Nursing rituals serve many important functions both practical and social. They demonstrate nurses’ commitment to patients, families, and each other, and are rooted in the values of caring and respect for human dignity that are fundamental to the practice of nursing. This text examines a variety of nursing rituals in the context of caring science and evidence-based practice, and demonstrates how understanding and incorporation of such rituals can have a transformative effect on contemporary nursing practice. It is written for undergraduate and graduate faculty and students, and is consistent with the integration of the liberal arts into nursing education as per AACN’s New Essentials of Baccalaureate Education.

The text explores the history of nursing rituals and the symbols, meanings, and overall usefulness nursing rituals can convey to the profession today. These rituals offer a window into the art of nursing that runs beneath the surface. The book examines rituals that take place in nurse-to-patient direct care situations, in nurse-to-nurse relationships, and those that mark the transitions into the professional nursing role. Rituals addressed include those used for bathing patients, postmortem care, ritualistic prevention of medication-related errors, rituals of socialization, and nursing ceremonies. Nurses’ association with sacred and profane aspects of life is also explored. For example, bathing patients and postmortem care involve nurses’ contact with bodily products considered profane, yet their work with people is sacred. Each ritual is accompanied by a description of its background, related traditions, ritual initiation, artistic aspects, evolving research, and symbols.

Key Features:
• Presents a history of nursing rituals and their significance, past and present
• Incorporates evidence-based research and an emphasis on caring theory
• Demonstrates how understanding and incorporation of nursing rituals can greatly enhance nursing care today
• Includes rituals for bathing patients, postmortem care, prevention of medication errors, interpersonal rituals, and nursing ceremonies
Exploring Rituals in Nursing
Zane Robinson Wolf, PhD, RN, FAAN is dean emerita and professor, School of Nursing and Health Sciences at La Salle University, and returned to full-time teaching in the fall of 2012. Her courses include nursing research, patient safety, evidence-based practice, and caring, and she continues to conduct qualitative and quantitative research on medication errors, nurse caring, nursing education concerns, and other topics. Dr. Wolf practiced as a critical care and medical-surgical nurse and has worked in nursing education, teaching in diploma, associate, baccalaureate, master’s, and doctoral nursing programs and was also the associate director of Nursing for Research at Einstein Healthcare System. Dr. Wolf is a board member of the Institute for Safe Medication Practices and a member of the patient safety committees of St. Christopher’s Hospital for Children and Fox Chase Cancer Center. She is a board member of the Pennsylvania State Nurses Association and also reviews manuscripts for various nursing and health care journals. Dr. Wolf has been an editor of the International Journal for Human Caring since 1999 and a former board member and past president of the International Association for Human Caring having hosted three International Caring Conferences in Philadelphia. The Christine E. Lynn College of Nursing at Florida Atlantic University honored her by designating her a “caring scholar” and is a member of the Anne Boykin Institute for the Advancement of Caring in Nursing.
Exploring Rituals in Nursing
Joining Art and Science

Zane Robinson Wolf, PhD, RN, FAAN
I would like to thank my husband, Charles J. Wolf, MD, and colleagues at the School of Nursing and Health Science at La Salle University for their steadfast support. I also appreciate the ongoing support of the Christian Brothers of La Salle University and the blessings of my fall 2012 sabbatical. The staff at Springer Publishing Company have guided and encouraged me throughout this endeavor, including Elizabeth Nieginski, Chris Teja, and Alan Graubard, formerly of Springer. I am grateful for all that I have learned from my undergraduate, graduate, and doctoral nursing students.

This book is dedicated to the nurses and women in my life who have encouraged and sustained me. The art included in this book was found in the nursing journal, The Trained Nurse, that was subsequently named The Trained Nurse and Hospital Review. The art was published before 1900.

Zana Ellen Robinson
Gale Robinson-Smith, PhD, RN
Elise Robinson Pizzi, MSN, CRNP
Jessica Wolf Dasher, MPH
Ciara Anne Dasher
Rory Ellen Dasher
Zana Cecelia Wolf, MS, MBA
Leslie Robinson Jarrell, MD
Gwynneth Leslie Jarrell, BSN, RN
Azadeh Khodabandelou Jarrell, BS, RDMS
Kelly Jo Gastley Wolf, JD
Elizabeth Celia Wolf
Keven Mara Robinson, MD
Nicole Albano Robinson, BA
Lindsay Jones Pizzi, BA
Julia Peoples Robinson, MD
Nora Leslie Robinson, BS
Kerry Cornforth Robinson
Elaine Beldyk Siebold, BSN, RN
Sharon Creamer Murphy, RN
Patricia DiVello Ford
Kathleen Harrigan Czekanski, PhD, RN, CNE
Barbara J. Hoerst, PhD, RN
Denise Nagle Bailey, EdD, MEd, MSN, RN, CSN
Mary T. Dorr, MSN, RN
Karen Rossi, MSN, RN, ACNS-BC
Patti Rager Zuzelo, EdD, RN, ACNS-BC, ANP-BC, FAAN
Sister Rose Carmel Scalone, EdD, MPH, BSN, RSM
Anne Boykin, PhD, RN
Kathleen Valentine, PhD, RN
Marian Turkel, PhD, RN, NEA-BC, FAAN
Renee C. Fox, PhD
Jean Watson, PhD, RN, AHN-BC, FAAN
CONTENTS

Foreword Jean Watson, PhD, RN, AHN-BC, FAAN xi
Preface xiii
Prologue: Rituals in Nursing: Underpinnings and Importance xv
   Ritual Foundations, Definitions, and Elements xvi
   Nursing Literature on Ritual xxvi

SECTION I: RITUALS OF NURSING PRACTICE

1. Interpersonal Caring Ritual and Interpersonal Relationships 3
   Nurse–Patient Relationship: Opportunity for Caring and Ritual 5
   Traditions, Beliefs, and Definitions 8
   Interaction Ritual and Interpersonal Caring Ritual 9
   Caring Theories as Framework for Caring Ritual 9
   Relationship and Ritual 13
   Initiation to Interpersonal Relationships 14
   Artistic Interpersonal Relationships 16
   Research on Caring Relationships 17
   Interpersonal Caring Ritual and Symbols 17
   Summary 25

2. Bathing Patients: Nursing Ritual in Transition 27
   Traditions, Beliefs, and Definitions 29
   Bodywork and Dirty and Clean Work: Pollution and Purification 32
   Initiation to Bathing Patients 33
   The Art of Bathing Patients 35
   Research on Bathing and Hygienic Interventions 37
   Baths, Bathing, and Symbols 37
   Summary 57
3. **Postmortem Care: The Last Nursing Care**  59  
Predicting and Caring for Patients in the Last Hours of Life:  
Immediate Context 62  
Traditions, Beliefs, and Procedures 64  
Initiation to Postmortem Care 67  
Artistic Performance 70  
Postmortem Care as Bodywork and Dirty and Clean Work: Pollution and Purification 71  
Summary 80  
Appendix A: Excerpt From Tudor (1890) 81  
Appendix B: The Body Flute 81

4. **Medication Errors and Medication Administration: Ritualistic Prevention**  85  
Traditions, Beliefs, Practices, and Definitions 87  
Initiation to Medication Administration 89  
Art of Medication Administration 91  
Research on Preventing Medication Errors 92  
Medication Errors: Ritual Objects as Symbols and Ritual Protection From Error 92  
Summary 108  
Appendix A: Affirmation 110

**SECTION II: RITUALS OF SOCIALIZATION**

5. **Change-of-Shift Report: Rite of Passage for Professional Nurses**  115  
Traditions, Beliefs, and Definitions 119  
Initiation to Change-of-Shift Report 123  
Artistic Performance of a Change-of-Shift Report 124  
Research on Change-of-Shift Reports 125  
Change-of-Shift Reports and Symbols 125  
Summary 140

6. **Nursing Ceremonies: Transitions Into and in Celebration of Professional Nursing Work**  143  
Nursing Ceremonies as Initiations 145  
Nursing Ceremonies in Celebration of Nurses’ Work 150  
Other Recognition Events 152  
Summary 154  
Appendix A: Nightingale Pledge Revised 155  
Appendix B: Nightingale Pledge 155  
Appendix C: VA Maryland Health Care System Observes National Nurses Week With Awards Ceremony 156
FOREWORD

It has been noted that we need a revolution of rituals in our world today: the world that now presents us with disconnections, discontinuous and asynchronous communication and relationships; separation of meaning from experiences; transcendence of time, space, and physicality; and no distinction between data and information, information from knowledge. We are often left bereft with little or no understanding and no space or place for wisdom. Nursing rituals offer a human reprieve and refuge that helps us unite, tying together our separate parts reconciling the sacred and the profane, the intimate with the cold impersonal, offering a ground of purposive action in an otherwise abyss of human and clinical, professional and scientific, technical complexities.

Zane Wolf is an expert in translating and grounding theory and abstracts into understanding and revealing critical practical rituals that stabilize us and our practice world; she helps us to integrate the personal with the professional.

Through Dr. Wolf’s comprehensive approach to helping us understand and integrate rituals, we recognize clinical rituals as important pointers that translate theory into purposeful, intentional, conscious art acts. Rituals serve as critical reminders, as anchors of personal intimate experiences and actions. Rituals serve as ceremonial acts, as turning points for celebration, or as guiding actions of passages of time and life moments. When we integrate rituals and understanding of purposeful rituals into our life and our clinical practice, we allow for smooth and purposeful life processes and transitions. Rituals help us to let go, opening to new, passing certain thresholds of life experiences, traumas as well as traditions.

Rituals in nursing are memory making, giving new directions for concrete practices. This book examines ritualistic meanings, symbolic interpretations, along with the overall role rituals play in an otherwise chaotic world of care.

Nursing rituals continue to be performed as timeless acts that stabilize the complexities of tumultuous care. They remain in the private inner world of nursing care, serving significant and important symbolic functions to honor and sustain basic human care needs at personal, professional, social, and
cultural levels, providing respites in the midst of an otherwise impersonal institutional darkness.

Rituals comingle with science and theory. They provide an inner private intimacy to the impersonal, often cold and detached professional clinical gaze of health and sick care, of birthing and dying practices. Nursing rituals take place in nurse-to-patient, human-to-human intimate care moments and personal situations. Dr. Wolf’s work highlights the sacred and profane nature of nursing.

This updated, scholarly, and wise view of classic nursing rituals incorporates theory with evidence-based research. The structure of the book moves from the background of the importance of rituals, to exploring the interpersonal artistic expression of rituals via several caring theories, for example, Paterson and Zderad; Watson, Boykin, and Schoenhofer; and Halldorsdottir.

This comprehensive text captures the vast nursing rituals and their traditions; such commonalities as bathing; bodywork; postmortem care; medications administration including rituals of safety and error prevention; and notions of confession, disclosure, and reporting of errors, all highly ritualized in their function and purpose.

Other rituals are identified and uncovered, such as socialization into the profession, and rites of passage are identified, named, and explored for us as the reader learns to be more cognizant and conscious of how we use ceremonial rituals. We have rituals for entrance into the profession, its traditions, beliefs, and customs, often taken for granted, but not illuminated.

And finally, in a most updated social and professional view of nursing rituals, this book helps us celebrate our own ceremonies across time such as capping, pinning, senior programs, and nurse practitioner ceremonies. However, the most interesting final touch is recognizing national ritualistic ceremonies such as the celebration of National Nurses Week and nurses’ work and scholarship, highlighted by American Academy of Nursing’s induction ceremony. This ceremony is perhaps the pinnacle of a mature discipline and profession for the ancient and timeless, yet very contemporary, profession of nursing. This mature and evolving profession of nursing, in the end, with all its transition and change, lives by ritual.

This work helps us to critique, to awaken to our history, our traditions, and our gifts to sustain human intimacy and professional practice we can recognize and intentionally integrate. Through this deeper understanding and uncovering of rituals, we can more fully celebrate the beauty of concrete nursing rituals that keep us whole and holy, even in the midst of the profane.

I am honored and privileged to participate in the ritual of endorsing this special scholarly work as a collection in Watson Caring Science–Springer Caring Science Library collection. This ritual practice and publication of the Caring Science Library will keep alive classic and timeless caring science literature for past and future generations. This work is one of them.

Jean Watson, PhD, RN, AHN-BC, FAAN
Founder/Director Watson Caring Science Institute
Distinguished Professor and Dean Emerita
University of Colorado Denver, College of Nursing
www.watsoncaringscience.org

xii

Springer Publishing Company, LLC
Rituals in Nursing examines nursing as a cultural system through purposeful reflection on selected nursing rituals. Almost inadvertently, the book brings nursing issues, trends, and roles into focus. It is a reexamination of nursing rituals in the context of professional nursing practice and continues my fascination with the topic that began with my dissertation at the School of Nursing at the University of Pennsylvania. An implicit subtext throughout the book is my conviction that nurse caring is essential to patients, families, and colleague nurses. As a reexamination of rituals in nursing, the chapters in the book bring forth some of the hidden, symbolic meanings of nurses’ work.

Nursing rituals take place in daily nursing practice. They serve many important functions, both practical and social, and distinguish the culture of nursing as some of its more private, hidden work is carried out. Nursing rituals take place in nurse-to-patient, direct care situations and in nurse-to-nurse situations, and mark transitions into the professional nursing role. Rituals show the sacred and profane of nursing through their performance.

Similar to Taylor (1994), I believe that nursing operates in social contexts in which intersubjective meanings are generated and are crucial to the healing of patients and nurses. In the many settings in which nursing care is provided, there are nursing rituals that are performed. They do not replace science, but coexist with it. Consequently, arguers deriding rituals might take another look, perhaps using the lenses of nursing, anthropology, and sociology.

Rituals in nursing, including nursing practice and socialization rituals, demonstrate nurses’ commitment to patients and families and to one another. The orientation of the rituals in caring–healing for patients, families, and fellow nurses is rooted in the essential ethical values of beneficence and respect for human dignity. As such, they operationalize nursing’s commitment to “touch the human center of the person” (Watson, 1988, p. 176) by the genuine
intention to do good and value the worth and integrity of all humans through compassionate care. Rituals help nurses transcend moments and potentiate healing. Those involved in transpersonal caring moments are consequently restored and preserved as they experience the health care system as mutual recipients and providers of caring and healing (Watson, 1988). Compassionate human service sustains and preserves human dignity and is deeply concerned with relationships between caregivers and care recipients (Clarke, Watson, & Brewer, 2009).

The prologue, “Rituals in Nursing: Underpinnings and Importance,” lays the foundation for the book. Definitions and descriptions of rituals are presented from the vantage points of different disciplines. The elements of rituals are emphasized with how they appear during ritual performances. Nursing literature on ritual is followed by positive and negative perspectives of nurse scholars. Section I, “Rituals of Nursing Practice,” concentrates on examples from daily nursing work. The interpersonal caring ritual and interpersonal relationships, bathing patients as a ritual in transition, postmortem care, and ritualistic prevention of medication errors are deliberately reviewed from the organizing themes of tradition and procedures, initiation into ritual performance, evolving research, art and ritual, and ritual symbols.

Section II, “Rituals of Socialization,” addresses change-of-shift reports and nursing ceremonies. These examples mark the transitions into professional nursing and some of the celebrations of professional nursing work in health care agencies. Initiation into the role of the nurse through change-of-shift reports and types of ceremonies are described along with related research and ritual symbols. Finally, the Epilogue provides a classification of the rituals in nursing investigated in this book and points out the ethical values at their foundation.

This book originates in the reflections and perspectives of a nurse–academic who values the enormous contribution of direct care registered nurses at the front line and at the sharp end of health care delivery. It is then an integration of thoughts, beliefs, values, and literature. Because of this, the strengths and limitations of the work are mine.

Zane Robinson Wolf, PhD, RN, FAAN
Rituals in American nursing culture along with many other aspects of the profession, for example, beliefs about the profession, use of technology, and application of science to clinical practice. How nursing rituals and rituals in nursing intermingle with cultural norms, customs, routines, art, technology, and science is important to understand. It is also worthwhile to clarify the meanings, persistence, elimination, and transformation of rituals. Nursing rituals may show that nurses are carrying out a developing international resurgence in reclaiming nursing as a profession (Ferguson et al., 2008; Hales, 2003).

In spite of laudable, essential, and critical efforts aimed at underpinning professional practice with evidence, science fails to answer all of the problems of clinical nursing work. Because of this, rituals are worth exploring. Nonetheless, nursing rituals and ritualism have been scrutinized in nursing literature for decades and not always appreciated in the context of viewing nursing as a cultural group. This attention, while sometimes controversial, signifies their importance and the value of examining this aspect of the culture of the nursing profession. In addition, some rituals incorporate both the sacred and profane of nursing work.

The nursing profession’s rituals provide an expressive and powerful supplement to its beliefs, art, and science. Nursing owns its rituals in the same
way that the profession has a distinctive culture. Nursing rituals demonstrate patterns of cultural behavior that assist in transmitting traditional knowledge and practices. They help nurses maintain social order by cohesion and interaction (Suominen, Kovasin, & Ketola, 1997). This book explores ritual definitions from the lenses of various disciplines, analyzes ritual elements and symbols, and examines themes pertaining to rituals in nursing literature.

RITUAL FOUNDATIONS, DEFINITIONS, AND ELEMENTS

Many cultural groups perform rituals that distinguish their social interactions and partially shape their identities. According to classic anthropological thought, rituals arise from crises of human existence, for example, those taking place during the circumstances of conception, pregnancy, birth, puberty, marriage, and death (Malinowski, 1992). Rituals are part of the fabric of human existence and accompany beliefs and rites. Often they combine with beliefs, religion, and magic, particularly surrounding the beginning and end of life.

For example, Malinowski asserted that:

*During pregnancy the expectant mother has to keep certain taboos and undergo ceremonies, and her husband shares at times in both. At birth, before and after, there are various magical rites to prevent dangers and undo sorcery, ceremonies of purification, communal rejoicings, and acts of presentation of the newborn to higher powers or to the community.*

(1992, p. 37)

*As death approaches, the nearest relatives in any case, sometimes the whole community, forgather by the dying man, and dying, the most private act which a man can perform, is transformed into a public, tribal event.*

(1992, p. 48)

Rituals are sometimes defined as practices that reflect relief of anxiety through performance of repetitive or obsessionally precise symbolic acts. Compulsive gestures, repetitive behaviors, and mechanical praying are also listed as elements of ritual (Murdock et al., 1961). Rituals contain a high level of symbolic activity and involve a degree of formality, rigidity, repetitiveness, and rhythm (Davis, 1981). They express symbolic meanings important to groups of people functioning within a culture or subculture.

Rites of passage (van Gennep, 1960) are rituals attached to transitions in individuals’ lives, such as marriage, purification after childbirth, and funerals after death. They are ceremonial, transitional rites including rites of separation, transition rites, and rites of incorporation. Preliminal rites are rites of separation; liminal rites are rites of transition; and postliminal rites are rites of incorporation (van Gennep, 1960). Liminality refers to thresholds.
Ritual is prescribed formal behavior for occasions not given over to technological routine, having reference to mystical beings or powers. Ritual affirms communal unity.

Rituals are dramas of social events that emphasize the importance of the event they symbolize or represent; they are standardized, repetitive dramatizations of social crises, functioning to minimize the effects of crisis.

Rituals confront the individuals of the tribe with common values; ritual is drama symbolizing an important social event.

Ritual is consecrated behavior; religious ritual involves symbolic fusion of ethos and world views. It involves a broad range of moods and motivations and metaphysical conceptions that shape the spiritual consciousness of a people; they are full-blown ceremonies as cultural performances. The symbolic acts of rituals are given order and structure by the explicitly stated purposes of those rituals.

[Ritual is] a generalized medium of social interaction in which the vehicles for constructing messages are iconic symbols (acts, words, or things) that convert the load of significance or complex sociocultural meanings embedded in and generated by the ongoing processes of social existence into a communication currency. ...Shared sociocultural meanings constitute the utilities that are symbolically transacted through the medium of ritual action.

Rituals represent a passage from one position, constellation, or domain of structure to another and insure maintenance of a cosmic order which transcends the contradictions and conflicts inherent in the mundane social system. Rituals use symbolic objects and cyclical and repetitive activities.

Public ritual expresses a common, public concern, and uses whatever symbolic language...for bringing the point home. Social context is important.

Ritual is patterned, symbolic action that refers to the goals and values of a social group.

Ritual provides relief from anxiety both for sick individuals themselves and for others concerned with their welfare. Effective meaning of any ritual depends not only on the character of the ritual itself but also on the perspective from which it is viewed. Ritual relieves distress by making illness meaningful. When the study of ritual is linked to the study...
of healing, the therapeutic value of a ritual for particular individuals with particular problems becomes an issue of central importance. Behaviors, social, and cultural milieu, meanings, communication, and barriers to communication are important. First, by working with knowledgeable informants, observing the behavior of participants in a ritual, and analyzing the social and cultural milieu in which it occurs, determines as far as possible what a ritual might mean. Second, consider the situation in which the ritual is observed and ask which of the ritual’s possible meanings are relevant and which are not. Third, ask what means of communication and barriers to communication are actually operating in that situation. Rituals are symbolic constructions analogous to works of art or literature; they label problematic situations, articulate their internal organization and relationship to the world at large, and orient responses to them.

Occupational rituals, such as attending and work rounds, case conferences, grand rounds, and mortality and morbidity conferences, may be analyzed as occupational rituals that allow physicians to dramatize, to teach, and to remind themselves and their colleagues of their sense of what it means to be a physician. Occupational rituals help physicians to resolve social problems endemic to patient management: managing uncertainty, making treatment decisions, and evaluating outcomes.

Rules that guide behaviors in corporate life and are dramatizations of a company’s basic cultural values. Behind each ritual is a myth symbolizing a belief central to the culture.

Standardized, detailed set of techniques and behaviors that manages anxieties but seldom produces intended, practical consequences of any importance.

<table>
<thead>
<tr>
<th>Definitions and Descriptions</th>
<th>Discipline</th>
<th>Citation</th>
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<tbody>
<tr>
<td>Rules that guide behaviors in corporate life and are dramatizations of a company’s basic cultural values. Behind each ritual is a myth symbolizing a belief central to the culture.</td>
<td>Business</td>
<td>Deal and Kennedy (1982, p. 62)</td>
</tr>
<tr>
<td>Standardized, detailed set of techniques and behaviors that manages anxieties but seldom produces intended, practical consequences of any importance.</td>
<td>Business</td>
<td>Beyer and Trice (1987)</td>
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</table>
Ritual is a significant feature of social life in that it secures a collective, extra-individual sense of events. Its patterned sequences are highly symbolic and thus meaningful for all participants, both actors and observers. The timing and order of events as well as role and identity of the participants carries condensed, symbolic information for those involved.

Ritual has a prominent role in securing cultural knowledge; ritual is an eminently suitable device for organizing a theoretical conversation that wishes to uncover cultural meanings through the interpretation of texts.

A ritual is a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation.

Rituals are visible expressions of community bonding and support through biological and psychological passages of life...the ways all societies give meaning, richness, and structure to life...rites of separation from old ways of being and thinking and behaving, and integrating into new modes of being.

Ritual connotes an already known, richly symbolic pattern of behavior, the emphasis falling less upon the making and more upon the valued pattern and its panoply of associations. ...Ritual is vital in processes of social change.

Ritualizing denotes the activity of deliberately cultivating or inventing rites (specific enactments located in concrete times and places; often named and intentionally practiced) that are recognized by group consensus and are nonutilitarian and expressive.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Source</th>
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<tbody>
<tr>
<td>Sankar citing Rappaport (1991, p. 44)</td>
<td>Anthropology</td>
</tr>
<tr>
<td>Bell (1992, p. 54)</td>
<td>Religion</td>
</tr>
<tr>
<td>Davis-Floyd (1992, p. 19)</td>
<td>Cultural anthropology</td>
</tr>
<tr>
<td>Achterberg, Dossey, &amp; Kolkmeier (1994, p. 2)</td>
<td>Nursing</td>
</tr>
<tr>
<td>Grimes (2000, p. 29)</td>
<td>Religion and culture</td>
</tr>
</tbody>
</table>
As dramas of social events, rituals emphasize the importance of the events they symbolize or represent. Turner (1967), an anthropologist, considered rituals as dramatizations of social crises that function to minimize the effects of such crises. These perspectives, chiefly coming from anthropology, begin to suggest that there are deeper (more hidden or latent), or implicit levels of ritual symbols along with their on the surface or explicit functions.

Table P.1 depicts definitions and descriptions of ritual, corresponding disciplines of authors, and citations. Their approaches to explaining ritual may assist in gaining a snapshot of the diversity of perspectives on ritual overall, including classic views.

This table only partially addresses the incredible amount of literature available on ritual. The discipline of anthropology predominates, while other disciplines have based much of their work on that of social and cultural anthropologists.

Elements, Functions, and Types of Rituals

The elements of ritual offered here come from an assorted set of texts and interpretations of writings on the subject. The amalgamation offered is intuitive and literature-based, combined to help analyze the complex topic of ritual.

Rituals operate in the context of societies with distinct cultures; they are evidence of communal bonds. They have structure, a beginning, middle, and an end (Achterberg et al., 1994), and are often described as solutions to crises and a way of dealing with and reducing the effects of crises. Ritual action is standardized, repetitive, prescribed, required, and commanded by the rules of social group, whether a culture or a subculture. The social group sets both the occasions and the forms of such ritual (Gluckman, 1975, p. 4). Rituals involve stereotypy: a certain degree of formality, rigidity, simplicity of movement, repetitiveness, and rhythm; they have a communicative function and are a response to anxiety (Davis, 1981). It is likely that the repetitiveness and prescriptive patterns of rituals and their connection to crisis situations generate much of their associated negativity.

Words, actions, objects, gestures, and relationships are important to ritual performance (Douglas, 1966; Malinowski, 1992; McCreery, 1979; Tambia, 1968; Turner, 1969; van Gennep, 1960). Symbols stand out in rituals; they are essential to ritual performance. They challenge both participants in rituals and observers of ritual to interpret meanings that are not necessarily conscious. Symbols represent condensed meaning and operate as a “cognitive reflex” (Munhall, 2007, citing Fetterman, 1989, p. 36). Because of the importance of symbols to understanding ritual, they need to be examined and framed by the cultural and social context in which they are generated and applied; the relationship of the symbol to the social order must be analyzed.
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<th>Topic</th>
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<tr>
<td>Routine develops into ritual to alleviate anxiety. Observance of ritual alleviates in a general way with an individual’s anxiety, avoiding clashes with other members of the group, or protects the member against the disapproval of the leader. Rituals continue even after the dangers or other reasons that brought them into being cease to exist. Many nursing rituals are associated with: cleanliness and order; time (speed and rigid schedules); communication (using professional language); talking to postpone action: fleeing from emotionally charged situations and withholding information from patients; and maintaining a professional attitude to preserve interpersonal distance with patients.</td>
<td>Much nursing care consists of prescribed routines that have evolved out of the need to budget time, effort, and money. Decisions about a patient’s life in the hospital are often unconsciously made on the basis of rules or routines. Rituals maintain consistency and keep nurses from learning about patients and from correlating their own reactions. Professional rites not routinized rites should be achieved.</td>
<td>Schmahl (1964)</td>
<td></td>
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<tr>
<td>Some nursing routines have undefined meaning for individuals who perform them. Ritualism is behavior that has a special significance to the actor rather than orientation toward achieving organizational goals. Behavior is directed toward tasks contributing to goal achievement; behavior satisfies some psychological need of the individual, for example, compulsive cleanliness, status needs, or reduction of anxiety. Examples are (dysfunctional) routine taking of temperature, pulse, and respiration; nurses’ notes (some positive functions); special report (medication errors and patient incidents) (ritualistic behavior in need of modification) and interruption and reassignment of nursing activities.</td>
<td>Ritualistic practice is sometimes beneficial: shift report serves to maintain group cohesion (latent function).</td>
<td>Ritualistic practice is sometimes inefficient and dysfunctional.</td>
<td>Walker (1967)</td>
</tr>
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<td>Participant observation case material on ritual procedures helps nurses defend against anxiety and are social acts generating and conveying meaning.</td>
<td>Nursing ritual practices have social and psychological meaning.</td>
<td></td>
<td>Chapman (1983)</td>
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<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>Narcotic count, medication administration, recording intake and output, oral temperatures, bathing patients, shift reports, etc.</td>
<td>Nursing rituals are a thinking nurse’s enemy. Need to recognize the source of rituals, otherwise the nurse is on automatic pilot; patient care is improved on the basis of reason, nurses think, and do not rely on ritual.</td>
<td></td>
<td>Huttmann (1985)</td>
</tr>
<tr>
<td>Nurses need to support a more systematic approach to the delivery of nursing care.</td>
<td>Routine and ritual need to be relied on less.</td>
<td>Many rituals fall short of what is intended and should be exposed and abandoned.</td>
<td>Bowman (1986)</td>
</tr>
<tr>
<td>Rituals that should be abandoned because of research: for example, protective isolation; changing the urine bag; periurethral care; unclamping and clamping Foley catheters; soaking wounds in povidone-iodine; etc.</td>
<td>A system of nursing rituals exists in hospital nursing, with latent and manifest levels of meaning. Examining nursing rituals illuminates the contribution of nursing to health care, despite the personal, profane, and sacred notions of some of the work.</td>
<td>The therapeutic effects of following the patient’s lead to use bedtime ceremonials may have therapeutic effects.</td>
<td>Huey (1986)</td>
</tr>
<tr>
<td>Nursing rituals coexist with science, technology, and procedure. Nursing rituals help nurses reaffirm some of the beliefs and values of nursing, such as doing good and avoiding harm. Nurses pass on subcultural knowledge by word of mouth and by demonstration. The embedded and hidden aspects of nursing ritual and of nurses’ work illuminate that much of nurses’ work may be largely unknown to the public.</td>
<td>The therapeutic effects of following the patient’s lead to use bedtime ceremonials may have therapeutic effects.</td>
<td>Wolf (1986, 1988a, 1988b)</td>
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<td>Bedtime ceremonials, repetitive performance of various activities to prepare the person for going to sleep, need to be encouraged for psychiatric patients. These behaviors can be distinguished from obsessive–compulsive rituals. Performance of these behaviors may indicate a journey back to health.</td>
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<td>Geach (1987)</td>
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Nursing fails itself and its patients because of traditional rituals and myths used in hospitals. Ritual action implies carrying out tasks without thinking it through in a problem-solving, logical way. Nursing rituals in clinical practice need to be exposed using findings from research. Examples include preoperative fasting, preoperative shaving, and postoperative dressing inspection and cleansing.

Family conflicts can be addressed through the creation and conduct of a therapeutic ritual during a therapeutic session.

Research-based practice needs to replace ritual in nursing.

Day-to-day activities are rituals and are not special. Handover report ensures that social order is maintained within the group by enforcing cohesion and interaction; reflects the values of the group. Putting on the uniform helps nurses to fulfill their role.

Rituals may have important social, psychological, and protective functions. In relation to the study of death, dying, and disposal of the body, the rituals of misfortune and the rituals of social transition have obvious importance. Modern death rituals, or the lack of them, in Western societies have been cited as a potential cause of the increased rate of death among the recently bereaved.

Nurses must develop a sociological and anthropological perspective to their way of thinking.

Rituals may have positive action, ritualistic symbolism latent functions, and meanings for patients and nurses beyond the instrumental function of ritual; acknowledge the value of ritual in modern health care practices.

Nurses need to explore the meaning or latent function of nursing routine and ritual.

Culture has to do with the deep and invisible structures in society that are transferred from one generation to another. Rituals form a part of a cultural system and are usually seen as a social phenomenon.

It is important to understand the purpose and meaning of symbols and rituals, because a nursing practice goal is to provide nursing care on the basis of culture.

Rituals and myths need to be exposed; they are ineffective and refuted by research findings.

Walsh and Ford (1989)

Therapeutic ritual created for a therapy session benefits families in conflict.

Bright (1990)

Ritualized practice needs to be replaced by evidence.

Benton (1993)

Nursing rituals perpetuate traditional knowledge and practices and are essential for ensuring that order is maintained in a much wider social context.

Holland (1993)

Nurses must develop a sociological and anthropological perspective to their way of thinking.

Mulhall (1996)

Nurses need to explore the meaning or latent function of nursing routine and ritual.

Biley and Wright (1997)

It is important to understand the purpose and meaning of symbols and rituals, because a nursing practice goal is to provide nursing care on the basis of culture.

Suominen et al. (1997)

(continued)
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<th>Topic</th>
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<tr>
<td>Nursing rituals affect nurses’ ability to act as patient advocates. Ritual action underpins most of nurses’ responses to act as advocates for patients.</td>
<td></td>
<td>Nursing routines and rituals serve to distance nurses from patients, to have poor advocacy skills, and serve to overcome the anxiety associated with care of the terminally ill.</td>
<td>Martin (1998)</td>
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<td>Traditional nursing culture with its task orientation, rigid hierarchical structures, and resultant staff disempowerment impede the delivery of patient-centered care. Task-focused nursing centers on the nurses’ need to detach from patients. Staff need to assist patients with meals and hygiene needs, not “do” patients.</td>
<td></td>
<td>Rituals, routines, and cultures developed in nursing prevent nurses from achieving individualized, person-centered holistic nursing care.</td>
<td>Tonuma and Winbolt (2000)</td>
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<td>Symbols and rituals are intimately connected as are the individuals who embody the symbols or perform the rituals. Rituals communicate values and produce desired effects. Ritual is universal phenomenon inherent to all human groups and societies. Nurses need to renew their appreciation for the transformative power of nursing rituals to embrace the holistic paradigm.</td>
<td></td>
<td>Nursing symbols and rituals are significant for the practice of professional nursing.</td>
<td>Catanzaro (2002)</td>
</tr>
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</table>
Vigilance is needed when thinking about nursing practice, but rituals are considered useful according to social science. While research-based practice is valued over ritualized practice, the symbolic function of ritual action is promoted. There is a lack of authority for understanding ritual within nursing literature, suggesting that groups define ritual for their own purposes and arguments.

The negative usage of ritual as unthinking, routinized action by nurses misses out on the wider symbolic meaning of the word. There is much to be gained from further elaboration of the ways in which nurses use rituals in the performance of their work; they provide a rich source of insight into the meanings attached in the accomplishment of nursing care.

Philpin (2002)

There are relationships among culture, family rituals, health, and illness. Family rituals are compelling and bounded behaviors with symbolic meanings that can be clearly described and serve to organize and affirm central family ideas; serve as a unifying factor for family identity and values. Definitions of family rituals and ritual types and dimensions are provided. Families in different developmental stages may find that family rituals and routines have implications for health.

Family rituals help think about potential relationships with adherence to prescribed medical regiments, therapeutic health management, and health or illness outcomes.

Denham (2003)
and understood (Douglas, 1970). Ritual activity is comprised of a high degree of symbolic input compared to other types of human activity (Davis, 1981). Symbolic objects can be physical and nonphysical.

Ritual symbols transmit cultural ideas and meanings. Symbols are “storage bins” of information; they are “not about pragmatic techniques, but about cosmologies, values, and cultural axioms, whereby a society’s deep knowledge is transmitted from one generation to another” (Turner, 1974, p. 239). By analyzing ritual symbols you may get to their implicit goal (Turner, 1967, p. 45) and meaning.

Rituals can also be examined for their functions and consequences. For example, “What are their manifest functions (objective consequences contributing to the adjustment of adaptation of the system…intended and recognized by participants in the system [Merton, 1968, p. 105]; explicit, on the surface)? What are their latent functions (…neither intended nor recognized [Merton, p. 105]; implicit, hidden).” Moreover, rituals can produce a feeling of completeness; participants in rituals have experienced “a whole act, a finished sequence, the achievement (at least for a while) of satisfaction, satiation, perhaps serenity” (Kafka, 1983, p. 31).

There are many types of rituals. For example, rituals of mourning and bereavement (Skultans, 1980) help individuals express grief over the death of a loved one. In interaction rituals (Goffman, 1967), there are rules for social encounters, during face-to-face behavior, based on established requirements whereby the kinds of practices employed maintain a specified and obligatory kind of ritual equilibrium. In addition, rituals of initiation help the new members of a society perform and demonstrate worthiness for admission to a tribe or social group (Starker, 1978), as in a hospital or a nursing unit. These rituals are similar to Bosk’s (1980) conceptualization of occupational ritual, where through meetings and case conferences physicians learn what it means to be a physician. Next, the corporate culture of business performs award rituals or “Attaboys,” seen as dramatizations of the company’s basic cultural values (Deal & Kennedy, 1982). Therapeutic or healing rituals help people to cope and become healthy (Achterberg et al., 1994; Galambos, 2001; Lakomy, 1994), while sacramental rituals in the Catholic Church reaffirm the oneness of its members in the Church and serve as “channels of grace” (Douglas, 1982, p. 8). Individual rituals are directed to the growth of one person and can be designed to meet the needs of an individual, for example, to change the meaning of an event or behavior (Galambos, 2001).

NURSING LITERATURE ON RITUAL

Accounts of nursing ritual have attracted greater or lesser attention over many decades. Early on, Virginia Walker (1967) conducted studies on common activities of nurses engaged in direct patient care and rituals. She suggested that these rituals have special significance for the nurse and satisfy some personal
need. Walker studied taking vital signs, special reports (medical errors and incident reports), and charting nurses’ notes. She judged the nursing rituals she concentrated on to be of little value. On the other hand, she saw them as being anxiety reducing, admitting their potential worth.

Many others have addressed nursing rituals (Catanzaro, 2002; Holland, 1993; Suominen et al., 1997; Tonuma & Winbolt, 2000; Walsh & Ford, 1989; Wolf, 1988a) and have held differing conclusions about their value. One consideration emerges when scanning the nursing literature; the definitions used by authors vary greatly. This book uses the definition of ritual by DeCraemer et al. (1976): patterned, symbolic action that refers to the goals and values of a social group (p. 469).

Even so, selections from the literature (Table P.2) have been collected intermittently over decades using search strategies with databases, mainly nursing, or have been found accidently while pursuing other topics or shared by colleagues. They stand as representatives on the topic. Not all the rituals are nursing rituals; for example, Geach’s (1987) article emphasizes the importance of nurses’ support of bedtime rituals for psychiatric patients.

The texts selected from sections of articles and books in Table P.2 epitomize what is a typical array on the topic: some are scholarly, some are research, and some are largely opinion. What they reveal is that the balance of opinion seems to be positive, to value the worth of not only writing about nursing rituals, but also seeing the place of nursing rituals in the larger context of professional culture.
Section I includes descriptions of nursing rituals consisting of direct care activities. The background of the ritual, related traditions, ritual initiation, artistic aspects, evolving research, and ritual symbol are explored in each part.

The interpersonal caring ritual is presented in the context of interpersonal relationships. It is viewed through the literature of nursing, including caring theories, and other disciplines. As the most important nursing ritual, it provides the stage for subsequent and simultaneous nursing care. The history of nursing’s association with cleanliness and hygiene frames the examination of bathing patients as a nursing ritual in transition. Nurses’ association with sacred and profane aspects of life is considered. Postmortem care, the last nursing care given to patients, is framed by end-of-life care. Similar to bathing patients, postmortem care involves nurses coming into contact with bodily products considered profane, yet with human experience that is sacred. One aspect of the medication-use process, medication administration, is explored from the perspectives of patient safety. Ritual numbers and their variations in the administration function are compared.
Interpersonal Caring Ritual and Interpersonal Relationships
Everyday nursing life is composed of multiple interactions with patients in many social and cultural contexts. Yet, when nurses begin to interact with patients, they meet strangers with a need for nursing care. In many settings, nurses begin to expand their knowledge of patients by virtue of traditional health histories, nursing histories, and nursing care plans that accumulate with electronic and paper documents detailing patients’ stories. Patients’ situations are further explained during change-of-shift report or handoffs, as patients are admitted to or move within the units of hospitals and long-term care agencies (Heliker & Scholler-Jaquish, 2006). Their stories continue to expand. It is nurses’ own experiences with patients during everyday clinical encounters that build nursing knowledge of individuals as nurses care for and learn from patients.

Nurses typically answer the call to care by greeting patients. Their greeting begins a relationship initiated during a meeting that is characteristically reciprocal as patients in turn respond to the nurses’ presence. The interaction takes shape and progresses, and nurses and patients connect. The work of caring–healing is “life giving and life receiving” (Watson, 2005, p. 3). There is a “rhythmic give and take between nurses and patients” (Finfgeld-Connett, 2008a, p. 530). The relationship that develops can be interpreted as a caring one, yet the judgment about whether it is caring or not varies according to the appraisals of both participants (Godkin & Godkin, 2004). Patients’ well-being and healing are at stake. Furthermore, the proposition that the interpersonal encounters between nurses and patients can be conceptualized as interventions to achieve intentional results has attracted nurse clinicians’ and researchers’ interest for decades (Beeber, Canuso, & Emory, 2004). This hypothesis is attributed to Hildegard Peplau (1952) and reinforced by the assertion that when there is synergy between patient characteristics and nurse characteristics, a desired outcome is likely to occur in optimal patient outcomes (Tejero, 2011).

Whether or not interpersonal caring rituals are cocreated and enacted by nurses with patients during clinical encounters is debatable. However, the performance of interpersonal caring rituals can be investigated and interpreted. So, too, can examples of ritual action be examined during nurse–patient meetings, as can the symbols nurses use when communicating with patients. In this portrayal of ritual in nursing, interpersonal caring rituals are explored from the perspective of nurse–patient interactions or relationships. It is assumed that during the enactment of interpersonal caring rituals, both nurses and patients are connected (Ranheim, Kärner, & Berterö, 2012), practically and symbolically, if only for a short time. The meaning of the ritual resides with both participants.
The role of the nurse has traditionally been viewed as a provider of direct, hands-on care; the role incorporates many other responsibilities. Nursing care often involves personal knowledge of the person, frequently carried out through bodily contact that is professionally intimate (Perry, 2002). They know patients’ secrets and are entrusted with them (Fagin & Diers, 1983). They initiate direct nursing care through the activities of the nurse–patient relationship; this relationship is essential to nursing and elemental to the well-being of nurses and patients (Jarrin, 2006).

Surrounding each person to be nursed is a subjective, physical space that marks his or her individual territory. Nurses enter into this space using visual, auditory, olfactory, thermal, and tactile perceptions (Hall, 1966). Nurses intrude into a patient’s territory by direct access to his or her personal space. The distance between both bodies is short. Within this distance they touch patients, ask questions about bodily functions, and start IVs. Nurses also enter intimate spaces. They see patients’ nakedness and provide care in a private zone. They preserve their dignity as they perform activities that patients would “do for themselves if it were at all possible” (Swanson, 1991, p. 154). Hall (1966) maintained that the physical distances individuals try to keep from others are in accordance with cultural rules. Nurses breach these boundaries and distances every day as the nursing situation evolves. Nurses who provide direct care to patients are physically present within patients’ personal space (Berman, Snyder, & McKinley, 2011). The intimate relationships developed during the caring interpersonal process are shaped by expert nursing and interpersonal sensitivity (Finfgeld-Connett, 2008b).

Much of nursing care is relational and interactive. Whether physical care predominates, or emotional, psychological, and culturally appropriate support is given, nurses function in zones that are inches to several feet from patients’ bodies, even when considering proximity to computer screens and interfaces during telehealth encounters. Consequently, they gain access to patients in ways that few are privileged to (Perry, 2002), including the sacred aspects of human life, such as suffering, death, grief, birth, and role transitions.

In institutional settings, nurses perform physical care: they bathe patients, administer medications, help them get out of bed, change dressings, and at the same time carry out interpersonal caring rituals during caring moments (Watson, 1988), in meetings (Paterson & Zderad, 1976), or in the nursing situation (Boykin & Schoenhofer, 2001; Paterson & Zderad, 1976). They touch patients and lay their hands to comfort and heal. They encourage patients and offer hope. They comfort patients and relieve their pain. In health care agencies, homes, and in the community or by telephone and through computers, they teach them. It is during these relational encounters that simultaneous events unfold. Practical, technical, and symbolic actions take place. The time spent together is sacred.
As nurses enter patients’ personal space, they set up an environment for healing. During such interpersonal encounters, they create human caring environments whereby they use themselves consciously and intentionally to achieve the outcome of healing (Quinn, 1992). Nurses’ intentions reflect their consciousness; they themselves are healing environments and creators of sacred space (Quinn, 1992). The contributions of interpersonal encounters that are authentic and intentional can have lasting benefits for patients.

In hospitals, doors are closed or curtains are pulled around a nurse and a patient to enclose both in a private space and protect the patient from passersby. The enclosure symbolizes the privacy needed by both involved in the encounter. In homes, nurses ask family members to leave the room if this is acceptable to the patient. If care is provided telephonically or via computer, privacy is ideally maintained during the dialogue.

As nurses begin to establish an interpersonal relationship with patients, they carry out a series of activities. For actions to be seen as caring, nurses must be aware of the need for care in patients; they must know that certain things could be done to improve the situation (Gaut, 1983). Nurses must intend to do something for patients and must choose an action aimed at serving as a means for bringing about a positive change in them. Next, they must carry out that action. Ultimately, the positive change must be judged on the basis of what is good for that patient rather than for the nurse or others (Gaut, 1983). The welfare of the patient is paramount.

As caring and support are offered in nurse–patient relationships, nurses must be aware of the value of interpersonal activities, such as verbal content and/or nonverbal communication actions (e.g., gestures, facial expressions, inflections placed on words, and silences) (Beeber et al., 2004). One hospital implemented a relationship-based care model and observed nurses in action with patients as they demonstrated caring behaviors, using a checklist (present or absent behaviors). Verbal behaviors were expression of concern, explanation of a procedure prior to initiation, validation of physical and emotional status; sharing personal observation in response to a concern, providing assurance, and discussing a topic of concern to the patient other than the current health problem (Winsett & Hauck, 2011, p. 287). Nonverbal caring behaviors included sitting at the bedside, touching exclusive of a procedure, sustaining eye contact, entering a patient’s room without being called, and providing physical comfort measures (Winsett & Hauck, 2011, p. 287). This interpretation of nurse caring behaviors shows that in the space created by the nurse–patient relationships, actions indicating caring are observable.

When nurses enter the personal space of patients, they may use three types of touch during an interpersonal encounter: task-oriented, caring, and protective (Fredriksson, 1999). Task-oriented touch is represented as procedural, instrumental, or working touch. Caring touch, such as nonverbal communication, is also known as positive affective touch, expressive touch,
nonprocedural touch, comforting touch, or unnecessary touch. Protective touch helps nurses distance themselves from emotional pain, preserve energy resources, and release tension. In Fredriksson’s model, presence, touch, and listening connect people. Hearing, task-oriented touch, and being there are also evident. Fredriksson saw nurses’ caring, connective touch, intentional silence, and concentrated listening to others as symbolic gifts for patients. An invitation or call from the patient allows the nurse to come into the patient’s world. Both share in the narrative of the patient’s suffering (Fredriksson, 1999). Two types of connection are accomplished: high intersubjectivity (being with) and minimum intersubjectivity (being there).

Another author (Routasalo, 1999) conducted an integrative review on forms of touch represented in nursing studies. The investigator classified the types of studies on the basis of touch: uses of touch, effects of touch, and experiences of touch. Body parts touched most frequently were hands, arms, forehead, hair, and shoulders. Caring touch was associated with largely emotional contact. The researcher concluded that physical touch, especially expressive touch, was not necessarily present in all nurse–patient interactions (Routasalo, 1999).

According to Engebretson (2002), hands-on nursing may represent the fundamental human connection nurses use to help patients heal.

The metaphor of hands-on care with the intent to heal combines the heart in compassion with the head in a conscious intent to help. The ubiquitous hand is the symbolic metaphor of embodied intent to act. Thus, hands-on has always represented the activity of nursing as more than mental understanding or compassionate caring, but it must be integrated with an action toward to patient. (p. 30)

Engebretson (2002) pointed out the use of head, heart, and hand during intentional action. The need for nurses to accomplish high technology–high touch care is framed by the core commitment of professional nursing to maintain caring with the intent to heal.

Even though communication is often challenging and difficult, considering the complex situations in which nurses and patients participate, nurses still are determined to connect with each person’s core. This is particularly problematic for nurses caring for patients who are locked in, unconscious, in vegetative states, or are infants. The following description illustrates a nurse’s intention to reach a patient:

A patient…could only communicate through his eyes, there was pain, yes, and anxiety in those eyes…we had eye contact until he closed them. …He didn’t speak, but spoke…through his body…then the patient didn’t feel alone, we shared. [T]hat’s what I hope was a help, but I can’t be entirely sure, you never can, although I try to do what I believe. (Arman, 2007, pp. 88–89)
I RITUALS OF NURSING PRACTICE

What nurses say and do is guided by the ethical principles of human dignity, autonomy, and caritas (Clarke, Watson, & Brewer, 2009; Fredriksson & Eriksson, 2003). Nurses respect themselves and their patients; they recognize the autonomy of both nurses and patients in the nursing situation, and they are motivated by caritas or compassion, originating in human love and charity (Fredriksson & Eriksson, 2003).

The real work of nursing, as hands-on care, implies nurses’ connection with patients and the intent to participate in the healing of self and others (Sharoff, 2009). It is through ordinary yet extraordinary nurse–patient interactions that relationships exist that potentially heal both. Some of these relationships represent profound moments (Sharoff, 2009) or “moments of intimate connection—the occasions in which both nurses and patient feel transformed (even if only for the day) for having made it through a challenging time together” (Swanson, 1999, p. 55).

TRADITIONS, BELIEFS, AND DEFINITIONS

Interpersonal relationships created by nurses with patients are highly valued by professional nurses. This is illustrated by the concern nurses have voiced about balancing high-tech care with interpersonal caring. The contributions of both to patient outcomes is indisputable and dramatized in the technologically intense intensive care environment (Almerud, Alapack, Fridlund, & Ekebergh, 2008). Patients and machines may be easily fused in this setting.

Nurses’ attention to comforting patients can be lured away by technology and laboratory results. Nurses’ caring comportment is challenged. Patients may not be given much chance to talk, and at times technology intrudes into limited opportunities to do so. Nurses may fear that dialogues with patients may evoke questions and emotions not easily handled. Rather than making space for social, emotional, physical, and spiritual support, they may “pick sides” and defer to technology (Almerud et al., 2008, p. 136). In spite of technology becoming a priority for nurses in intensive care environments, nurses intend to be with patients and maintain relationships with them through compassion (Kongsuwan & Locsin, 2011).

Morse, Solberg, Neander, Bottorff, and Johnson (1991) examined conceptualizations of caring, adequacies and inadequacies of the conceptualizations, applicability of caring as concepts to the nursing profession, and trends and gaps in caring research. Five categories of caring reported were: caring as a human trait (human mode of being), caring as a moral imperative or ideal fundamental value (preserve human dignity), caring as an affect (emotional involvement with empathetic feeling for patient experience), caring as an interpersonal relationship (interaction between nurse and patient expresses and defines caring), and caring as a therapeutic intervention (caring actions such as attentive listening, patient teaching, patient advocacy, touch, being
there, technical competence). Outcomes of caring identified included caring as the subjective experience of the patient and caring as a physical response. Morse et al.’s (1991) analysis provided a model and definitions for future studies of nurse caring. Not only do elements of the model validate Peplau’s (1952) views, but interpersonal relationship emerge as a construct important to the study of caring.

INTERACTION RITUAL AND INTERPERSONAL CARING RITUAL

Goffman (1967), a sociologist, analyzed ritual elements in social interaction. He noted that when people interact face-to-face, the behaviors exhibited include glances, gestures, positioning, and verbal statements (Goffman, 1967). During social encounters involving face-to-face or mediated contact, individuals act out a line or a pattern of verbal and nonverbal acts by which they express their view of the situation, and their evaluation of the participants, especially themselves.

The face is the positive social value a person effectively claims for himself or herself by the line others assume he or she has taken during a particular contact. Face is a self-delineated image of approved social attributes and an image that others may share, “as when a person makes a good showing for his profession or religion by making a good showing for himself” (Goffman, 1967, p. 5).

According to Goffman, rituals are present in everyday interactions and all interactions attempt to maintain the sacredness of the group. Applying this formulation to interpersonal relationships in nursing, the social interactions created by nurses and patients during nursing situations are ritual ceremonies whereby participants value the group, the nursing profession, and the social self, the nurse and the patient, as an object of sacred reverence. Goffman’s work helps make a case for interpersonal caring ritual in nursing by emphasizing ritual in social interaction and the sacredness of social interactions.

CARING THEORIES AS FRAMEWORK FOR CARING RITUAL

Interpersonal caring rituals can be framed from the perspective of nursing theories on caring and a caring science orientation. This model of science enables nurses to study the sacred in caring–healing work (Watson, 2005, p. xi). Those intent on understanding caring science aim to focus on developing a “deeper perspective on life and caring–healing work” (Watson, 1999, p. xii). Perhaps in striving to explore and understand caring science, nurses and others will “allow science, morality, metaphysics, art, and spirituality to co-mingle for new reasons” (Watson, 2005, p. xiii). Aspects of the intersubjective nature of the nurse–patient relationship and interpersonal caring rituals are clarified by selected caring theories.
I RITUALS OF NURSING PRACTICE

Humanistic Nursing: Josephine Paterson and Loretta Zderad

Paterson and Zderad suggested that nursing implies a special kind of meeting of human persons; nurses have a goal and patients may have one too. Nurses are goal-directed toward nurturing patients and their well-being (Paterson & Zderad, 1976).

Nursing involves a mode of being and doing something (Paterson & Zderad, 1976, p. 13). Framed by a phenomenologic view of nursing in the lived world, the theorists positioned Humanistic Nursing Theory as a living out of nurses’ authentic commitment and existential involvement with patients. Nurses are present “with the whole of...being” (p. 15) in personal and professional ways. Their involvement is based on art and science.

Paterson and Zderad proposed that nurses and patients relate to one another intersubjectively, or subject to subject. They also relate subject to object. Both are unique and come together with past and current social relationships. When nurses relate to patients and are present to them, they are open and receptive, ready and available to interact in a reciprocal manner. Nurses are “open-as-a-helper to the patient” (1976, p. 25). Nurses and patients relate in dialogue through call and response (George, 2002) addressing health needs (Parker, 1993).

According to Paterson and Zderad, nursing is a lived dialogue. As an intersubjective transaction, nurses and patients make choices. In the case of patients unable to choose, nurses support patients’ points of view most likely solicited from family and friends and obtained from health care documents. Furthermore, each nursing event with patients is a unique, one-of-a-kind intersubjective transaction.

In Humanistic Nursing Theory, the nursing situation is created as nurses meet patients. It is focused on “lived time and space as experienced by the patient and/or nurse, and as shared intersubjectively” (Paterson & Zderad, 1976, p. 19). Interpersonal caring ritual can be explained through selected formulations of this theory. The ritual takes place in the nursing situation during meetings of nurses and patients, which are shared events. As a socially and existentially constructed space, it is often very private, very reciprocal, and very dependent on what both bring to the occasion. The ritual action, however, is demonstrated by intentional nursing where some nursing wisdom resides. Nursing wisdom builds through experience as nurses bring past experience to present nursing situations.

Caring Theory: Jean Watson

Watson’s Caring Theory has garnered worldwide attention, no doubt because of its emphasis on caring, ethics, and consciousness, and on nurses and patients in a transpersonal relationship. It answers the hunger for human connection of the nurses who provide care and the patients who receive it. The theory is based on a moral/ethical/philosophical base of love and values (Watson Caring Science Institute, 2010). As a “unitary
field of consciousness and energy that transcends time, space, and physicality (unity of mind/body/spirit/nature/universe)” (Watson, 1999, p. 2), nurses as providers of health care services are honored and, in turn, honor patients or clients in the transpersonal caring relationship. Human caring and relationship-centered caring are “a foundational ethic for healing practices” (Watson, 2006, p. 51).

For Watson (1999), the transpersonal caring relationship is a special kind of human care relationship. Nurses go beyond themselves. They are well-intentioned and authentic, and convey concern about the inner life world and subjective meaning of another person who is fully embodied (Watson, n.d.). Nurses reach to deeper connections, to the spirit and the universe. The goal of the transpersonal caring relationship is to protect, enhance, and preserve dignity, humanity, wholeness, and inner harmony (Watson, 2001). Nurses’ caring consciousness preserves and honors patients’ embodied spirit and connection to them. The transpersonal caring relationship, as a spirit-to-spirit connection, has the potential to comfort and heal. Nurses’ intentionality and consciousness transcend the physical (Watson, 2002). According to Watson, both nurses and patients are unique and connect in a mutual search for meaning and wholeness. Suffering may be transcended through the caring relationship (Watson, 2001).

The caring occasion or caring moment (i.e., focal point in space and time) (Watson, 1988/1999) occurs when nurses and patients come together in an occasion for human caring. Both have unique phenomenal fields that include the totality of human experience of feelings, bodily sensations, thoughts, spiritual beliefs, goals, expectations, environmental considerations, and meanings of perceptions. All are based on life history, present moment, and imagined future. Nurses as caregivers need to be aware of their own consciousness and authentic presence of being in caring moments with patients (Watson, 1999).

As nurses experience a transpersonal caring relationship during caring moments, nurses and patients are influenced by one another through choices and actions taking place (see Ergott, 2008). The caring occasion becomes “transpersonal” when “it allows for the presence of the spirit of both—then the event of the moment expands the limits of openness and has the ability to expand human capabilities” (Watson, 1999, pp. 116–117). The caring moment becomes part of the nurse’s and patient’s life history. The caring moment is a phenomenal field created by, and which is greater than, the nurse and patient, each of whom has an individual field. The moment transcends the here and now. Healing occurs when the nurse connects with the spirit of the patient (Watson, 2006).

Watson’s formulations of the transpersonal caring relationship and caring moment provide a space and time for nurses and patients to heal. Within this phenomenal field, caring is communicated through nurses’ “energetic patterns of consciousness, intentionality, and authentic presence in caring relationship” (Watson, 2005, p. 7).
Nursing as Caring: Anne Boykin and Savina Schoenhofer

Boykin and Schoenhofer’s (2001) Theory of Nursing as Caring assumes that all persons are caring and that caring is an essential characteristic of being human. Humans’ wholeness is celebrated in their theory. Nurses offer caring in the context of the caring situation that is a shared, lived experience in which caring between the nurse and the nursed enhances personhood. Personhood is the process of living grounded in caring and enhanced through nurturing relationships. Nurses and patients are together valued and respected and energized in the caring situation. Nursing’s focus is in nurturing persons, living caring, and growing in caring (Boykin & Schoenhofer, 2001).

Consistent with the Theory of Nursing as Caring, nurses and patients are whole persons; nurses’ awareness of themselves as caring persons includes their consciousness to value caring and leads to the question: “How ought I act as caring person?” (Boykin & Schoenhofer, 2001, p. 4). Caring relationships express the fullness of being human and living caring each day. “A relationship experienced through caring holds at its heart the importance of person-as-person” (p. 4). An ongoing, authentic awareness of self is necessary to developing caring relationships, knowing self, and knowing others. Nurses as caring persons live caring and have the potential to participate in nurturing relationships by caring for others. Boykin and Schoenhofer contended that the profession of nursing applies knowledge gained from investigations conducted by the discipline and in response to human needs.

Theory of Caring and Uncaring: Sigridur Halldorsdottir

Sigridur Halldorsdottir (1996) proposed a Theory of Caring and Uncaring Behaviors that she developed from phenomenologic studies. She connected caring to patient outcomes and pointed out the potential of nurse–patient relationships for helping patients heal. Halldorsdottir emphasized the value of each human, the importance of relationships, the interdependence of humans, and the source of human suffering to be comprised of unmet needs.

Halldorsdottir described five basic approaches to being with another, presented as a continuum, to represent caring interactions. The biogenic mode of being is the approach where nurses or other health care providers as professionals recognize the personhood of clients through caring interactions. They strengthen clients, promote their healing, and reduce their vulnerability. Patients feel a sense of well-being. The bioactive mode is life-sustaining, and nurses and other providers support, encourage, and reassure clients. Clients are comforted. The biopassive or life-neutral mode of being occurs when clients perceive neither positive nor negative influences on their well-being. Next, the biostatic mode of being is life-restraining; providers are seen as indifferent or insensitive to clients’ needs. The biocidic mode of being results in clients feeling depersonalized and vulnerable. This mode is most
destructive for clients. All of these modes of being take place during nurse–client encounters.

During nurse–client encounters, nurses openly communicate and connect with patients. They demonstrate compassion and respect. The potential for uncaring is also there; in this case, nursing and other providers are disconnected, indifferent, and incompetent. Clients are discouraged (Halldorsdottir, 1996, 2007).

These caring theories reinforce the importance of nurse–patient relationships for professional nursing. Together, the caring moment, occasion, meeting, or situation provide the space and time for the development of the relationship. Values, such as respect and dignity, converge and the wholeness of nurses and patients are emphasized. Both nurse and patient benefit as they interact and grow.

RELATIONSHIP AND RITUAL

When nurses approach patients and begin a nurse–patient relationship, they participate compassionately in the experience. They are aware of the “pain and brokenness of the other” (Roach, 2002, p. 50). Nurses are responsible for alleviating suffering (Morse, Bottorff, Anderson, O’Brien, & Solberg, 1992). Helping patients is their mission (Perry, 2002). The weight of the relationship is carried by nurses; they intend to care for patients, to lessen their suffering, and to heal them. The quality of nurses’ presence in the encounter allows them to share with patients and make room for them (Roach, 2002). However, compassion or caritas is not always visible behaviorally.

Much of what transpires between nurses and patients comes about interpersonally, interactively, and transpersonally and is implicit or hidden to outside observers. This is not surprising because what nurses bring to the caring situation is shaped by beliefs and culture as it is reciprocally shaped by the beliefs and cultures of patients and family members in the situation. What follows is a variety of visible behaviors and verbal and nonverbal exchanges. Some patients are not responsive to nurses verbally or nonverbally. It is then up to nurses to gauge their effectiveness and to analyze whether the interactions were caring.

Nurses’ personalities, actions, and expertise as well as patients’ circumstances shape the nursing situation in the relational encounter. Often, what nurses learn about how to carry out interpersonal relationships is developed by trial and error and by assimilating the techniques of mentor nurses. Performance is gradually enhanced by experience and reflection on experience as maturation and insights develop (Finfgeld-Connett, 2008a).

Within the nurse–patient relationship, as nurses engage with patients who suffer, responses are triggered and nurses identify with patients’ experiences through empathetic insight. They attend to the objectiveness and abstract the conditions of patients as patients remain at the center
I RITUALS OF NURSING PRACTICE

(Morse et al., 1992). Nurses may use more energy as they engage with suffering patients to reduce suffering, rather than merely responding by rote. However, pseudoinvolvement, described as being detached and disembodied or disengaged, could take place, resulting in a nontherapeutic nurse–patient interaction. This outcome is always a possibility in nurse–patient relationships.

Interpersonal caring rituals take place at an individual level between the nurse and the patient and also function at a social level in the context of professional nursing. The interpersonal caring ritual provides meaning for nurses and patients and establishes order for their interactions and mutual experiences. The meaning of the relationship as experienced is realized through reflecting on experience. Nurses must make sense of the nurse–patient relationship in the context of the caring situation or moment and in the wider context of professional nursing.

Interpersonal caring rituals evidence both common and individualized activities displayed by nurses within the boundary of the nurse–patient relationship. In the relational encounters of nurses and patients, the words spoken, gestures used, and positions of nurses’ bodies evidence ritual activity. The ritual performance is often private, not witnessed by others, yet represents the nurse’s personal values as well as the core values of professional nursing. The nursing encounter or situation provides the space and time for nurse–patient relationships and interpersonal caring rituals.

INITIATION TO INTERPERSONAL RELATIONSHIPS

The ability to establish and sustain interpersonal relationships is a core competency for nurses (Christiansen, 2009). So when nursing students begin clinical placements in health care agencies, they often begin to communicate with patients before demonstrating other nursing skills. Although many nursing programs do not screen applicants for the ability to be compassionate and hold values consistent with those of professional nursing practices, faculty expect nursing students to be caring and respect human dignity.

Many nursing programs have incorporated reflective practice methods into nursing student assignments. Faculty believe that reflective practice helps students to make sense of events, situations, and actions that occur in clinical agencies. They encourage students to evaluate their impact on meeting patients’ needs and to determine their personal growth as beginning nurses.

Therapeutic communication is emphasized in nursing education programs using nursing fundamentals textbooks in support of student learning. It receives greater attention when students take psychiatric–mental health nursing courses (Antai-Otong, 2008; Gilje, Klose, & Birger, 2007) when therapy shifts the focus to more specific interventions. The imperative to be therapeutic challenges faculty and students alike, particularly when
considering the efforts of students to communicate with patients during first clinical encounters. The classic model of sender, message, receiver, and feedback-response is often presented and verbal communication models are explained with examples (Berman et al., 2011). Recently, students have begun to learn and practice SBAR (Situation, Background, Assessment, and Recommendation) to improve communication to health care providers and reduce errors (Manning, 2006). In addition, therapeutic communication, used in a helping and goal-directed relationship, may be characterized as demonstrating attentive listening and physical attending. Attentive listening focuses on patients’ needs and communicates caring and interest to encourage their response. Physical attending includes listening, being present or with the patient, using posture to communicate openness, and maintaining eye contact (Berman et al., 2011).

Techniques of therapeutic communication are listed in fundamentals of nursing textbooks, such as using silence, providing general leads, being specific and tentative, using open-ended questions, using touch, restating or paraphrasing, seeking clarification, and perception checking or seeking consensual validation. Additional techniques are: offering self, giving information, acknowledging, clarifying time or sequence, presenting reality, focusing, reflecting, and summarizing and planning (Berman et al., 2011, pp. 310–311). Phases of the helping relationship are taught: preinteraction phase, introductory phase, working phase, and termination phase (Berman et al., 2011). Later in the curriculum, phases of the nurse–patient or client relationship are reviewed as well, including orientation, identification, exploitation, and resolution (Antai-Otong, 2008). Active listening, identification with patients’ feelings, putting one’s self in patients’ shoes, being honest, genuine, credible, and ingenious or creative, being aware of cultural differences, maintaining confidentiality, and knowing role and limitations are outlined as ways of helping patients (Berman et al., 2011).

Faculty encourage students to develop self-awareness from one patient encounter to another so that strengths and limitations are analyzed and competency develops. Faculty may require students to perform process recordings of interpersonal communication episodes (Antai-Otong, 2008). They emphasize the development of a rapport with patients and supervise students’ growth via this assignment.

Students develop skills in the nurse–patient relationship gradually. They learn to interact and hopefully reflect on experiences with patients as they progress in undergraduate nursing curriculums. However, the development of self-awareness is not easy, particularly when students do not practice reflection or introspection. One investigator (Scheick, 2011) made a case for students to practice mindfulness. She pointed out that students bring their own unfinished conflicts to relationships with patients. Mindful aliveness then helps students to be fully attentive to patients as persons; students invest themselves consciously in the present nurse–client moment. Self-control involves students being resolute and taking charge about choices
in their lives, and self-concept behavior means that students are self-aware, open to themselves, and conscious of paying attention to inner thoughts and emotions. Although the sample size was small for experimental and control groups, some trends were promising regarding attentiveness in experimental group results.

Nursing’s oral tradition is strong in relation to the transmission of cultural knowledge. Because of this, expert clinicians participate by example in mentoring neophytes. It is likely that the skilled activities nurses use when creating interpersonal relationships with patients pass on to observers and are incorporated into their personal repertory of interactive strategies.

**ARTISTIC INTERPERSONAL RELATIONSHIPS**

Artistic interpersonal relationships are fundamental to expert nursing practice. Consistent with this belief is the argument posed by Johnson (1994). She described nursing art as “the nurse’s ability to grasp meaning in patient encounters, the nurse’s ability to establish a meaningful connection with the patient, the nurse’s ability to skillfully perform nursing activities, the nurse’s ability to rationally determine an appropriate course of nursing action, and the nurse’s ability to morally conduct his or her nursing practice” (p. 3). Grasping meaning in patient encounters is accomplished by nurses who understand what is significant in a particular patient situation. Establishing a meaningful connection with patients refers to an attachment or union between nurses and patients that promotes authenticity, wholeness, and integrity in the encounter and engagement that involves subject-to-subject interaction. Next, skillfully performing nursing activities requires demonstrating proficiency and dexterity in meeting patients’ needs while performing tasks, procedures, and techniques. Rationally determining an appropriate course of nursing action suggests that the intellectual abilities of nurses lead them to draw conclusions based on knowledge, including science, and the ability to arrive at the best possible outcome for patients. Lastly, nurses are motivated by moral values framing their care and concern for patients (Johnson, 1994, pp. 4–12). Johnson’s argument reinforces the essential nature and elements of the nurse–patient relationship for nursing practice and hints at how artistic performances by expert nurses accompany other nursing functions. “[In nursing as in art] you’re trying to creatively intervene with a patient and help them heal…it’s very abstract…” (Skillman-Hull, 1994, p. 119).

Benner (2000) also considered artistic nursing performance. She represented caring clinical practices as actions based on knowledge and a commitment to meet patients and families in their life worlds. She valued the insights gained from stories of clinical practice, noting that caring practices are revealed in such accounts. Benner emphasized that artful caring practices are
knowledgeable, lifesaving, and not perfect. Expert performances are revealed in this way:

…we know them when we experience them, and we recognize them when they are missing. Nothing less than safe passage through diagnosis and therapy, with a sense of integrity and dignity, is at stake when excellent nursing practice is eroded. (Benner, 2000)

Another discussion of nursing art positioned it in Eriksson’s theory (Nåden & Eriksson, 2000, citing Eriksson), whereby the ultimate essence of caring is the alleviation of patients’ suffering and the fundamental motivation is charitable. Framed by this theory, nurses invite patients into interaction as they turn toward them (Nåden & Eriksson, 2000) literally and figuratively at the starting point of nurse–patient relationships. Acceptance of patients begins with nurses recognizing them; acceptance serves as a foundation for the relationship. Similarly, the relationship is based on nurses confirming patients, that is, their attitudes are inviting and their behavior is calm. Patients’ experiences, existence, and their right to feel what they feel are respected. By communicating invitation and confirmation, patients are brought forward into the relationship. The expressions on patients’ faces, through their gazes, appeal to nurses. The nurse is ethically responsible to answer this call. Developing expertise at invitation and confirmation epitomize nursing art in interpersonal relationships.

RESEARCH ON CARING RELATIONSHIPS

Table 1.1 presents a selection of citations representing the evolution of research on interpersonal relationships in nursing and caring relationships over 10 years. A variety of research designs were used in the studies. Both patients’ and nurses’ perspectives were elicited.

INTERPERSONAL CARING RITUAL AND SYMBOLS

An interpersonal caring ritual is therapeutic in that it aims to improve the welfare, well-being, and condition of patients. It can heal patients and nurses. The ritual performance reaffirms the personal and professional values and beliefs of nurses. It enacts nurses’ respect for the dignity of all persons and nurses’ interest in doing good work. Nurses are compassionate as they commit to decreasing patients’ suffering, answer patients’ calls for nursing, and respond to the needs of patients. As an enactment of caring, it expresses human love and charity (Råholm & Lindholm, 1999).
<table>
<thead>
<tr>
<th>Study/Article</th>
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<tr>
<td>Fredriksson (1999)</td>
<td>Caring relationship is the basis of caring (Paterson &amp; Zderad, 1998); caring motive is to alleviate suffering (Eriksson, 1992)</td>
<td>Qualitative research synthesis; to develop an ontologic and theoretical understanding of presence, touch, and listening in a caring conversation; to describe and develop a deeper understanding of each concept by means of research synthesis of qualitative caring and nursing studies; to describe tentatively the relations between the concepts; 28 studies with 262 informants</td>
<td>Caring conversation, research synthesis on presence, touch, and listening</td>
<td>Hermeneutic circle</td>
<td>Two modes of relating in a caring conversation: connection with high intersubjectivity and contact with limited intersubjectivity Caring presence: being there (physical presence, communication, understanding); being with (interpersonal and intersubjective mode of being; gift and invitation to make room for the other person; patient invites nurse to see, share, touch, and hear the brokenness, vulnerability, and suffering) Touch, contact and noncontact types (task-oriented touch as procedural, instrumental, or working touch; caring touch as nonverbal communication, also known as positive affective touch, expressive touch, nonprocedural touch, comforting touch, or non-necessary touch; protective touch helps nurses distance themselves from emotional pain, preserve energy resources, and release tension); touch a form of relating Listening: as an intentional act; taking in all aspects of patients' message; allowing them time and space to think and tell the story; process; deliberate and active behavior; paying attention to the speaker; demands conscious effort, searches for meaning and understanding, creative activity essential to establish relationship</td>
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Villanueva (1999)  
Conceptual orientation: patient recollections of experiences during coma or after sedation; communication behaviors of critical care nurses  

Qualitative, grounded theory; to explore the experience of critical care nurses caring for unresponsive neuroscience ICU patients (in traumatic coma or pharmacologic paralysis); what type of care did the nurse provide to these patients? When did the nurse talk to the patient? What did the nurse talk about to the patient? What factors promoted or inhibited talking to the patient? How did the nurse assess the patient’s comfort needs? What interventions did the nurse perform to provide patient comfort? What do nurses believe a patient perceives while receiving NMBAs? 16 critical care nurses  

Experiences of critical care nurses caring for unresponsive patients  

Interviews, grounded theory method  

Core category: Giving the patient a chance; subcategories: Learning about the patient (gathering information; isolating subtle changes; interpreting needs); maintaining and monitoring (focusing on the technical); watching out for the patient (looking for change, keeping the patient safe, getting the patient comfortable, maintaining a delicate balance, making clinical judgments); talking to my patient (instructing the patient, reassuring the patient, providing individualized conversation); working with families (establishing a relationship, teaching the family, motivating the family, protecting the family, working around the family); struggling with dilemmas (forgetting there is a person, judging the patient); personalizing the experience (wanting to be talked to, needing family and friends, being medicated, having privacy, listening to the radio or television, having some quiet time)  

Many factors influence talking to the patient (characteristics of individual nurse, condition of patient, patient-related information, circumstances of injury, families, length of staff employment in unit)  

Doing everything to help the patient attain the best possible outcome  

Overarching themes: Characteristics of communication: Not Being Understood: inequality of communication, misunderstandings, altered perceptions; loss of control: unmet needs, dependency, dehumanization; negative emotions  

Carroll, 2004  
Importance of quality communication to quality nursing practice;  

Metasynthesis; what characterizes nonvocal ventilated patients’ perceptions of being understood across qualitative studies;  

Metaphors translated study to study:  

Analysis: Paterson (2001); Thorne & Paterson (1998)  

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<td>Peplau’s interpersonal relations theory (1992)</td>
<td>to provide an enlarged interpretation and understanding and to build cumulative knowledge of the communication experiences of the nonvocal ventilated patients’ perceptions of being understood; 12 studies; 111 participants</td>
<td>communication experience of nonvocal ventilated patients</td>
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<td>Nursing care desired: individualized care, caring presence. Nurses have a critical role in facilitating communication in nonvocal ventilated patients.</td>
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<td>Johansson, Skärsäter, and Danielson (2007)</td>
<td>Encounter as a prerequisite for building relationship, cornerstone of psychiatric nursing; encounters in psychiatric and mental health settings; basic understanding of what it means to be human</td>
<td>Encounters on locked psychiatric ward</td>
<td>Participant observation of encounters in dining and day room and patients’ activity room, smoking room, corridor rooms, informal interviews, document analysis, field notes; analysis (Krippendorff, 2004)</td>
<td>Caring relationship: personal relationships: between staff and patients, staff and next of kin, between patients, patients and next of kin and friends; staff treated patients with respect and ensured that staff-patient interactions from previous stays on ward were well established; staff took advantage of various opportunities; physical and spiritual closeness between staff members and patients Uncaring relationship: failure to create or maintain a caring relationship; failed to show respect by not adhering to rules of confidentiality, not taking patient seriously, being too personal; staff distant resulting in difficulties with establishing contact; lack of trust on part of patients and staff</td>
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was the common ground for being in the world with patients

Unrecognized relationship: patient relationships with each other; patients involved in each other’s care

Encounters led to personal relationships characterized by caring and uncaring relationships

Caring is an interpersonal process, characterized by expert nursing, interpersonal sensitivity, and intimate relationships

Antecedent to caring process: physical, psychosocial, and/or spiritual needs for and openness to caring on part of care recipient

Antecedent care provider preconditions: professional maturity, moral underpinnings, and conducive work environment

Consequences: patients’ physical and mental well-being; nurses’ mental well-being

Theoretical framework of nursing practice involves the context of a conducive environment whereby the patient perceives a need for and is open to a therapeutic relationship with the nurse; a relationship-centered intimate partnership develops; the nurse uses and creatively adapts personal and professional knowledge on the basis of values; nursing interventions are situation-specific, holistic, and accomplish patient empowerment; the patient outcome is enhanced with physical and psychological well-being; the nurse outcome is enhanced with psychological well-being

Nurse–patient interaction is relationship-centered, characterized by rhythmic give-and-take between nurse and patient. The cyclic interpersonal process is characterized by authenticity and trust

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<td>Brown (2009)</td>
<td>Stress in workplace, self-care in work environment</td>
<td>Qualitative, phenomenologic; to assess the meaning of caring for self by registered nurse leaders who participated in holistic caring-for-self project; 10 nurse leaders managers in acute-care hospital, purposive sample</td>
<td>Interviews with additional follow-up, open-ended questions; hermeneutic phenomenology (van Manen, 1990)</td>
<td>Metaphor: climbing to the mountain peak as journey of life; upward climb metaphor for care of self and challenge to incorporate care of self in their lives</td>
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<td>Henricson, Segesten, Berglund, and Määttä (2009)</td>
<td>Conceptual orientation on touch; tactile touch uses effleurage used to touch the skin using slow strokes with firm pressure, mainly performed by trained touch therapists with flat of hand with fingers close together</td>
<td>Qualitative, phenomenologic; to illuminate the meaning of receiving tactile touch when being cared for in an intensive care unit; six former ICU patients following discharge</td>
<td>Interviews using broad and open questions and follow-up questions; analysis methods of Ricoeur (1992), Lindseth and Norberg (2004)</td>
<td>Reflection on the journey; why to care for self on the journey; how to care for self on the journey; wisdom learned along the path</td>
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Main theme: Being unable to gain and maintain pleasure—being exposes to annoying stimuli (being exposed to unpleasant feelings, being moved to another surrounding);
being exposed to an annoying environment (being interrupted by the staff and the surroundings);
being left without comforting touch (being abandoned; being one among many again)

Students expressed their attitude toward patient through body movement, voice, and type
They differed from each other: they moved easily or were less spontaneous; the body was used as a tool adapted to the situation; situation-based humor was used

Students must develop their personal style in correlation with expectations of nurse’s role and commit to and become involved in patients’ experiences

Students need to work on their own expression to maintain important norms in developing patient relationships and faculty need to be their resources

Characteristics in interaction:
1. There were no negotiation processes: patient needs perceived and addressed by nurse as long as they are not in conflict with existing nursing and rehabilitation concepts
2. Patient and nurse able to negotiate: nurses and patient admit to uncertainty; nurse’s approach maintains contact with patient, submits suggestions, listens to patient’s point of view and adapts to patient’s individual pace and integration process
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<tr>
<td>Tejero (2011)</td>
<td>Synergy Model of American Association of Critical Care Nurses; dyadic relationship between nurse and patient related to patient satisfaction; mediated model</td>
<td>Correlational path analytic design; to test the direct and indirect relations of nurse characteristics and patient characteristics to patient satisfaction, as mediated by nurse–patient dyadic bonding; 210 nurse–patient dyads</td>
<td>Nurse characteristics, nurse–patient dyadic bonding, patient satisfaction</td>
<td>Unobtrusive observations, interviews, NPBI, observation checklist, measured nurse–patient dyadic bonding (mediating variable)</td>
<td>Path analysis: nurse–patient bonding (equated with bonding factor score) patient satisfaction highest coefficient (0.327), ( r = 0.70, \ p = .001 )</td>
<td>Nurse–patient dyad bonding mediates the effect of patient predictability and nurse facilitation of learning on patient satisfaction; patient predictability has direct effect on patient satisfaction; nurse facilitation of learning had indirect effect. Nurses should improve health teaching competence.</td>
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<td>3. Patient shapes and leads: high nurse turnover rate is context; patient assumes role as case manager, compensates lack of information and arranges well-proven procedures in nursing approach upheld; tensions arise</td>
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NPBI, nurse–patient bonding instrument.
The interpersonal caring ritual is carried out within the boundaries of the nursing situation, occasion, moment, or meeting. The nurse–patient relationship that develops as a consequence of the encounter is foundational to clinical nursing practice. The nurse enters the patient’s intimate or personal space and invites the patient’s response. His or her gaze is on the patient, in most cases, eye to eye. Visual, auditory, olfactory, thermal, and tactile perceptions are integrated. While the nurse may use caring touch, other types of touch may be used if accepted by the patient. Other gestures may be evident as words are spoken and nonverbal communication techniques are used; the nurse’s bodily position symbolizes both the intent to care and attentiveness. The words that the nurse uses begins with a greeting and progresses to a focus on what the nurse perceives to be the call for care. The encounter symbolizes hands-on care, even though physical contact may not be executed.

SUMMARY

Interpersonal caring rituals carried out by nurses every day are in fact dramatic, connecting encounters for nurses and patients. The importance of this ritual is confirmed by its emphasis on basic nursing programs and on nurses’ preoccupation with establishing and maintaining relationships with patients. As a stage or basis of subsequent and simultaneous nursing activities it is perhaps the most important ritual of all.