creative drama techniques; Group 2 was not provided a separate program. Nurses from Group 1 self-identified with statistically significant higher empathy scores than the control group. All participants were encouraged to share feelings and opinions throughout the program with a focus on improving communication skills to build empathic relationships. Although the results of this study were generalizable to only the nurses in the study's hospital, the statistical significance of improved empathy scores after the introduction of a training program that focused on didactic, role-playing, and drama techniques to improve empathy and communication techniques is pertinent to the education of students prior to entering the profession.

Simulation has emerged as an opportunity to apply Dewey's (1938) theory of experiential learning to acquire empathic skills. Simulation programs have shown to be an effective component in nursing education to help bridge the theory and practice (Gonzales et al., 2010). Vanlaere et al. (2012) discovered an increase in empathy by health care workers who role-played as simulated patients. Upon reflection, given their experiences as patients, participants altered

their actions in the delivery of care to others after the study had concluded. Vanlaere et al. (2012) identified that the affective change of the participants occurred as a result of role-playing as a simulated patient, as each participant situated himself or herself in the role of the patient. This experience adjusted the participants' perceptions of the care they provided to others. Maruca et al., (2015) observed a positively changed attitude in nursing students when they were asked to simulate the experience of a patient who was required to wear an ostomy device by wearing the same device, complete with moulage or simulated fecal matter, for a period of 48 hours. Similarly, to Vanlaere et al., (2012), participants self-identified with an increase in empathy with the patient after this experience. It appears that simulation has a place in nursing education to not only increase students' foundational skills but also play a significant role in addressing empathy in nursing curricula.

In many studies, reflection on the experience by participants proved to be a relevant exercise (Kleiman, 2007; Maruca et al., 2015; Vanlaere et al., 2012; Williams & Stickley, 2010). Participants either reflected through debriefing sessions (Maruca et al., 2015), written narratives (Kleiman, 2007; Vanlaere et al., 2012), or through face to face sessions and written narratives (Maruca et al., 2015). A considerable amount of literature supports pedagogical approaches to teaching empathy through reflection and using reflective writing. "Narrative medicine scholars have observed that the connections between reflection and empathy are bidirectional (i.e., they affect both caregiver and patient) and mutually nourishing" (DasGupta & Charon, 2004, p. 352). When doctors or medical trainees reflect on how they cared for others, the triggering of memories creates an explicit awareness of their own feelings and experiences, prompting them to be caring towards others (DasGupta & Charon, 2004). Adamson and Dewar (2015) address the importance of how stories not only assist in the reflection on practice but also the experiences of

patients, influencing beliefs and values which promote learning. The interconnectivity of personal life stories, combined with an opportunity to reflect on one's place within those stories, increases the propensity for empathic connection.

Kumagai and Naidu (2015) insist that reflection requires mindful attention to the space needed to produce the cognitive connection to the physical experience. Three conditions are necessary for reflection to occur: a need for safety, a sense of separateness, and an awareness of transition. A safe environment leads to confidentiality and respect for the reflection and vulnerability that is associated with such work. Intentionally creating a space removed from distractions will enable deeper reflexive activity. Finally, Kumagai and Naidu (2015) claim that reflection requires a state of liminality, similar to van Gannep's rites of passage, where a stage of transition or transformation occurs. It is here, where "an individual goes from what she was to what she is to be" (p. 286).

Empathy has a significant place in nursing practice and education. Nursing researchers indicate that more research is required to uncover new knowledge applicable for nursing education that will impact the care of patients.

Empathic Engagement

Few articles in nursing literature refer to the term *empathic engagement*. McCann and Pearlman (1990) reviewed how the therapist, when becoming empathically engaged with clients, must be cautious of countertransference when listening to the stories of patients living with post-traumatic stress disorder (PTSD). Countertransference refers to the "activation of the therapists unresolved unconscious conflicts or concerns" (McCann & Pearlman, 1990, p. 134). Therapists can be emotionally drawn into the stories of victimization but must be aware of their place within that exchange so as to be empathic yet responsive to the needs of the patient. This is a common

practice in healthcare. The nurse cannot get swept up in the emotional reality of the patients acting like a sponge to their despair or pain. McCann and Pearlman (1990) suggested the perspective of the therapist is an important factor when treating clients with PTSD and vicarious trauma.

Beyond nursing literature, the term empathic engagement may be found in other disciplines such as medicine. Hojat et al. (2013) provides a solid definition of empathic engagement: "empathic engagement revolves around reciprocity and mutual understanding. Such an empathic relationship evokes 'psycho-socio-bio-neurological' responses" (p. 6). At the psychosocial level, empathic engagement lays the foundation for a trusting relationship and at the bionoeurological level, empathic engagement represents the interpersonal attunement that involves a physiological activation of neurons (Hojat et al., 2013). Missing from this definition, however, is the recognition of personal values and beliefs that form the intrinsic nature of empathy.

Empathic engagement is explored in arts based and cultural studies literature about the function of narratives (Coplan, 2004) or film (Bruun Vaage, 2010), and fiction's capacity to promote empathic tendencies towards another (Jarvis, 2012). Coplan (2004) noted that readers typically feel empathy towards characters when "taking up characters' perspectives" (p. 141), similar to findings by Maruca et al. (2015) and Vanlaere et al. (2012) when placing students or nurses in the simulated role of patient. As the reader moves through a story, characters embody emotions that are familiar to the reader, allowing for a comparable point of view and deeper understanding of how readers process the emotions of characters in the narrative. The reader begins to engage in the character's emotions, actions, and processes (Bruun Vaage, 2010).

Coplan (2004) continued to identify key differences in how the observer/reader/empathizer identifies with empathy and the character/target:

> 1. The empathizer experiences psychological states that are identical or similar to target; 2. The empathizer imagines the target's experiences from the perspective of the target; 3. The empathizer experiences psychological states that are identical or similar to the target by virtue of taking the target's perspective; and 4. The empathizer maintains self-other orientation. (p. 144)

With empathy (we) readers imagine the world from the target's point of view and simulate the target's psychological states by sharing the other's experience and becoming deeply engaged in it. As Coplan (2004) stated, "We are engaged by our concern for the other, not by sharing his or her experience" (p. 146). The reader/observer of the story becomes embedded within the narrative, situating himself or herself into the experience of the characters, while remaining in a state of reality. This may play a key role in how nurse educators might relate empathic engagement in clinical practice with arts-based pedagogy.

Could Empathic Engagement be Known by Another Name?

In reviewing the literature, I found references to concepts similar to empathic engagement. As I have previously stated, there is minimal nursing literature that addresses empathic engagement or how nursing students come to understand this phenomenon. Knowing what empathic engagement is becomes important to understanding the literature of what it is not. To avoid any misinterpretation and to highlight the distinction of empathic engagement from other terms, I will discuss the following; authentic concern, empathic understanding, and spiritual mirroring.

Authentic Concern

Christiansen (2009) describes authentic concern as a relational capacity that "expresses itself through eye contact, voice, body language, and attention directed to the patient" (p. 429). Authentic concern provides way for students to physically express their concern through body movement, voice, style, positioning themselves toward the patient, or imploring humor with contact during relational moments with patients. Morse et al. (1992) defined this approach to empathy as strictly behavioral, lacking any cognitive or emotive components of empathy—merely a way for the patient to recognize through body language that the nurse is engaged with the patient. One limitation related to identifying authentic concern as actually authentic is that the perception of body language may be fabricated to give the appearance of acting in a purposeful way without any authenticity or concern actually present for the other person.

Empathic Understanding

Nagano (2000) attempts to measure empathic understanding with the intent to improve patient outcomes. Drawing from Morse et al.'s (1996) construct of empathy, Nagano (2000) suggests that the nurse's interest toward the patient, an active attitude about caring, mental capacity, similar experiences to include elements, age, years of experience and personality, will add to his or her empathic understanding. Although intrinsic traits of empathy are noted to be valid (Alligood, 2007; Nagano, 2000) prior to assuming a role of taking care of another person, a nurse is presumed to remain judgment free and cognizant of personal bias and values. This research does not align well with nursing practice and is not generalizable for patient care; therefore, this term should not be confused with empathic engagement.

Spiritual Mirroring

By definition, spiritual mirroring is the "empathetic ability to disregard personal logic, and foster another individual's spirits" (McNelly, 2005, p. 12). The purpose of spiritual mirroring, which is consistent with an empathic quality, is to share in that person's experience by placing him or herself in the perspective of another individual (McNelly, 2005). The intention of spiritual mirroring, especially from a health professional-client perspective, is two-dimensional; one person imitates the action of another, and there is conscious awareness of another's physical and spiritual presence: conscious listening, with particular attention to body language such as eye contact, nodding, and even leaning towards the person (McNelly, 2005). Spiritual mirroring may be correlated to Morse et al.'s (1996) moral, emotional, cognitive, and behavior components of empathy, whereby there is a deeper understanding and connection from one person to another as mimicked and imitated through actions. What seems to be missing from this definition is the assumption that spiritual mirroring is consistent and generalizable for all nurses. It is important to recognize that spiritual mirroring is a component of empathy, but should not be confused with how I have come to understand empathic engagement.

Against Empathy

Despite considerable nursing literature recognizing the importance of empathy in nursing practice, Bloom (2016) posits whether empathy might do more harm than good. Bloom (2019) argues that the absolutism of empathy in many realms of pro-social behaviors require a critique as to the motivations behind good actions. It is not a simplified explanation that empathy must exist in all social situations. It cannot, nor should it. Human beings, especially those in service such as nurses, cannot be expected to display empathy at all times to all patients. This brings to

question, do higher levels of empathy equate to being good and lower levels of empathy equate to being bad? It is not that simple.

Bloom (2016) and Prinz (2011) questioned the morality of empathic actions as a motivator. Prinz (2011) described the example where an individual might give some loose change to a homeless person but would not buy him lunch or subsidize the person's rent. The individual may be perceived by some people as one who performed a good deed guided by empathy; however, the good deed is not enough to solve the problems of homelessness. These arguments provide a critique of empathy as a moral compass in nursing practice.

The neural pathways that elicit cognitive and affective empathy, may also lead to a negative emotional impact. Singer and Klimecki (2014) discovered that repeated activation of the AI and ACC regions of the brain can have negative consequences leading to states of empathic distress. Exposure to the distress and suffering of others can lead to either empathic distress which results in negative feelings and associated with withdrawal, or compassionate responses, activating pro-social motivation and behavior (Singer & Klimecki, 2014). The repeated activation of these neural pathways may have lasting negative effects on nurses leading to burnout and exodus from the profession.

Summary

Throughout the literature, it is evident that nurses come to understand and find meaning through constructed experiences. Over several decades, the term empathy has been constructed, re-constructed, layered, and broken into pieces by several disciplines, so new knowledge can be garnered through multiple research methodologies. Empathic research is messy but necessary. For the purposes of this research and through this literature review, I have explored (a) the empathy enigma, (b) illustrations of empathy in nursing literature, (c) what is known about

empathic engagement, (d) and finally, if empathic engagement is known by other terms. I have provided a foundation for what has been addressed in the literature to date, leaving a space for my own inquiry into empathic engagement.

In the next chapter, I outline the methodological framework and perspectives that shaped the study. Nurses work with the stories of others during the delivery of care, but also become a part of their stories as well. There is an invisible narrative thread that connects all levels of human existence, universally, culturally, and individually (Bury, 2001). Narrative inquiry provides a methodology by which to closely examine the intersubjectivity of experience through the narratives of participants.

CHAPTER THREE: METHODOLOGY

The health-illness spectrum becomes a living story for those who experience illness and for the nurses who take care of patients and their families. In *The Wounded Storyteller*, Frank (1997) recognizes that "illness is one specific occasion for narrative wreckage, but a condition of perpetual narrative uncertainty" (p. 68). Experiences of illness are lived stories that are often messy and at times fraught with uncertainty. The story of the patient becomes enmeshed with the story of the health care practitioner, and the two narratives become fused together; bound by relationship. During moments of intense emotional and physical distress, it is difficult not to recognize the human being as separate from the experience. I have come to understand that the stories of one become the stories of another.

This research was conducted by way of narrative inquiry, based on the work of Clandinin and Connelly and building on Dewey's (1938) "understanding of experience" (p. 91). "Narrative inquiry is an approach to the study of human lives conceived as a way of honoring lived experience as a source of important knowledge and understanding" (Clandinin, 2013, p. 17). How participants come to understand empathic engagement and their interpretation of this experience is best expressed through narrative inquiry and a "way to think about experience" (Clandinin, 2006, p. 45). Nurses develop embodied knowledge through the storied lives of our patients and colleagues. It is through the narratives of both the participants and those that they shared with me about their experiences of empathic engagement, I was able to study how participants made meaning from their experiences.

Narrative inquiry is fundamental to the foundation of this study. Data is based on the narratives of participants as well as their storied experiences with patients and empathic engagement. It is only fitting to analyze the data through a narrative inquiry lens in order to

examine the nuances of story, experience, and how knowledge and meaning are derived through story. The practice of nursing is situated in narratives as well. Each patient is presented to one another during report in a storied manner, the nurse then assumes care of the patient interjecting and weaving within their story of health and illness, and ultimately some patients weave into the tapestry of our story as well. The premise of this study and learning more about empathic engagement was conducted through the narrative experiences of the participants, as evidenced by reflective visual and narrative accounts as well as through conversation with me, as the researcher. In this chapter, I will discuss the strengths of Clandinin and Connelly's (1990) methodology of narrative inquiry and how it pertains to the intricacies of empathic engagement, provide rational for interpretivist research and the social constructionist paradigm, and finally conclude this chapter by locating myself as a researcher from both within the story and as an observer unpacking and rebuilding the data to develop a deeper understanding of empathic engagement as experienced by the participants.

Narrative Inquiry

Nurses are woven into the stories of patients during times of illness, health, celebration, and death. That is one of the privileges and honors I have felt over the years working at the bedside, and now with students. It makes sense that intimate interactions between the nurse and patient may evoke Buber's (1970) I-Thou orientation as compared to an I-It orientation; however, I make no assumption that there is also room for I-It relationships within healthcare. For this study, my aim was to understand, recognize, and learn from spaces of empathic engagement.

According to narrative researchers Chambers, Hasebe-Ludt, Leggo, and Sinner (2012), "Stories present possibilities for understanding the complex, mysterious, even ineffable

experiences that comprise human living" (p. xx). Narratives describe the experiences and emotions of participants as they begin to make meaning from these human encounters. It is through stories where nurses find connection. Merriam, Caffarella, and Baumgartner (2007) explain that people create meaning with the story regardless if it is read, heard, or created through storytelling. Considering how the interconnectedness between a nurse and patient is centrally focused within story, narrative inquiry emerged as a logical choice of methodology for this work.

Juxtaposed alongside the health/illness spectrum are the relationships that exist between those who are sick and the nurses who care for the sick. Narrative inquiry provides a method that speaks to those relationships:

> Narrative inquiry is a way of inquiring into experiences that attends to individuals' lives but remains attentive to the larger contexts and relationships within which lives are nested. Stories are lived, and told, not separated from each person's living and telling in time, place and relationships, not seen as text to be separated from the living and telling and analyzed and dissected (Clandinin, Cave, & Berendonk, 2017, p. 91).

On a daily basis, nurses are engaged in story with the patient; either through reading a patient's chart, conversation, or through the daily tasks associated with caring for others. The story does not end when the nurse stops taking care of the patient, but can continue with new nurse-patient relationship that develops. It is also through this methodology that these stories of connection and relationship continue, providing an invitation for future discussion and possible research.

Narrative Inquiry as a Methodology for Nursing Research

Narrative inquiry provides an opportunity to understand the ontological question specific to the experience of empathic engagement, based on what is seen, felt, and lived through the

human health experience. Embedded within the stories emerge a uniqueness of the human exchange, between participants and patient, client, and family. It is a way to address those relationships and acknowledge the connection that was formed, even for a brief unsustainable moment in time.

Benner (1983) and Dewey (1938) acknowledged that learners develop knowledge through experience. Dewey (1938) wrote, "meaning is found in the continuity of developing experience" (p. 41). Reflective practice is a component of the undergraduate nursing program and required for yearly professional licensure. I was curious how the participants would re-create their experiences by way of narrative accounts if given the time, space, and freedom to reflect and then discuss in conversation. A deeper understanding of the experience through reflection allow a space for embodied learning. As Clark (2010) identified, adult learners make sense of their experiences through storying it and then construct a deeper understanding of themselves through the restorying of embodied experiences. The restorying of the narrative recreates the reality of the experience as it occurred as well as a reconstruction of the social interaction. Narrative inquiry might provide a way for participants to uncover a personal understanding about the richness of their experiences and now offers a way to articulate these important, yet emotionally complex, moments which occurred between themselves and a patient, client, or family member.

How this Study is Rooted in the Narrative

Given the woven intricacy of story within the practice of nurses, it seemed only fitting that personal participant narratives, conversation, and participant-patient/family/client relationship as well as participant-researcher relationship would become a valuable component to

the study design. As Riessman (2008) stated, stories are "strategic, functional, and purposeful" (p. 8). My role as the researcher, was to make sense of their verbal, written, and creative ways participants told their story to form an operational understanding of empathic engagement.

The study design was around two one-on-one conversations between the participant and me, at the beginning and end of the study, with a reflective component to be completed between the two conversations surrounding participant experiences with empathic engagement. After consent was signed by the participants, the first one-on-one conversation was a way to explore the impetus of the study and brain storm possible experiences through guided questions, where participants identified with relational exchanges of empathic engagement between themselves and a patient, client, or family. After that initial study conversation, participants were encouraged to reflect on those experiences of empathic engagement and provide me with a written or visual narrative to situate me within their experience. The final one-on-one conversation was to further discuss those experiences through conversation and identify if any meaning was derived by the participants from the restorying of the experience. Clark and Rossiter (2008) claim that human beings are wired to be story tellers meaning is derived from those stories. Narrative inquiry was a logical choice by which to situate and provide foundation for this study.

Rationale for Narrative Inquiry in this Study

Narrative inquiry, which allows participants to examine their own accounts of events that have affected their understanding of experience, their assumptions, and their subjectivities (Lyle, 2013), was well suited to this research study. The knowledge, deeper understanding, and wisdom (Denzin & Lincoln, 2011) gained through narrative inquiry belongs to all parties involved in the research process, even though these narratives will represent only a small sample of the larger population of nursing students. Uncovering and sharing the experiences of empathic engagement

through narrative inquiry is an extension of the participant and patient's living story. I am cognizant that in this dissertation, I am not only sharing the participant's experience as they recall but also a restorying the nurse's narrative of the patient's narrative as well. I want to honor both the participant's narrative but the individual patient, client, or family member that is central to each experience of empathic engagement.

As Walker (2007) identified, stories and narratives help readers reflect upon themselves and their practices. She continued to state that

> The exchange of stories challenges our complacency as interpreters 'outside' the story, and makes us aware that our own place in the world plays a part in our interpretation and shapes the meanings we derive, thereby producing a more accountable [sic] and more responsible knowledge (p. 296).

The narrative allows a space for reflexivity which situates the interpreter within the experience as either already lived or imagined. As Lyle (2013) states, narrative methodology "encourages meaning making in a personal way" (p. 18).

Narrative inquiry allows for the possibility of the participant, the researcher, and the reader to reflect on "why we do what we do" (Kim & Latta, 2010, p. 69). The intent behind a written narrative is to provide a reflective space that allows for careful examination and meaning making of a personal experience and through relationship central in the exchange of. Participants had the option for their reflection to present a narrative of their choice and for the study, I received written and visual accounts of experiences of how participants understood empathic engagement. With each visual narrative, participants provided background information to help me in understanding their perspective as they presented the narrative but also the opportunity for me, as the researcher, to draw my own interpretations based on my shared lens as a nurse.

Kumagai and Naidu (2015) recognize three requirements necessary to optimize reflective practices: a sense of safety and confidentiality, an intent to create space, and awareness of the transitory nature of the experience. All participants of the study had been previous students of mine; however, at the time of the study, I was not be in a position of power or teaching role with the participants. I acknowledge a pre-existing relationship but, in the end, the previous relationship allowed for more intimate conversations of the experiences with shared knowledge of participant experiences as a nurse. Participants revealed the pre-existing relationship enabled each to be more open with me as the researcher, as participants already felt a sense of safety and trust with me. I was familiar with each of the units and environments of the participants such as critical care, medical/surgical environments, but also with the role of attending to humanity in practice. Purposeful reflection of the experience followed by a debriefing with each participant created a space to explore the experience of empathic engagement—implying permission to discuss emotions, actions, and outcomes of the experience. In the past and only anecdotally, students have recognized the transitory nature of an experience that could be forgotten without careful attention and imposed reflection. This study captured the nature of the transition as experienced by each participant as well as identified four unique phases of empathic engagement.

Interpretivism and Subjectivity

This research is situated in the theoretical paradigm of interpretivism and constructionism. Interpretivism may be defined as subjective beliefs (Lincoln & Guba, 2013) that "replace the scientific notions of explanation, prediction and control, with the interpretive notions of understanding, meaning and action" (Carr & Kemmis, 1986, p. 83). The researcher utilizes interpretive inquiry in order to understand the lived experience of participants (Lincoln &

Guba, 2013). Interpretivism identifies transferability of the meaning determined by individuals who find meaning within nursing practice and nursing education. Lincoln and Guba (2013) indicate transferability in interpretivism to validity in positivism. Since nursing is a service profession that largely made up of relationships, transferability of the findings to other service professions such as medicine, education, social work, and to life experiences is possible. Recognizing the transferability of these findings identifies that spaces of empathic engagement do not only occur in the nurse-patient relationship but can occur in other disciplines. To examine more closely a participant's understanding and recognition of empathic engagement is an interpretive act; during the experience, reflective practice of the experience, through the restorying and reconstruction of that experience, and finally, in the analysis of the narrative.

Interpretivism is situated as an opposite of positivism ontologically, epistemologically, and axiologically. Ontologically, participants develop roles and location of self and others in relation to experiences of empathic engagement, potentially enhancing their future practice; epistemologically, participants interpret and construct personal meaning through experience which shapes and molds the personal locus of understanding; axiologically, ethical and moral distress often accompany experiences of empathic engagement; thus, interpretation leaves space for reflection, coping, and enhanced strength in practice.

Lincoln and Guba (2013) state that "relativism is the basic ontological presupposition for constructivism" (p. 39) and social constructionism. Although social constructivism and social constructionism are closely aligned, they are uniquely different. It is important that I address this difference as not to confuse why this study is based predominantly in the paradigm of social constructionism and not social constructivism. According to Gergen (2015), social constructivism "places the origin of knowledge in the head of the individual" (p.30) and how we

understand the world is constructed in our own terms, where as social construction "places the origin [of knowledge] in social process" (p. 30). This study is centrally focussed on how participants construct meaning based on the social processes gathered by conversation and through reflection strengthening a relationship with self. Experience is based in the reality of the participant, and meaning is derived from that experience. Lincoln and Guba (2013) identify that epistemologically, knowledge is personal and context-specific. For the purposes of this research, participants' knowledge was created through conversation and from the restorying of the narratives. If this study was based on a social constructivism paradigm, results of the study would have suggested meaning making was constructed solely in the minds of the participant and not through the focus on a relational context of nurse-patient or nurse-nurse or even participant-researcher. Reflective practice was embedded as part of the study to encourage a temporal understanding of relational practice. Although reflective practice is associated with social constructivism (Merriam, Caffarella, & Baumgartner, 2007), the restorying of participants' narratives were used to help guide conversation, not a specific focus on the narrative itself or how the narrative was constructed. Ultimately, the subjectivity of discovered meaning unfolded from the narrative of the experience and unpacking of embodied learning. A previous student-teacher relationship with each participant prior to the start of the study, may have assisted in drawing out a shared reality of the experience of empathic engagement within varying environments of nursing practice. Finally, Lincoln and Guba (2013) recommend that the researcher and participants work together to

> co-create knowledge and create a new, shared reality. In this shared and co-created reality, the values of the inquirer, the various value systems of research participants, the values which inhere in the context all must be uncovered and made transparent. (p. 41)

Values become important factors in this research.

With completion of the study, narrative inquiry and the nuances of an interpretivist and social constructionist paradigm were valued methods to understand and provide definition to empathic engagement. Nursing practice is a socially developed profession embedded with specific cultural and unique realities. Identifying the ontological, epistemological, and axiological nature of researching empathic engagement provided the necessary foundation of this work.

Locating Myself in the Research

According to Pinnegar and Daynes (2007), "the researcher not only understands that there is a relationship between the humans involved in the inquiry but also who the researcher is and what is researched emerge in the interaction" (p. 14). First, as the principal researcher in this study, my ability to guide the one-on-one conversation and interpretation of the narratives and transcripts of the interviews provided a unique lens that may not have been possible with a researcher who was not a nurse. Due to a pre-existing relationship with the participants, I had a basic understanding of who they were on an individual level prior to participating in the study, leading to the possibility of an I-Thou relationship developing early on in the research process as opposed to an I-It relationship. On a larger level, I already understood what can happen within spaces of empathic engagement and the necessary questions to enrich learning and meaning from the participants. There was a level of trust between me and each participant that enabled an authentic explanation of emotions, actions, and outcomes as indicated in the one-on-one conversations. I attempted to separate myself from the participant experiences and analyze each narrative in a holistic entirety given my previous experience with each participant and knowledge of nursing practice; however, I do not suggest that all bias was removed while I have

conducted this study or during analysis of the data. Narrative inquiry, like much qualitative research, is relational and relationships are inherently subjective and prone to bias. It is important to address how I locate myself within the researcher/participant relationship and to acknowledge the complexity of doing this type of relational research.

As a nurse, I have sat with patients who were dying. During the quiet and stillness of some deaths, while my patients have slipped away, I have held their hand as they take their last breath. I have been the last person who touched them, who cared for them, and gently spoke words of comfort as they quietly approached their journey's end. Despite my own personal experience with empathic engagement, this study was identifying how participants derived knowledge and found meaning within their own relational exchanges. I was aware this study was not about me, even though I had a close relationship with the topic.

I realize that I did not always share the same experience as the participants but that only increased my ability to recognize the delicate nuances of the liminal space of empathic engagement and how I came to understand the four distinct phases of empathic engagement. This first-hand knowledge allowed me to interpret and determine overall findings for this study, leading to this dissertation.

Research Setting

This research was conducted at the University of Calgary, with students in the Faculty of Nursing. This setting was representative of students in baccalaureate nursing programs and is consistent with many schools of nursing across Canada. The size of Calgary and the clinical placements available for students provided a rich opportunity for students to engage more intimately with the patient and or family. In the past, clinical placements in areas such as cardiovascular, internal medicine, critical care, general medical and surgical areas, pediatrics,

labour and delivery, mental health, and community have been provided to fourth-year nursing students from the University of Calgary. Participants in the study shared narratives from experiences throughout their undergraduate nursing program.

Research Population

Novice nurses exhibit foundational elements of relational nursing practice as compared to nurses with years of experience. For the purposes of this research, fourth-year nursing students, with previous degrees who were in their final practicum, comprised the chosen population. I chose this year of study because I believed that students at this level, who are months away from program completion, are more prepared to focus on the holistic aspect of nursing care and less on acquiring skill development. What surprised me was participants were able to share with me experiences from throughout their program about opportunities where they were able to move into these intimate spaces; however, at the time, participants did not have a name to apply to these experiences. Based on my personal experience as an educator, participants at the end of a nursing program exhibited the ability to articulate these experiences having developed comfort with skills, communication, and knowledge of nursing practice.

Data Collection

For the purposes of this study, over 100 fourth-year nursing students were presented with the option to participate in the study and self-selected to share their stories of empathic engagement. According to Clandinin (2013), there is no particular number of participants required to analyze the written narrative; however, there is an understanding that a relationship exists between the "humans involved in the inquiry but also who the researcher is and what is researched emerge in the interaction." (p. 14) I anticipated five to seven participants would be an adequate number to participate in the study. The potential participant and I would meet face-to-

face to determine eligibility, sign the consent form, and complete a one-on-one conversation guided by semi-structured questions. Participants would be asked after the one-on-one conversation to produce a narrative in the form of their choice and submit this narrative to me in person or electronically. The study would conclude with a final unstructured one-on-one conversation between the participant and me to discuss the narrative, the participant's experiences in the study, and to close the research relationship with the participant. In the end, seven students self-selected and volunteered to participate in the study. Eligibility of participant involvement in the study was to be determined during the first one-on-one conversation to determine if the potential participant had encountered spaces of empathic engagement. Aside from this one basic recruitment of having experienced opportunities of empathic engagement, there was no other eligibility requirement for people who contacted me to participate in the study. Recruitment was stopped once I had achieved a convenience sample. Seven participants were an adequate number in order to analyze their experiences, narratives, and obtain a robust discussion leading to the findings. Convenience sampling was a practical option for this study as the potential participants were close in geographical proximity and the subjects of the study were easily accessible to me at the University of Calgary.

After ethics approval was obtained, I contacted all the faculty advisors through email and requested an opportunity to speak with each group of fourth-year nursing students during on-campus seminar time. I provided each group with a brief presentation about the purpose of the study, questions that guided the study, and an email to contact me to participate. Students were given an option to further discuss the expectations of participation either in person or via phone conversation, but no students contacted me for more information, only to participate.

Prospective participants who demonstrated interest in the study were invited to meet with me face-to-face to answer any further questions about the study, provide further clarification about what is meant by an experience of empathic engagement, and if they wanted to continue in the study, all participants were provided an opportunity to review and sign the consent form. This was an exploratory study, beyond self-identification, self- declaration of possible opportunities of empathic engagement, and signing the consent form, there was not any other eligibility criteria that other people had to meet. I was interested in talking with people who came forward. After consent was obtained, participants were invited to engage with me in a brief, semi-structured one-on-one conversation guided by ethics approved interview questions (see Appendix A) and asked to think of a powerful incident that may have impacted their practice. The conversation unfolded with the focus of the incident as the premise of the inquiry; how did the participant find meaning in the incident, how did the participant make sense of the incident, did the incident impact his or her practice, identity, or role as a nurse. At the time of consent, I provided a loose definition of what empathic engagement was to help guide the participants in recognizing spaces of empathic engagement from their own experiences. I determined this definition of empathic engagement after carefully considering literature from the professional disciplines of nursing, education, and psychology combined with previous knowledge as an educator and practitioner. The six aspects of empathic engagement at the start of the study were defined as: 1. The participant recognizes in himself or herself a state of empathy. 2. There is an intent to be empathic. 3. There is definite action for relational engagement with a patient or family member. 4. Recognition of the presence of a relational liminal space. 5. The decision to enter into that space. 6. Leading to enhanced connection and a deeper therapeutic relationship. During the initial one-on-one conversation, semi-structured questions guided participants to

explore their previous clinical experiences for possible opportunities of empathic engagement. I allowed the conversations to flow organically allowing for adequate space within the dialogue to tease out narratives from each participant and expand on their experiences. After the one-on one conversation, each participant was encouraged to reflect on a previous moment that was discussed in the first one-on-one conversation or identify a new moment from practice that was meaningful to her and when they recalled being engaged with a patient and or family based on the six aspects of empathic engagement. Participants were reminded that connecting to an intimate and powerful moment requires a thoughtful approach to the situation. Levy (2014) reported that contemplative practices, such as mindfulness and thoughtful consideration, cultivate attention and balance. The reflective practice of recreating and restorying the participants' experience with empathic engagement was a powerful exercise for deeper learning and meaning making.

Participants were encouraged to reflect on their experience with spaces of empathic engagement and produce a narrative in written, oral, visual, or another context that was meaningful for the participant. I encouraged participants to revisit their experiences by placing me as an observer of that experience, addressing any pertinent sensory information. A few examples of suggested questions were: 1. Where was the participant standing/siting in the room in relation to the patient, family, or client; 2. What did the participant see when she walked into the room; 3. Could the participant hear anything in the room? Riessman (2008) claims, "narratives invite us as listeners, readers, and viewers to enter the perspective of the narrator" (p. 9). The narratives provided an opportunity and space for me as the researcher to enter and interpret the participants' lived experience of empathic engagement.

After participants submitted their narratives, they were asked to complete the study with a final one-on-on unstructured conversation with me about their narrative and experience. The timing of this one-on-one conversation was negotiated between the participant and I, based on the participants' practicum schedule and any travel outside of the country. The participants and I further explored their narrative, missed details from the story that were in the narrative but absent in the first one-on-one conversation to the narrative, why their experience with empathic engagement was meaningful for their learning, and what they learned about themselves as an individual and as a nurse. Given the high degree of emotions that accompanied these experiences of empathic engagement, it was important for me to assist the participants to unpack any unattended emotions, events, and to provide closure of the experience.

Both one-on-one conversation #1 and #2 were taped and transcribed for analysis of emerging themes. Participants were forwarded the transcripts to review, confirm, or revise the content of the conversation.

Through this process, a triangulation occurred firstly between the participant, patient/client/family, and the experience of empathic engagement, then secondly between the participant, their restorying and account of the narrative, and with me, as the researcher. Clandinin (2013) stated that "the researcher and the researched in a particular study are in relationship with each other and that both parties will learn and change in the encounter." (p. 9) Learning about the point of empathic engagement from the perspective of the participant revealed multiple insights about their experience, how each participant approached opportunities where spaces of empathic engagement presented, and finally how participants found meaning with the nurse-patient relationship and spaces of empathic engagement. I was a willing observer and element of the participant experience as I was both the reader and researcher. The reader

becomes a part of the participant's story and, when that information is analyzed and written up for others, the reader of that material becomes a part of the restorying experience as well. This study is representative of the participant's experience with empathic engagement and what we can learn from these spaces of relationship. As Josselson, Lieblich, and McAdams (2007) acknowledge, "relationships require narratives to evoke the empathy and multilayered attention necessary for one person to have some sense of the nature of someone else's relational experience" (p. 4). The participants' narratives of empathic engagement illuminated an area of research that has remained in the dark.

I remained steadfast to exercise caution in labeling each narrative piece as data. Denzin (2013) reminded us that the use of the word data has a "positivistic epistemology based on terms of reliability and validity" (p. 355). Because this work was interpretivist in nature, the quality of the data that emerged was relative to the reality of the participant; therefore, within the social constructionist paradigm. The aim of this research was to understand the phenomenon of empathic engagement through the storied lives of the participants and to learn how this knowledge could impact nursing curriculum for the adult learner. I agree with Denzin that qualitative work may treat the data as a commodity; however, engaging with patients' lives, and a snapshot of the participant's experience requires respect. I have not forgotten the confidential, intimate, and privileged nature of this work

Data Analysis

This study was analyzed using the thematic analysis method described by Braun and Clarke (2006). "Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data" that is compatible with a constructionism paradigm (Braun & Clarke, 2006, p. 79). According to Braun and Clarke (2006), there are six phases of thematic analysis, of

which I followed for the study: 1. Familiarizing yourself with the data which occurs during transcription; 2. Generating initial codes such as interesting features of the data; 3. Searching for themes by collating codes into potential themes; 4. Reviewing themes to check if the themes work in relation to the coded data (Level 1) and the entire data set (Level 2); 5. Defining and naming themes refining specifics of each theme; and 6. Producing the report with a selection of vivid examples relating back to the research questions and literature.

I transcribed all narratives, and one-on-one conversations. The process enabled me to be immersed with the data as I revisited the conversations between the participants and me. I was able to remember those often-forgotten moments where there were tears from the participants, laughter because of a shared experience, and interestingly when participants paused between statements which was recorded in the transcripts. I was able to generate initial codes when I heard broad yet similar statements and phrases from the participants. There is an intimacy that as a researcher, I developed while listening to the participant's accounts of their experiences with empathic engagement and then through a reading of those textual transcripts. Using the semi-structured questions as a guide, from the first one-on-one conversation, I aligned each transcript to address similarities and differences in what was experienced by the participants. Once all material was aligned, I was able to sort through the codes for potential themes. I identified relationships between the codes, relationships between the themes, and finally relationships between sub-themes (Braun & Clarke, 2006). I kept notes at all levels of thematic identification moving from broad codes, to themes, and then to sub-themes of information through a concept map. This method helped me to review and refine themes at two levels: level one included the review of extracts from themes of the data which identified a coherent pattern, and then level 2 of the data analysis process, enabled me to validate the themes and identify any meaning within

the data set. This phase of analysis took several weeks to ensure that I had not missed details within the data set and that I had taken rigour when defining and naming the final themes of the data which produced the four phases of empathic engagement. As the participants shared with me several narrative accounts of their experiences of empathic engagement, I had to separate each experience from the next, identify similarities and differences based on language and action, to fully understand and define the four phases participants demonstrated with empathic engagement.

To understand each participant better, I kept detailed notes and journal entries after each conversation and when I reviewed the participant's narrative. It was important for the work of narrative inquiry to create a narrative portrait of each participant. A narrative portrait aims to "capture the richness, complexity, and dimensionality of human experience in social and cultural context" (Lawrence-Lightfoot & Davis, 1997, p.3). The purpose of the narrative portraits is to convey the most salient, relevant details about each participant and their narrative. I have included the participant's portrait in this dissertation as well as an excerpt from their narrative experience of empathic engagement. After review of the participant's portrait, I could not discuss the findings of the study without addressing the experience of the participants entering into spaces of empathic engagement, as their experience shaped the findings of this study.

To enhance trustworthiness, all analytical decisions were recorded in separate notes and on the transcripts. Refined and defined themes were verified by returning to the original data sets. Thematic analysis is a useful and foundational method for qualitative research. In this study, four phases of empathic emerged from complex and dynamic relationships between participants and patients, clients, and family members.

Ethics

Prior to initiation of this research study, full ethics approval was obtained by the Conjoint Faculties Research Ethics Board. All participants signed an Informed Consent forms prior to the initiation of any research endeavors and a copy as provided. Participants were made aware that their identity could not be completely confidential from me, but that I will maintain their privacy and confidentiality in this thesis as well as identifiers in their experiences of empathic engagement. Each participant was given the option to choose their own pseudonym for the study. The participant could withdraw at any time from the study, but examples of their narratives and any content that emerged from the one-on-one conversations would be retained for use as results in the study. I obtained permission from each participant to add their photographs and a picture of the painting to this thesis. No participants or data was withdrawn from the study.

Participants experienced intimate moments of transition, death, regrets, suicide, sexuality, to name a few with patients, clients, and families during the study. These experiences cannot be dismissed as only a researchable moment, but should be recognized as complex and intricate components to the lives of the patients and families. Despite the intent of this study to understand more about the experience of empathic engagement, respect for patient, client, and family anonymity was maintained throughout the process. Participants did not use any patient, facility, or unit identifiers in their narratives.

In retrospect, I under-estimated the potential harm when I entered into conversations with participants about sensitive, clinically difficult situations with fourth-year nursing students and not seasoned nurses. The taken for granted assumption that participants were emotionally prepared and equipped to revisit and restory emotional experiences was an oversight when preparing for this study. Although the nature of the study intended for participants to re-explore

experiences with empathic engagement, I did not consider the potential risk for vicarious trauma or took extra steps in providing additional resources to participants if they should need it. This must be taken into consideration when undertaking this type of emotionally laden work.

It is important to recognize that the participants who volunteered to participate in this study had been my students, and that I was previously in a position of power in relation to them as their primary instructor. A professional student/teacher relationship existed but had ended before any study related actions took place. Only a researcher/participant relationship was present throughout the study. There were no potential conflicts of interest or any appearance of coercion, as my role in this study was only as the researcher, not the participants primary instructor.

Establishing Rigor

Any new episteme based on the perspective of the participant related to the experience of empathic engagement should not require justification. Ontological frames of reference provide valid information pertaining to the relationships of people in health professions, which in turn added to the knowledge of how participants related to patients. Denzin (2013) argues that qualitative data does not need to fit the standard hegemonic requirement of proof that has emerged from positivist, quantitative research paradigms and models, and that there is more at play about the politics of data collection. Human beings and the relationships between individuals cannot be coded or quantifiable, thereby indicating the complexity of studying how participants came to understand when they entered into a space and feeling of empathic engagement with another. Through thematic analysis of the relational exchanges between participants and patients, clients, and family members, I was able to generate themes based on similarities between participant experiences leading to the four phases of empathic engagement.

As Clandinin (2013) states there are "conceptual underpinnings of the relational living alongside in narrative inquiry . . . narrative inquiry is people in relation studying people in relation" (p.10). Qualitative methodologies and specifically narrative inquiry aligned with the narratives of nursing practice and the storied lives and experiences of the participants in this study.

Advancing qualitative research requires establishing trustworthiness and rigor in this work. According to Guba and Lincoln (1985), trustworthiness is a way to persuade the researcher and reader that findings are applicable and worthy of attention. Lincoln and Guba (1985) further expand the concept of trustworthiness to include criteria such as credibility, transferability, dependability, and confirmability to parallel quantitative assessment criteria of validity and reliability (Nowell, Norris, White, & Moules, 2017). Credibility refers to a study when presented or interpreted in such a way that other people, who may have also had a similar human experience, would immediately recognize it from the descriptions or interpretations (Sandelowski, 1986). Transferability of the study "refers to the generalizability of inquiry" (Nowell et al., 2017, p. 3) as well as the extent to which the findings can be applied to other contexts (Cope, 2014). Dependability can be achieved when the research process is constant over similar conditions (Cope, 2014), the process may be audited (Koch, 2006) as well as logical, traceable, and clearly documented (Tobin & Bengley, 2004). Finally, confirmability establishes how conclusions and interpretations were established throughout the study including reasons for theoretical, methodological, and analytical (Cope, 2014; Nowell et al., 2017).

There are identifiable cautions that I exercised as a researcher throughout this project. As a nursing educator and previous practitioner, I am close to the topic of empathic engagement. I was cognizant that my interpretations of the participants' experiences might, at times, differ from what participants were trying to convey. I endeavoured to identify my own bias, and understand

and relay their ideas as intended. As Crotty (1998) identified, social constructionist researchers must be cognizant of the reification of meaning, "the sense we make of things" as compared to "the way things are" (p. 59).

Summary

The chosen methodology for this study was narrative inquiry. It was a way to highlight the importance of story within nursing practice and address the narratives of participants through one-on-one conversation and a creative expression of narrative work explaining participants' experience with empathic engagement. Analysis of the data was conducted through thematic analysis (Braun & Clarke, 2006) which is compatible with a constructionist paradigm. Throughout the research process, I maintained written reflective notes in order to address the reflexivity. This enabled me to conduct analysis through an iterative and reiterative process allowing me to move back and forward between phases.

Moving into Chapter Four, I present narrative portraits of each participant and share excerpts from their experiences with empathic engagement. It is a way to honor the participants and their stories by sharing a textual representation of the complex dimension each participant brought to the study. This dissertation is an inquiry-based tribute to honor the stories woven within these pages of the participants, their patients, clients, and family members with experiences of empathic engagement. These narrative portraits offer an introduction to each participant and how they came to understand and made sense of empathic engagement.

CHAPTER FOUR: NARRATIVE PORTRAITS

In this chapter, I present narrative portraits of the seven individuals who volunteered to participate and share their experiences of empathic engagement. It was important for me to capture not only their experiences of empathic engagement with their patients, clients, and family members, but to develop a rich sense of who each participant was and find a way to convey that to readers of this dissertation. They had different clinical experiences, a fact that diminished the likelihood that they would repeat their stories to another participant. Only female students opted to participate in the study. There were a wide variety of practice environments discussed by participants where they recalled experiences of empathic engagement, such as acute care, long term care, palliative care, and community practice.

The aim of this work is to provide a narrative interpretation of each participant for the reader of this dissertation. According to Smyth and McInerney (2013), "It is the researcher's perspective, experiences, and ideological beliefs that influence the construction of the portrait" (p. 10). Although I limit my comments here to the information that participants shared with me through their participation in my study, I recognize that pre-existing relationships with participants allowed me to engage with them in a way that provided further depth and layers to each narrative portrait. In some spots in the following portraits, I have highlighted specific words and phrases to highlight my sense of the primary theme that emerged from the one-on-one conversations and heir narratives.

Narrative Portrait of Gillian

The first one-on-one conversation was completed at a restaurant, in a private room to maintain confidentiality of personal details and experiences in health care, with a view of the golf course. We sat across the table from one another. The second one-on-one conversation was

conducted in a private and neutrally agreed upon location with couches and home-like environment. It was late summer when both interviews occurred. I remember there were still leaves on the trees and the grass was still green. Gillian responded to my request to participate in the study.

Gillian had an eye for color and a creative flow. She said her previous degree "taps into the way people think and feel and what certain things evoke in people." She was an observer of the world and recognized the qualities of being human and empathic long before entering nursing school:

> I think that, yes, I have many experiences where you see situations and talk to people in different situations and you actually feel kind of you know the same way they do. Not that you know how it feels, but you know there is more to it, and you feel there is more. You see pains and joys and hen you see and feel that it's genuine, I feel that you are being a part of it.

Gillian was raised in a traditional home with clear rules and expectations set by her parents. She did not mention any siblings during the conversations. Boundaries were of comfort to her and she liked to live her life within the boxes that were set by the system or those that she implemented on her own. Emotions were carefully reserved when needed, but often they remained hidden. She explained that, "as much as I recognize emotions and feelings, I don't want to experience it." Avoiding emotions was directly connected to how she was raised as she commented to me that emotions were never discussed. She demonstrated skilled care in clinical settings but was cautious as not to make any errors. She was curious about learning and mastering the tasks of practice advancing slower into the relational exchanges between the nurse-patient dynamic. Moving into a reflective space was an exercise for Gillian as this meant she

revisited positive and negative emotions from experiences. She is the type of nurse who reflects on a situation in the immediacy of the moment, but once the moment has passed, she does not need to think about what has already passed. She lives in the present.

One of the traits I discovered about Gillian was how well she had enforced maintaining **boundaries** for practice and in life. She had a larger understanding of the work-life balance that was required for nursing practice; get close but not too close. I was impressed with her ability to maintain concise and neat boundaries with patients so early on in her career. I envied that about her. She seemed to understand this life long nursing skill far earlier, as I was still learning it myself. I listened to how reserved and careful she was about choosing when to engage with others and when to refrain from the relationship. I realized she had a maturity level atypical of many students. I was impressed with her poise at each conversation.

As I read through the transcripts and my notes of the one-on-one conversations, there is a distinct point in the conversations where Gillian starts to question me about the blurring of professional and personal roles; and the researcher becomes a part of the research. I have been a nurse for so long, I am not able to separate my role as a practitioner and as Kara. There is always someone asking me to diagnose an illness, asking for advice on taking care of someone else who is sick and needs to vent about their role, inquiring as to what does *this* drug do, and just needing another person to listen so they don't feel so alone. Gillian said, "I went into nursing thinking that I had the ability to turn things off. I would be fine in this profession. That's what I thought. I don't know." The reality is nursing takes a toll on one's body and mind, but Gillian knows herself well, that I anticipate she will be able to maintain those boundaries and keep herself shielded from the emotional taxing of others.

Here is an excerpt from Gillian's written narrative:

My patient's condition was deteriorating slowly as the patient waited for surgery. Being in the old age stage of life, the longer my patient waited for surgery, the more he lost hope and was in despair. His deteriorating physical condition and being on bed rest was beginning to overwhelm to him. Being on bedrest meant that he would need to work extra hard in recovery physically and mentally to overcome his muscle wasting while on bedrest. I witnessed frustration from both the patient and spouse while awaiting surgery. Listening to my patient verbally state that he was losing hope and what his life was like before the fall compared to bedrest [his current state in hospital was compared to being a rat] provided him with some relief, but I could tell that it was not enough. I knew something needed to be done to bring comfort and hope back to him. He had previously refused a bed bath so I tried to encourage it some more instead of leaving it up to his discretion.

Narrative Portrait of Suzie

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me. The conversations between us were easy and effortless as we navigated difficult concepts of practice, death, family, and critical care nursing. We found a shared understanding of what emerged in our discussions of personal and clinical experiences.

She was raised in a two-parent home with only one brother whom she addressed during the interviews. She mentioned that her mom was also a nurse whom she was close with and often unpacked clinical experiences after difficult days. Her brother had battled addictions in the past and this remained a point of rawness in her life. She was emotional about the fragile life we live and the impact others' actions have on family dynamic. Suzie and her mother were the conversationalists while her brother and dad kept emotions and feelings quiet. She said, "My

brother and dad are the same person and they don't talk, my mom talks all the time." Suzie certainly gets her robust socialization skills from her mom.

Suzie is keenly observant of human suffering. She is not afraid to be psychologically vulnerable and authentically present with others. She shared with me how she reads the cues from her patients and families and will hug those that may require touch, as evidenced by a few of her narratives. She recognizes the emptiness and **fear of being alone** and works hard to minimize similar feelings for others. Her willingness to be present with someone during times of loneliness such as sitting at the bedside or during transition such as in death, exhibits a strong sense of duty for those in her care. She has appropriate coping strategies with lessons learned from her mother about how to navigate the difficult, emotional nature of nurses. She has an intuitive practice and a sharp mind that is applicable to the tasks of nursing but also speaks to the hidden skills such as compassion, empathy, and authenticity.

Suzie recognized personal biases and judgments early on with patients. She was able to maintain boundaries easily because of her awareness and insight not only to herself but also the needs of her patients. This could be as a result of her previous degree in the social sciences. Suzie is deeply emotional and cares for the well-being of those around her. Her emotions do not prevent her from her work, if anything it seems they help bring her closer to her patients. She has a good grasp on understanding when she is getting exhausted but loves nursing practice and the challenges of controlled chaos in settings such as critical care.

Although Suzie is a reflective practitioner, she garners depth and understanding from experiences when they can be discussed face-to-face. Even though reflective narrative practice was a part of the study, Suzie indicated she was able to find more meaning through the conversations we had as she was able to connect with me at a collegial level with shared

experiences. I welcomed the opportunity to speak with her throughout the study. We were able to address similar fears associated with practice of death, dying, transition, loss, and how we both coped with those difficult moments. It was hard not to see myself in her and connect with her on many levels; she was just starting her career, she enjoyed an area of practice that I too, loved, and she cared for people on a personal level, like they were her family, which is something that I did too. Our practice and enthusiasm for nursing was similar and I enjoyed our conversations.

Here is an excerpt from Suzie's written narrative:

That evening, we had determined that B was a DCD [donation after cardiac death] candidate, and pending the multiple tests and screens over the next 24 hours, the patient would be donating organs [to save the life of another] . . . The silence was becoming overwhelming to me, because I thought that interaction and engagement is what H (B's family member) really needed in that moment. I decided to go to the other side of the bed and I told H that to hold the B's hand if H wanted to. H replied, "I don't want to hold a cold hand". So, I said, "well, the patient's chest is still warm", and put my hand on B's chest briefly. H mimicked my hand placement on B's chest and began to cry. I put my hand on H's shoulder and just stood there beside H. H made a sideways glance at me and nodded and said thank you, and it seemed like it was permission to take my hand away, but to me it also felt like that was out of politeness, and H actually really wanted or needed that connection, so I decided to keep my hand there. There were moments where I felt that this position was getting uncomfortable, and I felt the urge to move away, or to look at the clock, but I made sure that I didn't pull away and instead just watched the monitor.

Narrative Portrait of Leanne

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me. There were a few months lag between one-on-one conversation #1 and #2 as the participant was away for a period. But the time away, allowed a greater opportunity for reflective spaces that did not happen for the other participants.

Leanne was born into a family of nurses. Upon completion of the program and passing her registered nursing exam, she is the third generation, of her family, to become a nurse. Leanne credits her mom and grandmother for her ability to be emotionally prepared for the challenges of nursing practice. As she said,

> My mom is a nurse, that is a permanent debrief. My grandma is an LPN as well. I am always chatting, always debriefing which is super helpful. And um, yeah. I think I certainly wouldn't be like, as capable or emotionally competent if it wasn't for them. Because I take a lot form what they have done.

Leanne has been raised with nursing skills such as communication, debriefing, and unpacking difficult days and was surprised that these skills had to be addressed, "A lot of things in nursing, I didn't realize were nursing skills until I got into the program. You mean you guys don't know how to do this?" Humanistic skills such as empathy, compassion, communication, embodied learning, came naturally for her as was her ability to recognize and move into spaces of empathic engagement throughout the study. She connects deeply to the professional practice and what is expected of her as a nurse.

A theme that emerged throughout many of Leanne's narratives about her clinical experiences included how **protective** she was of vulnerable patients such as children and the

elderly. One of her strengths is her ability to be an advocate for patients and families during times of crisis. Due to excellent coping strategies, she is able to remove herself emotionally from a situation. Leanne recognized that she still has work to do on defining boundaries, by not "taking on too much."

Here is an excerpt from Leanne's written narrative:

While holding N's hand, she looked me in the eyes and begged me to kill her. She said, "Please kill me, please. I want to die." I immediately considered her safety and assessed if she had a plan to kill herself and if she had access to means to kill herself. She had neither. My heart sank. I reminded her that her family loves her and wants her to be happy. I apologized and said that there is nothing that I can do but I can relay her concerns to the healthcare team. I also gave her a tight hug.

Narrative Portrait of Mercedes

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me.

Mercedes was raised in a traditional background born to immigrant parents. She is rooted in heritage with a mixture of Canadian culture added to the family. She has one older brother. Her previous degrees and life experience have enabled her to understand the social dynamic of gender and to read people's verbal and non-verbal cues well. Her confidence in knowing what to say during uncomfortable moments has improved with experience.

Throughout her participation in the study, Mercedes grew as a nurse and as an individual. She embraced opportunities of reflection and has embedded these actions into her practice. She was open to learning about herself and through discussion was able to identify areas of her practice where she created emotional boundaries towards some patients. She informed me the

self-imposed boundaries prevented her from being caught in patient drama; which is something she avoided in her personal and professional life.

One of Mercedes' greatest strengths and themes throughout her narratives was her willingness to be **reflective**. This skill, although uncomfortable at times, enabled her to develop insight into her actions in order to improve her practice. She began to share her reflective practices with her preceptor who in turn shared her own bias towards others. The collaborative sharing prevented either nurse to feel shame or negative emotions for their actions toward others but to reflect and change behaviors. Mercedes said, "It is cool to learn about yourself and then like think about things, like I would have never thought about that had I not talked about it or not reflected on it."

Here is an excerpt from Mercedes' written narrative:

> *When I went in to the patient's room to do my assessment, I asked him how his night was. He told me that he was "tired of this" and "had enough". I could read from his body language that he was genuinely appearing sad and that he was serious in these comments. He was sitting on the edge of the bed, looking sleepy, looking hopeless and his tone was "heavy" and just overall "tired". I could also see that he was dishevelled and not recently showered. He did look depressed to me. I recognized in that moment that I needed to address what he was saying. I knew that it would be inappropriate of me to brush it off and continue with my assessment. I felt that I had to step in to a space to allow this patient to feel acknowledged in what he was trying to say.*

Narrative Portrait of Anastasia

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me.

Conversations between the two of us were collegial where I recognized her growth and maturity as a nurse.

I could tell she had high emotional walls. Anastasia presented two authentic selves to the world; one where she led with ego and knowledge, and the other where she was calm and emotional but only with a select few privileged to see the real person. Anastasia purposefully chose whom she could share her emotions.

Anastasia grew up as an only child with her dad assuming a larger responsibility of raising her when her mom fell ill with cancer. Anastasia was only ten years old when her mom was diagnosed, often driving herself to chemotherapy appointments. Anastasia drew strength from both her parents during that time, but as she said, she was only a kid and all she knew was her mom had cancer. Her father, "Was one of those people that if we don't talk about it, it doesn't exist." And Anastasia learned early on that emotions were seen as a weakness. She had to be emotionally tough.

These lessons carried Anastasia through a previous degree that was detached from connecting with another human, and she liked that part of it. Nursing though, took her first degree, and catapulted her into situations where emotions were prevalent. At first, Anastasia avoided getting too close to these situations, until she was faced with a patient and his terminal cancer diagnosis. She was not a child anymore and addressed this experience with maturity and grace. She confronted her emotions and allowed for the authentic release of years of keeping these emotions hidden when her mom was sick.

During Anastasia's participation in the study, the walls started to come down and she began to relax and shared more of herself with selective choice of patients. Somehow getting in touch with her feelings surrounding cancer opened up a door to emotions and they were not to be

feared. Through her narratives, I was able to see that she is **fiercely protective** of those who were easily bullied in in their own treatment.

I was surprised to learn that Anastasia was a photographer. When she submitted her photographs to represent her visual representation of her experiences with empathic engagement, I was moved. Her keen eye for detail in a lens captured her true sense of how she views the world as a snapshot of the moment. Both pictures depict the relational dynamic that surfaced through each exchange between Anastasia and her patients. There are clearly two distinct images of both life with vibrant colors and energy as compared to the winter scene with ice and cold:

Anastasia informed me that this photograph represents the patient dying of a terminal illness who had just agreed to medical assistance in dying (MAID). She took the photo around Christmas time.

It was like -1000 outside, obviously as you can tell by the icicles. And it was early in the morning because that was like fresh frost. And there was no clouds in the sky, it was a beautiful sunny day other than it was really cold. I just kind of went onto my parents front step and thought, "oh, that would be a cool picture of the tree" and if I could focus enough on this so that the background was blurred, that it gives you that optical illusion, and it's always hard to do when you're taking pictures to get that nice blurred background and have the focal point here.

In her conversation with me, Anastasia stated that, when she walked into the hospital room that morning, there was a heaviness of the reality that the patient was to die within a few days. The more time she spent in the room, the more she focussed only on the patient and his needs, just as the tree is brought to the front and the background is blurred. She continued to describe that the delicacy and beauty of the frost on the tree represented the patient and his family leaving the background to be opaque, just as the looming date he had decided he was going to pass away. According to Anastasia, she saw the beauty in his life, not the deadline of his death. It was in the space between his life and his death where Anastasia entered into the space of empathic engagement.

Another photograph that Anastasia shared was a close-up of a flower. With respect to this photograph, Anastasia provided the following explanation:

I chose this one for another patient because really, his injury wasn't going to hold him back, a very different situation than the MAID but that he would continue to blossom as he healed and get back to a regular state. So, I thought that this was more representative of that that blossoming out of surgery and back into real life. I liked the brightness of the colors and he was a very bright, smart, funny, and with-it kind of guy,

Sometimes it is not always what we can see with the eye that counts when taking care of others.

Narrative Portrait of Charlotte

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me. The conversations between her and me were like two colleagues discussing their day. I appreciated her perspective about how she was growing and developing as her previous degree had nothing to do with nursing practice. I enjoyed watching Charlotte find her place in nursing.

Charlotte was encouraged by a supportive family to follow her goals of becoming a nurse. I am grateful for their push. She has an exemplar bedside manner but also a way to touch

the hearts of her patients just by her clinical practice. Charlotte looks past the admitting diagnosis to see the person behind the illness. She connects with individuals easily and moves easily into spaces of empathic engagement. People are drawn to her kindness, nonjudgmental approach, and multiple ways to find humor with situations in respectful and professional ways. Charlotte has a caring **holistic way of seeing past the illness** and addressing what is often left unsaid and at times, unseen; pain, sadness, regret, etc. Her life experience has allowed her to develop strong emotional coping strategies and appropriate boundaries during emotional situations, such as death and transition.

I appreciated Charlotte's participation in the study. Although she has life experience, Charlotte has a lens of both a student and a colleague. I learned a great deal from her just how adult learners approach challenging clinical situations and difficult conversations. I respected her ability to be authentically herself while being vulnerable in a learning environment.

Here is an excerpt from Charlotte's written narrative:

> *He mentioned that he had worked in construction. I asked a few questions, such as whether or not he had enjoyed it, and for how long he was employed in that industry. He told me that he did enjoy it, but gave it up to drive trucks as the money was better. I then asked if he had a family that the truck driving took him away from. He then told me that he had had a wife and two children, but that he had not seen them in years. I told him I was sorry to hear that, and said that it must be very difficult. I asked if he had made any effort to get in contact with them, or if that was something he desired. He shook his head, and said no. He went on to say that he had "messed that all up" because of his drinking, and that it was "too late now". His eyes filled with tears. Throughout our conversation he had continued to look out the window. I sat quietly and watched him as he appeared to lost in*

his own thoughts. After a few moments he wiped his eyes and apologized. I place my hand on his arm and told him there was no need to apologize, that his feelings were understandable, and that it was okay to feel like this particularly when coping with his recent illness and all the changes he was having to face.

Narrative Portrait of Laura

Both one-on-one conversations took place in a private conference room in the Faculty of Nursing, at the University of Calgary. The setting was familiar to the participant and me. During the one-on-one conversations with Laura, I was able to appreciate a different side to her than I had not known before her participation in the study.

We did not talk about her family, but of how she viewed the world. Laura was able to look past patient circumstances and connect through humanity. According to Laura's narratives, she was drawn to people in vulnerable situations and wanted to be the positive change for those who could not find strength in themselves. Laura was the voice for those that had temporarily lost theirs, the strength for those that could not see their own, and an **advocate for those from marginal populations.**

Her previous degree had enabled her to be a reflective practitioner. She said,

> I'm a big, big fan of decompartmentalizing your experiences of the day. It was a big thing we learned that you have to reflect, you have to always reflect on things that you did throughout the day and affect on your learnings in order to kind of sent them into your long erm memory and I think that's a really important thing. So, if you have a really horrible conversation with somebody or a really awkward conversation with somebody, break down what made you feel crappy about it, or what made you feel like there was unfinished business. Then um, how do you, maybe would have liked to see the conversation go, I find

that, although you can't go back in time, but it kind of helps me sort out what I would liked to have said if I had the opportunity in that moment.

Laura's maturity, articulation, and passion for vulnerable populations were admirable. I had always worked in acute care and taken care of people from marginal groups, but she opened my eyes to a new way of understanding and seeing people and for that I am grateful.

When Laura shared her painting with me, I wept. I was surprised to learn of her abilities as an artist and that she was able to capture through her own lens what was at the core of empathic engagement. This piece was her interpretation of empathic engagement. I still get emotional when I look at the painting.

This was Laura's explanation of the painting *Listen* as she worked as a street outreach nurse:

A moment that really touched me was when we walked past a line of day labours on "cash corner" all hoping to be offered work for the day. Amongst them was a woman in her 50s who had her hi viz outfit and steel toe boots on but also had a full face of dramatic makeup. I talked with her for quite some time as she shared her struggles with being homeless and struggling to find work everyday in a male dominated industry. Her world was so far removed from my own, yet we shared so many of the same problems. Talking with her made me realize that beyond the surface, I'm really no different than anyone living in homelessness. We may have problems that are all our own, but we share many common problems as well, such as concerns over money, security, love, safety and health. I know what it feels like to be unemployed and relying on my credit card, I know what it feels like to be objectified by men and I also know what it feels like to be bitterly cold standing outside on a frigid January day in Calgary.

The red flower represents me, or any healthcare worker as red is associated with healthcare, but also wealth and privilege. The yellow flower represents the labourer in her bright vest, or any vulnerable person on the street. Like a dandelion, they are both visible yet invisible and easily disregarded or seen as a nuisance. The yellow also represents the needles we picked up as well as the bins we used to collect them. The chain link fence behind the yellow flower represents cash corner, and it also suggests a freedom from barriers as the flower extends beyond it while reaching out to the red flower.

Lastly, the two colours represent u of c. This is not an homage to the university, but an acknowledgment of how the nursing program afforded me this opportunity at the very beginning which shaped the way I viewed nursing and vulnerable people for the rest of my schooling.

As the two flowers are reaching out to each other, some pedals fall and go unacknowledged. However, more pedals fall in the middle and are orange, suggesting they are commonalities between the two flowers. Because despite their differences, they have much more in common than is readily seen on the surface. This is only discovered when the act of listening truly occurs in a conversation. And I believe listening is at the heart of empathy.

Summary

In this chapter, I presented the seven participants who self-selected to participate in this study. Throughout their final term and the study, I was able to observe personal growth, increased understanding of their role of being a nurse, and how each participant found meaning with their individual experiences of empathic engagement. At the end of the study, I was their student, learning from their habits and practice and how each participant constructed meaning from the study and empathic engagement.

In Chapter Five, I present the participant's experiences of empathic engagement leading to the Four Phases of Empathic Engagement. I have laid out each phase with subthemes as evidenced by the data. There is a beginning, a middle, and an end. I have used the analogy of a bridge connecting one side to the other to provide visual reference as to each of the phases and how participants moved through the phases.

CHAPTER FIVE: FINDINGS

After careful consideration, re-consideration, and several re-readings of the transcripts and narratives, four distinct phases of empathic engagement emerged from the data. As a social researcher, I want to not only honor the participants' experiences through this dissertation, but also honor the patients and families in this study. I have always felt privilege and honor as a bedside nurse to be present during patients and families most difficult times in their lives. In the process of working through the narratives and conversations, I felt not only connected to each participant because of shared experiences but also to their patients and families.

In this chapter, I lay out four patterns of experience as phases of empathic engagement with reference to participants transcripts and their personal narratives: Laying the Groundwork, Leaping into Uncertainty, Liminal State of Empathic Engagement, and Lifting the Veil. The findings of this study are relative to each participant's experience as they navigated through the greyness of relationship; in context with the other as in the patient or their social environment, or in context with self. This study in no way attempts to quantify the fluidity of relationships but to provide a sense of understanding and offer new knowledge about the liminal spaces of empathic engagement and personal transformation. It is important to remember as you read this chapter of the dissertation, the elements of each phase are occurring with little attention to the length of time it takes for each phase to end before moving into the next phase: even though quality of that time is unmeasurable. Often, the feeling of empathy, empathic concern and motivation to act while understanding the emotions of another, may only be seconds. I have broken down each phase of this phenomenon for further clarity based on my interpretation of the data: how participants understood, encountered, and responded to empathic engagement. This is what I have come to understand as empathic engagement.

Arriving at these four distinct phases was no easy task. As I was transcribing the audio recordings of my one-on-one conversations with participants, I began to realize that their isolated experiences were not as isolated as I thought. It was exciting to hear and read that, despite the differences in clinical experiences throughout the program, these subjective phases were woven throughout their narratives. My office floor was blanketed with papers and lists of coded data of each phase. I attempted to create a computer-generated concept map as suggested by Braun and Clarke (2006) to assist in organizing the themes/sub-themes; however, this task only created distance for me from the narratives, the participants, and their stories. I laid the coded data out physically to see exactly whether and how each piece was related to the next or had no relationship at all: a living concept map with movable pieces. I remember having a conversation with my supervisor and committee member about feeling that this process was messy. I was encouraged by feedback, assuring me that messiness was normal in an inquiry about a complex topic and that analysis is not always a linear process. It took me a while to sit (metaphorically and literally) with the data, the narratives, and the transcripts. I felt a responsibility to each participant in the re-storying of their experiences not only to honor the stories with patients and families, but also with their experiences of empathic engagement and subjective nature of participants' reality. The living concept map allowed me to move coded data around on the floor and to complete the analytical process. This process forced me to narratively move through the stories, individually and in comparison, with the others.

According to Creswell (2015), coded data is to be reduced to themes then further narrowed down to sub-themes with the intent to assist in organizing the narratives and commonality. As Gergen (2015) concluded, "linguistic constructions are embedded in forms of life" (p. 10). I wondered if the personal choice of participant phrasing was an individual decision

or the subconscious construction as a result of consistent discourse from an undergraduate nursing education program. I did not want to miss any details, so I re-read the transcripts, the written narratives, and studied the visual images with greater attention to intricacies of the phases. I did not want to misinterpret what the participants had shared but, more importantly, what was not explicitly stated during the one-on-one conversations and in the narratives. Textually, it may seem that these four phases were lying in plain sight on the floor, but in reality, how these distinct phases of empathic engagement emerged was complicated and splattered with nuances of emotion, complexity, and layered human experiences of participants. This is what I have come to understand about empathic engagement.

Phase One: Laying the Ground Work

> We need to honor our struggle by sharing it with someone who has earned the right to hear it.
>
> (Brown, 2010, p. 11)

The first phase of empathic engagement is intended to build a foundation for which to develop relationship between participant and the patient/client/family. This is the beginning phase where participants revealed they developed the feeling of empathy towards the other. To help understand empathic engagement, I present an analogy to help provide a visual representation of empathic engagement: It is of a person standing on the edge between two cliffs, with a swinging bridge connecting both sides. In the *Laying the Ground Work* phase, these are the building blocks necessary for all other phases to occur. It is the bluff of rock, firmly built, where relationship emerges. If the nurse-patient relationship begins with a rocky, unsettled foundation, these relationships begin fragmented and offer challenges within the relational dynamic as evidenced by the data. Nursing scholars affirm that positive nurse-patient relationships require: trust, respect, caring, presence, intimacy, interpersonal interactions, and

connectedness (Strandas & Bondas, 2018). Upon closer examination, these elements are threaded throughout the narratives from participants. Data from the study, revealed two primary themes for phase one: 1. relationship between participant and patient or family which includes first impression, shared experiences or personality connections, physical proximity of participant in relation to patient, client, or family member, paying attention to the non-verbal and verbal cues, emergence of affective elements of empathy, and empathic concern and 2. extrinsic factors that consist of time and environment, and intrinsic factors such as cognitive presence, caring interaction, and affective empathy.

Relationship

Following Paterson and Zderad (1976), nursing is seen as "an experience between individuals" (p.3). Strandas and Bondas (2018), nursing researchers from Norway, completed a meta-analysis study on literature attending to nurse-patient relationships. They likened the importance of relationship to a "story of health enhancement" illustrating meaning through a "common story" that is co-created between the nurse and patient. It is imperative that a foundation be created for not only positive attributes of a nurse-patient relationship to unfold, but for empathic engagement to exist.

First impressions. In Chapter One, I briefly introduced the concept that, prior to meeting the patient, client, or family, nurses learn about their patient or client's story and form an impression of whom they will care for in that shift. There are few professions, such as nursing, where a nurse learns intimate details about their patients' lives without that person, personally relating his or her experiences directly. Either details are shared when receiving report from the previous nurse or they are read in the medical chart prior to entering the patient's room. One participant Suzie, shared with me how she felt after reading in the medical chart, details of her

patient's life including mental health and drug addiction prior to the patient's subsequent suicide attempt.

> So, it was a donation after cardiac death and it was Thanksgiving and he had hung himself. And, um, he struggled for a long time with mental health and drug addiction, and he had an 18-year old daughter and a wife…there's a lot of factors that drove this guy to kill yourself [sic], because you just don't do that if nothing is going on. But I was like, you have an 18-year old daughter, a wife, it's Thanksgiving and you've ruined this holiday for them forever. And I thought that was very selfish.

In Mercedes' narrative, she pointedly reflected on how her initial presentation had an impact on the overall relationship with her patients,

> I had to recognize my tone, body language, and facial expression so that I could show my patient that I was genuine in my demeanor. Those allowed a connection between me and the patient that resonated and allowed the patient to open up and feel acknowledged.

Another participant, Laura, was aware the impact first impressions had on creating a positive relationship with clients. She made this comment about a realization that she had had during a clinical placement where she was doing street outreach and interacting with people who were living on the street:

> So much can be misinterpreted by the way you present yourself in an initial meeting. If you come across judgmental, they are going to pick up on that and I know that because I have had other patient interactions where maybe I've come in a hurried state, or not interested, or they smell or I immediately have a face that I'm not controlling very well, or something, and it automatically creates that divide.

Laura's understanding of the invaluable nature of developing trust between nurse and client was the foundation for helping these clients. It is not uncommon for clients who are homeless to be suspicious and untrusting of healthcare workers as many people have the ability to restory painful hospitalizations and less than compassionate care (Christensen, 2009). Laura was aware of the nature of a strong relationship in order to help vulnerable clients.

These participants recognized the importance of presenting themselves to the patient and client with genuineness and authenticity. It is interesting to note that, even though these participants felt that genuineness and authenticity in nursing practice was valued and ultimately improved nurse-patient relationships, authenticity is more often discussed in literature pertaining to physicians. For example, Yagil and Schnapper-Cohen (2016), explored how physicians' regulation of displayed emotions impacted patient satisfaction in states of distress. Results demonstrated there was a high correlation between genuine physician expression of emotions and patient satisfaction with overall delivery of care (Yagil & Schnapper-Cohen, 2016). The patient's overall health experience was improved by genuine and authentic relationships with health care providers. Initial impressions made by either the nurse or the patient, client, or family had a significant impact on the relational connections that developed between all individuals. Either the first impressions hampered connection such as the case of Suzie when she initially discovered the admission history of her patient, or garnered a more humane association such as in the case of Laura and Mercedes.

Shared experiences or personality connections. All but one participant identified enhanced relational associations with patients and families when a shared experience or similar personalities were identified. Gillian, recognized a sarcastic tone with a patient in long-term care that was similar to her own sense of humor; Leanne, identified similarities between a patient on a

mental health unit with parkinsonian like attributes and her own grandmother; Suzie, connected to issues of mental health and addiction of the patient who had committed suicide with similar struggles of her own brother with addiction; Anastasia, was deeply connected to patient who had decided to exercise his rights for what is known in Canada as MAID (i.e., medical assistance in dying) given his cancer diagnosis based on a previous breast cancer diagnosis of her own mother; and Charlotte connected to the patient in transition as he reminded her of her own father-in-law. Laura had no personal associations with the people she came into contact with while working outreach, but connected to their shared humanistic qualities; I see in you what I see in me. Stronger correlations between self and others led to increased opportunities for empathic engagement to occur; however, the greatest foundation for empathic engagement is recognizing human sameness.

When I reviewed the audio recordings while reading the transcripts and written narratives associated with these patients, there was a direct correlation between shared experiences or similar personalities between all participants and the patients, clients, and or families. It was only with these patients with whom participants identified a similarity or commonality were they able to move into spaces of empathic engagement. These shared experiences and commonalities were most significant in helping to solidify a stronger relationship between participant and patient, client, and family member.

Suzie developed a stronger connection to the patient's brother as opposed to the patient. The strong emotions associated with addictions and ultimately his choice to end his life were inextricably linked to her own personal experience with her own brother who suffered from addictions.

> I think because in thinking about myself, I would have a tough time knowing the patient's history, and what he did to his family. And my brother had a brief period with drugs and I think for me, if it that was him in there, and no one was coming in and knowing how hard it was for the brother to go in in the first place, and he just needed some support and no one was offering that.

This overriding sense to be present for the patient's brother was a need she would have wanted for herself. Suzie continued, "I identified more with the brother and the family. I still would have felt like the brother, still really angry, even if I was present and had been there." A key aspect of empathy is seeing yourself in the shoes of another or sharing the feelings of others (Bernhardt & Singer, 2012).

Charlotte, a mother herself, saw in her patient the worry of leaving behind her children as she entered hospice care.

> And now I'm on a palliative unit, and so I think for the people with kids, they know that I get it. I've had a few younger women as patients and one of their big concerns was, of course, is who will take care of my family.

As per my discussion with Charlotte, this sense of parental responsibility and sadness was silently acknowledged from one parent to another. Many can empathize with what it must have felt like within that extreme state of transition and the difficult decisions that mother had to endure as she prepared to leave behind her children after her death. As Charlotte stated, "who takes care of your kids when you no longer can?"

Anastasia had a very distinct relationship with her patient who had decided to end his life as a result of learning of the fateful diagnosis of terminal pancreatic cancer. Although she was only a small child when her mother was diagnosed with breast cancer, she watched her mother

embark on the journey on her own, often driving herself to receive chemotherapy. Through our one-on-one conversations in this study, Anastasia began to express how she identified with the gentleman and his family as someone that could have been her, years ago with her mom.

> I think once I started thinking how this could have been one of my parents, it changed the way I talked to him and tried to, again, do as much as I could for him; whether I got him towels for having a shower and really tried to do anything and everything I could to try and make his last day with me at least, as good as it could be. Um, and then, you know I cried the whole way home.

Nursing practice has a way to entwine previous life experiences into the daily practice of taking care of others. For Anastasia, the realization of death and her own mother was in a way transferred to this patient. What was surprising was that Anastasia had taken care of other patients who had cancer, but this gentleman was different, as his death was planned for only a few days after this encounter. At times, past emotional tensions bubble up in ways that can be unexpected.

Gillian had a very complex association with a patient who presented intoxicated to urgent care. Prior to entering the nursing profession, Gillian had been involved personally with a person who had issues with addictions, so her knowledge helped guide the conversation in the urgent care setting. As she explained, her personal, experientially developed knowledge allowed for a more thorough assessment and helped her connect with the patient:

> I had someone come in for alcohol withdrawal and that's when you have to build conversation, rather than ask the assessment type questions, or rather do that at the same time. I wanted to know if she wanted help . . . how long she's been doing it for, or if she

knew what to do, or if she's tried, what she hasn't tried. Those, but the only way she would talk is if she felt more comfortable.

It is in this manner through therapeutic communication, where the foundation of laying the groundwork and nurse-patient relationships start to develop. It is difficult to discuss with others intimate details of their lives, illnesses, addictions, families, and motives for health and well-being, if no previous relational foundation has been initiated. At first, the nurse is the one who provides a safe space for deeper conversations to occur. It is only in the second phase where according to the data, the patient takes the conversation to a new level.

Another participant, Laura, disclosed that she had no previous experience with homelessness, or family members who had previously been homeless, but her ability to recognize that those living on the street were not any different than she was at the time of the interaction, led to significant insight into sameness. From the explanation of her painting, Laura shared these comments with me:

> A moment that really touched me was when we walked past a line of day labours on "cash corner" all hoping to be offered work for the day. Amongst them was a woman in her 50s who had her high visible outfit and steel toe boots on but also had a full face of dramatic makeup. I talked with her for quite some time as she shared her struggles with being homeless and struggling to find work every day in a male dominated industry. Her world was so far removed from my own, yet we shared so many of the same problems. Talking with her made me realize that beyond the surface, I'm really no different than anyone living in homelessness. We may have problems that are all our own, but we share many common problems as well, such as concerns over money, security, love, safety and health. I know what it feels like to be unemployed and relying on my credit card, I know what it

feels like to be objectified by men and I also know what it feels like to be bitterly cold standing outside on a frigid January day in Calgary.

During our one-on-one conversations, Charlotte disclosed that she intentionally finds the common ground with patients and that helps develop an initial place of relationship. As she stated, “Finding common ground, I think, helps a lot.” She further discussed how getting to understand patient’s goals, and dreams was important to opening up the dialogue. Patient-centered communication is one of the key components to relational communication for nursing practice. It is through grounding in conversation where mutual understanding and foundations for relationship emerge (Clark & Brennan, 1991). This element of reciprocation in conversation and moving through the utterances of what is said and meant through conversation is necessary to identify when spaces of empathic engagement are necessary.

Shared characteristics of personalities also bonded participants and patients in relationship. Gillian identified that a relationship with a lady in long term care was enhanced because they shared the same sarcastic humour and their conversations has an ease about them because of their mutual understanding of character. Anastasia commented in an interaction with a patient post hip repair, she “saw a lot of myself in” [him] because of his desire to want to get up and move after surgery. This independence and need to move forward, in Anastasia’s own words, “his similarity to myself, opened a few of my locked doors.” She felt she could be herself around him and ultimately their relationship improved as a result of this common personality.

Previous shared experiences and commonalities provided an opportunity for relationship to develop between participants-patients-clients-and family. These relationships were unique in that commonalities assisted participants to find common ground through conversation and identity. This helped lay the necessary foundation for phase one of empathic engagement.

Physical proximity of participant in relation to patient, client, or family member.

All participants in the study, shared in their narratives the impact that close physical space between participant and patient, client, or family played in the development of relationship. Often, the actual location of where the participant was in the room was either a subconscious or conscious act. Data revealed, closer physical proximity of where the participant was in relation to the patient, family, or client helped to define the patient-nurse relationship in this study.

Participants did not remember in great detail about their physical proximity to the patient, client, or family member until further discussion revealed this subtle and often forgotten factor had an overall impact. For example, while the brother stood at the patient's bedside in ICU, Suzie stood beside the brother as he touched the patient.

Charlotte told me how she had taken the patient out of his room to a quiet location on the unit, and their conversation unfolded as she sat beside him, allowing him to reflect while he watched a construction site take place outside. Charlotte said,

> I think that's partly why the conversation happened because we had this sort of distraction and little conversations. But when that happened [he revealed to her about the loss of his sexuality] I patted him on the arm and said, you know, acknowledged, "That must be really, really difficult".

When I had asked Charlotte why she chose to sit beside her patient instead of facing him, she informed me that as a parent, she has found that the best conversations that unfolded between her and her children were done in the car, side by side. When the patient started to converse with her and open up, the side by side body position allowed for the intimate nature of the conversation to organically unfold.

Another participant, Leanne, found herself sitting in front of the patient, on a chair, while the patient remained lying on the bed. She was encouraging her patient to take medications when the patient revealed that she wanted to die. Based on a less aggressive form of non-verbal communication, non-behavioral researchers identify that posture and proximity of physical distance can enhance or inhibit relationship (Burgoon, 1991) and thus enhance or inhibit opportunities for spaces of empathic engagement.

Close proximity of nurse to patient is common in nursing practice. From the moment the patient is assumed into care of the nurse, the nurse becomes physically close during the assessment of vital signs, completion of physical assessment, and during hygiene. When patients are unable to take care of personal hygiene, a nurse can step in to assist and in the case of several participants, they were challenged with the task of assisting patients with personal hygiene. Laura had an experience with a patient admitted to the stroke unit who also had lice. Once a treatment has been administered, nits are to be removed to prevent the eggs from hatching. Although the patient was confused as to why Laura was required to remove the nits, she indicated that she "spent a fair bit of time picking them out, so during that time we got to talking." In order to neutralize the situation and remove stigma often associated with lice, they talked about family, how upset she was, how she had let her health go, etc. Through the act of helping her, Laura and her patient bonded.

Gillian and Leanne had similar experiences of bonding with their patient but this occurred as a result of hygiene. Both patients had not bathed for days and nursing staff had either missed this detail or chose not to observe the necessity of basic hygiene. Gillian and Leanne assumed responsibility, strongly encouraged the patients to shower, and assisted them in the shower. According to Maslow's (1943) hierarchy of needs, fulfilling basic needs such as

hygiene is a component of attending to the human being. Exposing one's physical nakedness creates vulnerability which a safe space of relationship can mitigate.

Paying Attention to the Non-Verbal and Verbal Cues. Whether it be a shared physical space or the element of touch to enhance the nurse-patient relationship, one key element threaded between all the participants' stories was the act of being present with patients and focused on their story. Over the past few years, the act of presence or being present, mindfulness, and meditation have emerged from main stream media as important constructs for overall mental health and well-being, despite Heidegger (1962) introducing the phrase "to presence oneself" in Being and Time. Benner and Wrubel (1989) describe "to be present" as the ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the base of much of nursing as a caring practice (p. 13). Presence can be further defined as sitting with purpose in any given present moment (Verhaeghen, 2017); to act with mindful attention to details that act on human sensations of sight, sounds, taste, texture, and smell. The act of being present or to have presence with a patient is a key component to empathic engagement.

Participants identified paying attention to the verbal and non-verbal cues of their patients, clients and families as part of laying the groundwork for empathic engagement. If we take a moment to think back to Suzie's story about the brother, and his constant question asking, and perceived fear to touch the patient. Suzie recognized the non-verbal cues of distress in the brother for that human need for him to connect skin to skin was important for the brother. So, she helped facilitate the act by modelling for the brother, exactly what was needed for him to feel comfortable enough in that moment; she took his hand and placed in on the chest of the patient, and then placed her own hand on the brother's shoulder. Gillian noticed what she classified as distress in her patient who was waiting for a surgical time.

> So, I had this one patient, I remember, who he had a broken hip, and he was lying there, because I was on an orthopedic unit, and he probably waited four days before going to surgery on a broken hip. He couldn't move, he couldn't eat or drink because he was just waiting for his surgery, and he was he hated life. Like he wanted to give up. He compared life to a rat. You know? And I don't exactly remember why, but it was a moment where I knew I needed to talk to him. And I think it helped.

I further prompted her and asked, "Why did you say, 'I knew I needed to talk to him'? She continued on,

> Because he said, this was no way to live. He couldn't eat or drink anything during the day, and he couldn't move. And really, literally, all I did was talk to him a little bit and do basic hygiene for him and he felt so much better. Basic hygiene, that was it.

The study revealed that there were moments when patients would have unexpected outbursts of emotions. Leanne had a profound experience where her patient requested her to kill her. After walking around the unit several times, holding her patient's hand and chatting about family and activities prior to admission, she looked Leanne in the eyes and said, "please kill me, please. I want to die." In the second conversation, Leanne revealed that the patient's Parkinson's disease was progressing and the mental health team were questioning if the patient had developed dementia. These signs of clear verbal distress by the patients towards the participants, including patients' references to of ending their own lives, were strong cues for the participants to push further into the conversation.

Mercedes had the wherewithal to recognize the tone of her patient's voice as he said three words.

> I think it was the tone of his voice. Like the way he said it. It wasn't like, "Oh, I'm tired." It was "oh, I'm tired." [pitch was lower and more monotone than first statement] It was like a deep and then when he said it, then I was like, this guy is actually depressed and really upset right now. Um, I guess I just felt like I can feel that he is depressed and he's feeling down and it just wouldn't be right to ignore that and just move on. He needed a minute of me being empathetic and "Oh I'm sorry." And not like I wouldn't have felt right just brushing it off and being like, "okay, I'm going to move on to taking your blood pressure.

At the heart of empathic engagement is the art of deep listening. It is in the stillness of silence and being present with a patient where the participants demonstrated deep listening skills as evidenced in the study. It is watching the non-verbal cues of what a patient does with their body do they shift as they are talking with you, do they avoid eye contact, play with their hands, shift from side to side or is it in the tone of their voice, the expression of fear, sadness, or help in at times darkest moments. Nurses bear witness to intimate emotions from patients often when masks of "keeping it all together" are stripped and only vulnerability exists. It is in these moments of expression, participants found the courage to recognize an emotional need for mere presence alone.

Several participants acknowledged that they were not aware if they have missed any other opportunities for empathic engagement. As a nursing student, attention is often placed towards the completion of tasks, obtain more skills, and at times, focus less on the patient's needs but more of one's own. Laura's view of the omission of empathy from her practice occurred as she moved into clinical practice in acute care settings

> When I started in the program, it wasn't hard for me to be empathetic with patients but I got so in-depth into the clinical and acute care settings, I would get too task-oriented that I would kind of lose sight of that.

Wright (2006) indicates the reason people miss out on connections with others, is the incessant chatter that goes on in the heads of nurses such as getting caught up in roles, tasks, and a preoccupation with personal matters. These self-imposed barriers prevent the act of deep listening and opportunities to recognize when further conversation is needed or if spaces of empathic engagement and connection can happen. Furthermore, Wright (2006) himself writes that "listening at a deep level does not come easy and is rarely arrived at simply by life experience. It takes courage to set aside all our 'stuff' and to be fully present for, and attentive to, the other" (p. 18).

Emergence of affective empathy. Throughout the participants' narratives and one-on-one conversations, I found this was where affective empathy, or the emotion of empathy, started to emerge and participants started to feel empathic towards their patient, client, or family. Remember, affective empathy emphasizes the capacity to understand and enter into the experiences and feelings of another person (Eres, Decety, Louise, Molenberghs, 2015; Morse et al., 1992; Shamay-Tsoory, 2011). After a certain level of relationship had been started between the participant and patient, client, or family, the participant had recognized either through non-verbal or verbal cues, a need beyond physical care was necessary for the patient's well-being.

Laura told me the story of a grandmother who had been admitted due to a stroke. She had other issues such as diabetes, family dysfunction, and she had lice. One of her duties as a nursing student was to pick the lice out of her hair. Laura recalled how upset and mortifying this task was for the patient as she felt it came across as very dirty**.** Through the task of picking the

nits and eggs out of the patient's hair, Laura was able to spend considerable time with this patient. She commented on the isolation of being afflicted with lice,

> It was so incredibly challenging and nobody else wanted to deal with her on the unit, but I felt this weird, need to be her primary source, her connection on the unit, because I felt like nobody else was listening. They were looking at this family and looking at her, assuming all the stereotypes you do with the population and I felt for her.

Another participant, Anastasia, recalled the time it "clicked" for her was when she reflected on the patient who had chosen to end his life due to his terminal diagnosis of pancreatic cancer, her strong familial association with cancer, and the recognition of a life soon to be ending. She said

> I don't know if it was maybe finally putting down my walls, right because I have strategically put up all of my walls so I don't bring home patients. I don't want to be one of those nurses that goes home crying every night because somebody died. And that's not my personality anyways. So, I don't know if that was part of it as well, but there was something about because I saw my mom in him, I saw my family in him, that I let down my walls and I was able to have conversations with him versus going in and out and saying how are you doing, can I get you anything else, kind of the usual nursing chit chat.

Key phrases from participants such as, "I could see it from *his point of view*" in the case of Charlotte and a gentleman who discussed openly about the loss of his sexuality; or "what really *tore me* was that he was starting to sell off all his gear" a young patient with a recent spinal cord injury and subsequent paraplegia, asking Laura if she knew anyone, since she also enjoyed climbing, who would want to buy his gear; or Suzie talking about the brother standing in the patient's room, "..there's the glass and it's dark because it's 8 o'clock, and there's this

silence, and to be so empty already knowing you're only keeping him alive to donate. He really was empty as it was, it wasn't him anymore."

The emergence of affective empathy prompted the participant to move into phase 2 of moving towards a space of empathic engagement. The seconds between a feeling of empathy towards the patient, client, or family and the actions that encompass leaping into uncertainty are minimal in relation to time. However, this in no way, minimizes the need for participants to have felt empathically towards the other.

Emergence of empathic concern. The final element associated with relationship, is the emergence of empathic concern for the patient, client, or family. Empathic concern is what "reflects the core of empathy" (Bloom, 2016, p. 80). As Goleman claimed, empathic concern helps to understand the perspective of another person, but it is the driving force to help if needed (Goleman, 2007).

Empathic concern surfaced in the data when participants felt that not enough care was being provided to their patient and further action was needed further. Phrases like, "I am going to take the time to talk with her a nobody else has" or "I was actually surprised that no one had offered or given him a bed bath in so many days" were cues to participants that care was missed. Anastasia recognized a disconnect between her actions and her preceptor's actions in regards to an older adult with dementia. Anastasia reported that she developed a relationship with this lady who had had orthopedic hip surgery and her preceptor did not like the fact that she was spending as much time as she did with her. After taking care of the gentleman with terminal pancreatic cancer, Anastasia discovered that she enjoyed spending time with this patient, and would work at the pace of the patient instead of the patient having to work at the pace of a nurse with a busy patient load.

External Elements

Data from the study revealed two external processes that affect whether spaces of empathic engagement can even occur between nurse or patient. During transcription followed by extensive readings of the transcripts and narratives, I began to notice that the experience of time and environment played a significant role in this foundation for empathic engagement. The phenomenon could only occur if there was sufficient time for relationships to develop and as per the participant's experience, on just the right units or nurse-patient settings.

Experience of time. The practice of an eight or twelve-hour shift consists of many nursing related tasks such as taking vital signs, interpreting lab values, nursing rounds, administering medications, assisting with hygiene, encouraging mobility, among other tasks specific to the unit. These tasks are associated with acute care practice. As my supervisor reminded me during our discussion of this chapter, everyone has the same amount of time to complete tasks and ultimately it is up to each nurse to decide how that time is divided and spent. When students begin clinical practice on an acute clinical unit, they tend to have difficulty adjusting to effective time management such as planning (Litchfield & Chater, 2007), prioritizing (Kaya, Kaya, Palloş, & Küçük, 2012), and evaluating care of a patient.

Early on in the undergraduate nursing program at the University of Calgary, students are to focus on communication, basic hygiene, and contexts of health as it pertains to the Social Determinants of Health through the Population Health Model as it pertains to the community. Both Gillian and Laura found that this context allowed for engagement with clients living in their own community settings away from acute facilities. Gillian claimed,

> When you started with hygiene, it seemed to open up a channel for you guys to even have… [more conversation]. And it makes me think how often we miss the basic entry.

> That we overlook the littlest of details and not meet those needs. I [still] feel like there's less and less time.

Laura commented that in the community setting as she was engaging with clients who were homeless, the focus was on communication and less on tasks. At times, the tasks in the hospital consumed the day, especially early on in the nursing program.

Participants communicated early on that, when they entered acute care clinical placements, their responsibilities were not as high as they were expected closer to the end of the program. Leanne remembered the following about her progression:

> We honestly chatted a lot [with the young patient admitted to neurology rehabilitation after a spinal cord injury]. It was a cool setting. And so, it was more open than the standard unit, there was s dining room and at first in term 5 you were just doing vital signs but we were busy but we also had a lot of time to chat. So, a lot of time, everyone would just sit at the big table and have breakfast.

As participants progressed to their final term of the program where they were assuming care of a full nursing workload, Anastasia made a conscious decision to spend more time with patients. Her mindful attention to the emotional needs of the patient and his partner, enabled her to develop deeper relationships, and provide impactful holistic care. She continued:

> I think what I did differently was like actually slowing down and taking time to get to know them. And learning a bit more about them and staying in the room longer… I think it was the slowing down and talking with them, and talking about sporks, and what was going on outside, because it was a nice day, ad that kind of usual, chit chat, that I don't ever do with patients unless they are talkative patients.

The temporal nature of time, where “time flies by” or “time moves so slow”. Conti (2001) discusses how time can be intrinsically motivated. This theory could explain the rationale for participants not having enough time at the beginning of their clinical practicums, then prioritizing their professional demands and somehow making time for their patients to experience, deeper, more meaningful connections with their patients and families. Time is a constant to all humans but it is never stationary and is always moving forward. Time can either serve humans as either a resource or be explained through flow (Kruglanski, Pierro, & Higgins, 2016). They conclude that time is considered a resource as it is necessary for acquiring things, and can be quantified and measured; “time is money” the cliché is a notion that time is a valuable and required in order to acquire funds. Flow can be explained as a dynamic and evolving imaginary line where “events are sequentially ordered” (p. 100). According to Conti (2001), there is evidence to support students are intrinsically motivated, to seek the flow state, and “may develop habits that help them to lose track of time and thus become fully involved in what they are doing” (p. 5). Over time, participants developed strategies to improve time management, leaving more opportunities to be present with patients in a caring, holistic manner.

Physical environment. Of particular interest to me throughout the study, was the correlation between nursing environments and the participant’s subjective assessment of time. I had worked only briefly on a medical/rheumatology unit prior to being hired in the ICU, so my only experience with the essence of time on a busy medical unit is through my observations of students on these units. Participants in areas such as the pediatric intensive care unit, palliative care unit, intensive care unit, mental health unit, and community settings, described more available time to sit and talk with patients and clients. It was here, in the stillness after tasks had

been completed, where participants appeared to have more free time to become more connected to their patients, or just a different expression of time.

> When Laurie took care of pediatric patients in the intensive care unit, she commented that Even with like with others and being a nurse and being there for like twelve hours. And I have different preceptors so, I was with her more than others like I was on a stretch for three days. And um my preceptor was changing and I stayed with her, so you get to know her and how she responds more than other people.

Charlotte had a placement on a palliative unit and she also described the free time that she found on nights:

> I've been working a lot of night shifts, a really long night shifts, I've become an owl, so, yes, those are a little bit different. I find that you have more of that time, particularly with the twelve hours- you've got bedtime, and it's also when people don't have family visiting, they are starting to get a little introspective and stressed out. And you know getting alone with your thoughts, so part I think is the night shift has allowed me a lot of opportunities for that, whereas opposed to day shift where you're running around like a chicken with hits head cut off.

Gillian and Anastasia conveyed how the physical environment and expectations resulted in less time spent with patients. Gillian had an experience in urgent care where each stretcher was divided by curtains and prevented complete patient confidentiality:

> There was this one patient who I, came in, with a sore throat. And I started assessing her and she started balling, tearing up. She said she was generally overwhelmed. It was an initial assessment and it wasn't what she came in for so it wasn't a private space, so I

couldn't ask further, any questions. I didn't feel like I should because everyone around else could hear us.

While completing a rotation on a busy orthopedic unit, Anastasia commented that her days were usually filled with completing tasks with less time to give to communicating with patients.

Leanne and Suzie commended two programs that were implemented on their intensive care units to assist staff in dealing with difficult deaths. It was a debriefing program where staff were encouraged to discuss their feelings, overall health and well-being, and potential impact certain deaths and circumstances surrounding patient admissions. What a safe space to express and I commend the managers of that unit. Creating a safe space where patients, clients, and families, feel comfortable to share is just as important as supporting the mental health of staff taking care of the acutely ill.

In summary, two distinct external elements enact significantly on the phenomenon and occurrence of empathic engagement. Whether it be the experience of time requires a conscious effort to carve out time for connection and relationship or the physical environment plays a significant role in allowing safe spaces for patients and staff alike, these two themes played a significant role in the development of Phase One: Laying the Groundwork.

Phase Two: Leaping into Uncertainty

Faith is a place of mystery, where we find the courage to believe in what we cannot see and the strength to let go of our fear of uncertainty.

(Brown, 2016, p. 90)

The Alchemist by Paulo Coelho is one of my favorite books. It is the story of Santiago, a young Andalusian shepherd boy, who travels from Spain to Egypt in search of treasure supposedly buried beneath the Pyramids. His journey was fraught with challenges, setbacks, and

lessons. After being robbed upon his arrival to Tangier, he needed money to survive and began working for a crystal merchant. He worked for a year and saved considerable amount of money, although he grappled with a difficult decision, does he buy a herd of sheep and return to the life of being a shepherd or pursue his dreams of reaching the Pyramids and finding the treasure that he longed to find. It is in this scene where Santiago must make a choice; return to a life of familiarity or embark on new adventure filled with uncertainty. Ultimately, he decides that his dream is too close to leave and sets out for the desert. What would have happened had he decided to return back to familiarity and being comfortable or take a chance. It is in phase two where participants demonstrated a conscious decision to act on their feelings of empathy for their patient, client or family, while moving one step closer to a space of empathic engagement and the uncertainty of what that space will entail.

Phase one was about developing the relationship that led to the feeling of empathy, and the second phase of empathic engagement is where a conscious action of participants takes place. Phase two is full of uncertainty for the participant. For the purpose of this dissertation, it was important to have a working definition of uncertainty which is defined "as a particular kind of unknown, incompleteness or ambiguity. Uncertainty, above all, is a mental state, and it can arise either from incomprehension (not understanding an entity of event) or indecision (not knowing what to do) (Smithson, 2012, p.621). Based on the analogy of a cliff that I introduced at the beginning of this chapter, Phase Two is standing at the edge of a cliff, looking towards the other side, connected by a bridge. It is safer on the side where foundation exists, a type of solid ground, and walking beyond out onto the swinging bridge is unknown, uncertain, and unfamiliar. It is at this point where participants decide to act on the affective empathy felt for the patient, client, or family or consciously choose not to proceed into deeper conversation and relationship

with the patient, client, or family. In this phase, I will present from the data, the cognitive components as explained to me by the participants that precede the actions of participants, discuss the emergence of emotional concern, and finally introduce how emotional intelligence and trust play a role in empathic engagement.

Emergence of Cognitive Elements of Empathy

Cognitive empathy plays a significant role in whether the space of empathic engagement emerges. As explained in Chapter One, cognitive elements of empathy involve an understanding of the emotional state of another, and include one's ability to "regulate and control emotions, thoughts, and behavior" (Decety, 2011, p. 102). Cognitive empathy is the ability to sense the feelings of another person beyond having one's own emotional response. This is where the brain of the perceiver acknowledges the experience of the other and the perceiver consciously decides to act or to refrain from action. In the first phase, participants began to recognize the verbal and non-verbal cues given by patients, clients, or family. Now, participants interpreted those cues as meaningful, requiring further action. Based on the data, it is important to remember that these actions, in conjunction with affective empathy, likely occur within a very short time frame. For purposes of this dissertation, I have broken down each step of this phase as it was presented to me by the participants.

Making the decision to act or not to act.

What's in a touch. Throughout the narratives and conversations, touch kept appearing as a first action to emerge after affective empathy. After relationships have been established between the nurse and patient, client, or family, touch becomes an intrinsic motivation to let the other know they are not alone. Holistic benefits of therapeutic touch were introduced and

modalities of touch were developed by Krieger and Kunz in 1979 and often taught in undergraduate nursing programs. Therapeutic touch is defined as "a holistic, evidence-based therapy that incorporates the intentional and compassionate use of universal energy to promote balance and well-being" (retrieved from http://therapeutictouch.org/). Touch is not an involuntary act, it is a purposeful, directed motion for either positive or negative outcomes. During times of illness, promoting balance and overall well-being is necessary. Touch is an important element of nursing practice as nurses must touch their patients in order to care. This does not refer to an element of emotion involved with that type of care. For example, touching their patients to make the nurse feel better but the intentional and sometimes unintentional ways nurses touch patients, especially in an acute care setting, for the sole purpose of connection.

The act of helping a patient in the hospital to bathe is a vital component of physical and emotional assessment for any nurse. There is much information that can be learned by watching the patients, helping support autonomous self-care, assessing skin, respirations, cardiovascular status, mobility, and an intimate time to communicate. Students are taught to observe a patient's mental health affect by their behavior and the way they dress. When Gillian walked into her patient's room, she observed that her patient had not bathed for several days while he waited for surgery, so she decided to undertake the responsibility. She told me in the first conversation, "So, in the mornings, during that time, give him his medications, chat with him a little bit. I mean, morning hygiene, even the NA (i.e. nursing attendant) could help with but I wanted to take it on myself, just so it's more continuity of care." The act of touch during this intimate act enabled their relationship and opened opportunities for further engagement.

Leanne shared with me about a patient she took care of in the pediatric intensive care unit. The small child was connected to a ventilator, unresponsive, and had multiple intravenous

solutions flowing into her body. She did not squeeze Leanne's hands when asked nor she could move her hand, fingers, or any part of her body to command. Her eyes remain closed during assessments and her heart was only beating because she was connected to a ventilator. She was a shell of tiny soul. Yet, she had primitive brain stem function and would respond to touch. Many patients in an intensive care environment have a small plastic catheter inserted into their radial artery to monitor blood pressure and heart rate, called an arterial line, accurately as opposed to a blood pressure cuff that is typically used for this assessment. In her case, this small patient had an arterial line as well as a line to monitor the intracranial pressure (ICP) inside her skull. Both lines are crucial when titrating medications for blood pressure, heart rate, and positioning for ICP, to know if the titration was therapeutic and provide positive effect for the patient. Her only visible response was to touch and audible stimulation such as visitors in the room. Leanne said,

> Like I guess you feel obligated to go in there and do everything perfectly. How you position all the lines. And like, how you touch her. And you even with the family. There were tons of visitors that would come in and in other situations, you would be more lenient. And I felt I had to be like, ok, only two people. This is serious. Because you could kind of see where there was a lot of chatter in her room, you could see her ICU go up. And how, um. I don't know.

Leanne mentioned that although there were multiple family members present at certain times, there were other times when no family members were at the patient's bedside. Leanne became more cognizant of the care she provided to the child, "I would say I spent extra attention to detail to make sure the lines are straight, the um, her hair wasn't getting wrapped around anything, her lips were moisturized and stuff, right, things that you can teach family members to do, but in this case, it wasn't really appropriate."

Another participant, Suzie, had a similar experience with touch but it did not involve the patient but the family member. The brother of the patient who had committed suicide was the only one of the family who chose to be present when all life support was to be removed prior to going to the operating room for the donation of his organs. Suzie could tell that he was uncomfortable by the significant amount of questions he was asking of the staff, body language, and the way he was talking.

> The brother was the only one there the next day and you could tell he was a religious guy and didn't really agree with the way his brother led his life. He was talking with the staff, so me and the primary nurse, the RT (respiratory therapist) and two physicians who had to be present, and he was just kind of standing there and had a lot of questions, tried to make small talk and no one was really talking to him. He was talking about getting forgiveness from God for his brother, and he like asked the physician, "what do you think about that? What do you believe?" I felt like he was trying to cling to something and the physician kind of stepped forward and said "well, I didn't really know him." And that was all he said. And I was like, "Oh my God, he just wants something." So, I felt like really awkward in that situation. It was my first time in that situation, I didn't know what was appropriate, And I didn't know what I should do, but like after, it was after the physician that just said that, I went over to his side of the bed and said, "you know, you can like hold his hand." And he was like "I don't want to hold his cold hand" And I was like, "his chest is still warm." So, he put his hand on his chest and started to cry and I put my hand on his shoulder but I was the only one.

This was a profound action of therapeutic touch as it not only connected the participant to the brother, but also the brother to the patient. She enabled the connection to unfold by the

simple gesture of helping him touch his brother. Suze was scared as this was the first time, she had been a part of a DCD. The brother was scared as exhibited by the number of questions. But in that moment, Suzie created a bridge. But she did not leave the brother alone. She stood beside him, with her hand on his shoulder, quiet. Letting him know she was there but not to be impose and consume his need to be with his brother one last time.

As Charlotte sat beside her patient, away from the chaos and noise of the busy unit, distracted by the construction site during the conversation, her patient began to reflect. It was at this time, that Charlotte, "Just patted him on the arm and said, 'You know', acknowledged, 'That must be really, really difficult.'" Charlotte made her presence known to the patient and he continued on reflecting about his past behavior, sexuality, and mistakes he had made causing his children to be estranged from him.

In each of the participant accounts, touch was the conduit in creating a safer space for reflection, revelation, and reminiscing clearly needed by the patients. It was the door that opened the patient, family, or client the opportunity to present more details about their concerns but only based on the decision of the participant to exercise the act of touch.

What is fascinating about this exchange between nurse-patient, is acknowledging it as a form of mimicry through the neural processes of mirror neurons. Firth and Singer (2008) identified that there are shared neural networks for sensations, emotions, and motor responses. Mirror effects from one person to another can occur when observing motor action such as touch without awareness. They continue to report that "our mirroring or the actions of others seems to depend upon whether or not we believe them to be people like ourselves, with whom we can engage in social interactions" (p. 3876).

For spaces of empathic engagement to occur, there is a mirroring effect where the participants draw in the patient through the use of touch followed by states of acknowledging the patient's distress. Just as participants had the option to make the conscious decision to act eliciting further responses from patients, clients, or families, there were a few who revealed situations where they did not act on the cues.

Charlotte reflected on her experience with a patient whom she felt was not being cooperative:

> I had another patient that was so withdrawn and very depressed and yeah, everything about him was leave me alone. I was getting one syllable answers from him all day long and he kept waving his hand at me and not really making eye contact and I just sort of left it, because I felt that he wanted to be left alone. Sometimes people need time to digest, but then afterwards, I wondered, "gee, maybe, I should have tried to spend a little more time drawing him out" it was a very busy shift, so that was probably not going to happen.

As Gillian shared with me, "Because if you are really busy on some level you want to ignore the cues too. That would open up a whole new conversation that you don't have time for." Charlotte reflected after on an opportunity where she could have tried to communicate more openly with this patient. She noted he was depressed, yet made the conscious decision not to take further action with him. Being busy on a unit is a plausible and notable excuse to provide in these instances; at times the unit is very busy, or are people, as Gillian said, choosing on some level to ignore the cues that others may be exhibiting because they do not have time to open up the conversation on a different level.

Gillian continued to explain in her experience, there are times she chose not to engage with patients further as she felt she did not have the skill to "curb the conversation to go in a

certain way." Based on the evidence, only the initial elements of the conversation are somewhat directed by the participants, once the patients, client, or family feel safe within the relational context, they were able to express what was already on their mind.

It's all in the dialogue - bridging statements. Prior to participants moving into a space of empathic engagement, participants recognized states of transition requiring trust to continue with the conversation as well as the impact of bridging statements. For one, participants recognized, that in each case, there was a moment of transition such as death or a new understanding of what is meant by health, as either observed by the participant or expressed by the patients, client, or family, and second, many participants followed this by acknowledging the other's emotion with a statement such as, "I'm sorry you feel this way." By the participant acknowledging the other person's revelation, this continued the conversation opening up a safe space for the connection to further unfold organically.

As I have mentioned earlier in the chapter, communication and focused dialogue is important between the nurse-patient/client/family to assist with initiating a strong relational foundation and discovering a commonality. It looks like a dialogical dance with exchanges of personal information. As the conversation continues to evolve, a swapping of information occurs developing the dynamic of the nurse-patient relationship. Without this exchange of personal information, trust, which has been deemed inherent in positive nurse-patient relationships (Strandas & Bondas, 2018), a deeper connected relationship leading to empathic engagement cannot develop. It is in this dialogical dance where participants listened, reciprocated experiences, and learn holistically about their patients, clients, and or families. As Laura identified,

> One of the tricks to that is being the one to ask more questions so you know you don't' have to make it appear that you're withholding information, rather you're the one assign questions to find out more about them and trying to make them feel like this is a conversation focused on them.

Laura even acknowledged that the study was centered on that same premise:

> Just in the way, right now, you're asking me questions about myself and you're not really giving me anything about your life. So, I don't feel like you're withholding anything or you're being walled up, it's just that the conversation is geared towards my interests and my life.

In the first phase of empathic engagement the developing relationship between the nurse-patient is important; however, as this relationship becomes stronger, trust begins to develop between the nurse and patient. Trust is central to moving into a space of engagement, as emotional responses are typically only shared within safe, non-judgmental spaces. Trust can be defined as "accepted vulnerability" (Baier, 1986, p. 235) and in the context of the study, an interpersonal trust between the nurse and patient. According to Strandas and Bondas (2018), trust in nurse-patient relationships "seems to both foster and be fostered by nurse spending meaningful time together; becoming acquainted; personal conversations; laughter; reciprocity; the nurse's competence, personality and attitude; and patient's feeling taken seriously and at ease" (p. 18). As trust develops between the nurse and the patient, patients feel comfortable to divulge problems, states of transition, or concerns which is vital to quality nursing care (Bindels, Cox, Widdershoven, Schayck, & Abma, 2014; Wälivarra, Sävenstedt, & Axellson, 2013). A strong interpersonal relationship helped to progress participants along the phases of empathic engagement.

In many of the participants' experiences, expressions of transition occurred. Suzie, Leanne, Mercedes, and Anastasia all had patients who expressed a desire to die. There is something very emotionally laden in that moment when a patient says they do not want to live anymore and ultimately what the participants chose to do in those moments. Many of the participants stated that they felt other health care professionals did not have the time or motivation to sit and talk with the patients about their feelings and to sit in the heavy emotional discussion that could have followed. In all the situations with these participants, they recognized that this statement by their patient, presented an opportunity to continue the conversation and demonstrated trust to express such emotional vulnerability. Remember, Gillian, acknowledged previously that taking the time to sit and talk with patients requires the nurse to be present with the patient and if the nurse is aware of the needs of the patient, then "that would open up a whole new conversation that you don't have time for." This is where time becomes an important factor in whether the participant continued the conversation or ended it.

In what started out as Charlotte taking her patient to a quiet area outside of his room, moved her patient to reflect on his life. She acknowledges that a rapport had already developed between her and the patient prior to the dialogical dance, so when he began talking about his children, how he was estranged from them due to drug and alcohol problems and never connected with them, he felt it was too late and he became emotional and started to cry. Charlotte could have stopped this conversation, taken him back into his room but she continued with therapeutic conversation and said, "That must be really, really difficult." This simple statement allowed for the conversation to evolve into a deeper reflection for him. Without the initial rapport and foundational relationship, trust could not have developed for the patient to

express such vulnerability to Charlotte, and then in reciprocity, for Charlotte to acknowledge this transition and reflective moment for the patient.

Once a revelation had been made by the patient, cognitive empathy played a role, assisting the participants to act or not in emotional situations. When the participants recognized a need to act, this was followed up by a physical touch as previously described or a simple open-ended statement. Bridging statements such as, "That must be really, really difficult", or "I'm sorry you feel this way" were commonly used to help the conversation move in a direction that elicited more detail as to what was concerning the patient, client, or family.

All participants reported situations where they knew what would assist in continuing the conversations or ultimately ending the connection at this point. Some participants like Leanne, Gillian, and Charlotte shared stories where they recognized a need to proceed in the conversation but felt at the time in the program, they did not have the knowledge as to how to bridge the difficult conversation. Anastasia expressed that she was cautious discussing the transition of death with her patient who was having MAID a few days after that shift. She was not sure as a student whether if it was appropriate to discuss death but knew that it was an area that could be further explored with the patient and his partner. She reflected on the safety that "being a student" held in preventing difficult conversations from unfolding.

For example, Gillian who had completed her final placement in urgent care was assessing a woman with a seemingly benign complaint in a cubicle separated from other patients and caregivers by curtains:

> There was this one patient who I, came in, with a sore throat. And I started assessing her and she started balling, tearing up. She said she was generally overwhelmed. It was an initial assessment and it wasn't what she came in for, so it wasn't a private space, so I

couldn't ask further, any questions. I didn't feel like I should because everyone around else could hear us

A bridge could have helped in this situation by providing an opportunity for the patient to divulge further details. In this case, Gillian chose to refrain from further engagement only illustrates a cognitive element when recognizing someone's distress, but consciously decides to avoid further communication on the topic.

Based on this data, there is a defining moment where participants consciously decide to enter further into relationship with patients, clients, or families. The decision to act, is preceded by a thought, followed by the affective element of empathy, then empathic concern which motivates the individual to make a cognitive decision requiring further action within the situation or alter the course of the conversation from the patients' original dialogical point of reference. The data demonstrates a sequential process of steps associated with moving into the liminal spaces of empathic engagement.

Mutual Vulnerability

Phase two encompasses a mutual experience of psychological vulnerability and arose in this study in participants' accounts of their encounters with patients. According to Sellman (2005), "vulnerability is a part of the human condition" (p. 6). In the context of nursing, "Confronting the vulnerability of patients actualizes the vulnerability of care providers" (Thorup, Rundqvist, Roberts, & Delmar, 2011, p. 427). Vulnerability always has contextual specifics. When someone enters tertiary care or is homeless and living on the street, the definition of vulnerability is adjusted, so that people experience physical, social, financial, nutritional, and psychological vulnerabilities or heightened ways. For the purposes of this study, vulnerability is defined as "a highly dynamic process of openness to circumstances that positively or negatively

influence individual outcomes" (Purdy, 2004, p. 32). From the data, within the human exchange between the participant and the nurse, there seems be a degree of vulnerability; 1. In the expression of statements, 2. The receptiveness of what is being said, and 3. What do I do with that information.

When Charlotte was sitting beside the gentleman, watching the construction site, it was he who initiated the conversation. Charlotte acknowledged that her previous rapport with the patient, that was already created prior to that exchange, was part of the comfort level between the two of them. According to Charlotte, as she sat beside him, the intimate nature of the conversation unfolded through the patient's recollections and reflections:

> He was an elderly patient, he was on isolation, he was all alone. He had nobody. He had a brother who he didn't have a good relationship with, he did have a common law wife, but she never came around either and they fought, that was not, and he was getting very, very sick. His condition was deteriorating and he wasn't getting any better. He was older, and he started opening up about his sexuality and how much losing that part of his life had bothered him. Which surprised me. I didn't approach that part of the conversation, he brought it up himself, and so I just let him talk and let him vent about it. I didn't even have to prod him too much with that. And yeah, I think that one stuck in my head so much because he was willing to, kind of lay that stuff out, that I think ordinarily he wouldn't have. He did have two children, he was estranged from, he had drug and alcohol problems when he was younger so he had never connected with his kids and now of course, now it was too late in his mind and that was over. That was when he became most emotional in our conversation.

Charlotte allowed the opportunity for the patient to share as well as a safe, quiet, and private space to allow for this emotional conversation to unfold between the two of them. The patient was psychologically vulnerable as he shared his life regrets with Charlotte, and she too allowed herself to be placed into a type of vulnerability, uncertain as to what he was going to say. And finally, a shared or mutual vulnerability emerged between the two of them as they connected on a more intimate relational level given the circumstances and details of the conversation.

Leanne was thrust into the cloud of vulnerability when her patient asked her to kill her, expressing that she wanted to die. After Leanne ensured the safety of her patient and that no suicide plan was in place, she could proceed with asking further details as to what the patient was feeling, why she was feeling like she wanted to end her life, helping her to remember that she was not alone. I am amazed as the courage of these young participants to bear witness to suffering, sadness, illness, and still manage to keep their own emotions in check. It is from these spaces of vulnerability that empathic engagement might emerge.

There is something to be said about "taking on somebody else's emotional baggage," especially as it pertains to someone's sadness and grief. The stories nurses are privileged to hear daily can be heavy and burdensome. Gillian has excellent insight into the boundaries that nurses need for their own self-care, especially in spaces of empathic engagement:

> You can't take on other people's emotions and other people's stress. And I think I've just learned that. When you engage empathically, you are on some level recognizing it, which could be stressful and you recognize it and you see it in their light. Which is mentally exhausting.

Two of the participants submitted a visual for their narrative; one participant submitted a painting and the other participant submitted two photographs. Each visual represented for each

of the participants, their creative perspective on what it meant for them to understand spaces of empathic engagement. What I find interesting in these pieces, is both participants chose to use flowers and a tree in their representation. The use of color and texture clearly demonstrate the vulnerability in each piece; in the painting, the vibrancy of the red and yellow color catches my eye against the dark backdrop, asking for each flower to be seen. There is a gentle sway leaning towards one to the other flower in the painting, as there is a giving and receiving between the two flowers as the petals are orange as they fall to the ground. The texture of the brush strokes highlights the delicate and layered nuances of the human experience. In the photographs, the vividness of the petals; life, exuberant color and vibrancy of the patient as he pushed forward to a healthier state, in contrast with the naked, bare branches of the tree in the winter, glistening with the snow on the branches, holding tight and connected, as the branches show each of us that there is still beauty in letting go, represents the patient who chose to end his life due to his terminal illness. Both visual narratives remind me of the vulnerability of what nurses do daily, the details of people's lives that we are privileged to hear and take on for the short time nurses care for their patients.

In a few of the situations, participants revealed crying about their experiences; whether in the presence of the patient, client, or family, or in isolation from others. Suzie discussed with me where she cried with her patient, as he discussed with her what is meant now to him about dying and Anastasia cried on her way home in the care, after finishing her shift with the patient with a planned MAID two days after. She was alone and isolated in her emotional vulnerability. The expression of humanness in empathizing with patient situations, and what that feels like for the participants certainly came through in the conversations. Laura acknowledged,

> You have to accept that you're going to walk away feeling a bit uneasy and you just have to, because it doesn't just neatly tie itself in a nice little package and then okay, that thing is done for the day, you carry that story with you all day, and perhaps for the rest of your life.

As participants moved from phase two into phase three, is the beginning of a dance between the participant and the patient, client, or family became clear. From the data, with each dialogical exchange, the participant moved emotionally closer to the needs of the patient, client or family, stepping into the space of empathic engagement.

Phase Three: Liminal State of Empathic Engagement: Where Connection Happens

> The off-centre, in-between state is an ideal situation in which to open our hearts and minds beyond limit.
>
> (Chodron, 1997, p. 12)

One of my favorite songs, *If I Needed You,* originally written by Townes Van Zandt in the early 70s, demonstrates the vulnerability that happens in relationships with one person asking if the other would be willing to show up in the darkest times for them; to be there for someone else, step into an act of selflessness, and be present.

If I needed you
Would you come to me?
Would you come to me for to ease my pain?
If you needed me
I would come to you
I would swim the seas for to ease your pain

(Retrieved from https://genius.com/Townes-van-zandt-if-i-needed-you-lyrics)

These lyrics represent the dance which is embedded within the space of empathic engagement and ultimately the level of intimacy that can occur in nurse-patient relationships. It is where the he(art) of holistic practice and authentic care for another move from emotional states of compassion, empathy, the neural processes of cognitive empathy, and into the liminal and unknown space of empathic engagement. In keeping with the analogy of the bridge, it is the space where the bridge connects two people and you find yourself in the middle; only knowing what has come before, but uncertain of where exactly the bridge will take you. It is the transitional place of liminality; not grounded, uncertain, and if possible, a change in purpose, spirituality, and practice. I have come to understand about myself, the in-betweenness of spaces of engagement and relationship with another, is what emotionally connects me to not only the profession but to others in general.

The spaces of empathic engagement are specific and unique to each circumstance; however, there were some common threads consistent from the data. When I started this study, I wanted to learn from participants what it meant for them to move into this space as I thought that knowing more about this particular dynamic of relationship was the most important component of empathic engagement. I was wrong. It is not the a-ha moments that were of importance but the sitting with, being with, and presence with another in silence and in the stillness of moments that is of significance. With regard to spaces of empathic engagement, I have come to understand that it is not the liminal space that is of most importance, it was the steps that came before connections with humanness and the possibility of lessons learned after connection, where participants found meaning. It is within this space of unknown, where connection was made with another

Sitting With, Present With…

Within spaces of empathic engagement there are no lights going off and on like when luggage comes down the shaft at an airport and the lights signal when the luggage is about to start on the conveyor belt. It is but a temporal transition of sitting with, being with, and present with in the midst of conversation with another person. It is a space that is held in time, despite the ticking of the clock as time passes. It is in these spaces where only the moment of connection exists.

Participants revealed that the cliché "time stood still" holds some truth. There is an awareness that all other tasks and priorities had stopped for that moment and being present with the other in conversation was needed. During examples of empathic engagement as described by participants, phrases such as, "chunks of uninterrupted time" or "it just takes sitting down for two minutes" or "it took him 30 minutes to die. Still, a long kind of pause" or "I think what I did differently was like actually slowing down and taking time" or even, "There were so many times that I would just sit there and talk with him for an hour" emerged. Participants were able to recognize the importance of how time, played a role in developing relationship as indicated in Phase 1, but also the unfolding of spaces of empathic engagement. Earlier in the program, participants felt that they had to complete the tasks of nursing practice, and often felt rushed to get these done; however, as they developed more strengths in completing tasks while attending to the holistic aspect of practice, many participants were able to recognize that when time is given priority, then spaces of empathic engagement have an opportunity to blossom. Participants were able to feel their patient's fear, uncertainty, and need for another as attention was directed towards only the patient. The unending tasks of nursing practice ceased to exist when the patient was authentically seen through emotional vulnerability.

The Sound of Silence

Silence "enables us to be deeply in touch with oneself and the true reality" (Pandikattu, 2013, p. 84) but also be in communion with another. In the busyness of tasks associated with practice and even in life, silence can sometimes be elusive. It is in, and through the silence and stillness, where participants discovered hidden identities of patients, families, and clients. As Aldridge (2000) states, "our stories are our identities. How we relate them to each other constructively, so that we mutually understand each other, is the basis of communication" (p. 17). It is only then where we find meaning to not only understand empathic engagement, but ourselves. Respecting the gems of what can be birthed from silent study, listening to others, is impacted by several factors; environment, and even relationship with self and with others.

In this study, certain environments enabled the silence within spaces to emerge differently as compared to other working environments. Anastasia was able to keep the room calm and quiet as she exchanged in conversation with the MAID patient and his partner who was in a private room. She was mindful not to be rushed when she entered the room to complete tasks, but to sit in the moment and in the silence. In Anastasia's narrative, the photograph that represented this patient was of a branch covered with ice and frost, with the warm sunshine cascading the light on the branches. She went on:

> I chose this one for my guy with MAID because, obviously frozen and lost all its leaves for winter…It was like -1000 outside, obviously as you can tell by the icicles. And it was early in the morning because that was like fresh frost. And there was no clouds in the sky, it was a beautiful sunny day other than that it was really cold. I just kind of went onto my parents' front step and thought, "oh that would be a cool picture of the tree" and if I could focus enough on this so that the background was blurred, that it gives you the optical

illusion, and it's always hard to do and I's always hard to do when you're taking pictures to get that nice blurred background and have the focal point here.

To Anastasia, this tree represented the patient who was passing away in a few days and his partner, who was directly in front of her in the moment, and the blurred houses in the background represented his decision to die. She went on and told me that the room was not heavy, the silence of what was to happen, did not overshadow the life that was in the room.

There can be moments where the silence is what is needed for participant and family or patient. Patients in the ICU are attached to a cardiac monitor that signals any aberrations in the heart rhythm with an alarm. These safety mechanisms are necessary to alert staff of deadly rhythms for the patient; however, when someone is passing away these alarms are also present. Suzie acknowledged that "you can't silence the alarms which I think is horrible. I think there should be an end of life monitor system or setting." Silence was welcome, despite that it was "so empty already knowing you're only keeping him alive to donate." It was within the silence that she helped the brother reconnect with the patient prior to his passing by standing with him as the brother laid his hand on the patient's chest, it was in this silence, that she connected with the brother recognizing his uncomfortableness with death.

Upon closer review of the data, moments of empathic engagement occur when less power is given to external distractions and attention is brought back to the patient, family, and client. It is only then, that silence may assist to draw out vulnerable reflections, shame, regrets, and personal disclosures, from patients that could not emerge during chaos. An authentic focus on only the present.

Place of Connection and Intimacy

All participants commented that they just "knew" that they had connected with their patient or family. Brown (2010) defines connection as "the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship" (p. 19). Whether it be intuition or an unconscious thought process, there was an internal cognitive dynamic shift in each of the participants. There was something unique and special about the relational exchange between the participants and patient or family, and participants left those spaces unable to explain how or why each of them was connected to the other in those moments but participants knew that there was something different about that moment with the patient, client, and family.

Understanding what is meant by the connection, how and why these spaces of connection are meaningful for participants, and learning more about the eye of empathic engagement was the initial impetus for this study. Even though I had previously encountered these moments in practice, just like the participants in this study, I knew spaces of empathic engagement had occurred, but I did not have the available language to apply it to a nursing discourse. As a result of the study, I have more language and understanding about the phases of empathic engagement, but what I have felt and experienced, just as the participants in this study, there is still a language deficit in nursing discourse to explain human connection. We all just know it to exist with some patients and family members, and not with others. Based on the data, the foundation that is constructed in phase 1, has a significant impact on the degree of connection between the nurse-patient, and the ability to enter into spaces of empathic engagement.

The intimacy that pulls the participant to the patient, client, family, or narrative of the experience opens the chasm for connection. As Marar (2014) explained, "Intimacy can offer

safety, trust, and the feeling of being uniquely understood: the opposite of isolation. The possibility of intimacy is always there, if elusive. Even a brief connection made can console and comfort for some time after it has passed" (pp. 12-13). This space of empathic engagement creates a safe space to release, discuss, and trust that what is said is free from judgment.

During intimate exchanges between participants and patients or family, a phenomenon far deeper than the generic nursing-patient relationship, exists. As this study is only focusing on the participants emotions behind spaces of empathic engagement, more can be learned from experiences and perceptions of patients and families in the future.

Difficult Conversations: The Places that Scare Me

One common thread amongst the deepest connections between participants and patients, clients, and families in the study, was when participants were willing to hear and move into a space that held a difficult conversation about death, transition, loss, grief, uncertainty, abuse, fear, regret. It is in these conversations where participants had to sit with someone else's emotions about parts of their life that were not always glamorous and then to know what to do with those conversations long after it was finished.

Not all participants in the study had the same experience of connection and intimacy with patients, clients, and or family. It was only those participants that were willing to sit in the uncomfortable space of empathic engagement, even if they did not have the wherewithal to know what exactly to do to "fix" what the topic of discussion was about.

Anastasia could not remove herself from the situation or the fact that her patient had chosen to medically end his life due to a terminal illness. Suzie did not run from ICU room as there was a need to reconnect two brothers prior to death. Laura did not shy away from her patient and the shame she expressed as Laura picked lice out of the patient's hair. Leanne could

not flee from her patient's presence at the disclosure that wished Leanne could end her life. As Charlotte sat with her patient as he expressed deepest regrets about his children and his sexuality, she did not shame the patient for his disclosure. Mercedes embraced the opportunity to sit with her patient in a state of transition as she was being discharged from the safety of the hospital. And Gillian recognized the sadness of her patient as he sat for days waiting surgery, wanting to give up on life.

When I look at the narrative visual representations of empathic engagement, I am sitting with those spaces of uncomfortableness. Leanne eloquently expressed that the painting represented not only the client's vulnerability of being homeless but her own vulnerability of recognizing that she was not that different than anyone on the street and at any time that could have been her. Anastasia recognized the finiteness of death in her photograph representing her patient that had decided to end his life; the picture of a winter scene, the branches bare, touched only by the frosty bauble of water. As with all the written narratives, as the reader, I am also sitting with participants' experiences of fearlessness as they moved into spaces of empathic engagement willing to sit with and listen to the difficult conversation that was about to unfold.

As I immerse myself in this study, there are many things I have left to learn about intimate space of empathic engagement; the center of the bridge, and more about what can be discovered about the he(art) of empathic engagement in the context of relationship. This study is only an introduction into what we know about connection in the relational ontological nature of nurse-patient relationships, a foundation for learning more about empathic engagement. Given the newness of studying and learning from these spaces, this dissertation serves as a conduit to igniting further conversations about empathic engagement and revelations about self in respect to relationship with others. This is where the final phase of empathic engagement begins.

Phase Four: Lifting the Veil

The simple things are also the most extraordinary things, and only the wise can see them.

(Coelho, 1998, p. 12)

The final phase of empathic engagement is what happens after the connection has occurred between the participant and the patient, client, or family. Based on the analogy of the bridge, phase four, moves the participant from a place of liminality and an intimate empathic connection with another, towards the other side of the bridge, into a post-liminal period of incorporating what has been learned into practice. Empathic engagement is the liminal space of transition which enables the participants to move into another level of understanding of self and further developing a higher awareness of one's role as a nurse and human being.

I have titled this final phase as lifting the veil because almost all of the participants were changed in some way from each of their experiences with empathic engagement. The contemplative focus of phase four enables the participants to reveal what was hidden through the actions of debriefing, reflection, and becoming transformed as a result of the self-directed focus of analysis. Through the transcripts, narratives, and one-on-on conversations, participants were able to detail specific and fluid elements of this final phase all leading to deep learning about themselves and their practice.

Importance of Debrief

One interesting finding that emerged from the data and only occurred within phase four, was the need for participants to debrief with another person after their experience with empathic engagement. Participants recognized that "something" meaningful had happened, even if they did not have the appropriate language to label their experience and possible connection with their patient, client, or family. Suzie identified it as "some kind of connection made and it was

important." Participants opted to seek out someone of trust, either their instructor, family, or even another nurse who would listen to their narrative, emotions, and actions about the experience.

During clinical practice, reflection-in-action, reflection-on-action (Schon, 1983), and reflection-beyond-action (Dreifuerst, 2010) are techniques used to help learners navigate meaning from experience. During reflection-in-action (Schon, 1983), practitioner must reflect, and draw conclusions "in-the-moment" without time for deliberation. Internal dialogical reflection is a necessary counterpart to bring awareness to situations such as highly emotional and often difficult conversations associated with spaces of empathic engagement. Recognizing the need to further discuss personal experiences of empathic engagement, was the first step in seeking out others.

Anastasia had a reflective-in-action moment after she had initially assessed her patient who had decided on MAID which prompted her to call a nursing friend. She said:

> So, when I went for my first break that is when it really hit me. I went down to the cafeteria and sat at a table by myself and I cried, silently of course so no one would see me. Because no emotion. [Anastasia is referring to her ability to maintain defined emotional boundaries up until this event] Uh, so, I had tears streaming down my face for sure and I was texting one of my friends who is already a nurse and was like, "Oh my God, you will never guess what, this is what happened. I don't know what to do with myself. I am sitting in the cafeteria crying right now and this has never happened." I have never felt this emotion.

Nursing is an isolating profession from loved ones and family who are not familiar with the role nurses play in people's lives. Seeking out others in the same profession who could understand

the emotion of taking care of someone, knowing it was his or her last Tuesday, is a profound experience that cannot easily be placed into words. Anastasia spoke with her friend, collected her emotions, and then returned back to the unit.

After every shift, clinical instructors gather students together to debrief about their day on the unit, discuss any events or interesting clinical cases that would be of interest to everyone in the group. On this particular final clinical shift for the term, and with some prompting from her nursing instructor, Anastasia shared her experience with her classmates. Anastasia very easily could have shared only about the recommended and policy actions of what is means to take care of a patient who has decided to complete MAID, but instead she shared her emotional experience with the group. She went on:

> I still wanted everyone to kind of, as much as it was a learning opportunity for me, I kind of wanted to share half of the experience, so everyone eels could kind of hear what had happened and because [a previous student in the group] had had him, like two or three, like two weeks before, so she could kind of get an update as well or like the other people who had him. Um, but I wasn't prepared to fully disclose everything. And then when [same student as above] tried to hug me, I was like, "don't touch me." That was too much emotion.

It was in this moment, Anastasia sought the guidance and support of her classmates and essentially future colleagues, about an experience that she could not make complete sense of at the moment. Learning together reminds us that each of us are not alone in these moments, if one chooses to share. It is a life-long coping strategy to teach nursing students that nursing is a profession where we individually take care of a patient, but through a team and network of trusted individuals, we also take care of each other in times of loss, emotional grief, or emotional

pain. This will be further unpacked in the discussion chapter of this dissertation, as environment and colleagueship are crucial components of empathic engagement, social constructivism, and how participants found meaning in these experiences.

Other participants sought support and further debrief from their clinical instructors or preceptors. When Suzie's patient was waiting to go to the operating room to donate his organs and even after the experience, it was Suzie's preceptor and colleagues in the ICU who made certain to assess Suzie's preparedness for this difficult task. After Charlotte's patient passed away in palliative care, she chose to discuss the emotional distress that accompanies losing a patient, even if it was expected, with her preceptor. Leanne discussed with her preceptor the emotional outburst by her patient requesting that Leanne kill her. Having a trusting relationship with someone present at the time of empathic experiences or even other emotionally laden experiences in practice, helped to analyze participants' emotions, actions, and next steps.

Two participants from the study had family members who were nurses. Each of these participants held debriefing conversations with their parent to unpack the significant emotions associated with the loss of their patient and any emotions that was associated with their experience of empathic engagement. Suzie discussed with her mom, her emotions associated with not the death of her patient, but the lifestyle of her patient and how similar it was to her brother's experience with addiction. Leanne also discussed with her mom, who is also a nurse, the difficult emotions she had while taking care of a child in the pediatric intensive care unit who was admitted after allegations of abuse at the hands of the parents. In nursing, all patient experiences are to remain confidential, to protect the privacy of the patient and family, and to respect the patient narrative as something that does not belong to the nurse. Nurses are privileged to the most intimate details of another person's life, oftentimes, without the person themselves

revealing the information directly to the nurse, but as it is written in the patient's chart, any health care provider will know the details. This information may include lab tests indicating a probable diagnosis of cancer that have not been revealed to the patient yet, knowing the baby that was just born to an immigrant was conceived by rape and the mother who has no social supports in place yet will be discharged from the hospital, or taking care of individuals who choose to keep their personal story/identity/lifestyle hidden from others but is wildly, although respectfully, shared with those assuming care of that patient. Health care providers are the keepers of secrets. Debriefing with someone of trust provides an outlet to the emotional burden often plagued in the profession.

I often wondered through this study, that without the boundaries, as described by Gillian as necessary for maintaining emotional distance, or those nurses who lack of coping strategies with emotionally heavy personal information contributes to the burnout of many new nursing graduates and even by experienced nurses. How do we prevent excellent nurses from leaving the profession because they cannot handle the deeply emotional work nursing often brings to their mind and heart? Is talking about self-care, and addressing work-life balance enough if in the end the nurse is alone with his or her thoughts? Based on the need for connection after experiences of empathic engagement, as described by participants, there is higher need to eliminate emotional isolation. I question if the right amount of safe and supportive networks is in place within nursing programs across the country and if educators have appropriate tools, which make students feel that someone is sitting with them, being with them, and present with them. Do programs and educators have the ability to move from compassion, to a place of affective empathy, to recognizing action as in required for cognitive empathy, finally moving into a space

of empathic engagement with students? I think further research is needed in this area to understand if systems and educators are prepared to help students cope with difficult emotions.

One participant, Suzie, commented during the one-on-one conversations, that the study was in fact, similar to a debrief as well.

> It's made me think too, this almost, was as effective as a debrief. I think you learn a lot more from it by dissecting it, but you can't really do it on your own. You're not bouncing anything off, well I'm not, but I wouldn't pick up on things that maybe you picked up on, maybe I wouldn't like, talked about my brother, if you hadn't asked certain questions. It definitely is harder to do self-reflection with something like this.

It seems that the study provided a way for participants to not only reflect on experiences with empathic engagement but also how those experiences tie into their own personal connections to specific events and people. In another words, participants relayed the importance of having someone other than an intrinsic self-discovery and self-reflective practice.

Mercedes found that through the process of the study, she was able to understand herself more, both as a person and as a nurse. During the initial one-on-one conversation, she said, "When you're talking, I'm like, 'yeah, that's exactly it' and like talking about it is helping understand it and define it." At the end of the study, she discovered about herself limitations in her own practice that prevented her from moving into spaces of empathic engagement with young, female patients but also embracing opportunities with older adults. During the final one-on-one conversation, she said, "And I am very thankful for this because I learned a lot about myself and it was nice to like talk, and get these things off my chest as well and learn about myself."

Debriefing in the manner by which was conducted in this study, seemed to assist as a construct for human connection not only between the participant and their experience but also the participant and myself as the researcher. The experiences of empathic engagement as described by the participants, occurred several weeks, and even months prior to participants volunteering to participate in the study, yet through the one-on-one conversations as completed by the study protocol, participants were able to discuss their experiences in a manner which improved the narrative process and reflective techniques. Typically, the technique of debriefing in nursing is used as an opportunity to provide formative feedback for skills such as during a simulation experience, but also a communication process that allows for students to discuss ways of to improve future performance (Cant & Cooper, 2011). Through the debriefing process, either with another person such as in the case of a parent, instructor, preceptor, friend, or even myself in the research role, participants were able to connect with another through similar experiences and like-minded responses; in a way, searching for someone else to feel the same as you did as not to be alone in one's experiences. The debriefing was a powerful exercise for participants to re-connect after the experience of empathic engagement had occurred. A final opportunity to connect with the experience occurred in phase four through the act of reflection. It is through the debriefing process that once again, connects I and Thou as in Buber's philosophy of recognizing sameness in humanness and nursing practice. It is not solely about the experience, but how to deconstruct emotions, actions, and individual intentions. In each of the situations, the other that participants searched for, was a pre-existing safe, relationship which allowed for an authentic exchange and ultimately a way to find meaning and make meaning from the experiences. As Cloud (2016) states, interpersonal connections, personal experiences with those connections, and neural circuitry play a role in helping people grow past limits than basic friendly interactions. It

is in through relational connectedness (Cloud, 2016) that Siegal (2012) refers to the triangle of well-being that includes a mind, body, and relationships.

Reflection

During the final phase of empathic engagement, participants identified that the process of reflection played a significant role in how each of them found meaning from their experience of empathic engagement. To contextualize the findings related to reflection, I provide some explanation of how this concept appears in nursing education. Dewey first introduced the idea of reflection in 1933, defining it as "the turning over of a subject in the mind and giving it serious and consecutive consideration" (p. 3). It has become common practice, even for annual professional nursing licensure, to demonstrate the act of reflection in practice. Early on in the undergraduate nursing program, at the University of Calgary, participants were taught to incorporate Tanner's (2006) Model of Reflection, into their day-to-day routines of care to assist students with learning how to think like a nurse. Tanner (2006) examined nearly 200 studies and created a model based on conclusions drawn from the studies to inform clinical judgment which is critical in the development of clinical knowledge and to improve clinical reasoning. The term "thinking like a nurse" encompasses a deliberate process to weigh evidence, critically analyze and interpret information, that informs clinical reasoning. Although this model of reflection is utilized extensively in nursing curricula, what is missing is the role of emotions in the reflective process.

It was intentional on my part for some form of reflection to be built into the study as part of the methodology; however, participants discussed how this practice of reflecting-on-action, and reflecting-beyond-action (Dreifuerst, 2010) had become a key aspect of their practice. Based on data from my study, the process of reflection has become more meaningful for participants.

As they progressed to a point of recognizing spaces of empathic engagement, each participant was able to identify how emotions and previous life experience played a role in their reflection; highlighting the significance of emotions and embodied learning in the context of constructing meaning.

Prior to the participants actively seeking out others for emotional debriefing, many spoke of a reflection-in-action (Dreifuerst, 2010) that occurred at the time of interpersonal connection with the patient, client, or family. As previously discussed, Anastasia, sat with the heavy emotionally laden knowledge that her patient would die within a few days of that last shift. She recalled, "I think once I started thinking how this could have been one of my parents, it changed the way I talked to him" presenting a reflection-in-action event. She reflected on her role as the nurse and of course her mother, who had battled and successfully won the fight against cancer. She continued, "And then, you know, I cried the whole way home. And I don't really know. I still don't know, to this day what really set that off," attending to Dreifuerst's (2010) reflection-beyond-action. This type of reflection occurs after the experience has stopped and people are mindfully analyzing personal actions and responses.

Charlotte commented on the importance of reflection in her practice:

> I honestly think that the journaling and the reflecting does help a lot. And that's something I've always sort of done, for myself, but I think that helps. I do a lot of decompressing in the car, on the way home as much as I lament the commute between the foothills and way down in the south, I find that's kind of my shifting gear time between being at the hospital and being at home, and same the other direction, it's when I get my head in the right space.

Kumagai and Naidu (2015) insists that designated and intentional reflective spaces are valuable in order to create habit. In respect to reflective spaces, one may think of time and

duration and a specific locale, only, but reflection provides an opportunity to develop "identity and ethos" (Kumagai & Naidu, 2015, p. 284) in a manner than honors the experience. It is within this space, as defined by an individual, an inherent ability to develop "personal values, an orientation towards oneself, others, and the world" (Kumagai & Naidu, 2015, p. 284). Through this reflective practice, participants were able to re-connect with the experience through the narrative as well as re-connecting to the relational self "through practices of memory and emotion" (Gergen, 2015, p. 109).

Many participants found that isolation was important during the reflective process after experiences with empathic engagement. Laura identified, just as Charlotte, that reflection was a common practice for her:

> I'm a big, big fan of decompartmentalizing your experiences of the day. I've learned that you have to reflect, you have to always reflect on things that you did throughout the day and effect on your learnings in order to kind of sent them into your long-term memory and I think that's a really important thing. So, if you have a really horrible conversation with somebody or a really conversation with somebody, break down what made you feel crappy about it, or what made you feel like there was unfinished business. Then you, how did you, maybe would have liked to see how the conversation go, I find that although you can't go back in time, but it kind of helps me sort out what I would [liked] to have said if I had the opportunity in that moment.

There is power in characterizing the importance of isolation during reflective practice to bring deeper awareness to the experiences of empathic engagement and to help find meaning for those experiences. But the lessons learned during a phase of isolated reflection may be further enhanced with discussion and dialogue.

Other participants claimed being involved in the study, assisted with reflecting on the experience. It was a purposeful and intentional action not only in the re-creation of the personal narrative of the experience but also through the one-on-one conversations that were conducted as part of the methodology. Mercedes commented on her experience:

> I think that writing it down, because you were saying, put me in that moment, I was trying to put you in that moment, so I was trying to look back and think about everything. I guess it's different verbalizing it to someone versus than siting and thinking about yourself in the moment and you're writing it down and you only have yourself to put into it.

Based on the participants discussion with me during the second one-on-one conversation, participants claimed there was a deeper connection to the experience after the reflective process followed by discussion. It seems that reflections in isolation may not be enough for some people to come to a deeper understanding as to the meaning of an experience in nursing practice. Despite requesting undergraduate students to utilize Tanner's Model of Reflection, it may be the extension of those reflective pieces to guide for deeper meaning.

During the final phase, debriefing- reflection-(debriefing) was helpful for the participants in this study to connect to their experiences of empathic engagement. Through the process, participants were able to direct attention to key defining moments that was meaningful to them in the exchanges with patient, family, and client. In each of the experiences, participants learned more about their practice and how they chose or chose not to connect with others during opportunities for empathic engagement.

Transformative Nature of Empathic Engagement

During my one-on-one conversation with Laura, I brought up the metaphor of peeling back the veil. As she talked about recognizing the similarities between herself and the vulnerable

female who was homeless, it struck me that participants not only recognized sameness in the patient, family, or client, but also learned something more about themselves in the process. Laura acknowledged that all people are not immune to the struggles of homelessness and accepted that she too, at one point, she knew what it felt like to be unemployed and relying on her credit card. Through our discussions, and other discussions with participants, the end of phase four is marked with transformation; participants said they knew that there was a connection with another, but they did not have any words to label that connection. Their perspective had changed by the interpersonal exchange between themselves and the patient and then again changed by the dialogue between myself as the researcher and each participant. The metaphor of peeling back the veil was to highlight that each participant learned about themselves, either small or large ways, about how they conducted themselves as nurses and at times personal intentions for future practice.

Increased awareness of self and other. On the "other side" of what is empathic engagement, moving into reflection, and finally dialogue with me, participants started to recognize patterns in their own care, that became heightened in the space of empathic engagement. For example, Laura already had a strong sense of advocacy for those who came from marginalized populations; however, her intuitive nature and curiosity about her patients, elevated her advocacy in her role in labour and delivery, past the initial presentation of the patient's narrative to address policy and systems. Mercedes learned that initially, she avoided particularly young, female patients who would be dramatic in their presentation of pain but drawn towards the older adult as she had a sense of making a difference in their care. Charlotte, who already embodied a skill in helping others during difficult conversations, discovered her growth in palliative care in addressing uncomfortable conversations of death. Suzie, became

more skilled in not only recognizing spaces of empathic engagement, but became more comfortable with having difficult conversations with others about areas that are sensitive to her personally, such as addiction, suicide, and making certain others are not alone in times of distress. Anastasia, became more open to her own feelings surrounding emotional topics, and became transparent with patients showing them a personal side to her practice. Gillian, remained aware of her emotional boundaries with patients, but reminded me that spaces of empathic engagement are not only found in nursing practice but every day personal lives and impact not only professional but personal relationships. Finally, through the one-on-one conversations, Leanne started to recognize that her natural skillset of moving in and out of spaces of empathic engagement was a lifelong relational attribute that she had always done, personally and professionally, except now she had a language to apply to this behavior that she thought everyone could do.

Changed behaviors for professional and personal relationships. In the final phase, participants revealed how the study has affected their life professionally and personally. Coming to the end of her involvement in the study, Suzie said,

> It was strange because I thought more about how my life affects what is happening to me, and what I've experienced outside of nursing and how that comes in, and I definitely thought about it yesterday because I was helping with a burn victim and it was the same kind of feelings, like more detached, because I personally have a problem with that. I thought about it that way, how sometimes things I've experienced would prevent me from making connections. But um, again, I felt more empathy for her kid and her mom than her. So, I am kind of exploring that right now.

She continues on to comment about coping with difficult patient situations and what she will do moving forward:

> I didn't expect to get so emotional [during the death of her patient donating his organs] like I did in the first place, and the fact that I did, maybe I should actually think about this a little bit, um, like and I also see it with other nurses and not that I know their life stories, how certain people react in certain situations. They might have something that they've gone through or experiences that to think about. Like I guess, we've all had things that affect how we practice, whether they are good or bad, so I am working on self-awareness about that.

After reflection and additional dialogue, participants started to develop their own identity about who they wanted to be and how they wanted to act as the nurse. After Laura's experience with street outreach, she said, "I feel like my experience in the program has been a lot different just based on that, impacted how I view other people, how I want to be as a nurse." She took this perspective into how she viewed spaces of empathic engagement as well, creating more opportunities for interconnectedness with her patients, families, and clients.

Many participants such as Mercedes, Gillian, and Leanne began to recognize how personal triggers affect their ability to move into spaces of empathic engagement, either drawing people closer to these spaces or creating distance and preventing connections. Mercedes acknowledged her intentional distance for young women seeking medication with dramatic behaviors, Gillian recognized her previous life experience with addiction acted as a barrier to maintain professional distance, and Leanne recognized similarities between her own grandmother with Parkinson's and her patient, with the sadness in her eyes. At times, these

invisible barriers only became clear as the study progressed but made each participant more aware of what they bring to the role as a nurse.

In conclusion, the final phase of empathic engagement, lifted the veil to a re-connect with self, and helped the participants identify a new understanding about spaces of empathic engagement. The final phase of empathic engagement, based on study data, was a self-discovery of the experience, reflection, and personal as well as professional growth.

Summary

In my analysis, I outlined four phases of empathic engagement: Laying the Groundwork, Leaping into Uncertainty, Liminal State of Empathic Engagement, and Lifting the Veil. The complex and multi-layered nature of nurse-patient relationships leads both parties to a unique, liminal, and transitory space of in-betweenness that connects one to the other; a juncture of intimate communication. Based on the data, spaces of empathic engagement, have a beginning, a middle, and an end in the experience, but an opportunity to move participants to a higher level of self-knowledge.

In Chapter Six, I discuss the significance of empathic engagement and present key findings of the study, the impact on nursing education, adult learning, and nursing curricula, my suggestions for future research, limitations of the study, and concluding remarks. I expand on the elements of social constructionism, highlight relational ontology of empathic engagement and the relationship vector between instructor-participant-patient, client, or family.

CHAPTER SIX: DISCUSSION

When I began this study, I thought the space of empathic engagement may be a critical element within the nurse-patient relationship. Despite my own experience of connection with patients and families, I was curious about participant experiences, how they came to understand and find meaning for spaces of empathic engagement. In terms of timing, this study was unique in being centred on the dynamic between the transition of student to nurse. This led me to the start of inquiry for the study. I have learned, that these moments of empathic engagement, help define an aspect of holistic practice of nursing in the liminality of health and illness. What is missing from nursing literature is a closer examination of the liminal experience of empathic engagement. Within this space of relational possibility, an emotional bridge emerges connecting the nurse and patient. Aoki (1993), a prominent Canadian scholar, said, "On this bridge, we are in no hurry to cross over; in fact, such bridges lure us to linger" (p. 255). It is on this bridge, where a dimension of the nurse-patient relationship is explored and as McNamee (2004) claimed, "We enter a new domain of relational" (p. 4).

As I have established through my analysis and as described by participants in this study, patterns of empathic engagement have a beginning, a middle, and an end. The results of this study offer new insights into the complexity of nurse-patient relationships and suggest a certain process might be at play in developing empathic engagement. Patterns of experience from the data emerged to reveal the complexity of emotion within the relationships between participants and patients, clients, and families. Spaces of empathic engagement are messy and at times undefined. Despite the inter-subjectivity of the patterns, I have outlined phases of empathic engagement which have emerged through conversations with participants and their narratives and as experienced by these participants. I present patterns of experience only to provide a sense

of structure to the fluidity of relationship and provide clarity based on what I have learned from the data. This study represents a lens into the socially contextualized participant-patient, client, or family relational dynamic as experienced by a small sample size of fourth-year nursing students. Spaces of empathic engagement are layered with nuances, emotions, but deeply rooted within the relational exchange from one to another. In this chapter, I discuss and summarize key findings of the study, present implications for nursing education and curricula, as well as other professions of service, address limitations of the study and conclude with questions that remain relevant for future research related to empathic engagement.

Key Findings

There are two fundamental results from this study addressing how participants come to understand, encounter, and respond to empathic engagement in their work:

First, the dynamic structure and fluidity of **relationships** play a significant role in the development and process of empathic engagement. What emerged from the participants' own experiences were the social processes and relational patterns between participant, a central character, in relationship with another person. These processes and patterns included: enhanced nurse-patient relationships impacted by past relational experiences, participants recognized the humanity within the nurse-patient relationship, and participants were in holistic relation with another.

Participants described an enhanced connection when entering into spaces where the patient, family, or client reminded the participant of a previous relationship or shared experience. For example, Suzie connected more to the patient's brother as a sibling herself with a brother who also had issues of addiction; Anastasia connected to the patient dying from cancer as her mother was a breast cancer survivor; Charlotte connected a similar personality in the male

patient that she saw in her father-in-law; Leanne connected with the lady who asked for her to help her die as she reminded her of her grandmother; Gillian connected with the patient with addictions as she had previously been in a relationship with someone who also had issues with addictions.

Participants moved into spaces of empathic engagement where the participant was able to connect with the humanity of the patient, family, or client. For example, Laura connected with her client living on the street as she recognized they had more in common than they had differences; Mercedes connected with older adults as vulnerable and requiring her help; Anastasia connected with an older adult with dementia whom staff were not able to spend extra time addressing holistic nursing practice.

Participants derived meaning from their experiences of empathic engagement, when in holistic relation to another. Upon reflection and conversation, participants became more aware of opportunities for empathic engagement as the study progressed. At the beginning of the study, Anastasia was the type of nurse who provided exemplar care but avoided emotionally connecting with patients. By the end of the study, she was more open to learning about her patients and willing to connect with them on a deeper holistic level as opposed to only the biophysical component of their care. She told me of the older adult with dementia whom she prioritized spending more time with if given the chance:

> This little lady that was very pleasantly confused and you had to remind her to speak English. She was the sweetest little thing in the world and I spent any time I had when I had her as a patient. I spent a lot of time in her room. There was a couple of times she was in a bad mood and she refused to do things but she was just such a cheerful happy little lady. “Oh, I pay for you, I pray for you.” [she would say to me] And she would just babble

> on about random things and I would just sit and listen and smile and nod. I don't think my preceptor liked how much time I spent with her.

Mercedes discussed this study with her preceptor and with other nursing colleagues on the unit. As the study progressed, she was more frequently able to identify opportunities where patients invited her into these spaces and how she could support the emotional needs of her patients with more confidence and skill. Participants such as Suzie and Leanne, who found themselves moving into these spaces easily even before the start of the study, now had a language and affirmation that these spaces did exist and they were not alone in their experiences.

A final key finding of the study, explored how participants developed a better **understanding of self** and the importance of empathic engagement in their role as a nurse. Laura commented to me she found value in these types of connection and made a conscious effort to prioritize her time in order to make those connections with patients. Another participant, Charlotte confirmed that the type of nurse she wanted to be was the one who connected with her patients:

> That's the reason I went into nursing. Just the experiences I've had, being a patient, of the family of a patient, you know, it's not the nurse hanging the IV bag that makes a difference, it's the ones that take the extra minute just for the little extra care you need.

Based on existing literature and studies on empathy, what is already known about empathy can be applied to participants' experiences of empathic engagement. These accounts may offer an explanation why some participants were able to connect with patients increasing the likelihood of moving into spaces of empathic engagement, and not with others. I further expand on the two key findings from this study: connecting in relationship and heightened understanding of self.

Connecting in Relationship

Highlighting past relationships and shared experiences. One of the key findings from the study highlighted how past relationships and shared experiences affect relational connection and enhanced engagement between participants and those they cared for while participating in the study. This addressed how participants encountered and understood their role with empathic engagement. Participants engaged more openly with patients, families, and clients whom they developed an immediate connection as a result of a past relationship or previous situational circumstances as in the case of a patient, family member, or client. Based on data, the initiation and depth of empathic engagement was impacted by previous social relationships. The importance this key finding addresses the impact of previous life experience, relationship, and meaning which was already in existence prior to entering undergraduate nursing programs.

It was through these social connections where participants found meaning in relationship with patient, family, or client as well as within the relational dynamic of empathic engagement. These nurtured relationships provided a structure and overall basis for the potential development of empathic engagement. When a lack of emotional connection within the nurse-patient relationship, participants were less inclined to take action and move into the liminal space of empathic engagement. At the time of interaction between participant and the individual whom they engaged empathically with, participants such as Suzie commented, “I felt that was a big moment of a connection.” It was as if participants knew something special have developed between them and someone else, but understanding that moment required further exploration, which was accomplished through conversation and reflection. It was through these other social exchanges which ultimately led to a greater sense of meaning for participants and a different sense of understanding than they had previously encountered at the time of entering into spaces

of empathic engagement. This is discussed further in the section of this chapter titled, *In holistic relation with another*.

Emotions and embodied learning were once thought to be a barrier to learning (Dirkx, 2008). Findings from this study highlight emotions cannot be removed from nursing practice and enhance participant-patient relationships. New research is demonstrating the integral role, emotions have with learning, and meaning making (Jarvis, 2006; Merriam, Caffarella, & Baumgartner, 2007). Burkett (2014) believes that human beings are "always in patterns of relationship to other people and to the world, and feelings and emotions form our embodied, mindful sense of different aspects of those relationships" (p.15). Past experiences associated with significant relationships such as personal experience with addictions or cancer, cannot be completely removed from actions of professional practice such as in the case of this study. This leads to dimensions of relationship that may not be fully understood and require further research for nursing practice.

The relational dynamic of the nurse-patient relationship remains fluid throughout all interactions. Each conversation and care of a patient, family, or client remains individualistic and situational. Burkitt (2014) suggests,

> Social relations are never static, remaining in the same state, but unfold over time in a process of continual change. They are dynamic, unpredictable and co-created, so that no one person is never in complete control over the way the relation will evolve (p. 19).

These results of this study are intended to initiate a discussion for nursing education and provide new ways to foster spaces of empathic engagement.

Connecting to humanity. When Laura shared with me her visual narrative of how she perceived empathic engagement in practice, I became emotional. The painting highlights for me

a visual representation depicting the importance of relationship within the context of empathic engagement between two sentient beings. I found it interesting, how the flowers are leaning towards each other as opposed to away, which to me indicates an innate need for both to lean into the liminal space of emotional vulnerability. At the heart of all the participant encounters with empathic engagement is the fundamental nature of humanity: I see in you what I see in me. In all revelations of experiences, participants leaned into the liminal space of uncertainty within the conversation. It is in these moments of humanness, where participants recognized sameness instead of difference and found meaning within those interactions.

The complexity of these relational moments of empathic engagement embodied a value of nursing practice consistent in nursing literature and expectation for new nurses entering the profession (College and Association of Registered Nurses of Alberta, 2013; College of Nurses in Ontario, 2014). At a basic level, the characteristics of humanity often associated with a helping profession is central to this research; however, nursing practice also consists of complex human relationships and nuances of socially constructed behaviors. This study is meant to provide a window into one aspect of relationship within nursing practice as experienced by the participants.

In holistic relation with another. At the beginning of the study, my curiosity was only to include a view of the nurse-patient dynamic and how participants garnered meaning from these relational exchanges. Clearly, spaces of empathic engagement cannot exist without at least two people being present; the participant and patient, client, or family. To address the holistic aspect of practice, it was important to discuss where participants were in relation to the patient, family, and client, and also discuss how participants were also in relation with others. It is

through these relationships, participants were able to understand and respond more meaningful to spaces of empathic engagement.

During states of illness, there are benefits to overall health and well-being when people feel less alone and emotionally connected to another. Social support can be defined as multidimensional construct of social relationships that enhances overall physical and mental well-being (Rodriquez & Cohen, 1998). There is, as Buber (1970) suggested, an "innateness of the longing for relation" (p. 77). As per one-on-one conversations with participants and their narratives, patients shared their feelings with participants during moments of reflection, expression, or suffering. There was even one moment where Leanne was able to enter into a space of empathic engagement with a patient who was unable to respond verbally to her care. The patient was in a coma; yet remained connected to a monitor that recorded her physiological responses to positive and negative stimulation. Leanne provided care that was slow and purposeful as not to evoke a negative physiological response with the patient. Empathic engagement cannot exist without two souls.

It is through this specific context of relationship where Buber's I-Thou principles become apparent and focus on "self and the other" (Josselson, Lieblich, & McAdams, 2007, p. 7). Through an I-It relationship, Buber acknowledges that boundaries exist thus keeping distance between two people; however, with I-Thou relationship, individuals "stand in relation" (Buber, 1970, p. 55) often in a boundary-less dynamic. There is a commitment to the other that does not require reciprocation, although an exchange or dialogue enhances the nurse-patient relationship. It is through the original interaction, in which You (as in reference to another being) emerges in the relationship. When nurses enact an I-It relationship with patients, clients, and families, boundaries form preventing spaces of empathic engagement as I discovered in the data. In

contrast, when they entered into an I-You relationship with others, authentic and relational connection emerges recognizing the humanness in one to the other.

I was surprised to discover that the nurse-patient relationship, although a significant and important aspect of empathic engagement, was not the only relationship that was of value for participants. I did not expect one point that emerged in the data: participants derived more meaning from the relational exchanges with patients, clients, and family members when another person, often emotionally close in relationship to the participant, becomes involved in debriefing of the experience. From that finding, I have come to understand that, not only does empathic engagement require another to be involved with one-to-one interactions, as with the nurse-patient dynamic, but also that a closer relationship with another helps the participant unpack the experience to deeper levels of understanding. I will return to this point further in this chapter where I discuss implications for adult learning and pedagogy.

In Figure 1, I provide a visual representation of the integral relationships required for the development of empathic engagement for nursing students. The participant is central to relationships with patients, clients, or family as well as in relation with another such as an instructor, family or close friend who has knowledge about the intricacies of the health-illness spectrum, or even me, as the researcher. Within each relational dynamic there is a liminal space where empathic engagement may emerge.

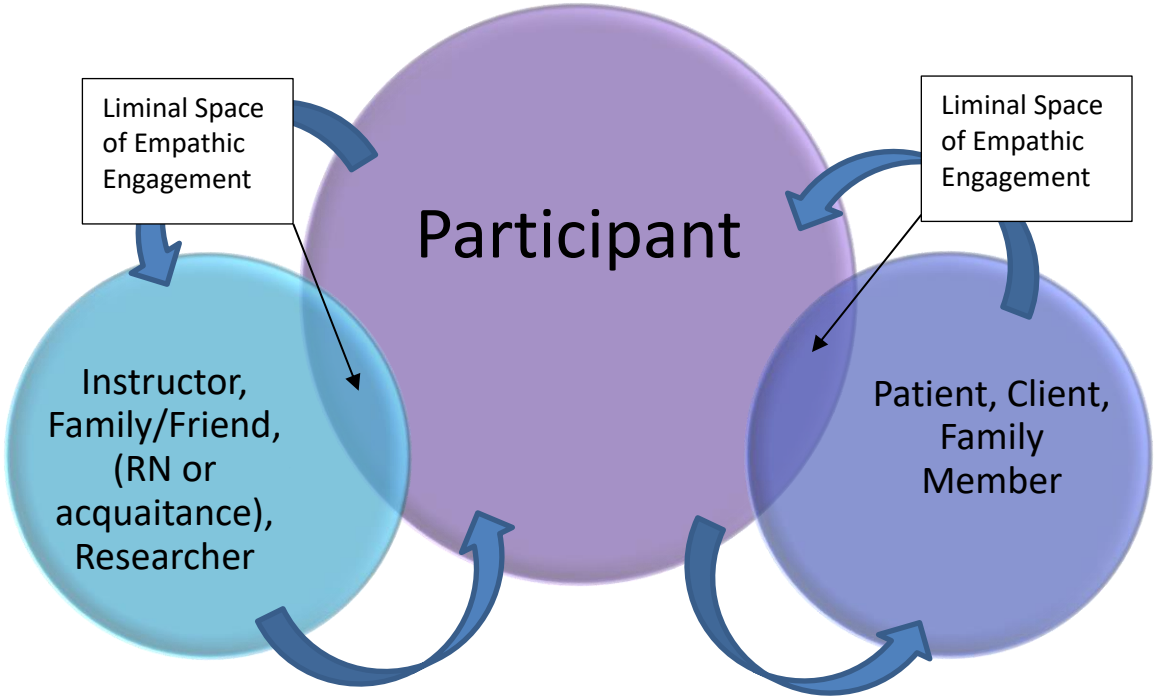

Figure 1: Integral Relationships Required for Development of Empathic Engagement Among Nursing Students

Upon closer review of the data, I noted that two of the seven participants were able to reflect independently and derive some initial meaning from their experiences of empathic engagement and relational connection. Four participants developed deeper meaning from experiences when they discussed the context of the patient situation, and any emotions that arose from that interaction, with another person. One participant was able to acknowledge having developed spaces of empathic engagement in both personal and professional life, a phenomenon that helped her develop coping strategies and appropriate boundaries with patients, clients, and families. Each participant commented about having access to another person that was close in relationship, and had relevant knowledge, such as a mother who also happened to be a registered

nurse, a close friend who was a nurse, instructor, preceptor, or me, as not just the researcher in this study but also a previous instructor. All participants indicated during their final one-on-one conversations, the discussions between participant and me enabled each of them to derive deeper meaning about their experiences with empathic engagement. Although some participants were able to seek out debriefing opportunities at the time of their experience with empathic engagement, others had not fully unpacked their experiences until they participated in the study.

Through dialogue with me, participants identified deeper understanding of their own bias, judgments, personal practice, emotions associated with death, addictions, abuse, regrets, loss, identity, and family dynamics. Siegal (2012) concludes there are three facets of interconnectedness and process in human relationships, referred to as the triangle of well-being: 1. One point includes sharing between individuals and quality of relationships, 2. There are neurobiological aspects of how people perform, relate, achieve, feel, and behave which has a direct effect on relationships with others and self, and 3. Finally, the degree to which the mind regulates the flow of energy and information impacts not only the body but also within relationships with others. It was through the interconnectedness of relationship where participants in the study were able to not only develop and find meaning within relationships with their patients, clients, and families, but also with another person. These relationships with others, helped to reveal hidden meaning from the experience. In relationship with another, participants discovered shared meanings of space, similar experiences, and a reciprocation of meaningful connection. Once again, I see in you what I see in myself.

According to Buber (1970), there are three basic spheres of how individuals relate within and to the world: “First, his relation to the world and to things, second his relation to men- both to individuals and to the many- third, his relation to the mystery of being which is dimly apparent

through all this but infinitely transcends It" (p. 177). Buber addresses that individuals are in constant relationship with their physical environment all that is present within that environment, in relation to others, and finally in relation to the complexity of human connection.

Through the study, participants could be seen as developing a relationship with the world through dialogue with others. As Decety (2011) identifies, "Conversation helps to develop empathy, for it is often here that people learn of shared experiences and feelings" (p. 96). It is through the sharing of experiences where social construction of knowledge emerges. This study is a bringing together of individual experiences to a shared understanding of empathic engagement. As Mercedes stated at the beginning of our first one-on-one conversation, "When you came to talk to us about it [empathic engagement] in my seminar, I kind of completely related to stepping into that space . . . I definitely think everything you were saying I could completely relate to that."

***Power of narrative*.** This research was grounded in narrative whether, verbal, written, or visual. Moreover, there was something very powerful I noticed as a researcher as I began to analyze and disseminate the importance of this work. Although unknown to the participants, their stories, experiences, and meaning derived from participation in this study were similar, yet unspoken between one another and to others. The power I speak of is not of dominance, but of centrality in a coming together of sorts. "Stories are the threads of our lives and weave together to form the fabric of human cultures" (Rainsborough & Canning, 2010). It is through the narratives where a "shared narrative unity" (Connelly & Clandinin, 1990, p. 3) exists and a common experience by which personal and new nursing knowledge can be developed. Each participant became a narrator of the co-constructed reality between the participant and patient, client, and family, and then again when their experiences were shared with me, as the researcher.

The power of the narrative illuminates that, even in these isolated and intimate moments between people, the exchanges between participants and another are not that different and nurses are not alone. Gergen (2015) indicates that through personal stories, acceptance and affirming another's "expression, that is, understood and appreciated" signals an area not often discussed as a similar experience (p. 137). There is considerable nursing literature that demonstrates the high incidence of anxiety and depression amongst practitioners (Elsayad, Hasan, & Musleh, 2018; Moss, Good, Gozal, Kleinpell, & Sessler, 2016; Papathanassoglou & Karanikola, 2018; Tito, Baptista, da Silva, & Felli, 2017). Sharing the story of experience in spaces of empathic engagement may help alleviate any moral distress that could be associated with hearing others' story, especially if that story may uncover personal and individual tragedies.

The narrative method, reflective practices of written or visual stories, provided opportunities for participants to re-connect back to their experiences and stories that were significant to their understanding of empathic engagement. Reflective practice is "a process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies in terms of self and which results in a changed conceptual perspective" (Boyd & Fales, 1983, p. 100). In this study, participants not only identified spaces of empathic engagement, but also identified their feelings around those discussions, eliciting an emotional connection and subsequent learning through the experience. Meaning was derived from the reflective practice as well as through the dialogue that ensued in the one-on-one conversations, unpacking the experience and ultimately meaning. Atkins and Murphy (1993) lay out the reflective process required for embodied learning: self-awareness of the event, critical analysis, evaluation leading to new perspective. Through careful examination of self-reflection and dialogue, participants were able to recognize and utilize how their emotions played a role in

finding meaning from experiences of empathic engagement. For the purposes of this study, reflective practices were utilized to re-construct the participants' experiences of empathic engagement which could be viewed from a social constructivist paradigm; however, meaning gained by the participants was achieved through conversation. Participants commented that the reflective practice was helpful to situate themselves and me within their experience but the one-on-one conversations elicited deeper understanding of their role within the patterns of relationship and empathic engagement.

Affirmed Sense of Self

With new knowledge from lessons gained through participation in the study, participants revealed a deeper understanding of how their sense of self and role as a practitioner entering spaces of empathic engagement changed from the beginning, middle and to the end of the study. It was through active participation, Mercedes discovered a personal aversion to taking care of young female patients with addictions. This aversion stemmed from a personal avoidance of females based on their over-dramatized representation of pain. In practice, Mercedes tended to avoid female patients who exhibited similar expressions of pain, despite being treated appropriately. This awareness enabled her to understand why she exhibited less compassion towards these patients preventing her from developing stronger relationships and the ability to move into spaces of empathic engagement.

The constructed reality by new nurses entering the profession includes multiple ways of knowing; how new nurses have been socialized into the culture (Day, Field, Campbell, & Reutter, 2005), self concept of what it means to be a nurse (Hensel & Laux, 2014; Ware, 2008), and identity formation (Andrew, 2012; Benner, Sutphen, & Day, 2010). Through the one-on-one conversations with me as well as the narrative reflection, many participants revealed a deeper

sense of knowledge pertaining to self and how they practiced. A few participants such as Charlotte, Leanne, Suzie, and Laura acknowledged the significant role others, such as a preceptor or instructor, had in their professional development by observing what it meant for positive professional engagement and then mimicking that behavior when on their own.

Other Considerations Associated with Empathic Engagement

Participant data reveals other elements of their experiences separate from relationship with others and with self that require further consideration from the study. At the end of the study, participants recognized specific and unique elements of empathic engagement such as: moving into spaces of empathic engagement requires practice, the nursing culture plays a role in how and when experiences of empathic engagement occur, and finally highlighting experiences of empathic engagement are not always present in all nurse-patient relationships, which does not minimize the care delivered to patients, families, and clients.

Increased Awareness to Spaces of Empathic Engagement

Develops with repeated practice. In this study, participants reported an increase in the cognitive component of phase 2 of recognizing a need to move into a space of empathic engagement and being prepared for where a conversation may unfold. Early in the participants' education and experience, all indicated a particular fear with lack of skill in knowing exactly what to say to a patient, client, or family during conversations about crisis and transition. Closer to the end of their educational program, participants developed a stronger sense of self in knowing that the strength of being present during emotional situations was not because they knew the exact words what to say but to be present with the other reducing their loneliness, fear, and empathically engaging with mutual understanding. Participants identified that as more opportunities began to present themselves in practice, their greatest ability was to sit with the

patient, client, or family physically, emotionally, and spiritually. This ultimately led to enhanced engagement in holistic practice while tending to the humanistic experience. They found an ease in knowing that the willingness to be present and engage emotionally with another was enough. Nothing more was needed from them.

Dewey (1938) argues that, with experience, habits are formed; through the experience of repeated conversations in relation with another. I continue to return to Dewey's seminal work on experience and learning, as it has provided a primary foundation for nursing literature on experiential learning and reflective practice. This was true for participants as they developed a stronger sense of purpose, ability to recognize opportunities for empathic engagement, and increased skills in entering into difficult conversations. Practice with face-to-face difficult conversations proved to be beneficial in helping participants develop confidence. From the start of the study to the end of the study, most participants revealed they felt more prepared to engage in difficult conversation with patients, clients, or families instead of withdrawing and avoiding the situation. Dewey (1938) insisted that a habit helps to form both emotional and intellectual attitudes which add to every experience. The quality of the interaction may be different with modifications to the approach.

Throughout the participant narratives, crucial conversations surrounding topics of loss, regret, sadness, transition, and death occurred within spaces of empathic engagement. Although skills such as communication are often embedded throughout undergraduate nursing programs through an early pedagogy of simulation, the complex dynamics and subtleties of face-to-face interactions cannot be reproduced through engagement in simulations. Participants revealed feeling unprepared to engage in emotionally laden conversations with patients, clients, and families but learned how to develop this skill independent of curricula. A primary implication of

my findings, then is that it is imperative to assist students to develop and recognize when spaces of empathic engagement are potentially helpful or valuable and when it is in the best interest of the nurse to remain physically and emotionally distant from the patient situation. Participants indicated that they tended to feel more comfortable having difficult conversations as their ability to be present with someone in need became more skilled.

Cultural norms can inhibit or enhance spaces for empathic engagement. The nature of social systems has greater influence from sociological research, than nursing research. Properties of social interaction can be defined "as a situation where the behaviors of one [actor] are consciously reorganized by, and influence the behaviors of, another [actor] and vice versa (Turner, 1988, p. 14). Turner (1988) further explained the scheme related to the three elements associated with social interaction: motivational processes, interactional processes, and structuring processes. There is a strong correlation with the influence of social systems and others and how this leads to individual decisions and prosocial behaviors. Based on the data, there was a direct relationship with components of time, unit culture, value of action, and personal values of the participants, that led to or inhibited actions of the participant.

Nursing practice requires social interaction with patients, clients, families, colleagues, and support staff. There are moments in practice, which demands that nurses be more aware, observant, and emotionally connected with the needs of another. As Lipson Lawrence identifies, "Intuitive knowing is one of the most complex and misunderstood ways of knowing" (Lipson Lawrence, 2012, p. 5). This is where spaces of empathic engagement demand more attentiveness and presence of the nurse within the social interaction. Participants reported that they "just knew" they were needed; an intuition that independently developed through experience. Intuition can be defined as, "a way of knowing that transcends intellect and reason" (Vaughan, 1979, p.

10) and “a realization of wholeness which is simultaneously internal and external, it is an event which is both experiential and cognitive” (Blanchard, 1993, p. 10). Participants developed intuitive ways of knowing when to enter into spaces of empathic engagement based on their interpretations and overall assessments of the needs of the patient, client, or family. Those participants who practiced within nursing cultures and units, such as the intensive care unit, palliative care, or street nursing, that placed importance on connection and spaces of empathic engagement, were more likely to engage with patients, clients, and families as it was a supported and often encouraged practice.

Culture and environment played a significant role on the amount of time participants were able to spend with others and ultimately the amount of time necessary to assess a personal need for spaces of empathic engagement. Relationships are socially constructed by the culture (Josselson, Lieblich, & McAdams, 2007) in which they develop, emerge, and flourish, As Roberts (2003) concluded about Dewey’s theory of experiential learning, “people live in a world surrounded by people and other things that are a result of previous human experiences. These combined experiences construct knowledge, as we know it” (p.2). Social interaction and culture are inextricably linked to the value placed on deeper connection with others and less skills focussed. Dewey (1938) stated, "The principle that development of experience comes about through interaction means that education is essentially a social process" (p.58); therefore, nursing practice environments and cultures existing within those environments become socially constructed by the members within that practice space.

During each interaction and through each conversation, a deeper level of knowing and being emerged for the participants. Social constructionism is “always changing and subject to reconstruction” (Rudes & Guterman, 2007, p. 387); therefore, participants were in a continuous

reconstructive phase with each conversation with patient, client, and/or family as well as with me as the researcher.

Empathic Engagement is Not Necessary for All Relationships or for Good Practice

Another key finding of this study is that it would be emotionally exhausting to find spaces of empathic engagement with all patients and in all encounters. These types of intimate and vulnerable connections with people require a deep level of emotional commitment so that, in the context of this study, participants can be prepared to meet the emotional needs of another person on the heal-illness spectrum. Each participant shared with me many situations of relationship, connection, and ultimately, ways in which they moved into spaces of empathic engagement, but not all meaningful, positive encounters required this depth or form of relationship. This in no way diminishes their work and professional effect on their patients but in the end, they were better able to recognize lost opportunities when empathic engagement may have been beneficial, or when it was in the best interests of both their patients, clients, and families and themselves not to move into these spaces. Each participant had varying degrees of relational comfort, knowledge about self, and abilities related to when to recognize and move in and out of spaces of empathic engagement. As well, participants varied in their understanding that not entering into spaces of empathic engagement could be a caring decision, given the situation.

As the study progressed, I was concerned that active participation in the study and being engaged in emotional situations may have increased the potential formation of moral distress leading to job burnout for participants. Burnout is defined as a psychological syndrome consisting of exhaustion, detachment from the job, reduced personal accomplishment (Katsifaraki & Tucker, 2013; Maslach, Schaufeli, & Leiter, 2001). The Canadian Nurses

Association and Registered Nurses Association of Ontario (2010) identified nearly 65.5% of over 7000 nurses surveyed, were experiencing symptoms of nursing fatigue, which has been a contributor to unsafe patient situations. It was further revealed that 25% of that group was leaving the profession. Burnout and nursing fatigue are serious ailments that are to be avoided and with proper training of coping strategies, these symptoms may be mitigated. None of the participants who were involved in the study self-identified with having symptoms of burnout or nursing fatigue, but it should be considered when asking students to be more emotionally involved with patients. Developing boundaries in care is necessary but this skill requires modelling for novice nurses with the overall goal of reducing burnout and ultimately losing skilled and educated nurses.

Could There Be A Possible Neurobiological Connection?

Participants who discovered a shared connection with patients, families, or clients, seemed to also have enhanced spaces of empathic engagement. I began to question why this was the case. Participants who felt a stronger connection to patients with whom they shared experiences than to others, addressed the significance of these relationships in their narratives and in conversation. I reviewed nursing literature and found little evidence to support why nurses connected more with some patients over others. The assumption was nurses were to care for all patients, families, and clients equally, but, based on the results of this study, that was not always the case. Based on my own practice, I knew this to be true as well.

Trying to understand this common behavior amongst participants, I reviewed literature related to social psychology which then led me to review literature based on the neurobiology of social connections. It seems that, within social relationships, there are biological elements which may offer structure as to why participants felt more connected to some patients leading to the

development of empathic engagement. I do not claim to have evidence as to this behavior, but offer possible explanations from other disciplines that may add to the discussion of the importance of relationship within spaces of empathic engagement.

Nursing literature claims positive benefits of developing strong nurse-patient relationships, yet little evidence within the literature provides an explanation as to underlying knowledge of how that develops. Based on the study, empathic engagement cannot occur without relationship. I have already discussed in the literature review the importance of neuroscience in relation to affective and cognitive empathy, as a potential element in the development of empathic engagement. Neurobiological literature may offer further consideration to the social construction of empathic engagement. It is difficult to dismiss the possibility of a neurobiological element in the role of emotional connection and relationships.

Participants discussed openly with me they were more likely to engage with others and enter into empathic spaces if there was a deeper connection through shared experiences, if participants applied a memory or similar personality attributes of someone from their past to the present patient, client, or family, or if participants saw themselves in the patient's, client's, or family's circumstance. It is only my opinion and based on a strong understanding of the human body, the cognitive decision-making process experienced by participants may occur as a result of activated regions of the brain when constructed memories of past relationships are triggered. This result was unexpected and not explored; however, the consistent descriptions by the participants with whom stronger connections were made cannot be ignored. It seems that participants engaged more fully and openly, even if subconsciously, with those of similarity than with those of difference. It was only in conversation, either with me or others, and further

personal reflection where participants began to recognize their own patterns of engagement and how they encountered and responded to empathic engagement.

What is already known in existing neurobiology literature (de Vignemont & Singer, 2006; Decety, 2011; Keysers & Gazzola, 2007; Preston & de Waal, 2002; Singer & Klimecki, 2014), is the existence of a shared pathway between the anterior insula (AI) and the anterior cingulate cortex (ACC) in the brain, that becomes activated as evidenced by functional magnetic resonance imagining (fMRI), during studies that address states of empathy and empathic responses (i.e. pain). Further evidence supports the interconnectedness between the AI, ACC and with the amygdala and hypothalamus of the limbic system (Decety, 2011). In review, the AI receives stimuli from the center of the thalamus which expresses emotional and homeostatic information, then connects to the sensory cortex that is responsible for the subjective awareness of emotional states (Craig, 2002). The ACC participates in the regulation of behavior through the motivation to act (Bernhardt & Singer, 2012). Finally, the limbic system plays a significant role in mediating emotion, motivation, goal-directed behavior, as well as integration of memory and engagement of the attachment system (Siegel, 2012). This may account for the role of emotions at play where participants entered into spaces of empathic engagement and indicates further research is needed to understand this dimension of relationship and how it correlates to empathic engagement.

It is important to address the possible connection between emotion, relationship, action, and empathic engagement. When participants developed relationships with patients, clients, and families, as in phase I, previous social experience of relationship emerged, eliciting deeper emotions related to the situational circumstance of each patient, client, and family member. For example, Suzie connected with the brother of her patient in how he addressed the patient's issues

with addictions; Anastasia connected with her patient's terminal cancer diagnosis, Leanne connected with the correlation of her patient and grandmother. These now-emotional connections increased the propensity for each participant to be more aware of the verbal and non-verbal cues of their patients, leading to empathic concern, cognitive empathy and empathic action. This could explain the behavior patterns of participants as they moved from phase II into a space of empathic engagement. As evidenced by participant themselves where they did not engage empathically with patients, families, or clients, many of the nurse-patient relationships lacked an emotional connection or shared experience which could not replicate a neural connection either. The participants still cared for those where they did not enter into phase III, providing competent care, but these encounters just lacked the potential for empathic engagement.

Is there a Problem with Experiential Similarity?

In my analysis, I presented a structured perspective associated with participants' experiences of empathic engagement; however, I acknowledge that not all nurse-patient relationships may fall within these patterns of experience, even if individuals involved still find meaning within the relational dynamic. I do not propose that all relationships must have elements of empathic engagement in order for them to be fulfilling and meaningful. This would be an oversight into the complexity and fluidity of relationships found within the heath-illness spectrum. My intention in this study is not to provide absolutism or a primary method of empathic engagement. I present these findings to initiate a dialogue about the possibility that these intimate spaces of relational engagement may occur and to develop awareness into possible patterns of communication between people. It is problematic to align relationships as singular in nature. I maintained throughout this study that complex nuances exist with the nurse-patient

dynamic and the liminal spaces of empathic engagement. Based on the participants' experiences with empathic engagement, I recognized similar patterns which may be related to this group.

Implications for Education/Teaching, Professional Practice, and Scholarship/Theory

There is significant importance in addressing curricular discussions surrounding the topic of empathy and empathic engagement in undergraduate nursing programs. Professional licensure bodies across Canada such as College and Association of Registered Nurses of Alberta (2013) and College of Nurses in Ontario (2014) indicate empathy is a component of professional behaviour as demonstrated by registered nurses and is included on the entry-to-practice competencies for registered nurses in each of the respective provinces. Empathic engagement is an extension of empathy in practice. A primary intent of the study was to open up a discussion and include more conversations about the humanistic qualities of nursing practice in correlation with the concrete skills and knowledge acquisition of nursing programs.

Implications for Teaching

Findings from this study offer insight into spaces of empathic engagement. Educators and students may begin to recognize potential opportunities to foster these spaces of relationship within clinical and classroom environments, define what that constitutes for personal meaning and professional practice, and finally discuss openly when students and educators did not enter into spaces of empathic engagement.

One of the key findings from this study demonstrated that participants were more inclined to enter into spaces of empathic engagement where there was a connection with past relationships or a shared experience; however, I postulate, does connection between one human being to the other only occur when there is sameness and not when there is difference? This discovery from the data opens up a new space for discussion around how to address indifferences

in nursing education and not just through the comfort of similarities or shared experiences. Finding a connection through communication is a skill set novice nursing students are encouraged to explore with patients, clients, and families. It is important to acknowledge the differences as well. If difference is a deterrent to enter into these spaces of empathic engagement, then is something lost within the nurse-patient dynamic? It seems important that educators build into curriculums, a capacity to address and bridge connection between students with patients, clients, and families where there is uniformity. Throughout the data, the theme of sameness was reflected in the participants' narratives which is a reflection of my own biases about connecting with others in practice.

It is through conversation and debriefing where education can address implications for practice and student development. At the end of the study, participants addressed how participation in the study impacted their attentiveness and mindfulness to self and in relation with others. Educators have a responsibility to create a safe space for learning in order to openly discuss similarities, indifferences, and how this affects nursing practice impacting patient outcomes.

Results from this study, are needed to inform undergraduate nursing education curricula pertaining to the difficult nature of human experiences which nurses encounter daily. Educators can make assumptions that students are emotionally prepared to navigate difficult conversations or have proper coping strategies as they encounter intimate and emotional clinical experiences. This study highlighted the complex nature of relational work in nursing, where students encounter difficult human experiences without proper emotional support in place from their education program or their educators. Debriefing of the experience helped to inform meaning for the participants in this study, but it would be negligible to assume that an inexperienced or

experienced educator, may also cause a trigger for students leading to vicarious trauma, burnout, anxiety, or mental health concerns. Faculty need to consider how curricula could address and reduce potential implications as novice students move to professional practice.

It is important to consider the pedagogical and curricular implications as students encounter spaces and experiences of empathic engagement. There may be positive and negative outcomes for students as they enter into this type of relationship with a patient, client, or family. Spaces of empathic engagement have potential professional impacts for novice nurses; therefore, I would suggest offering opportunities such as mindfulness-based stress reduction in nursing curricula for faculty and students scaffolded throughout an undergraduate nursing program. Further research would be needed to address spaces of empathic engagement in undergraduate nursing curricula as well as addressing a need for students to be emotionally prepared to encounter difficult nature of nursing practice.

Implications for Professional Practice

Participants of this study engaged in clinically emotional situations such as death, suicide, homelessness, sexual assault, and transition with patients, families, and clients. Despite the mature perspective of these participants as they encountered intimate experiences of empathic engagement, I am reminded that they were only fourth-year nursing students and not seasoned nurses. Benner (1984), classifies nurses as entering one of five stages of skill acquisition: novice, advanced beginner, competent, proficient, and expert. As nurses encounter new experiences throughout their professional career, they enter into these stages just as the participants had encountered experiences of empathic engagement in this study.

In retrospect, I had not considered the vicarious trauma that participants may encounter while participating in the study. I did not have proper resources in place as participants restoryed

intimate and meaningful experiences with patients, families, and clients. Although participants did not report inabilities to cope with their experiences, the purposeful revisiting nature of the study design, could have a negative impact on the participants. In the future, the ethics of this type of research must be considered by researchers.

It is important as an educator to address the potential risk for nursing students as they encounter difficult experiences during clinical and theoretical learning spaces. Unknowingly, there may be triggers for students throughout undergraduate education prompting an inability to cope leading to increased levels of anxiety, mental health concerns, and burnout. There is a responsibility by educators to include within curricula coping strategies and tools to enable novice nurses with resources as they progress through Benner's stages of skill acquisition. Novice nurses entering into professional practice must be prepared mentally to cope with difficult encounters nurses face daily.

There is more to be learned about empathic engagement and how these spaces impact nursing education, students, and implications for practice.

Recommendations for Scholarship and Future Research

More research is needed to address how empathic engagement could be implemented in nursing programs as this study was only preliminary work. I propose several potential future research studies building on the work that I have presented in this dissertation. Future studies might focus on developing more insight about empathic engagement with a curricular and adult learning focus in an undergraduate nursing programs, implications for pedagogy, closer examination of patients and other health care providers experience, and interdisciplinary work increasing the scholarship of teaching and learning with empathic engagement. Future research might address methods of instruction to embed empathic engagement in undergraduate nursing

curricula; how is empathic engagement experienced by nursing educators and students in both clinical and classroom environments; what is the experience of patients and other health care providers with moments of empathic engagement; how do moments of empathic engagement occur in other practice disciplines such as social work, education, and medicine; and finally, a closer inquiry as to the neurobiological processes at play in the development of empathic engagement.

Undergraduate nursing education programs have a responsibility to include content pertaining to the humanistic qualities required for nursing practice. This study is an introduction to empathic engagement and how elements of the empathic engagement can be explored in nursing education; therefore, a closer inquiry as to how to embed discussions pertaining to empathic engagement in undergraduate nursing curricula would be helpful. Modes of communication and relational skills are taught early in nursing programs such as circular communication, open-ended questioning, developing listening skills for assessment purposes, and addressing difficult conversations. Future research could look at introducing empathic engagement as it is associated with communication and relational skills and then following student development, if at all, of this skill as the student progresses through the program. Independent studies could review at what point in nursing curriculums would a discussion about empathic engagement occur, if the best time would be when communication and relational practices are introduced as content. Results from this study could inform the development and skills associated with how students take up and move into spaces of empathic engagement.

Nursing educators play a significant role in developing nursing students within a classroom and clinical environment. Future research could review how empathic engagement is experienced by nursing educators and students in both clinical and classroom environments. I

would review how empathic engagement is taken up by nursing educators individually, nursing students individually, and then a combined inquiry of nursing educators in conversation with nursing students. Gillian concluded that empathic engagement does not just happen between nurse and patient, it happens in every day life as well. I am curious if spaces of empathic engagement occur between nursing educators and students, and what can be learned from this type of relationship. Results from this study would inform nursing pedagogy.

At this point in understanding empathic engagement, this study addressed only the experience of a student. What is missing from the conversation is the experience of patient and other health care providers. I would be curious to discover what is the experience of patients and other health care providers with moments of empathic engagement. From this study, participants were able to connect with experiences and spaces of empathic engagement. Results from this study would inform if empathic engagement is partially experienced or if both individuals experience something unique from the relational exchange.

Nursing is not the only practice discipline where relationships significantly impact the work. I would be curious to learn how do moments of empathic engagement occur in other practice disciplines such as social work, education, and medicine, if at all, and how students in these disciplines come to understand and find meaning with empathic engagement. Would the evidence be similar or different to how nursing participants took up the concept of empathic engagement? This proposed research could inform opportunities to develop training programs related to the patterns of experience of empathic engagement, coping strategies, and navigating difficult conversations for students. Results from this study would explore a possible interdisciplinary connection between service professions.

Finally, in this study I introduced how there may be neurobiological processes at play in the development and performance of empathic engagement. I am curious to see how regions of the brain are activated when participants encounter spaces of empathic engagement. Would similar regions of the brain such as the amygdala and hypothalamus be activated as in the case of experiences of empathy alone? Results from this study would inform if there are neural pathways associated with empathic engagement.

Researchers who take on this type of qualitative work, must be sensitive and aware of the ethical considerations when working with students in the context of emotional clinical experiences. Proper supports must be in place throughout the study as students encounter potential triggers. I assert that this work is important for understanding nuances of relational experiences in nursing education; however, caution should also be exercised when addressing the intricacies of student experiences.

A Moment of Reflection: "*From One Version of Myself to Another*?"

As this study comes to an end, I reflect back on my role as an educator and as a researcher. In the beginning, my intention was to explore only the spaces of empathic engagement; however, I have learned more about the dynamic of empathic engagement as a whole as opposed to only the liminal state of empathic engagement and empathic engagement is not static but a co-constructed reality between two people. My own participation in this study has impacted me as an educator and as a researcher.

As an educator, I am more mindful of my physical, emotional, and cognitive presence in relation to others but also my role to help students and colleagues discover what is meant by entering into spaces of empathic engagement for practice and personal growth. I am more aware

of the intentional connections I create with students and the possibility to enter into spaces of empathic engagement. In reflection, I recognize when external elements such as time and environment may impede my ability to move into these spaces and also when it is not necessary to enter into these spaces with every person during every relational exchange. I am more aware of how I address indifferences with students and colleagues in order to address the I-You in relationship versus I-It. This has provided me with enhanced meaningful discussions with students and colleagues, that I may have avoided prior to the study.

As a researcher, I have become an observer of the world. Participants invited me into their experiences of finding meaning with empathic engagement for the purposes of the study. I find that I am actively engaged with others in conversation listening for the existence of patterns of experience that align with participants' experiences of empathic engagement. I am curious of similarities and inconsistencies between narratives associated with empathic engagement. The complexity of these spaces related to nurse-patient relationships and nurse-other relationships provided me with an external view of the world. Spaces of empathic engagement are not limited to health care professions but offer possibilities to how each of us is in relation to others in every day existence. I catch myself during daily life trying to spot spaces of empathic engagement with others.

I have been changed as an educator, a researcher, and as a person now that this study has come to an end. Although I have more questions about empathic engagement and spaces of empathic engagement, I look forward to where my research and personal growth will take me.

Limitations to the Study

One limitation of the study was that all participants were female. Sadly, gender stereotypes remain in undergraduate nursing programs where the number of female students is much greater than the number of male students; however, there is research addressing this discrepancy (Dyck, Oliffe, Phinney, & Garrett, 2009; Kouta & Kaite, 2011). It would have been interesting to see whether and how male participants experienced empathic engagement and found meaning from experiences of empathic engagement. Dyck et al. (2009) discovered that male nursing students felt at a disadvantage in nursing programs where emotional learning was emphasized because they believed that such an approach interfered with their learning preferences for task achievement over emotional expression.

In this study, participants developed different degrees of meaning from their experiences with empathic engagement and results may be limited to only these participants. Results from the study illustrate that not all participants had the same experiences with empathic engagement, either by choice or as the situation presented itself. Participants' experiences were individual as was the meaning garnered from participating in this study. Although many participants felt the study had merit and provided a title to an experience that had none before, not everyone found value in the experience.

It is difficult to provide empirical truth and validity. In the study of human experience and relationships, there is not one idea of truth that can be universal "for all people, at all times", but multiple truths, which "are useful ways of communicating for various peoples at various times" (Gergen, 2015, p. 12). Truth is as the participants found individual meaning through their experiences. The work of qualitative studies, such as this, rooted in social constructionism can be determined meaningful and valid by the experience and verbalization of individual participants.

Empathic engagement is not just limited to nursing practice, but as one participant communicated to me, “it occurs in every day life.” These spaces of relationship do not occur in just professional nurse-patient relationships. This study only viewed experiences of undergraduate nursing students which leads me to wonder if similar service professions in health care such as medicine, would offer the same results. Are spaces of empathic engagement necessary for effective practice in medicine and nursing professions? I have proposed future research to inquire whether students in other service professions have similar or different experiences.

The sample size of this study was small, but manageable for the methodology and time required for completion. With such a small sample size, I was only able to review seven participants and their experiences. I wonder if experiences would be similar and if I would draw the same interpretations with a larger sample size. This would be an interesting perspective to compare results.

The Faculty of Nursing at the University of Calgary, where the study took place, has two streams of entrance into the undergraduate nursing program: admission for students directly out of high school entering post-secondary education and students with previous degrees or transfer students from other post-secondary programs. The participants of the study all had previous degrees; therefore, they would be older than a direct entry student who would have participated in the study. A limitation, based on this fact, only focussed on degree and transfer students. With limited time, I wonder if the results would be similar or different if the participant sample group had both direct entry students and degree/transfer students.

A primary limitation to narrative inquiry as a methodology places researcher bias as a consideration throughout the study. Narrative inquiry is a relational process which involves

narratives from participants, narratives of patients, families, and clients, woven with my own stories of practice. I cannot completely eliminate myself from the process of story telling; however, I recognize that my interpretations involve my own biases as well. This is the reality of conducting narrative inquiry in that researcher biases may be present and should be acknowledged as part of the analytical process.

Upon reflection, data may have been enhanced if participants were asked to define empathic engagement as opposed to a loose definition already provided to the participant at the time of recruitment. I may have guided and primed participants' thoughts and memories, potentially leading them to draw conclusions based on my own biases and experience. They may have reflected on their own experiences with empathic engagement in a different manner rather than identifying with sameness as it was defined by the provided definition.

For this study, I chose thematic analysis as a particular analytical approach, which has been used in other nursing research. There are many analytical approaches available to narrative inquirers such as Clandinin and Connelly's (2000) three dimensions of space analysis which includes: backwards/forward, inward/outward, and situated in space. This approach may have presented new information of empathic engagement, in a way that is unique only to the particular analytical approach utilized during analysis. By using one approach as opposed to another, allowed me, the interpreter, to focus on some aspects of the data, while pushing other aspects of the data out of focus.

A limitation associated with conducting research with past students, potentially created an ethical complexity. Participants provided their time, shared their experiences, and revisited experiences of their practice that may have been emotionally difficult. I am aware that despite an official teacher/student relationship has ended, the educator continues to remain in a power

differential. One example may be if a participant had requested a reference letter based on their involvement in the study. Establishing specific boundaries of professional relationships needed to be explicitly defined early on in the study process. Although, participants provided rich and intimate experiences of empathic engagement, I remain cognizant of the complex nature of doing work with past students.

One final limitation in the study was this group of participants were from the same cohort of degree/transfer students. This could account for a specific social construction of values, ethics, cultural and social norms, and doctrines at play given a generally similar undergraduate experience. Identifying how different years of student cohorts have different experiences with empathic engagement would be an interesting future research endeavor; however, it is important to keep in mind that this group of participants was educated under a similar program philosophy.

Conclusion

The impetus to study empathic engagement started from a place of curiosity. Based on my own experiences working with patients and families from the ICU, and now as a nursing educator, I began to observe similar experiences between nursing students and their patients and families. Just like me, they knew that a unique and special nurse-patient relationship had developed but did not have anything tangible to label the experience. This is where my inquiry into learning from fourth-year nursing student participants in how they come to understand, encounter, and respond to relational experiences of empathic engagement became the focus of this study.

Participants who self-volunteered, were asked to meet with me at the beginning and end of the study for one-on-one conversations to discuss their experiences with empathic engagement. Between the one-on-one conversations, participants were asked to develop a

narrative of their choice based on their experiences. I received both written and visual narratives in the forms of photography and a painting, describing how they encountered spaces of empathic engagement in their undergraduate nursing program.

It was during analysis where I started to interpret patterns of cognition and behaviors associated with how participants approached, performed, and reflected on empathic engagement. From these patterns, four phases of empathic engagement emerged in the data. These phases are specific to the experiences of these participants as they encountered empathic engagement with their patients, families, and clients. It was important to me to sit with the data and organize the phases based on the participants' experiences. The four phases provide a sense of structure to the grey and often dynamic space of relationship with a beginning, a middle, and an end within the experience.

The results of this study contribute to a discussion about the concept of empathic engagement and the relationship to nursing episteme, advancing consideration of the topic nursing discourse, and highlights the intricate and often complex, nuances of the nurse-patient relationship. A central concluding point is that nursing curricula and nursing educators can emphasize humanistic elements of empathic engagement, based on its four phases, and discuss the importance of building spaces for all of those phases in practice. Further research can inquire about a possible correlation between the neurobiological factors of empathy in relation to empathic engagement. Other research endeavors with service- based disciplines such as education, social work, and education, may provide further evidence of how others find meaning with empathic engagement and come to understand the role empathic engagement plays in relationships with others.

There is more we can learn from spaces of empathic engagement and what is at play for nursing education, teaching, practice, and scholarship. My goal from this study is to address a humanistic element of nursing practice that is often unseen but felt during practice and with limited literature to support what is known about empathic engagement. A study such as this, is needed to contribute to knowledge pertaining to empathy in nursing practice but opening a dialogue that nursing educators can learn more from the communication and relational practices that govern how nurses relate to patients, and within the health-illness spectrum. Drawing from other disciplines such as social psychology and education, there is much that can be applied to nursing education and practice now and for the future.

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Appendix A: Semi-Structured Interview Questions

1. Why did you feel drawn to participate in this research study?
2. Can you tell me about your experience with empathic engagement?
3. Why was this experience meaningful to you?
4. How did you come to recognize that this experience could be classified as empathic engagement?
5. What was the process you used or did you use any, to engage in reflection with the story?
6. Did you speak to anyone about this experience? If so, what did you talk about? What was the context of this discussion?
7. Has this experience of empathic engagement altered how you choose to practice? If so, please explain how this has affected you as a nurse?
8. Is there anything else that you feel was missing from this discussion about empathic engagement? Please add it at this time.