Care-givers have always lived with the paradox that they are supposed to care deeply about their clients, but not get too involved. In addition, caring itself has been viewed as dangerous for the one caring, such that care-givers are urged not to care too much, for fear of burnout (Maslach, 1983). In spite of these admonitions successful care-givers and therapists continue to get involved with clients, often in ways that have profound significance for both of them, though professionals may rarely talk to each other about these experiences.

Our usual theoretical base for the therapeutic relationship offers little support for personal involvement. Actual practice, nevertheless, may be more caring and involved than orthodox theory and formal professional discussion ordinarily indicates. Moreover, at least one observer (Stiver, 1985) has argued that it is time to take caring "out of the closet" and give it the legitimacy and value it deserves.

The purpose of the present study,' based on research into nurses' perceptions (Montgomery, 1990), was to determine the nature of caring from the perspective of the care-giver's experience. I wanted to determine the nature of caring communication, and what this experience is for the care-giver. Is it associated with burnout, or is caring the essence of professional satisfaction? If both situations exist, how do successful care-givers manage this paradox? In
this study I chose to focus on nurses for several reasons. First, my own personal interest in these questions grew out of my experiences working with nurses as a psychiatric/mental health consultant in hospital settings. I was struck by my experiences with those exemplar nurses whose capacities stood out in contrast to the demoralization and detachment which is so pervasive in institutional settings. I was intrigued with how these care-givers managed to maintain a level of excellence and satisfaction with their work after so many years in, what seemed to me, an often demanding and demoralizing job. My philosophical orientation leads me to study that which works, to learn from it, and be inspired by it rather than focus on deficiencies—thus my interest in these exemplar nurses. Finally, based on an earlier pilot study in which I interviewed both patients and nurses, I had discovered that the nurses that I interviewed seemed to share a common language for, and understanding of, caring. This finding clarified the amorphous and ill-defined nature of this concept. Thus, although the theory developed from this research is limited to this population, it does provide insights which have, at the very least, heuristic value for others in the helping professions.

I used a naturalistic grounded theory approach in which I interviewed nurses and asked them to talk about experiences that stood out for them in terms of caring. Thirty-five nurses were selected by a process of theoretical sampling (Glaser & Strauss, 1967). The initial sample group were referred by others to represent exemplars of caring, and were considered "experts" according to Benner's (1984) framework. Subsequent sampling sought to represent differing dimensions of caring including: a) fewer opportunities for relational involvement; b) exhibited non-caring behaviors (actually I tried to seek out non-caring nurses, but aside from presenting an ethical dilemma for how I would explain myself to them, the one that I did contact was not interested in being interviewed—because she didn't care—s-an ontological problem. Therefore, I asked my referral sources for nurses who did in fact care, but behaviorally did not present themselves as caring); c) felt negatively about caring (included here were "burned out" nurses and one who suffered post-traumatic stress following the death of a patient); and d) less experienced nurses.

What emerged from the interviews as an over-riding theme of caring was the experience of spiritual transcendence. Spiritual transcendence was defined as experiencing oneself in relationship as a part of a force greater than oneself. This spiritual transcendence experience was critical, not only in terms of the nurses' satisfaction with caring, but also as an explanation of the paradox of distance and closeness. It also challenged some of the conventional understandings of the helping relationship.
This formulation of the spiritual dimension of caring includes three properties. The first is the **nature of the connection**. The unique spiritual nature of this relationship distinguishes caring from what we commonly refer to as over-involvement, rescuing, or co-dependency, which are considered destructive for both the care-giver and the client. The second property is the **source of energy**. This source of energy explains how spiritual transcendence serves as an important resource for self-renewal and motivation for the care-giver, so that caring is associated with profound fulfillment and growth rather than burnout. Finally, the third property of spiritual transcendence is its **effect on the care-giver**. The ability to experience relationships at this level seems to be related to whether the care-giver experiences personal fulfillment, or emotional depletion and even trauma. I will now describe each of these properties in more depth.

**NATURE OF THE CONNECTION**

Caring involved a deep sense of personal involvement. A post-anesthesia nurse described caring as "A deeper expression and deeper relationship of yourself with somebody else that you care about.... And it's okay to be emotional about it." The depth-of-feeling dimension was brought out most clearly by the affect of the subjects during the interviews. Almost all of the subjects were teary or cried openly when recalling significant experiences with patients.

The term "love" was used frequently in describing their feelings for patients. A rehabilitation nurse described caring as "unconditional love.... I think it's hard to stay distant from patients. If you feel for them, you are going to enter into their experience whether you want to or not. It's just something that you do." Another nurse felt that in order to care she must be willing to "fall in love" with her patients.

A medical-surgical nurse described being deeply involved with a patient who was dying of AIDS. "Even if I was not caring for him, I always had contact. I had quite established relationships with his family, his lovers.... I didn't know what I was doing until his mother said, 'you know, he loves you.'" She described her involvement with him as he was dying: "I helped him strike his pillow and helped him say 'I am angry.' I was angry too. I have never had that close of an experience with a patient who's dying. I was sitting on his bed one day and he was asking my permission to let him go. I said, 'I will miss you [name of patient].'" She experienced his death as a significant personal loss and still grieves for him a year later.
This level of involvement raises some concerns, for if we give up the model of detached objectivity, how then do we prevent ourselves from becoming "overinvolved" and losing our therapeutic perspective? Furthermore, how can we continue to risk caring when it involves such personal loss? Again, we are faced with the paradox of caring deeply about our clients, but being cautioned about getting too involved.

Empathy, the construct most often used to understand the helping relationship, does not offer much guidance with this paradox, for the literature is characterized by considerable disagreement and lack of conceptual clarity (Marks & Tolsma, 1986) which the search for a broader framework, such as caring, might provide (Arnett & Nakagawa, 1983; Broome, 1985; Gordon, 1985).

Empathy involves an inherent paradox between immersion/union and distance/objectivity which can be confusing at a clinical level. Flasketrud et al. (1979), based on a descriptive study of nursing, observed that the nurse-patient relationship was characterized by avoidance and distance, and concluded that the message to not get too close to patients was based on the concept of empathy, because empathy required a certain amount of distance in order to allow for objectivity. "Unfortunately the appropriate amount of objectivity has never been defined" (p, 170). Maslach (1983) recommends adopting the other's perspective rather than feeling the other person's emotions. But separating the emotional from intellectual empathy is impossible in the realities of care-giving (Munley, 1985).

The use of the term "boundaries" is also found in the clinical literature to describe the appropriate amount of interpersonal distance between therapists and clients. Generally this term is used to admonish care-givers from getting "too involved" (Jordan, 1986; Pasacreta & Jacobsen, 1989; Stiver, 1985); again, however, the nature of an appropriate boundary has yet to be specified. Thus, a contradiction seems to exist between the need for union, and the need for interpersonal distance in the helping relationship.

An example of data from a pilot study might serve to illustrate the limitations of a traditional view of empathy to explain one nurse's response to a patient. A nurse was caring for a man who was extremely anxious about having to face emergency open-heart surgery. He had always lived a healthy and active life, and the seriousness of his cardiac problem was quite a shock to him. He was feeling panic stricken and didn't feel he could go through with the surgery. The nurse tried to calm him down. At one point he said with great intensity, "I'm just no hero, I just can't go through with this!" The nurse responded by saying forcefully, "Heros are ordi-
nary people faced with extra-ordinary circumstances, and instead of running away they stand and face whatever the circumstance is!" This hit him like a "cold washcloth to the face," and he said, "Where did you hear that?" The nurse was somewhat embarrassed and told him that she had just then thought of it. He repeated her statement often and credited her with his getting through the surgery experience. He did well with his surgery and recovery and was out of the hospital quickly. To this day he visits the unit every year to bring a gift of flowers or candy for the nurses and give special thanks to the nurse who helped him through the experience. He says to her, "You know, I never thought I'd have this time."

When questioned about her response, this nurse did not recall ever having felt like this man did, or being in a similar situation which might allow her to identify with him. Her understanding did not involve active projection or putting herself in his position. In fact, I think her understanding of what she said was not experienced at a conceptual level. She had no idea where her idea came from. This is an example of understanding that is characterized by receptivity. She allowed herself on some level to become one with his experience, and I believe, subliminally received from him what he desperately needed to hear. It was as though her consciousness acted as a conductor to provide the completion of his idea, in the way an electric current completes a circuit if it has a medium.

The above example illustrates that communication need not occur from a position of interpersonal distance or within a fixed self boundary, although the appropriate distance and nature of boundaries within which this communication can occur is not yet clear.

Rather than trying to resolve the paradox of how close is too close, an alternative suggested by this research is to look at the nature of the connection itself. There is a distinct qualitative difference between helping relationships connected at the level of the ego and those connected at the level of something greater. This research suggests that in a caring encounter, the care-giver and the client experience union, but that this union occurs beyond the level of self, at the level of spirit. Spirit can be understood as a common humanity, the fundamental sacredness and unity of all life (Quinn, 1989), or shared phenomenological fields as suggested by Watson (1985). This view is also consistent with Burke's (1950) concept of consubstantiality. Consubstantiality occurs when two or more individuals share a common substance. The individuals involved in a caring encounter experience their common substance at the level of their shared humanity or spirit. One subject expressed this best when she said, "I have the opportunity to experience a thousand different lifetimes through someone else's eyes." In contrast, what we usually refer to as "over-involvement" is characterized by a
highly personalized connection that is not experienced in this larger sense.

A lack of ego involvement among the subjects was first brought out in the initial data analysis. I kept looking for what these nurses actually did that was caring. I was frustrated by the descriptions of the experiences that emphasized the patient's qualities, the team support, what they learned from the patient, and what it felt like to be part of this experience, rather that any thing that they did. Typically, the word "we" rather than the word "I" was used. The focus was not on the self of the nurse. As one said, "I was just there .... "

Their goal or intention was simply to connect, rather than to achieve any particular agenda. In describing working with an elderly gentleman with Alzheimer's disease, one nurse said:

He was at that state of the illness where he knew that something was missing and he was very very disorganized. And he was very frightened and I just, I just stood behind him kind of like this you know (demonstrated putting hands on shoulders) with my hands on him and just kind of grounded him, and the way he interpreted that was, "this is kind, these people are kind, this place is kind."

She goes on to say, "My intention is to be helpful and be connected. I can ... make lots of mistakes as far as theory goes, and [yet] the patient will pick up on that connection."

This way of helping is very different from the achievement oriented focus that has the goal of curing disease or eliminating problems. While such goals are appropriate to the curing aspect of what care-givers do, they need to be distinguished from the caring aspect. When our agenda is to fix or to cure, the focus is on the self as the "ego-hero" (Rushing, 1989). This is the masculine model of the hero rescuer, and while it is appropriate in many contexts, it can lead to disaster when caring is attempted from such a position.

Several of the subjects talked about this lack of ego-involvement directly. "It [caring] puts you more in touch with everyone else, rather than on a pedestal." Another says, "I don't think ego is involved. I think it's at a higher level than the ego because you are not trying to inflate yourself." An oncology nurse described not wanting to be the center point, or the focal point of the patient's experience: "I'm not the one, they are the one, and ... if they are strong, they are healthy, they go on, and know that they did that-I didn't do it... " I appreciate being ... acknowledged and that, ... but this is their illness experience." Notice the difference here from "over-involvement." She's able to maintain a deep level of intimacy without getting into trouble because she doesn't try to
"own" the patient's experience or make it her experience. She can tell the difference.

One nurse emphasized this quality as part of her own growth process. She compared caring with the more ego-centered helping she had done earlier in her career:

I was sort of addicted to excelling ... and moving and like that, instead of having [my] feet on the ground. It felt more like ... a drive from my part instead of with what was best in the environment. It's kind of my need to have that experience for myself, ... In some ways I see it [caring] [now] as ... sort of pulling more out of an abundance. The other [way] is trying to get self-esteem or get recognition or prove a point or jack yourself up, and [the other way] is kind of going with the flow and being there.

This idea of "pulling from abundance" implies the existence of some greater force. This spiritual force is described further:

Spiritualness is important. I don't define that according to any particular religion; it comes from a deep sense of ministration to the individual. You minister to the spirit within the body. Sometimes you will not even recognize the person outwardly because of the deterioration. You minister to the spirit. ... I wasn't aware of that twenty years ago, and I think for many nurses it's dormant.

This nurse worked with AIDS patients, so the physical deterioration was very real, but I found that these comments had relevance to my work as a psychotherapist. Particularly if we are associated with a clinic or an institution, we find that we must work with all kinds of people, some of whom can seem very difficult to like. But I think what allows us to connect with these people, those we might choose to avoid in a non-professional context, is this idea of ministering to the spirit within. We may not recognize the person behind the mask of schizophrenia or with a personality disorder, or suffering from extreme abuse and deprivation, but ministering to that person's spirit is what allows us to connect to them.

For some of the subjects the sense of spirituality was understood within a pre-existing religious framework, while others found their religious assumptions challenged. A medical surgical nurse describes how being a Christian gives meaning to the work that she does:

I really feel like nursing is where God wants me and ... he's given me that gift of ... being able to care for people when they are sick. And sometimes my own little selfish needs can get in the way and then I don't have that compassion. But by asking God everyday to renew that commitment, it's like a commitment of Him, it makes me look at people differently.
Another nurse spent time doing missionary work on the Gaza Strip and during that time her traditional religious beliefs were challenged and she was forced to create her own meaning:

Can you in fact care for diverse groups of people with this sort of rigid set of rules and regulations? ... I felt like I either had to suffocate and pretend and accept things, or I had to open the box up, and it was a real hard decision to make because it wasn't as comfortable in some ways.

Now she finds that her spiritual beliefs are not as clear cut, but "I feel ... more connected to humanity in general." Another nurse denies any religious affiliation but was affected by her experience with it "very Catholic nurse" when they were working with refugees in Thailand: "I took that on to mean people who are in these situations are in a state of grace or in a state of holiness. And so I do think it is a privilege ... and an honor to be able to be with people like that. ... As nurses our spirit is what it's all about and we go there."

SOURCE OF ENERGY

The energy needed for caring was seen to come from a greater source beyond the self. This spiritual sense explained why they did not experience burnout. One nurse says, "I feel tremendous love for patients and I feel that they genuinely love me and it seems like it comes from some sort of higher place, that it's driven from ... a nurturing place that I think is kind of beyond myself." The subject I quoted earlier described this source of energy as "pulling out of abundance" rather than the "grasping" for experiences that characterized her earlier ego-centered attempts at caring. Another says, "I don't know how to sustain it without that connection, without something greater." Another says: "There is an endless amount of love of God for people so I don't even worry about that. ... I really feel like there is a wealth of love that God has given to the whole. to everybody, and it's available to be used. And so I can love these people with my whole heart." These observations are consistent with Benner's (1984) idea that it is not caring that leads to burnout, but the lack of caring. Caring itself allows access to a very important source of energy and renewal.

This energy and renewal seemed to have an alchemical quality, an energizing effect on the nurse that might be described as a peak experience that creates meaning and reinforced commitment. Without caring the work would be "bleak." A hospice nurse said, "I go on a high when I've gone into a patient's home and done something that's making them comfortable. I come out feeling like I'm drugged because it feels so good and they are grateful."
Another nurse described feeling "more alive" after her experience with caring. The nurse, mentioned earlier, who had been so involved with the patient who died of AIDS, described his death as "the most powerful, the most uplifting, the most complete experience.... I felt exhausted and depleted but with a sense of peace and accomplishment. ... This to me is the greatest thing in nursing. It's the greatest reward." Another described caring as a "spiral kind of thing, and it makes me more open and more open." When asked how she took care of her own well being when she is loving so many dying patients, she said, "that is the management of it. I'd probably need healing if! weren't open to it."

The energizing effect also affected the subjects' self-esteem and feeling of personal empowerment. One subject said that as a result of caring "you enjoy life more." Many of the subjects reported that caring experiences have improved their confidence and self-esteem.

The intense closeness to the patient that these nurses allowed themselves, let them actually experience on some level, the patient's healing, or the positive effects of their own caring. For example, one subject said: "A part of them is a part of my heart, and helping to heal them, by bringing them to a peaceful end, or however that healing takes place, heals my heart."

**EFFECTS ON THE CARE-GIVER**

Finally, spiritual transcendence was associated with what the experience of caring was like for the care-giver, and whether they were able to maintain close involvement or whether they needed to maintain a position of detachment when working with people. In order to have access to the experience of spiritual transcendence, these nurses had to have a philosophical or spiritual understanding that allowed them to deal with being "repeatedly confronted with one's own mortality, the inhumanity of others in cases of violence, and the threat of pain and disfigurement. " (Benner, 1984, p. 377). One nurse tried to make sense out of why a "very very nice" 32-year-old woman died, when "you see some old codger on 14th and Colfax with his emphysema machine going, and smoking away, with his oxygen, and you are just [wondering], where are the variables here? It just doesn't make sense." He referred to this as "spiritual doo doo.‘ As another subject said: "I feel like in six years I've probably aged twenty or thirty years, and I probably have seen more in six years, as far as human nature and the basics of human life, more than most people will ever see in a lifetime." This exposure could be experienced as gaining philosophical wisdom, or simply as wearing down of the spirit.
The ongoing sense of connection was expressed in a different way by a nurse who had changed specialties from obstetrics to oncology: "They [the specialties] feel the same in some ways because I almost cry at a birth the same way I cry at a death. It's so poignant at the beginning and at the end ... it's very alike." The operating room nurse also expressed a sense of connection and was able to get beyond the pain:

As long as you remember people they never die.... We sometimes avoid being attached to people in this business because we are afraid of the pain. But there is a lesson to be learned from that, and it isn't just pain we should be looking at. It's the quality of the relationship ... and sometimes you can't have one without the other. And I'm not tearful because I'm sad, that's not it at all. Sometimes I think tears are a sign of fullness, and when you overflow, you overflow.
This subject continued and explained the wisdom she has received from attending to people during their dying. She began talking about her relationship with a dying priest:

I got to see this mirror image of myself somehow because I thought this is what it is like to be dying, to go through all of this review of things, to have the joys and the sorrows encapsulated in a form that you can experience in a very short time, but with all of the intensity that you had as you went through your life doing things a bit at a time and never realizing. And I think what I have learned from these people is that there is no right and no wrong way of living, there is no other way of being a human being or worse way of being one. Everybody does the best they can with what they've got to work with at the time. And mistakes don't matter in the end and really the triumphs don't either. It all melds together into one big experience that has its own worth by virtue of the fact that it has been lived.... I can reflect back on these people and realize that my outcome will be pretty much the same as theirs. All in all I can't flub it up too badly, and I'm not going to be a saint, either.

In contrast, some of the subjects who had negative death experiences did not express a philosophical or spiritual peace with death. The sense of connection between life and death that characterized the previous philosophies is contrasted with the feelings of a nurse who decided to emotionally disengage from her work following the death of a child with whom she had become very attached:

Each time I let someone like that come into my heart, when they die, it's just like I close off even more, it's just like, okay, I'm going to do what I have to do. I can feel sorry for you but that's it you know, when you die you are gone. I won't even remember your name.

She describes how she felt after the death of that child:

I'm the type of person that if I give you my all, I give you my all. And it is just too much, and I don't like hurting like that. I don't like going home and not being able to sleep.... And I still think so much about [name of patient] ... just little things, you know, teaching her something and my heart just wrenches, and ... each time it does, my resolve gets stronger and stronger that I not allow myself to go through that again.

She was left only with this anguish. There was no sense of transcendence or positive meaning to help her with this pain. Therefore, she had no choice but to not let it happen again.

Another intensive care nurse described losing what he called "that spark" following the death of a patient. He could find no meaning in death:

Well Kubler-Ross' s theory is that death is just basically one of the most wonderful advancements in life and you go through all these neat little...
channels and changes. How can it possibly be neat? You know. It's like, let's get real. You die, you die.... How can you possibly be at peace with the end of your life?

One can clearly see here the total lack of any meaning that might allow either of these nurses to move beyond the feeling of loss and devastation.

IMPLICATIONS FOR THE SELF IN RELATIONSHIP

As we can see from these descriptions of what it is like to care, we allow ourselves access to an expanded consciousness beyond the self. As Kenneth Burke says, "We make a kind of ascent from the realm of motion and matter to the realm of essence and spirit" (Burke's definition of transcendence, 1966, p. 8) Or as Jean Watson describes caring:

An ideal of intersubjectivity and transcendence is based upon a belief that people learn from each other how to be human by finding their dilemmas in themselves. What is learned from others is self-knowledge. The self learned about or discovered is every self; it is universal, the human self. People learn to recognize themselves in others. The intersubjectivity keeps alive a common humanity (Watson, 1989, p. 180).

All of this has implications for how we view the self in relationship, especially the helping relationship. As Joanna Macy (1990) points out, the self is merely a metaphor or a concept. We construct reality, we select where we place our boundaries. We can decide to limit it to our skin, our person, humanity or the planet.

When we take the risk of getting involved with our clients from a position of caring, we expand our consciousness such that our notion of self includes another, and consequently all others. We then have access to what Jean Watson (1989) calls a primal and universal psychic energy, 's reservoir for wisdom and self-renewal, and we need not fear that we will lose ourselves in the process. For as Joanna Macy describes it:

To broaden the construct of self this way does not eclipse one's distinctiveness. You will not lose your identity like a drop in the ocean. ... From the systems perspective, this interaction, creating larger wholes and patterns, allows for and even requires diversity. You become more yourself. Integration and differentiation go hand in hand (1990, pp. 59-60).

Those of us who are in the business of helping to heal physical, emotional or psychic pain draw upon a unique kind of courage when we are willing to expand our consciousness to incorporate
the experience of other people's pain. If we can extend our notion of self-interest in this way, caring becomes a self-enhancing way of being, such that we can appreciate the essential truth of a caregiver's reflection: our clients are a part of our heart, and helping to heal them heals our hearts as well.

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