

The Man in the Hospital Bed

Personal Professional Narrative
of Transformative Learning:
A Nurse Practitioner's Self Reflections
on
Caring for the Man in the Hospital Bed
University of Windsor

Joint Doctor of Philosophy in Educational Studies

Transformative Learning

A Nurse Practitioner's Self Reflections on Caring for the Man in the Hospital Bed

Introduction

In this paper, I provide a personal professional narrative of a poignant clinical experience whereby I dealt with the management and care of a resistive, suicidal patient. The patient was of Muslim descent and had attempted to stab himself in the stomach. I chose this particular case not because it was a gruesome act of self injurious behavior but more to illustrate the personal journey of self reflection and professional growth, I embarked on as a Nurse Practitioner (NP) in order to energize and understand how not only the patient's behavior, but also my own, were informed by personal and historical learning and individual emotions. Thus, my story is as much about me as it was about the patient whom is identified as Mohammad. This narrative through reflective practice has the potential to be transformative as I examined, challenged, and redirected the power relationship between Mohammad and myself.

For this story line, I chose the application of more than one theoretical practical framework in order to better understand the phenomena of Mohammad's suicide attempt. The implementation of Prochaska's (2001) Stages of Changes provided a guideline to assess the patient's readiness for life changes. The implementation of the Calgary Assessment Model developed by Wright and Leahey (2000) provided a non-hierarchy framework which facilitated a collaborative approach of discussions between the family and myself. The Hamric Model of advanced practice provided a framework of advocacy and policy changes for curriculum (Hamric, Spross, & Hanson, 2000).

As the narrator of this story, I drew on both historical and contemporary sources of curriculum and the specific writings by Manning (2003) and Pinar, Reynolds, Slattery, and Taubman (2004). The construction of meaning for this autobiography stems from my education, beliefs, self assessment skills, communication patterns, interpretations from curriculum, interventions, narrative findings, and post-modern thinking. The introduction of aesthetics was of value in the interpretation of works of art as I endeavored to describe psychoanalytic approaches in understanding the psychological impact they produce in the viewer.

Communication

Interestingly, I was almost tricked myself into thinking my failure to understand the Arabic *language* of "Urdu" would inhibit me from understanding the needs of Mohammad. I also refer to Mohammad as the man in the hospital bed. Mohammad's mother spoke only Urdu and initially she was my only source of information regarding the circumstances surrounding her son. I was aware that it would be easy for me to fall into the comfortable state of only being familiar with the language of English which is central to culture and politics in Canada. In actuality, my ability to communicate with the mother was a re-articulation of the political which was a departure from the metaphysical concept of usual language (Pinar et al., 2004).

At first, Mohammad did not respond verbally to my initial and subsequent visits to his hospital bed. Instead, his body language conveyed non-verbal messages of anger and avoidance as he thrashed about in his bed (Carkhuff, 1987). He refused to converse with me or establish eye contact. The language of the patient or lack thereof motivated me to create a composition of verse characterized by the intensity of emotion I was feeling related to the management of care for this patient. I felt it was poetic justice to express

my frustration at being rejected, in the form of prose. Huebner (1966) identifies aesthetic language as an alternative form of expression.

The Man in the Hospital Bed

*It is not foreign to me,
to visit suicidal persons
in their hospital beds.*

*For, I have witnessed
the after math,
of suicide actions,
frequent times before.*

*Today,
the man in the hospital bed
exhibits an abdominal wound,
where remnants of a knife
had been lodged before.*

*He slept so soundly,
as if unknown,
to the aftermath
of his self abuse,
that occurred the night before.*

*Then from the corner
of my eye
a sad faced woman
came to view.*

*Her name was Amma,
and as the man in hospital bed's
mother,
she spoke only, Urdu.*

*Together, as we gazed
at the man in the hospital bed.
I observed, a leakage
of his emotions;
evidenced by appendages that
failed, to cease to move.*

*I noted,
that although the eyes and face
of the man disguised the messages of his*

*turmoil.
With the hands and feet,
the truth prevailed!*

*That night,
as I walked along the road;
I thought about the man
in the hospital bed.*

*As I watched a deer,
run amuck
I wondered, was the deer
displaced from the forest
by the construction
of new homes?*

*I pondered, was the deer,
like the man in the hospital bed?
Did he fall prey to political folly
or loss of territoriality.*

*Similar to the deer,
the man in the hospital bed
conveyed a message,
that my proximity
was too close!*

*For, when I appear,
to both the deer and the man
in the hospital bed,
they resist me and
attempt to disappear!*

*I wondered,
did this man in the hospital bed
create a phenomenon of
Selbstumord or "self murder."
A uniquely, human occurrence.*

*So, as I come to know
the man in the hospital bed,
no assumptions of his problems,
will I make.
Instead, I will learn of his dilemma
and why he put his life at stake.*

*I wondered,
was the man in the hospital bed
affected by the context influences
of his culture?
Or was it a case of thwarted love?*

*For, from the man in the hospital bed,
I would rather hear,
the fury of his words
than no words at all.*

*In reflection I wondered,
were his actions
the result of political follies
or instead related to
a history of discourse?*

*I wondered,
was he dissatisfied
with his nation of choice?
Or did the man in the hospital bed
forsake cultural tradition
and become a victim
of social addictions.*

*I wondered,
were his suicide thoughts
ephemeral and his self abuse,
an exclusionary act!.*

*When I speak to him of narcissism
will he reply;
it's a matter of his life.
Or, will he find his act of suicide
a betrayal of his body,
as he still survives.*

*For remnants of a suicide note
had been found.
The man in the hospital bed
had written:
"I began to dream of dying,
and the plan went on and on."*

As the man in the hospital bed

*lay sleeping,
I began to ponder.
Will you accept my succnornance?*

*However, this was not the case.
For when he awakened
and I inquired.
“Are you glad to be alive?”
he stated, “Leave me be.”*

*You may think
I was saddened by his rejection.
Maybe I was,
but more importantly, I was
glad he had spoken.
As alas,
a connexion had been established.*

*Hence forth,
from our connexion
I endeavored
to initiate,
therapeutic activity
to excogitate,
and learn about
the man in the hospital bed!*

Subsequently, Mohammad’s utterance of the words, “Leave me be” eventually led to his display of prolonged pleasant verbal communication patterns with his mother but unfortunately, he chose not to speak with me. Thus, the therapy could not begin. As the professional, I felt excluded by the language of the mother and Mohammad as they easily conversed in the dialect of Urdu without my understanding. In contrast, to Mohammad’s exclusion of myself, usually I have encountered only receptive patients. They may have been troubled by their medical and suicidal condition but they were eager to talk with me. I have found that usually, patients will fall on either side of a spectrum of information flow. Either they aren’t saying enough or they are saying too much. At this point, I would have been delighted if Mohammad decided to say too much. However, I had to remind myself that it was not my fault for unless I was a laughably incompetent or physically offensive Mohammad’s hostile attack was the product of his pathology. As a clinician, I was insightful enough to understand that Mohammad’s anger was the result of his emotional pain.

Research Curriculum

Crabb (2005) contends that before education can begin an understanding of the patient’s culture and lived experience of suicide is required. Until now, my practice for assessing suicidal persons has been to implement a risk category assessment questionnaire which included high and low risk features as related to substance abuse,

mental illness, age, sex, and other sociodemographic factors. I had known for a while that this form of assessment was inadequate, especially for culturally diverse persons. I agreed with Gard, Cavlak, Sunden, and Ozdincler (2005) that there is a need for a deeper understanding of different cultural influences on life views, among health care providers. After critical examination of current paradigms which are largely undimensional and focused only on risk factors, I determined a shift of paradigms was required into the legacy of explanation of suicidology.

According to Derrida (as cited in Manning, 2003) a re-articulation of suicide interventions included a unique sociocultural and political perspective. As an ethical interviewer, I knew I had a responsibility to be inventive in order to provide culturally sensitive care for suicidal persons. Thus, I became energized and headed off to the library to retrieve information on Muslim cultural practices. At that point, I realized that a deeper understanding of Mohammad's suicide would only be realized through theory which incorporated the dialect of person and culture (Kamal & Loewenthal, 2002; WHO, 2006). Although researching Muslim practices and suicideology was time consuming, it was exciting to be repeating metaphysics differently by the deconstructive operation of stereotypical suicidal assessment frameworks which did not allow for culture and individualized narrative stories.

Research studies indicate that persons draw upon their cultural meanings when choosing their methods in suicide attempts (Boothroyd, Spreng, Malus, Hodgins, 2001; Hicks, 2005). Khan and Reza (2000) reports that Islam religion, forbid the taking of one's life. However, I had to be careful not to stereotype a culturally specific belief system for Mohammad. In order to improve my practice, I wanted to learn how deeply embedded suicidal ideation was in Mohammad's cultural system of ideas. For example, Mohammad's specific type of suicide attempt may be validated by cultural patterns of usage of knives (Jacobs, 1999). I was careful to note as identified by Carlat (2005) that an underestimation of social influences can be referred to as a fundamental attribution error, which I wanted to avoid.

Theoretical Frameworks

A guiding principle of my suicidal care is that suicide is a multi-dimensional phenomenon and requires a multidimensional approach without pre-conceived assumptions (Gordon & Drummond, 2002). From my experiences, suicide assessment and prevention efforts are less effective if they are not set within multiple frameworks. Rubinstein (1995) urges care providers to implement broader ranges of theories in suicidal studies. Pinar et al. (2004) note that the whole person includes both physical and emotional well being. Similarly, both the Calgary Family Assessment Model by Wright and Leahey (2000) and Hamric's Model by Hamric et al. (2000) promote holistic care measures in understanding the individual perceptual maps of culture and stories.

Although I implemented a variety of theoretical frameworks in managing Mohammad's care, my first priority was to better understand the patient's readiness for behavioral and emotional change. Prochaska's (2001) theoretical stages of change include precontemplation, contemplation, preparation, action, maintenance, and termination.

Prochaska's Stages of Change (2001)

Precontemplation	Contemplation	Preparation	Action	Maintenance	Termination
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With health teaching, I conveyed to Mohammad how important change would be to his health and relationships as he was feeling demoralized after the suicide attempt. Because I cared about Mohammad, I was ready to work with him regardless of his stage of readiness for change. For example, I asked Mohammad if he had stopped dreaming about his gambling addiction. Until this occurred, we could not move towards an action stage. In reflection, I determined it was important for me to progress through different stages of change on my own in order to provide successful patient care. As I progressed through Prochaska's stages, I acknowledged that a communication problem existed and that preparatory research on culture was required in order for me to move towards an action stage of therapeutic interventions. My plan was to test the waters of communication with Mohammad with the elimination of traditional passive psychotherapy and the implementation of a proactive approach of persistently reaching out to Mohammad with cultural specific care (Prochaska, 2001).

Calgary Family Assessment Model

The Calgary Family Assessment Model (CFAM) is a multidimensional framework embedded with views of cognition, diversity, family, and community involvement. Through the implementation of the CFAM, I was able to understand the concerns of family members and the painful images and feelings created by the suicidal event. I was able to alleviate some of the concerns the mother presented with and support her as she experienced intense guilt about not being able to prevent her son's suicide. The CFAM provides linear, circular, and triadic questions within a family context. With the implementation of the CFAM, I became the facilitator of therapeutic family interactions as I felt it was my professional duty to improve the cognitive, affective, and behavioral functioning of its members (Wright & Leahey, 2000).

Hamric's Advance Practice Role

In an advanced practice role, I became an *advocate and leader* for the implementation of narrative accounts of the lived experience of suicide and family assessments. According to Hamric et al. (2000) advance role of *change management*, I endeavored to revise customary hospital curriculum practices of a suicide risk check list to include interview practices that were informed by individualized, narrative responses from patients and families.

As I was new to the role of nurse practitioner, my professional role was evolving. My identity as a nurse practitioner in mental health was in a stage of infancy. I was concerned not only with helping Mohammad make positive changes but how I represented myself. In the advance practice role, I needed to understand that Mohammad's cultural needs were calling me to political action. My plan was to influence public policy and have the individual needs of all suicidal persons be addressed. When I examined protocols of suicide assessments from a political perspective, I knew I needed to market the value of the lived experience of suicide from a narrative, social, cultural, and political perspective as part of *contemporary suicide assessment curriculum*. See Appendix A, Hamric's Advance Practice Nursing Model (Hamric, 2000).

Self Exploration

My lack of interaction with the man in the hospital bed helped me to re-examine my own cultural assumptions and how they influenced my professional practice. I felt that no matter how little I knew about Mohammad and how un-biased I believed I was, it was

impossible for me as a human being not to have preconceived notions about his behavior, even if they were of a very general nature. I was aware, that unconsciously and uncritically I took my world view for granted as the presumed way things were. In retrospect, I was a bit arrogant in my knowledge. I required a reality check in order to direct me where I should be going with this case. As a result, Mohammad's resistive behavior was my reality check.

My world view pervaded and influenced most of my thinking and actions. One thing I knew for sure, I was not happy waiting for the patient to accept me. I was unaccustomed to rejection. As a result, I felt the man in the hospital bed was a challenge to me and that was the key to the value of our relationship because I wouldn't give up my endeavors to communicate with him. I felt the need to succeed in the establishment of a therapeutic relationship with this patient, partly for my own self esteem and more importantly it was critical that Mohammad experience less depression, stop gambling, and refrain from harming himself. Since I evaluated my professional successes as reflective of how well my patients manage their lives, things were not looking successful for me or Mohammad either.

Self Reflections

In self reflection, I began to question myself and raise the *ontological* issue about what I could do about retrieving the true story of Mohammad's life. The *epistemological* issue was for me to understand the inner experience of mental pain and cultural world of Mohammad. Normally, I practice close repeated listening of patients' stories along with methodic transcribing which leads to insights that in turn, shaped how I choose to represent their personal stories as narratives which capture the vivid experiences of suicide. Usually, my clinical assessments and counseling strategies are established from the patients' verbalizations of the fine grain details of their life. However, close listening was not an option at the beginning of our relationship as Mohammad kept me at a distance. Normally, I have the ability to "breeze" into hospital rooms and introduce myself; and in return suicidal persons are more than agreeable to share with me all the details of their lives and reasons for their suicide attempts. During client interviews, I employ only minimal investigations as the patient was there for the telling so I could often sit back and collect field notes about their lives, in a timely fashion.

Often, I used self-effacing humor which is inconsistent with any threatening intentions towards the patient. Thus, patients feel safe with me. I knew that the breadth and depth of suicidal evaluation varied from interview to interview, according to the willingness of patients to provide personal information (Goldman, 2000). In order to understand my introspective views concerning the resistance from the man in the hospital bed, I needed to examine my own sensitivities. As a result, I decided to embark on a traditional writing task of self-exploration in relation to analysis of my own fears and emotions in my efforts to discover how I could best meet the needs of the patient. See Appendix B, Introspective Writing (G. J. Dhinsa, personal communication, December 2, 2006).

Emotional Intelligence

From my experiences with Mohammad, I knew I was right to question my underlying assumptions about how professional relationships should progress and that with understanding culture and the individual act of suicide a more rightful society will be achieved. I used reflective practice as a method for my continual professional

development which became an integral part of my emotional development. In retrospect, it was fear that facilitated the growth of my emotional intelligence for I was frightened of the patient who rejected me. My fear came from personal injury to my self-esteem and fear of the observations of others and the embarrassment of possibly being viewed as an ineffective therapist. As I began to question myself on my abilities to manage my own emotions, I underwent the process of completing a self-report of emotional intelligence which highlighted the psychological process of my observed fear. My self-report identified alexithymia leading to a negative effect which in turn indicated my potential for counterproductive work behaviors. However, the negative self-report was reflective of my low self-concept not my abilities. In order to reduce counterproductive behaviors, I tried to reduce the negative affect of the relationship by the identification of my emotions and then the establishment of new methodology in order to connect with Mohammad (Mayer & Salovey, 1993).

Just as learning can facilitate transformative changes so too can unlearning (Newstrom, 1983). I realized a need existed to reduce pre-existing knowledge that represented barriers to new learning. You might say that in order to work in health care all you need to do is acquire sufficient knowledge of biology, physiology, and psychology. However, we cannot deny that to work with patients also requires health professionals to work with their affective aptitudes or feelings as well as with the interpersonal attitudes of others (Macdonald, 2002). The process of unlearning began with my appreciation of accumulated nursing knowledge, reflecting positively on its relevance and being aware of assessment practices that may need to be replaced. For example, I was delighted to move beyond the standardized generic risk form of suicide assessment. The educational and emotional work of unlearning skills and assessments was a transformative step which led me to feelings of receptivity and respectful recognition of new information of cultural and individualized needs.

Transformative Interventions

As Mohammad's abdominal wound began to heal, so too our initially rocky relationship slowly began to improve. So, I endeavored to expose and re-expose this man to my presence. My strategy was similar to subliminal advertising whereby I exposed him to frequent, constant, exposure of my being. The image of my presence was to appeal to his subconscious mind as a supporter and an encourager of his well-being. Although this method of marketing or psychological interplay lacked empirical support, I felt it was worth a try (Myers, 1989).

Each day, I went to Mohammad's bedside and again re-introduced myself and awaited his response. Still there was no response from this client. Most often I left the room after five or ten minutes as I was on a stringent schedule and needed to move on with my patient assessments. However, one day irrespective of time, I decided to play a waiting game with Mohammad to determine if he would give in and speak with me. I was steadfast as I sat in close proximity to Mohammad and continued to wait for his response. As I continued to play the waiting game, I took up the activity of completing clinical notes which was also on my agenda. The connection almost didn't happen as I waited for Mohammad to speak to me. We were both proving to be champions at the waiting game. So after approximately thirty minutes, Mohammad addressed me and stated in a brusque voice, "How long are you going to sit there?" I was secretly happy to hear his attempt at communication. At that point, I replied, "Until you are willing to talk with me."

I realized, I had to be careful that Mohammad's avoidance behaviors did not in turn, cause me to take a negative attitude; as attitudes become potent guides to actions. Ultimately, I believed that seeing and doing would result in a more positive attitude on my part. As a clinician, I felt an obligation to learn more about Mohammad's culture in order to better understand his physical and psychological needs. As I began to learn more about Mohammad's homeland, I realized I was starting not only to understand the client more but also like him. This evoked a warm feeling inside me and I noticed that fears and frustrations that I may have encountered when I began my library research on Iraq were now replaced by peaceful feelings as I became immersed in my learning. Research on the history of Iraq proved to be a positive strategy by opening up future possibilities of communication with Mohammad.

With the introduction of Iraqi photos that I retrieved from the library, I was able to use mnemonics as aids to ensure that I asked about major diagnostic criteria. For example, I inquired as we gazed upon the photos, "Do many individuals in Iraq become involved in gambling?" Mohammad verified this was true. I proceeded to open up the lines of communication by going from the general to the specific. I inquired "How would you compare patterns of gambling in Iraq to Canada?" I was again attempting to move from the deductive to the inductive in order to obtain specific data of Mohammad's socio-cultural experiences with gambling. My questions seemed to fit naturally into the context of the discussion.

In order to establish the flow of communication, I was able to position Mohammad as the protagonist and myself as the listener in a dialogue about culture, society, and politics. In Mohammad's story about Iraq and his family I traveled to another context to double voice the story from the patient's perspective and recount the protagonist's own story of one's homeland and political injustice. I invited Mohammad to participate in the discursive interplay of "living dialogues" (Davies & Harre, 1990). As Mohammad began to speak more often, I was able to look more closely at his moment-to-moment construction of identity in the context of his dialogic narratives. See Appendix C, illustration of therapeutic communication with Mohammad (G. J. Dhinsa, illustration of personal communication, December, 2, 2006).

Because I knew that certain experiences are lost or diluted when put into words, I implemented the aesthetic media of art in order for Mohammad to tell me about his homeland. Mohammad attempted to recreate through rudimentary art work a drawing of his childhood home. Bollas (1992) speaks of self idiom as a language of self actualization. Just as Mohammad was expressing himself in his art forms, I was using his drawings to appeal to my own senses and by pass language. As I operated from the borders of language I began to realize that it is all about chemistry. The development of chemistry between Mohammad and myself provided me with a sense of fullness and beginning of wholeness to our relationship. All along, I was destined to seek the sparks of chemistry in Mohammad so as to elaborate parts of myself that required fulfillment of my self esteem and self actualization. As a clinician, I recognized that all things cannot be put into words and situations of quiet shared aesthetic experiences stem from chemistry which was the bridge to the development of our therapeutic relationship.

I suspected Mohammad was experiencing symptoms of Post Traumatic Stress Disorder (PTSD) related to the violence of his father's death (American Psychiatric Association, 1994). Persons who come from nations of political strife and atrocities often

experience traumatic events (Goldman, 2000). Although the road of advanced nursing practice allows me to perform independent counseling measures, I knew that Mohammad was too vulnerable to endure discussions related to the violent death of his father at that time.

There are qualities that Mohammad needed and looked for in me. He wanted reassurance. He wanted to be listened to. He needed to know that it made a difference to me whether he lived or died. Each day I attempted to reduce the physical distance between Mohammad and myself, as I inched my way from the doorway to the bedside. Eventually, I was able to sit beside the client and create a shorter distance between my eyes and Mohammad's in a horizontal line. This straight line was only achieved when I was able to sit across from Mohammad and engage him in the communication processes leading to his emotional growth. These dialogues with patients were part of the process of constructing my own professional identity. The professional identities that nurses construct need to include a broadening of their belief systems. Furthermore, this work needs to be done in the context that situates nurses and patients in the larger discursive interplay of the community culture.

Transformative Learning and Reflection

The rationale of reflective practice provided me with an opportunity to learn from past mistakes which seemed to have an intuitive appeal to me. Reflective practice has the potential to be transformative resulting in changes to my professional practice and bigger implications for society (Sander, 2006). My initial event or concrete experience with Mohammad prompted me to reflect on our relationship and develop new strategies about how to communicate with him. During the process of fulfilling my learning needs, I was able to effectively put new communication strategies into practice. It has been noted that physicians intuitively use transformative learning as an approach for lifelong learning (Slotnick, 2001).

In order to ensure learning occurs from reflective practice, I chose a three loop learning tool as there is extensive evidence that single loop results in only the recognition that Mohammad was resistive to my care. Single loop learning does not result in reflective practice or behavioral changes (Sanders, 2006). For me double loop learning occurred when I identified my lack of cultural understanding as one of the reasons my communication with Mohammad failed. With the development of triple loop learning I acknowledged the importance of power relationships in our clinical relationship. In the past, I may have been overly in charge of the clinical situation and now I was required to share the power relationship with the patient.

As a NP, I realize there has been a failure in health care organizations with the single loop learning mainly because underlying patterns of suicide assessments have never been challenged. It was important for my learning to go beyond standard models of suicide assessments and implement library searches related to the culture of Iraq. The approach of triple loop learning facilitated my transformative learning whereby with my new cultural and aesthetic knowledge, I had the potential to go forward and develop a therapeutic relationship with Mohammad. Sanders (2006) notes that many educational philosophers regard transformative learning as of importance in the development of curriculum. See Appendix D, Model of Triple Loop Learning (Schon, 1987; Senge, 1990; Checkland & Scoles, 1999).

Narrative Methodology

Narrative inquiry was the methodology of choice in understanding both Mohammad's and my story. The methodology of narrative understanding was a way to give contour to experience, life conceptualizations, preserve memories, and understand traditions. Because collaboration occurs with narrative inquiry, I was collecting field notes about not only Mohammad, but myself. As I began to look at my field notes, I realized I had a story to tell. Similarly, Schon's (1983, 1987) recent narrative work fit with my educational lines of inquiry and reflective practice. Schon's strategy of narrative story telling was to connect the autobiographical social history to the connectedness of actions. By the implementation of Clandinin, (1986) Connelly and Clandinin (1988) narrative inquiry of theory of story telling, I was able to reconstruct my interactions with Mohammad and convey his personal story. A small fragment of my notes included ways I constructed my ideas of what was needed for future therapy.

I was aware of a particular danger in narrative writing whereby everything in the story works out well. According to Spence (1986) this is known as narrative smoothing or a Hollywood plot. However, I worked hard to ensure the authenticity of my story. Even though I think I have fulfilled the criteria of writing a good narrative, I still wonder if this narrative story will be a 'good one.' When I disclose my personal professional experiences in this narrative, I hope my reflections will stimulate multidisciplinary team members to look at what I say. The display of my writing invites feedback of how I managed holistic assessments and health teaching in this clinical situation.

Currere

Pinar et al. (2004) recommends lived experiences as a data source and describes *currere* as interpretation of experiences which involve reflection and interpretation of meanings. Although Mohammad was slow to the process of critical reflection of his experiences, I was not. As a student of *currere*, I was developing new skills in the deconstruction of traditional methods of inquiry and creating transformative curriculum whereby I empowered the man in the hospital bed to reflect on his own suicide actions. In line with this thinking, I was able to reflect on the effectiveness of my own communication strategies.

Postmodernism

In order to understand Mohammad's social and cognitive paradigms it was important for me to change my ideologies on suicide assessments. As a professional, I was able to take my understanding of Mohammad's situation and develop a culturally specific community program to meet his needs. With postmodernism a paradigm shift was happening for me whereby the new paradigm rejects and replaces the old one. The beliefs and values of understanding the individual lived experience of suicide represent a radically different way of seeing the world of suicidal persons. A unique aspect of my new paradigm included dialogic narratives with Mohammad. This approach provided me with the opportunity to author the narratives. How exciting and fulfilling it was for me to write a story and adopt a model of social positions by juxtaposing the other's voice (Doll, 1989).

Aesthetics

It was important for me to emphasize the notion of *aesthetic curriculum* for the man in the hospital bed. In order to keep Mohammad's interest my plan was not to do away with thoughts of the suicide experience but to transform the learning from outcomes of our discussions into an aesthetic experience. Pinar et al. (2004) identify art

forms as aesthetic literacy. As a creative measure, I requested Mohammad to examine photos of Iraq and provide clarification of the historical, social, cultural, and political contexts of the photos. I was careful in my selection of photos and chose only aesthetically pleasing pictures in order to not stimulate negative or unpleasant thoughts. I implemented the technique of observations of pictures of Iraq as a medium to render metaphorically what the client perceived from the illustrations as related to his life-world perceptions. At this point, I knew I was going beyond the call of duty but I was ready to pull out all the stops in order to keep Mohammad communicating even if it meant transferring library books upstairs to his hospital room. In retrospect, I felt elated that I was able to facilitate aesthetic exploration for Mohammad as he was able to journey to Iraq through art and experience a better time in his life.

In this story, I illuminate the features of a ‘Conversational Model’ of art therapy that was used to engage this reluctant suicidal person (Eisdell, 2005). The playful nature of our observation of pictures triggered poignant conversation with the translation from the visual to the verbal, with the joint focus on the artwork in which embedded a metaphor, created within the dyadic intersubjectivity of Mohammad and myself. The artwork symbolizes the intersubjective dimension of the therapeutic relationship (Bollas, 1987). As we gazed upon the art work of Iraq and discussed his homeland, I was able to use art as a therapeutic tool whereby Mohammad could imagine a future closer to his past. My task was to stay within the metaphor, remarking only upon the artwork, rather than the client.

For myself, I know a variety of psychoanalytic approaches have proved helpful in understanding the impact of works of art. As I re-created the illustration of Suicide Prevention as interpretive of Mohammad’s emotional status, I realized that art could be studied from the perspective of art history, stylistic, and other perspectives. See Appendix E, re-creation of Anon Migratte (Suicide Prevention, n.d.). One approach I considered was my own response to the art work of a half fish half human being and to highlight how the work resonated with my own psychology.

In my efforts to depict Mohammad’s cry for help as a migratory victim experiencing the psycho-social process of loss and change, I was interested in the mechanisms of mediation of, that is, the manner in which I expressed his suicidal experience in artistic form. In addition to considering the evocative nature of my artistic work, I incorporated a psychoanalytic approach into my interpretation of the illustration. In my efforts to create a work of art that illuminated Mohammad’s condition, I became so intent on personifying him as a victim of loneliness that when I began to feel an association between my inferior feelings in understanding Mohammad and the art subject, I was overcome with a fear of intrusive violation. I wondered how similarities between the fish/human creature and myself could ever be possible. I questioned how could my aesthetic interpretation of Mohammad ever be linked to me when truly it was a story about Mohammad? But as I set aside the issue of ownership of art and accepted its explanatory power as anybody’s story I began to relax and understand the fish to be a self portrait of me as I struggled to understand the psychological displacement I was feeling in my inability to connect with Mohammad’s psychological needs.

Education Curriculum

As a NP and educator, I envision my health care role as a *catalyst for change*.

Since I am autonomous in my role, I can define my practice. I felt, it was time to take suicidal assessments to a higher level of narrative understanding in order to provide culturally competent care for diverse groups. Usually, I am never satisfied until I provide an educational component to suicide assessment curriculum. I am continually shaping and reshaping strategies of effective suicide health teaching. *Phenomenological inquiry* provided me with the opportunity to investigate the distinct consciousness of Mohammad's perceptions. As a clinician, I realize that I could never fully comprehend whether my own interpretation of Mohammad's psychological status was absolutely correct. I practice from a humanistic psychology which has grown out of the need for what I believe is a more positive view of human beings. I believe that persons are born with a desire to grow and have the power to direct their own lives. Similar to Durkheim (1952), I believe the environment of *cultural, political, and social climate* can interact with the patient in either a positive or negative way. My care was completely patient focused. I gave of my self and time in order to help Mohammad to understand that his emotions and behaviors needed to be confronted. I showed him how to substitute his suicidal ideations and actions with constructive patterns of thinking and behaviors. Similar to Manning's (2003) theory of turning client historiography into a lesson of rehabilitation, I facilitated Mohammad to turn his anguish from gambling into constructive measure of a debt proposal and to attend gambling addiction support groups.

Territoriality

In order to understand cultural views and find my way through the cognitive and perceptual maps of Mohammad's social and political *landscape*, I wanted to visit his home. Because collaboration occurs from beginning to end in narrative inquiry, I wanted to summarize my entire inquiry which chronicled Mohammad's return to the community. In order to assess my own success with the rehabilitation of this patient, a narrative sketch of his life after hospitalization was of importance to me. I was not sure if this would come about. However, as Mohammad recovered within the hospital our relationship grew stronger. Over time, the purpose of my inquiry evolved to include facets of psychosocial learning about myself. Thus, data collected and shaped for the purpose of helping Mohammad had become broadened to include an insipient narrative about what I had learned about myself as a therapist and how to deal with resistive patients.

During my community visit, I adopted a position as observer of the nuances of family interactions. For the purpose of this narrative, I have recreated the *aesthetic*, sociocultural effects of the home visit. See Appendix F, Sociocultural Home Environment (G. J. Dhinsa, personal communication, December, 2, 2006).

After I left Mohammad's house that day, I felt happy and contented. What could me more right, Mohammad and I had established a therapeutic relationship. I knew I was right not to have given up on him. I am grateful to Mohammad now for the lesson I learned from him for I had unconsciously and uncritically taken my world view for granted as the way things were. I realized that day that transformative learning is to some extent a change in epistemology rather than an increase in knowledge.

Conclusion

In conclusion, the clinical experience with Mohammad proved to be a re-conceptualization of "self" for me. My professional relationship with Mohammad facilitated me to explore and reflect on my own personal growth in integrating factors of

individualized, cultural, political, and social factors in understanding the lived experience of suicide for individuals. The writing experiences of poem and introspective writing allowed me to interpret my clinical experiences within multiple contexts of aesthetics which were a guide to communication and therapeutic interventions for this client and me. The introduction of multidimensional theoretical framework models and narrative inquiry were instrumental in understanding the phenomena of transformative learning and emotional intelligence.

In closing, the word acknowledgment is pallid and passive to describe how enlightened I became as a result of my interpersonal relationship with Mohammad. As a nurse practitioner I feel I have studied and trained and put all my energy into helping others with their mental health needs. Then I found myself in the middle of an experience with a resistive client whose behaviors facilitated me towards a state of transformative learning not only about his needs but my own.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders DSM-IV* (4th ed.). Washington DC: APA.
- Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known*. New York: Columbia University Press.
- Boothyard, L. J., Spreng, S., Malus, M., & Hodgins, S. (2001). Completed suicide as interplay of genes and environment. *Forensic Science International*, 147, 1-3.
- Cardwell, M. (1996). *Dictionary of psychology*. Chicago: Fitzroy Dearborn Publishers.
- Carkhuff, R. R. (1987). *The art of helping VI* (6th ed.). Mass: Human Resource Development Press.
- Carlat, D. J. (2005). *Practical guidelines in psychiatry. The psychiatric interview* (2nd ed.). Philadelphia: Lippincott.
- Checkland, P., & Scoles, J. (1999). *Soft systems methodology in action*. Chichester: Wiley.
- Clandinin, J. (1986). *Classroom practice: teacher images in action*. London: Falmer Press.
- Connelly, M. F. Clandinin, J. D. (1988). *Teachers as curriculum planners: narratives of experience*. New York: Teachers' College Press.
- Crabb, P. (2005). The material culture of suicidal fantasies. *The Journal of Psychology*, 139(3), 211-220.
- Davies, B. & Harre, R. (1990). Positioning: The discursive production of selves. *Journal of the Theory of Social Behavior*, 20, 43-63.
- Doll, W. (1989). Foundations of a postmodern curriculum. *Journal of Curriculum Studies*, 21, 243-253.
- Durkheim, E. (1966). *A study of sociology*. New York: Free Press.
- Eisdell, N. (2005). A Conversational model of art therapy, psychology and psychotherapy: Theory, research and practice. *The British Psychological Society*, 78, 1-19.
- Gard, G., Cavlak, U., Sunden, B. T., Ozdincler, A. R. (2005). Life-views and ethical viewpoints among physiotherapy students in Sweden and Turkey- A comparative study. *Advances in Physiotherapy*, 7, 20-31.
- Goldman, H. H. (2000). *Review of general psychiatry* (5th ed.). New York: McGraw Hill.
- Gordon, G., & Drummond, R. (2002). *Users' guides to the medical literature. Essentials of evidence-based clinical practice. The evidence based medicine working group*. Chicago: AMA Press.
- Hamric, A. B., Spross, J. A., & Hanson, C. M. (2000). *Advanced nursing practice an integrative approach* (2nd ed.). Toronto: Saunders.
- Hicks, J. (2005). *Statistics on deaths by suicide in Nunavut (and other Inuit regions in Canada) 1975 to 2004*. Unpublished Manuscript.
- Huebner, D. (1966). Curricular language and classroom meanings. In H. Robinson (ED.). *Precedents and promise in the curriculum field* (pp.94-112). Washington, DC: ASCD.
- Jacobs, D. G. (1999). *The Harvard Medical School guide. Suicide assessment & intervention*. New York: Jossey Bass.

- Kamal, Z., & Loewenthal, K. M. (2002). Suicide beliefs behavior among young Muslims and Hindus in the UK. *Mental Health Religion & Culture*, 5(2), 111-118.
- Khan, M. M. & Reza. H. (2000). The pattern of suicide in Pakistan. *Crisis*, 21(1), 31-35.
- Macdonald, G. (2002). Transformative unlearning: safety, discernment and communities of learning. *Nursing Inquiry*, 9(3), 170-178.
- Manning, E. (2003). *Ephemeral territories. Representing nation, home, and identity in Canada*. Minneapolis: University of Minnesota Press.
- Mayer, J.D. & Salovey, P. (1993). The intelligence of emotional intelligence. *Intelligence*, 17, 433-442.
- Myers, D. G. (1989). *Psychology* (2nd ed.). New York: Worth.
- Newstrom, J. (1983). The management of unlearning: Exploding the 'clean slate' fallacy. *Training and Development Journal*, 37(8), 36-39.
- Pinar, W. F., Reynolds, W. M., Slattery, P., & Taubman, P.T. (2004). *Understanding curriculum. An introduction to the study of historical and contemporary curriculum discourses*. New York: Lang.
- Prochaska, J. O. (2001). Pro-change behavior systems. Stages of change. *Psychotherapy*, 38(4), 443-448.
- Rubinstein, H. D. (1995). Love and suffering: adolescent socialization and suicide in Micronesia. *The Contemporary Pacific*, 7(1), 21-53.
- Sanders, J. (2006). Transformative learning: the challenge for reflective practice. *Work Based Learning in Primary Care*, 4(6), 6-10.
- Schon, D. A. (1983). *The reflective practitioner: how professionals think in action*. New York, Basic Books.
- Schon, D. A. (1987). *Educating the reflective practitioner* (London: Jossey-Bass).
- Senge, P. (1990). *The fifth discipline: the art and practice of the learning organization*. USA: Bantam Doubleday Bell.
- Slotnick, H. B. (2001). How doctor learn: education and learning across the medical-school-to-practice trajectory. *Academic Medicine*, 176, 1013-1026.
- Spence, D. P. (1986). *Narrative truth and historical method*. New York: Norton.
- Suicide Prevention, (n.d.). Anon Margritte. Retrieved August8, 2006 from <http://www.sociodepreventtriangle.org/artist.htm>
- World Health Organization (2006). Building awareness-reducing risk: Mental illness and suicide. World Mental Health Day. *World Federation for Mental Health*. Retrieved October 23, 2006, from www.wfmh.org
- Wright, L. M., & Leahey, M. (2000). *Nurses and families. A guide to family assessment and intervention* (3rd ed.). Philadelphia: Davis.

Appendix A

Hamric’s Advance Practice Nursing Model

<i>Research by Case Studies Reflective of the History of Islam /Suicide Among Muslims Qualitative Studies Cultural picture</i>	<i>Ethical decision making- >Confidentiality >Treatment >Diagnoses Start to formulate lived experience curriculum</i>	<i>Assessment of >Risk factors >protective factors >prevention measures >culture >social >political</i>	<i>Implementation of Theoretical Framework Models >Calgary Family Assessment Model >Hamric Advance Nursing Practice >Prochaska’s Stages of Change</i>
<i>Assessment Location: >Hospitals: > Clinics >Community</i>	<i>Methodology Patient feedback Family Feedback Psychosocial understanding</i>	<i>Methodology Observations political, social, cultural climate Narrative Inquiry</i>	<i>Alternative data of consultation note, poems, pictures, introspective writing, self reflection</i>
<i>Assessment Location: Community setting, homes cultural settings</i>	<i>Recreate narrative of in the lived experience of suicide</i>	<i>Awareness of my professional behaviours, self exploration Communication</i>	<i>Patient and my goals collaborative of suicide prevention and education and therapeutic interventions</i>
<i>Incorporate understanding of lived experience into assessment curriculum</i>	<i>Bring in support networks Gambling Association Addiction Program</i>	<i>Introduce multidisciplinary team members Advocacy role for patient</i>	<i>Future plan of policy making for changes to suicidal assessment strategies in the hospital and community Self- Reflective Practice</i>

Adapted from Hamric’s Advance Practice Nursing Model (Hamric, 2000).

Appendix B

Introspective Writing

The event of self-exploration did not happen overnight. Instead, it took a bit of time for me to reflect on my process of analyzing and re-analyzing my desires in order to understand the suicidal behavior of the culturally diverse man lying in the hospital bed. It was good that I wanted to help the man in the hospital bed but I wanted to find my own story too, as it related to caring for him.

The man in the hospital bed was of Muslim descent. He had attempted suicide by stabbing himself in the abdomen. As a nurse practitioner, my position was one whereby I would assist this gentleman to explore his reasons for suicidal ideation. My plan was that a “connexion” with this client would occur when he was extubated and he would then be able to speak with me. However, this was not the case, as the man in the hospital bed conveyed he still did not wish to be alive and he was resistive to the development of a therapeutic relationship.

As I began to bear my soul to myself, it was both an exciting and fearful experience. I realized it takes courage to look at yourself. Even as a child and to this day, I have always felt extreme compassion for persons or animals which might be broken and in need of comfort and rehabilitation. It was only fitting that I went on to choose a career which involved caring for others. At times, I liken myself to a contemporary Florence Nightingale. This may seem a bit arrogant to others, but at times I do believe I possess the inner spirit of this heroic woman. During my career I have always cared for suicidal or dying persons in the context of a hospital or community setting. At times, I wonder why I am the way I am and do the job I do. In reflection the answer is quite simple and always the same. Externally, I have the ability to help others and in return, I feel internally fulfilled.

As a clinician in health care, I encourage others to implement the practice of self reflection and introspective writing related to events contributory to their suicidal actions. Now it was my turn to talk and write about my experiences with the man in the hospital bed. My clinical experiences with Mohammad facilitated me to face the emotional logic of my actions formed through my own instinctual strivings and ego defenses. I determined that most of my work with suicidal persons occurred under a social structure. That is, social structures allowed me to use my personality when I establish interpersonal situations in order to elicit culturally suitable emotional responses. My actions with clients were determined by the interaction of my personality, clinical knowledge, education, and understanding the needs of the client. Invariably, clients develop positive relationships with myself when I implemented strategies of mental health assessments. So I chose to focus on the question of why this culturally diverse individual was resistive to therapeutic interventions. I began to wonder if I was starting to feel insecure. I asked myself, if I was taking rejection from the man in the hospital bed, personally!

I found Mohammad's hostility unacceptable, as it caused me to become slightly perturbed with his prolonged state of agitation. If his agitation had been related to a psychotic state I could of easily comprehended his rejection. As a professional, I was unaccustomed to rejection from clients for usually I am warmly received by persons who feel marginalized by society and are in despair. Also, I felt embarrassed by his rejection as usually suicidal persons anxiously await my help. At that point, in order to therapeutically connect with this client, I realized I needed to develop new interventions in order to meet his cultural needs.

At this point in our ineffective relationship, I began to examine myself instead of the client. Maybe, just maybe, I had become over confident in my abilities to walk into a hospital room and have persons automatically answer all my inquiries. I developed a sort of parable whereby I described my role and then put forth my inquiries and was duly empathetic as clients recount individual traumatic life stories. Over time, I had grown confident in my successes at helping others. Even now, as I ramble on about how great I am in my professional role, am I not in actuality trying to justify my successes over the failure of this relationship with Mohammad. I was afraid if I wrote about this experience I might expose myself negatively. At that point, I began to wonder if there was a way I could avoid this situation all together.

The experience from the man in the hospital bed started this whole introspective process, even though I did not write it down at the time. This experience facilitated me to begin an inquiry process of one's self. In retrospect, I wondered, had I become arrogant in my knowledge and successes of providing comprehensive care, treatment, and supervision for mentally ill persons as they integrated into the community? In order to step into the psychosocial world of Mohammad, I attempted to review both historical and contemporary curriculum on Muslim practices and Islam. I needed to learn more about Iraq, Mohammad's homeland and the language he spoke. My clinical motive was to step into the cultural world of the man in the hospital bed, in order to better understand his psychological being.

I enjoy success and if that means additional research on my part, so be it. A learning experience would benefit not only myself, but the client. Also, I wished to settle an internal score of always being successful with the care I provide for clients. As a result, I determined both reasons were driving forces to promote success for myself and the man in the hospital bed. It seemed like a good plan to me. This gentleman presented me with a long, arduous journey in understanding his psychological needs. In efforts to address his needs I had to spend several hours in the hospital library collecting literature reviews on Muslim practices. At that time, I was in the depth of introspective psychology with myself. I was having conversations with myself about how I was feeling powerless to help the man in the hospital bed. I knew the client had a story to tell and that an awful lot of talking and listening needed to occur, in order to establish a therapeutic relationship.

Even now, as I think about my initial contacts with the man in the hospital bed I experience unrest and internal turmoil which has subsided with the writing of this

clinical experience. I have always thought my life was too full and busy to partake in introspective writing, however this writing task was a necessary piece of work. I pondered over the option of keeping a journal of my introspective writings related to my professional practice and it seemed like a good idea to me. Introspective writing allowed me to not only re-live the interview experience but capture the effects it had on my both my personal and professional life. As a clinician, it was important to attend to the problems and concerns in my own life and reflect on how they affected my practice for the way I interact with clients can not be divorced from the effect my personal life has on me. In retrospect, my life was fairly settled at the time I encountered the man in the hospital bed, however I am experienced in maintaining a professional stance even in the wake of home upsets.

The behaviors of the man in the hospital bed brought me back to reality. The truth be told, I had become so busy with an extensive work load of consults that maybe I had slipped away momentarily from the notions of psychic truths being individualized and culturally specific. Thus, for a time period I had become insensitive and lacked cultural awareness which reduced my capacity to perceive and communicate with the man in the hospital bed. In fact, my lack of culturally specific knowledge had impoverished my counseling strategies. I had never thought, but had heard that clients too can help clinicians gain a deeper understanding of what is required from professionals in order to help individuals overcome their emotional trauma.

The introspective writing task process was therapeutic for me in that I had to admit that I almost made a mistake by making assumptions about the client's readiness for change. As I was about to give up on the client I quickly corrected myself and identified a need on my part to become further knowledgeable about Mohammad's culture and traditions. In retrospect, I am thankful to the client in the hospital bed as his needs facilitated me to change my clinical practice. Today, I utilize research and professional practice standards to understand the meaning of enculturation and suicide. Pedagogical questions related to introspective writings have added to my nurse practitioner knowledge, my interactions with the client, subjectivity, and my sense of self.

Introspective writing brought the subjectivity into my conscious awareness and helped me unearth Mohammad's story of lived suicidal experience. This form of writing proved to be both an expository and personal revelation for myself. In reflection of my introspective perspective, I am sure the writing sounds like me. My sense of self comes through in this writing. I learned to have patience with this client, but chiefly I learned to have patience with myself. I did not lose courage in considering my own imperfections but set about to remedying them. From this experience, I found that in helping others I was able to help myself and this came full circle when the man in the hospital bed began to trust me and share the feelings that were close to his heart.

Appendix C

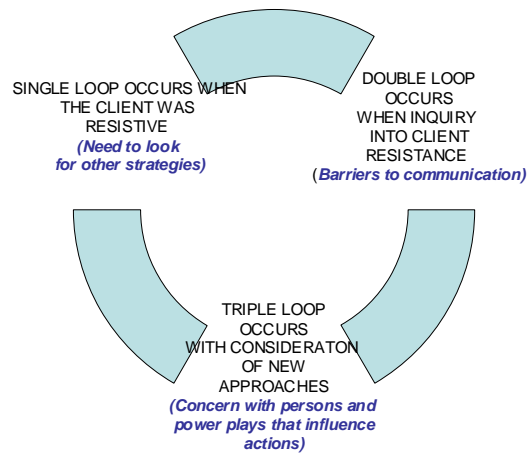


G. J. Dhinsa (illustration of personal of communication, December, 20, 2006).

Appendix D

TRIPLE LOOP LEARNING

This type of learning can be transformative and has the potential to change persons and the wider society (Adapted from Schon, 1987; Senge, 1990; Checkland, & Scoles, 1999).



Appendix E

Anon-Margritte



This illustration depicts the ambivalent human emotions, which swing between hopeful and hopelessness, with the migratory victim as still in need of help.

The illustration is a "cry for help" by the victim. This victim is unable to act effectively in saving themselves. Their position of lying on the beach is reflective of the psycho-social process of loss and change which occur with suicidal migratory individuals (Suicide Prevention, n. d.).

Appendix F

Sociocultural Home Environment

My first impression of the home environment was that it was a comfortable atmosphere, created by both the surroundings and welcoming attitude of the home members. Immediately, Mohammad his mother and visiting brother made me feel welcome. They told me it was customary to remove my shoes and wear household slippers. Already I was feeling physically and socially comfortable. I could tell Mohammad felt slightly uncomfortable with my visit but he proved to be the perfect host.

Espresso coffee which was too strong for me was served in miniature cups. A variety of desserts were provided such as date halva and cardamom cookies along with a variety of nuts which included red skin peanuts which I had an appetite for and toasted almonds with an assortment of figs and dried fruits. The home was a one level bungalow situated on a busy street. The living room furniture was comfortable and included various mismatched over stuffed chairs. The sofa was covered with a fleece blanket which appeared to be warm and cozy. The family explained the carpet on the living room floor was brought from Iraq when they immigrated to Canada. The texture of the carpet was thick and luxurious in an array of gold and ruby colors.

There was an absence of ornaments or table top fixtures that usually exist in residences. Instead, two large pictures adorned the walls. One of a mosque and the other a family photo of Mohammad, his mother, brother and father. I also noted an array of plants in the home. The plants included hibiscus plants, cactus, and a crawling green leaf vine that was woven across the door frame and curved around the enlarged picture of a mosque. Mohammad referred to the crawling vine as the money plant which meant increased fortune in relation to the length of the vine. As I love to eat the poignant odors of food identified as Zater bread and filled pastries called Ba' Ba Beh Tamur attracted my olfactory senses.

Satellite connections brought visually stimulating Asian entertainment to the home as an Iraqi movie played without volume. It appeared to be a movie reminiscent of slap stick humor which I failed to find humorous. The home landscape carried with it seeds of transgression as if I was in Iraq. However the blending of cultures was evident in the home as the local newspaper lay on the centre table and purchases such as spaghetti sauce and Wonder Bread from the local grocery store were observable on the kitchen counter.