UNDERSTANDING NURSE PRACTITIONER-PATIENT COMMUNICATION: RECONCEPTUALIZING POWER AND RELATIONSHIPS THROUGH MUSIC METAPHOR

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Dedication

To my grandma Chelo whose naïve craziness and beautiful death showed me a little fractal of a different type of divinity.

To the people that have or have not realized that WE ARE POWER.

Thesis Abstract

In nursing literature, power is conceptualized as an object transferred, distributed, controlled or conquered by empowerment. In this management care paradigm, the service of care provides power to achieve the product of health. The socio-philosophical framework proposes power as intra-interpersonal set of relationships. Interdisciplinary collaboration allowed discovering power-and-relationships as inseparable mind-body subunits constituting micro and macro health interactions, through a mixed methods instrumental case study. Control and power mechanisms were revealed analyzing body movements and conversations in Case A-15min- and Case B-16.10min- nurse practitioner-patient videotaped encounters. Catalyzed by a hermeneutical music metaphor this thesis proposes relational healing care. Despite interruptions and disruptive postures, nurse practitioners-patients reverse differentials by sharing potentials in simultaneous connections. Power balance is developed by equitable-inequitable communication. Like diverse related tones, nurse practitioner-patient is an Intermelody solving tension continuum in concordance. Health struggles in that way are nothing to be fixed, but healing cycles to be played.

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LIST OF ABREVIATIONS

CA	Conversation Analysis
CHE	Critical Health Education
H	Hypothesis
MEM	Mental Analysis Model
MI	Multiple instrumental

M-M	Mixed Methods
MMI	Mental Model of Integration
n	Sample
Np	Nurse practitioner
Op	Observational points
Pt	Patient
Q	Question
SOMchs	Sounds of Movement Channels
TOMchs	Textures of Movement Channels

CHAPTER ONE: INTRODUCTION

In health disciplines such as nursing, power has been typically perceived as a negative condition, one that requires an antagonist construct – empowerment – in order to create balance in the care relationship. In clinical settings, this typically amounts to a "banking" vision of power and empowerment. In such a perspective individuals necessarily come to the table as unequal partners and, by "giving" his/her power (knowledge) to clients, a health professional effectively "empowers" them to "gain" control over their conditions. This viewpoint deems that power can be possessed, given, taken or controlled as though it were a transferable object and, as such, has implications for the way care relationships are constructed, perceived, and experienced. The ubiquitous presence of this paradigm in health care provision might lend an impression that it is the *logical* way to think for relationships where one party, in order to remediate his/her problem, consults with a knowledgeable, authoritative other. This thesis challenges both the necessity and logic of such a creed. To do so, philosophical outlooks from areas other than nursing are examined in the expectation that they can facilitate a deeper understanding of power and relationships in ways that might help nursing practice. By analysing the implications of differing conceptions of power and relationships, a paradigm shift is suggested for nursing practice, one that encourages the co-construction of equitable-inequitable balanced care relationships rooted in shared potentials rather than managed interactions inequitably based on a perception of differential of potentials.

During the course of analysis, this thesis will formulate arguments from fundamental premises found in the fields of philosophy, sociology, communication, and psychology, integrating them into a theoretical framework to undermine a dualistic "banking" perspective of power balance. Among twelve premises established in the theoretical framework, the first premise comes from Zen philosophy (Osho, 2007): power as well as relationships are neither "good" nor "bad", both simply exist, which, in the case of the current study, effectively removes value driven, judgmental and separatist subtexts embedded in more archetypical understandings of those words. Hence, we must reconceptualise both terms (i.e. power and relationship), so that their combinatorial consequence, "power relationships", can also be re-conceptualized. This first premise facilitates a neutral definition of power, which concurs with the perspective outlined by Michael Foucault in his mature discourse on the topic (Foucault, 1977). In his early discussions, power was synonymous to what he later recognized as a *difference of potentials* (Foucault, 1977). In his most mature view he offers a single definition of *power and relationships* which will become the second and core philosophical premise of the theoretical framework of my thesis: "In reality power means relations, a more or less organized, hierarchical, co-ordinated cluster of [interactions]" (Foucault, 1977, p.206). This perspective acknowledges a connectedness among diverse potentials, and the consequences of these two premises suggest greater consistency with more naturalistic philosophies that emphasize mind-body relationships such as Tai-Chi (Horwits 1976; Liao, 1995) and cultures that acknowledge interconnectedness as an essential part of living, such as those of many indigenous peoples throughout the Americas (Cajete, 2000; Lowe, 2002).

A third premise is derived as a logical extension of basic statements above. Interconnectedness starts within a person via relationship between the potential of her/his mind and the potential of her/his body. In truth, these potentials are inseparable fractals of being which need to be considered in a healing process, and that many health fields had failed to account, as Gabor Mate recognizes (2011).

> Many doctors over the centuries came to understand that emotions are deeply implicated in the causation of illness or in the restoration of health. They did research, wrote books and challenged the reigning medical ideology, but repeatedly their ideas, explorations and insights vanished in a sort of medical Bermuda Triangle. (p.6)

In this thesis, mind-body complex, is a first interaction to be considered; mind and body are none-the-less valuable to differentiate as a first step in reconceptualising power and relationships as analogous constructs in health matters.

If, as is asserted by Foucault, "power means relationships" (Foucault, 1977, p.206), and if an individual's mind-body relationship is a "hierarchical, co-ordinated cluster" (Foucault, 1977, p.206), then, an individual *is* power because a mind-body interaction, as a first order relationship, exists. Thinking in terms of interconnectedness between the mind-body potentials of one individual with those of another, one can understand increased relational complexity as a second order relationship where the intra-connectedness of each individual is part of a power structure. Coherence in a second order relationship, such as that between nurse-practitioner and patient, generates a intra and interpersonal complex power. In the case of nurse practitioner-(Np-Pt) relationships such coherence can better promote wellness and address existent health struggles. Non-coherence, i.e. when there is a fracture in the connectedness of any of these intra (mind-

body) and inter (person-person) relationships, results in a complex web of relationship challenges – ones that thwarts health promotion and the addressing of existent health struggles.

Thinking about the words “power” and “relationships” in this way has consequences for some existing subtexts in nursing practice. If a patient interacts with a Np in order to be “fixed”, fixing becomes a non-collaborative, event-driven procedure that promotes a perception of separation. This is a power-transfer management care paradigm based on a banking perspective of power balance. Alternatively, healing (i.e. what health care strives toward) can be a collaborative integrative process that emphasizes experiences and knowledge within a temporal continuum, inferring ongoing relationship. This might be thought of as a power-healing care paradigm. Such an understanding acknowledges health as a process that fosters intra- and inter-connectedness, rather than treating care as a series of remedial or management interventions. In short, we begin to comprehend that there is nothing broken to be fixed when we think this way; rather there is a healing process to be embraced.

Considering the last premises, the health care system, in fact, constitutes a third order relationship made up of second-order interactions and its own management. In these terms, management of a health care system adds complexity. Depending on how it is accomplished, management of this system can either bring resources to first and second order relationships or it can manage people and care using a supply and demand model as though health was a commodity and care was a service in a client-provider system. In this regard, system management can either promote relationship or disassociate

relationship potentials. When formulated on a power-transfer care paradigm, health care management fosters a cycle where relationship devolves into a buyer and seller interaction. Further it functions as an overseer of third-order complexity by means of its dissociation with the concept of a healing continuum. This resembles the labour-power cycle of commodities exchange identified by Karl Marx in his "Capital: A critique of political economy" (Marx, 1976). If this comparison seems distasteful, it provides additional rationale for a re-examination of the concepts of power and relationship in health care. In fact, as this thesis will show, an alternative view, the power-sharing, healing care paradigm, makes us all part of the health "system" by embracing the process of healing, fostering connectedness and building ongoing relationships.

According to Paulo Freire, a main contributor in the critique of an educational system supported on a banking model and creator of a solving problem education known as pedagogy of the oppressed, to facilitate an equitable relationship, both parties must bring their voice (experience) to the relationship, and for that, communication is required. His critical awareness dialogue-based problem solving method outlined in "Pedagogy of the oppressed" (Freire, 1970), supports a fourth premise of this thesis. This premise postulates that: where voices, knowledge, and experiences are shared, then, there is an equitable problem-solving relationship where people involved in a circle of domination can collaborate to solve this situation. Through communication, equitable relationships are developed and all parties are liberated from oppression. In the case of Np-Pt relationships, it may seem apparent that, when one party holds power (e.g. knowledge) and another needs to receive it (e.g like a commodity), there is sense in which the

relationship can include a measure of oppression. To be clear, power-holding and power-giving are necessarily antagonist constructs, just as being oppressed suggests the need for an oppressor. However, according to Freire (1970), in a reflection/action dialogue, both parties power and liberate *themselves*. Hence, in such a relationship there can be no oppressor and no oppressee. Unfortunately, Freire is frequently misinterpreted because of his use of the word "powered" (the connotation of which has been transformed into "empowerment"). Empowerment, the idea that one individual holds power and can impart it to another in a coercive action of convincement of what is best for him/her (Laverack, 2005) is actually the converse of Freire's ideal. It is more akin to the "banking" model of relationships and power where there is a cycle of alienation because relationship transforms into a "simple circulation or the exchange of commodities" (Marx, 1976/1887). Through a critical awareness of Freire's stance, it can be understood that individuals acting in relationship liberate themselves and each other through communication.

However, such a web of understanding is antithetical to some of the concepts found in disciplines such as Nursing which typically conflate power with a differential of potentials (according to Foucault, a power–knowledge conception) (Foucault 1977), emphasizing disparity in relationships and frequently failing to embrace the *connectedness* of potentials. The expression "power relationships" then brings a negative connotation, where the illusion that one individual can execute, perform or impose power over another is, without much difficulty, dismantled by an integrated perspective of the phenomenon, as will be observed in the chapters that follow. In Np-Pt care settings, as in

every other relational setting, an inequitable control mechanism of expression based on a "differential of potentials" (Foucault, 1977) attenuates the experiences of both. An equitable relational mechanism of expression based on "sharing of potentials" can enhance relational experiences for collaborative problem-solving, and, as my case analyses will show, better health promotion.

Foucault and Freire are two frequently referenced individuals in nursing's power/relationship/empowerment literature. The critique of inequity in relationships is a central tenant of both. Unfortunately, as has been shown above, misinterpretation of their ideas can lead to a banking-perspective, moral-driven, and dual (contradictory) understanding of power. Hence a fresh understanding, using a diverse set of lenses to redirect our attention to the essence of power and relationships, proves valuable.

Current communication theory explains intercommunication as a relational and transcendence process (Condit, 2006; Shepherd, 2006). Communication is the open channel through which relationships are possible and to study power, communication processes need to be addressed. Perhaps the most commonly held view is that language has a universal capability associated with the biological predisposition to activate verbal and writing mechanisms such as grammar (Chomsky, 2000). The difficulty suggested by this perspective is that it considers mainly the mind as capable of language. However, communication is much more than the sum total of the words and cognitive processes used during human interaction. Silences, body movements, and the interplay of the words are an integral part of the interpersonal experience. Thus, the quality of a relationship is a contingent condition that can be understood as an integration of verbal and nonverbal

language fractals. Although there is a small body of literature investigating communication between nursing professionals and patients, the vast majority of research has focused on verbal fractals of communication and, in the case of nurse practitioners in particular, verbal and nonverbal components of the interpersonal experience had not been examined at all. Upon considering a misunderstanding in the interaction of power-and-relationships, as well as the lack of nonverbal studies of power in nursing, it became apparent that providing a fresh perspective and analysis on manifestations of power within and between nurse practitioner-patient communications would require going outside of the traditional nursing literature and nursing research.

As such, the purpose of this thesis is to unveil power mechanisms of expression, through the exploration of nonverbal and verbal interactions in care attenuation and care collaboration encounters in different care settings. Such an exploration underscores, through the study of actual cases, what philosophically is uncovered in the theoretical framework.

Using two video-taped interactions, non-verbal and verbal communication was analysed. In the understanding that body-and-mind are inseparable entities their differentiation and integration were vital for a deeper study of relationships. Since non-verbal behaviours amount to the communication fractal of the body, prior to hearing dialogue or reading transcripts of the Np-Pt interactions, quantitative analysis of the video and examined the body fractal particulates ("channels" of body language- e.g. eye contact, arms-hands gesture, posture orientation, etc.). As well, since verbal behaviours amount to the communication fractal of the mind, the verbal language of Np-Pt

interactions were qualitatively analyzed (using conversation analysis) was studied by its particulates (e.g. topic structure, intentions, preference organization, pronouns, etc.) contained in verbal patterns of conversation. As such, a mixed- methodology is employed throughout this Case Study thesis.

Chapter 1, the introduction, provides a general overview of what the reader can expect in greater detail in subsequent chapters, foreshadows later discussions of its importance. In Chapter 2, a literature review highlights the most common understanding of power as a protagonist construct and empowerment as its antagonist in the nursing literature. These two conceptions of power and empowerment found in the areas of public health and health promotion may be considered exemplary of conceptions of power-empowerment in the health system as a whole. In this chapter, articles from 1994 to 2010, revising and studying power-empowerment concepts in nursing, are explored. In these articles, diverse ideas on the topic are found, many of which have become ingrained in nursing practice. The articles can be clustered in six thematic areas: 1) "Power in Nursing"; 2) "Empowerment as Health Distribution"; 3) "Empowerment as a control of (the self) health"; 4) "Empowerment as an analysis of power"; and 5) "Empowerment as a reflective-active sharing of different potentials"; and 6)"Empowerment: returning to the source of power". At the end of chapter 2, the most recent articles on power and empowerment in nursing can be seen to reconcile these as inseparable concepts. Between Chapter 2 (Literature Review) and Chapter 3 (Theoretical Framework) there is a brief commentary that functions as a bridge between the conclusion of Chapter 2 and the opening of Chapter 3 by exposing two differing paradigms of power and power balance.

In Chapter 3, an integrative theoretical framework draws fundamental premises from sociology, education, philosophy, psychology, communication, as well as embracing outlooks from varying world cultures. These premises reorganize and re-present diverse concepts entrenched in the phenomena of power and relationships (e.g. intra- and inter-personal relationships, power mechanisms, struggle-solving dialectical continuum, mind-body integration, and communication) in a way that challenges the perspective that I show to be normative in nursing practice in Chapter 2. To do so, definitions of power and its mechanisms of expression are addressed. At the end of Chapter 3, terminology borrowed from the discipline of music is introduced so that, during the analysis and interpretation of results and findings, it can facilitate critical reflection.

In Chapter 4, the purpose clarifies the intent to this thesis to exemplify in a concrete form, that which abstract philosophical premises discovered in the theoretical framework suggest about power and its mechanisms. This intent to develop a philosophical-practical agreement, explains the choice to and examine two video-taped care encounters involving the same Nurse practitioner (Np) with two different patients (i.e. Case A and Case B). In the understanding that body-and-mind are inseparable entities, their differentiation and integration, were necessary for a deeper study of relationships. Non-verbal behaviours amount to the communication fractal of the body. Verbal behaviours amount to the communication fractal of the mind. The body fractal is underrepresented (and indeed, undermined) in existing studies of communication in nursing; quantitative tools used in this thesis allowed us to reveal its voice. Of course the mind fractal must be heard as

well; qualitative methods allowed this aim. As such, a mixed- methodology is employed throughout this Case Study thesis.

In Chapter 5, non-verbal and verbal communication is analysed. Prior to hearing or reading transcripts of the verbal Np-Pt interactions, an analysis of non-verbal language was undertaken by studying the video and quantitatively examining the body fractal particulates ("channels" of body language- e.g. eye contact, arms-hands gesture, posture orientation, etc). A qualitative conversation analysis was used to study the verbal language by its particulates (e.g. topic structure, intentions, preference organization, pronouns, etc.) contained in verbal patterns of conversation.

In Chapter 6 mixed methodology and metaphors drawn from music, a discipline that specializes in non-verbal communication and lends both vocabulary and context to better understand nonverbal and verbal communication, creates the basis for a reconceptualised understanding of power and relationships –one that connects mind and body fractals of communication- within Np-Pt interactions. In chapter 6, a hermeneutical route facilitates the understanding and interpretation of verbal and nonverbal fractals in these encounters first by differentiating them into particulates (component parts) and then by reintegrating them into a perspective of the whole (process of relationships). Terminology from music is employed to allow a deeper metaphorical reflection on power-as-process in caring settings as organized interactions in time periods. Because music can be defined as the "organization of sounds and silences passing through time" where tones or pitches "must be arranged in some consistent, logical, and (usually) pleasing way before calling these sounds 'music' instead of just noise" (Wright, 2008,

p.2), relationships between sounds are considered as time-based interactions in an arsic and thetic process – i.e. a dialectical process of ebb and flow. This reflection is used to defy a dual (polarity) perception of power (e.g. power/empowerment, conflict/non-conflict powerful/powerless, lose/gain, provide/receive).

Use of metaphor (Ricoeur, 1978) drawn from the discipline of music proves, in the context of this thesis, to be provocative. It triggers reflective actions by "listening" to a phenomena one commonly related to force and control. It does so in four significant ways: 1) By accentuating the differences between hearing -a sensory passive activity, and listening -an active analytic interpretive one, awareness is raised about how relationships and power are dynamic processes, and not determined dual states promoting voiceless and voiced roles; 2) By showing that interaction of parts (potentially) "herald something new or different such as a change in pattern" (Laitz, 2003, p.4), an understanding of how constructors and disruptors can work in balance to build a caring masterpiece of interaction; 3) By highlighting that individual elements are part of a much more complex interaction, each voice is found to bring a complementary integrity bear in the construction of a more complex power structure and; 4) by promoting the reflection a shift is suggested in the way we look at conflicts. Further, musical interactions reassure us that dissonance is not something to be terrorized by; struggles are not good or bad, they are merely part of a temporal relationship. Thus, the quality of music, as with the quality of human interactions, depends on the ways the elements (which may, at first sight, appear to be separate or disparate from each other) interact.

Because music terminology allows us to differentiate qualities of interaction as part of a process, its use in metaphor opens a hermeneutical route to a deeper understanding and revelation of power and relationships in care settings. In transdisciplinarity many conflicts can rise, but they can be resolved by translations among areas. Even though these translations seem to complicate things, they are necessary in this endeavor. Facilitating communication among so many areas is possible by the neutral agreement of terms in a constructed *mother* tongue. The *mother* tongue of this thesis is music.

CHAPTER TWO: LITERATURE REVIEW OF POWER IN NURSING

Introduction to literature about power in nursing

In health and nursing literature, the phenomenon of power has been commonly addressed by two concepts that are apparently contrary to each other: power and empowerment. The term 'power' has been constantly related to a mechanism where there is an unequal care relationship and a *differential of potentials* (Foucault, 1977) drives the relationship. The term 'empowerment' has been commonly related to the mechanism generating an equitable care relationship. Although none of the articles found in the literature make this distinction of *mechanisms of power*; they address them by explaining two "different" but linked phenomena. Both terms, power and empowerment, have been widely discussed and revised (Bradbury-Jones, Sambrook & Irvine, 2007; Kuokkanen & Leino-Kilpi, 2000; Oberle, 1990;Oudshoorn, 2005). This separation between power and empowerment has lead to a negative connotation of power and a reduced view of the phenomenon (Kuokkanen & Leino-Kilpi, 2000). For the phenomenon of power within the body-mind and between nurse practitioners and patients to be studied, the concept of empowerment needs to be addressed and both terms reconciled.

In a three step process, this Chapter explains the different approaches of power and empowerment in nursing from 1994 to 2010. First, I compare public health and health promotion perspectives of power, to show two prevalent views of power-empowerment in the health care system. Second, I show the combination of perspectives around power-empowerment that might be driving nursing practice.

Third, I cluster articles containing similar perspectives around both terms into 6 proposed thematic areas: 1) "Power in Nursing"; 2) "Empowerment as Health Distribution"; 3) "Empowerment as a control of Health";4) "Empowerment as Analysis of Power"; and 5) "Empowerment as Reflective-Active Sharing of Different Potentials". The 6th thematic area "Empowerment: Returning to the Source of Power", explains a recent view of power in nursing, in which both conceptualization, empowerment and power, are reconciled.

Through this review, I provided critical assessment and commentary and on fresh perspectives are needed in the study of power within the body-mind and between nurse practitioner-people relationships.

Two views of power and empowerment in the health system

Laverack (2005) in his book *Public Health. Power, Empowerment and Professional Practice* affirms that these concepts are central to public health and that many practitioners have a superficial understanding of their meanings. This author recognizes six forms of power in care relationships. '*Power over'* includes coercive, reward, legitimate, expert, referent and informational power. '*Hegemonic power'* is a form of 'power over' that is invisible and internalized. '*Power with'* is identified as a form of 'power over' which this author asserts needs to be carefully and deliberately used to increase other people's power from within and not as a means to dominate or exploit them. *Zero-sum* is a circumstance where 'power over' plus absence of power equals a zero-sum in which someone wins and the other looses. In *Non-zero-sum* one person wins

power and the other wins it too, implying a 'win-win' situation. *Power-from-within*, also known as empowerment, is described as an experience of 'self', a personal power, that involves self-knowledge, self-esteem, and self-discipline. Laverack (2005) suggests that health practitioners must use the last type of power to aid patients in 'gaining' power and 'gaining' a sense of control over their personal lives. To do so, the author proposes a guided method to help clients to increase their critical self awareness by mapping positions of power, ranking complex issues, and proposing strategies for decision making to exercise **control over** their decisions.

What we can discover from this view of power in Public Health, among many other perspectives, is how, even when talking about power as a tool to help patients, its conceptualization implies a power-object way of thinking. This conceptualization promotes a view of power balance - or so called empowerment- where to generate equity, the acts of giving, winning and controlling are necessary.

A view from health promotion

Tones and Green (2004) in their book *Health Promotion* recognize that there is an imbalance of power in all personal, social, political and cultural dimensions which affects people's well being. Moreover, they understand well being as a balance, as coherence within the physical and emotional dimensions of the person, and with his/her environment. The two processes of health promotion used to foster this balance are advocacy and health education. Tones and Green recognized that the term 'empowerment' needs to be addressed especially by health education. In the chapter

dedicated to this topic, empowerment is seen as a process to enhance the assertiveness skills of the people so that they can question and challenge the situations in which their health is involved (Tones and Green, 2004).

In relation to empowerment and health education, the authors distinguish between two perspectives. The first one is associated with 'coercing' people into *adopting* health, illness and sick role behaviours in order to prevent disease. This view sees health education as a strategy of persuasion that is a mere complementation to wider environmental interventions (Tones & Green, 2004). The second one relates health education with strengthening individual capacity and promoting the achievement of social and political change, towards supportive empowering environments by influencing healthy policy (Tones and Green, 2004). The authors explain how this last perspective, builds on a 'critical health education' coming from authors like Paulo Freire (1997) who suggest that education is a process of reflexivity and actions that requires dialogue and experience based knowledge contributed by all the parties. In my view, the perspective of health education as empowerment differs from the perspective of education as coerciveness, in that coercion endorses a static role of convincement of one part, and a static role of the one doing the convincement. It endorses that one individual is more knowledgeable than other and for so is the one capable and responsible to decide. Based on these decisions the knowledgeable individual tries to convince the one who does not know, about what is best for him or her.

Tones and Green (2004) propose a model of empowerment based on Freire's philosophy where both, health professional and patient, are *powered* through critical

thinking and collaborative actions. These authors see it to be unfortunate that, in clinical settings (as opposed to community settings), this vision of critical health education is constantly marginalized by the medical model. They suggest that 'patient' education can be comfortably accommodated within a general empowerment model of health promotion. "Indeed, empowering strategies typically result in more effective outcomes than so-called, victim-blaming approaches" (Tones & Green, 2004, p.303).

In this health promotion approach, empowerment does not involve control of behaviours or decisions. Rather, it is about promoting coherent balance among many dimensions of the person and the community through critical awareness. A view of empowerment addressed through a critical education perspective suggests a more socio-centric view of relationships and an integral view of health where all (health promotion professionals and patients) are *powered* to individually and communally do things for their health. As Paulo Freire (1970) proposed, freedom is not something that can be gained or lost as an object or as a goal; rather it is a continuous process within a person and among people. From this perspective, health as freedom is not a gift or a self-achievement, but a mutual process (Freire, 1970). The term power-empowerment from this approach reflects a shared balance, or coherence, between the individuals involved in the relationship in order to improve individual and community health.

During the next pages, we will examine the development of these two views of power-empowerment (similar to those of Laverack's (2005) and Tones and Green (2004)) as they are found in a wide spectrum of public health and health promotion

stances. Two perspectives of power (and) balance are unveiled before the theoretical framework, through the discussion of the terms power-empowerment in this Chapter.

Power-Empowerment

In their articles, Kuokkanen and Leino-Kilpi (2000), and Bradbury-Jones, Sambrook and Irvine (2007), addressed the conceptual combination of "power-empowerment" (Rodwell, 1996). Although, both articles addressed both terms as a dichotomy, they addressed empowerment in a deeper way than they addressed power.

Arising from vast nursing literature reviewed by these authors, four themes were found by Kuokkanen and Leino-Kilpi (2000) and Bradbury-Jones, Sambrook and Irvine (2007): 1) power is related to an action; 2) action oriented towards a goal achievement; action oriented towards having control over one's life; and power is a dominance of one person over the other.

Kuokkanen and Leino-Kilpi (2000) identified three theoretical approaches embedded in the nursing literature around power-empowerment. Seven years later, Bradbury-Jones, Sambrook and Irvine (2007), took into consideration these three approaches and identified a fourth one.

The first approach of empowerment proposed by these authors is the Critical Social Theory approach, which the authors agree, is concerned with the dominance of one group and the subordination of another, and as a consequence is concerned about oppression (Bradbury-Jones, Sambrook and Irvine 2007; Kuokkanen and Leino-Kilpi 2002). The authors interpret that, from a critical theory point of view, power is related to

oppression and empowerment to freedom. Even though it is true that Critical Social Theory is concerned with oppression, this common misinterpretation in many disciplines was found in both articles. A latest conception for critical theory (e.g. Freire, 1977) suggests that there are no oppressed and no oppressors, but both individuals could be embedded in a circle of oppression. The existence of an oppressed and an oppressor implies inequity since the beginning, and can be at risk of seeing empowerment as the antagonist of power. From a Critical Social Freireian view both groups (the one clearly viewed as oppressed, and the apparently viewed as subordinated) are being oppressed, and as such, in collaboration they both can liberate together (Freire1985, 1970). For Freire, power was not in opposition to empowerment, but the people are or can be "powered" by the dialogue with each other.

The second approach, "organizational and management theories", is concerned with the hierarchical distribution of power at a Macro level (i.e. institutions) from top to bottom (Bradbury-Jones, Sambrook and Irvine, 2007; Kuokkanen and Leino-Kilpi 2002). The common things found in these two articles about this perspective, were that a) power is understood as the ability to get things done, b) things to be done are distributed from up down, and c) having things done brings efficiency to the institution. Bradbury-Jones, Sambrook and Irvine (2007) suggest that this perspective is based on power as the ability to control one's work's life, and empowerment as the opportunity to increase productivity and effectiveness. In my viewpoint, even though this approach conceptualizes power as ability –as process-, it proposes a dominant act.

The ability to control the self and life –as this approach proposes- assumes that domination (control) of the self is positive, and it can be used to produce an effective power distribution. In this management approach the word power seems to involve the action of transferring or distributing power to attain a goal effectively, and exercise self-control over the health professional's work life. Power also means a transferable object. If power can be distributed, then to be distributed necessarily requires an object.

The third approach, "social psychological theories", is concerned with self. In this categorization, although it includes the word social, the authors only addressed articles that see empowerment as personal process. In a brief summary they describe empowerment as a developmental process related to the next attributes which many behavioural theorist identified as individual psycho-social determinants: responsibility, self-efficacy, self-esteem, motivation, reflection, independence, power surrender and conquest, and mastery over one's life (Bradbury-Jones, Sambrook and Irvine, 2007; Kuokkanen and Leino-Kilpi 2002). Although the term *social psychological theories* suggest a social component, in the articles retrieved by these authors (Bradbury-Jones, Sambrook and Irvine, 2007; Kuokkanen and Leino-Kilpi 2002), it seems that this approach is individually-based. The second one is that based on these authors, it seems that the social psychological theories are centered on self-skills. Self-efficacy, power conquest, and mastery of the one's life, are three of the skills needed as a way to confront environments and interact with them. This approach also suggests an act of domination or control and of management for efficacy.

At first glance, the second and third approaches apparently seem different. Looking closely, both suggest power and empowerment as skills that enable the individual to manage the self or others, in order to distribute self and other activities adequately enough to achieve what appears to be the ultimate goal in health behaviours: efficacy.

Neither of the second and third approaches addressed balance, a key concept needed when talking about power-empowerment. The second approach as opposed to the third one, understands power as the ability to exercise control and empowerment as the means to distribute and manage things for efficacy. In the third approach empowerment was the ability to exercise control, manage and distribute activities effectively enough that power can be defeated (power conquered). Mastery of one's life, is strongly suggestive of domination. Self control and conquest are subtle ways of dominance, and in many occasions, is viewed as a positive attribute.

The last approach of power-empowerment addressed by Bradbury-Jones, Sambrook and Irvine, (2007), is the poststructuralist. Contrary to many of the articles supported by a Foucaultdian view of power, these authors captured a positive perspective of power contained in the postructuralist paradigm. They explain how power is productive and creative. Power is in every relationship and it influences the individual, his-her body and his-her attitudes and actions. It can produce and create pleasure, knowledge, discourse and new ways of seeing and speaking about what is considered truth (Bradbury-Jones, Sambrook and Irvine, 2007). This article contributes to position the term power from one of the Foucaultdian lenses and which has a positive connotation; though, they never addressed a definition of power. Although later in the article, the

authors explain two core elements on Foucault's work- *disciplinary power* and *knowledge power* (see Chapter II theoretical framework) related to negative attributes. The authors recognized that empowerment was not addressed by Foucault, but from their perspective, based on a poststructuralist paradigm, empowerment is not a liberation or distribution process as other approaches suggest. Rather, it is about "understanding the operations through which nurses and patients are situated and how power is exercised variously in different contexts" (Bradbury-Jones, Sambrook and Irvine, 2007, p.261) I agree with this last point, in that empowerment, among other things, requires an understanding of power. For this reason one of the categories proposed later on for articles addressing empowerment, will be empowerment as an analysis of power.

It was clear that Kuokkanen and Leino-Kilpi (2002) advocate for a critical theory vision of power-empowerment. On the other hand Bradbury-Jones, Sambrook and Irvine, (2007) advocated for a Foucaldtian lens to study power-empowerment. However a deep understanding of both Foucaultdian and Freirean approaches, can be differentiated and then integrated to conciliate power and empowerment.

"Power" in Nursing

In nursing "power" has been classified in many ways, specifically by its functions (types of "power", and "power" in relation to "empowerment") (Henderson, S, 2002; Hewison, 1995; Laverack, 2005) and attributes (Gibson 1991; Rodwell 1996). The attributes of power described in the literature depends on the view of power that each author has. Although power sometimes is considered as a 'capacity to', and has positive

attributes (Hokanson, 1991), most studies consider the negative function of power (i.e *power ov*er) and thus explain power by its negative attributes.

In 1991, Hokanson wrote one of the first articles relating power and nursing. *"Power: a concept analysis"* described power "as the actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve the goals are mutually established and worked toward" (Hawks 1991). The author identified two contrary functions of power; 'power to' versus 'power over'.

The first one refers, not only to the capacity to do something, but to do something in a mutual interpersonal process to achieve mutual goals. The second one, 'power over' refers to a struggle for dominance to raise from an inferior to a superior position (Hokanson, 1991). The author inclines toward the first perspective of power (i.e 'power to'), and thus the attributes of power described in her article are: capacity, interpersonal process, mutual establishment of goals and mutual work toward.

No other article in Nursing was found up to the 1990's and the beginning of the Twenty-first century which interpret power as a mutual potential to act. On the contrary, power appeared as the antagonist of empowerment. Almost all of the articles which consider power with a negative connotation were supported by the earliest Foucaultdian perspective regarding the term (i.e. Biering, 2002; Gastaldo and Holmes, 1999; Henderson, A 1994; May, 1992; Wilson, 2001), or/and in studies developed in clinical settings, mostly in hospitals (i.e. Henderson, 2003; Hewison, 1995; Kettunen, Poskiparta & Gerlander, 2002; Sines, 1994).

The early Foucaultdian perspective and articles supporting it, brought an important critique to the health system and specifically in nursing, but they also introduced confusion and a reduced view of power. These articles are supported in a stage of *this* Foucault who focused his analytic view more than in describing power, in describing relationships based on the *differential of potentials* in terms of power-knowledge and power in health institutions (Foucault, 1973, 1978, 1980). For that reason, and in this thesis, those articles (i.e. Biering, 2002; Gastaldo and Holmes, 1999; Henderson, A 1994; May, 1992; Wilson, 2001) are classified in the thematic area "*Empowerment as an analysis of power"*. The other articles (i.e. Henderson, 2003; Hewison, 1995; Kettunen, Poskiparta & Gerlander, 2002; Sines, 1994) which specifically addressed power, and are supported by clinical studies, focus on "power" relationships, "power" imbalance, and "power" imposition through language. As we will see, all of them reflect a view which considers that power can be transferred, gained or lost (as if power were an object). The use of word "power" reflects a negative situation where the nurse oppresses the patient in an asymmetrical interaction.

Sines (1994) wrote "*The arrogance of power: a reflection on contemporary mental health practice"*. In it, he explores the role of mental health nurses and the challenges that they have to acknowledge the influence that power relationships have on clinical practice (Sines, 1994). Although this author addressed power imbalance, he never defined power. The whole article reflects a negative connotation mostly related to the physician-nurse relationship. When talking about nurses and patients he addressed the terms empowerment and advocacy as ways to empower consumers (Sines, 1994). This

article gives a wide and inclusive spectrum of the historical and sociological challenges of nurses in a power imbalance, but no definition of power and power imbalance was found. It was the first article (1994) that related power to a negative connotation.

Hewison (1995) in her article *Nurses' power in interaction with patients*, through a Grounded Theory approach, and using participant observation, studied how nurses impose "power" through language. Power is seen as a 'give-and-take' interaction, and language is seen as the main component of interaction. The author found that the common type of interactions where a nurse exerts 'power over' the patient was through: a) *overt power* in which the 'patient' was ordered to do something or verbally prevented from doing it; b) *persuasion* which involves getting patients do things without recourse to direct commands, mostly in cases where patients say 'no' to something; c) *controlling the agenda*, characterized mostly by routine communication which indicates the action that should be taken; and d) *terms of endearment* with messages like 'good girl', or 'there you are poppet' when nurses were working mainly with elderly people. This is the first article (1995) found that relates power and language in nursing settings. Power has a negative connotation that can be seen in the categories made by the author around power and verbal messages. Another characteristic of this article is that when talking about language, Hewison (1995), similarly to the common approach in linguistics (see Chomsky, 1976 and 2000; and Pinker, 2005), limited the term language to verbal speech, putting aside probably without intent, the language of the body.

Almost ten years later, Kettunen, Poskiparta and Gerlander (2002) studied power messages in nurse-patient encounters. This article sees power "as a concept that is

manifested as dominance, asymmetry and control" (Kettunen, Poskiparta & Gerlander, 2002, p.103). They studied patient "power" messages during interactions and how nurses respond to them. They concluded that in such interactions, patients can minimize power asymmetry and control the interaction through questioning the nurse, interruptions, and extensive health knowledge and experience discourse. The authors propose that nurses can support and encourage patients to take control of the interaction through power messages. The authors recognized that nonverbal communication was just superficially addressed, and that the examination of "multiple power processes in which patients and nurses recognize different manifestations of power" (Kettunen, Poskiparta & Gerlander, 2002) is needed.

These two studies are relevant to the proposed thesis. In first place because they are the only ones found in the literature in nursing that study at least one perspective of the phenomenon of "power", through language. Secondly, because body movement expressed by the non verbal communication was not considered within the context of power and patients as a language that can express a potential, a relationship, and power. I perceive this as a gap in the study of relationships in health such as the nurse practitioner-patient; I considered it as an empty space that needs to be filled. Even though they considered that a power asymmetry needs to be reduced, they addressed power as an object of control. The last study (Kettunen, Poskiparta & Gerlander, 2002) surprised me the most. How are they talking about reducing an asymmetry by enhancing a mechanism whereby the patient controls the dialogue over the nurse? Is this action simply repeating the asymmetry, only now the patient controls the nurse?

In 2003, Saras Henderson described power imbalance as an inhibitor of partnership in care. She argues that nurses need to be encouraged to share their power and facilitate empowerment by giving patients information and support. Using Grounded Theory and in-depth interviews she showed that nurses viewed involving patients in care as giving patients information and sharing their power of decision-making. She explained how "with the exception of a few, the majority of nurses were unwilling to share their power to maintain control" (Henderson, 2003 p. 501). The author suggests that a way to reduce the power imbalance is to improve how nurses give information to patients and the type of language that they use (Henderson, 2003). This author emphasises the importance of having patients believe that they have power; it is not that they have more power than nurses, but that they *feel* more powerful. (Henderson, 2003) She also advocated for a delegation of "power" and a certain degree of control from nurses to patients.

As a summary of "Power in nursing" I will now highlight some insights. All of the articles described above are based on qualitative research. Only the first one (Hokanson, 1991) addressed power as a positive potential capacity to *be*. The review of literature suggests that in Nursing the view of power is mostly related to a negative connotation, which can lead to confusion in studying the phenomenon. Moreover, authors did not consider the positive and dynamic interaction of power; rather they simply describe empowerment as the positive. From the two articles that relate language and power, none of them studied nonverbal language. Most of the articles (Henderson 2003; Hewison, 1995; Kettunen, Poskiparta & Gerlander, 2002; and Sines, 1994) are based on a

banking view of power (and) balance, which described situations of power as being given or taken through messages, language, information, or decision making.

What is surprising about this last insight is that in the early and middle 1990's even authors who take into consideration power as an interaction and as relations (Foucault, 1973), view the phenomenon as a transferable object, and not as a dynamic process. We can find a clear example in the article *"Contra-Foucault: Soldiers, nurses and power"* (Porter, 1996). In this article Porter (1996) explains a posture against Foucault's perspective which considers that power is generated everywhere at the point of interaction. The author argues that Foucault's nihilist description of power has lead to confusion on what constitutes power. From this thesis perspective, Porter, rather than supporting that power is where relationships are being developed; he supports a banking view of power and balance, and the negative connotation of power. He observes that "power is something that is possessed by certain persons or groups" (Porter, 1996, p.61), not a dynamic interaction generated in the little things before moving into organizations, as Foucault proposed.

The last and more important insight is that none of these studies around "power" considered specifically nurse practitioners-patient relationships. Although there were some studies of "power" in the relationship between nurses and "patients", most studies addressed the unequal mechanism of power, and focused on relationships between nurses in general, and nurse-practitioners and other health professionals such as physicians, psychiatrists, and nurses with other nurses (e.g. Ballou & Bryant, 1997; Gastaldo and Holmes, 1999; Jo-Roberts, 1996; Matter 2006; Moores,1993).

"Empowerment in Nursing": Involving the micro-relations and evolving to the macro relations

Empowerment in the literature review has been classified as a process or as a strategy (Perkins, 1995; Rodwell, 1996; Ryles 1999; Skelton, 1994), and as a variable either of input-output (Perkins, 1995; Rodwell 1996; Ryles, 1999) or as a dependant, independent or intervening variable (Gibson, 1991). In Nursing and other health professions, empowerment is not considered as a mechanism of power but mostly as the antagonist of it.

Kuokkanen and Leino-Kilpi (2000) and Bradbury-Jones, Sambrook & Irvine (2007) proposed four approaches to power-empowerment and arising form: organizational and management disciplines; psychological or behavioural theories; the Critical Social theory approach; and the poststructuralist or Foucaultdian approach. These authors identified approaches to power-empowerment in Nursing. In contrast, I am proposing a new categorization only for empowerment. This section, "Empowerment in Nursing" introduces five thematic areas: "Empowerment as Health Distribution"; "Empowerment as a control of the (self) health"; "Empowerment as an analysis of power"; and "Empowerment as a reflective-active sharing of different potentials". The same article can be classified in more than two thematic areas, because within the article two or more perspectives about empowerment are presented. This also reflect how contradictory is the literature sometimes around terms like power and empowerment and around the term empowerment and the actual exercise of it. It also give us some cues to

think how power imbalance is sometimes promoted (probably unconsciously) disguised as empowerment.

During the next section of the literature review we will see how the concept of empowerment has evolved. Although it certainly has evolved over time; as the first conceptualizations of the term in the health care system in the 1990's are different from the twenty first century, current articles will probably share an older vision, and vice versa. This accommodation reflects that even while the term has been evolving, there were authors from the 1990's who addressed empowerment as a reflective-active sharing of potentials (5th thematic area), and yet there are authors (post- 2000's) who are still addressing power as in the first categories (i.e "Empowerment as Health Distribution"; or "Empowerment as a Control of Health). Such categorizations suggest an *in-volution* of the way empowerment is understood and experienced in the micro relations of health (nurse-patient relationship). Through this critical categorization I am also proposing how empowerment has to *e-volve* as a macro relation (health care system) to understand and experience empowerment.

How can we change the care relationships expressed in difference of potentials in which the relationship will be unequal ("power") to care relationships expressed in a sharing of different potentials where they can be equitable ("empowerment")? Probably it all begins in our reflection of what power-empowerment really means and how we "live it" in our care settings. Is empowerment the illusion that health can be distributed with information? Is empowerment a control of health? Can empowerment start through a reflexive analysis of what is called power and empowerment? Is empowerment a

mechanism of expression of a relationship: an equitable reflexive-active sharing of different potentials in that relationship? Can empowerment be actually power? Let's reflect together.

"Empowerment" as health distribution

This first categorization can be paired to the organizational-management approach, which claims that power needs to be distributed. As we saw in "Power in Nursing", for organizational-management theories, power distribution must be done hierarchically from the top down, delegating activities so that the organization can be more efficient. "Power is described as the ability to get things done" (Kuokkanen & Leino-Kilpi, 2000 p.238), and "the basic element of empowerment is the opportunity to take action that will generate positive results at both the individual and organizational level" (Kuokkanen & Leino-Kilpi 2000 p. 238). As we will see in Malin and Teasdale (1991), Hokanson (1992), Skelton (1994), and Henderson (2003), authors who do not support an organizational-management perspective can unconsciously promote or have been promoted a view of empowerment as a health distribution; a concept which evidently involves health and power distribution.

In 1991, Malin and Teasdale wrote a very important article for this thesis that addressed the contradiction between the concept of caring and the concept of empowerment as lived by nurses. In the article the authors explain how caring is necessary to patients who are momentarily or constantly in a loss of independence because of their illness. It also explains how the concept of caring sometimes confronts a

real empowerment. The core idea is that in *caring* for patients where there is the absence of independence and autonomy, and thus patients are "protected"; but empowerment promotes independency, autonomy and responsibility on the patient through a partnership between both (Malin & Teasdale, 1991).

Although this article, written at the beginning of the 1990's, could be a good exemplar of the last thematic area ("empowerment as a sharing of different potentials") because of its ideas I classified it in this theme. The authors engage in a case study to explore caring versus empowerment, in terms of the type of information presented to the patient. Two types were evaluated: "predictive information (for example by describing operative procedure)" and "empowering information which will allow the patient to control the event (for example, by explaining pain control options)" (Malin & Teasdale, 1991, p. 659). When information to control an event, is considered as empowerment, the whole point of the term empowerment is denied. 'Giving' information to the patient is important, but it if it is the only way to empower the patient, then it reflects a banking view of health and power, thus a banking model of health, in which by information distribution and control of events, welfare is recovered or gained. As this article also treats the contradiction of that view who sees the patient as powerless and the nurse as powerful so that he or she (nurse) needs to give power to the patient, and the one who sees both as partnerships; and actually advocate for the second perspective. Then, it will also be considered in the thematic area mentioned above. This article could also be considered for the thematic area "empowerment as control of (the self) health".

The same condition is exposed in an article written twelve years later. Even when Henderson (2003) in her article *"Power imbalance between nurses and patients: potential inhibitor of partnership in care"* talks about partnership -a term related to empowerment as collaboration- the study focused only on empowerment as distribution of information. The author suggests that empowerment can equalize power imbalance, but she encourages nurses to 'empower' patients by "sharing their power" by giving them information, so that they can feel empowered to make decisions. A limited view of empowerment is generated in this article. This article aligns with Malin and Teasdale in terms of seeing empowerment as information distribution. Henderson (2003) can only be placed in the present thematic area because it had no intentions to promote, not even theoretically, an empowerment beyond information distribution. In addition, it is surprising that this article is still focused on information, being relatively contemporary. It also shows a narcissistic view in which the nurse is powerful, and the patients need the nurse to be empowered. A banking view of empowerment to reduce power imbalance is extremely notorious in this article. To empower is to distribute power –health- by 'giving' or 'sharing' the informational or power object needed to have the weight balanced on the side of the patient. Information can help in the caring relationship and to support people in their health process; but view information as the object to empower a patient falls into a reduced perspective. When sharing experiences and supporting the patients to reflect and act around their own health issues, then information as a secondary object to support care, can be taken into consideration. Information is only a small part of caring relationships. Distributing information, is not distributing health.

A similar contradiction present with Malin and Teasdale (defending certain types of empowerment while promoting a distribution of power) is also found with Skeleton's (1994) article "*Nursing and empowerment: concepts and strategies"*. His contribution to the topic is relevant in the sense that he raised the concern of how in a "rhetoric of 'empowerment' there lurks an older view that 'the professionals knows best'" (Skelton, 1994 p.417). Two views of empowerment are exposed in the article. One proposes that a handover of power is needed, but that the powerful are not going to hand over resources, information and responsibility of decisions; and that health promotion from the 1990's which suggested that empowerment is giving power to users over decisions, and sometimes taking it away from providers. At the end of the article Skelton (1994) proposes that if the nurse wants to empower the patient, strategies at the macro level, rather than at the micro level are needed. Although he explains the problem of many health professionals to think that they can empower the patient through making what they (the professionals) 'know' is best for them (the patients). He also enters into a contradiction when promoting a view in which the nurse needs to empower the patient. These articles belong to "empowerment as health distribution" because they position the nurse as the one who empowers the patient. The nurse distributes whatever she-he has to the patient (even advocates for him-her in a Macro level) so that the patient is empowered. This perspective maintains somehow a narcissistic view of the nurse who is powerful enough to empower others; rather than a socio-centric view that promotes that both can be empowered as partners.

Hokanson's (1992) article "*Empowerment in nursing education: concept analysis and applications to philosophy, learning and instruction"* is interesting because theoretically it addressed constructivist education and critical education paradigms (and philosophies) which explore experience and collaboration as the center of education and thus of empowerment. However, it has two characteristics related to the current categorization of empowerment. The first one is that the author defines empowerment as "the interpersonal process of providing the proper tools, resources and environment to build, develop and increase the ability and effectiveness of others to set and reach goals for individual and social ends." (Hokanson, 1992 p. 609) The second one is that she thinks (or thought back in 1992) that empowerment "occurs between two or more people the person who empowers and the person(s) who is (are) empowered" (Hokanson, 1992 p. 609). The author definitely goes beyond information, but still promotes a provision of "something" that gives power (tools, resources, and environment) to the one who does not have it. This perception exhibits a narcissistic point of view in which the nurse has everything to give to the patient. It is completely contradictory to the constructivist and critical education approaches which enhance a partner-equitable relationship in which both empower each other because they have the capacity to, they are able to.

Some of the articles reviewed in this section consider empowerment as a way to 'give' power to the 'powerless'. This definition reflects a 'banking' conceptualization of the term. 'Giving' (as in the term care-giver) information, resources, tools or even power of decision making, 'taking', 'empowering the patient or client' and 'sharing the power of' (e.g power of decision making) are the most common words used in these

perspectives of empowerment. In addition, the *power-knowledge* linkage is well reflected in these articles where to empower is to give information, thus the one who has the information is empowered (or 'has' the power). Power and health are transferable objects that can be 'given' or 'taken' as empowerment to reduce power imbalances.

Although most of the articles are from 10 to 20 years ago, this view of power as knowledge, (meaning information as knowledge) and thus power as information, a second wave persists nowadays. A recent current that emerged within the health professions is evidence-based practice and a whole movement has derived form it. In Canada, evidence-based decision making, evidence-based practice, evidence-based nursing practice, and/or evidence-based nursing, "have received a recent boost from the National Forum on Health (Estabrooks, 1998, p. 17). Settled in the socio-economic demands for specialized knowledge held in the institutions (banks, enterprises, hospitals), and thus a demand in the universities for specialized knowledge; particular people (nurses and patients) base their practice on, or demand specialized knowledge too. As the particular people in conjunction are indeed the institutions, knowledge demand is a constant cycle. Although it is not the aim of this review to make a critical analysis of this cycle, which has its advantages and disadvantages, it is important to address how knowledge can be perceived. If evidence is knowledge, and nursing practice is commonly supported in evidence, a misconception of knowledge (and evidence) could also be driving the understanding of power and empowerment, as was apparent in the Malin & Teasdale (1991) study. Confusion of all these terms can lead to the risk of perceiving health through a *banking* view, as an object that can be distributed, gained or lost.

Commonly, knowledge is reduced to 'facts', 'data', 'information', and 'know how'. We can think that the most we know from articles, books, school, instructions, etc., the best we can inform our 'patients' so that they have enough 'facts' and 'data' to make decisions. If we perceive knowledge as an object, then power can be in the object of knowledge and not within and between the people in the care relationship.

We have to be aware of not making the mistake of understanding and experiencing evidence-based practice as the transmission of *power knowledge* (like if the nurse is transferring money to the 'patient') from nurses to patients, so that the last ones can be empowered. If the nurses are confused with this view of knowledge, they will certainly transmit the knowledge (in the form of evidence) when seeking for their 'patients' health. In the same way, the 'patients' will demand then facts and data to "take decisions" (as seen in Henderson, 2003). Then, a potential second wave of empowerment as health distribution could develop in the discourse of evidence-based practice. The knowledge from this view can also be use like a tool of control where the one who has the knowledge can hide or not hide the knowledge to the other so that the one who possesses it can have the control of the situation, either deliberately or in a naïve position when seeking the best for their 'patients' (as seen in Skelton, 1994).

This view of "empowerment" (first wave and potential second wave) actually reflects a *power-knowledge* or *power-labor view* (e.g give and provide information, or 'share' the power of decision making) discourse. Different powers are not shared, but the nurse is still in the role of the expert and can be able to empower another, basically through a distribution of information. The 'patient' is still in the role of the vulnerable

and to feel empowered demands the "adequate" information that is "out there" within the experts. The information comes, as pills, in many presentations: oral descriptions, oral recommendations, *know how* leaflets, evidence, etc.

The next view of empowerment goes beyond the information (and/or evidence) as knowledge, and the distribution of information, resources, tools, power of decision, to 'empower' the other. But we will see how it stays in an individual point of view. Empowerment, from the next perspective is commonly seen as developing the skills for control of the self, in terms of individual centric (ego-centric) goal achievement.

"Empowerment" as a control of (the *self*) and health.

This second thematic area, "Empowerment as a control of health (the *self*)" can be paired to the social-psychological theories approach in Kuokkanen and Leino-Kilpi, (2000) and Bradbuty-Jones, Sambrook and Irvine (2007) who describe "empowerment as a process of personal growth and development … where power is surrendered and conquered" (Kuokkanen & Leino-Kilpi, 2000, p.238). Even though this approach moves closer to the actual conceptualization of empowerment derived from Critical Social Theory, which represents a collaborative partnership, they still sustain a discourse of domination, not from the nurses over 'patients' but from 'patients' over themselves, and sometimes over the nurses. The "power" has shifted in this perspective. Now the "patient" is the expert; who has to be empowered and to demand whatever he or she needs to control and manage his-her life. A client or patient-centered approach

misunderstanding, leads to an egocentric vision of the patient who has now the "control" over the nurse and over his-her life, promoting again mechanisms of self-domination.

Gibson (1991), Kettunen, Poskiparta & Gerlander (2002) and Aujoulat, d'Hoore and Deccache (2006) are good examples of the transition between a view of empowerment as health distribution, to empowerment as self-control or patients' control over situations.

In 1991, after one of the first analysis of the concept of empowerment in the last two decades, Gibson (1991) redefines empowerment. "Empowerment is a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives (Gibson, 1991, p. 339). This is an interesting article that I should have put at the end, as a transitional article between this thematic area and the next one, because of the contradictions (between this and the next area) found in it. Though, I mentioned it as the first one because it is the latest article in this theme, and because it is also a transitional article between the previous theme, and the current.

A contradiction exists between the consideration of empowerment as a collaborative communitarian social action in which the nurse does not empower the patient; and a discourse of individualism approach in which patients need to empower themselves to manage their own lives (the nurse is only a facilitator external to the process of empowerment). Four assumptions can reflect the contradiction. 1) Health belongs to the individual and he-she is the principal responsible for it. 2) Individuals'

capacity for self determination must be respected but they may need information. 3) Health professionals (i.e., nurses) cannot empower people, people can only empower themselves. And 4) Health care professionals need to surrender the need for control and adopt the community necessary for cooperation (Gibson, 1991).

Falk-Raphael (2001) is also transitioning between categories. Her view of empowerment completely agrees with Critical Social Theory perspective. She defines empowerment as "a process of evolving consciousness in which increasing awareness, knowledge, and skills interacted with the clients' active participation to move toward actualizing potential" (Falk-Raphael, 2001, p. 1) However, in her qualitative study, she reflects patients and nurses perspectives of empowerment. Although the experiences shared through focus groups (Phase I) and interviews (Phase II) are transformed by the author into a *model of empowerment as evolving consciousness*, the experiences also explained a view of empowerment as helping patients to gain some power to exert control over their lives. "Nurses identified increased awareness as critical to empowering process.

That awareness was threefold and included awareness of one's own strengths and limitations, one's own rights to have control over personal/family health issues, and a voice in decisions." (Falk-Raphael, 2001, p.4) The nurses in the study also noted that empowering approach is client-centered. Some client centered strategies were, to meet the patients where they were at, talking to them at their level, and following the patient's agenda (Falk-Raphael, 2001). These perspectives give us a sense of an evolution of the concept of empowerment in Nursing. Patients are also responsible for their

empowerment, and in their empowerment their environment, and also the nurses felt more empowered. However, a client-centred approach does not emphasize that both can be empowered in equal positions, in mutual agreements, and in partnership. It is still in an egocentric view, where empowerment is centered on one person; in the case of this article, it is centered on the patient or client.

In their study *"Nurse-patient power relationship: preliminary evidence of patients' power messages"*, described before in the section "Power in Nursing"; Kettunen, Poskiparta and Gerlander (2002) first propose that power shared through participatory processes is required to facilitate the patient's progress toward health promotion goals. Then, they suggest that nurses could "encourage patients to take control and to be dominant through questioning, interrupting and disclosing" (2002). In this study we can see a similar contradiction, and an extreme emphasis on the patients having control over their own lives, and over nurses. The article shows awareness of patients' participation, but paradoxically they reflect a conceptualization of empowerment as a mechanism of domination. Nurses are encouraged to promote "power" in patients through interruptions, questioning and disclosure (Kettunen, Poskiparta & Gerlander, 2002). And we must ask: Is this real empowerment or is it just a shift of control? Is it that the nurse has also something to say, to express, to share and to be? Is this real collaboration or is it still an ego-centric view where everything is around the client whom is now the expert and has the control?

A more recent article, *"Patients empowerment in theory and practice: polysemy or cacophony?"* (Aujoulat, d'Hoore & Deccache, 2006) heighten what we pretend to

show in this thematic area. The authors claim that "the provider-patient relationship needs to be continued and self-involving on both sides" (Aujoulat, d'Hoore & Deccache, 2006, p. 13). A patient-centered approach is addressed. Health providers attend to the needs, feelings and experiences of the patient (a shared view with the next thematic area); but the goal of nurses, from the perspective of these authors, is to get patients to manage their own lives and illness. The concept of management and control in articles like the current one, assimilates to the organizational-management approach mentioned in Kuokkanen and Leino-Kilpi, (2000) and Bradbuty-Jones, Sambrook and Irvine (2007) articles; only that there is no management of power at an institutional level, but at an individual level. The risk of this concept of empowerment "as a control of health (the self)" is to focus less in the nurse-patient relationship as a mutual transformative health experience, and more on individuals' management achievement.

In this thematic area, two tendencies are found. The first one encourages the nurse to empower 'patients' so that they can solve their problems without depending on nurses' care, which is a revolutionary phase in the conceptualization of health and health education, but the self-caring is still based on control, conquest and domination. A second and not so radical tendency is to encourage nurses to promote patients' empowerment but being aware that nurses and patients environment can be empowered as well, but focusing the relationship on getting the patients inflict control over their lives to "conquer" themselves, and to manage themselves. In both tendencies, "patients" are seen as experts of their own lives. This approach is a bridge between the management and organizational approach and the original conceptualization of empowerment which we

will review further on. Apart from Aujoulat, d'Hoore and Deccache (2006), none of the other studies reviewed in this section, used social-psychological theories (behavioural theories), though, when talking about empowerment phrases such as to 'gain self-control', to 'take control over their lives', 'to provide', 'to empower the patient' or 'patient empowerment' are widely used. This reflects continued a discourse of domination over the self. To become empowered is to conquer or manage the 'selves', or to demand from the nurse what we need or want because as 'patient' I am the expert, it is again repression, not empowerment.

A view like this still promotes an ego centric view either of the nurse or of the patient, where there is "me" ('care' giver) empowering "you", and there is "me" expert (client) around which 'all' needs to be centered (in a client-centered approach).

Empowerment as an analysis of "power".

The third approach is post-structuralist, where Foucault (1977) has been positioned for many years. As the subtitle suggests, this is not an actual stance taken by nurses or other health professionals in the ways they act with 'patients' or the way they perceive and use the concept of empowerment. It is an approach that can be used to make analysis of relationships, and thus of power, in many settings including the health care setting. We open a space in here for this approach because reflecting about what power and empowerment really means, is probably one of the first steps to promote an "empowerment-power" process.

At the end of the 1990's Gastaldo and Holmes (1999) provided an extensive review of publications by nurses who applied a Foucaultdian perspective. Between 1987 and 1998 they found 27 publications that mostly reviewed the concepts; power/knowledge, surveillance, discourse, discipline, resistance, docile bodies, clinical gaze, and panopticon (Gastaldo a& Holmes, 1999). Power-knowledge, surveillance, discourse, and clinical gaze are terms addressed in this section and in the theoretical framework. A critical reflection supported by perspectives arising from Foucaultdian analysis, widely contributed to and impacted the profession of nursing. The authors affirm that Foucault's perspective impacts nursing in the following way: "Nursing care becomes a political event, nursing knowledge contributes to dissemination of regimes of truth, and nurses, rather than being powerless, are perceived as professionals who exercise power" (Gastaldo & Holmes, p.231).

In 1992 and 1994 (May & Henderson) addressed power in nursing through a Foucaultdian lens. In 2001 and 2002, Biering and Wilson, conducted studies which demonstrated what these authors (i.e. Henderson 1994; May, 1992) described in their theoretical articles. May (1992) explored the way in which problems of the subject in many disciplines (e.g Nursing) demand new techniques of exposure, interpretation and resolution, and how these techniques demanded practices of individualization and surveillance through the objectification of the subject (e.g. patient) (May, 1992). He is aware of the tendency in nursing of the last two decades, to see the patient as a "whole person", and how objectification, surveillance and individualization techniques are

obstacles that hinder this tendency. Objectification from a Foucaultdian perspective, means the following to May (2009).

> Patients' status as the public object of clinical attention and administrative procedures: that is, a body to be manipulated and modified. The patient exhibits and describes specifiable signs and symptoms which may be observed and recorded, and through these observations the relationship between her and a range material practices and practitioners is designated and activated. (p.590)

The main expression of this objectification takes place in a process of subject fixation. The individual body is defined into categories after a clinical gaze. (May, 1992). Henderson (1994), supported by Focault's ideas, explains how power operates upon the human body. The body has become the subject of the 'gaze', and the corpus of knowledge. Knowledge is produced after the examination and categorization of the object (body). The body is considered as an object of perception, examination and categorization. The human has been reduced to the object of knowledge (the body), and this reduction influences the 'whole' clinical practices. "The power of this gaze in medical practice creates interactions of impersonal form. It establishes the precedent for the quality of clinical interactions" (Henderson, p.936)

Objectification and clinical gaze are strategies described by Foucault in several interviews, conversations and writings (1973, 1978, 1980b, 1980c). Macro relations (e.g helath care system) strategies to survive as respected and 'purified' professionals, inoculated into the micro relations (e.g nurse-patient) (1973, 1980c). The way in which nurses are required to extend their 'gaze' is through the role of *surveillance* in which she-he monitors and evidences the patient. Patients must confess and nurses must listen.

(May, 1992, Foucault, 1973, 1980b). Mostly in psychiatric medicine, psychoanalysis and psychotherapeutics, *pastoral power* coming from the secularization of institutions (see theoretical framework) finds its expression in the therapeutic 'gaze' (May, 1992).

The role of surveillance, vigilance and constant examination through 24-hour observation sheet and chart documentation, for example, allies physicians and nurses as collaborative professionals in order to separate the body into physical components which can be measured to produce knowledge (Henderson 1994). "The knowledge, however, is not powerful for the development of 'meaningful' nurse-patient relationship. ... This objective knowledge serves to reduce the power of the nurse in relation to the traditional role of 'caring'." (Henderson, 1994, p.938)

The most common studies "power" as *difference of potentials* or power imbalance as commonly defined by health and nursing disciplines, are taking place, for obvious reasons, in mental health institutions (e.g. Biering, 2002; Ryles, 1999; Sines, 1994). Biering (2002), as Wilson (2001), through a Foucaultian perspective approached the 'phenomenon of power', or rather to say the phenomenon of difference of potentials. The first study focuses on power subjectivity and power knowledge in adolescent mental health institutions. The second one reveals the surveillance and subtle surveillance roles that child health nurses are exercising through home visits.

The first study reveals the impact of this mechanism of power among people in hospitals (e.g. nurses, physicians, psychiatrists, etc.) and illustrates how the subject (in this case adolescents) and their bodies are being marginalized in the clinical settings. To

try to understand this mechanism of the body's marginalization, Bering (2002) explored widely the Foucaultdian terms *'medical gaze' and 'power-knowledge'.* She revealed in 2002 that mental health institutions persistently diagnosed adolescents with having hyperactivity or obsessive compulsive disorder and retained them against their will. In this case, she shows how the 'expert' extracts information needed from the body of the 'patient', so that they could retain them in the psychiatric hospitals and while in it, generate more knowledge where patients become the object from whom information is extracted.

The second study reveals how child health nurses perceive home visiting as crucial for "hooking" mothers into healthy parental care. She contrast this perception with other studies that explain how mothers feel home visiting as an intrusive act, and only respond to the questioning because they feel the obligation. She analyses this contradiction and explains how nurses are convinced of the importance of this role (identified by her, as "gentle surveillance"). Through discourse analysis she discusses that "although many mothers are prepared to subject themselves and their offspring to the gaze of experts , the nurses' discourses reveal them as actively participating on their own terms in the process" (Wilson, 2001, p. 299).

Ten years before, May (1992) and Henderson (1994) addressed the same issues addressed by Biering on 2002 in mental health institutions, and by Wilson in 2001 in child health care. The role of *surveillance* maintains an inequitable difference of potentials, even though this role could have silently and unconsciously being perceived by nurses as 'caring', 'collaborative partnership' or even 'empowerment'.

It seems that Foucault's work that caught Nursing's attention was the one who addressed "power relations" as a difference of potentials. Although some of Foucault's work also explained power as relations (no 'positives' or 'negatives' in that affirmation), and some of them talk about power as creative, dynamic, and generator of positive situations, in nursing, Foucaultdian studies focus on the *difference of potentials*. Studies developed through that particular Foucaultdian lens, can guide nurses to propose a break in the cycle of *power-knowledge* domination where there are experts and non experts, or vigilant and one being invigilated to maintain a "healthy" style and change "unhealthy" patterns. The risk of a lack of awareness about actions and roles in the profession of Nursing is high. We could be promoting the process of "change" from a narcissistic and an ego-centric view of health, instead of a more socio-centric view that considers that change is already happening all the time so there is no need "to change", but to reflect and act together in that challenging change. On the other hand, studies supported of other 'sections' of Foucault's work which describe power as relations and as a creative force, can help us break the cycle of difference of potentials in which the profession and the micro relations that constitute it are captured.

Empowerment as an analysis of power is an attempt to fairly represent the lack of Foucault's 'other-side' view of power in Nursing. And to fairly represent his wide explanation of the mechanism of difference of potentials in care settings, which impacted health fields so much that studies, experiences and even social movements have been generated on behalf of his work. Most importantly, in this section is the possibility of

critical reflection of inequitable relationships ("power"); this is one of the processes that need to be enacted to construct equitable relationships of potentials ("empowerment").

Empowerment as an equitable reflexive-active sharing of different potentials.

A fourth thematic area, *"Empowerment as an equitable reflexive-active sharing of different potentials"* resembles the fourth approach proposed by Kuokkanen and Keino-Lipi (2000) and Bradbury-Jones, Sambrook and Irvine (2007): the Critical Social Theory approach, but in its latest view. From this view, empowerment is a method of awareness through problem-solving dialogue where the different potentials of everyone are shared to act together. There is not an "empowerer" on an "empowered", as several articles suggest in confusion about Freirean and constructivist-participatory education perspectives. A critical social theory that at first was concerned about the domination of certain groups was opened to a broader sense with the critical awareness method through a dialogue that promotes reflection and action as proposed by Freire (1970, 1985). No longer 'ones' are oppressed by the dominating group, but 'everyone' is dominated by a system of oppression. As such, involving 'all' in a participatory process could free everyone. In a dialectical relationship they are all empowered.

Although this approach is commonly used in community settings and with a group of people through a Participatory Action Research, as we saw in the "Health Promotion view of power" at the beginning of this Chapter; it can be developed in clinical settings as suggested by Tones and Green (2004). The articles that exemplify this approach are beyond information or evidence-based care, beyond a managing or

controlling-based care, and beyond an 'expert' or 'client'-based care. The next articles are based on a critical health education perspective. In the clinical settings this approach recognizes empowerment as an active process that involves both the health professional and the person (Falk-Raphael, 2001; Kettunen 2001 & 2006; McWilliam & Stwart *et al*., 1997; Oudshoorn, 2005; Patterson, 2001). Five articles showing (intentionally or not) a critical education's perspective, were found (i.e. Falk-Raphael, 2001; Malin, 1991; Perkins, 1995; Rodwell, 1996; Ryles, 1999). Articles that claimed to be supported by a Freirean critical theory stance, but whose discourse strayed from it, were not taken into consideration in this section. Moreover, authors who made some contradictions, but addressed in the discourse or findings a Freirean stance, are taken into consideration even when they were explained in other categories. In that way, we will see the subtle evolution that the term empowerment has made over the last two decades.

Malin's (1991) article shows the first wave of empowerment as a collaborative sharing of potentials, when analysing the terms empowerment and caring. As was the case of many of the articles from the early 1990's, Malin (1991) was also concerned about the role of caring and the influence of information over patients in terms of it. The author addressed empowerment through information, as probably information was one of the most important issues at that time, to "empower" the patient. However, the author did not talk about nurses "empowering" patients. Instead, he addressed how a 'victim' oriented role of caring presents or hides information to the patient, as the patient is not in an equitable situation to understand or cope that information. An empowerment oriented

role, instead, considers the nurse-patient relationship as a partnership where both need to know the information, no matter how "bad" it was for the patient.

In 1995, Perkins merged psychological empowerment theory and community-based research and intervention, through a profound theoretical review. The author included articles about the construction of knowledge around empowerment and their impact on education field, as opposed to the health and nursing fields. The basic components found in his article that defined the term during the reading were: participation with others; mutual goal achievement; efforts to gain access to resources; critical understanding; and individual, environmental and socio-political spheres.

The following citation is the best example of his elegant reflection about the theoretical analysis that Perkins (1995) made about empowerment.

> Empowerment theory, research and intervention link individual well being with the larger social and political environment. Theoretically, the construct connects mental health to mutual help and the struggle to create responsive community. It compels us to think in terms of wellness versus illness, competence versus deficits, and strengths versus weaknesses. Similarly, empowerment research focuses on identifying capabilities instead of cataloguing risk factors and exploring environmental influences of social problems instead of blaming victims. (p. 569)

This article, written in 1995, was probably the one that addressed in a global way what empowerment means. Perkins reflects how empowerment is beyond mere information or evidence. Empowerment involves psychological skills, and so much more. Empowerment is embedded in the ways we do things, as individuals and as community. As Ryles (1999) recognized "people are motivated to care or act not by their differences

but by their ability to recognize themselves within others" (Ryles, 1999, p.605). In Education, the meaning of attitude is different than from health disciplines. Attitudes are the ways we do things. The way we do things, in the end is the way we "are", and the way we are with others in the world.

"Empowerment is about 'what you are', rather than 'what you do" (Aujolat, d'Hoore, Deccache, 2007), so the development of attitudes is one of the most important processes in empowerment.

In Rodwell's (1996) article, partnership was recognized as the defining element of empowerment. The author affirms that partnership respects and values the self and enables people power and freedom to make choices. Furthermore she recognizes that "enablement is about changing the nature and distribution of power which ... originates from self esteem" (Rodwell, 1996, p. 309). Although at some point the author mentions the phrase "control of their (patients) own lives" we can see in this article the recognition that power comes from an internal enablement in a partnership which values the other. The defining attributes of empowerment found in this article were helping process, partnership, mutual decision making and freedom to make choices. Moreover we found something new. Autonomy, responsibility, and accountability were found as related concepts, which in terms of education (the home discipline of the term empowerment), are considered attitudes.

Although Falk-Raphael (2001) also uses phrases like "client-centered approach", "participation of those becoming empowered" and "increase control over", she clearly

proposed a model of empowerment derived from her study with nurses, very similar to the participatory approach used in community settings. In her model, she conceptualizes empowerment as an evolving helical process of increasing awareness, promoting 'clients' participation in interaction with them, and developing (not just providing) knowledge and skills (and so on). For her, a relationship that can develop and maintain empowerment involves mutuality, sense of partnership, and attitudes such as nurse authenticity, empathy and respect from both (nurse and patient)(Falk-Raphael, 2001).

Although these attitudes were not interwoven in the model, she emphasised three of them, as Rodwell unconsciously (without naming them attitudes) did. As attitudes are related to the way of *being*, of the way in which we do things, the element *attitude* is one of the essential differences between the first two approaches of empowerment and this one. Three additional core elements that differ from the first two approaches of empowerment found in Falk-Raphael (2001), Ryles (1999), Rodwell (1996), Perkins(1995), and Malin (1991) are mutuality, collaborative participation and partnership. These elements connect the individual to the health professionals; both are being empowered through an equitable relationship.

Through the review of literature in nursing in which **re**flexive-active sharing of different potentials as an expression of equitable relationships are addressed, we can appreciate a dynamic mutual empowerment. Sharing their potentials, both nurse and patient, can decide about the best solutions to maintain a body-mind balance, instead of marginalizing the subject and the body through techniques that promote a differential of potentials. The harmony of the relations between "health professionals" and "patients" is

in change but balanced in a cyclical process of open communication where both can express and share their potentials, co-construct knowledge based in reflective experience, and solve health problems based in reflective action.

Through this approach, we can appreciate the socio-centric view, where the potentials are shared in a persistent cycle of fulfillments of needs (knowledge, skills, attitudes, acts, health), rather than accommodating themselves in a 'scale' which on one side there is the oppressed who needs to 'gain' power or be empowered, and on the other side the oppressor who needs to 'share or give' her/his power to the powerless. His approach is a non-banking perspective of empowerment.

From my own view, evidently influenced by Freirean and community health perspectives, empowerment is not the repression of the self or of others through goals to 'change', 'fix' or 'suppress' an action (unhealthy behaviour). Empowerment is the liberation of the self that can *be* in the *beings* with other potentials, and can act in a process of harmonious collaboration with others. Empowerment is created in dialectical relationships. In dialectic relationships there is a sense of partnership and connection, and a incessant reflection-action movement produced by partnership. The method of empowerment is a reflexive dialogue of the fears, expectations, the context, the beloved things and persons, *the self*, the community. It raises awareness about problems, and promotes the collaborative solution with all the parts of the relationship, sharing all the potentials and resources. If proposing goals in the relationship, mostly centered on the patient, as sometimes we are pushed to do in clinical settings, those goals must rise from awareness and active participation of both, as well as their achievement.

My own personal reflection around empowerment is the focus on how empowerment is different from power. I hardly use the word empowerment, and thus, my practice in both the fields of education and health, have assisted me to understand the term better. Moreover I am inclined to a participatory type of action research, and I have applied the method of critical awareness in both fields. And I need to say I never think about empowerment, I think about potentials. I reflect about how can we (the 'students' and I or the 'patients' and I) express our potentials?

From power to empowerment

Where does power and empowerment merge? Are they different? Are they the same?

Through this literature review we can appreciate how the term "power" is confused with a differential of potentials. Conversely, empowerment is being seen, studied and used as the antagonist of power. We could also appreciate how a difference of potentials can be disguised and classified as empowerment, as in the first two categories of empowerment. Health professionals can become confused by this situation. This confusion can be a barrier to strategies that can be used to have a truly equitable expression of relationships (internal and with others). A critical view, such as the one promoted by Foucaultdian and Critical Social Theory perspectives can clarify the meaning of power-empowerment and change the strategies and the way we experience power in nurse-patient relationship.

Ryles (1996) supported on a Foucaultdian view but addressed empowerment through Critical Social Theory, argued against the emphasis within nursing upon individuality. Individuality for Ryles, is alienating and divisive. If we could consider a different view of power, we could see how power and empowerment are not different at all.

A better understanding of power through a global Foucaultdian view, and a better understanding of the Freirean perspective of "empowerment" could return us to the view of health as balance within the person and among persons, and to the source of power experienced by ancient philosophies such as Tai Chi (Chukrow,1998; Horwits, Kimmelman& Lui,1976; Liao, 1995), Buddhist Zen (Osho, 2007), the perennial philosophies with the Great Chain of Being (Wilber, 2000), and the Native American circle of relationship and Cycle of Life (Cajete,2000). This view of health as a holistic balance, and a return to the source of power is what nurses experienced a long time ago, when caring was about being with the other in mutuality and in continuous transformation (Falk-Raphael,1998). Nursing was not concerned with power-knowledge models, or around control of the self or control from an expert and a non expert. Caring and power were the same: an experience of *connectedness* and collaboration within persons. There were no object-patients to vigil, but whole individuals-communities to connect with. From that interdependence, hang the whole world.

Empowerment: Returning to the source of power

After an extended explanation of how "power" has been perceived in health and Nursing, and how "power" appears at simple sight as the antagonist to empowerment, we can now follow a returning path to this phenomenon. During the literature review around power in nurse practitioner-patient relationships I came across articles that caught my attention over the rest. The authors addressed connection between the people involved in care. As the rest of the articles, the articles in the thematic area "Empowerment: returning to the source of power", addressed specifically the nurse practitioner-patient relationship. They include not only nurse-patient relationships, but also extended relationships generated in health care such as the family and the community. I decided to include these articles (i.e. Engstrom and Soderberg, 2007; Falk Rafael, 1998; Hill, 2006; Lowe, 2002; McWilliam, *et. al*, 1997) because a more integral view of power in health care relationships is needed, even when the focus, as in my thesis, is on one relationship (nurse practitioner-patient). This last area goes beyond the discussions that have been taking place in nursing years ago about power, empowerment and "power balance". The next and last part of this Chapter will show us a holistic and different perspective of power in Nursing. It will unveil a socio-centric view of power balance; a view that warrants consideration not only in the Nursing profession but in all the health professions.

Through the phenomenological hermeneutic method, Engstrom and Soderberg (2007) unveiled the experiences of critically ill mechanically ventilated patients in the ICU's, around having their close relatives supporting them in this difficult moment. The

two main contributions of this study were that critically ill people experienced close relatives as the motivation to stay alive, and that through confirmation by close relatives they experienced the power to continue the struggle to live (Engstrom and Soderberg, 2007). The confirmation was experienced in various ways, but four are emphasized here: By seeing a close relative that they could recognize and who could explain to them where they were and help them remember what really happened; by feeling that in spite of the lack of verbal communication their close relatives could understand their feelings, pain and fears, and communicate through them with the staff; by feeling safe and accompanied through the presence of their close relatives whom they could be aware through their voices, their touch and their smell; and by getting strength and will-power to continue to struggle so that they can stay alive to be with their close relatives. In this study the persons involved in that struggle, the critically ill person and the close relatives, described how after sharing that experience they had become even closer.

Although this study addresses the power arising from a connection outside the relationship between nurses and people, it opens the dialogue among the rest of the articles in which sharing and connection is the path to a harmonious communication within each person and between nurses and people.

McWilliam, *et. al* (1997), view empowerment as the emergence of "power" (or potential) in an holistic and interactive process in which professional and, in the case of their study, chronically ill older persons, together evolved a caring relationship and enhanced conscious awareness of life and health experiences. This emergence of power was not merely given by someone but co-created in the caring relationship (McWilliam,

et. al 1997). This last voice, as the other ones standing in the Critical Social Theory approach, tells us that there is an internal potential or power that can emerge through a relationship in process. This process is called empowerment. The relationship in process (empowerment) is as well constituted by another power in the sharing of the different potentials between the two persons involved in that relationship, and that happened to be 'the nurse' and the 'patient'. It is an internal and external continual process, *involving* within a one-on-one setting, two dimensions of relationship and thus of communication: intrapersonal and interpersonal dimensions (Aujolat, d'Hoore and Deccache, 2007).

Falk Rafael (1998), based on the book, *Women Who run with the wolves* by Estes (1992), proposed how a transformative caring practice is empowering not only for 'clients' but also for nurses. It allowed them to "connect with the wild nurse and run with the wolves" that meant a connection with their nursing legacy of caring. In a previous article in 1996, Falk Rafael developed a dialectical examination of the concepts of power and empowerment which appeared to be polar opposites, just as the antagonists power versus empowerment suggested in this literature review. In both articles she rediscovered a meaning of power that was always there, in the nature of nurses. Through a historical dialectical method (experienced by Hegel and Marx a century before) and a reflexive dialogue (experienced by Foucault and Freire during the last century) with nurses, she reconnected not only the nurses with the nature of Nursing, but intertwined and mutually re-generated the concepts of power and caring, in an emergent approach called "empowering caring".

> At the core of intentionality is the dimension of connectedness.
> Connectedness occurs through dynamics of relationship.
> This relationship exists between everything and every person within the creation/universe. (Lowe, 2002, p.5*)*

Doris Leal (2006), in her article *Sense of belonging as Conectedness, American Indian Worldview, and Mental Health,* observes how the Native American holistic view is represented by the Circle of Life where the physical (body), the emotional (feelings), the mental (intellect) and the Spiritual (spirit) dimensions are connected in a dynamic balance process. The Circle represents the cycles of life and where there is no beginning, no end and no time; it is a symbol of infinity where all is connected, all belong to one another in a never ending all. "American Indian sense of belonging is represented on the east aspect of the Medicine Wheel; it signifies the connectedness of wisdom and illuminates the individual's and community's place within the tribe" (Leal Hill, 2006, p.211). Everything is interconnected so the harmony between the person and the environment is important, as Leal explained: "Therefore, a strength of American Indian culture is the tradition of thinking as "we" instead of "us"" (Sutton and Broken Nose 1996, as cited by Lowe, 2002). Also, the body is a central consideration because it is the source of thinking, sensing, acting and being within all, and the harmony of the body and the mind has the same importance, as harmony among people, and the person with his/her environment. The body offers many metaphors; the metaphor in a tribal sense expresses the physical body, and the body-mind as well, that experiences and participates in the world (Cajete & Little Bear, 2000).

John Lowe, a nurse and a Cherokee PhD, describes how Native American nurses facilitate and promote harmony and balance through this view of connectedness. He mentioned that the practices of the Native American nurses are: caring, tradition, respect, connection, holism, trust, and spirituality. This view, focused mostly in the sense of caring, connectedness and holism, is similar to the view expressed by Engstrom and Soderberg (2007), Falk Rafael (1998) and McWilliam, *et. al.* (1997), three non-Native American authors.

Respect, caring and holism are ways of being and becoming because all the things exist in interdependence with others, and all are of equal importance. Harmony is a way of life and relationship of inner peace and contentment that is based on cooperation and sharing, and it results from being in balance. In a journey experiencing a process of self-actualization, through the connectedness of relationships, nurses engage in this process themselves while assisting others in being and becoming. (Lowe, 2002) As a dynamic process, this journey implies a connectedness of the self in balance and harmony into a being with spiritual (not linked to religion), physical, and mental/emotional dimensions; a connectedness of the self with others in balance and harmony in the world; and in connectedness of all in balance and harmony into the circle of life. "Connectedness occurs through the dynamics of an interdependent and interrelated relationship between nurse and client" (Lowe, 2002, p.4).

Some of the views found in Native American nursing articles consider the person, the close relatives, the family and the tribe, in the process of decision making, because the person belongs to that circle; all of them are part of the 'patient' and everything which

he/she is connected gives him life and energy (Lowe, 2002). Native American nurses do not consider themselves the center of the universe or special creatures who can dominate or control the world, so they assist people through exchange, unconditional attitude, respect, trust, partnership, and most important, through silence. Not through a controlling or uncomfortable silence, but through a listening silence which is opened for the dialogue and harmonious balance with one self, with the other in the consult, and with the all through this continuum cycle of life.

"Nurses use silence as a way to avoid control and maintain harmony" (Lowe 2002, p.9), just like in the music where a simple note within the melody, or a complex melody within a dialogue among Melody (the leading voice) and Harmony (the accompanying voices) open the silence for the other to be heard and vice versa, so that the composition can be a harmonious melody. "Through the presence of silence, a oneness of spirit is created and a way for the exchange of healing life-energy occurs". (Lowe, 2002, p.9).

As a summary of "Empowerment in nursing" I will highlight some insights. All of the articles described in this review are based on qualitative methodology. Apart from the articles described in "Empowerment: returning to the source of power", the review of literature suggests that in Nursing the view of empowerment is mostly related to a positive act to confront "power", which can lead to confusion in studying the phenomenon. Authors who studied empowerment did not address non verbal language as if the body has nothing to say or has no relationship in an "empowerment" process. Articles classified in the first two categories (i.e. "Empowerment as a health

distribution", and "Empowerment as a control of the (self) health") reinforce a banking view of power balance, where power exists as a transferable object.

Lately I found an article in nursing entitled "Harmony: A concept analysis" (Easley, 2007) and I remembered something. When I was young I learned in school that health was balance, and that balance was harmony, but suddenly the definition of health and balance changed through the years. I forgot the relationship, because I pictured balance as in a scale. How could health be balance, when balance appears as an apparatus constituted by two different plates separated one from each other? Through the last three categories I saw an evident evolution of the term empowerment, which gets closer to a non banking view of power where the balance is at the core of connectedness. This latest article form 2007, kept me thinking and suddenly, everything made sense again. My question was solved.... Connectedness is power!

And this thesis began.

Questions provoked by the literature review

What can this revision tell us about the common view of power? Is power really the antagonist of empowerment or are they the same phenomenon? What if more studies can return us to the essential sense of power and make us see clear its mechanisms in clinical settings? Is it possible to give a voice to the power of the body which is as special as the mind when connecting with others in relationships? How important can it be to open a space for nurse practitioners-persons relationships, in a literature where power in all its extension have not been unveiled in this relation?

CHAPTER THREE: THEORETICAL FRAMEWORK OF POWER

Power and Balance: Moving from the Literature review to the theoretical framework

A common tendency in political and social studies is to consider power as a negative or as a positive. As was seen in the literature review, in Nursing, a usual conception underpinning power and empowerment involves categorization of a "good" protagonist and a "bad" antagonist. Common connotations of "good" and "bad" involve moral underpinnings. From a moral perspective, these are two characteristics in opposition to each other. "Good" might be considered the extreme to which humans need to aspire. On the contrary, humans move away from this extreme to qualify "bad". It is a common stand in the nursing literature that empowerment appears as a protagonist and power as an antagonist. Empowerment is needed to control power, surrender it, or liberate people from its' arrogance. This promotes a separatist view between two poles; and therefore a dualistic perspective about the phenomenon.

As a consequence, empowerment is seen as a way to give power the patients or nurses. Power, in this sense, is seen as a "good" potential, characteristic, or capability, can be transferred from one person who is already empowered, to a person that needs power. Therefore, a "good" action for a person with power is to provide power to others. This vision also promotes a separatist view between those who are seen in a position of power, and those who are not seen in that place – an additionally dualistic perception. Power in this conception, is perceived as something that individuals can possess and transfer, and for that reason it can also be taken or be lost. The subtle combination of these standpoints entails both a dichotomous moral separation and a "banking

perspective" of power. In this combination power is a transferable commodity that places individuals in positions of extreme such as good or bad, having or not having, powerful and powerless, strong and vulnerable, or dominant and dominated. An ultimate good of balance and equity, is found in equalizing the amount of power, by means of distributing power to the ones who lack it, and control of the people who have it. To empower, then is the act of controlling the distribution of power in order to help (in a good action) the ones suffering from inequity (the powerless, vulnerable, or dominated).

The confusion brought from this moral, dual, and banking power balance conceptualization, has been internalized in every level and in every activity of human life. When power takes the form of a material good (as in the economic system), knowledge to be transmitted (as in the education system), and a product to be provided (as in the health system), then it differentiates people in two categories: the one who has the commodity in form of money, knowledge, and health; and the one who lacks that commodity. The first one is categorized as the powerful and the second as the powerless. If this were truth then empowerment would be the process of transferring the object of power. Furthermore, from this perspective, "having" too much power is "bad", but "sharing" it is "good". If that were truth, then being powerful would be "bad" and being "powerless" would be "good". The confusion is entrenched between the moral driven banking vision, and what appears to be truth from there. The logical consequence arising from this perception is that "having" is "good" and "not having" is "bad". Therefore the message would be confusing. Is having "good" and not having "bad", but being powerless is "good" and being powerful is "bad"? So, do we need to transfer power or

not? Do we have to be powerful or powerless? Do the separated extremes of "powerful" and "powerless" really exists, or is it only an illusion of what power really means?

As we will see in this chapter, Marx (1976/1887), Foucault (1977) and Freire (1970) have pointed out certain matters around how in a closed circle of *power-labour* or *commodities* (Marx, 1976/1887), in a closed circle of *power-knowledge* (Foucault, 1977), or in a closed circle of oppression (Freire, 1970), people are confused between "having" and "being". In these closed circles, existence and relationships are alienated into the objects to be gained or lost. In the circle of oppression, people no longer are, but have (Freire, 1970). The deep understanding and integration of these authors can enlighten a better understanding about how in a Macro relation such as the health system, people can be at risk to demand objects of an illusory "power", rather than focusing the external resources and intra-inter potentials to connect, heal, and be. In this moral dual banking conceptualization there are powerful people (who 'have' the power) who can "give" power to the "powerless", or "powerful" from which it is necessary to decrease power to establish an egalitarian (fair) situation. Equity from a "banking" and dual (two categories) perspective sees a powerful and a powerless, a healthy and an unhealthy, an expert and an ignorant, and suggests a loss of power by the powerful and a gain of power by the powerless.

In the nursing literature review two more visions around power-empowerment were found. In the first one empowerment is the means by which power rises; in the second one empowerment and power are not even distinguished from each other. These two stances allowed an alliance between the terms. At the end of the literature review it was

discovered that the terms empowerment and power are very close to each other: a continual changing process of relational connectedness within and among individuals and communities. This thesis makes no such a separation and directs the focus to power.

Contrary to the banking perspective of balance and equity, other conceptualizations consider that the mind and the body and the people in relationship are not separate from each other and no one alienates the other, but both are and can be expressed in balance with each other. The potential of the mind and the potential of the body, and the potential of one person and the potential of another can work together equitably in a different kind of balance. This balance works through the connection of potentials in a struggle continuum.

In the next chapter we will discover that in a real equitable relationship both individuals ARE –not have- a relationship. They both share and express their potential in a relationship called power. In permanent inequitable relationship where the potentials are separated or one is alienating the other, it is the object or commodity that is being expressed; therefore, if they cannot continue expressing themselves, and stop *being*, there is no power. .

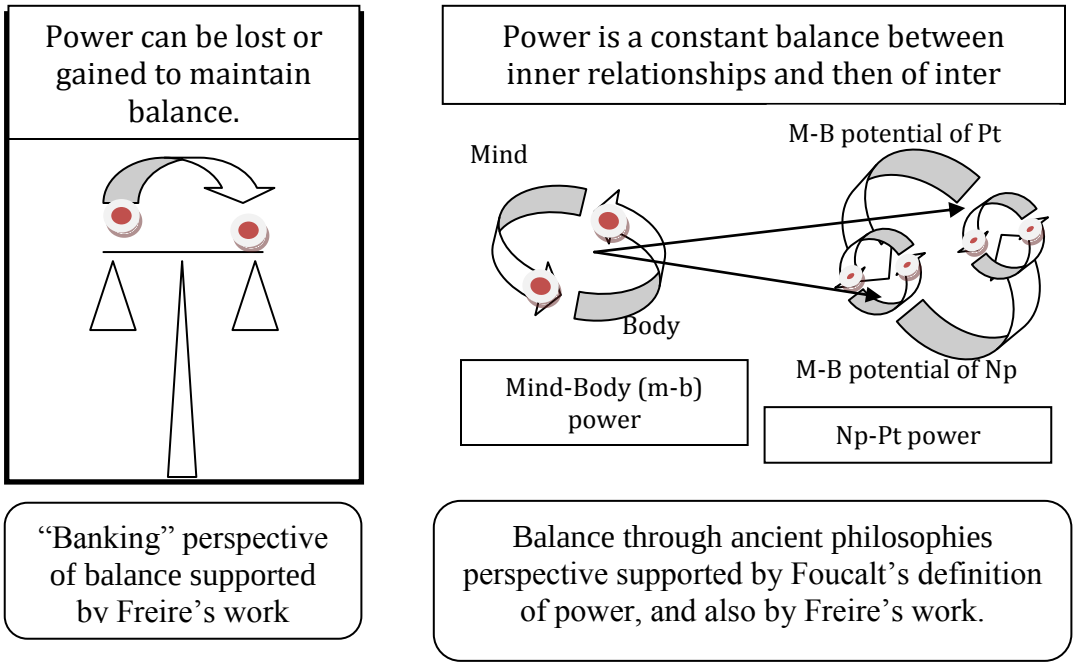
From some ancient and some postmodern points of view, entities are not "good" or "bad" (or any other dual category), but only *are*. The important thing is to maintain that what appears to be contrary opposites is in fact balanced. Tai Chi philosophy (Horwitz, Kimmelmman and Lui, 1976; Waysun, 1995) for example, illustrates a different type of balance. In this balance, both parties (the so called "good" and "bad" from the first

perspective) are not separated but connected to each other and in movement. This is represented through the *ying and yang*: an apparent circle with two colors, but connected and in continuous movement in the middle. The moving interconnected middle suggests that it is not a circle but a cycle comprised of intra cycles. For example the black color has within, a smaller cycle with the white and black colors, and the black color has the same. This represents how power balance of two entities is constructed by an inner power balance of two entities and so on. From this point of view what appeared to be two extremes in the last perspective (healthy and unhealthy, expert or ignorant, etc.) are both part of the same connected moving process. Both entities in relationship are, as Foucault (1977) claimed, power.

Before entering into the theoretical framework, in Figure 3.1we can appreciate the two conceptualizations of power and balance that the next chapter is addressed in. The left side illustrates power in a banking conception where power is an external object to the person. The image at the right illustrates the definition of power discovered through this thesis. In this Figure we can see that power is a process: an ongoing dialectic relation of potentials. In the next chapter I will reconceptualize the term power, and the process of power balance. We will find the explanation of power as relation between people - let's say the one between Nurse practitioner and patient. We will also find the explanation of power within each person - let's say between the potential of the mind and the potential of the body. The construction of this philosophical perspective around power will be exemplified quantitatively and qualitatively in the analysis of a nurse practitioner and two patients' videotaped interactions. A metaphor of music at the end of this thesis, intends to

deconstruct this moral driven banking perspective and break the illusion of power offered in it, an illusion in which we are all enchanted.

Figure 3.1
Power (and) balance through banking and ancient-postmodern perspectives



Introduction to the theoretical framework

In this thesis, power is defined as the relationship between potentials. The expression of a relationship where needs are to be fulfilled and those potentials are developed, is defined as *mechanisms of power*. From my perspective, social thinkers such as Marx (1976/1887) Foucault (1978, 1977, 1973) and Freire (1985, 1970), were focused more than in analyzing power, in the mechanisms through which power is expressed.

Foucault was an important author who contributed to the definition of power and I draw on his work in this thesis. In the first part of the chapter and to explain the term power, I will make use of Michael's Foucault perspective; the second part of this chapter is informed by some ancient cosmologies such as Zen (Osho, 2007), Tai Chi (Horwitz, Kimmelmman and Lui, 1976; Waysun, 1995) and a Native American perspective of Science (Cajete, 2000). To explain the inequitable mechanism where a relationship is expressed in a difference of potentials or the alienation of potentials, Marx's power-labour circle, Foucault's perspective regarding power-knowledge, and Freire´s perspective of oppression (Freire, 1970) are illustrated. Paulo Freire's (1985, 1970) perspective of critical education, the Zen (Osho, 2007) perspective of existence, Tai Chi (Horwitz, Kimmelmman and Lui, 1976; Waysun, 1995) and the Native American (Cajete, 2000) perspectives of connections and balance, are developed to explain an equitable mechanism where a relationship is expressed in the sharing of different potentials.

For a relationship -meaning a dialectical interaction- to exist, a communication process is needed. The process that allows either equitable or inequitable relationships is communication. This communication can be internal to the person (intra-communication) or in relation with others (intercommunication). The development of internal set of relationships between mind and body within each person is explained through Native American (Cajete, 2000) science and Wilber's (2000) integral psychology. Intercommunication as a relational and transcendence process is explained through Condit's (2006) and Shepherd's (2006) views. In spite of perspectives drawn by distinct

authors like Pinker (2005) and Chomsky (2000) that refers to language only as the oral and written language, this thesis will consider two other different types of languages to communicate with others: Statistical language that can metaphorically reveal the body (nonverbal language); and the artistic or musical language which expresses a mind-body unity.

The whole framework that will contain, lead and interweave the ideas in this thesis will be the Metaphor of the Music, which coincides with an Art-Based Inquiry perspective that is in favour of incorporating art in all the stages of the research process in various forms to complement qualitative, quantitative or mixed methodologies (Estrella and Forinash, 2007; McNiff, 2008).

Power and its inequitable mechanism of difference of potentials

In his "Capital: A critique of political economy" one of his most known treatise, Marx revised, among other things, a view of productive relationships constituted by the money owners or "bourgeoisie" and the workers or "proletariat". With the construction of the term *labour-power* as a circle of commodities' exchange (Marx, 1976/1887), he clarifies the relationship between the money-owners (the buyers and the sellers) determined by their "free will" to perpetuate the "sphere of simple circulation or the exchange of commodities" (Marx, 1976/1887) and the workers (the processors and then the buyers), determined by their "free" will to work. If we analyze this *labour-power* relationship closer, we can find a history contrary to freedom -of domination- as many of Marx's works suggest. At first glance of this exchange of commodities, we can see that

the money-owners who sell what they construct or believed as commodities, are the possessors of the money to elaborate a product and to pay to the workers that will elaborate them. Thus they possess the products as well as the workers. At a second level, we can see that the money-owner who buys the commodity possess not only the product and who elaborates it, but transforms himself into the owner of the money-owner with who he exchanges the commodity, the seller (that in this case is the worker of the buyer). At a third and deeper level, we can see that the money-owner who sells, imposes or creates a necessity called commodity, to the money-owner who buys it, being the possessor of the buyer and the worker (which in many cases are the same).

Although Marx's perspective of the study of the phenomenon of power lead to explain the relationship between the "bourgeoisie" as dominators and the "proletariat" as the dominated, from the view of my thesis we can see how both, the buyer and the seller; both, the "bourgeoisie" and the "proletariat"; both the money-owner and the processor, are the possessors of the other and are possessed by the other in a circle of oppression that controls the necessities of the humans' body-mind.

If we see power and health as commodities like in the power-labour circle, and if empowerment is to "give" power to someone, then empowerment can be confused with a way to distribute wealth. Then, a mind-body would be at risk to no longer know by experience and cannot have the capacity to express what they needed, but what this circle of commodities' exchange or *labour-power* told them what their needs are. The in depth analysis of "power" found in Foucault's essays, lectures and interviews, reveals a

definition of the term was found –one that radically differs from the one found in nursing articles applying a Foucaultdian view.

In a conversation among Foucault, Grosrichard, Miller, Miller, Miller and others, called "Confessions of the Flesh", exposed in the book *"Power/Knowledge*" (Foucault, 1977), Foucault offers several ideas, that form the core of this thesis.

1) "Power in the substantive sense of '*le' pouvoir*, does not exist (1977, p.198)". From this perspective it is not located at –or emanating from- a certain point.

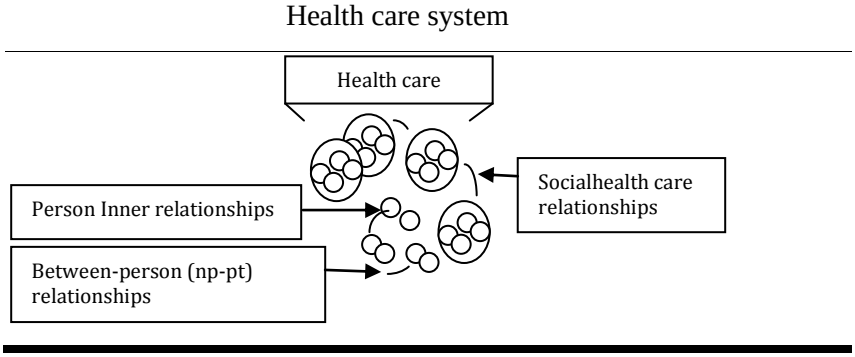
2) Power does not emerge from any point but "in reality power means relations, a more or less organized, hierarchical, co-ordinated cluster of relations". (1977, p.206) Then "if power is in reality an open, more or less coordinated cluster of relations, the only problem is to provide oneself with a grid of analysis that makes possible an analytic of relations" (p.206).From this perspective, all relations are power relations that can be analyzed.

3) Later in the conversation he expressed that in his first works he found that power has its genesis in the "little places", organizing itself in terms of the "little things" before it gets to the stage of concentrated organization. In his latest works he proposed that "there are also movements in the opposite direction whereby strategies which coordinate relations of power produce new effects and advance into other domains" (1977, p. 200).

As we can see in Figure 3.2, macro relations are constituted by micro relations. There is a correspondence between the "little things" and the system in which they are

organized (as Foucault proposed, and as explained in premise 3). From these standpoint explained above, we can study complex relationships through micro relationships and vice versa. A micro relation system within the person, for example, constitutes a person; in proportion to the micro relations, the person will be a macro relation. A micro relationship between persons can define a wider social network that in proportion will be the macro relation and so on. From this perspective, the health care system has a direct correspondence with the micro relations among the people that constitute the system.

Figure 3.2
Correspondence between micro and macro relations



4) Foucault (1977) suggests that the great strategies of power in the macro relation (system) depend on the exercise of micro-relations. Strategies constitute manoeuvres that a certain relation of force needs to do to maintain itself.

If there is a strategy that is leading to inequitable relationships in the system, it is probably being reproduced by the micro relations. Thus, micro relations sustain the imbalance in the macro relations, and the macro relations are supporting and promoting the imbalance strategies within the micro relations. After point five, I will explain the

relationship between the mechanism of oppression and its inoculated strategies from Foucault's studies.

5) When saying: "In so far as power relations are an unequal and relatively stable force, it's clear it implies an above and below, a difference of potentials" (1977, p.201), Foucault lets us know that in his critique to the disciplines (i.e. Medicine and Nursing) and institutions (i.e. mental health) he was not analyzing power, but a difference of potentials. Though, he never made that distinction clear; using the term power in his critique to institutions, to indicate that unequal and relatively stable force implicating a difference of potentials. For this reason I will use quotation marks to indicate when power means difference of potentials, and italics when power is part of another term.

Foucault also analyzed "power" inoculated strategies in health care system. Two sets of strategies that lead to oppressive relationships in the health system are related to the secularization of the institutions (*pastoral power*), and with the production and application of knowledge (*power knowledge, disciplinary knowledge*) within the institutions (Foucault, 1978; Foucault, 1977; Foucault, 1973).

About the first set of strategies, he analyzed how in the pastoral discourse of the Catholic Church, the will of god is to fight against the 'sins' of the flesh (the body), and the will of god is humans will. Through pastoral discourse the reason of the mind or 'consciousness'–a concept misinterpreted and used in religion- represses the desires of the body. In order for the pastoral system of the Church to maintain itself -where the

'conscience' of the mind can oppress the sin of the body- the heads of religious houses had to manoeuvre in order to make themselves recognized not only as part of the ecclesiastic authorities but as *purified personnel* in the system. The inoculated strategies between the macro system of politics in religion and the micro system of individuals in society, consisted of a method for the 'confessions of the sins' of the flesh. In this method, "techniques of self examination … direction of 'conscience' and regulation of the relationship between director and directed" (Foucault & Gordon, 1977, p.200), were required. In this way, the *purified personnel* institutionalized this 'sin's confessions' strategy as a requirement to persist in the Catholic Church. Foucault, called to this set of strategies- *pastoral power*.

In the book "Of power and prisons" (Foucault, Morris &Patton, 1979), Patton observes how the health institutions are not only an instrument and operation of "power", but a site of the production and application of knowledge (Patton, 1979).

According to Patton and Foucault, operation of "power" in health institutions, occurs into two different ways, one is related to the labour force and the second one to production and application of knowledge. In the first sense, they affirm that in health institutions the physical well-being of the "sick *poor*" needed to be fixed, no longer as a "charitable" *paternalized* activity, but to enable the body as a useful labour force; assuring as well, that people could pay by themselves for the cost of his/her sickness " (Foucault, Morris &Patton, 1979).

In the second sense, Foucault studied how the health institutions were transformed into sites of production and application of "power". A set of strategies allowing operation of "power" in relation to knowledge were called *power knowledge*. First, by means of medical diagnosis, the medical authority was entitled to "take out" or extract body information needed to produce knowledge; what Foucault called the *clinical gaze* (Foucault, 1973) -a first strategy of *power knowledge*. Second, the health professionals, specifically in mental health areas (i.e. psychiatrists) established their role as "experts" capable of categorizing the "knowledge" extracted from the patient, to dictate a person´s "insanity", as well as categorizing treatments in order to fix "sickness". In this way psychiatrists, for example, perpetuated themselves as the expert producing and applying this knowledge. They established people´s role as sickened "hysterical bodies" (Foucault 1977, p. 198) from which knowledge had to be extracted, diagnosed, categorized (strategies of knowledge production) and treated (strategy of knowledge application).

Furthermore the "experts" were able to decide, sometimes even against the patients' will, if they needed to be placed into the hygiene system where -similar to *pastoral power*, patients confess their symptoms of sickness. The expert in turn, will listen to "extract" information, diagnose the problem based on the pre-established categories (evidence), and indicate the patient what to do, by means of a treatment prescription. These set of cyclical strategies constitutes, in Foucault´s perspective (1978), a *disciplinary power*.

An exceptional strategy to maintain the circles of *power knowledge* related to *disciplinary power* was inoculated on a micro scale by the nurses within the politics of

the health system –in which inoculation occurred in a macro scale-. The role of *surveillance* (Foucault, 1978) was executed by nurses, as a way to maintain themselves in the *power knowledge-disciplinary power* system. Their role was to watch for knowledge production and treatment application to be successful. To do so, they scrutinized patient's actions to be sure they would follow the correct procedures. In mental health institutions their role was to make sure the patients would take the medications and follow certain behaviours. By this means, the patient, being under medication and the "expert´s" instructions, the medical "authority" would be able to continue extracting information for knowledge production. This set of strategies is called by Foucault, *power knowledge*.

An example of this role is developed in the article "Caring for the involuntary hospitalized adolescent: The issue of power in the nurse-patient relationship", where Biering (2002) exposed how this system is maintained until nowadays.

He explains how *medicalization* allows health professionals to be in an authoritative role to establish medical categories extracted from the body by means of diagnosis, and placing more people under surveillance to produce more knowledge. This author highlighted how "some of these diagnosis or medical categories (e.g., conduct disorder, hyperactivity, and chemical dependency) have increased the numbers of involuntary hospitalized adolescents under the surveillance of mental health nurses" (Biering, 2002, p.67)

The *pastoral, knowledge,* and *disciplinary* strategies inoculated in medical "authority" groups and in nursing groups, provokes the health system to be a site of

production and application of knowledge where in ‘confession’ and ‘surveillance’ the information to produce knowledge is available in the “sickened” bodies. Furthermore, the health professionals assume the role of the “expert”. The “expert”, “having” the evidence of knowledge, enables them as an authority to decide the behaviours to be followed by the patient, and the roles to be followed by the other health professionals (e.g. nurses).

The term “power” is in quotations, because in this thesis, power has not the negative implication it has in the earliest views of Foucault about the term. In this understanding, control would be the right term to describe such a set of strategies. The term “knowledge” is also in quotations, because it has several connotations. I suggest knowledge is a long term process of de-constructing reality, reorganizing it, and constructing new realities. On the contrary, in a circle of *power knowledge* this term has two meanings attached to it. One connotation is that knowledge is information; another is that knowledge is the transactional procedure to have or give the information. In this thesis, both connotations can be related to Marx´s terms commodity and transaction.

A relationship between Marx´s circle of *labour power* and Foucault´s studies around knowledge was found. Knowledge production and application in health institutions is not far from a circle of commodity transaction, where knowledge would be both, the object to be transferred and the procedures to transfer it. Information is to be taken from the non-expert, organized into knowledge, and given from the “expert” to the “non-expert”. The medical authority “having the knowledge” can be compared to the money owners and the sellers. The other health professionals can be compared to the processors of this desired object, product or service. The patient being the non-expert can

be compared to the buyer. The information extracted from the patient, and the treatments -that do not involve patients' participation but instead promote patients' control- are compared to the objects, products or services to be transferred.

Building on the Foucaultdian term *power knowledge* (1977) and Marx´s term *labour power* (1976), and moving towards a shift in the conceptualization of power, this thesis found the rationale to suggest that control would be a better term to name the a difference of potentials. In my point of view, altogether these sets of control strategies (i.e. self sickness confession, medical gaze, surveillance, discipline, and production and application of "knowledge") are contributing to transform a health system than needs to be focused on people´s (subject's) health, into a controlling system that focuses its attention towards objects and procedures to be achieved and enhanced in a transfer operation. This operation was called by Patton and Foucault, an operation of "power".

Since the term control would replace the concept of power in this sense, now the term power can be assumed, as "relations, a more or less organized, hierarchical, co-ordinated cluster of relations"(1977, p. 206), as Foucault also recognized in other parts of his work. Then, for an unequal relationship implying "above and below a difference of potentials" (1977, p.201) is not power. In this theoretical framework inequity – representing a difference of potentials- is the expression of a relationship which is being managed in a mechanism of control. This suggests that a differential of potentials mechanism does not promote relationships (power) at all; instead it enhances a managing –controlling- system in which all the parties involved remain on it, in order to produce, transfer and/or receive the desired commodity.

Foucault´s work help us understand power as a set of relationships at the macro level where the health system is situated, and as a set of micro relations such as the nurse practitioner-patient interactions, occurring at, and being conformed as macro relations. Foucault's (1973, 1977) work as well as that of Marx (1976/1887), assist us in the proposal of one of the mechanisms of "expression" of power –the mechanism of differential of potentials-. Moreover they promoted the understanding of three sets of strategies supporting this mechanism and inequity. Therefore *labour power*, *pastoral power*, and *power knowledge*, contribute to controlling relationships in the health care system, specifically in nursing.

Through this mechanism, apparently the mind can dominate the body -as explained in *pastoral power*-. In the same way, it appears that the 'expert' can dominate the 'sick' and the 'non-expert', as explained in *power knowledge*. And because this mechanism operates from above and below and vice versa, the micro relations (e.g nurse practitioner-patient) contribute in an extensive way, to the sustainability of this mechanism. If micro relations function by a differential of potentials, then the macro relations will work the same way. If the Health system -being a macro relation constituted by micro relations- functions in inequity, then this mechanism will be repeated in the micro relations. This, as you can see, is an ongoing circle of domination.

There is oppression in a closed circle of domination. Enhancing some strategies, it appears at first sight, that mind can dominate the body, people can dominate people, and the people constituting a macro relation can oppress another individual or group given differing views. In mind-over-body domination, people can no longer experience in his-

her body the knowledge derived from within. People have to wait for an "authoritative other" to tell them what their problem is (clinical gaze), what they need to do (commodity-knowledge-health), and how to fix it (product-service-treatment). In this circle of domination it appears that in one extreme, there are oppressors who have and execute power over the oppreessees in the other extreme. This view brings an illusion of separation between both entities: the oppressed (e.g. body/nurse/patient) and the oppressors (mind/"medical authority"). It also brings the illusion of separation between both, the experts (e.g. the mind that controls the body to prevent sins, and the medical authority that fixes categorized sicknesses and dictate health system roles), and the non-experts (e.g the sinner and sickened body, and the patients and the nurses).

Freire (1970), a communitarian educator, researcher, and writer involved in teaching as well as in politics, lend a different view about this apparent separation of experts and non-experts, and oppressors and oppressees.

Accepting his profound influence from Hegel and Marx, Paulo Freire constructed the concept "banking education" (Freire,1970). From a "banking education" perspective, the teachers considered themselves as the knowledgeable. The one who "owns" the gift of knowledge pictures the students as the receptors of that given object. Almost like a passive monetary transaction, the ones appearing to have the "knowledge" 'give' education ("knowledge") to the individuals in apparent lack of it. This circular action, keeps them both, teachers and students, in a closed circle of oppression where no one can express their voice (Freire, 1970).

This author affirms that in the narrative of the teacher, the students are empty recipients (the ignorant) who need to be filled with the object of knowledge –the information-. The teacher "by considering their (students) ignorance absolute, justifies his or her own existence. The students, alienated like the slave in the Hegelian dialectic, accept their ignorance as justifying the teacher's existence –but, unlike the slave, they never discovered that they educate the teacher" (Freire, 1970, p.59). In this circle -as in the circle of commodities proposed by Marx (1976/1887) -says Freire, they are all oppressed: the student is invalidated by the teacher who relies on the beliefs that the student "needs" to receive the information. The teacher on the other hand, invalidates him-herself by wasting the opportunity of being educated by the student, converting him-herself into the emissary carrying the needed object (information).

This principle of alienation of the subject with an object was discovered by Freire (1970) when studying this circle of oppression based on a "banking education", is exactly as the one found in *labour-power* (Marx, 1976/1887) and *power-knowledge* (Foucault & Gordon,1977) analysis. Supported by these authors, this thesis suggests that by starting a mechanism of differential of potentials, a circle of oppression arises. The teacher, for example, who could bring a set of potentials to the relationship (experience, knowledge, skills, information, attitudes, capabilities, etc) is at risk of bringing only one- the information. The student in turn, could bring a different set of potentials to the relationship; instead the student brings nothing. In this situation both are interacting in a differential of potentials in three ways. First, the teacher "brings" more to the table than the student. Second, the teacher can "have more voice" in educational matters, than the

student, whose voice is not important. Third, the existence (sets of potentials) of both, the teacher and the student, are invalidated and replaced by a commodity, service or product.

In this oppressive alienating circle the transaction of information is completed, but the real needs of the people involved in that interaction are hardly addressed (e.g. health). The movement of both parties are immobilized by passive transactions. The voice of the 'emissary' and the 'receptor' are silenced. The experience of both parties, are invalidated; all suppressed by the dominant object: information. "In the egoistic pursuit of *having* the knowledge they suffocate in their own *possessions* and no longer *are*; they merely *have.* … and the more the *oppressors* control the *oppressed,* the more they change them into apparently inanimate *things*" (Freire, 1970, p.45)

Although at present, the educational systems in many parts of America and around the world have transformed ways of teaching, there are still domination-oppressive practices. The same occurs in health system, and thus potentially, in nursing practice.

What kind of movement can emerge from individuals, groups, and communities that are dominated by a continuous circle of oppression? What kind of movement can emerge where oppression operates precisely as Foucault brilliantly recognized in an unequal and relatively stable relation of forces that implies a difference of potentials? How can WE reverse a mechanism of differential of potentials where inequity is brutal?

Power and its equitable mechanism of sharing different potentials

It is this same question or set of questions that I have been asking for many years when entering into the educational and then into the health fields. It was not until

dialoguing with Paulo Freire´s who (1970, 1985), that I saw a second mechanism of power. Based on the contact with communities as a teacher and also as a researcher, this author suggested and applied a method of liberation from oppression.

In dominating and oppressive circles, underlies a circle of certainty (Freire, 1977). Supported by the ideas of Marx and Husserl, Freire (1977) affirms that the function of oppression is to maintain people in the fear of being annihilated, remaining in non-existence. It is in the certainty offered by a circle of commodities (Marx, 1976/1887), that existence can apparently be assured. Where people no longer *are*, but *have*; if they do not *have* then they no longer *exist.* Therefore if people *have* they are more certain about their *existence*. It is in the fear of annihilation (non-existence if not having) that people in order to maintain themselves in the system (existing), transform themselves into oppressors and the oppressees. In fear -as a function of domination- paradoxically people do not exist anymore, but is this mechanism –the oppression, the only one that can be seen or heard. Both, oppressors and those who appeared to be oppressed are all, in the end, oppressed.

In his work, Pedagogy of the Oppressed or Pedagogy of Liberation (1970), Freire explains a path to challenge the circle of oppression, conciliating and resolving Marx´s and Foucault´s approaches and questions around power. The method of liberation proposed by Freire (1970) consists of a cyclical and collaborative method of reflection and action. Through this method based in open dialectic communication –as opposed to emissary-receptor mechanics- the knowledge based in experiences arises from the continual questioning and dialogue between people. Moreover, the individuals involved in this cycle, share their capabilities, experiences, and knowledge to solve their struggles

and needs. In this way, there is no "expert" carrying the object of knowledge, and a "non-expert" in the need to receive it. Both bring themselves to the table in equity of voices. The method of *critical awareness* promotes, in Freire's words, "the transforming power of a process where knowledge is constructed" (Freire, 1970, p.57).

Freire believed that the only way to liberate both, the "oppressed" and the "oppressors" from the circle of domination, was through an equitable collaboration of discovery, construction and re-construction of their experiences. The strategy that could reverse the closed circle of oppression and generate a co-transformation and co-solution of challenges and problems is dialogue. The internal dialogue within and among people is entitled reflection. The one between them and their challenges and problems, is identified as action. The struggle can be the challenge that activates the voice(s) for this dialogue. Freire (1970) contemplates a dialogue in which each voice has the same opportunity to speak, to listen and to be listened. In this method of "critical awareness" all the voices can interact equitably.

Freire (1985) argues that society comprises a multiplicity of social relations embedded in struggles and still that they can organize themselves. This argument rejects the idea that there is a universalized form of oppression, as Marx affirmed (1976/1887). Instead there are particular modes of domination, and consequently diverse forms of collective struggle and resistance (Freire, 1985). The forms of resistance in this mechanism of power could be compared to the term strategies used in Foucault's work. Based on a phenomenological standpoint supported by Husserl's studies (Freire, 1975), Freire proposes a problem-posing education based on a continuous dialogue of reflections

about a problem and actions to solve it. This education unifies the people into a broader transformative power without losing their different characteristics (Freire, 1985).

In problem-posing education, the educator, the leading voice, presents a contextualized struggle that both (educator and "students") have been living. Then educators and "students" reflect on their own experiences around that specific situation. Once reflecting about the implications of the struggle, they stand out and "assume the character of the situation as a problem and therefore of a challenge" (Freire, 1977, p.71). To resolve that challenge, several causes and solutions emerge from that shared reflection. The collaboration of all transforms those struggled solutions into actions. Once the actions are implemented, a new reflection will arise, to evaluate the actions and to search for more struggles to be solve.

In this reflection-action ongoing dialogue no voice is powerful and powerless, but they are all listened. "The educator and the "student" *conscientize* themselves, thanks to the dialectical movement that relates critical reflection on past action to the "continuing struggle" (Freire, 1985, p.125). Supported by Freire's ideas it is clear to me that by facilitating a critical shared dialogue, a circular mechanism of oppression can be transformed into an open spiral of reflection-action that never ends. In this cycle everyone is expressing their power, their potential to reflect, to be heard, and to solve their struggles.

Through this method, supported in open dialectic communication –as opposed to an emissary-receptor misconception of communication- the knowledge based in experiences

arises from the questioning and dialogue between people. Moreover, the individuals involved in this cycle (open circle) share their capabilities, experiences, and knowledge to solve their struggles and needs. In this way, there is no "expert" carrying the object of knowledge, and a "non-expert" in the need to receive it. Both bring themselves to the table in equity of voices. The method of *critical awareness* promotes, in Freire's words, "the transforming power of a process where knowledge is constructed" (Freire, 1970, p.57).

Freire's method has been explored and applied in health settings especially in community areas, where Participatory Action Research methodologies allow its use. An example of it is the photovice method (Wang & Burris, 1997). In this method, a group of people in community take photographs related to a health struggle in order to analyze it, discuss it, reflect about it, and develop solutions. It is in the dialogue among people that reflection leads to action, and action to reflection. Unfortunately, as Tones and Green (2007) affirm, methods of this nature have been attenuated in clinical settings, by a medical model posture where the health professional solves the patients' health issues, instead of establishing collaboration to solve more complex struggles and promote health.

Supported by Freirean roots, in this thesis, liberation is in close relationship to *care collaboration.* I propose that to reverse the effects of the inequitable mechanism of differential of potentials, *different potentials* must be *shared* to *overcome the challenges* presented in a *struggle continuum as life and health* are. In this thesis power expression will be called a share of different potentials mechanism.

Through this mechanism, the harmony of the relations between "health professionals" and "patients" is in change but balanced in a cyclical process of open reflective-action communication where both can express and share their different potentials, in order to co-construct knowledge, solve health issues, and promote health.

Power: A balanced view of its meaning within and among people

Through the dialogue these three authors, Marx, Foucault and Freire, we have discovered some clues about the power enigma. What does power mean from a banking perspective?; what are the differences between two confusing terms posed by Foucault?; what is power, and which are its different mechanisms of expression? However, a piece still remains unrevealed. What does power mean for other cosmologies? How does power relate to the inner relationships between mind and body? Which are the voices that dominate or are shared inside each person interacting with others that can possibly be sustaining the mechanism of oppression or the mechanism of liberation? How is this related to health?

To continue with this reflection, the voices of ancient cosmologies that can are found in Zen and Tai Chi philosophies, and a different view of Native American science principles, will explain to us more about inner power, or the inner relationship (i.e mind-body) and how this is related to the inter relationships between people.

The first premise in this thesis is that power is not positive or negative. For Zen, everything IS, not bad or good, but IS (Osho, 2007, p.6). This philosophical perspective could be seen as a very simple way of looking at things but it permits us to study power

in nurse practitioner-patient encounters from its core. When we label things, entities or people as good or bad, right or wrong, ignorant or knowledgeable, rich or poor, powerful or powerless, healthy or unhealthy, we –might say the Zen- stops seeing the thing, the entity or the person (Osho, 2007). From a judgemental and moral vision we stop seeing the person and start seeing only categories: dualistic categories.

Supported by this simple Zen premise I suggest that power is not good or evil, power just is. It is not a labelled transferable object or a characteristic; it is a process, as everything else is. And its expression has its place in another balance-unbalance struggle process; life.

Lao Tzu (sixth century BC), one of the constructors of Taoism, was a co-founder of Tai Chi (Horwits, Kimmelman & Lui, 1976). Tai Chi was formed through generations of interaction with Hindu thinkers such as Siddharta Gautama- a man who experienced and gave voice to the essence of Zen. Although Tai Chi is well known as a martial art, its origins emerged from a need for balance or health among the monks who spent many days in sedentary meditation (Horwits, Kimmelman & Lui, 1976). Through time the teachings of the yielding and blending philosophy of Lao Tze were transformed into the Tai Chi, also known as a technique of power.

"The Chinese word Chi literally means 'air', 'power', 'motion', 'energy', or 'life'. According to Tai Chi theory, the correct meaning of Chi is 'intrinsic energy', 'internal energy', or 'original, eternal and ultimate energy'. The way in which Chi is expressed -in the nearest position of balance and harmony- is called Tai Chi- a process of change from

one formation to another, from stillness to movement (Horwits 1976; Liao, 1995). Both the medicinal technique and the martial art are supported by the same philosophy. This philosophy explains how through the connected balance between the *yin* and the *yang*, the two opposite but complementary forces, the Chi-the inner power- is constituted in a cycle of movement. On that balance is where health arises. In contrast to what we can call a banking conception of health where the person needs to be filled with objects of care (e.g medication, treatment, "knowledge"), this cosmology searches the internal "fulfillment of the individual person, through moderate natural ways of living" (Liao, 1995, p.11), "moving through cycles of change, over and over again, gently and with freedom" (Chukrow 1998, p. 11).

In this philosophy the essence of Chi is originates in a first level of the living organism: the body (Liao, 1995). The body starts twirling in both directions –clockwise and counterclockwise- making forms of natural entities through eight cardinal points. The essence, Chi or power, continues its manifestation in a second level. The function of the mind learns through the body how to move in the frequent confrontation of confusion and conflict that the twirling body movements bring. This body and mind solution elevates to the third level, the *shen*, the spirit. Through repetitive and confusing movements, the individual mind and body connect with each other, and then the movement of one person (mind-body) is connected to the other people moving in the same room. The breathing and the movement of many people exercising Tai Chi in the same place, is unified as a one movement and a one breath, but the characteristics and the uniqueness of each individual is conserved. "The power that is generated by Chi is called *jing,* … the internal

power. Experientially you can only feel another's person *jing* and not his ch'i; but you can only feel your own *Chi* and not your *jing.* … All human beings can be powered by the same source of energy, the ch'i". (Liao, 1995,p.35). Ancient philosophies as the Chinese and the Hindu combined in principles like the Tai Chi, allow us to appreciate that: The power, the energy, the Chi IS. It IS a coordinated relationship among *yins* and *yangs*, between body and mind, and among the unified body-minded people. The Chi is not "good" or "bad", "positive" or "negative", it just IS; The Ch'i, the 'power', the 'potential' is the relationship between other potentials; between *yin* and *yang*. It is in the mechanism of expression of the Ch'i, that the movement of the *yin* and the *yang* can be harmonious or dissonant, but can also be balanced from dissonance to harmony.

"Because the two powers are always conflicting yet balancing each other, our Universe is constantly and indefinitely changing" (Liao, 1995, p.32), and vice versa. Tai Chi explores the mechanism of balancing interactions from dissonance to harmony, of the internal Chi and lets us recognize that the same mechanism can work to generate the harmonic interaction between *jings.* "Everything, even unfilled space, derives its existence from the balanced interaction of this two contrasting forces" (the *yin* and the *yang*) (Liao, 1995, p.32).

From this perspective, it is in the persistent connection of potentials, that both entities are empowered. In the power of one is the power of the other. There is no such thing as the body empowers the mind or vice versa or the nurse practitioner empowers the patient or vice versa, but both are empowering each other in the conectiveness of their different potentials. It is in the collaborative relationship between the health professional

and the ”patient” that both are expressing their ‘selves’ (body-mind or the Chi) through the other (the *jings*), generating a more complex power where their different potentials remain. This relationship, this new more complex potential, can be shared with other relationships to solve more complex struggles or fulfill more complex needs together. That is what Freire, from which the term empowerment starts emerging in education and then in health disciplines, meant by the term empowering (Freire, 1979).

In some of the western cultures the mind and the body have been separated, and it seems that the only ways to “achieve” -as an intense goal- the “balanced” mind and the “balanced” body is through purely body practices or through purely mind practices (Liao, 1995).

The banking perspective of balance and power, such as the one we experience all over America is based on the split of potentials and its conflicts. This split has generated the culture of the individual body and the culture of the individual mind. For example, on the contrary of what balance meant for ancient philosophies like the ones found in the Tai Chi or in the Zen, to fill the needs of the body many of us keep ‘taking’ only medication. To fill the needs of the mind we ‘take’ evidence based on external and validated information. This split has also generated the culture of the individual person dependent or independent from another person, whereas the essence of the nurse -the caring- emerges as the interdependent connectedness between the nurse and her/his patient. As we appreciate in the literature review of power in nursing, the “power” of the nurse has potentially been reduced to an individualized evidence-based role of *surveillance*. With connectedness as the core of relationships, in contrast to the fear of not being part of a

power knowledge, power labour or oppressive system, a more complex power of the nurse practitioner-patient can be expressed. This complex power can work through a continuous process from dissonance to harmony, to solve more complex health struggles and relational struggles emerging as a consequence of human interaction.

Gregory Cajete (2000), a Tewa author and academic pioneer on reconciling Native American science with western perspectives, fully explains indigenous perspectives from Canada to South Mexico about relationships and their interdependence. Likewise Tai Chi and Zen perspectives, the Native American science revealed by Cajete is based on the next principle: "the only constant is change" (Cajete & Little Bear, 2000, p. 273-274) and in that movement call change we are all interconnected. Because of that interconnectivity if one changes, others change and that one can be changed by others. Body, mind, people, the tribe, and the whole environment are all connected. That is mostly the reason why to study the power of people we have to address the inner relationships or the power within people. To understand the connectedness between potentials of two whole persons, we need to understand the internal relationships of potentials.

"The body, as the source of thinking, sensing, acting and being, and as the basis of relationship, is a central consideration of native Science" (Cajete, 2000, p.25). For Native American cultures, says Cajete, the sensing body not only describes the physical body but the mind-body. The body is the creative moving center that comprises all –the mind, the body and the spirit- and through which we all connect with the world that Native American perceive full of active *entities.* Through the body, humans experience and

participate in the world; all humans are in incessant interaction with the physical reality through perception, the combination of receptivity and creativity (Cajete, 2000).

This creativity is shared between the body and the metaphoric mind. The metaphoric mind for Native science is the "oldest" brother; the way the metaphoric mind processes is natural and instinctive, so it is the one who creates. "This type of mind invents, integrates and applies deep levels of human perception and intuition" (Cajete, 2000, p.27). It is the mind that connects the individual in itself, with the others and with the world. The metaphoric mind expresses itself through abstract symbols, sound, kinesics expression and other metaphoric modes that are also the foundations of various components of Native Science such as art, music and dance (Cajete, 2000).

The "younger brother", the rational mind is linked to the oral language. In Native science the rational mind invented language, the written word and eventually the disposition to control nature rather that to be of nature. For Native American, the tendency towards a rational mind has lead to a science that legitimized the oppression of nature and consequently oppression of the metaphoric mind. "Native science is thoroughly wrapped in a blanket of metaphor, expressed in story, art, community, dance, song, ritual, music, … healing, … its "younger brothers" have difficulty understanding its essence of creative participation" (2000, p.30, 31).

For this thesis and from this Native American view, a natural way to meet with the world is by engaging with it in reciprocal communication, through a verbal language that is not separated from a body language. In spite of this seemingly common sense, Cajete

recognizes that Western cultures disaggregate the mind from the human body and the body of the world. While Native Americans use their own bodies to talk, "choreographing" their experience in the world through stories, dance and songs, in western cultures this dissociation becomes more pronounced (Cajete, 2000). For example, for modern academics like Chomsky (1972, 2000), Bunge (1980) and Check (1990), the body-mind split problem that for Centuries has been controversial in philosophical realms, can be solved by saying that the mind is in the body; which many psychologists and ancient philosophies might agree.

What differentiates the western perspective from Zen and Tai Chi philosophies and Native American science is that the first one, as we see in Chomsky´s perspective reduces the body to the brain where the processes of the mind can be developed. But those ancient perspectives consider the whole body as a participant of the world and a co-participant of the mind. Mind and body are comprised one in the other, and they are both in connection experiencing and connecting with the greater world together. For those ancient philosophies, the body is not the same as the mind, but they are equal in potentials; they are connected in a way in which they can share the capacity of each in a unity (as seen in Figure 3.1 right side). In Western perspectives as seen through Foucault (1973, 1978), the mind has been positioned at a higher level than the body, so the mind can control the body; the mind can oppress the desires, the feelings, the experienced knowledge of the sensing body. The same happens among people; some appears to be placed in a higher position than other people (as in the common term "position of

power"). This misunderstanding lead to a separation of potentials instead of a *sharedness* of the different potentials (capacitates, actions, experiences).

Supported by Zen, Tai Chi and Native American perspectives, we can say that power (i.e. inner relationships) balance is not a give-and-take situation from two separate scale plates or persons. For these three ancient perspectives power is, as brilliantly discovered by Foucault, a set of relationships. Balance is a process of connectedness continuum where each entity shares its potential with the through a communication process to form a more complex power. In terms of music, this concept of balance is the consonance or harmonic melody. In this type of balance, internal relationships (mind-body) simply ARE –and do not have- power. If in an equitable integral unity the mind-body of the patient can balance with another mind-body potential (e.g. Np) then they will create –not take or give- a complex and broader power. If these two people enact a balanced relationship with more people they will be –not own- an even more complex and much broader capacity to solve more complex struggles and so on.

What I am proposing in this thesis, supported by Zen, Tai Chi, Native American and Freirian teachings is the following. If each potential is split from the other and the balance is broken leading to an unsolved or partially solved problem, it can be established again through the moving connection between them. A harmonious relationship, like the one constructed by the nurse practitioner and the patient can establish a mind-body balance, even though if along the way the relationship presents dissonances. In the same manner, a harmonious mind-body relationship can recover a person-to-person

relationship as in the case between nurse practitioner and patient. From these little places, a macro relation such as the health care system can be balanced too.

For that matter, the mind-body integration is a topic that deserves a complete space in this thesis. It needs to be addressed not only through purely rational-mind or through purely emotional-body perspectives, but through a more integrative psychological-philosophical point of view. This perspective will help us understand the interdependence of both entities (mind and body), and the interdependence of a complex relationships like the one between nurse practitioner and patient. That is what Ken Wilber's (2000) integral psychology work focuses on. In the next couple of pages I will explain the mind body integration through his integral theory.

Mind-Body Integration

Ken Wilber (2000) in his work, Integral Psychology, explains an integral perspective of the self, or in other words an integral view of the "*all chi's*", the "all powers", the "all sounds-silences" of the self, which transcend in a unity conserving the different potentials. In it, he critically organizes, develops and relates many pre-modern, modern and post-modern theories that explain the layers of the self -the layers of the inner relationships. For the purpose of this thesis, I will address the layer of the body (*matter-self* and *emotional body-self*), and the layer of the mind (*early mental-self* and *latest mental-self*) and the mind-body, as two of many other layers connected among each other. Those other layers of the self integrate the human self with the world, in an inseparable whole movement.

Synthesizing many psychological theories, Wilber explains the process of the development of the self. The inner communication process consists in the differentiation of one stream of the self from the previous and simpler stream of the self, and the integration with the next complex one. Considering life as a moving change and as a incessant struggle posing and resolution, Wilber (2000) calls *transcendence* the process of differentiation that many psychologists like Mahler (1968) addressed in their work. Wilber also entitled *resolution* as the next part of development -integration. There are three streams of the self: matter-self, body-self and mind self, and mind-body self which he called the *Centaur* (Wilber, 2000).

In a struggle-continuum, the streams of the self (material, emotional, rational, etc) differentiate (transcend) from a simpler stream and integrate (resolve) within the next complex layer or stream. A complex stream does not reject a simpler, but includes it. For example, "the body is experienced as being inside the physical environment; the mind is experienced as being inside the body; the soul is experienced interior to the mind" and so on (Wilber, 2000 p.102). Although the stage of consciousness or self development is related to age; sometimes if one stream does not transcend and resolve, the self of an older person, for example, can still be in a simpler stream. It also happens that in the process of life the self returns to some stages depending on the type of needs or the perspective of the world that it has.

The first stream is the material self. At this stage the self is still undifferentiated from the physical world. The needs of the self at this stream are material and so are its relationships. In the ***matter-self*** there is a mere material or physical exchange, like food,

labour (Wilber, 2000), money, medication, and data/facts. There is an archaic consciousness that if not developed, the experience of the world can remain almost *autistic* (Wilber, 2000) where no or smaller interactions can be developed with others. At this stream the self is physical oriented (Wilber, 2000, p.208).

Through a second stream, the emotional body self (***body-self***) differentiates itself from the physical world. The needs of the self in this stream are emotional and so, as previously noted are its interactions. There is a physical-emotional exchange including the material exchange exposed above, but in addition a need for safety, power, belongingness, care (Wilber, 2000 p. 198), treatment, and emotions exchange. If the self does not continue developing to the next stream, the experience of the world will remain *narcissistic*, where the self is omnipresent and the others are just extensions of the self (Wilber, 2000 p.103). The interaction will be centered on a "me".

In the third stream, the early mental self called persona (***mind-self***) "differentiates from the body and its impulses, feelings and emotions, and attempts to integrate these feelings in its newly conceptual self" (Wilber, 2000, p.103). There is a need for mental exchange like rational explanations and membership discourses. The interaction moves from a "me"; to a "me" "you" view, which is still narcissistic but starts considering others. In the process from an early mental self to a latest mental self it arises a fourth layer called ego **(*emotional body self*** within the earliest ***mind self*)**. There is a need for deeper and complex interactions, where the narcissistic perspective of the world is transformed into an egocentric view. "Me" "you" moves to a "me and you".

There is also a "mythical rule-role consciousness" (Wilber, 2000, p.104) where the *self* accepts the rules and roles of the system. For example, the typical role of some of the people who consider her or himself as the "health expert" is the mythic hero who will rescue the vulnerable "patient"; the "vulnerable" patient is powerless and needs the health expert to save him/her. The "expert" has the *matter*, the *emotions* or the rational *evidence* that will help the one who does not have it, in this case the patient. So the patient will expect that too. If the self does not continue its transcendence resolution process to the next stream, the world view will remain *ego-centric* mythic. Through the resolution of this stream, a more self-reflexive interaction is developed, including reflection about needs, concerns, fears, motivations, rational explanations, experiences and solutions. In the latest mental self, it differentiates an "I" and "you", and integrates them into a "we".

"With the emergence of formal-reflexive capacities, the self can plunge yet deeper" (Wilber, 2000, p.105), moving from a mythical rule-role to a more holistic view. Between them, there is a "mythic-membership consciousness" (Wilber, 2000 p.105), where for example the health professional is no longer in the role of the 'expert'-hero who will rescue the patient, or the 'expert'- 'client' that will claim what needs to be done. Both can begin to guide the other, both can be the leading voice in different moments of the relationship. In the emergence of the *mind-body self*, the fifth layer, the self differentiates from only the body and only the mind and integrates the self in a unity. Then, an autonomous exchange can occur, where a holistic interaction of matter, emotions, evidence and experience as a whole can be developed. There is a self actualization within global awareness, thus a self and common *socio-centric* view. (2000). In these latest

stages of the integrated mind-body consciousness, the language not only comprises a "we", but an "all of us".

Relating the Tai Chi and Native American concepts with mind-body integration standpoint, the balance between the potential or *Yin* of the mind and the potential or the *yang* of the body is a continuous movement that constitutes the inner relationship of mind-body, or the inner power call 'Chi'. Life is a struggle continuum in the next sense. There are struggles or needs to address all the time that can sometimes cause a dissonance among both. It will be common then, if a continuum split of the ***mind-body*** remains in one person, the *yin* or the potential of the body can marginalize the *yang* or the potential of the mind, or vice versa.

In this thesis, although it is not the focus of the study, I propose that a constant dissonant intrapersonal (mind-body) communication can more likely cause a dissonant interpersonal communication. As such, the close circle of oppression maintained through this mind and body separation, can be repeated between persons. If mind-body are integrated in connections, this circle can be broken. Communication in this thesis is the way to facilitate those connections.

Communication

Communication has been researched from many disciplines such as psychology, anthropology, sociology, linguistics and of course communication. Various concepts, mechanisms, strategies and definitions have been addressed and the interest of its study has been increasing specially over the last six decades (Narula, 2006). The traditional and

mechanical communication theory claims that there is a transmitter that sends a message to the receptor, who processes the message and sends a response. This approach can be simple to understand but also be viewed as a mere transaction of a material good. The transmitter has something to transfer to the receptor; the receptor receives it. The receptor can then be the transmitter. Although I understand the mechanic perspective of it, the perspective of communication in this thesis goes beyond that.

In Condit's (2006) essay she proposes that "communication is a process of relationships" (Condit, 2006, p. 3) that not merely change or not merely differentiate, but they are interdyanamic forces. In this interdynamism, communication is not only a set of signs and symbols but a process that reconstitutes the entities that are related (Condit, 2006). Supporting Condit's perspective, another author can be mentioned. Shepherd (2006) in his essay, "Communication as transcendence" explain his perspective that communication is a relation; it is "the experience of transcending one's (current) self, to become more than what *one* was, through connection with another" (Shepherd, 2006, p.22). These communication perspectives are like the initial view of power retrieved from Foucalt's studies and the Tai Chi perspective, where power is relations. In this thesis I support that the process that make possible the differentiation and integration of internal (i.e. mind-body) and inter (i.e. Nurse practitioner and patient) set of relationships, is the communication process.

Shepherd (2006) explains that there is a communication *as experience of the self*, and a communication *as experience of other*, not in a separate ecstatic way but in a process of *always becoming a self*. This means that everything, including humans, are

changing; humans are not static are not the same. Humans are *always becoming* in the interaction with others. About the first experience (*self*), Shepherd proposes that we are not born with a sense of the self; it is developed in the interaction with others. About the second experience *(of the other)* he proposes that communication allows the understanding of one another and this understanding has to do with an orientation of sympathetic awareness and not with an accurate interpretation of the other. "When we experience another in communication, we come to be in sympathy, or in common feeling with each other. This common feeling is the sense of sharedness we often assume in engaging with others (Shepherd, 2006, p.24).

Freire *(*1970, 1985) envisioned this communication with the self, the others and the environment, as a process of reflection and action. He called the whole communication process *method of awakening critical consciousness (*Freire, 1970, 1985), where silence can be opened to let everybody speak their word and their movement and inter-act with their internal and external constructed and re-constructed world. This thesis suggests that in this type of communication, the exchange is not only *material*, *emotional* or *rational*, but is also a *reflective active* communication between or among individuals. The struggles, either the health problem or the "natural" relational struggles developed during the interaction, are solved, as Freire proposed through an active shared process of reflection and actions (Freire 1970, 1985). This relationship also includes the other simpler types of exchange (*material, emotional and rational*).

For Zubiri (2006), a philosopher theorist of knowledge, the action of the human intellect ('*intelegir'*) as a specific characteristic of humans, is not only a synthesis but an

actualization of the 'real' in the sensitive-intelligence. This means that through our senses (the body) we are in a never ending co-actualization of reality that is a conscience (mind) of reality. There cannot be a separation between the feeling senses and the intelligent mind; simply because we are sensitive intelligence or body minded.

The "body language" and the "mind language"

Typically the internal communication –which facilitates the inner power-is known as Intrapersonal Communication. The communication between people or between powers is called Interpersonal communication. For both types the communication process has been differentiated into verbal and nonverbal communication. The verbal communication is commonly represented by the speech and related to the *rational mind* that Native Science describes, and to the *early mental self* that Wilber explores. The nonverbal communication is commonly represented by the body movements, and is more related to the *sense body* of the Native American cultures and the *emotional-body* of Wilber's theory. The integration of both languages are related to the Native Science *metaphorical mind* and illustrate Wilber's explanation of mind-body, and that I will attempt to understand and in a mind-body integration level of analysis through the metaphor of music.

Although this thesis is aware and supports that within an individual human the processes of that individual mind can take place in the brain, it also support that the body is not only the brain but the whole material stream of the self, that can transcend in the mind and then in the mind-body connection. Based on a western cosmology, Chomsky's

perspective as a recognized linguist is that language is a universal capability associated with the biological predisposition to activate verbal and writing mechanisms such as grammar (Chomsky, 2000).

The difficulty suggested by Chomsky´s perspective is that it considers only the mind as capable of language. The whole body is not considered with the capability of language because as he says, language is a system of ideas that must be studied empirically through the lens of natural sciences (Chomsky, 2000). If it is only a system of ideas my question would be: Are there no expressions (communication) without a grammatical structure? Chomsky probably is aware of this, but a common interpretation supported on works like this can lead us to a confused interpretation. That is, that the verbal and written language "contained" in the speech, is separated from the body and its language (not recognized by Chomsky), and from the context and experience of the particular person.

Verbal communication

In spite of the lack of nonverbal behaviour recognition as a language, as if only words can express a system of thoughts -and of feelings and experiences- other philosophers, although talking about a language in a verbal sense, suggest a more integral view. Verbal communication and words are an inseparable unity with the body and its feelings and the person in the world and his-her experiences, thus with reality.

For Britton, human communication is a social relation. Communication-by-language (verbal language) is the main instrument for communication (Britton, 1939,

2001). He suggests that the simple minded used to believe that language has one use; the conveyance of truth or the conveyance of falsehood from one mind to another. He explains how on the other hand thinkers of many ages and countries have observed a 'dangerous influence of words' not only upon the opinions of mankind but upon the emotions.

For Britton words have two different intentions: *Informational* and *Dynamic*. The first kind relates to the symbolic use of the words where words are *statements* (facts, information, and symbols). The second one relates to an emotive use related to express *feelings and attitudes* (Britton, 2001). Very often, according to the author, both intentions are unified in the same words. Even if the intention was informational any understanding person cannot easily avoid feelings. Conversely, when the intention is dynamic "-words may be used to communicate feelings by means of communicated thoughts" (Britton, 2001, p. 20).

This thesis advocates for a verbal-nonverbal language unity as a way of an integrated mind-body that is also part of a world that a person experiences –not only thinks or feels- Wittgenstein, says Britton (2001), suggests that the world that is observed is *my* world, and that is a world that is experienced (Britton, 2001). Supported by these two authors, this thesis suggests that *Informational* and *Dynamic* intentions can be differentiated from each other, but can also be integrated to transcend into a more complex one: An *Experiential* intention.

Nonverbal communication

Non verbal communication has been mostly represented by *kinesics (*body and facial movements or postures-gestures), *proxemics* (space), *chronemics* (time), *haptics (*touch*), and vocal cues* (loudness, speed and amount of talking, vocal warmth, vocal pleasantness, and laughter)-, among others (Andresen, Guerrero & Jones, 2006). For the purpose of this thesis, I will study *kinesics*, *haptics*, and taking into consideration some limitations of measurement, *proxemics*.

Although nonverbal behaviour has been more related to the body, it can express the body-mind relationship. Our movements can also speak. Although the process of perception, interpretation, feeling, imagination, and construction of ideas, are cognitive functions and outputs that happen on the brain. The brain is not the only body part involved in an experience of communication. Every part of the body is involved in it. Nonverbal communication is generated in the contact from the whole body with an inner and external world (if we can make that separation). Words, as well as specific body movements, are particulates constituting the fractal of the mind, and the fractal of the body, which interplay in a whole mind-body unity.

If a first order power is the body-mind relationship, and communication is the path to enhance connections, then body-and-mind communications are of equitable importance in the construction of power. If a second order power is the individual-individual relationship, then the mind-body communication of one individual and the mind-body communication of another are, as well, of equal importance. The same

happens in a third order power (i.e. relationship among many individuals constituting a macro system); all the mind-body individuals' involved in it, have the same right to be listen, the same right to speak, and the same right to transform each other.

In regards to nonverbal behaviour, Hawkins (2000) classified several nonverbal dichotomies, drawn by his own kinesiology and physics studies. In his book *Power vs. Force: The Hidden Determinants of Human Behaviour*, this author affirms that the "reflection of the many contrasting pairs of qualities can initiate a consciousness-raising process, so that one gradually becomes aware of patterns operating in relationships ... and all the various interactions that make up the fabric of life" (2000, p. 119). In his studies Hawkins found that power behaviours are completely different to weak behaviours. However, at a first sight, they appear to be similar. "Power versus Force" is the broader classification for high level and low level energetic patterns of behaviours tested with a validated logarithmic scale to calibrate the energy (power) of different attitudes, thoughts, feelings, situations and relationships. This author relates power to patterns that strengthen humans. Force, is the opposite and is related to patterns weakening individuals.

His studies are in concordance with the discoveries made through this theoretical framework. He argues that because force and power appear to be similar, sometimes it is difficult to uncover the hidden forceful behaviours. Although in thesis the word *force* is hardly ever used, it is very similar to the frequently used words *oppression, domination and control*. Even though this thesis promotes no separation in dual categories, I want to bring a set of quotations illustrating some of the conclusions around power versus force based on Hawkin´s kinesiology studies.

> It is clear that power is associated with that which supports life, and force is associated with that which exploits life for the gain of an individual or an organization. Force is divisive and, through that divisiveness, weakens, whereas power unifies. Force polarizes (p.128 129) Conflict finally appears to be approaching resolution not through violence, but communication, at long last, between the adversaries" (p.129).
>
> Force sells out freedom for expediency. Force offers quick, easy solutions. In power, the means and end are the same but ends require maturity and patience (p.129).
>
> Force often relies upon rhetoric, propaganda and specious argument to garner support and disguise underlying motivations. One characteristic of truth, though, is that it needs no defence; it is self evident … it requires no argument (p.128)

In doing so (bringing these quotations) a process from a dual to a non dual perspective of power starts now in the next sense. A first step to connect the theoretical framework with the quantitative strategy in this thesis starts from the support given by Hawkin's appreciation of power behaviours and weakened behaviours. I realize the importance of Hawkins organization of non verbal behaviours. As such, I used a list of dichotomised behaviours among which constructive and harmonious, and destructive and disruptive behaviours oppose to each other (For more detail see Chapter 4, Methodology). This classification will enlighten the nonverbal language analysis, as a first step of analysis and illustration around power mechanisms, by unveiling the hidden voice of the body.

Integrating the theoretical framework with music metaphor and terminology

Music has often been considered a means to express and communicate deep forms of internalized emotions. As Mithen (2006) recognizes in his book *The Singing Neanderthals: The origins of music, language, mind and body*, language is a particularly complex form of communication that necessarily must have evolved through a process that coordinated a succession of other complex ancestral communication systems (Mithen, 2006). At its core, his understanding of verbal communication appears to be significantly broader than those which are suggested in most linguistic studies of the last three decades, which focus on speech as the primary motivator of communication and understanding (Chomsky, 1976, 2000; Pinker, 1997). Communication in Mithen's broader sense can include systems of non-verbal signals which complement, explicate, or even possibly contradict that which might be understood from verbal language. In this way, movement (and indeed other forms of human knowing and understanding such as music or mathematics) might be considered modes of language expressing that which words do not or cannot.

In this sense, as a fractal of communication, body and facial movements express an individual' s inner relationship – his/her potential coming from the mind-body connection. Or between two individuals, they may provide insight into second order relations and communication. Correspondingly, without sensitivity to fractals of non-verbal communication, comprehension in second order relationships, such as those in Np-Pt interactions, can remain limited or incomplete. Unfortunately, in the nursing literature the body of research in this regard is slight. Therefore, lateral routes are justifiable in

exploring this subject. It is the assertion of this thesis that, because the discipline of music has, at least in part, had to devise ways of understanding instrumental (non-verbal) as well as vocal music, music terminology and metaphor may have significant utility in examining non-verbal fractals of Np-Pt communication.

It does so because, music as a discipline has developed terminology to differentiate qualities and interaction of parts, while still understanding them to belong to a process as a whole. In this sense, elements of music can metaphorically represent a whole system of relations and communication that can be compared to human power structures. Thus, the use of music – a "transformative technology of the mind" (Patel 2010, p.1) – as metaphor in the Np-Pt setting provides a hermeneutical route to a deeper and nonjudgmental understanding and revelation of power in caring settings.

As in every other dialectical and dialogical relationship, musical compositions may be thought of as existing in (or representing) a *struggle continuum.* Although a note is a just a note (it just IS, and remains different from other notes that just ARE), it is in combination with other notes and then in the combination of a groups of notes with other groups of notes that music arises. "Music is the rational organization of sounds and silences passing through time" where tones or pitches " must be arranged in some consistent, logical, and (usually) pleasing way before calling these sounds 'music' instead of just noise" (Wright, 2008, p.2). The same may be said for human communication. Words, numbers and even people´s gestures and postures just ARE. But, in combination a whole system of patterns and behaviors is established in an effort to create a shared expression, a communication system of internal and external coherence.

For music, it is a listener's internal perception of the organization of sounds in time that constitutes his or her experience. Internally, it is a successive relationship of arranged pitches or tones -relative positions of a musical sound- that create differentiation of melody from harmony. Externally, in a simple explanation, the relationship among melody(ies) and harmony constitute the music. The melody is the "tune", the leading voice, the part of the music that we usually sing or whistle. Harmony is the arrangement of diverse pitches, typically called chords (because they together sound to us as if they are "in accord"), that reinforces or accompanies the melody to enrich and make it sound deeper (Wright, 2008, p.22, p.35). For example, at the beginning of a musical interaction, one or more different sounds are presented. A conflict is developed in the internal and external relationships within and among the pitches, rhythms, melody(ies) and the harmony(ies). Where there is just the leading voice, there is just melody. Where there are voices without the leading voice of a melody, there is just harmony. Where all the voices are shared to solve the struggle presented in the musical piece, there is a harmonized melody.

Hence, the *"quality"* of a musical relationship may be seen as being dependent on temporal interaction of elements of expression within that relationship. For example, the "*Quality"* of a relationship in a composition can depend on (among other elements) a balance between **Dissonance** and **Consonance (**Tension and resolution), in the expression of individual roles -**Textures**, and in arrival at points of repose - **Cadences**. Such words will be shown to have significance for our study.

Consonance, commonly known as a harmonic integration, is when the chords sound agreeable and stable (Wright, 2008). Tension, commonly known as Dissonance is when the chords sound (momentarily) disagreeable and unstable (Wright, 2008).

Texture is "a word taken by analogy from the world of textiles to describe the interweaving of fibers, help describe how melody and harmony interact in various music" (Titon et al., 2009, p.13). The term texture explains the nature of musical interrelationships at the same time as it describes something about the individual parts of those relationships. *Textures* in music are defined by the type of relationship found between melody and harmony and their internal elements (i.e. pitches and chords) (Wright, 2008). The term *Monophony* is used to describe a texture that has a single line of melody without harmony (Wright, 2008). *Heterophony* is an organized combination of more than one voice (or instrument) where they can elaborate the same melody but in different ways roughly at the same time. Wright (2008) explains that there are two different kinds of heterophony: *homophony and polyphony*. *Homophony,* meaning "same sounding", is a state where a single identifiable melody is "accompanied" by harmonic reinforcement (e.g. one case of this might be a melody with accompanying chords). Whether dissonant or harmonious, homophony is an interaction of voices or lines that move together to new pitches at roughly the same time. "In homophonic textures the fabric is marked by lines that are more vertically conceived as blocks of accompanying chords" (Wright, 2008, p. 57). *Polyphony* describes a texture where there is more than one melodic line in the musical fabric, and each one is perceived as being more than less autonomous and independent from each other, often entering at different times. The musical fabric has a strong horizontal thrust as the ways in which the different lines

support each other only unfolds over time. The voices are of equal importance, moving against one another to create what is called counterpoint, which is no more than the harmonious conflict of two or more lines (Wright, 2008).

To talk about the resolution of a conflict in musical relationships, or the lack of it, is to ultimately talk about cadences. Cadences are musical patterns that mark the conclusion of phrases, sections or a complete piece (Bufe, 1994; Wright, 2008). They are moments of repose in the continuous process of concordance and tension of the elements in a musical piece. For so, cadences represent the multiple ends, or the final end of a whole period of related elements interacting in concordance and tension. Cadences reflect the closure of a period of tension solving (concordance) and open the next struggle period (dissonance). They assure the melodic continuum from one "struggle" and its resolution, to a next "struggle" and its resolution, until the story-telling in the musical composition ends. Cadences occur with varying degrees of strength.

Wright (2008) explains that the simplest categorization of these differentiates *half* from *full* cadences. A wider categorization consider *authentic, amen, half,* and *deceptive* cadences. The first of these, the *Authentic* cadence is the most complete and emphatic of the *full* cadences. Authentic cadences provide "real" conclusions and are the most final sounding. *Amen* cadences are also conclusive, but they are generally soft and peaceful - less forcefully final-sounding than authentic cadences. A *half* cadence does not finish a musical thought, rather it sounds inconclusive and implies something yet to come.
A *deceptive* cadence is surprising because it is almost exactly like an authentic cadence, but with one mere note difference. That note has a substantial effect on the cadence's sense of finality. A *deceptive* cadence strongly demands that something is yet to come

because full resolution has not been achieved. (Bufe, 1994; Wright, 2008). In most "common-practice era" music (from 1600 to the early twenty century), if tensions in a musical relationship are not resolved and discordance prevails, then cadences will not have a sense of finality. To resolve tensions, a harmonious melody and a final cadence are expected.

In musical storytelling a succession of cadences can come in any order, with moments of tranquility, uncertainty or doubt, but most pieces arrives at an empathic conclusion (Wright, 2008). With a proper development of cadences, if the conflict is well solved, another conflict can arise and if it too can be solved, then the next conflict will appear, and so on. If a conflict is not solved because of the predominance of one element over the others or the lack of relationships among the elements constituting the musical piece, the overall effect is one of unresolved dissonance.

> The power of music resides in the dynamics among the peaceful and restful *amen* cadences, the surprising *deceptive* cadences, the unfinished quizzical *half* cadences, and the most empathic of all, the *authentic* cadences which brings with it a feeling of real conclusion, as if to say, THE END! (Wright, 2008, p.36).

About the power enigma of people

Wilber's explanation of inner relationship development coherently matches the structure of music. Supported by Wilber's development of the self description, this thesis will pair the three ways of musical interactions, or *textures* (Monophony, Homophony, and Polyphony), with what, supported by Wilber (2000), are three types of communication textures (Autistic, Narcissistic-Egocentric and Socio-centric). The term *autistic* in this thesis is not used as in the discipline of psychology to determine a neural

development condition, but only as a transitional term among disciplines to define a lack of interaction.

In the human experience, the potential of a person just IS, and remains different from the other potentials that just ARE. It is in relationship between people that their different potentials can be expressed. Like a musical composition, human relationship between people within their environment is indeed a *struggle continuum*, a continual fulfillment or thwarting of needs, a continual development of capabilities, and the expression of potentials. At the beginning of a relationship different potentials of each person or group are presented. Then interactions emerge, expressing themselves within the natural *struggle continuum.*

The expressions of power such as the ones experienced by the nurse practitioner (Np) and patients (Pts) that are subjects of my thesis, resides in three *Quality* elements. First, it resides in the way their relationship "sounds" in different point in time (dissonant or harmonious); second, in the textures of the relationship, i.e. how their voices are related to each other (e.g. monophony, homophony, polyphony); and third in the way struggles were brought from to rest or progressed from one struggle to another (half or authentic cadences).

Because typically, the two differentiable parts in a musical piece are the melody (the leading voice) and the harmony (the accompanying voice), and because harmony in a common parlance –not musical terminology- often refers to what in musical terminology is call concordance, I did not used the terms melody and harmony. In this thesis the two

parts of an intra relationship are mind-and-body; and those of an inter-relationship are the nurse practitioner and the patient. To avoid confusion between harmony and harmonious I assigned the following metaphoric concepts.

In terms of constructive and disruptive Sounds (consonance and dissonance) harmony is used to denote concordance; dissonance is the term use for tension and conflict. Melody indicates a possible relationship: INTRAmelody evokes the mind-body relationship of each individual-i.e each in the Nurse practitioner and in the patient; INTERmelody evokes a relationship between two Intramelodies. An Intermelody is thus constituted by a relationship between Intramelodies.

In periods of tension, an Intramelody or the Intermelody will be deemed to "sound" dissonant. In resolution of that tension, an Intramelody or the Intermelody will "sound" harmonious.

In terms of voice and lack of voice describing the textures (monophony, homophony, polyphony) of the Intermelody.- If a lack of relationship between Intramelodies prevents an Intermelody, then Monophony –one sounding (Wright, 2008) is the term used. This amounts to an autistic (no) communication (Wilber, 2000) preventing the interaction. A Monophony between Np and Pt indicates that only one of the voices sounds. This term will reflect the most severe case of differential of potentials (e.g. differences in the length of talking periods between Np and Pt).

If interaction between different voices increases, then hetero-*phony* will be observed, either in a homophonic or a polyphonic form. Intermelody is only possible in

heterophony. In a homophonic interaction, an Intermelody is the leading voice and the other is the accompanying voice. The accompanying voice is aligned with or alienated in a "same sounding" (Wright, 2008) movement. An Intermelody can be the leading voice in some periods, and the accompanying voice in others. Homophony can be the term used describing a narcissistic-egocentric interaction (Wilber, 2000) where only one Intramelody sounds and the other "voice" has minimal participation in the creation of Intermelody. This term describes a reduction in a differential of potentials (e.g. The Pt initially talks more than the Np, but the duration of the Pt talking periods reduces and that of the Np increases), and a minimal association of potentials (e.g. both affirm the other with a head movement) between Intramelodies.

If both Intramelodies bring their different voices and every voice is of equal importance, being both the leading voices developing a same Intermelody, the context is like polyphony. Polyohony is the term used to describe a socio-centric relationship (Wilber, 2000) where both Intramelodies sound in countrerpoint with the other. This term describes a relationship of different voices where there are minimal differentials in participation (e.g. both Np and Pt bring during the same periods of time, constructive facial gestures).

In terms of cadences.- If the Intermelody is able to solve past or current struggles (i.e health and relational struggles), then an authentic cadence will be achieved by the end of the interaction. If the Intermelody is unable to solve one struggle but continues to the next, a half cadence will have occurred. In the non verbal analysis portion of this thesis, cadences are discovered by examining the continuum of harmony and dissonance-

sounds- and textures over the course of the interaction. It is probable that verbal analysis will also be able to describe the cadential process.

For the purpose of this thesis, the Quality of an Intermelody therefore, is found in the combination between Sounds (harmony and dissonance), Textures (monophony, homophony, polyphony), and Cadences (half and authentic).

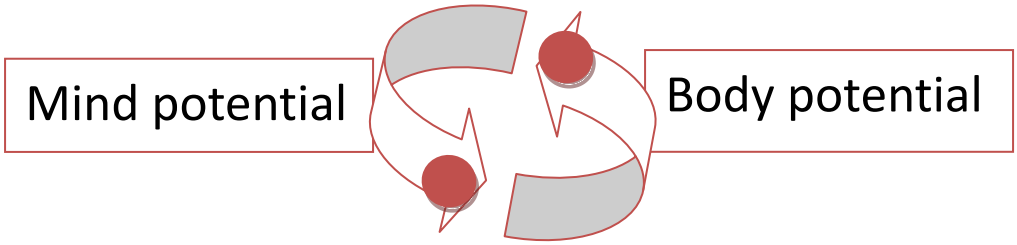
Philosophical Premises inferred from the theoretical framework

This integrated theoretical framework has twelve core premises. In their understanding, practical exemplification, and by reflecting about them, a radical change in understanding of power and relationships is possible. It can facilitate the shift from a power-transfer care management paradigm based on a banking-vision of power and relationships, to a power-healing care paradigm rooted in intra (i.e. body-mind) - and inter (among-people) connectedness. These twelve core premises are as follows:

1. As Foucault recognized, "In reality power means relations, a more or less organized, hierarchical, co-ordinated cluster of relations" (1977, p.206).
2. Things are neither positive or negative, they simply ARE (Osho, 2007). Power (set of relationships) is not negative or positive; power simply IS.
3. A person in connectedness IS power-a first order relationship–Ch'i-: an internal set of relationships between mind and body (Chukrow, 1998; Liao, 1995; Horwits, Kimmelman & Lui, 1976) (See Figure 3.3).
4. Supported by Wilber's integral psychology (2000) a person (the self) is constituted by several related streams of consciousness. Complex streams involve

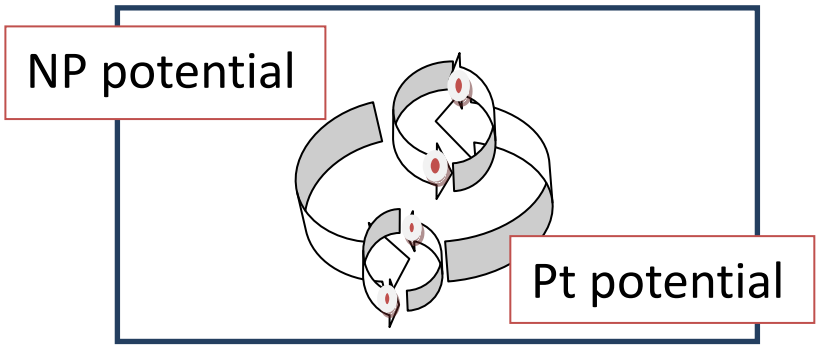
simple streams. In a process of differentiation and transcendence, the first streams' evolution process is: matter-self to body-self, body-self to body-emotional self, body-emotional self to mental-self, and body-emotional-mental self to mind-body self.(Wilber, 2000).

Figure3.3
Mind-and-Body potentials in relation: A person IS power.



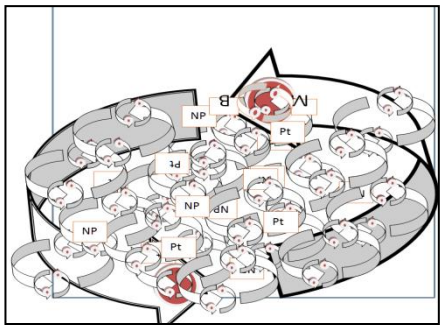
5. Inter-relationships (i.e. between nurse practitioner and patient) are power-a second order relationship, constituted by the interaction of two first order relationships. As several identified authors have asserted, we are interrelational connectedness (Cajete, 2000; Hill, 2006; Lowe, 2002). In other words, we are all Inter-dependant (see Figure 3.4).

Figure 3.4
Np-and-Pt in relation: People ARE power



6. Power has its genesis in the "little places", organizing itself in terms of the "little things" before it gets to the stage of concentrated organization. (Foucault, 1977) From this perspective, institutions and organizations - (i.e. health system) in the interplay of second order relational connectedness- is power; it is a third order relationship representing a more complex web of relationships in the power structure (see Figure 3.5).

Figure 3.5.
The health system (e.g Nurse practitioners and patients) IS power



7. Life is a struggle continuum. Relationships are shaped in this struggle continuum.

8. "Communication is a process of relationships" (Condit, 2006, p. 3). In human interdynamism, communication is not only a set of signs and symbols but a process that reconstitutes the entities that are related (Condit, 2006). Shepherd (2006) affirms that there is a communication *as experience of the self*, and a

communication *as experience of other*. He called this process, communication as transcendence.

9. In terms of intra personal interactions (*self communication*), according to Wilber, if struggles in the first relational transcendence are not overcome, a person might remain in an autistic view of the world. In this instance, only small interactions are developed with an "other". If this failure occurs in a second and third relational transcendence, an individual can remain in a narcissistic or egocentric state. In this reality there is a body, caring, safety, and intellectual explanation, physical orientation, and so forth, only because material, emotional, or information exchanges are needed. However, deeper interactions can be developed as interaction moves from a 'me' to a 'you' and 'me'. In the earliest realization of this matter to mind-body self transcendence, an egocentric to socio-centric view of the world arises. Even more complex and deeper interactions can be developed. Reflexive capacities arise, and a 'me' and 'you', are transformed to a 'we' or an 'us'.

10. In terms of interpersonal interactions (*communication with the other*), where those are set in a *differential of potentials* (Foucault, 1980) inequity rises. In inequity, the parties involved in the relationship can remain in a static circle of power-knowledge (Foucault, 1989), labour power (Marx, 1976/1887) or oppression (Freire, 1979).Where voices, knowledge, and experiences are shared then, there is an equitable problem-solving relationship. Through communication, equitable relationships are developed and all parties can be liberated from oppression (Freire, 1970, 1985).

11. As music helps us understand, struggles, in themselves, have no negative connotation attached to them. Relationships are dialectical struggle continuums. In musical relationships, among tones and between melody (principal voice) and harmony (accompanying voice)-in this case Np Intramelody and Pt Intramelody-there are multiple beginnings, struggles and endings. Music Quality as it relates to our central topic, is defined to describe relationships among musical elements (i.e. Sounds -Harmony or Dissonance; Textures-Monophony, Homophony, Polyphony; and Cadences-authentic and half).

Conclusion: potentials, power and its mechanisms of expression in health care

The term potentials in this thesis comprises the entities involved in a given relationship. The definition of "potential" can vary depending on the situation being analyzed. In a body and mind interaction (intra relationship), body gestures and postures (kinesics), body orientation (proxemics) and body contact (haptics), as well as conversational codes and behaviours representing a "mind-language", are potentials of the self to be differentiated and integrated. These are the fractal of the mind and the fractal of the body. In an intrapersonal interaction, mind and body are seen as related potentials. In an interpersonal interaction two persons engaged in relationship building, are the potentials constituted by two different mind-and-body potentials. In a systemic interaction of groups, the groups are the potentials. Power structure, as a set of organized relationships, is founded in the connection of potentials.

This thesis also proposes that, in terms of the health system, a mechanism of differential of potentials within a power structure provokes *care attenuation*. Shared

different potentials mechanism can promote *care collaboration*. *Care attenuation* replicates inequity, whereas *care collaboration* develops equity. Equity and inequity are in a balance continuum. Balance is not a transactional procedure of commodities, but the process of differentiation (disconnection) and integration (connection) of potentials, and ultimate transcendence to a complex power. In this way, health care is not a transferable commodity, but a balance of potentials in a struggle solving continuum. Care is not the service of transferring (providing) health. Instead, it is a continual communication process in which all the potentials need to be involved in order to connect with each other and provide resolution.

To differentiate among sets of potentials in a power structure, two additional terms are proposed. In this thesis, considering the term *fractals* for the mind and the body, infers that they are fractals of an inseparable whole. The self, as a continuous result of differentiation and integration of streams (e.g. *matter-self* and *emotional body-self* with *early mental-self* and *latest mental-self*) in a process of transcendence-resolution (Wilber, 2001) is considered as a mind-body whole. Considering the term *particulates* for the nonverbal channels and verbal codes and behaviours, infers that they are parts of an inseparable fractal: mind or body. The differentiation and integration of particulates and fractals into the whole is possible through a perspective of communication as a process of transcendence (Shepherd, 2006; Wilber, 2000) and resolution (Wilber, 2000) of relationships (Condit, 2006).

As well music structure where there are multiple beginnings, struggles and endings involving notes, melody and harmony (all of them potentials), I propose that life is a

dialectical continuum. Human life is a cycle of struggles, where two or more people (potentials) encounter each other. If they remain separated there will be autistic communication as in a monophony (Wright, 2008). If they engage in a relationship, relational struggles will present themselves. Throughout this chapter we have proposed that power as a relation of potentials, cannot be gained or lost because power is an incessant relational process that already exists with and among people. If a relation is cultivated then there is power. Supported by ancient and postmodern perspectives, this theoretical framework suggests that power -relationships- can be manifested (or annihilated) through two different mechanisms. When one potential alienates the other in a "same sounding" (Wright, 2008, p.57) interplay expressed in an inequitable differential of potentials (Foucault, 1977), a dissonant homophony will sound. A dissonant homophonic care mechanism can be called care attenuation. When both potentials are connected equitably and each different potential sound in counterpoint with the other in a harmonious interaction of two or more lines -polyphony (Wright, 2008) will rise. In this type of the relationship everyone's voices can be expressed and heard while their differences remain, but integrated into a master piece. Harmonious polyphonic care can be called care collaboration.

We also propose that the more inequitable a relationship the more unlikely it will be that the struggles can be solved, this will typically result in a dissonant melody and *half cadences*. In contrast, in an equitable relationship, it is more likely that a resolution brought by sharing simultaneous voices continues and ends in an *authentic cadence.* In care collaboration, in spite of dissonances and *half cadences* during the process of

interaction, a final authentic cadence can result. An equitable relationship may ultimately sound harmonious at the end.

Responding to the complexity of the theoretical framework constructed in this chapter, Table 3.1, Figure 3.6, and Figure 3.7, present the core concepts and connections in a philosophical re-conceptualization of power in Nurse practitioner-patient relationship through music metaphor.

Figure 3.6
Philosophical re-conceptualization of power through musicmetaphor

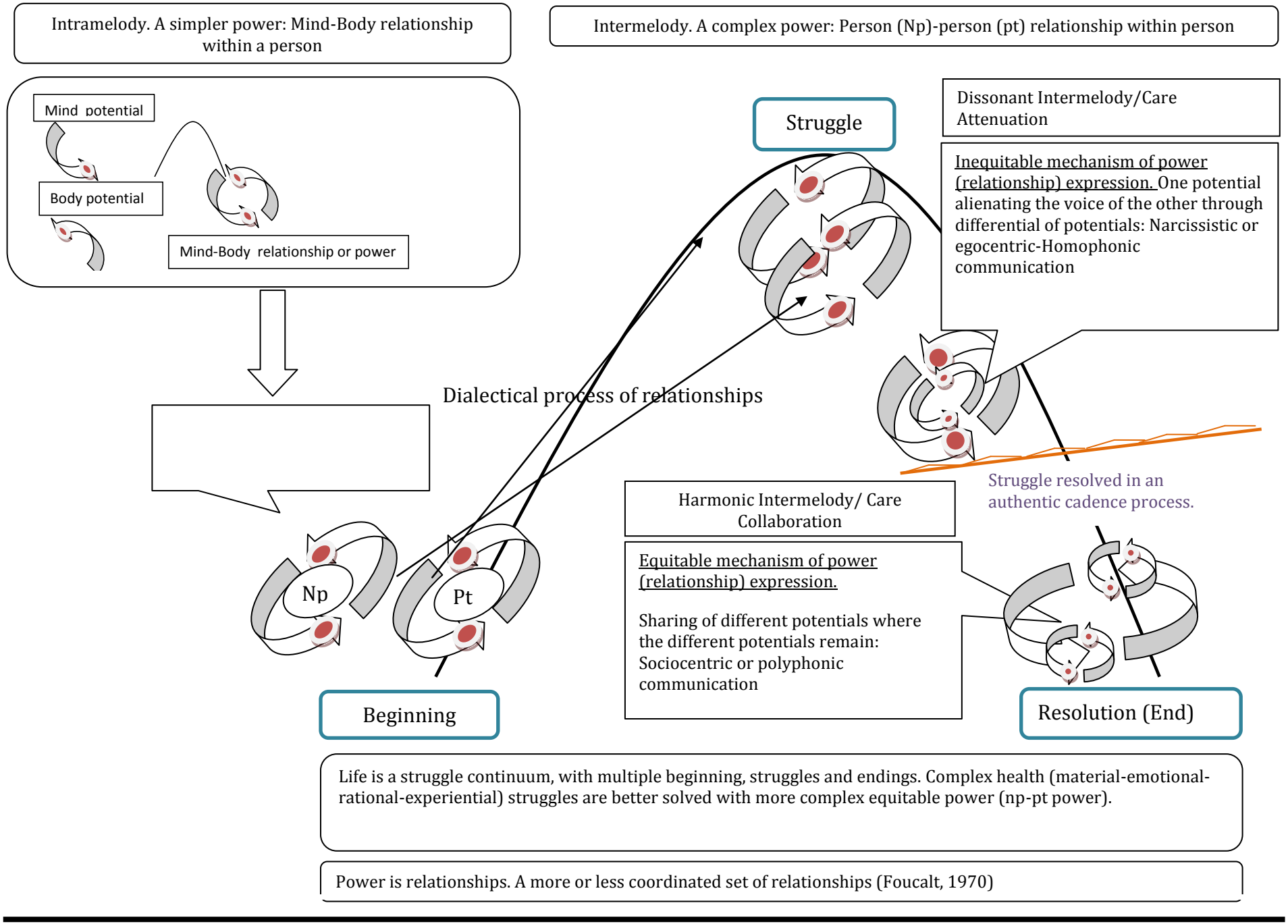


Figure 3.7
Music Interaction in relation to Nurse practitioner and Patient communication process

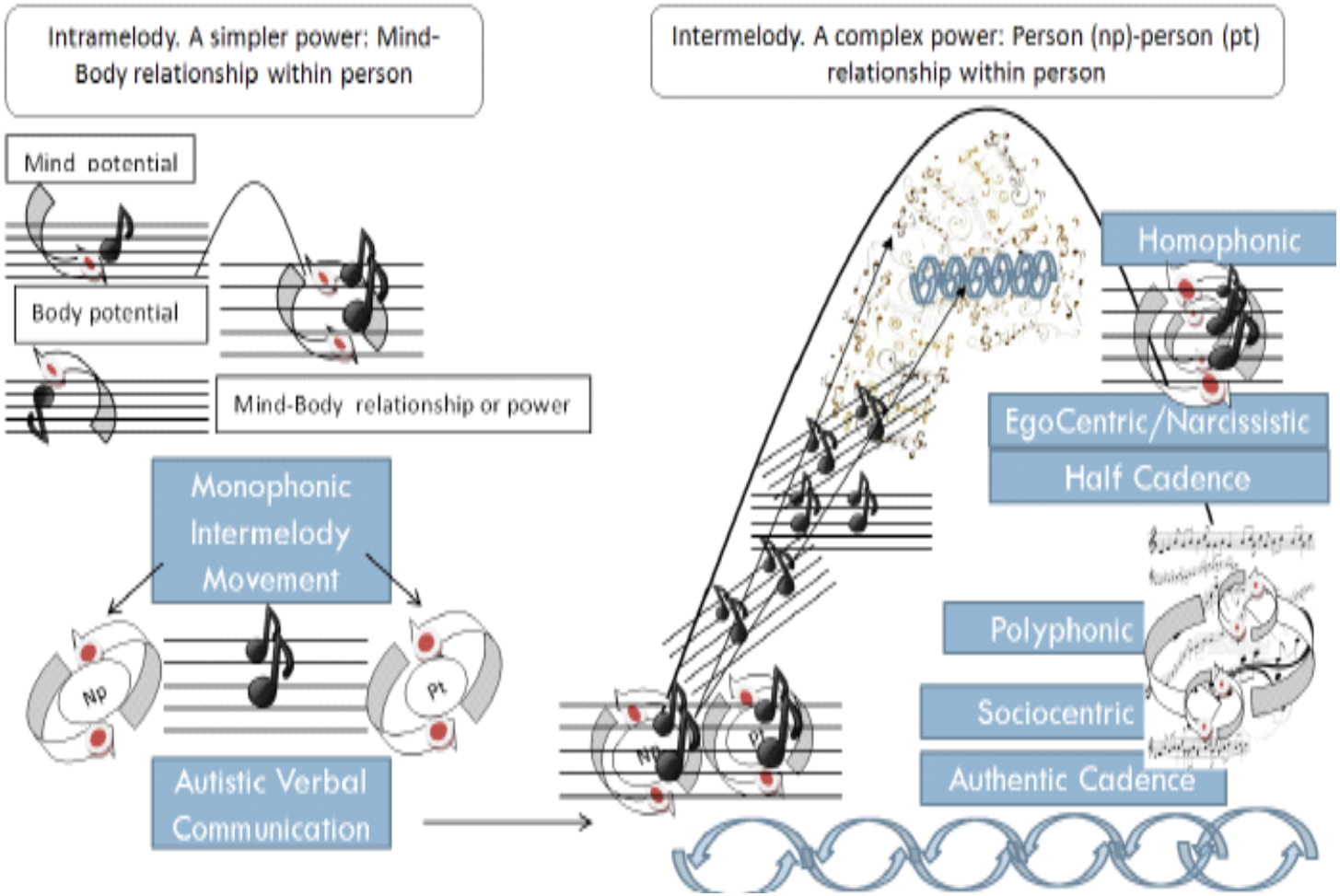


Table 3.1.

Definition of power, communication, and the psychological and music basic terms for interpretation of results

Power, communication, and mechanisms of power expression			
Potentials	Entities involved in a relationship. The definition of "potential" can vary depending on the situation being analyzed.		
Particulates	Term used to situate nonverbal channels and verbal codes and behaviours as potentials involved in the body fractal and mind fractal relationship.		
Fractals	Term used to differentiate and integrate the verbal potentials into the term mind and the nonverbal potentials into the term body. Mind fractal and body fractal promotes an integral view of mind and body, in transcendence and resolution of an incessant changing whole (mind-body).		
Power	"A more or less organized, hierarchical, co-ordinated cluster of relations". (Foucault, 1977, p.206). Inner relationship between mind and body, is considered as a first order power: the Chi or the inner power (Horwits 1976; Liao, 1995). Interpersonal relationship between people (Np-Pt) is considered as a second order power.		
Communication	Verbal (mind language) and nonverbal (body language) behaviours are identified as potentials. Communication (mind-body communication) as a relational process (Condit, 2006) allows connectedness of potentials through collaboration –shared constructive potentials-. Hoarding potentials, or expressing disruptive potentials, can cause a fracture in the communication process, in the connectedness, and in power.		
Mechanisms of power	The ways of power expression	Power as a set of relationships can express itself equitably, or inequitably. Freire call the movement form equity to inequity through communication, an oppression-liberation process (Friere,1970)	Oppression: inequitable mechanism where a relationship is expressed in a difference of potentials where the dominant is alienating both potentials. Liberation: Equitable mechanism where a relationship is expressed in sharing different potentials that can remain but unified in a more complex power
Power, Connectedness, self and music: Interdependent connectedness is the way of balance and harmony. Harmony, meaning power balance, is only achieved through connectedness (Lowe, 2000). Inner connection (Intra –*self*- power) and inter connection (Inter –*selves*- power) can be metaphorically explained through music metaphor and transpersonal psychology nomenclature.			
Intramelody	The sound of internal set of relationships (power), through mind and body languages.	This term is constructed in the theoretical framework to understand Intermelody.	Intramelody: Is the internal relationship (mind-body) constructed through intrapersonal mind and body communication.
Intermelody	The sound of the Np-Pt relationship (power) , through body-mind languages.	The purpose of the study is focus on the Intermelody analysis.	Intramelody: the relationship between people, co-constructed through interpersonal verbal-nonverbal communication,

Table 3.1 (continued)

Intermelody Sounds and Quality of Sounds.	It is how the relationship metaphorically "sounds"	The two major quality sounds are harmonious and dissonant sounds. We expected "hear" the sounds of the nonverbal communication through a statistical analysis (sounds of movement). We also expected to "hear" the sounds of the whole Intermelody at the end of the interpretation when relating verbal and nonverbal languages of both relationships (Case A and Case B). Both, movement textures – mono, homo and polyphony-, and cadences –half and authentic- contribute to the way the Intermelody sounds (Quality).	Harmony: Is the peaceful arrangement of diverse pitches (chords) that raises the voice that will accompany the melody to enrich it and make it sound deeper. (Wright, 2008, p.22 and p.35). Consonance: pitches sounding agreeable and stable. (Wright, 2008, p.22 and p.36) Dissonance: pitches sounding disagreeable and unstable (Wright, 2008, p.22 and p.36). *Power vs Force* (Hawkins, 2000) binary classifications used to define harmony and dissonance after the analysis: General categorizations.-powerful-forceful; constructive-destructive and harmonious-disruptive; and sharing-hoarding. Specific categorizations.-aware-preoccupied; carefree-frivolous; cheerful-maniac; confident-arrogant; detached-removed; energetic-agitated; flexible-rigid; gentle-rough; humorous-somber; observant-suspicious; open-secretive; serene-dull; tender-hard; thoughtful-pedantic; timeless-fadish. When the relationship is expressed in a differential of potentials and one imposes his-her voice on the other, alienating all the voices in a dominance of power, that struggle will remain and the Intermelody will continue to be dissonant. When the relationship is expressed in an equitable unity where the different potentials sound, then it will be harmonious.

Table 3.1 (continued)

Textures	The word texture describes the interweaving of musical fibers. It helps describe how melody and harmony interact in various music. (Titon, Fujie and Locke *et al*., 2009)	The three categories were used to describe nonverbal textures of movement are monophonic, homophonic or polyphonic interactions. For assigning values to the nonverbal behaviours *power vs force* classification was supported through Hawkins (2000) theory of the Hidden determinants of Human behaviour.	Monophony: a single line of music, a melody without harmony. (Wright, 2008). For Titon (2009), in music, a relationship begins only when we add one or more voices. Homophony: "same sounding", is an interaction of voices that move together to new pitches at roughly the same time. (Wright, 2008) Polyphony: It has two or more lines in the musical fabric; each one more autonomous and independent from the other, often entering at different times. The fabric has a strong horizontal thrust. The voices are of equal importance, moving against one another to create what is called counterpoint. Polyphony is the harmonious conflict of two or more lines. (Wright, 2008)
		Three categories were used to guide the analysis of the verbal "textures" of words. Categories were supported onWilber's integral psychology perspective; autistic, narcissistic- egocentric, and sociocentric interactions.	*Autistic communication*: In the ***matter-self*** an archaic mere material or physical exchange is developed. The experience of the world can remain almost *autistic* (2000); no or smaller interactions can be developed with others. At this stream the self is physical oriented. (2000, p.208) *Narcissistic-Egocentric communication:*In the ***emotional body self*** physical-emotional exchange. The experience of the world will remain *narcissistic*; the self is omnipresent and the others are just extensions of the self (2000 p.103). Narcissistic interaction is centered on a "I". The ***mind-self***differentiates from the body and its impulses, feelings and emotions, and attempt to integrate these feelings in its newly conceptual self." (Wilber, 2000, p.103). There is a rational exchange moving form *a narcissistic to an egocentric view.* centered on an "me" and "you". *Socio-centric communication:* In

			the emergence of the ***mind-body self***a holistic interaction of matter, emotions, evidence and experience as a whole can be developed. There is a self actualization within global awareness, thus a self and common *socio-centric* view. (Wilber, 2000). The interaction will be centered on a "we" or"us" and even in an "all of us".
Cadences	Musical (chord) patterns that mark the conclusion of phrases, sections or a complete piece. (Bufe, 1994 and Wright, 2008) .	Cadences are used to end a part or the whole piece, or to continue the openness of the melody from one "struggle" to a next "struggle" until the story telling in the musical piece ends. We will "hear" the type of cadence, mostly through the verbal analysis. In this thesis cadences means the process of struggle solution.	*Half* cadences does not finish the complete phrase, they sound inconclusive and imply a next repose. (Bufe, 1994 and Wright, 2008) *Authentic* cadences, are more empathic, they are "real" conclusion and the most final sounding (Bufe, 1994 and Wright, 2008)
We describe monophonic-autistic communication in half cadence when there is a minimum interaction, accompanied only by material exchange, and the struggle is not solved. Homophonic-narcissistic or egocentric communication may result in half cadence when the two potentials are "alienated" usually accompanied by rational or emotional exchange of one dominant person. This relationship does not solve struggles. Polyphonic-sociocentric communication are in authentic cadence when each power is autonomous and independent, often entering at different times, but connected through an interdependent movement, usually accompanied by experiential exchanges. The struggle in this type of relationship is solved.			
Power expression in care settings			
Care relationships (care power)	Np-Pt health relationship intermelody, or power.	Care as a health relationship (power) identified as Intramelody is in a process of struggles continuum that can be solved in authentic cadence through a harmonious polyphony, or unsolved in a half cadence through a monophony or dissonant homophony.	*Care Attenuation:* The inequitable (monophony or dissonant homophony in half cadence) mechanism of power expression in the nurse practitioner-patient relationship. *Care Collaboration:* The equitable (harmonious polyphony in authentic cadence) mechanism of power expression in the nurse practitioner-patient relationship.

CHAPTER FOUR: METHODOLOGY

Purpose, research questions, and Mixed-methods hypothesis

Purpose

The purpose of this thesis was to unveil power mechanisms of expression through the exploration of nonverbal maximized differences and verbal interactions in care attenuation and care collaboration encounters between a Nurse practitioner (Np) and two patients (Pt) in different care settings. Such an exploration underscores the practical exemplification of what philosophically -by means of the theoretical framework elaboration- was discovered around power and its mechanisms. As such, the care encounters demonstrating attenuation and collaboration were thoroughly selected. A hermeneutical process allowed the fulfilment of this purpose and the interpretation of the verbal and nonverbal fractals by their particulates, as well as their integration in a whole unified process. A hermeneutical metaphor of music was used for a deeper, non-banking non-moral and non-dual driven understanding of power in care settings (See Chapters 1, 3 and 6 for clarification of non-moral and non-dual conceptualizations). Sounds, Textures and Cadences, as related elements in the conformation of a melody, enlightened the ongoing struggle solving relationship between patients and the nurse practitioner in each case (care attenuation and care collaboration cases).

In the theoretical framework, power was not related to positive/good or negative/bad manifestations, as found in the literature review. Power "means relations, a more or less organized, hierarchical, co-ordinated cluster of [relationships]" (Foucault, 1980, p.206). There is also the consideration that communication is "a process of

relationships" (Condit 2006, p. 3). Therefore, investigating the details of nonverbal and verbal communication was unfailingly required to explain the development of power in care relationships.

Verbal and nonverbal communications are essential open spaces for relationship building and power expression. For that, they are the particular sources from which power was studied in this thesis. Nonverbal behaviours (voice/silence and constructive/disruptive behaviours) and verbal behaviours were investigated and integrated. Mixed Methods served as the paradigm and methodology supporting a particular case study method. Quantitative and qualitative traditions were exercised and interweaved through three cycles of one hermeneutical circle (Heidegger, 1962/1927; Ricoeur & Valdes,1991).

The internal individual relationship, as a first order interaction, is a mind and body communication process. The external or interpersonal relationship, as a second order interaction, is a subject to subject (Np and Pt) communication process. Metaphorically the first order relationship or power, was identified as Intra-Melody, and a second order relationship or power was identified as Inter-Melody. The analysis of the Intramelody coherence was beyond this study; only their potentials (mind and body behaviours data) were collected and managed in the analysis of the Intermelody.

The cases also exemplified power in the macro relations of the health care system by observing the micro relation of the patients and nurse practitioners. Table 3.1 (in

Chapter 3) displays the basic terms for the understanding of the analysis and interpretation of results.

The expression of power as experienced by the nurse practitioner (Np) and patients (Pts) in my thesis, resides in three *Quality* elements. First it resides in the way their relationship *Sounds* (dissonant or harmonious); second, in the *Textures* of the relationship, meaning the way their verbal and nonverbal voices are related to each other (monophony in autistic communication, homophony in narcissistic egocentric communication, and polyphony in socio-centric communication); and third in the way their Sounds and Textures are evolving during time to solve struggles (half or authentic cadences).

As we will see along this Chapter, for the nonverbal study, Sounds of Movements Channels (SOMchs) are all the observed parts of the body contributing to how the relationship Sounds (Dissonant-Attenuated or Harmonious-Collaborative); the nonverbal potentials (behaviours in each channel) observed in SOMch are either disruptive or constructive potentials (e.g. smooth/loud arms-hands). Textures of Movement Channels (TOMchs) are all the observed parts of the body contributing to the type of care relationship (monophonic, homophonic, polyphonic); the nonverbal potentials (behaviours in each channel) observed in TOMchs are potentials that could only be divided in behaviour and absence of behaviour (e.g. eye contact/ no eye contact). In nonverbal terms the study of the Cadences was reduced to explain how SOMchs all together and TOMchs all together in a same Np-Pt relationship moved along three periods of time. The verbal study of potentials (conversational behaviours), however,

bring to light the process of the relationship, and the way the Np-Pt interactions act when struggles are presented, and the way in which they solved them.

Research Questions

For the purpose of this thesis, I answered a set of quantitative-nonverbal questions through statistical tests (see Table 4.1). To analyze Sounds and Textures (Table 4.1) of the Np-Pt relationship, three type of questions were established to observe: 1) Differential between Np and Pts' Sounds (disruptive/constructive potentials) and Textures (voice/ lack of voice potentials); 2) Association between Np and Pts' Sounds and Textures; 3) Differences in Sounds and Texture of the Np-Pt relationship among three intervals of time (Cadences).

Questions addressing significant differences and significant associations between Np and Pt potentials constituting Sounds and Textures, were divided according to: a) particular questions (intended for the channel-by-channel analysis) and; b) general questions (intended for the averaged channels and levels of interaction analysis).

Table 4.1.
Nonverbal communication questions, in terms of Sounds and Textures of Movement

Sounds	Textures
1. Questions on differential of potentials between Np and Pt, in terms of Sounds and Textures of Movement	
a) Particular questions	
Q1. 1 For each Sounds-of-Movement channel (see Table 4.6), is there a significant difference in the proportion of potentials (constructive/disruptive nonverbal behaviours) between Np1 and Pt1 (Case A), and between Np3 and Pt3 (Case B)?	Q1.2 For each Textures-of-Movement channel (see Table 4.6) is there a significant difference in the proportion of potentials (voice/silence nonverbal behaviours) between Np1 and Pt1 (Case A), and between Np3 and Pt3 (Case B)?
b) General questions	
Qs1.3 Is there a significant difference between Np and Pt average number of constructive potentials, during the 15min/16min10sec (Case A/Case B) observed periods of interaction? Is there a significant difference between Np and Pt level of relationship, in terms of constructive behaviours?	Qs1.4 Is there a significant differential of the average number of voice potentials between Np1 and Pt1, during the 15min/16min10sec (Case A/Case B) observed periods of interaction? Is there a significant difference between Np and Pt level of relationship, in terms of voice?
2. Questions looking for association of potentials between, Np and Pt, in terms of Sounds and Textures of Movement	
a) Particular questions	
Q2.1 For each correspondent channel, is there a significant association between Np1 and Pt1 constructive potentials, and between Np3 and Pt3 disruptive potentials, in terms of Sounds of Movement?	Q2.2 For each correspondent channel, is there a significant association between Np1 and Pt1 voice, and between Np3 and Pt3 silence, in terms of Textures of Movement?
b) General questions	
Q2.3 Is there a significant association between Np and Pt average numbers of constructive/disruptive potentials, during the 15min/16min10sec (Case A/Case B) observed periods of interaction? Is there a significant association between Np and Pt level of relationship, in terms of constructive/disruptive behaviours?	Q2.4 Is there a significant association between Np and Pt average numbers of voice/silence potentials, during the 15min/16min10sec (Case A/Case B) observed periods of interaction? Is there a significant association between Np and Pt level of relationship, in terms of voice/silence?
3. Cadences	
Q3.1 For Sounds-of-Movement does the observed data show a significant difference in the Np-Pt interactions, over the course of time?	Q3.2 For Textures-of-Movement channel, does the observed data show a significant difference in the Np-Pt interactions, over the course of time?

Parallel to answering these quantitative hypothesis, I answered qualitative-verbal questions through Conversation Analysis tools (Table 4.2).

Table 4.2
Qualitative research questions and Conversation analysis tools

Qualitative Research questions
Q1: How is the Np-Pt encounter (Case A and Case B) developed over the course of time, in terms of context and the particulates of the interaction?
Q1 Secondary questions: What are the main characteristics of Np and Pt? How is the beginning of the interaction? Why did the patient come to see the Np? Which is the central health struggle to be addressed? Are there relational struggles during the encounter? Which is the climax in the interaction? Were the relational and/or health struggles solved?
Q2: How is the Np-Pt encounter (Case A and Case B) developed over the course of time, in terms of Sounds and Textures of the conversation (Quality of Words)?
Q2 Secondary Texture questions: Is the conversation particularly centered in a particular subject? Is there a preference organization of requests and responses between Np and Pt? Are there conversational codes between them? If so: Which are they and how do they work? Q2 Secondary Sound questions: How are the requests and responses behaving over time between both characters? Are there some conversational disruptors and facilitators? Q2 Secondary combined questions: Are both (Np and Pt) equitably participating in the conversation in terms of (shared) codes, turns and topics? Is someone inviting collaboration? Who and How? Is someone controlling the conversation? Who and how?
Q3: Are the conversational center, and the preferred conversational structure organization, changing over time? How are the conversational disruptors being solved and facilitators enhanced?
Q3 Secondary Texture Questions: Does the main topic of conversation change over time? Does the preference organization change (to a shared preference organization) over time? Q3 Secondary Sound Questions: What follows a construction (invitation) or a disruption (interruption) in the conversation? Q3 Combined questions: How are the conversational codes, the talk turns, and the topic turns shifting? How are the topics ending? What follows if someone invites collaboration? What follows if someone takes control over the conversation? How is equity balanced when that balance is upset? How is the transition from control to collaboration?

Through the use of quantitative methodology, hypotheses were developed as required. To analyze Sounds and Textures, Hypotheses were established for (Table 4.3): 1) Differential of Np and Pts'potentials; 2) Association between Np and Pts' potentials and; 3) Differences in the Np-Pt interactions among 3 intervals of time. Differential of potentials and association hypotheses were divided in: a) Particular hypotheses (intended

for the channel-by-channel analysis) and; b) General hypotheses (intended for the total of channels and levels of interaction analysis).

Statement of quantitative hypotheses

Two cases were considered namely:

Case A – Np1 and Pt1.

Case B – Np3 and Pt3.

Table 4.3
Nonverbal communication hypotheses, in terms of Sounds and Textures of Movement

Sounds	Textures
1. Differential of potentials between Np and Pt in terms of Sounds and Textures of Movement	
a) Particular hypotheses	
H1. 1 For each Sounds-of-Movement channel (see Table 4.6), there is a significant difference in terms of the proportion of potentials (constructive/disruptive nonverbal behaviours) between Np1 and Pt1 (Case A), and between Np3 and Pt3 (Case B).	H1.2 For each Textures-of-Movement channel (see Table 4.6), there is a significant difference in terms of the proportion of potentials (voice/silence nonverbal behaviours) between Np1 and Pt1 (Case A), and between Np3 and Pt3 (Case B).
b) General hypotheses	
H1.3 There is a significant difference between Np and Pt total number of constructive potentials, during the 15min/16min10sec (Case A/Case B) observed periods of interaction. There is a significant difference between Np level of relationship, and Pt level of relationship, in terms of constructive behaviours.	H1.4 There is a significant differential in the total number of voice potentials between Np1 and Pt1, during the 15min/16min10sec (Case A/Case B) observed periods of interaction. There is a significant difference between Np level of relationship, and Pt level of relationship, in terms of voice.
2.Association between potentials in terms of Sounds and Textures of Movement	
a) Particular hypotheses	
H2.1 For each correspondent channel, there is a significant association between Np1 and Pt1 constructive potentials, and Np3 and Pt3 disruptive potentials, in terms of Sounds of Movement.	H2.2 For each correspondent channel, there is a significant association between Np1 and Pt1 voice, and Np3 and Pt3 silence, in terms of Textures of Movement.

Table 4.3 (continued)	
b) General hypotheses	
H2.3 There is a significant association between Np and Pt total numbers of constructive/disruptive potentials, during the 15min/16min10sec (Case A/Case B) observed periods of interaction. There is a significant association between Np level of relationship, and Pt level of relationship, in terms of constructive/disruptive behaviours.	H2.4 There is a significant association between Np and Pt total numbers of voice/silence potentials, during the 15min/16min10sec(Case A/Case B) observed periods of interaction? There is a significant association between Np level of relationship, and Pt level of relationship, in terms of voice/silence.
3. Cadences	
H3.1 For Sounds-of-Movement channels, the observed data shows a significant difference in the Np-Pt interactions, over the course of time.	H3.2 For Textures-of-Movement channels, the observed data shows a significant difference in the Np-Pt interactions, over the course of time.

Expected General Results and Findings

In the combination of verbal and nonverbal potentials (sometimes called particulates when related to the mind fractal and the body fractal), the Sounds, the Textures and the Cadences of Movements and Words, will give the Quality of Intermelody Case A and Intermeldoy Case B encounters. The Quality of the relationship will reveal the mechanisms of power expression: Case A harmonious polyphonic care collaboration (shared of different potentials) and Case B dissonant monophonic or homophonic care Attenuation (differential of potentials).

Paradigm, Methodology and Method

Mixed Methods: A creative paradigm and multi-methodology

To answer the research questions and corroborate the hypothetical exemplars, a Mixed-Methods *Multiple Instrumental* (MI) Case Study was developed.

Along its construction, in the 1980's and 1990's, the Mixed Methods (M-M) methodology was identified by the two existing paradigms as a method called *triangulation* (Erzberger & Kelle, 2003, p.459), but it rapidly developed into a

philosophical methodological approach. As Green stated, "the development of mixed methods theory has involved a dynamic interplay with creative practice in highly practical fields and with the felt limits of traditional theory in fields with strong disciplinary theoretical traditions" (Green, 2008, p.8).

Differently from the other two paradigms, the Mixed-Methods approach or multiple methods approach (Denzin, 2009, p.312), allows a creative and more open study of a phenomenon. From the M-M perspective, the research questions do not have to fit a particular quantitative or qualitative tradition; instead, the multiple methods coming from both traditions guide, solve and serve the research questions. As Green described, "The core meaning of mixed methods social inquiry is to invite multiple mental models into the same inquiry space for purposes of respectful conversation, dialogue and learning one from the other, toward a collective generation of better understanding of the phenomenon" (Green 2008, p. xii).

M-M is currently known as a broader paradigm including a plurality of paradigms (Green, 2007, p. xxi), with its own ontology, epistemology, methodological and ethical assumptions. M-M "*transformative-emancipatory* ontological assumption claims that there are diversities of viewpoints with regard to social realities. Epistemologically and in *transformative* terms, in M-M objectivity is valued as well as the subjective and interpretative contextualization of the phenomenon, "in the sense of providing a balance and complete view" (Mertens, 2003, p. 75).

I considered M-M as the thesis paradigm for the following reasons. This paradigm offered the opportunity to answer complex questions and allowed creativity to guide the

analysis and interpretation of results and findings. Ontologically, because the relationship between the researcher and reality could work in multiple ways. First, the researcher could objectify a reality that is already there to be known. Similarly, the objectification of reality could be inter-subjective because the subject is part of that reality. Second, because the subject who is part of reality can be simultaneously knowing it. Therefore, the subject would be able to transform and construct a "new" reality. Epistemologically, because it brings infinite possibilities for objectively and subjectively study one phenomenon.

I also considered Mixed Methods as my umbrella methodology and its very specific research design for the next reasons. The selected method -Case Study- needed an open methodology with a research design in which it could take shelter. Methodologically, because the M-M methodology is now considered as a separate research design that goes beyond collecting and analyzing two types of data (Bazeley, 2003; Morse, 2003; Sandelowski, 2003). In some cases, "narrative" data is transformed into "numbers", or the "qualitative" data into "quantitative" results, and then the transformed data is analyzed again. Instead in this thesis, the collected data -with qualitative or quantitative characteristics- were analyzed separately and then integrated in equity in the last hermeneutical cycle of the study with an artistic layer wrapping them all. Artistically, the M-M resonated with the metaphorical way I wanted to approach the phenomenon of interest, with the way I organized the literature review, with the construction of a blended theoretical framework and with the metaphorical manner in which I wanted to interpret the results and findings. Finally, I decided on M-M as the

methodology because it is one of the only possible ways to engage in true transdisciplinary research. Going beyond the edges of disciplines requires a paradigm, a methodology, and a way of thinking that could integrate them all in the middle. Building bridges by creating a common language to promote communication among diverse traditions is difficult but not unachievable. It is possible with openness, flexibility, creativity, collaboration, and a paradigm and method that enhance that possibility.

Ethically, M-M considers similar criteria as the other paradigms. Canadian ethics requires an approval of Research Ethics boards to assure the protection of others and of the researchers, to minimize any potential harm and to increase the sum of good (Israel & Hay, 2006). Four basic requirements needed to be fulfilled: informed and voluntary consent for participation; confidentiality; avoiding harm and doing good which implies not only to minimize risks for harm and discomfort but to promote well being maximizing the benefits to society as a whole; and research integrity (Israel & Hay, 2006).

Considering the multiplicity of paradigms integrated in-a-whole, the thesis considered M-M as an umbrella methodology. With M-M as the methodology, the Case Study worked as the general method; allowing the use of a quantitative method through statistical analysis as one level of analysis; and the qualitative method through the Conversation Analysis (CA) approach for the study of verbal language (Breeman, Teevan & Bell, 2009), as a parallel method of analysis. This allowed us to build a bridge between the two methodologies and integrate the results.

Method: Case Study a "natural" of Mixed-Methodology

Case study is one of the best methods "when the phenomenon under study is not readily distinguishable from its context" (Yin, 2003, p.4). Among the various types of case studies, "*multiple-case*" or "*two-case*" *instrumental studies* are used to produce adequate insights into an issue or to contribute to generalizations (Stake, 2005, p.445). In a multiple-case situation, each case needs to be selected so that it can replicate each other "-either predicting similar results (literal replication) or contrasting results for predicable reasons (theoretical replication)" (2003, p.5). According to Yin (2009) a single or a multiple case can have one or multiple *units of analysis*. In terms of the units of analysis the study case can be classified as: Type 1, single-case with one unit of analysis (holistic); Type 2, single case embedded; Type 3 multiple case holistic; and Type 4, multiple case embedded.

Because the phenomenon of power is barely distinguishable from the rest of the other processes that occur in Np-Pt environments and in the Macro relations of health, the Case study approach was the most adequate research method for this thesis. Distinguishing two manifestations of power and its patterns along time in the care relationship was only possible by taking into consideration a multiple case situation. As exemplars of my theoretical framework, two different cases needed to replicate each other, and by contrasting their results, enable theoretical replication. The verbal and nonverbal results and findings maximized differences between the two cases were possible by following the structure of a Type 4 multiple case embedded.

The Research Design: A musical hermeneutical mixed study

Research Design Stages

To produce generalization of results around the phenomenon of power in the contrast between the theoretical framework and the Np-pt encounters, a two case instrumental study was used as my research design. Type 4 *multiple case embedded* allowed the integration of four subunits of analysis (Nurse practitioner 1, Patient 1, Nurse practitioner 3, Patient 3); see Figure 4.2 in the research design section. Supported by Stake (2005) and Ying (2003, 2009), the research design included 5 stages: 1) Selection of the Cases; 2) Use of multiple cases as part of the same case study; 3) Stipulation of rival theories; 4) Data Collection and Data Analysis; 5) Data Integration and Generalization of results. As Green described, the core meaning of mixed methods is to invite multiple mental models into the same inquiry to generate a collective and better understanding of a phenomenon (Green, 2008). For this reason, at the end of Chapter 6 (Generalization and Integration of Results and Findings) I constructed a *Mental Model of Integration* (MMI) to honour M-M and to comply with Stage five.

Three more stages not proposed by Stake and Yin complemented the thesis process: 6) Addressing M-M *design quality* and *interpretative rigor*; 7) Ethical considerations; and; 8) Dissemination of Strategies.

Stage 1. Cases Selection.

Selection process.

The data for this thesis arose from a SSHRC-funded study, based in Winnipeg, MB (Gregory, Katz, MacDonald & de Leon Demare, 2006). The purpose of the study was to explore the nature of nurse practitioner-patient relationships. Six pairs of nurse practitioners and patients were videotaped in three sequential encounters between 1.5 and 43 months. Thus, a total of 18 encounters were filmed. The encounters lasted from 25min to 70min.The encounters were videotaped in various clinical settings. They all reflect a micro relation within the Macro Relation of the professionals in nursing and in the health system.

The PI from this study (Gregory) served as my thesis Supervisor. The development of the theoretical framework and case selection was a parallel spiral process of reflection and action. It involved collaboration among people and integration of perspectives from several disciplines. It occurred as follows.

Gregory and his team read, studied, and knew the verbal details occurring in the video encounters and the transcripts. I only saw the video clips without any sound, or without reading the transcripts. At the same time, I researched power in Nursing. Coming from another discipline and being always interested about power in all its expressions, I wanted to expand my search around the phenomenon. Reading sociological, educational, philosophical and ancient perspectives, I came up with a transdisciplinary theoretical framework integrating multiple perspectives to create my own. Through three meetings, I shared with Gregory my general findings and the first impressions of the term “power”

arising from the sociological, health sociology, philosophy and socio-educational literature. He also shared the general findings and first impressions of "power" in the encounters. At last, supported by the theoretical framework, Gregory and I selected two different cases (video-cliped encounters) that potentially illustrated the two contrary mechanisms of power; in the same way, supported by Gregory's knowledge about the encounters, I researched other aspects of relationships, communication and power.

The first impressions of the observed encounters and the literature review revealed "power" as a force that was imposed on one person by another; our view of power was limited to a negative connotation. Empowerment on the other hand, was seen as the process capable of saving health professionals and patients from power. Along the cycle of sharing the practical and theoretical experiences and collaborating with each other, our view was expanded. We, then, could reach a broader sense of this complex phenomenon. The theoretical framework informed the selection of the cases, and through the course of data analysis the "goodness of fit" between the cases and the theoretical framework was explored.

Following, a creative, artistic and interdisciplinary intuition; it occurred to me, that a complex innovative idea could only be studied through diverse methods, and explained and understood from every point of view if a common language would make the complex seem elegantly simple. Collaborating with Gregory, not only as my supervisor, but as a knowledgeable qualitative researcher, as well as with a statistics researcher (Awosoga) we were able to expand a philosophical idea, to a practical way of exemplifying it.

Enlightened by regular meetings with the violinist and kinesiology researcher (Visentin), several insights came together supported by a music terminology and an artistic view of the world. Gregory, Visentin and I discovered that the "first blush" findings in the encounters could be paired with the theoretical framework, and both of them paired with the musical construction of a melody.

Setting and Population.

After ensuring some clarity on what we wanted to select from the combination of encounters (6Np-Pt pairs with 3encounters each), we finally identified video vignettes with the aid of a research assistant (Palin) who transcribed and coded the verbal interactions. Case A (Np1-Pt1) was suggested as illustrative of an equitable mechanism of power, which we identified as care collaboration. Case B (Np3-Pt3) would illustrate an inequitable mechanism of power, which we identified as care attenuation. Palin, and I selected the sections of each encounter (see Table 4.4) that best illustrated attenuation and collaboration. Palin would bring in mind the best sections of the verbal interaction; and I would bring the best sections of the nonverbal interaction. In order to explore quantitatively and qualitatively what philosophically was shown in the theoretical framework, we agreed on selecting 5 non-continual sections. Although there was a loss of continuity, sectioning the interaction permitted maximized differences between cases. However this loss in continuity did not risk the whole understanding, because the Cases (A and B) were very similar to the sectioned selected pieces. For a research of a major magnitude, analysis of the complete encounter is suggested. In this thesis continuity was

addressed by constructing a variable of time. This variable was constituted by periods of time. Ten observational points (Op) constituted each period.

Table 4.4
Analyzed sections (in time) for both cases

Case A Care Collaboration Np1-Pt1	**Case B Care Attenuation Np3-Pt3**
1:30-4:30: 3min	0:10-2:20: 2min10sec
5:30-8:30: 3min	7:40- 15:50: 8min10sec
10:30-11:30: 1min	17:00-20:10 3min 10sec
19:30-26:10: 6min 50sec	21:00-21:50: 50seg
27:30-29:00: 1min 10sec	22:00-23:50: 1min 50sec
15min	16min 10sec

Inclusion criteria.

In order to unveil power mechanisms of expression through the exploration of nonverbal maximized differences and verbal interaction, two care encounters demonstrating attenuation and collaboration (exemplifying the theoretical framework) were thoroughly selected.

Five inclusion criteria were followed: 1) One of the areas of verbal communication study in this thesis was to understand the different ways in which the health condition was addressed. For that reason, the first inclusion criteria was that both cases needed to have a patient with a health condition (struggle) that was not solved, but only addressed in the past; 2) A second focus of the verbal and nonverbal communications was placed over the relational struggles happening in the selected

encounter, and the ways of solving them. For that reason, a second criterion was that in both cases, other relationship struggles needed to be present during the encounter; 3) To highlight differences between the relationships in each case, and to address the possible influence of the Np personality, a third criterion was applied. In both Cases the nurse practitioner needed to be the same, and the patients different; 4) A fourth criterion was the encounters to be observed. To assure that the health conditions were fully addressed and the relational struggles had already started, we needed to select the second or third encounter between Np and Pt, not the first one; 5) A fifth and last criterion was followed by selecting parts from the beginning, the middle and the end, to have a full vignette lasting around 12 to 17minutes.

Sampling.

Even though this thesis has a strong quantitative component, it relies on a Mixed-Method approach. The quantitative-qualitative Case Study Method allowed to select a *non probabilistic* (Tashakkori &Teddlie, 2003, p.279) *stratified purposive* (Marshall and Rossman, 2006, p71; Sandelowski, 2000, p.250) *convenience* (Bryman, Teevan and Bell, 2009 p.197) *sample*.

Nonverbal sampling.- To observe the Np and Pts nonverbal behaviours (potentials) and their interaction, a combination of different body movements were called channels (e.g arms, arms-hands, facial gesture, posture, etc). Those channels indicated the part(s) of the body expressing a potential. Potential, in this situation evokes a nonverbal contribution to the relationship. Supported by Andresen, Guerrero and Jones (2006), classification of nonverbal behaviours, 14 channels were selected after observing

the muted videotapes after viewing them five times. Those 14 channels corresponded to three of the categories suggested by these authors. Two channels studying *Proxemics* (distance); two channels studying *Haptics* (touch); and ten studying combined *Kinesics* (2 for posture, 6 for body gesture and 2 for facial gesture) were identified. One more channel (channel 15) was constructed from the combination of *haptics, proxemics and kinescics*. The channels by its classification based on these authors are displayed in Table 4.7 (see research design Stage 4).

To score the behaviours along time; Visentin and I decided that I was only going to score what was happening at every 10 seconds in a period of one minute for the course 15 or 16.10 min constituting each (Case A and Case B) vignette. Therefore the 15 minutes, for example, was divided per minute, and each minute in 6 intervals of 10 seconds. For every 10 seconds I scored the nonverbal behaviour happening only at second 5. These moments in time selected to observe and score the nonverbal movements were called Observational points (Op). All the numbers in the analysis (n) refers to the movements (nonverbal potential) in terms of Observational Points. I observed every channel for every subject.

With a 15min vignette for Case A, and 6 observational points (Op) per minute, the total Op per subject (Np and Pt), was N=90. Considering that 90 Op´s for two subjects (N=180) were covered for all the 15 nonverbal channels to be scored, in total for Case A, I observed and scored N=2700 movements over the 15min vignette. With a 16min10sec vignette for Case B, and 6 Op per minute, the total Op per subject was N=97. Considering that 97Op´s for two subjects (N=194) were covered for all the 15 channels to

be scored, in total for Case B, I observed and scored N=2910 movements over the 16min 10sec vignette. A total of 5610 movements completed the total sampling. We can observe the whole sampling procedure on Figure 4.1.

Verbal sampling.- For verbal analysis I considered the same periods observed for the nonverbal sample (5 sections). The length of each vignette was: 15min for Case A, and a vignette with a total of 16 minutes10seconds for Case B.

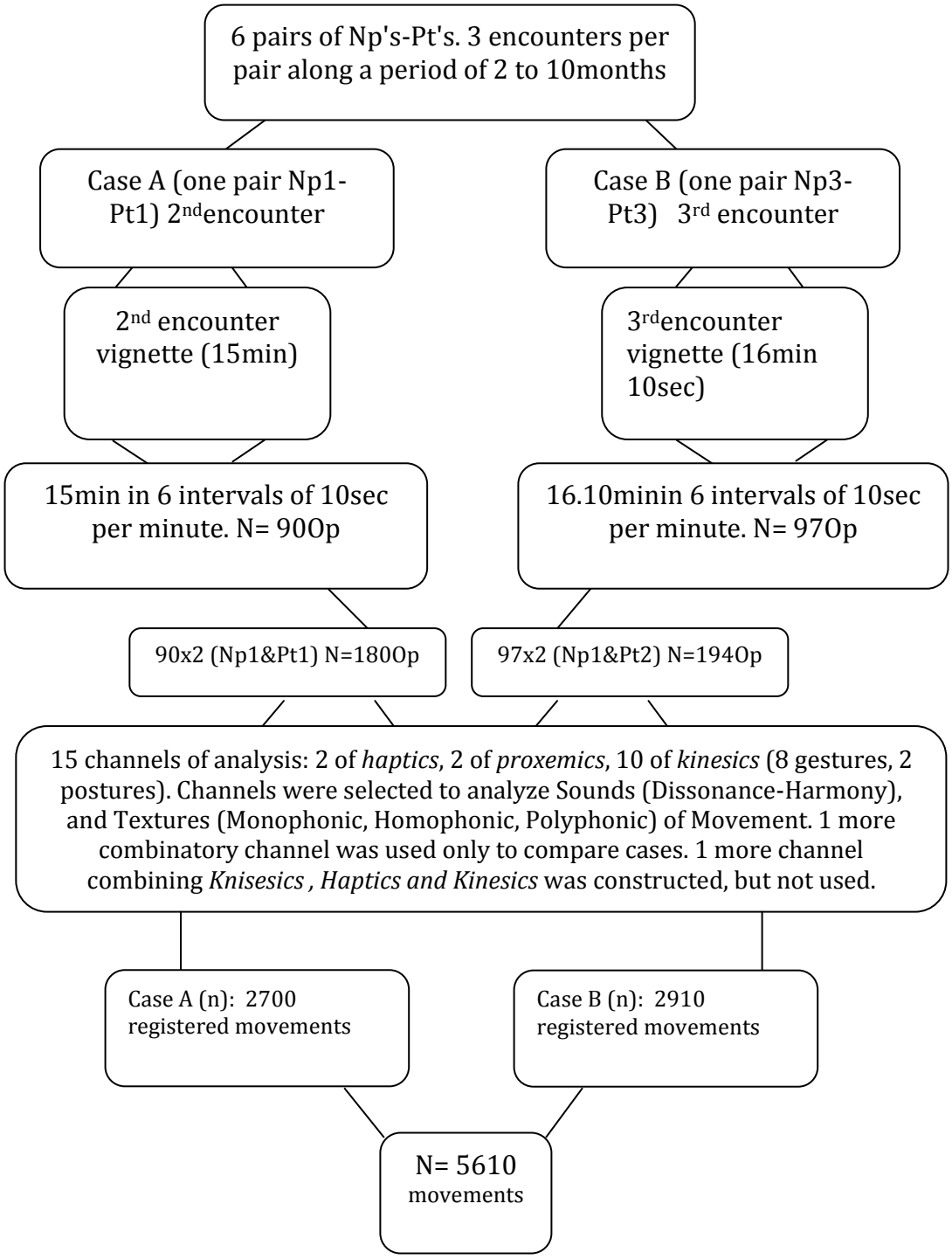
Stage 2. Using multiple cases within the same case study.

Case A and Case B would replicate each other. Contrasting their results allowed the explanation and complementation of the theoretical framework and a potential theoretical replication. The verbal and nonverbal results and findings between the two cases, was possible by the following *Instrumental Type 4 multiple case embedded.*

The embedded cases are called subunits of analysis (Yin, 2003). From simple to complex and from inside to outside we can see in Figure 4.2, a first order relationship – between the mind language and the body language-. These are considered the power fractals into a second order relationship –Np-Pt. Nurse Practitioner and patient relationships are considered the power wholeness.

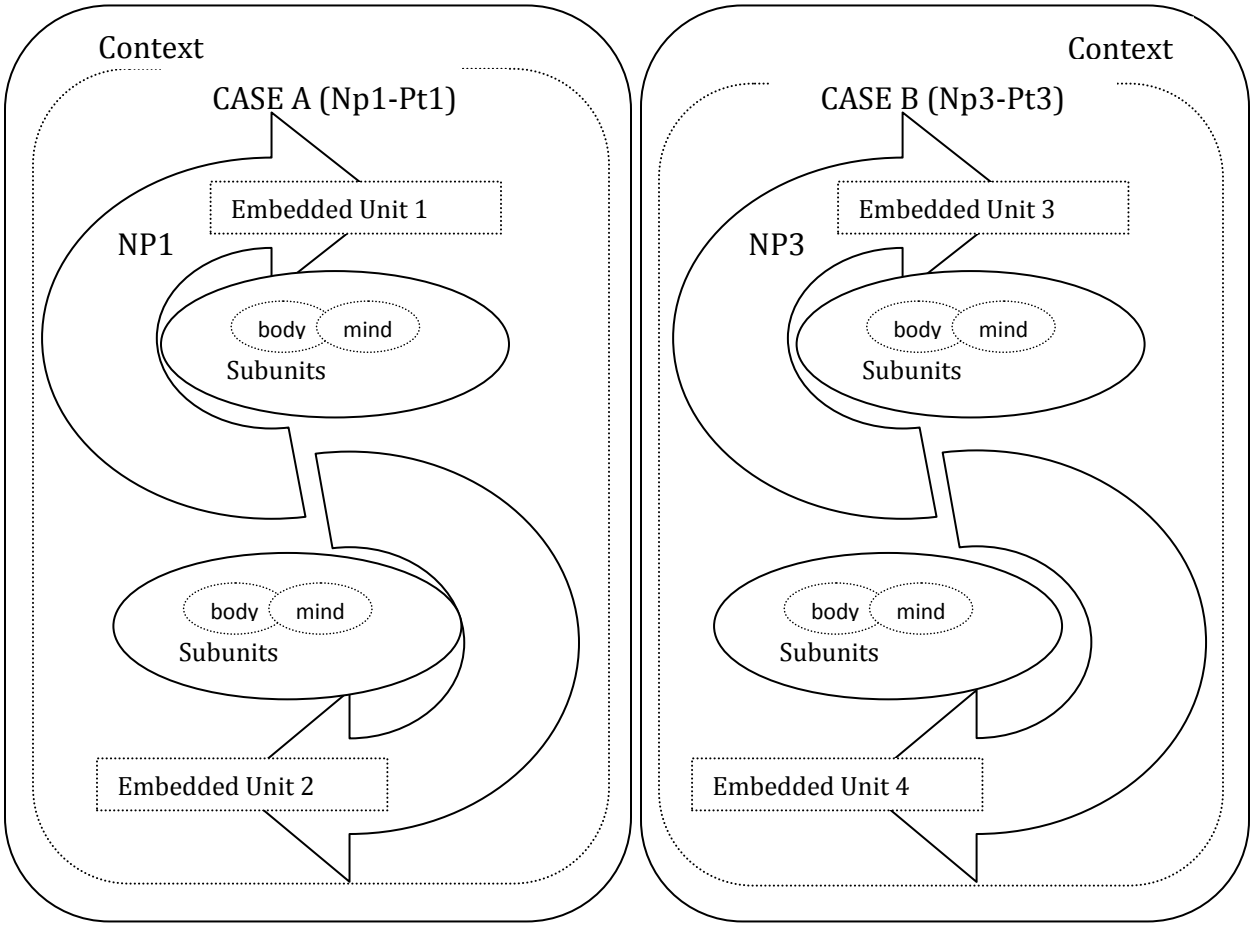
Case A and Case B, being the contrasting care relationships and broader cases, were identified as power units of analysis embedding the Nurse practitioner and the patient. Following the same structure the Np and the Pt acting as embedded units also involved verbal and nonverbal power subunits of analysis.

Figure 4.1
Non-Probabilistic Stratified Purposive Convenience Sampling Procedure



Metaphorically, as we will see in the last Mental Analysis Model (*MAM*) in this (See Figure 4.7 at the end of Chapter 4) Intermelody (Np-Pt relationship through communication) involved two subunits: Nurse Intramelody (verbal and nonverbal languages), and patient Intramelody (verbal and nonverbal languages).

Figure 4.2
Multiple Embedded Units and Subunits of analysis



Stage 3. Stipulation of the rival theories.

The integrative theoretical framework comprises the selected theories. For full explanation see Chapter 3.

Stage 4.Data Collection.

Data collection and data management

Data collection involved Np-Pt video recording encounters and transference onto CD's. In order to analyze nonverbal data, a second set of collecting processes was needed.

Nonverbal subunit (body fractals) data collection

Case A (Np1-Pt1) exemplifying care collaboration was observed over five periods of the encounter, summing in total, 15min. Case B (Np3-Pt3) exemplifying care attenuation was observed over five periods of the encounter, summing in total, 16min 10sec. Exact scoring periods, are shown in Table 4.4.

First the researcher familiarized herself with the movements observed in each videotaped encounter, by watching in silence each video encounter (Case A and Case B) five times. Second, the researcher differentiated the movements of several parts of the body and their combinations (e.g. torso, arms, hands, fingers; arms-hands-fingers; hands-torso-arms) in 15 channels.

Second, based on Andresen, Guerrero and Jones (2006) classification of nonverbal language, movements were clustered in: *Proxemics* including distance and orientation; *Haptics* including touch and eye contact; and *Kinesics* including a variety of body postures (gross movements), body gestures (fine movements), body posture-gestures (gross and fine movements) and facial gestures. For details see Table 4.7.

Third, Visentin and the researcher decided to treat the data in a binary system; Awosoga and Gregory confirmed this decision. The binary system consisted of categorizing the movements in two different ways. For channels representing a movement or a lack of movement, they were classified into *voice potentials* and *lack of voice* (*no potentials*). These were named Texture of Movement channels (TOMchs). TOMchs served to analyze the equity of voices in the relationship and, as the name indicates, contributed to the Textures (Monophony, Homophony, Polyphony) of the interaction analysis. The Sounds of Movement channels (SOMchs) served to analyze which kind of potentials were brought to the relationship, and as the name suggests, contributed to the analysis of how the interaction Sounded (Harmonious/Dissonant). Based on Hawkins (1998) classification of powerful and forceful nonverbal behaviours, SOMchs represented dichotomous movements classified as *constructive* and *disruptive* potentials. This classification was completed by Visentin and the researcher (see Table 4.5).

Table 4.5.
Hawkins (and thesis researchers) Power vs Force hidden behaviours classification used for the analysis of nonverbal analysis

Channel	Power	Force	Proposed by
Distance	Close	Far	The researcher
Orientation	Other oriented	Independently oriented	Visentin and the researcher
Head and body posture "Flexibility"	Flexible	Rigid	Hawkins
Hands, torso arms and/or hands "Dynamism"	Dynamic	Static	The researcher following Britton's (1939, 2001) communication perspective
Arms, hands and fingers "Openness"	Open	Secretive	Hawkins
Arms and Hands "Soft_Loud"	Soft (Smooth)	Loud (violent)	Visentin and the researcher supported on musical terms.
Arms and Hands "Req/ Expl_Dem/ Compl"	Request/Explain	Demand/Complain	Hawkins and the researcher
Head Face "Affirmation"	Accepting	Rejecting	Hawkins
Head Face "Dynamism"	Expressive Dynamism	Non Expressive Staticism	The researcher following Britton's (1939, 2001) communication perspective
Facial Gesture "Consonance"	Harmonious	Disruptive	Hawkins

Table 4.5 (continued)

	Carefree	Frivolous/Removed	Hawkins
	Gentle/Tender	Rough/Hard	Hawkins
	Confident	Arrogant	Hawkins
	Humorous/ Cheerful	Somber/Suffered	Hawkins and the researcher
	Energetic	Agitated	Hawkins
	Understanding/ Thoughtful/Aware /Empathetic(self)/ Observant (UTAEO)	Pedantic/Worried/ Preoccupied/Self- Pitying/Suspicious (PWPPS)	Hawkins and the researcher
	Serene	Dull	
Facial Gestures for frequencies	Timeless	Fadish	

Fourth, values to score each channel were assigned. For TOMchs, value 1 represented voice (shared potential), and value 0 represented no voice (no potential). For SOMchs, the researcher observed which parts of the body or their combinations represented which dichotomous behaviour. For example, it was observed that the individuals' flexibility/rigidness was more evident in the head and body, which was a postural (gross) movement. It was also observed, for example, that closed/opened posture

gesture was more evident in the arms-hand-fingers combination; arms are a postural movement whereas hands and fingers are body gestures (fine movements). This classification was discussed and agreed upon with Visentin, who observed that these dichotomies (i.e. loud and soft) are also present on musical interactions. Awosoga and Gregory also agreed with the classification. For SOMchs' then, behaviours representing construction were assigned with value 2 (e.g flexibility), and disruption with value 3 (e.g rigidness). See Table 4.6.

Case A and Case B

Table 4.6
Sounds of Movement Channels (SOMchs) and Textures of Movement Channels (TOMchs)

Type	Specific Channel and their dichotomy
SOMchs	Constructive /Disruptive potentials contributing to harmony and dissonance
	Distance
	Orientation (other oriented/individually oriented)
	Gross posture flexibility (or rigidness)
	Body gesture smoothness (or loudness)
	Posture gesture affirmation (or rejection)
	Posture gesture openness (or closedness- secretivness)
	Posture gesture dynamic expressiveness (or static non expresivness)
	Body gesture requesting/explanation (or demanding/complaining)
	Facial Gesture consonance (or dissonance-disruptive)
TOMchs	Voice (potential)/ Lack of voice (no potential)
	Presence
	Touch

	Table 4.6 (continued)
	Eye contact
	Body-posture dynamism
	Moving lips to talk

Fifth, the researcher constructed detailed standards for the observing and scoring every channel; later on Gregory and Visentin agreed about those standards. Table 4.7 shows all the channels belonging to every nonverbal behaviour cluster, its standards and its binary values. This standards were applied to both Cases (A and B). A limitation of the study was the absence of a reliability check and/or inter rater reliability.

Table 4.7

Concepts and indicators, variables, standards and values of registered channels to measure the constructs Sounds (Harmony and Dissonance) and Textures (Mono, Homo or Polyphony) of Movement

Clusters (concepts and indicators)		Channels	Recording Variables	Standards	Binary categories	Value	Recode	Constructs being measured (Sounds or Texture)
Proxemics (Distance)	Distance	Ch 1	P_Close_Far	A person stays in the middle (ref point=table edge)	Static distance	0	0	Sounds
				A person stays in place, close to the other (Passing edge)	Stays close	2	1	
				A person stays in place, far from the other (Passing the edge)	Stays far	3	0	
		Ch2	K_P_ Orientation	A person is oriented towards the other (At least half of the torso)	Other Oriented	2	1	
				A person is oriented forward; his or her posture (more than half of the torso) is independently oriented.	Independently Oriented	3	0	
				A person is half oriented to the other, half forward oriented (At least one shoulder oriented to the other)	Half Oriented	23	0	
				The Np and the Pt are oriented towards the same goal (g), target (t) or place (p) (2&2, 23&23, 22&22)	SH_Oriented	22	1	
				They are oriented toward different g, t or p. (3&3, 23&3)	IH_Oriented	33	0	K_SH_IH
Haptics (Touch)	Touch and Eye contact	Ch3	H_touch	A person does not touch the other	Non touch	0	0	Textues
				A person touches the other	Touch	1	1	
			H_eye contact	There is no eye contact with the other (Pt or Np)	No eye contact	0	0	Texutres

		Ch4		A person establishes eye contact with the other	Eye contact	1	1	
				A person establishes eye contact with computer	Eye onCompu	78	1/0	
				Eyes are on some notes	Notes Eye C	79	1/0	
				No Eye contact with a third person in the room	No 3th Eye C	90	0	
				Eye contact with a third person in the room	3th eye contact	91	1/0	
				The Np and the Pt are having eye contact (1) or both are looking towards the same goal, target or place (22)	SH_Eye	221	1	
				The Np and the Pt are not having eye conact (0) and oriented toward different target or place (33)	IH_Eye	330	0	H_SH_IH
Kinescics (Movements)	Posture (Gross movements)	Ch 5	K_Ps_ Prescence	A person is in the room	Present	0	0	Textures
				A person is not in the room	Not Present	1	1	
		Ch 6	K_Ps_ Flexibility	The overall head and body are loose, and allowing subtle or evident movement. The most evident sign of flexibility or rigidness is found in the back and neck (and its consequence in the abdomen). If both are arched a little bit to the front or to the side there is a sign of flexibility. Another sign is in the movement of the arms. If there is movement there is a sign of it.	Flexible	2	1	Sounds
				The overall head and body are controlled and contained in the	Rigid	3	0	

				same position, and blocking movement. If the back is completely straight or static even though the person is moving, then there is a sign of rigidness, and vise versa (the abdomen shows a rigid consequence to this movement). Other sign of rigidness is found in the arms; if the arms are not allowed to move to the sides there is a sign of rigidness.			
		PG	K_Ps_HTAH_ Dynamism	Hands, torso arms and/or hands are static	Static HTAH	0	0
		Ch7		Hands, torso arms and/or hands are moving	Dynamic HTAH	1	1
Gesture (Fine movements)	BG		K_BG_ Openess	Arms, hands and fingers are not covering the core middle space from groin to head	Open hands and fingers	2	1
	Ch 8			Arms, hands and fingers are covering the core middle space from groin to head	Close hands and fingers	3	0
	PG		K_BG_Soft_ Loud	Arms and Hands are slower and softer	Soft/Smooth arms hands	2	1
	Ch9			Arms and Hands intensify their movement and are hard.	Loud arms hands	3	0
			K_BG_Req/ Expl_Dem/ Compl	Hands are static, not expressing anything; neither sharing nor individualizing.	Requesting/Explaining arms hands	2	1
				Request/Ask: Hands are writing while the patients is talking and the hands are in patients direction; also hands are showing something to ask the			

				people (Pt or Np) about something				
		BG		Explain/Tell: Hands are explaining with flexible movements; also hands are showing something to clarify something to the other person.				
		Ch 10		Demand-Mandatory: Hand is pointing rigidly to him-herself, the other person or the air. Hands moves rigidly in a one shot move. Hands are demaning moving from the person towards her-himself	Demanding/ Complaining arms hands	3	0	
				Complain-Worried: Hands are moving from head-face to a forward direction. Hands are covered by cross arms, hands covered mutually, or hand(s) is or are pressing face.				
				Notes, Sheets and computer are being shared. One or both hands are near the shared object (e.g.computer)	SH_Object	22	1	K_SH_IH
				Hands are writing or rolling the mouse while the other person is talking. Hands have something that the other person is not seeing or touching. Hands have an object; this object is given or received.	IH_Object	33	0	
		BG	K_FG_Lips_ Talk	Lips are not moving to talk	No talking lips	0	0	Textures
		Ch 11		Lips are moving to talk	Talk lips	1	1	
		PG		Lips are moving to talk to a third person in the	Talking to a 3rd p	78	0	

				room				
		Ch 12	K_FG_Head Face_ Affirmation	Attentive head face (U): Head position is to the side (three forth), looking to the other person, and it seems as he or she are understanding. It seems that there is a reinforcement of the other. Affirming head face (A): The head is moving from up to down, and it seems that there is a reinforcement of the other. Explaining head face (E): Head is towards the other and gesture has a reinforcement look.	Affirming head face	12	1	
				Ignoring head face: Head position is looking forward in another direction that is not towards the other; it is mostly static and not looking to the other.	Rejecting head face	13	0	
				The same as FG_Affirming but to another person in the room that is not either the Np or the Pt.	Affirming 3rd person	72	0	
				The same as FG_rejecting but to another person in the room that is not either the Np or the Pt.	Rejecting 3rd person	73	0	
		Ch 13	K_FG_ HeadFace_ Dynamism	Head is in a static, rigid, non-expressive position	NonExpressive Staticism	0	0	
				Head is in a static or dynamic, flexible, expressive position	Expresive Dynamism	1	1	Sounds
		FG						
		Ch 14	K_FG_Gestur es	Harmonious (Hawkins, D) Consonant (2)	Harmonious	2	1	Sounds

			Consonance	Disruptive (Hawkins, D) Dissonant (3)	Disruptive	3	0	
		Ch 15	K_FG_ Specific Facial Gestures	Not paying attention to the other person. At some points he or she seems it is paying attention, but it´s clearly pretending to be taking care.	Frivolous/ Removed	1	1	Specific Sounds
				Genuinely involved, and paying attention to the other person, without being worried.	Carefree			
				Soft expression demonstrating empathy and like for the other person. The gesture is not of tolerance, but of genuine like.	Gentle/Tender	4	4	
				Rigid expression demonstrating that a person does not like the other person. A person is clearly having to bear or put up with the other person. She or he is making an effort to like the other, and she or he is demonstrating a non empathetic gesture	Rough/Hard			
				A person has a patient and soft gesture while talking. His or her gesture has a firm and explanatory tone. Eyebrows are arched at the same level.	Confident	5	5	
				A person has a rigid and conceited tone while talking. His or her gesture is strong and in a tone of knowledge demonstration. Eyebrows are being arched and lifted; sometimes one is more	Arrogant			

	arched than the other.				
Specific Facial Gestures were combined in the same variable with Gesture Consonance. For example Humorous/Cheerful and Suffering/Somber value is 6. If it had a value 2 before it (26), it was Humorous/Cheerful. If it had value 3 before (36) it was Suffering/Somber.					
K_FG_Specific Facial Gestures	The lips are laughing, the eyes looks tender, the mouth is lifted, and the rest of the face is soft, demonstrating joy. (Not only the lips are laughing, but it seems that the rest of the parts of the face are laughing too)	Humorous/ Cheerful	6	6	Specific Sounds
	The lips are laughing, but either the eyes look sad, secretive, or obscure, or the lips and facial muscles around are weak or decay. (The lips are laughing but the rest of the facial parts are demonstrating suffering or a hidden tone of sadness)	Somber/ Suffered			
	His or her movement intensifies, demonstrating excitement around the issues what he or she is telling about	Energetic	7	7	
	His or her movement intensifies, demonstrating anger or discomfort.	Agitated			
	Understanding/Thoughtful/Aware/Empathetic (self)/Observant	UTAEO	8	8	
	Pedantic/Worried/Preoccupied/Self-Pitying/Suspicious	PWPPS			
	Her or his face look calm and relaxed, tranquil, open, and still interested.	Serene	9	9	

				Her or his face looks bored, heavy, sad, without shine, gray, covered.	Dull		
				Her or his face looks calm, as if she or he has more time to spend.	Timeless		
				Her or his face looks rushed, ready to go.	Fadish	11	11

Note. Proxemics (P), Kinesics (K), Haprics (H), Body Posture (Ps), Posture Gesture (PG), Body Gesture (BG), Facial Gesture (FG), Textures of Momevent -Monophony, Homophony, Polyphony (MHD)-, Sounds of movement -Harmonious, Dissonant (HD), Sharing (SH), Individualizing/Hoarding (IH), Hands, Torso Arms and Hands (HTAH), Understanding/Thoughtful/Aware/Empathetic(self)/Observant (UTAEO), Pedantic/Worried/Preoccupied/Self-Pitying/Suspicious (PWPPS)

Sixth, the researcher constructed a scoring template to record the movements of the videotaped interaction, and assigned values to the behaviours.

Seventh, the researcher scored 3 minutes of each case (Case A and B) in the scoring template to be sure there were no inconsistencies with the classifications and the standards, and that the template will fully comply its function. These scores are not part of the analyzed data.

The eighth and last step in nonverbal data collection was to start the body movement scoring. Every channel was scored separately for each subject, but the observations were done with the same parameters. Within a minute, registrations were done at 6 Op´s. In a period from 1 to 10 seconds, the scoring was done only at second 5 (see example in Table 4.8). Once I scored all the movements, I contrasted them with the video one more time to make sure I had no errors.

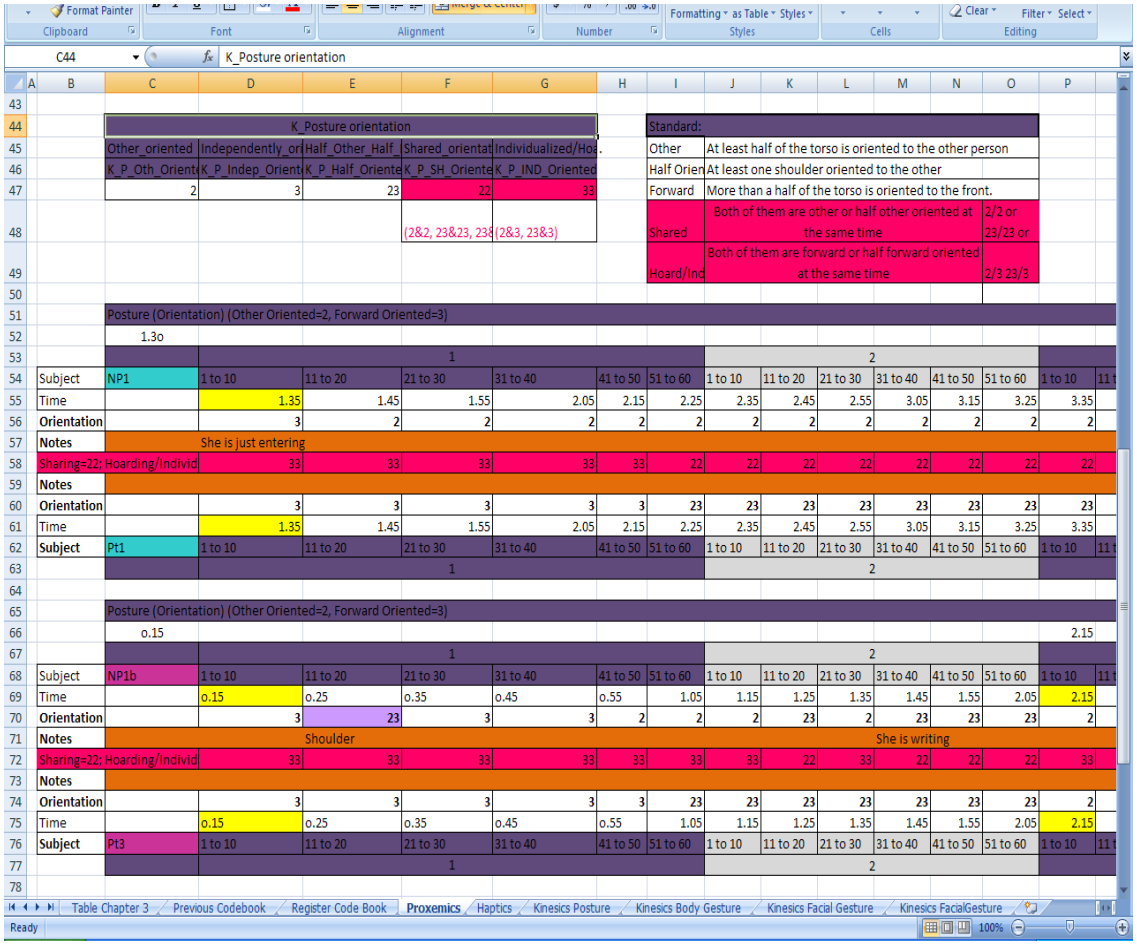
Table 4.8
Example of scoring

Subject	Np1	1 to 10	11 to 20	21 to 30	31 to 40
Time		1.35	1.45	1.55	2.05
Channel (Orientation)		3	2	2	2

Figure 4.3, illustrates an example of one scoring template sheet. One sheet was used for every cluster of channel (e.g. *Proxemics*). On every sheet, the channels in that cluster were scored (e.g. Within *Proxemics* sheet, channel Posture was scored). In Figure 4.3: The left hand top square indicates the channel and its possible variables with assigned values. The right hand top square indicates the standard to guide the value

assigned to the movement channel (in the example case, posture orientation). Once the scoring was completed, the data was carefully revised before being transferred to several analysis databases.

Figure 4.3
Example of the Recording database (Sheet Proxemics)



Nonverbal behaviour data management.

Nonverbal behaviour was addressed first. Until the end of the nonverbal analysis, the videos were not listened to and the transcripts were not read. This was designed to address possible bias during the nonverbal analysis. Only after nonverbal analysis was completed, verbal behaviour was managed and analyzed.

The data contained in the scoring sheets were coded into excel spreadsheets. Each channel was considered a variable. To obtain binary databases the SOMch underwent a change in its values. Values 3 in the scoring database for disruptive potentials were converted to value 0, and value 2 for constructive potentials into value 1. TOMch values remained as 1 for voice and 0 for no voice. In case B, 23 Op (From minute 11.55, to minute 15.35) and for Np3 all the channels were registered as "absence of behaviour" when the Np3 left the room. Absence of behaviour was converted to 0, like the value given to disruption.

To corroborate Hypothesis 1 (differential of potentials) and 2 (association of potentials), three levels of variables were needed: Nominal channel by channel variables; scale variables for Sounds and Textures; two ordinal variables for level of constructiveness (sounds); and two ordinal variables for level of voice (textures). In the studies of significant differences, the independent variable was Person_number (Np1=1 & Pt1=2; and Np3=4 & Pt3=5). To test Hypothesis 3 (differences in time=cadences), one ordinal variable and one independent variable were created.

Levels and types of Variables:

1. Nominal channel by channel variables (Dichotomous) (For particular findings)

To study the differences of potentials between Np and Pt in the two Cases, every channel was transformed into a dichotomous (nominal) variable (e.g. Touch) per Case. To study associations between the potentials of the Np and the Pt in each case, one dichotomous variable per person for each channel was needed (e.g. Np1Touch, Pt1Touch). This procedure was applied to the Sounds and Texture channels. SOMch variables' values were 1= constructive potential; 0=disruptive potential. TOMch variables' values were 1=voice; 0=lack of voice. These variables determined which Intramelody (Np or Pt) was bringing which type of potential to the Intermelody (differences) and which were shared between them as a characteristic of the Intermelody (associations). (See Chapter 6).

2. Scale variables for Textures and Sounds (For general results)

To study the general differential of potentials between Np and Pt for every Case, one scale variable for Textures and a one scale variable for Sounds for each Case were computed, to add all the potentials contained in the SOMch variables; and to add all the potentials contained in the TOMch variables. The computed variables were called SOUNDS and TEXTURES. To study the general associations between the potentials of the Np and the Pt in each case, one scale variable per person for each computed variable was needed (i.e Np1SOUNDS, Pt1SOUNDS, Np1TEXTURES, Pt1TEXTURES, Np3SOUNDS, Pt3SOUNDS, Np3 TEXTURES, Pt3TEXTURES). SOUNDS variables' values ranged from 0 to 9 where (0= no potential and 9=9 potentials). TEXTURES variables' values ranged from 0 to 5 where (0= no voice and 5= 5 voice potentials). These variables determined the amount of constructive or disruptive potentials (SOUNDS), and

of nonverbal voice or silence (TEXTURES) of every person (Intramelody) involved in the Intermelody. By knowing the amount and type of potentials, a general sense of differentials and associations between Np and Pt in every Case was possible (see Chapter 6).

3. Ordinal variables for Levels of constructiveness (Sounds) and Levels of voice (Textures)

Level of constructiveness (sounds) variables.- To study the significant differences between Np and Pt in every Case in terms of Levels of constructiveness/disruptiveness, two ordinal variables were created for each Case; one to measure significant differences and the second to measure significant associations.

Variable 1.- Disruptiveness_to_Constructiveness variable has three levels (Level I-Disruptiveness=1; Level II-From disruptiveness to constructiveness= 2; Level III-Constructiveness=3). The levels in this variable came from the SOUNDS variable. From the sum of all the SOMch potentials per person, if the value in each Observational Point (Op) ranged between 0 and 3, the person at that Op was at Level I; between 4 and 5 was at Level II; and between 6 and 9 was at Level III.

Variable 2.- To study significant associations between Np and Pt in every Case in terms of Levels of disruptive-dissonance/constructive-harmony, one ordinal variable for each person was created, under the same parameters than variable 1, but with different labels. Dissonance-to-harmony variable has three levels (Level I-Disruptive – Dissonance=1; Level II-In process from dissonance to harmony=2; Level III-Constructive –Harmony=3). Variables per person are: Pt1Dissonance_to_Harmony;

Np1Dissonance_to_Harmony; Pt3Dissonance_to_Harmony;

Np3Dissonance_to_Hamrony.

Level of constructiveness (harmony) variables determined if: a) the Np and the Pt in each Case (Intramelodies) shared or differed in the level of disruptiveness (dissonance) to constructiveness (harmony); b) which Intramelody was provoking or facilitating a level of disruptiveness, in process to constructiveness, or constructiveness, in the Intermelody (differences); and c) which levels of dissonance, in process to harmony, and harmony were shared between them as a characteristic of the Intermelody (associations) (see Chapter 6).

Level of voice (textures) variables.- To study the significant differences between Np and Pt in every Case in terms of Levels of nonverbal voice/silence, two ordinal variables for each Case were created; one to measure significant differences and the second to measure significant association.

Variable 1.- From silence_to_voice variable has three levels (Level I=No voice; Level II=Individual voice in relationship building-; Level III=Sharing voice). The levels in this variable came from the TEXTURES variable. From the sum of all the TOMch potentials per person, if the value in each Observational Point (Op) ranged between 0 and 1, the person at that Op was at Level I; between 2 and 3 was at Level II; and between 4 and 5 was at Level III.

Variable 2.- To study significant associations between Np and Pt in every Case in terms of Level of silence-no relationship/ voice-relationship, one ordinal variable for each person was created, under the same parameters than variable 1, but with different labels

From Monophony-to-Polyphony variable has three levels (Level 1-No (voice) related– Monophony=0; Level II-Individualized voice in progress of relationship building– Homophony=2; Level III-Highly (voice) related –Polyphony=3). Variables per person were: Np1 From Monophony_to_Polyphony; Pt1 From Monophony_to_Polyphony; Np3 From Monophony_to_Polyphony; Pt3 From Monophony_to_Polyphony.

Level of voice (textures) variables determined if: a) the Np and the Pt in each Case (Intramelodies) shared or differed in the level of voice and silence; b) which Intramelody was provoking or facilitating a level of silence, individualized voice, or sharing voice, in the Intermelody (differences); c) and which were the levels of relationship (Textures) between them, conforming a characteristic proper of the Intermelody (associations) (See Chapter 6).

4. Ordinal variables for Sounds Cadence and Textures Cadence

To test Hypothesis 3 (Cadences: changes in Sounds and Textures over the course of time) one independent variable and two ordinal dependent variables were created for every Case. To study the significant differences between three intervals of time in terms of Sounds and Textures of Movement; the independent variable Time Interval had three values (Interval 1=1; Interval 2=2; Interval 3=3). In Case A: Interval 1 consisted of the first 30 Observational Points (Ops); Interval 2 by the next 30Ops; and Interval 3 by the last 30Ops (N=90Ops). In Case B: Interval 1 consisted of the first 32Ops; Interval 2 by the next 32Ops; and Interval 3 by the last 33Ops.

Sounds Cadence variables.-The dependent variable Sounds Level has three levels (Level I-Dissonant attenuation=1; Level II-In process from dissonant attenuation to

harmonious collaboration=2;Level III- Harmonious collaboration=3). The levels in this variable came from the Dissonance-to-Harmony variable (with values 1, 2 and 3). If both Np and Pt had a value 1 in both variables (e.g. Np1Dissonance-to_Harmony and Pt1Dissonance-to-Harmony) , or one of them had a value 1 and the other a value 2, they were considered a Level I-Dissonant Attenuation. If both had value 2, one had value 2 and the other value 3, or one had value 1 and the other value 3, they were considered a Level II-In process from Dissonance to Harmony. If both had value 3 they were considered a Level III- Harmonious Collaboration. Variables per Case were: Np1Pt1Dissonance-to-Harmony; and Np3Pt3Dissonance-to-Harmony.

Textures Cadence variables.- The dependent variable Texture Level had three levels (Level I-No relational-Monophony=1; Level II-Individualized-Homophony=2;Level III- relational-Polyphony=3). The levels in this variable came from the Monophony-to-Polyphony variable (with values 1, 2 and 3). If both Np and Pt had a value 1 in both variables (e.g. Np1Monophony-to-Polyphony and Pt1Monophony-to-Polyphony), or one of them had a value 1 and the other a value 2, they were considered a Level I-No relational-Monophony. If both had value 2; one had value 2 and the other value 3; or one had value 1 and the other value 3, they were considered a Level II-Individualized-Homophony. If both had value 3 they were considered a Level III-relational-Polyphony. Variables per Case were: Np1Pt1Monophony-to-Polyphony; and Np3Pt3Monophony-to-Polyphony.

Cadences (sounds or textures) variables determined if: a) the relational level in terms of Sounds varied as a function of time; and b) the relational level in terms of

Textures varied as a function of time. In other words, if Sounds and Textures at each Interval of time significantly differ from the other, in order to see the process of the relationship.

The following Tables; Table 4.9, Table 4.10, Table 4.11, Table 4.12 and Table 4.13 show the process from dichotomous (channel by channel), to scale (SOUNDS and TEXTURES), to ordinal (e.g. Harmony-to-Dissonance); to ordinal depending on time (Np1Pt1SoundsLevel & Time Interval) variables.

Step1: Dichotomous variables (See also Table 4.14)

Table 4.9
Example of three dichotomous nominal TOM channel variables for Np1

Np1 Presence	Np1 Touch	Np1 Moving lips to talk
1	0	1
1	0	1
1	0	0
1	0	1

Step 2: Scale Variables (See also Table 4.14)

Table 4.10
Example of TEXTURES Scale Variables for Np1, process of construction

Time	Np1 Presence	Np1 Touch	Np1 Moving lips to talk	Np1 Body-posture dynamism	Np1_Moving lips to talk	Np1_TEXTURES (Np1_Total of voice potentials)
Op1	1	0	1	1	1	4
Op2	1	0	1	0	1	3
Op3	1	0	0	1	0	2
Op4	1	0	1	1	1	4
Op5	1	0	0	1	1	3
Op6	1	1	1	1	1	5
Op7	1	1	1	1	0	4

Table 4.11
Example of TEXTURES Scale Variables for Pt1, process of construction

Time	Pt1 Prescence	Pt1 Touch	Pt1 Moving lips to talk	Pt1 Body-posture dynamism	Pt1_Moving Lips to talk	Pt1_TEXTURES
Op1	1	0	0	1	1	3
Op2	1	0	1	0	0	2
Op3	1	0	0	1	0	2
Op4	1	0	1	0	1	3
Op5	1	0	0	1	1	3
Op6	1	0	1	1	1	4
Op7	1	0	1	1	0	3

Note. Op: Observational point. Np1= Nurse practitioner 1. Pt1=Patient 1

Step 3: Ordinal Variables (See table 4.14)

Table 4.12
Example of the of the Level of voice variables contrsuction for Np1 and for Pt1 independently

Time	Np1_TEXTURES	Np1_Levels (From silence_to_voice & From Monophony_to_Polyphony)	Pt1_TEXTURES	Pt1_Levels
Op1	4	Level III=3	3	Level II=2
Op2	3	Level II=2	2	Level II=2
Op3	2	Level II=2	2	Level II=2
Op4	4	Level III=3	3	Level II=2
Op5	3	Level II=2	3	Level II=2
Op6	5	Level III=3	4	Level III=3
Op7	4	Level III=3	3	Level II=2

Note. Op: Observational point. Np1= Nurse practitioner 1, Pt1=Patient 1

Step 4: Ordinal variables depending on time (See also Table 4.14)

Table 4.13
Example of the Sounds Level and Textures level constructed interval variables

Time	Np1_Voice Level	Pt1_Voice Level	Np1Pt1 Textures Cadence (Level)
Interval 1	3	2	II (2)
	2	2	II (2)
	2	2	II (2)
	3	2	II (2)
	2	2	II (2)
	3	3	III (3)
	3	2	II (2)

Note. Np1= Nurse practitioner 1, Pt1=Patient 1

Table 4.14, shows the level and type of variables for Hypothesis 1, 2, and 3.

Table 4.14
Level and Type of variables for Hypothesis 1 (H1), Hypothesis 2 (H2), and Hypothesis 3 (H3)

H1 Differential of potentials variables	Level and Type of Variable	H2 Association of potentials variables
IV= Number_Person (nominal) DV= Channel variable	Nominal (Dichotomous): -Channel by Channel (SOM & TOM) variables	2 IV= Np channel & Pt channel (for every SOM and TOM channel, per person)
IV= Number_Person DV (SOM)= SOUNDS DV (TOM)=TEXTURES	Scale: -Total of SOM and TOM channel variables	2IV (SOM)= Np Sounds & Np Sounds. 2IV (TOM)=Textures & Pt Textures
IV=Number of person DV= Disruptiveness to Constructiveness	Ordinal: -Level of Constructiveness (sounds) variables.	2IV= Np Dissonance to Harmony & Pt Dissonance to harmony

IV= Number of person DV= From silence to voice	-Level of Voice (textures)	2IV= Np Monophony to Polyphony & Pt Monophony to Polyphony

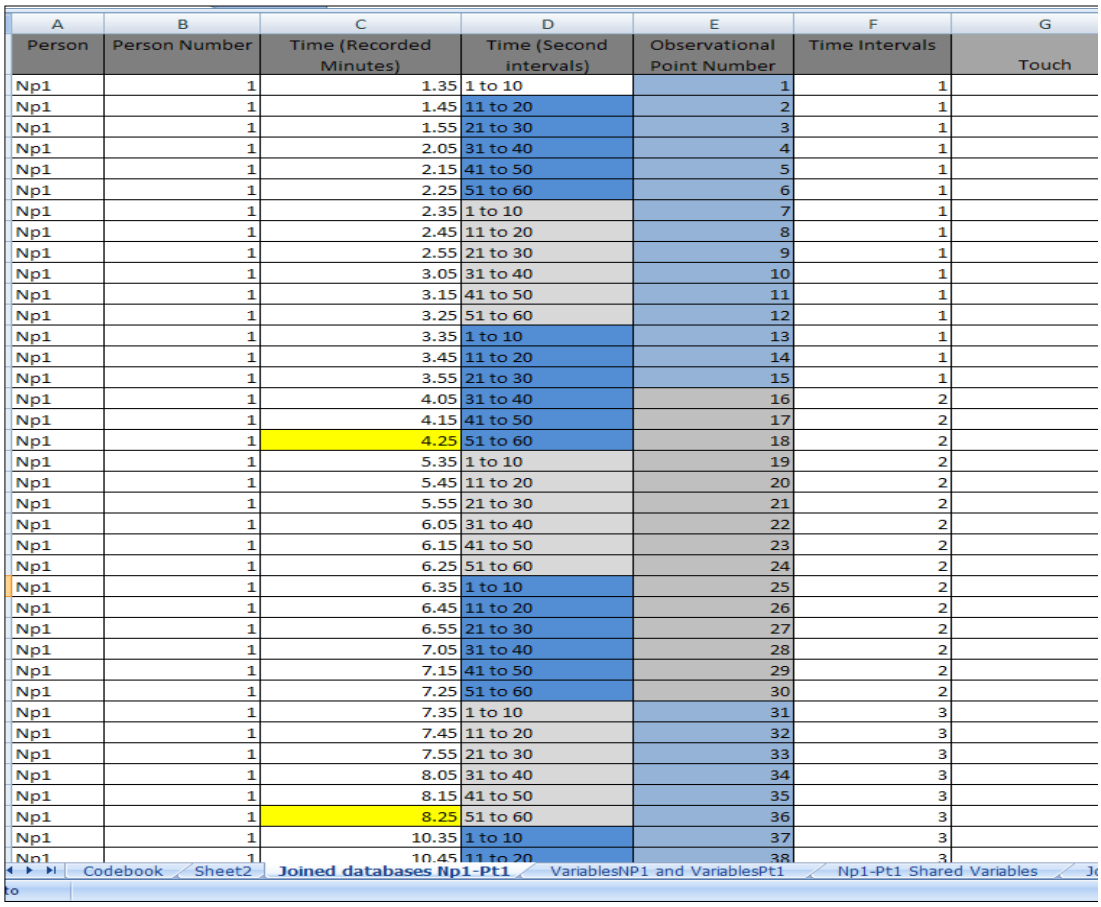
H3 (Sounds and Texture Cadences) Differences among Time Intervals

IV= Time Interval Dv=Sounds level	<u>Nominal:</u> -Time Interval	
IV=Time Interval Dv= Textures level	<u>Ordinal:</u> -Sounds Level -Textures Level	

Note. H1=Hypotheis 1; H2=Hypothesis 2; H3=Hypothesis 3; IV=Independent variable; Dv=Dependent variable; TOM=Textures of Movement; SOM=Sounds of Movement; Np=Nurse practitioner; Pt=patient.

An example of an analysis database excel sheet, is displayed in Figure 4.4 the databases for each Case and per Hypothesis were transferred to SPSS Version 18 (Green and Salkind, 2008) for the analysis.

Figure 4.4
Example of one Analysis Database (Differential of Channel by channel potentials Case A with variable time interval)



A	B	C	D	E	F	G
Person	Person Number	Time (Recorded Minutes)	Time (Second intervals)	Observational Point Number	Time Intervals	Touch
Np1	1	1.35	1 to 10	1	1	
Np1	1	1.45	11 to 20	2	1	
Np1	1	1.55	21 to 30	3	1	
Np1	1	2.05	31 to 40	4	1	
Np1	1	2.15	41 to 50	5	1	
Np1	1	2.25	51 to 60	6	1	
Np1	1	2.35	1 to 10	7	1	
Np1	1	2.45	11 to 20	8	1	
Np1	1	2.55	21 to 30	9	1	
Np1	1	3.05	31 to 40	10	1	
Np1	1	3.15	41 to 50	11	1	
Np1	1	3.25	51 to 60	12	1	
Np1	1	3.35	1 to 10	13	1	
Np1	1	3.45	11 to 20	14	1	
Np1	1	3.55	21 to 30	15	1	
Np1	1	4.05	31 to 40	16	2	
Np1	1	4.15	41 to 50	17	2	
Np1	1	4.25	51 to 60	18	2	
Np1	1	5.35	1 to 10	19	2	
Np1	1	5.45	11 to 20	20	2	
Np1	1	5.55	21 to 30	21	2	
Np1	1	6.05	31 to 40	22	2	
Np1	1	6.15	41 to 50	23	2	
Np1	1	6.25	51 to 60	24	2	
Np1	1	6.35	1 to 10	25	2	
Np1	1	6.45	11 to 20	26	2	
Np1	1	6.55	21 to 30	27	2	
Np1	1	7.05	31 to 40	28	2	
Np1	1	7.15	41 to 50	29	2	
Np1	1	7.25	51 to 60	30	2	
Np1	1	7.35	1 to 10	31	3	
Np1	1	7.45	11 to 20	32	3	
Np1	1	7.55	21 to 30	33	3	
Np1	1	8.05	31 to 40	34	3	
Np1	1	8.15	41 to 50	35	3	
Np1	1	8.25	51 to 60	36	3	
Np1	1	10.35	1 to 10	37	3	
Np1	1	10.45	11 to 20	38	3	

Codebook | Sheet2 | Joined databases Np1-Pt1 | VariablesNP1 and VariablesPt1 | Np1-Pt1 Shared Variables

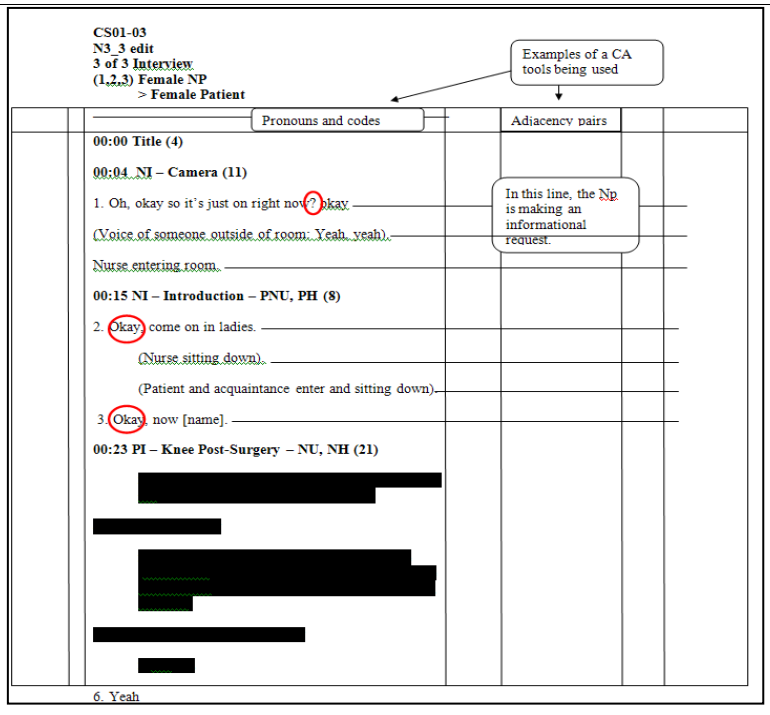
Verbal subunit (mind fractals) data management.

Nonverbal data management involved transcripts to analyze the conversation. Initially, verbal language was divided into three aspects to be analyzed: 1) The context and the facts contained at the beginning, the climax –struggles- and the end of the encounter. 2) The use of pronouns (I, you-me, we-us). 3) The verbal intentions

(*informational*, *dynamic* –Britton 2001- and *experiential*); and types of exchange or interaction (*Autistic*, *egocentric-narcissistic*, *soci-centric* –Wilber 2009-).

Throughout the revision of a couple of pages, I realized that those three aspects would predetermined and limit the analysis. Instead, the information was analyzed using Conversational Analysis (CA) methods complemented by *Sounds, Textures and Cadences of Words,* as the theoretical and metaphorical underpinnings wer paired with the quantitative analysis. The three other aspects were only considered as guidelines for the analysis. Based on this pattern, I separated the transcripts into lines of analysis and columns indicating the CA specific methodological element being used for it, as shown in Figure 4.5.

Figure 4.5
Example of a CA line–by-line tools separation over the transcript



Data Analysis

Tan, Wilson and Olver (2009) denote that "to speak of revealing and unveiling, has connotations of description, interpretation, and language and hence of hermeneutics" (2009, p.4). In this sense, hermeneutics was the natural way of generating and addressing the purpose of this thesis. The authors explain that life is like a text: "Our pre-understanding influences our interpretation of this text but, in turn, is changed and enlightened by the interaction" (2009, p.4). A radical perspective of hermeneutics followed Heidegger and Gademer perspectives (Caputo, 1987). Ricoeur's explanation of the hermeneutical circle, his perspective of multiplicity of interpretation of a text, and his perspective of metaphor, resonate with the study of power phenomenon drawn in this thesis. Ricoeur's radical posture of hermeneutics supports the multiplicity of views studied and evident in this thesis. The complex analysis of power was only possible by following a general hermeneutical route from the beginning of the thesis until the end; enlightened by the practical interactions studied by Mixed-Methods Case Study analysis.

Hermeneutical Circle: aligning theoretical, quantitative and qualitative paths to power.

As Ricoeur said "the hermeneutical circle … is between my way (or mode) of being –beyond the knowledge which I may have of it- and the mode (or the way) of being disclosed by the text as the work's world" (Ricoeur & Valdes, 1991, p.316). Ricoeur, says Geanellos (2000), "notes the way interpretation moves forward from naive understanding, where the interpreter has a superficial grasp of the whole of the text, to

deeper understanding, where the interpreter understands the parts of the text in relation to the whole and the whole of the text in relation to its parts (the hermeneutic circle)" (Geanellos, 2000, p.112). Ricoeur's posture reinforced the way I wanted to understand the whole phenomenon of power by its fractals, and vice versa.

Distanciation-as *objectification*-is the first stage of Ricoeur's circle, followed by *appropriation* (i.e. understanding of the self through the analyzed text), *explanation, interpretation, and understanding* (Tan, Wilson and Olver, 2009). That this thesis followed a hermeneutical route means that it was developed in a cyclical non linear path, where one or more stages of Ricoeur´s circle were attained: a) From the theory (holistic theoretical framework) to the exemplars and vice versa; b) From the fractals (subunits) to the whole (units) and vice versa; and c) from a naïve understanding of power developed at the beginning of the process by the interpreters eye -myself and the committee-, to data analysis, and vice versa. In the end, a deeper understanding of power was reached, accomplished through the combination of an integral theoretical framework and an integral data analysis exemplifying the framework.

Three hermeneutical cycles unfolded between the elaboration of the theoretical framework and the interpretation of results. Like layers, unwrapped to discover the essence of power in care relationships, each cycle informed the other. Within each cycle, the first or more general point of the cycle informed the last and more specific point. The first two cycles embraced *Distanciation*, *objectification*, *appropriation* and *explanation*. The third cycle covered *interpretation* and *understanding* stages. It was frequent that some of those stages were observed as well, within each cycle. Several *hermeneutic arcs*

between a naïve and an in-depth back and forth movement interpretation (Ricoeur, 1981) were produced.

First, general cycle.- The first and more general "evident" hermeneutical cycle developed in this thesis, naively and without being aware of it, was presented while theoretically enlightening the meaning of power. In this first cycle, the starting point about power ("first blush") was discovered in the interaction among some parts of the muted (only the movement) videotapes, and the constructed literature review in nursing around power. *Distanciation* was achieved through a long and integral process of studying power and communication from different perspectives, authors, disciplines and philosophies; from the raw data contained in the video recorded interactions; and from my own perception of the phenomenon. *Appropriation* was reached with my own interpretation of the authors, and the construction of a holistic theoretical framework around power, to be explained by the cases. This cycle ended with a three dimensioned -socio-philosophical and artistic- theoretical framework, which could potentially be explained by maximizing power (relational) differences of the two video recorded cases.

Second, specific cycle.- Geanellos explicates that Ricoeur was focused on textual interpretation, and developed a perspective of hermeneutics that considers language, reflection, understanding and the self (Geanellos, 2000, p.113). These four components of Ricoeur's theory parallels the second hermeneutical cycle that arose in this thesis. The second "evident" cycle involved the analysis of the "text" frequently used only in qualitative approach, and the analysis of "movement". Both, verbal and nonverbal language fractals, were considered as the starting points of this second cycle. Based on

Case study methodology, they were considered subunits of analysis. The verbal subunit analysis was a reflection about spoken language, and interpreted as an understanding of the mental layer of the self. The nonverbal subunit analysis was a reflection about language manifested by the body, and was interpreted as an understanding of the corporal layer of the self. Verbal and nonverbal languages were then considered as fractals of a complex whole unit: the self. The Np-Pt relationship constituting each case, were the complex units considered as the ending points of the second cycle. Nurse-as-a-whole, and patient-as-a-whole were considered the fractals of a much more complex unit of analysis: the relationship between selves.

Especially in this second hermeneutical cycle, objectivity, the most radical point in Ricoeur's theory, was applied. I established distance from the whole communication process, and thus from power (Np-Pt relationship through communication) by closely studying its fractals (Np´s and Pt´s body language and mind language), as objects of analysis. The nonverbal language was studied through Quantitative Analysis (Green and Salkind, 2007), using Hawkins' (1998) classification of *power vs. force kinesics behaviours.* The nonverbal language was objectified by assigning values to movements and, statistically analyzing each subject and each relational patterns. The verbal language was subjectively studied through Conversation Analysis (Bryman, Teevan & Bell, 2009), applying its assumptions and methodologies.

Observing the fractals close enough, my interpreter eye was *distanciated* to better appreciate the whole, and ***vice versa***. A second and deeper *appropriation* of the topic took place at this cycle, when I started having hints of the practical aspects reflected in

the analysis, of what was written on the theoretical framework around power. With appropriation and the awareness that the theoretical framework was able to discover power manifestations, a better and deeper explanation of the phenomenon allowed the interpretation and understanding of the hermeneutical circle over the third cycle. The ending point of the second cycle was the quantitative results and qualitative findings unveiling the fractals of power.

The third cycle, comprised generalizations of findings and results: *Interpretation,* a deeper understanding and generalization about the topic, were only possible by bringing multiple methods and multiple results into a hermeneutic metaphorical overall interpretation. Ricoeur's notion of *metaphoric truth*, addressed in works such as *The Rule of Metaphor* (1977) supported my decision that the whole study was going to be driven by an art metaphor.

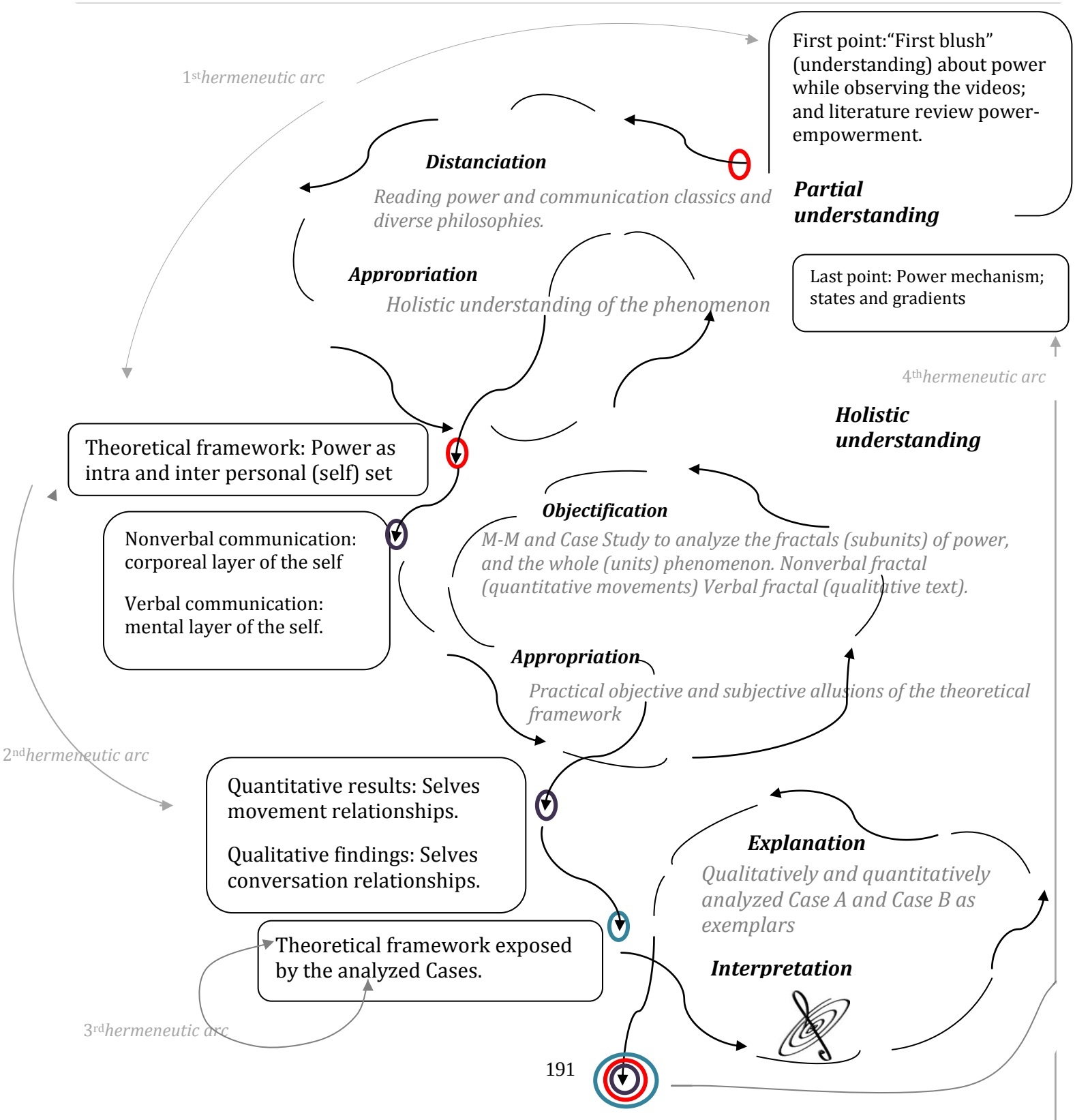
The third "evident" hermeneutical cycle was completed when embracing the fractals into the whole. This was accomplished by pairing the movements and the psychological interpretation of *self* development, to a music interpretation of relationship development. The third cycle included the two previous cycles. The three previous cycles were the starting point of the fourth cycle. In this last cycle the interpreter eye returned *herself* to the wholeness of the situation, and revised the cases to be generalized as two exemplars of two different power manifestations. In a holistic understanding of power, other substantial findings were discovered.

Explanation of the phenomenon was possible by interweaving the theoretical framework to the exemplars. *Interpretation* was possible by exercising the hermeneutical

concept of *metaphorical truth*. Using a non-moral driven hermeneutical metaphor, I was able to demystify the perception contained in the common view, that power is a negative force while empowerment is its positive opposite, and support the less frequent perception around power. The ending point of the second cycle was the holistic *understanding* of power: "power is relations".

My thesis, thusly met its purpose: It revealed care power through metaphorically maximizing differences between cases representing its two mechanisms of expression. Moreover, the process of these mechanisms were studied. Other findings were discovered, among which one of the power mechanisms was observed as something else. Figure 4.6, explains the hermeneutical circle aligning theoretical, qualitative and quantitative paths to power.

Figure 4.6
Three cycles, One Circle: Unveiling Power Through Hermeneutics



Following a hermeneutical structure, the *two instrumental case study (Multiple Case embedded)* (second cycle) entailed three levels of analysis. From particular to general, or from the "fractals" to the "whole", the first level of analysis included a quantitative analysis of the body movement happening in the Np-Pt interaction, and a qualitative analysis of the mind speech occurring in each case. In this first analysis I observed what is privileged in the body language or movement that is not privileged in the mind language or speech, and vice versa. The second level included the integration of the body movement and the mind speech of each person (Np and Pt) in both Cases. This level maximized the differences between cases, and related the processes by looking closely to the particulates, and in perspective to the wholeness, of each particular case. Cases were not compared to each other, but within their level of analysis, their study, which allowed us to differentiate one mechanism of power expression (Case A) from the other (Case B), and the process from one manifestation to another. This resulted into a general verbal-nonverbal relational discovery.

From theoretical revision to data analysis.

The quality of health care power, or health care relationships framework is exemplified by analyzing the sounds (harmonious or dissonance) and the textures (mono, homo, polyphony) of movement and words. Their evolution along time, is studied by analyzing the process of cadences (half and authentic).

Nonverbal Data Analysis.

Nonverbal communication was registered by 15 different channels applying Hawkins (1995, 1998, 2000) categories. It was analyzed using SPSS Version 18.1 (Green & Salkind, 2008), and interpreted using music nomenclature. The overall results were then related to the qualitative findings, and interpreted exercising the hermeneutical circle (Caputo, 1987; Geanellos, 2000; Tan, Wilson, & Olver, 2009; and Ricoeur, 1978).

The *Quality* of the nonverbal relationship between nurses and patients in Case A and Case B was revealed by the *Sounds and Textures of Movement*. It was based on equitability of potentials between each pair (Np and Pt), and the level of relationship. The process of overcoming struggle and building *Quality* relationship over time can be developed and finalized into certain *Cadences*. The Cadences of the nonverbal interactions were studied from the significant changes that the relationship suffered over time. The changes are expected from a less to a more harmonious sound, and from a less to a more polyphonic texture.

Sounds of Movement and *Textures of Movem*ent are the predetermined channels representing the body fractals being registered and studied to "hear" the body as a whole. *Sounds of Movement* channels included: distance, orientation, flexibility, smoothness, head-face affirmation, openness, and head-face expressive dynamism. Their combination gives the *Sound* of the relationship; harmonic or dissonance. *Textures of Movement* channels included: touch, eye contact, presence, head-torso-arms-hands dynamism, and moving lips to talk. Their combination gives the *Textures* of the relationship; monophonic, homophonic or polyphonic. The *Cadences* were studied by analysing the

sounds and textures of movement behaviours during the course of three intervals of time. The combination of *Textures and Sounds* in a *cadent* process constitutes the Quality of a relationship.

Every channel was considered a separate dichotomous variable. Sounds of movement channels contain two values, 0 for disruptive potentials, and 1 for constructive. Textures of movement channels contain two values, 0 for silence and 1 for voice.

Binary databases allowed the construction and analysis of scale and ordinal variables. Different statistical tests were applied to answer the different questions addressing one of the three quantitative hypotheses.

- **To study equity** in the relationship, significant or no significant differential of potentials were analyzed.
- **To study** if a **relationship** was built, significant or no significant associations were analyzed.
- **To study types** (dissonant or harmonious, and mono, homo or poly) **and levels** (disruptiveness to constructiveness and silence to shared voice) **of relationships,** and the **cadent process (**changes in type and levels of relationships over time), more complex correlated variables, using the simpler variables, were constructed.

Table 4.15 shows the questions derived from hypotheses 1, 2 and 3, and corresponding inferential tests, applied to solve them.

Table 4.15
Nonverbal communication tests, for Sounds and Textures of Movement analysis

Sounds	Test	Textures
	Tests for Particular questions Hypothesis 1	
Q1. 1	X^2 'test of independence, & Fisher's Exact Test for variables that present cells with expected value less than 5 category (Data sets 1A and 1B).	Q1.2
	Tests for General results Hypothesis 1	
Qs1.3	*T-test* for two independent groups & Mann-Whitney U (Data sets 1A and 1B)	Qs1.4
	Tests for Particular questions Hypothesis 2	
Q2.1	Cramer`s V (Effect Size) (Data sets 2A and 2B)	Q2.2
	Tests for General results Hypothesis 2	
Q2.3	Kendall's Tau b and Pearson r (Data sets 2A and 2B)	Q2.4
	Cadences tests Hypothesis 3	
Q3.1	Kruskal Wallis Test, Mann-Whitney U test with Bonferroni correction for Post hoc tests (Data sets 3A and 3B)	Q3.2

Note. Data sets 1A and 1B are *combined sets of data* (*Channels*) for every case.
Data sets 2A and 2B are *individual data sets (Np1 channels and Pt1 channels)* for every case.
Data sets 3A and 3B are *data sets* with s*hared variables* (*Np1Pt1 and Np3Pt3 channels*) for every case.

Data sets 1A and 1B were used to test significant differences between Np1 and Pt1 and Np3 and Pt3, to corroborate Hypothesis 1, and to answer questions 1.1 to 1.4. Data sets 2A and 2B were used to test significant associations in hypothesis 2, and to answer questions 2.1 to 2.4. Data sets 3A and 3Bwere used to test any significant changes in the interaction over the course of time, and to answer questions 3.1 to 3.4.Inferences based on hypothesis 1, 2 and 3 results were used to maximize the *Quality of relationship* differences between Case A and Case B, in terms of *Sounds, Textures and Cadences of Movement*.

Verbal Data Analysis.

Verbal communication was analyzed through Conversation Analysis (CA) methods (Breeman, Tevan & Bell, 2009), and supported by various communication theorists (Britton, 2001; Condit, 2006; Shepherd, 2006; Wittgenstein, 2000) and by Wilber's integral psychology theory concepts. The overall findings were related to the quantitative results and interpreted implementing the hermeneutical circle (Caputo, 1987; Geanellos, 2000; Ricoeur, 1978; Tan, Wilson, and Olver, 2009).

The *Quality* of the verbal relationship between nurses and patients in Case A and Case B was given by the *Sounds and Textures of Words*. The Quality of the speech was based on equitability of conversational elements between each pair (Np and Pt), and the level of conversational response and repairs that were made to build an equitable relationship. The process of overcoming struggle and building *Quality* relationships over time developed and finalized in certain *Cadences*. The Cadences of the nonverbal interactions were studied from the conversational changes that the relationship endured over time, from a less to a more harmonious sound, and from a less to a more polyphonic texture. It was also studied from how the health struggle and the relational struggles were solved, grounded on conversational data.

Conversation Analysis (CA) is one of the two approaches for the study of language. The other is discourse analysis. CA is "a multifaceted approach- part theory, part method of data acquisition, part method of analysis" (Breemand, Tevan and Bell, 2009, p.303). These authors affirm that the analysis of speech in natural settings fits well with the qualitative naturalistic paradigm; and the systemic procedures fits well with the

quantitative paradigm. Although contextual and naturalistic analysis without prior theoretical commitments, are qualitative features found with CA, rigorous systems of analysis with reproducible results are also required. "It is not surprising, therefore, that CA sometimes described as having a positivist orientation" (Breemand, Tevan & Bell, 2009, p.303). Though, the authors affirm that through CA "a cluster of features tuned with qualitative research, are married to traits that are found with quantitative research" (Breemand, Tevan & Bell, 2009, p.303).

Transcripts were analyzed using the next CA assumptions and methods. The first assumption is that speech is structured. This means that talk comprises patterns, and implicit rules that participants follow in awareness. The focus of conversation analysts is most often "the underlying structures of talk revealed in its pauses, emphases, questions, preceding answers, etc." (Breemand, Tevan & Bell, 2009 p.303). The second assumption is that talk is forged contextually. Although qualitative researchers identify context as a broader cultural aspect, conversation analysts study only the context in which the conversation was held.

Case studies require a description of the facts developed over the course of time. The first stage of the qualitative analysis for this thesis comprised a factual synopsis of the context, and a summarized version of the interaction. In this first stage, the characters involved in the Case were described, as well as the principal and secondary health struggles. Macro (i.e. health system) and micro (i.e. Np and Pt) relational struggles were also illustrated. In the context and the summary of the encounter, I pointed out the major questions, demands, or intentions for which the appointment was scheduled.

The second stage encompassed the conversational analysis in itself. The methodological elements used for this stage were: codes, turn taking, adjacency pairs, and preference organization. Although pronouns, and topics are not explicitly considered as part of CA tool, for the purpose of this thesis, they were considered as such.

Codes are considered as words or sentences that have a function on the speech, within a certain context in the conversation. In Conversation Analysis, codes are used to highlight patterns of speech or recurring features that provide information of how speech is organized (Bryman, Teevan & Bell, 2009). According to these authors when analyzing a conversation, certain codes or patterns emerge from the data (e.g. shared codes, opening or ends of utterances, smoothening transitions, interruptions, short or prolonged pauses-silence, indications of turn taking, etc.). However, the same words, can acquire a different function in the conversation depending on a variety of elements. In this thesis, the tone of voice, the eye contact, the length of the pauses, and the combination with facial gestures determined the function of the words and the silences. Once these codes are identified, they are used to locate them in the transcripts (in this thesis Case A and Case B transcripts) in order to highlight conversational patterns. A complete list of the used codes and their description is in Table 4.16

Turn taking "illustrate that talk depends on *shared codes* indicating the end of utterances" (p.304). It is summarized by indicating that speakers take turns to talk while the others listen, taking minimal gaps of talk between them. *Simultaneous talk, long pauses and interruptions* are considered failures in communication. *Repair mechanisms* addressed the failures (see Table 4.16).

Topics were studied from a conversation analysis perspective, rather than from a content analysis point of view. *Length* and *topic turn* informed the resolution of questions 2 and 3. Nevertheless, *topics content* helped to contextualize the care encounters and the findings of questions 2 and 3 (for Topic turns, see Table 4.16).

Table 4.16
Codes, turn taking, and topic turn description

Code	Description
Opening or closing topic turns	Words or sentences used to start certain topic or to close it to start a new one.
Affirmation codes	Words or sentences used to reaffirm the other person.
Cutting codes	Words, sentences or questions used to abruptly change the conversation.
Smoothening codes	Codes that attempted to soften a question, topic change or cutting code.
Shared codes	Codes used by the both subjects; and codes that are simultaneously present in both subjects as a mirrored action. Sometimes the last one is call mirrored code.
Self-cutting codes	Codes that abruptly change or stop the fluency of one's conversation.
Intervention attempt codes	Words or sets of words used to *try* and participate in the conversation.
Interruption	Codes that terminate the other's continuation of speech.
Self-interruption	Codes that terminate our own continuation of speech.
Interruption repair	When two people talk at the same time, or when one interrupts the other, certain mechanisms are developed to maintain the conversation (i.e. silence).
Talk turns	These codes are used to transfer the other person the turn to talk.
Self-talk turns	Sentences or words used by the subject as a way to continue talking, or to change the topic within a monologue. Usually self-talk turns lead to self-topic turns.
False talk turn	A code that appears to transfer the conversation to the other participant, but is followed by a continuation of a monologue. It usually appears as a consequence of a self-talk turn, leading to a false topic turn, and conversation control.

Table 4.16 (continued)

Self-topic turn	Codes that are used to turn the topic in a conversation to a previous topic of the subjects' interest.
False topic turn	Start a previous topic once that topic was ended. Usually a false topic turn appears as a consequence of a self-topic turn.
Natural or agreed Topic Turn	The topic is ended with no force; usually an agreement of topic turn has an implicit agreement.
Forced topic turn	The topic is ended abruptly; it is usually with no implicit agreement between both. Usually a forced topic turn is used as a way to control the conversation.

Adjacency pairs consider two phases. The first one implies that a question, an invitation or a greeting, for example, posted by one person, will follow a response. The second one implies how the adjacency pair is supposed to respond.

Preference organization is quite similar to adjacency pairs phase 2. This tool entails that "some responses are preferred to others" (p.304) The key point of this tool is to study if the participants recognize the preference structure of the adjacency pair, and how does the response affect the conversation. Preference organization maintains that an accepted response needs no explanation, whereas a negative response does.

Pronouns analysis was done to illustrate if the characters in the case, changed perspective during the course of the encounter.

The qualitative Conversational Analysis used *Sounds, Textures and Cadences of Words,* as the theoretical and metaphorical underpinnings that were paired with the quantitative analysis. These constructions involved discovered themes in the analysis, informed by the theoretical framework and the CA methodology, as were observed in the hermeneutical Circle scheme. Every theme covered a range of discovered categories

(finings). Themes and categories represented the fractals from which the mind as a whole was “heard”.

Sounds of Words obviated the constructors of collaborative verbal behaviours, as well as the disruptors of attenuating verbal behaviours. *Textures of Words* clarified the orientation and the intentions contained in the verbal behaviours of the conversation. *Cadences of Words* illuminated the evolution of sounds and textures over time.

Theoretically, collaborative speeches were more likely to have no disruptions; and a more socio-centric orientation with an experiential based relationship between speakers. In contrast, controlling speeches were more likely to have more disruptions and no facilitators; and more autistic or narcissistic-egocentric orientation with an informational or rational/emotional exchange.

Table 4.17 displays the verbal communication methods that were used to answer the qualitative questions.

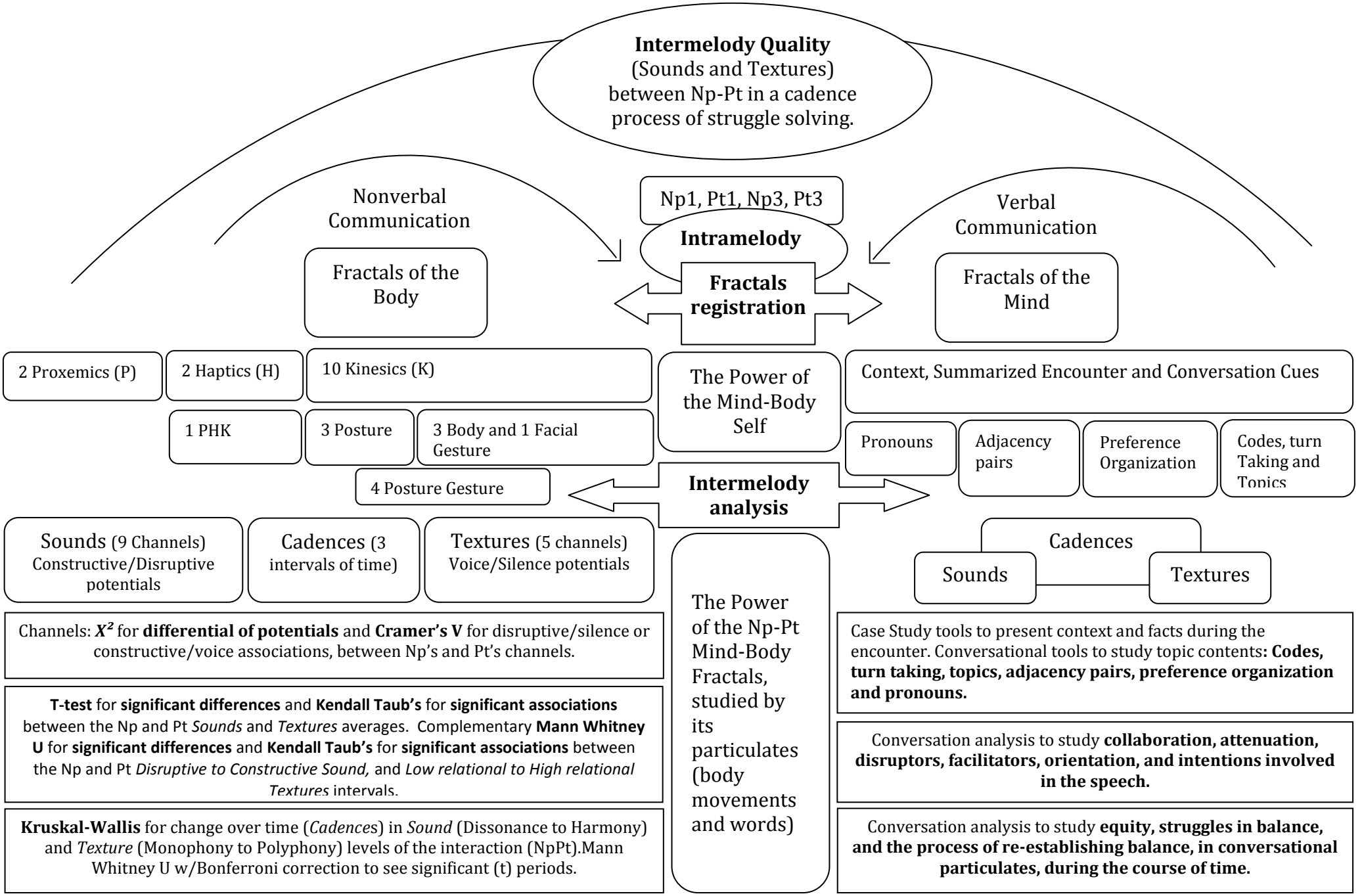
Table 4.17
Verbal communication tools, for Sounds and Textures of Movement analysis

Case Study and Conversation Analysis Tools	Qualitative Questions
Context, Summarized facts and Topic Content.	Q1: How is the Np-Pt encounter (Case A and Case B) being developed over the course of time, in terms of context and the particulates of the interaction? Q1 Secondary questions: Which are the main characteristics of the Np and Pt? How is the beginning of the interaction? Why did the patient come to see the Np? Which is the central health struggle to be addressed? Are there relational struggles during the encounter? Which is the climax in the interaction? Are the relational and or health struggles solved?
-Turn taking (*Simultaneous talk, long pauses, interruptions, and repair mechanism*) -Topic (*Topic turns, topic length and topic content*). -Pronouns -Adjacency Pairs (Ap) Ph1 -Preference Organization	Q2: How is the Np-Pt encounter (Case A and Case B) being developed over the course of time, in terms of Sounds and Textures of the conversation (Quality of Words)? Q2 Secondary questions: How are the requests and responses behaving over time between both characters? Are there some conversational disruptors and facilitators? (Sounds) Is the conversation particularly centered by someone? Is there a preference organization of requests and responses between Np and Pt? Are there conversational codes between them? If so: What are they and how do they work? (Textures) Are both (Np and Pt) equitably participating in the conversation in terms of (shared) codes, turns and topics?Is someone inviting to collaboration? Who and How? Is someone controlling the conversation? Who and how? (Combined)
	Q3: Are the conversational center, and the preferred conversational structure organization, moving over time? How are the conversational

	disruptors being solved and facilitators enhanced?
	Does the center of the conversation changed during the course of time? Does the preference organization changes (to a shared preference organization) along time? (Textures)What follows to a construction (invitation) or a disruption (interruption) in the conversation? (Sounds) How are the conversational codes, the talk turns, and the topic turns shifting? How are the topics ending? What follows if someone invites to collaboration? What follows if someone takes control over the conversation? How is equity balanced when that balance is broken? How is the transition from control to collaboration? (Combined)

Verbal and Nonverbal Analysis. The Mental Analysis Model (*MAM*) exhibited in Figure 4.7 depicts how the qualitative and quantitative analyses were paired.

Figure 4.7
Mental Analysis Model (MAM)



Stage 5. Data Integration and Generalization of results

In Chapter 6 a Mental Model of Integration (MMI) of results is used to illustrate the mind-body fractals of the micro relation Np-Pt integration, with music language.

Stage 6. Addressing design quality and interpretative rigor

The term validity is used in the quantitative approach to determine the rigor criteria for an objective measurable reality. Dellingerand Leech (2007), in their article Toward a Unified Validation Framework in Mixed Methods Research, explain how the term validity has been losing currency because of its ambiguity. In quantitative research, "objective" research is attained through internal and external validity, reliability, and objectivity (Bryman, Teevan & Bell, 2009). In contrast, the term trustworthiness is used in the qualitative approach. Guba and Lincoln identified trustworthiness criteria, which parallel conventional validity criteria; credibility, transferability, dependability and conformability (Guba& Lincoln, 1989).

In M-M, "the term legitimization, as opposed to validity, is used because of the connection of the word validity to the quantitative research paradigm." (Dellinger & Leech, 2007). For the "legitimization" of M-M research Teddlie and Tashakkori (2003), suggest that *inference quality* is a "better term to use when describing the mixed (QUAL and QUAN) results" (p.37) in mixed-methods research. Three aspects of inference ***quality*** are *design quality, interpretative rigor,* and *inference transferability* (Bickman & Rog, 2009; Dellinger & Leech, 2007; Teddlie & Tashakkori, 2003).

Design Quality. Design Quality refers to the degree to which the investigator has used the best methods, adequately, to answer the research questions, and if their implementation was effective (Bickman and Rog, 2009). The criteria for design quality include: *suitability (translation fidelity)* which considers whether the method of study

was appropriate to answer the research questions; *adequacy/fidelity* reflects if the stages and steps (elements) of the design were implemented adequately; *within design consistency* reflects if the components of the design fit together in a seamless and cohesive manner; and *analytic adequacy,* reflects if the data analysis techniques are appropriate and adequate for answering the research question(s). (Bickman & Rog, 2009; Dellinger & Leech, 2007; Teddlie & Tashakkori, 2003).

In this thesis *suitabilty, design consistency* and *analytic adequacy* were fulfilled through the five stages proposed by Stake (2005) and Yin (2003, 2009) for this *Two-case instrumental Case Study:* 1) Selection of the Cases. 2) Stipulation of rival theories. 3) Using multiple cases as part of the same case study. 4) Data Collection and Data Analysis: Strengthening the Evidence. 5) Data Integration and Generalization of results.

Interpretative rigor. Interpretative rigor is used to evaluate the degree of credibility in the interpretations.Interpretative rigor includes the following. *Interpretative consistency* evaluates if multiple conclusions closely follow the findings, and if the level of intensity reported is consistent with the magnitude of the found events or effects. *Theoretical Consistency (explanation credibility),* evaluates if explanations of the results and the relationships are consistent with current theories and empirical findings. *Interpretative Agreement*, evaluates the degree to which peers, participants, other scholars and/or the scientific community are in agreement with the manner in which the conclusions were drawn. *Interpretative Distinctiveness* evaluates if the investigator was able to refute or eliminate other plausible explanations (hypothesis, informant interpretations, or participant constructions) of the results. And *Integrative Efficacy* that evaluates the "degree to which inferences made in each strand of a mixed methods study are effectively integrated into a theoretically consistent meta-inference."

(Bickman & Rog, 2009, p.311).The criteria to address *interpretative rigor* was accomplished through the meticulous review by my committee members at all the stages above, particularly with the construction of rival theories, data analysis and data integration stages. These criteria were also fulfilled by assuring a proper model of integration.

Inference transferability. Inference transferability integrates the terms *external validity* addressed by quantitative rigor and the *transferability* addressed by qualitative rigor. It considers the generalization of results (Bickman & Rog, 2009; Teddlie & Tashakkori, 2003). Bickman and Rog (2009) suggest that even though some authors regard sampling adequacy as the main determinant of the degree of transferability, it depends on the similitude of results between the study and the past, current or potential studies that address, for example, the same phenomenon. They agree in that determining this is beyond the scope of the investigator knowledge and resources. Inference transferability was addressed by following and enriching the proposed sampling procedure, as well as the data collection and analysis. To achieve *external validity* Visentin and Awosoga closely examined the proposed quantitative variables for *kinesics, haptics and proxemics* dimensions. To assure transferability, Gregory engaged and reviewed the qualitative variables and the integrative findings.

Stage 7. Ethical Considerations

As proposed in the SAGE Handbook of Qualitative Research, "Case studies often deal with matters that are public interest but for which there is neither public nor scholarly *right to know."* (Stake, 2005, p. 459). For this matter, it was crucial to fully comply the M-M ethical principles.

This proposal was part of a study previously submitted for ethical review. It received

ethical approval from the University of Manitoba, Faculty of Medicine, Health Research Ethics Board (HREB) (2006). Confidentiality of participants was assessed by giving each participant an identification (ID) number; names were removed from all transcripts. The videotape encounters were viewed only by the members of the team, and the faces the names and the particulars of each case were not revealed. Right for refusal or withdrawal at any time was clarified in the letter of consent. The CD's with the videotape encounters remain locked in a secure drawer; and the information will be disposed of as confidential waste after seven years.

Stage 8. Dissemination Strategies

The dissemination strategies will consist of a thesis that will be part of the University Library, and some potential publications. The literature review may be submitted to a Sociological nursing journal. The theoretical framework can be submitted either to a sociological or a philosophical nursing journal. The description of the method can be submitted to a Mixed Methods Journal. The Theoretical framework exemplified by the Case study results and findings, enlightened by a music metaphor, can be submitted to a health sciences journal.

CHAPTER FIVE: QUANTITATIVE RESULTS AND QUALITATIVE FINDINGS

Quantitative Results

Quantitative analysis consisted of nonverbal fractals that involved particulates (potentials). These particulates were different body channels (e.g. eye, arms-hands gesture, posture orientation).

Some of the body channels entailed an action/lack of action dichotomy (e.g. presence-no presence, moving lips to talk-no movement, eye contact-no eye contact). Metaphorically, those were considered as channels contributing to the nonverbal study of voice/lack of voice potentials. From this understanding, eye contact for example demonstrated an act of voice, and no eye contact demonstrated a lack of voice (no-voice or silence). These channels were considered as *Textures of Movement channels (TOMchs)*, describing the nonverbal interaction or the **Textures** in which the Np-Pt in every Case (A and B), was engaged: Monophonic (where there is voice of one individual only); Homophonic (where one voice predominated over the other); and Polyphonic (where both brought their voices to the interaction).

Other body channels entailed a disruptive/constructive dichotomy (e.g. closeness/farness –distance-; flexibility/rigidness -of head and body posture-; openness/secretiveness -of arms hands and fingers posture gesture). Metaphorically, those were the channels contributing to the nonverbal study of disruptive/constructive potentials. From this understanding, posture orientation for example demonstrated a disruptive nonverbal behaviour (individually-oriented) or a constructive nonverbal behaviour (other-oriented). These channels were called *Sounds of Movement channels*

(SOMchs), describing the nonverbal concordance and tension within the Np-Pt interaction. **Sounds** demonstrated: Dissonance (where tension between individuals existed), and Harmony (where concordance was possible).

Results for the first hypothesis (H1) in each Case (CA.H1 and CB.H1) addressed differential (significant differences) of potentials between Np and Pt in terms of SOMchs (constructive or disruptive), and TOMchs (voice potentials or silence). Results for the second hypothesis (H2) in each Case (CA.H2 and CB.H2), addressed the significant association of potentials in SOMchs and TOMchs. Results were based on three types of analysis: a) channel by channel (differences and associations); b) total of SOUNDS and TEXTURES channels (differences and associations); and c) level of constructiveness/sounds or voice/textures contributing to the relationship (differences and associations). Results for the third hypothesis (H3) in every Case (CA.H3 and CB.H3) defines differences among Sounds level and among Texture level as a function of time (Interval 1, Interval 2, Interval 3). To test significant differences in all the types of analysis, the variable Number of person (Np=1 & Pt=2; and Np3=4 & Pt3=5) was also used.

Table 5.0 displays the variables available for the analysis, and the type of test applied to corroborate the three hypothesis.

Table 5.0

Level and Type of variables (H1), (H2), (H3) and their statistical tests

H1 Differential of potentials variables and tests	Level and Type of Variable	H2 Association of potentials variables and tests
X^2		*Cramer's V*
IV= Number_Person (nominal) DV= Channel variable	Nominal (Dichotomous): -Channel by Channel (SOM & TOM) variables	2 IV= Np channel & Pt channel (for every SOM and TOM channel, per person)
T-test		*Kendal Tau b (linearity markedly violated)*
IV= Number_Person DV (SOM)= SOUNDS DV (TOM)=TEXTURES	Scale: -Total of SOM and TOM channel variables	2IV (SOM)= Np Sounds & Np Sounds. 2IV (TOM)=Np Textures & Pt Textures
Mann Whitney U and comparisons of *column proportions (z test)*		*Kendal Tau b*
IV=Number of person DV= Disruptiveness to Constructiveness	Ordinal: -Level of Constructiveness (sounds) variables.	2IV= Np Dissonance to Harmony & Pt Dissonance to harmony
IV= Number of person DV= From silence to voice	-Level of Voice (textures)	2IV= Np Monophony to Polyphony & Pt Monophony to Polyphony
H3 (Sounds and Texture Cadences) Differences among Time Intervals		
Kruskall Wallis		
IV= Time Interval Dv=Sounds level	Nominal: -Time Interval	
IV=Time Interval Dv= Textures level	Ordinal: -Sounds Level -Textures Level	

H1=Hypotheis 1; H2=Hypothesis 2; H3=Hypothesis 3; IV=Independent variable; Dv=Dependent variable; TOM=Textures of Movement; SOM=Sounds of Movement; Np=Nurse practitioner; Pt=patient.

In every case, for H1 and H2, the quantitative results are presented from general to particular. The nonverbal patterns (significant or not) are described first, as an introduction to the most outstanding nonverbal behaviours observed between Np and Pt (Case A and B) and their interactions. For H3, only one type of result for Textures and one for Sounds is presented.

Hypothesis 1: Results

Case A (*CA*).

From 14 analyzed channels, the TOM channel *Presence* is a constant. Therefore, no statistical test was available. The other thirteen *Sounds and Textures channels* (SOMch and TOMch respectively) were available for Case A analysis. Seven out of 13 channels (53.84%) presented no significant differential of potentials between Np1 and Pt1 as expected. Six out of 13 channels (46.15%) presented unexpected significant differential of potentials between Np1 and Pt1. During the 90 observational points (Ops) in the 15min encounter vignette, some patterns were found (See *Appendix A* tables of proportion A1 to A9 and A19-A23).

CA. Outstanding Sounds and Textures of Movement patterns.

Channels presenting no significant differences:

1. For *Haptics* (touch) both characters were silent (Np1 no touch= 87 Op; Pt1 no touch= 90 Op).
2. For *arms hand gesture* both presented more disruptive than constructive behaviours (Np1 demanding/complaining = 52 Op; Pt1 demanding/complaining= 46 Op).
3. In all the other channels, Np1 and Pt1 presented more constructive than disruptive, and more voice than silent potentials.

Channels presenting significant differences:

4. Np1 was moving closer (n=76 Op) to the Pt1, than the Pt1 (n=37 Op) to the Np1.
5. Np1 presented more flexibility in torso, neck and head (n=80 Op) than the Pt1 (n=65 Op).

6. Pt1 head, neck, face posture-gesture affirmation was more frequent (n=79 Op) than the Np1 (n=60 Op).
7. Np1 constructive facial gestures (n= 88 Op) were slightly more frequent than the Pt1 constructive facial gestures (n= 74 Op).
8. Pt1 was moving her lips to talk (n= 60 Op) more frequently than the Np1 (n=44 Op).

Sounds.

Sounds CA.H1 Total channels' analysis (t-test).

Using the variable *SOUNDS,* A *t*- test was conducted to determine whether the average number of constructive potentials that Np1 had over a 15min interaction period (M=6.90; SD=1.399) was significantly different from the average number of constructive potentials that Pt1 had over the same period of time (M=6.20; SD=1.868). There were no missing values. The *t* statistic was significant, t (164.946) = 2.846, p = .005 (2 tailed), indicating that in SOMch averaged channels, there was a differential of potentials.

Sounds CA.H1 Level of constructiveness-disruptiveness analysis (Mann-Whitney)

Using the Disruptiveness-to-Constructiveness variable, A Mann-Whitney U test was conducted to test whether the level of constructive potentials (Level I-Disruptiveness=1; Level II-From disruptiveness to constructiveness= 2; Level III-Constructiveness=3), brought by the Np1 (n=90) to the interaction, differed from the level of constructive potentials brought by Pt1 (n=90). There were no missing values. The average number of Np1 potentials was 2.84 (SD=.364). The average number of Pt1 potentials was 2.51 (SD=.364). The mean rank between both was significantly different

U=2890, Z= -4.182, $p < .001$ (2 tailed). The following pattern in the relationship was found:

a) There were more *constructive potentials* (Np=76 Op; Pt=51 Op), than *from disruption to construction* (Np1= 14 Op; Pt=34 Op) and *disruptive potentials* (Np1=0Op; Pt=5Op). Although there was significant differential of constructive potentials, it was based on constructive more than disruptive potentials.

b) The Pt1was moving toward more *constructive behaviours* (n=54 Op) compared to the Np1 (n=14Op), which already had a high level of construction (Np=76 Op) (*See Table 5.3*).

Sounds CA.H1 Channel-by-channel analysis (Chi square).

X^2 channel-by-channel analysis showed that the following SOMch's were responsible for the differential of constructive potentials between Np1 and Pt1: *Distance*, X^2 (1, N=180) = 36.162, $p < .001$; *Gross posture flexibility*, X^2 (1, N=180) = 7.980, $p < .005$; *Body gesture smoothness*, X^2 (1, N=180) = 18.514, $p < .001$; *Posture gesture affirmation*, X^2 (1, N=180) = 11.402, $p < .001$; and *Facial gesture*, X^2 (1, N=175) = 14.205, $p < .001$ (See Table A for comparison with the rest of the channels).

Channels that presented no significant differences contributing to a harmonious relationship were*: Orientation; Posture gesture openness; Posture gesture dynamic expressiveness; and Body gesture requesting/explanation* (See Table 5.1 for comparison with the rest of the channels).

Textures

Textures CA.H1 Total channels' analysis (T-test).

Using the variable *TEXTURES* , a *t*- test was conducted to determine whether the average number of voice potentials Np1 over a 15min interaction period (M=2.79;

SD=.918) was significantly different from the Pt1's (M=2.94; SD=.812). There were no missing values. The *t* statistic was not significant, *t* (178) = -1.204, *p* = .286 (2 tailed), indicating that Np1 shared the same amount of voice than the Pt1.

Textures CA.H1 Level of voice analysis (From silence to voice) (Mann Whitney).

Using the variable From silence to voice, a Mann-Whitney U test was conducted to determine whether the level of voice (Level I=No voice; Level II=Individual voice in relationship building-; Level III=Sharing voice) (1=no voice, 2= individual voice, 3= shared voice) brought by the Np1 (n=90) to the interaction, differed from the level of voice brought by Pt1 (n=90). There were no missing values. Average amount of the Np1 voice was 2.84 (SD=.445) and for the Pt1 was, 2.71 (SD=.456). The mean rank between both did not differ based on Mann *U*=3960, Z= -.331, *p. =.740* (2 tailed), indicating that there are no significant differences in the level of voices (textures) between Np1 and Pt1, being both in the highest relational level (Np=62Op; Pt=64Op).

Textures CA.H1 Channel-by-channel analysis (X^2).

X^2 channel-by-channel analysis showed that *Moving lips to talk*, X^2 (1, N=180) = 5.830, *p*= .016, was the only channel that presented differential of voices between Np1 and Pt1 (See table 5.1 for comparison).

The next channels presented no significant differences, contributing to an equity of nonverbal voices in the relationship: *Touch* (Fisher's exact test); *Eye contact*; and *Body-posture-facial-gesture dynamism*. (See Table 5.1 for comparison).

Tables of proportion (A1 to A9 and A19 to A23) in the *Appendix 1* show that even in channels presenting differential of potentials between Np1 and Pt1, the most frequent behaviours from both characters are constructive and voice potentials. Results of this nature indicate an overall harmonious care encounter for Case A.

General and particular results show that in comparison, TOMchs presented less differential of potentials between Np1 and Pt1, than SOMchs. Thus, voice was more equitable between both characters, than constructive behaviors. In spite of this, constructive behaviors were more frequent than disruptive.

Hypothesis 1 results for every channel are available in Table 5.1.

Case A

Table 5.1

Types and specific Case A channel test and p values for significant and non significant differential of potentials

Type	Specific Channel (N=190)	Test value (Chi-square or Fisher's –F-)	*P* value	Sig.	Non-sig.
SOMchs	Distance	36.162	*p*< .001	X	
	Orientation	826	*p*= .363		X
	Gross posture flexibility	7.980	*p* < .005	X	
	Body gesture smoothness	18.514	*P* <.001	X	
	Posture gesture affirmation	11.402	*p* <.001	X	
	Posture gesture openness	2.877	*p*= .090		X
	Posture gesture dynamic expressiveness	1.006	*p*=1.000 (F)		X
	Body gesture requesting/explanation	.806	*p*= .369		X
	Facial Gesture (N=175)	14.205	*P* <.001	X	
TOMchs	Presence	Not possible	Constant (Np1 -50% voice-, Pt1 -50% voice)		
	Touch	3.051	*p*= .246 (F)		X
	Eye contact	.096	*p*= .757		X
	Body-posture dynamism	.024	*P=.877*		X
	Moving lips to talk	5.830,	*p*= .016	X	

Note. F= Fisher's Test

Case B (*CB*).

From 14 analyzed channels, ten out of 14 channels in Case B (76.92%) presented a significant differential of potentials. Four out of 14 channels (30.76%) presented no significant differential of potentials. The channel *Touch* reflected a constant no potential ('silence'). Therefore, no statistical test was available for this channel. The other thirteen *Sounds and Textures channels* (SOMch and TOMch) were available for Case B analysis.

CB. Outstanding Sounds and Textures of Movement patterns.

During the 97 Observational points (Ops) in the 16min10sec encounter vignette, the following patterns were found (For more detail see Appendix A tables of proportion A10 to A18 and A25 to A28).

About channels presenting significant differences:

1. The Pt3 talked more (n=43) than the Np3 (n=24), which infers that Np3 was frequently in silence (n=73).
2. Both Np3 and Pt 3 were farther apart (disruption) than closer to each other; Pt3 stayed farther (n= 95) from the Np3, even when the Np3 got closer (n=75) to the Pt3.
3. Both, were more *individual* (disruption) than *other* oriented; though, Np3 had more other oriented posture (n=24) than the Pt3 (n=2).
4. Almost half of the time, Pt3 was in a rigid posture (n=47) and half of it in a more flexible posture (n=49), but Np3 was in a rigid position (disruption) for most part of the entire observed vignette (n=81).

5. The Np3 affirmed the patient less (n= 29), than the Pt3 affirmed the Np3 (n=59); by consequence, Pt3 was more neglected by the Np3 (n=68), than the Np3 neglected by the Pt3 (38).
6. Both, Np3 and Pt3 had more closed body posture-gesture (disruption) than opened body posture gesture; Pt3 was more closed (n=78) than Np3 (n=58).
7. Both Np3 (n=89) and Pt3 (n=76) facial gestures reflected disruption.
8. The Pt3 was present during the 97 Ops (100%), whereas the Np3 was present in only 75 Ops (77.31%).
9. The Pt3 (n=96) showed more face-head dynamic expressiveness than Np3 (n=74).

About channels presenting no significant differences:

10. The Np3 (n=62) and Pt3 (n=68) had static (silence) head, torso, arms and hands.
11. The Np3 showed slightly more body gesture smoothness (n=57) than the Pt (n=53).
12. The Np3 (n=87) and Pt3 (n=84) arms and hands reflected demanding and complaining gestures (disruptive), rather than requesting or explaining gestures.
13. The Np3 (n=70) and Pt3 (n=68) had less eye contact (silence), than eye contact (Np3=27, Pt3=29).
14. The Np3 (n= 0) and Pt3 (n=0) had no haptics interaction at all

Sounds.

Sounds CB.H1 Total channels' analysis (t-test).

Using the variable *SOUNDS*, a *t*- test was conducted to determine whether the average number of disruptive potentials Np3 exhibited over a 16min10sec interaction period (M=2.85; SD=1.873) was significantly different from the average number of

disruptive potentials that that Pt3 had over the same period of time (M=3.20; SD=1.222). There were no missing values. The *t* statistic was significant, *t* (165.179) = -1.544, *p* =.010 (2 tailed), indicating that there were significant differentials between the Np3 disruptive potentials, and the Pt3 disruptive potentials.

Sounds CB.H1 Level of constructiveness-disruptiveness analysis (Mann Whitney).

Using the variable Constructiveness to Disruptiveness, a Mann-Whitney U test was conducted to test whether the level of constructiveness (Level I-Disruptiveness=1; Level II-From disruptiveness to constructiveness= 2; Level III-Constructiveness=3) brought by the Np3 (n=97) to the interaction, differed from the level brought by Pt3 (n=97). There were no missing values. The average amount of Np3 potentials was 1.46 (SD=.578) and average of amount of Pt3 potentials was, 1.44 (SD=.520). The mean rank between both was not significantly different *U*=4689, Z= -.004, *p. =.965* (2 tailed). The Table of proportions (Table 5.3) shows that in the overall relationship:

a) The level of disruptiveness from the Np3 (n=56) and Pt3 (n=55) in the interaction, was more frequent than the progress to constructive, or constructive level.
b) Pt3 (n=37) was moving toward a more constructive behaviour compared to the Np3 (n=41).
c) Np1 (n=4) was more likely to bring constructiveness to the relationship compared to the patient. Pt1 (n=1).

Sounds CB.H1 Channel-by channel analysis (X^2)

X² channel-by-channel analysis showed that the next SOMch presented differential of potentials between Np3 and Pt3, contributing to a dissonant relationship. The following channels presented significant differences: *Distance*, X² (1, N=193)= 21.522, *p*< .001; *Orientation*, X² (2, N=194)= 25.52, *p*< .001; *Gross posture flexibility*, X² (1, N=193)= 25.781, *p* <.001; 4); *Posture gesture affirmation*, X² (1, N=194)= 18.718, *p* <.001; 5); *Posture gesture openness*, X² (1, N=194)=9.838, *p* <.001; 6); *Posture gesture dynamic expressiveness*, X² (1, N=194)= 23.014, *p* <.001; and *Facial gesture*, X² (1, N=189)= 9.186, *p*= .002.

Channels with no significant differences included: *Body gesture smoothness and Body gesture requesting/explanation*. *Smoothness* contributes to a constructive nonverbal process. On the contrary, demanding/complaining arms and hands, contributes to the disruptive nonverbal Case B result.

Textures.

Textures CB.H1 Total channels' analysis (t-test)

Using the variable *TEXTURES*, a *t*- test was conducted to determine whether the average number of voice potentials Np3 had over a 16min10sec interaction period (M=1.66; SD=1.198) was significantly different from the average number of voice potentials that Pt3 had over the same period of time (M=2.04; SD=.803). There were no missing values. The *t* statistic was significant, *t* (167.725) = -2.605, *p* =.010 (2 tailed), indicating that there were significant differentials between the Np3 and the Pt3's amount of voice.

Textures CB.H1 Level of voice analysis (From silence to voice)(Mann Whitney).

Using the variable From silence to voice, A Mann-Whitney U test was conducted to test whether the level of voice (Level I=No voice; Level II=Individual

voice in relationship building-; Level III=Sharing voice) brought by the Np3 (n=97) to the interaction, differed from the behaviour brought by Pt3 (n=97). There were no missing values. Average number of Np3 potentials was 2.05 (SD=.713) and average of number of Pt1 potentials was, 2.26 (SD=.440). The mean rank between both was significantly different *U*=4009.500, Z= -2.063, *p.* = .039 (2 tailed). In further observations, it was found that in the overall relationship:

a) Voices between Np3 and Pt3 were not equitably shared.
b) The level of silence by the Np3 was higher (n=22) then Pt3's level of silence (n=0).
c) The level of individual voice by the Pt3 (n=72) was higher than the Np3 individual voice (n=48).
d) The Np3-Pt3 levels of silence and individual voices were higher than the level of shared voices; individualized voices were almost equitable between Np3 (n=27) and Pt3 (n=25). (*See table 34*)

Textures CB.H1 Channel-by channel analysis (Chi Square).

X^2 channel-by-channel analysis showed that the following TOMchs presented differential of potentials between Np3 and Pt3, contributing to a dissonant relationship: *Presence*, X^2 (1, N=194) = 24.814, p <.001; and *Moving lips to talk*, X^2 (1, N=194) = 8.231, p= .004.

The TOMchs that presented no significant differences were: *Eye contact*, and *body-posture- dynamism*. Both channels contribute to a disruptive nonverbal overall Case B result. Tables of proportion (A10 to A18 and A25 to A28) in *Appendix 1* show that even in channels presenting no differential of potentials between Np3 and Pt3, the most frequent behaviours from both characters were disruptive and silence versus voice

potentials. Therefore, our results indicate an overall dissonant care encounter for Case B.

Case B General and particular results show that voice was found inequitable in 2 channels (*Presence* and *Moving lips to talk*), and it was found equitable in the other 2 channels (*Eye contact* and *body-posture- dynamism*) between both subjects. This suggest a certain level of equity. However, disruptive behaviors were more frequent than constructive. Even in equity, disruption was present.

Hypothesis 1 results for every Case B channel are available on Table 5.2.

Case B

Table 5.2
Types and specific Case B channel test and p values for significant or non significant differential of potentials

Type	Particular Channel (N=194)	Test value (Chi-square or Fisher's –F-)	*P* value	Sig.	Non-sig.
SOMchs	Distance (N=193)	21.522	*P <.001*	X	
	Orientation	25.52	*p* <.001	X	
	Gross posture flexibility (N=93)	25.781	*p* <.001	X	
	Body gesture smoothness	.336	*p*= .562		X
	Posture gesture affirmation	18.718	*p*< .001	X	
	Posture gesture openness	9.838	*p*= .002	X	
	Posture gesture dynamic expressiveness	23.014	*p* <.001	X	
	Body gesture requesting/explanation	.444	*p*= .505		X
	Facial Gesture (N=175)	9.186	*p*= .002	X	
TOMchs	Touch	Not possible	Constant (Np1 -50% silence-, Pt1 -50% silence).		
	Eye contact	.100	*p*= .751		X
	Presence	24.814	*p* <.001	X	
	Body-posture dynamism	.839	*P=.360*		X
	Moving lips to talk	8.231	*p*= .004	X	

Note. 5 channels present no significant differential of potentials.

Maximizing difference 1: Sounds of Movement differential of potentials

In Table 5.3 we clearly see how the pattern of Case A results (Np1=76, Pt1=51 constructive behaviours) is related with Case (Np3=56, Pt3=55 disruptive behaviours)

in the exact opposite direction of construction and disruption. Both cases have difference of potentials between the Np and the Pt in each case, but clearly, Case A represents a more constructive relationship than Case B. However, for the frequency of the level *in constructive progress*, we can see that the Np and Pt from Case B are moving towards construction.

This comparison also shows the pattern of behavior of the Np. In Case A, the Np is more constructive in her approach than in Case B where she maintains an overall disruptive level.

Table 5.3
Maximized differences between case A and B in the distribution of constructive potential categorizations as a function of subject (Np and Pt) (Table drawn from Mann Whitney U tests)

	Case A		Case B	
	Np1	Pt1	Np3	Pt3
Disruptiveness (0 to 3 shared constructive potentials)	0	5	**56**	**55**
In constructive progress (4 to 5 shared constructive potentials)	14	34	37	41
Constructiveness (6 to 9 shared constructive potentials)	**76**	**51**	4	1

Maximizing difference 2: Textures of movement differential of potentials

Table 5.4 illustrates how Case A results are exactly opposite to Case B results in terms of Texture. In Case A there is no significant difference in the nonverbal voice between Np1 and Pt1. In contrast, Case B presents a difference of the voice frequency between Np3 and Pt3. Case A presents a shared voice exemplar, while Case B represents an individualized voice exemplar. This suggests that when voices are shared,

there is no differential of potentials. In contrast, when an individual voice prevails there is a differential of potentials that may or may not move forward in a path of shared voices.

Table 5.4

Maximized differences between Case A and B in the distribution of constructive potential categorizations as a function of subject (Np and Pt) (Table drawn from Mann Whitney U tests)

	Case A		Case B	
	Np1	Pt1	Np3	Pt3
No voice (0 potentials)	0	0	22	0
Individualized voice (1 to 2 shared potentials)	24	26	**48**	**72**
More shared voice (3 to 5 shared potentials)	**66**	**64**	27	25

Hypothesis 2 Results

For particular analysis, each subject's (Np1, pt1, Np3, Pt3) channel functioned as an independent interval variable (Variable Person). *Cramer's* V was applied to test independent patient's variables against nurse practitioner's independent variables to establish significant associations within each pair (Questions 2.1 and 2.2).

For total channels results, several tests were used. *SOUNDS* and *TEXTURES* (Question 2.3 and 2.4), were both scale variables presenting no skweness or kurtosis. For this reason *Pearson r* was the best option for testing correlation between Np's and Pt's average potentials. However, Kendall Tau b were run because linearity assumption was markedly violated.

A set of Kendall Taub's were run to test associations between nurse practitioners and patient's Levels of Harmony (1= *Disruptive-Dissonance*, 2= *In process from dissonance to harmony*, 3=*Constructive-Harmonious*); and Levels of Relationship)

Case A

Of the 14 analyzed channels, the channels *Head face expressive dynamism* and *Facial gesture* represented constant constructive potentials between Np1 and Pt1. Both individuals were dynamic and had constructive facial gestures during their interactions. In contrast, *Touch* was a constant representing an equitable disruptive behaviour between both. Therefore, no statistical tests were available for these three constants.

The other eleven *Sounds and Textures channels* (SOMch and TOMch) were available for Case A association analysis. Among them, only two TOMchs out of eleven channels presented significant associations (18.18%). Nine presented no significant associations (81.81%).

CA. Outstanding Sounds and Textures of Movement patterns.

During the 90 Observational points (Ops) in the 15min encounter vignette, some patterns were found (See Appendix 1 Tables of proportion: A33 - A41 and A51-A55).

Some of the channels presenting no significant associations but showed constructive potentials; others presented a peculiarity; the frequency of the combination between NpPt constructive and disruptive potentials was higher that the frequency of the combination between NpPt constructive or disruptive potentials. The numbers contained in the next set of explanations are the observational points in which both, Np and Pt had the same behaviour. The combinations can be: a) disruptive-disruptive, b) constructive-constructive, and c) disruptive-constructive.

Distance (constructive=34;disruptive-constructive=45), *Orientation* (constructive=30, constructive-disruptive=46) , flexibility (constructive=56), *Smoothness* (constructive n=54), *Affirmation* (constructive n=53), *Openness* (constructive=37, constructive-disruptive=39), *Hands gesture* Requesting/Explaining-Demanding/Complaining (disruptive-constructive= 46), and *Eye contact* (voice=39, voice-silence=36). Results show that no significant disruption association was found between the Np1 and the Pt1.

In addition, the pattern frequently found in all the channels was that the Np1 and Pt1 relate to the other: a) with a constructive behaviour and equity of voices as well as b) with a disruptive-constructive behaviours and silence-voice, showing that the relationship was moving to a shared voices behaviour.

Sounds.

Sounds CA.H2 Association analysis for the total of channels (Kendall Tau B).

Using the variable *SOUNDS* a Kendall Tau B correlation was used to examine the association between Np1 number of constructive potentials –Np1SOUNDS- (M=6.90; SD=1.399), and Pt1 number of constructive potentials –Pt1SOUNDS- (M=6.20; SD=1.868). There were no missing values leaving 97 Ops available for the analysis. A non significant correlation was obtained, Tau= .025, *p=.767* (2-tailed).

Sounds CA.H2 Level of Dissonance-to-harmony association analysis (Kendall Tau B).

Using the variable Dissonance-to-harmony, a second Kendall Tau B correlation was used to examine the constructive-harmony level association (*1= Disruptive –Dissonance-; 2=In process from dissonance to harmony; 3= Constructive –Harmony-*) between Np1 (M= 2.84; SD=.364) and Pt1 (M=2.51; SD=.604). There were no missing values leaving 97 Ops available for the analysis. A non significant correlation was obtained, Tau= .002, *p*=.985.

Table 5.5 shows that a constructive-harmony level (Harmonious) prevailed in terms of sounds between the Np1 (84.4%) and Pt1 (56.7%). The subsequent more frequent level between the Np1 (15.6.1%) and Pt1 (37.8%) was the process level *from dissonance to harmony*. A disruptive level (Dissonance) was rarely found.

Table 5.5
Np1 and Pt1 constructive relationship level gathered from the sum of the nine Sounds of Movement channels (SOMchs)

Level	Frequency	Percent	Frequency	Percent
	Np1		Pt1	
Disruptive (Dissonant=0 to 3 constructive potentials)	0	0%	5	5.6%
From dissonance to harmony (4 to 5 constructive potentials)	14	15.6%	34	**37.8%**
Constructive (Harmonious= 6 to 9 constructive potentials)	76	**84.4%**	51	**56.7%**
Total	Op N= 90	100%	Op N= 90	100%

Sounds CA.H2 Channel-by-channel association analysis (Cramer's V).

As it was shown before, no particular SOMch had significant constructive or disruptive associations.

Textures

Textures CA.H2 Total channels' association analysis (Kendall Tau B).

The variable *TEXTURES,* a Kendall Tau b correlation was used to examine the association between Np1 voice average –Np1TEXTURES- (M=2.79; SD=.918), and Pt1 voice average –Pt1TEXTURES- (M=2.94; SD=.812). There were no missing values leaving 97 Ops available for the analysis. A high significant negative correlation was obtained, Tau= -.195, *p=.035* (2-tailed), indicating that Np1 voice and silence was significantly related to Pt1 voice and silence.

Textures CA.H2 Level of Monophony to Polyphony association analysis (Kendall Taub).

A second Kendall Tau b correlation was used to examine the relational level (Level 1-No (voice) related–Monophony=0; Level II-Individualized voice in progress of relationship building–Homophony=2; Level III-Highly (voice) related –Polyphony=3) association between Np1 (M= 2.73; SD=.445) and Pt1 (M=2.71; SD=.456). There were no missing values leaving 97 Ops available for the analysis. A significant negative correlation was obtained, Tau= -.218, *p*=.040, indicating that Np1 level of relationship was significantly related to Pt1 level of relationship. Table 5.6 demonstrates how the most frequent relational level of both Np1 (73.3%) and Pt1 (71.1%) was the highest relational level (Polyphony).

Table 5.6
Np1 and Pt1 relational levels gathered from the sum of the four Textures of Movement channels (TOMchs)

Level	Frequency	Percent	Frequency	Percent
	Np1		Pt1	
No relationship (Monophony = 0 voice potentials)	0	0%	0	0%
Individualized action in progress of relationship building (Homophony= 1 to 2 voice potentials)	24	26.7%	26	28.9%%
High relational level (Polyphony= 3 to 5 voice potentials)	66	73.3%	64	71.1%

Textures CA.H2 Channel-by-channel association analysis (Cramer's V).

Channels presenting significant association were: *Head-torso-arms-hands (HTAH) dynamism*, and Moving lips to talk. The first one shows a frequent pattern of dynamic association (n=42) of potentials between the individuals. The second one suggests that frequently when the Pt1 was talking, the Np1 was in silence (n=62). However, in 21Ops both of them were talking simultaneously, and in 7 Ops they were both in silence.

Case B

Of the 14 analyzed channels, *Touch* was a disruptive constant when Np3 and Pt3 did not touch each other; and *Presenc*e was a disruptive channel in which at least one cell (Pt3) was a constant. Therefore, no statistical tests were conducted. The other twelve *Sounds and Textures channels* (SOMch and TOMch) were available for Case B analysis. One SOMch and two TOMchs out of twelve channels in Case B (25%)

presented a significant association. Nine out of 12 channels (75%) presented no significant associations.

During the 97 Observational points (Ops) in the 16min10sec encounter vignette, some patterns were found. (For detailed information see *Appendix 1 tables of proportion A42-A50 and A56-A60*).

CB. Outstanding Sounds and Textures of Movement patterns.

Some of the channels presenting no significant association showed disruptive potentials; others presented a peculiarity; the frequency of the combination between Np3Pt3 constructive and disruptive potentials was higher that the frequency of the combination between NpPt constructive or disruptive potentials. The numbers contained in the next set of explanations are the observational points in which both, Np3 and Pt3 had the same behaviour. The combinations can be: a) disruptive-disruptive, b) constructive-constructive, and c) disruptive-constructive.

Channels presenting no significant association were: *Distance* (disruptive=73), *Orientation* (individual/disruptive=72), *Flexibility* (disruptive-constructive= 50), *Affirmation* (constructive=74) , *Openness* (closeness/disruptive=49), *Dynamic expressiveness* (static/disruptive=30 and disruptive-constructive =46), *Hands gesture* (Demanding/Complaining-disruptive=76), *Facial gesture* (disruptive=72), and *Head-torso-arms-hands dynamism* (silence=47, voice-silence=36).

Results show that no significant constructive associations were found between the Np1 and the Pt1. In addition, the frequent pattern in all the channels was that both of them related to the other in two ways. The first one is in a disruptive way and in equity

of silence. The second one is in a disruptive-constructive and voice-silence way, showing that subjects in case B were moving towards a more equitable relationship.

Sounds

Sounds CB.H2 Association analysis for the total of channels (Kendall Tau B).

Using the variable *SOUNDS,* a Kendall Tau b correlation was performed to examine the association between Np3 number of disruptive potentials –Np3SOUNDS- (M=2.85; SD=1.873), and Pt3 number of disruptive potentials –Pt3SOUNDS- (M=3.20; SD=1.222). There were no missing values leaving 97 Ops available for the analysis. A significant correlation was obtained, Tau= .222, *p=.007* (2-tailed).

Sounds CB.H2 Level of Dissonance-to-harmony association analysis (Kendall Tau B).

A second Kendall Tau b correlation was used to examine the constructive-harmony relationship level association (*1= Disruptive –Dissonance-; 2= In process from dissonance to harmony; 3= Constructive –Harmony*-) between Np1 (M= 1.46; SD=.578) and Pt3 (M=1.44; SD=.520). There were no missing values leaving 97 Ops available for the analysis. A significant correlation was obtained, Tau= .270, *p*=.007 in this variable. Table 5.7 shows how a disruptive-dissonant level prevailed in both the Np3 (57.7%) and the Pt3 (56.7%). The second more frequent level for both, Np3 (38.1%) and Pt3 (42.3%) was the process level from disruption-dissonance to construction-harmony.

Table 5.7
Np3 and Pt3 constructive relationship level gathered from the sum of the nine Sounds of Movement channels (SOMchs)

Level	Frequency	Percent	Frequency	Percent
	Np3		Pt3	
Disruptive (Dissonant=0 to 3 constructive potentials)	56	57.7%	55	**56.7%**
From dissonance to harmony (4 to 5 constructive potentials)	37	**38.1%**	41	42.3%
Constructive (Harmonious= 6 to 9 constructive potentials)	4	**4.1%**	1	1%

Sounds CB.H2 Channel-by-channel association analysis (Cramer´s V).

Cramer's V channel-by-channel analysis showed that the next SOMchs presented significant associations. The rest of SOMchs presented no significant associations between Np3 and Pt3.

Channels presenting significant association were: *Smoothness* and *Moving lips to talk*. The first one showed a pattern of constructive smoothness association between the individuals. The second one suggests that frequently when the Pt3 was talking, the Np3 was in silence (n=61). However, in 31 Ops both of them were in silence, and only in 3 Ops they were talking simultaneously.

Textures

Textures CB.H2 Total Channels' Association Analysis (Kendall Tau B).

Using the variable *TEXTURES* a Kendall Tau B correlation was used to examine the association between Np3 number of voice –Np3TEXTURES- (M=1.66; SD=1.198), and Pt3 number of voice –Pt3TEXTURES- (M=2.04; SD=.803). There were no missing values leaving 97 Ops available for the analysis. A significant disruptive correlation was obtained, Tau= .286, *p<.001* (2-tailed), indicating that Np3 silence was significantly related to Pt3 silence, and vice versa.

TexturesCB.H2 Level of Monophony to Polyphony association analysis(Kendall Taub).

A second Kendall Tau B correlation was used to examine the relational (voice) level (Level 1-No (voice) related–Monophony=0; Level II-Individualized voice in progress of relationship building–Homophony=2; Level III-Highly (voice) related – Polyphony=3) association between Np3 (M= 2.05; SD=.713) and Pt3 (M=2.26; SD=.440). There were no missing values leaving 97 Ops available for the analysis. A non significant correlation was obtained, Tau= .113, *p*=.244.

Table 5.8 exhibits how the most frequent relational (voice) level of both Np3 (49.5%) and Pt3 (74.2%) is the relationship building level (Homophony).

Table 5.8
Np3 and Pt3 relational levels gathered from the sum of the four Textures of Movement channels (TOMchs)

Level	Frequency	Percent	Frequency	Percent
	Np3		Pt3	
No relationship (Monophony = 0 voice potentials)	22	**22.7%**	0	0%
Individualized action in progress of relationship building (Homophony= 1 to 2 voice potentials**)**	**48**	**49.5%**	**72**	**74.2%**
High relational level (Polyphony= 3 to 5 voice potentials)	27	27.8%	25	25.8%

Textures CB.H2 Channel by Channel Association Analysis (Cramer's V).

Cramer's V channel-by-channel analysis showed the following TOMchs significant associations:

a) The Np3 eye contact silence, varied (*Phi*= .298, *p*=.003) depending on Pt3 eye silence and vice versa, as expected. (*See table A56 in appendix 1*).
b) The Np3 voice coming from the *Movement of the lips as talking*, significantly vary (*Phi*= -.367, *p<.001)* depending on the Pt3 silence and vice versa. (*See table A60 in appendix 1*) .

Maximizing difference 3: Sounds of Movement associations

Case A has one SOMch with significant constructive association (*Dynamic HTAHD),* and Case B has one unexpected constructive association (*Smoothness*); the rest have no significant constructive or disruptive associations. Nonetheless, in Tables 5.5 and 5.7, we clearly see how the pattern of results in Case A (Pt1: 56.7% potentials in the constructive level), coincide with the pattern in Case B Pt3 (56.7% potentials in

the disruptive level) results but in the **exact** opposite direction of disruption and construction. Very similar to this difference, Np1 reflects a level of constructive relationship (84.4%) in Case A, that was not reflected in Case B where the percentage of constructive potentials was notably less than in case A (4.1%).

Maximizing difference 4: Textures of movement associations

Case A has one TOMch with significant voice associations (*Talk),* and Case B has two silence associations (*Eye contact and Talk*) as expected; the rest had no significant voice or silence associations. Nonetheless in tables 5.6 and 5.8, we clearly see how the pattern of Case A Pt1 results (71.1% potentials in high relational level - Polyphony), similarly coincide with the pattern in Case B Pt3 results (74.2% potentials in individualized action in progress of relationship building level-homophony), but exactly in the opposite direction in terms of textures of the relationship. Similarly, Np1 (73.3%) reflects a high level of relationship (polyphony) in Case A, that was not reflected in Case B where she reveals a 72.2% in monophony (22.7%) and homophony (49.5%).

Hypothesis 3 Results

Only general results were used to test hypothesis 3. Two new variables were created for every case. These results define differences among Sounds level and among Texture level as a function of time (Interval 1, Interval 2, Interval 3). Sounds level has three degrees (Level I-Dissonant attenuation=1; Level II-In process from dissonant attenuation to harmonious collaboration=2; Level III- Harmonious collaboration=3).

Textures level has three degrees (Level I-No relational-Monophony=1; Level II-Individualized-Homophony=2;Level III- relational-Polyphony=3),

Case A.

Sounds CA.H3 Cadences (Kruskal-Wallis).

A Kruskal-Wallis test was conducted to evaluate whether Case A interaction (Np1-Pt1) had different Sounds levels over the course of 3 different intervals of time. There were no missing values. The test found significant differences in the mean rank between intervals of time, $\chi^2(2, N = 90) = 18.987, p < .001$.

Follow-up Mann-Whitney tests using the Bonferroni correction were conducted to evaluate pair-wise differences among the 3 time intervals. The first interval was found to have a significantly different pattern of sounds of movement, compared to the second interval, U=205.500, Z= -4.167, p<.001 (2 tailed) and the third interval U=263.500, Z=-3.258, p<.001.

Table 5.9 exhibits Sound levels as a function of time. Data in this table suggest an Np1-Pt1 evolving process from Level II-In process from dissonant attenuation to harmonious collaboration, to Level III- Harmonious collaboration. We can imply that the relationship started in process from dissonant attenuated care to harmonious collaborative care, and by interval 2 evolved to a harmonious collaborative care. No differences were found between time 2 and 3. However, we can see a combination of Level II and Level III at interval 3, being more frequent Level III (harmonious care).

Table 5.9
Case A Sounds of Movement as a Function of Time

	Interval 1	Interval 2	Interval 3
Dissonance Level I	1		
From dissonance to harmony Level II	24	9	13
Harmony Level III	5	21	17

Note. The sum of the numbers in this table is equal to the 90 observational points (Op) analyzed in this Case. Thirty Ops were analyzed at interval 1, 30 at interval 2 and 30 at interval 3. This table shows the distrtibution of the 30Ops per interval, in terms of the level of relationship achieved.

Textures CA.H3 Cadences (Kruskal-Wallis).

A Kruskal-Wallis test was conducted to evaluate whether Case A interaction (Np1-Pt1) had different texture levels (*Monophonic, Homophonic, Polyphonic*), over the course of 3 different intervals of time. There were no missing values. The test found significant differences in the mean rank between the time intervals, $\chi^2(2, N = 90) = 6.694$, $p=.035$.

Follow-up Mann-Whitney tests using the Bonferroni correction were conducted to evaluate pair-wise differences among the 3 intervals. First and third interval, U=300.000, Z=-2.566, p=.010 were found to have significantly different pattern of sounds of movement.

Table 5.10 displays Texture level categorization as a function of time. Data contained in this table suggest that there was a positive significant difference in terms of levels of textures form interval 1 to interval 2, and a significant difference was found from interval 2 to interval 3. In the first interval a combination between Level II-Individualized-Homophony, and Level III- relational-Polyphony was developed. In the second interval, a Level III- relational-Polyphony was more frequent than a Level II-

Individualized-Homophony. And in the third interval, the relationship inclined to homophony.

Table 5.10
Case A Textures of Movement as a Function of Time

	Interval 1	Interval 2	Interval 3
Monophonic	0	0	0
Homophonic	15	11	21
Polyphonic	15	19	9

Note. This table shows the distribution of the observational period (Op) analyzed per interval, in terms of the level of relationship achieved.

Case B

Sounds CB.H3 Cadences (Kruskal-Wallis)

A Kruskal-Wallis test was conducted to evaluate whether Case B interaction (Np3-Pt3) had different Sound level (Level I-Dissonant attenuation=1; Level II-In process from dissonant attenuation to harmonious collaboration=2;Level III-Harmonious collaboration), over the course of 3 different intervals of time. There were no missing values. The test found no significant differences in the mean rank between the times, $\chi^2(2, N = 97) = 5.818$, $p = .055$.

Table 5.11 displays Case B Sound level categorization as a function of time. The non significant results suggest that Case B remain in dissonant attenuation most of the time. However, some attempts to evolve from dissonant attenuation to harmonious collaboration can be appreciated.

Table 5.11
Case B Sounds of Movement as a Function of Time

	Interval 1	Interval 2	Interval 3
Dissonance Level I	21	29	24
From dissonance to harmony Level II	11	3	9
Harmony Level III	0	0	0

Note. This table shows the distribution of the observational period (Op) analyzed per interval, in terms of the level of relationship achieved.

Textures CB.H3 Cadences (Kruskal-Wallis).

A Kruskal-Wallis test was conducted to evaluate whether Case B interaction (Np3-Pt3) have different Texture levels (Monophonic, Homophonic, Polyphonic), over the course of three different intervals of time. There were no missing values. The test found significant differences in the mean rank between the time intervals, $\chi^2(2, N = 97) = 42.229$, $p<.001$.

Follow-up Mann-Whitney tests using Bonferroni correction were conducted to evaluate pair-wise differences among the 3 time intervals. The first interval was found to have a significantly different pattern of textures of movement, compared to the second time interval, U=187.000 Z=-5.096, $p<.001$. The second interval was also found to be significantly different U= 183.00 Z= -5.189 $p<.001$ from the third interval.

Table 5.12 displays Texture level categorization as a function of time. Data contained in this table suggest that nonverbal communication at time 1 and 3 inclined to homophony, and at time 2 tended to monophony. Because of this, there were no significant differences between interval 1 and interval 2. Significant differences between interval 1 and 2, and between interval 2 and 3 were found.

Table 5.12
Case B Textures of Movement as a Function of Time

	Interval 1	Interval 2	Interval 3
Monophonic	0	22	0
Homophonic	31	8	30
Polyphonic	1	2	3

Note. This table shows the distribution of the observational period (Op) analyzed per interval, in terms of the level of relationship achieved.

Maximizing difference 5. - Sounds of Movement cadence

Case A time 1 presented a level of dissonance to harmony (n=24) that progressed to a harmonious level at time two (n=21). At time three, the relationship was maintained in the harmonious level (n=17). The climax of harmony was found at time two, and the process was completed in a harmonious way in an authentic cadence.

Case B time 1 presented a level of dissonance (n=21) that increased at time 2 (n= 29), and was maintained at time 3 (n=24). Dissonance was the constant over the course of time, resulting in a half cadence.

Maximizing difference 6. -Textures of Movement cadence

Case A Interval 1 presented the same level of homophony (n=15) than of polyphony (n=15), that progressed to a polyphony at Interval 2 (n=19). At interval three the relationship was mostly homophonic (n=21). The climax of polyphony was found on time two, and the process was completed in a homophonic way.

Case B Interval 1 presented a level of homophony (n=31), which decreased at Interval 2, mostly caused by the Np3 absence in the room. Interval 2 was mostly

monophonic (n=22), recovering its homophonic form at Interval 3 (n=30). The climax of monophony was found at Interval 2.

Qualitative Findings

To answer the qualitative questions, I present the cases in terms of their context and a summary of the whole encounter. Subsequently I examined the nonverbal particulates entrenched in the conversation.

To construct the contexts and the summaries, I considered the whole encounter (i.e. the complete period). Only the verbal particulates present in the nonverbal (quantitative) observational periods were considered for the qualitative analysis, i.e.Case A (15min), and Case B (16.10min). In the awareness that cutting conversations can de-contextualize their meaning, I considered –if needed- some conversational pieces even when they were not part of the analyzed minutes.

Since the purpose of the metaphoric was to “hear” the text, some of the qualitative results contain the words “heard” or “sound” in quotation marks; they are used as common word like "see, observe, or exhibit". In this way, the reader can recall that the text can also be “heard” by other means apart from words, like rhythm, fluency, open keys, and counterpoints.

The context, the encounter and the struggles

Case A Context

The participants involved in this conversation are a nurse practitioner and a male patient. This is the second encounter of three. I have no data about when the last encounter occurred. Personal information related to the nurse practitioner is limited in the transcript except that the male patient was a new patient, and that she was the same nurse practitioner attending Case B. The patient is a male Caucasian in his 70's or 80's. He had hernia surgery in the past, and "passed about seven or eight kidney stones" (p.7) last year. During the encounter he recalled having problems with one side of the hip and his back. At the moment of the interview he was struggling with another side of his hip, as well as having pain in his buttocks. He wondered if the type of work he did before, and/or a falling during skating caused the pains. During the 28:52 appointment, the Np went through blood work results, X-rays and some complementary information with him. First, they talked about his vitamin levels.

Afterwards she talked with him about his cholesterol levels, some ways to reduce them, and the possibility that he could go to a dietitian. Finally, they talked about his X-rays and some possibilities for action. The central point of this Case relied on how both addressed the patient's health issues, rather than trying to resolve only one particular health struggle (his hips and back pain, and the spinal bulks seen in the X-rays). They both addressed their agendas, and furthermore, at the end of the encounter they agreed on an action plan. With this plan they intended to take care of the Pt´s health by : a) preventing the triglyceride levels to increase, b) maintaining adequate Vitamin levels, c) maintaining an adequate weight, d)attending to probable osteoporosis, and e) investigating if the cause of the back pain was spinal stenosis, a

previous tumor, injuries or arthritis. Table 5.13 contains a summary of the complete Case A encounter.

Table 5.13
Case A complete summarized story

The encounter began when the patient asked the Np if she was okay with the filming. He was worried that the NP was not comfortable with it, and wondered "whether the system is forcing… (p1.)" her to do it. The Np was positively surprised that the patient was asking a caring question. She reminded him that both agreed on being filmed for "advanced research in what (she) I do" (p.2). She returned the gesture and asked him whether the camera was bothering him, even when he had agreed to participate in the study. He said that if she was okay with it, he was fine with it too. Np and Pt went through a 28.52minquestion-answer dialogue to address the main conflict (his hips and back pain, and the spinal "bulks" seen in the X-rays), and the secondary health oriented issues(vitamins, cholesterol, and weight).

At minute 2:00pm, the Np asked him if he was here because she asked him to, or if there was a specific problem he wanted to address. He reminded her about the X-rays and the blood work she asked him to do over the last encounter. He was interested in knowing if there was something "good or bad, or…" (p.3) in his results.

At min. 2.26 they went together, through his blood results, as the Np suggested. With her body posture and gesture the Np invited the Pt to get closer to see a sheet and he accepted the invitation. They were completely *other oriented*. The patient presented a normal count of red and white blood cells. Vitamin B12 was still within the normal levels but the Np recommended him to take the lower dose (500mg) to prevent nerves problems. When the patient asked why, the Np explained him how with aging, the "gut just doesn't absorb it from the food the way normally did" (p.4). The Pt said that in fact had taken the A to Z Kimberland vitamins daily, and Vitamin D from October to May, especially in the winters if going to the south was not possible. The Np listened to the Pt, and between his experience and the Np´s information about the Pt´s vitamin levels, they agreed that he would take500mg of Vitamin B12, as well.

He was also taking Verapamil, and he did not know the reason. He reminded the Np that last time he was there she told him she was going to look into it. The Np said she did not get any results yet, and she did not remember if she actually ordered the study to know why he was taking Verapramil.

The back and hip pain topic was addressed for the first time at min 5:35. The Pt told

the Np that in the past his Dr (name A) sent him for a CT scan because he was in pain, "and all the pills that he gave me for pain didn´t work" (p.7). Afterwards, the same Dr (name A) gave him a little patch "that (he) I put on my back of the hip" (p.7). The Np asked him if what he was trying to tell her, is that his back pain "has all been looked into before" (p.7). He affirmed, but the Np claimed that his Dr (name A) had not sent all that information. The pain increased and he ended up passing "seven or eight kidney stones" (p.7). The Np asked him if "everything resolved after that? (p.7). "Everything went pretty easy … but then (he) had those back and hip pains" (p.7). He addressed the pain topic again, but this time intertwined with emotional and experiential content. In turn, the Np made a complete topic change.

"Then I just started with this (pause); here up (pointing it with his hands) at the top of the hip here, this pain, it hurts when I walk, like sitting here, I got no pain, that's the, that's the frustrating part, If I do nothing I'm okay. But I like to walk and it hurts" (p.8) During his declaration, she kept looking into his files and made a complete topic turn. "Okay, now. You had a carotid Doppler study…" (p.9). The patient's answer tone and words were of complete disorientation: "What's (pause)" (p.9) (he tried to concentrate) "Oh, yeah I went into (pause) St Boniface Hospital while I thought I was having a stroke" (p.8).

After a brief talk about his heart tests, the Np came back to the last topic "okay, so let's talk about your blood work". The Np was concerned about his cholesterol levels: "Sugar is fine, no diabetes … thyroid level is fine … your cholesterol is the only thing we need to look at" (p.9).The Np invited the Pt with her hands and arms posture-gesture to look at the results with her. He accepted. Every time that the Np invited him, during the whole interaction, the Pt accepted and both were oriented towards the results. He reported taking nothing for cholesterol, having a wife and two daughters who also have cholesterol problems, not drinking that much every night with his wife, and only taking "two little chocolates everyday".

After a series of questions to know how much was he drinking, the Np invited him to see a sheet with "the basic recommendations of … what they should do to … modify their cholesterol" (p.12) so that later on "we don't have to consider pills" (p.14). They both read it together. She encouraged him to read the sheet by himself and decide what he wanted to do. For example, see the dietitian and make those changes before he became borderline. "Go home, think about this a little bit, about what changes you can make" (p.15). During that section of the encounter, both, Np and Pt, participated in his health matters. He made a set of questions about his eating habits and his exercise. He was interested in knowing if some things were better to eat than others and what could he do to get active now that he could not

walk because of his back pain. She offered brief answers, and then invited him to see the dietician. “I am not a dietitian”. “But if you see her and um, and seeing the dietitian is free of charge”. “She is the expert” (p. 16). The Np reminded him that “seeing a dietician here is free” because he is “a client” (p.17).

Around min 15.30, after looking into many other things to maintain the Pt's health, and “because time is running” (p.17) she suggested to go back to the X-ray results to address his principle health struggle (back and hip pain). “I´m gonna cut right to the chase and let´s talk about the X-rays” (p.18).

The Np invited the patient to look at the X-rays results together, as she did with the blood tests. The patient got closer, and they both went through them. The X-rays showed “a lot of bulk … in the lumbar sacral spine (and) disk space narrowing” (p.18). The Np explained the patient with finger movements, what happened with his vertebrae. The Np had some material prepared on the computer for him, so that he could better understand. She invited him verbally and nonverbally to get even closer; she moved the screen to a position in which he would be able to see. “And eventually I brought that up on the computer here…let me see. You got your reading glasses with you?” (p.21) The Pt participated in this conversation, relating the information shared by the Np with his pains and daily life. The Np made slight pauses with deep eye contact to continuously revise: a) if the Pt was understanding; b) to see if the Pt could relate the information to his experience, and c) to ask the Pt if the pain described by her, was similar to the pain experienced by him. (e.g. Np: “The most common symptoms are pains in the buttock <eye contact and pause>, or in the legs? <eye contact and pause>”. Pt: “No, the legs aren´t bad” –p.22)

During the Np explanation, the Pt revealed that the last Dr (A) did not help him solve his back issue, so he went to the physiotherapist (name B). The Pt and the Np agreed that he could go to the physiotherapist. He asked her for a copy of those results to show them to the physio. (name B) “I can take it and show her, because I wasn’t getting anywhere with the doctor about the pain and that, and somebody suggested her (the physiotherapist)…” (p.26) “I went to her; in a month I was fine” (p.26) “You know, I could move”. The Np participated with him in regards to this topic. “Well, it probably helps, to, to move the muscles away … and um, helps in that respect but it’s not going to help with the main cause. We’re going to look into that. And in the interim if she can get some pain relief for you that’s perfect” (p.26). The Np encouraged him to see the physiotherapist again but letting him know that they “found a lot of abnormalities in the spine” (p.25) At the end of this part, they talked about some other tests that were done before or that they could do. The Pt shared briefly with the

Np information about his hernia surgery. After he told her the operation did not work, she told him, she was going to ask for that information as well.

She explained to him, supported by the X-rays and a colleague's (Dr. X) opinion, that the possibility of him having osteoporosis was high. The Np recommended him to start a medication plan right away when she had the approval to have the medicine for him. The Np also wanted a bone mineral density test and a spinal CT scan to find out the cause of the pain. When she addressed the CT scan topic, the Pt inquired about how long did it take to do it because "the last one took so long, that the problem was gone when I got up there" (p.21). By her own, she suggested writing an expedite letter to help accelerate the process. She suggested a tumor as the worst-case scenario, and spinal *stenosis* as a second cause. She also pointed out injuries and degenerative changes -like arthritis- as probable factors too.

The encounter ended with a summary of the Case and evoking the plan they both were going to follow from the current day to the near future. They agreed to start an action plan. He would reinforce his vitamin levels, go to the dietitian to learn about exercise and eating matters, look into the changes to lower cholesterol, and go to the physiotherapist to find relief his pain. She would ask for medication approval –Fosimax- to put him into a medication plan right away, to help him with his probable osteoporosis. She would also write a letter to accelerate the process for him to have a spinal CT scan taken, and order a bone mineral density test.

Within this section, the Pt reported having several falls on the ice in the past. The Np asked him a couple of questions, and then she continued summarizing the plan. After the action plan was agreed, a social conversation followed. The encounter ended when the Np asked him to come back in three or four weeks, and reminded him about taking B12 once in a while. The Pt said goodbye.

Case B context

The participants involved in this conversation were a Nurse practitioner and a female patient. This was the third encounter out of three. The last encounter happened a year ago. Personal information related to the nurse practitioner was limited in the transcript, except for the next few data. She was the patient's primary health care

practitioner now, because the Pt transferred in from another clinic. She was the same nurse practitioner attending the male patient in Case A. She was also the patient's partner Nurse practitioner. At some point in the encounter she claimed not being a specialist in the area of ANAs (Antinuclear antibodies).

The patient was a female micro biologist engaged in field work, and who had played field hockey, tennis, had done cycling and skiing before. She was presenting with knee joint problems since 2004, along with other issues. She came to the appointment with her partner (name B), because both were concerned about the persistence of her knee pain even after a surgery was performed to "fix" it. Her partner was also going through some struggles, so the patient was taking care of her. The knee pain was holding her back from taking care of her partner, continuing with the microbiology fieldwork and attend to conferences, as well as from having a life without struggles caused by the condition. She was referred to a rheumatologist to assess and treat her for arthritis, because other practitioners failed to tell her what the health problem exactly was. Her appointment with the rheumatologist was going to be in four months. She wanted to see him earlier.

The central point of this story is that the patient needed to be assessed by her General Practitioner (GP) and her Nurse practitioner (Np) for them to write a letter that could expedite the referral process to the rheumatologist. The Np and Pt went through a 24.34min relational struggle solving process, to address the main conflict (referral letter for accelerating her appointment with the specialist)and to be able to solve her health struggles (related to herknee condition). Table 5.14 contain a summary of the complete Case B encounter.

Table 5.14
Case B complete story summarized

In 2004 the patient's knee was inflamed. A cortisone shot was given at clinic X "which resolved things almost immediately" (p. 2). The patient did not see any other problems again until 2008 when the knee joint problem started again.

"Under the assumption that it was going to be a fairly simple arthroscopic surgical repair on a fairly minor cartilage" (p. 1) she had knee surgery on December 2008, after the first encounter with this nurse practitioner. The health problem was not resolved through that means; after the surgery she continued to have knee pain. Dr A, who supported the surgery, gave her Celebrex post surgery but the knee was still swollen.

On February22nd of 2009, Dr A told her that with the surgery they were able to fix the mechanics problem, but that another problem could be going on. He made the referral to the rheumatologist because she had arthritic symptoms and told her she would have to wait. Dr. A agreed to give her a cortisone shot in 2008 when the patient asked him to. She reported that unlike 2004, this dosage "was only effective maybe 6 to 8 weeks"(p.2). The patient assumed that the last cortisone shot was not effective as long as the first one because the knee was already inflamed for much longer than in 2004, and because her body had probably changed. In spite of this, the cortisone worked enough time to let the patient to be "foolish enough to do some things, something at work that (I) shouldn't have"(p.2).

Apart from the knee symptom, she reported jamming her finger "really hard on a doorframe … and few days later it was stiff in the morning and has been stiff since then" (p. 6); having a current problem with the left hand that did not go away and having injured her left ankle twice jumping from a counter. She had been to an athletic therapist to assess her condition. After various range of joint motions, the therapist "concluded … this inflammation was more than what they would expect given … what happened". She claimed that since "the ankle flared up and hasn't gone away, (I) kind of put two and two together that may be the same things happening in (my) hands" (p.3). She claimed "things are not getting any better, and …" she "is really struggling in the morning especially" (p.3), when she could hardly walk.

The patient was "concerned about the situation" (p.3). She expressed thinking Dr A was not aware of the complications, and she wanted a second opinion. In respect to that, another resident saw her and ordered some X-rays. She was in the current clinic 4 weeks before this encounter with the nurse practitioner, to see Dr E, because at the time she hadn't heard about the rheumatologist referral. Some blood work was done as well. "I am frustrated

and scared and worried that this is autoimmune and there could be something going on" (p. 4).The Nurse practitioner shared her blood results, few seconds after she expressed these feelings, so no more emotional talk was developed. After that, no more emotional data was expressed; although, she seemed worried, concerned and at some level angry, and her corporeal position looked uncomfortable and angry as well.

The patient needed several things, which she demonstrated by her appointment agenda:

a) She wanted to see if the appointment with the rheumatologist could be accelerated.
b) In the matter of expediting her rheumatologist appointment, he affirmed that she needed to see her General Practitioner (GP) and her Nurse Practitioner (Np) to get an assessment from them. Dr E's secretary told her that if her GP and NP considered that the results from the assessment "would warrant an advancement of the appointment" (p.7), then they would call the rheumatologist.
c) She wanted to know if the X-rays done on April 3rd had come back to the clinic. In the same section, the patient also pointed out that, apart from the X-rays, some blood work was done about 3 or 4 weeks ago, as well.
d) She wanted to be coached on how to check over another request made on April 3rd. She submitted a form requesting her files be transferred from the previous clinic to this one.

There was no room to address any other issues than the struggles noted above. The whole encounter was centered around her health struggle (knee and junction pain which she thought was an immune issue), and point b.

During the Pt´s broad explanations, the nurse practitioner discovered that the patient, in addition to her main health problem (knee joint and other joint dysfunctions and pains), presented other symptoms. She had a history of psoriasis (p.7), had poison ivy and had low white blood counts (which one of her Dr's dismissed). The Np also discovered that the patient had been taking medications apart from the cortisone such as Aniprox (currently), and paired Naproxen and Tylenol (eventually), and probably prednisone (in the past) when she had poison ivy. She also discovered that antinuclear antibodies tests were done after the patient attended this clinic on April 3th to have a second opinion from Dr E.

After the Np search for several minutes into her files to see if she had the X-rays and the blood tests, she realized she didn't have this information: X-rays, blood cells count, and ANA´s results. "So we definitely should have that by now but I'm not seeing them there. You know what, let me just make sure I don't have it in my stuff that I've been putting aside because it wasn't normal (chuckle). That would have been put under Dr. D." (p. 7). (The RA,

T.Palin, who made the transcripts, pointed out it was a nervous chuckle, which I agree).

The blood tests, as well as the X-rays done by Dr E's resident, are not in the Nurse practitioner's file. As soon as she finished searching in her drawer and noticed that the patient information was not complete, she left the room to see if she could get them. She asked the patient if "she could bear with her for a few minutes" (p.8) to leave the room and see why she had not received them.

When the Np left the room, there were long silent periods, even while the patient's partner was present. At some point after one of those silent periods, her partner reminded her about the Parking. The patient answered her: "I think we are pretty much finished here. I don't know whether. Five months is crazy" (p. 9).

When the NP came back, she told the patient that she got the Antinuclear Antibodies (ANA). The Np invited the Pt with her posture and gesture, to get closer and review the results with her. The Pt did not get closer. The Np was not able to accurately interpret the patient results, and chuckling (nervous), explains the patient that "this is not (her) my specialties" (p.9). About the X-rays she said that "they are lost, somewhere along the way, or Dr E has got them stash" (p.9). She chuckled again while saying this.

After trying to interpret some data, the Np agreed for the third time but more emphatically, on writing the referral letter. Supported by Dr. D's recommendation note, she also asked the patient if she was willing to take prednisone for 5 days. The patient struggled with having a type cortisone treatment again. She knew the maximum permitted injected cortisone dosage in a lifetime, was from two to three times, so she asked for short and long term secondary effects. The Np responded that this kind of non-injectable systemic (no local) prednisone would not have secondary effects if taken for 5 days.

After this information, the patient said that "at this point (I'm) -she's- ready to try" (p. 14)"I'm looking for answers (p.14)", she affirmed. Then, they went through a small coaching about how to check if the patient's files were transferred. While the Np was silently writing in her computer, the patient looked at her partner and told the Np that her partner was also worried. The patient insisted that this situation was hard for both. "Well, it's been hard for us" (p.15), the patient said; "I was kind of not very active for a while and she's, can barely walk" (p.15).

After some social talk, and another prolonged silence, the Np gave something to the patient, moved her chair to stand up and to tried to say goodbye. "Okay ladies." (p.16) "I'll give you this. And I'll write him a letter and, uh, try to make a case for expedited" (p.16). Nevertheless, later the Np went back to her notes, asked if the patient was a microbiologist

and if she had fieldwork to do. She wrote down the affirmative answer. The Pt told the Np again, how much this is affecting in her work, and daily life. The patient's partner also told the Np that the patient was also her caregiver. The Np made a prolonged head affirmation movement as if she was trying to understand the patient's partner point. The partner thought that such information could help the NP as a "way of pushing things" (p. 16). The patient insisted one more time that her partner was doing really well "considering what's she's gone through, so" (apparently her partner was also sick and the Np knew this); then the partner completed the patient sentence: "this could help". The Np realized that the partner was giving more reasons for her to put in the letter and accelerate the referral; a behaviour that was repeated throughout the whole encounter. "That's a point" (p.17) said the Np. "You are right. It never hurts to stack the odds" (p.17), and wrote the information on her notes while making an apparent face of interest. They stand up to say goodbye.

The patient affirmed it was painful and appreciated, before hand, her judgment and anything that she could say. Grabbing her own elbows with her hands, closing her abdomen and chest, the Np waited for them to prepare to leave. Meanwhile, she supported the patient by telling her she needed a diagnosis to get on with the rest of her life, to know what to expect, and how to be prepared. She also told the partner: "It's a good thing that you are here" (p.18). The Pt thanked her twice and so did her partner. The three of them leave the room.

Case B and A: a process of relationships

Case A mixed methods findings revealed a more collaborative care encounter, and Case B a more attenuating care case. Despite this, they are not contraries but complemented each other. By positing the cases as contrary, we reiterate the separatist view, which pulls the negative into one extreme and the positive into another. Conversely, Case A and Case B as complementary, helps us to understand power as a process of relationships, instead of viewing it as a determined state with two extremes.

A process develops (begins, continues, and ends) in several phases, and then starts again, bringing into play the last phases. We will start understanding the first phase of a power process form Case B, representing a lower relational level. The continuation of this process will be understood by looking at the relationship between

Case B and A. At the end, I will present Case A analysis representing a higher relational level.

These findings demonstrated that relationships are a continuous process. Therefore, it is clear for us that Case B does not represent the first phase of all the relationships, and do not represent the worst relational level that could possibly exist. Case A does not represent the last phase and the best relational level that could possibly exist, either. Qualitative Conversation Analysis (see chapter 3 for a description of the Conversational Analysis method),revealed the mechanisms, disruptors and constructors to facilitate, paralyze and balance power as a set of human relationships constituting a Macro relation such as the Health System and played out at the Micro level; the Np-Pt relationship.

To illustrate a continuum, Case B is addressed first. In the qualitative analysis, Case B contributed more to the unexplored. We referred to codes as the set of words that have a function on the speech submerged in the context of the conversation.

Case B. Prerequisites to mirror construction and disruption: conversational codes (Adjacency pairs phase 1) and interruption management

Conversational codes are important particulates to be described before explaining more complex qualitative findings. Disruptors, facilitators and an evolving disruptive-constructive-disruptive processwere “heard” through conversational codes.

The Np3 conversational codes

The Np used frequent conversational codes for several reasons. The first code found was *“okay”.* Sometimes she used it as an *opening or closing* topic code. The

second code- *"yeah"*/ "*Uh, huh"*was used to make small interventions either to reaffirm the Pt or to indicate that she had finished talking. When "okay", "yeah", and "yeah, yeah" were used to reaffirm the patient, the behavior was call ***affirmation codes***. When "yeah" and "okay" indicated the end of a topic or a sentence, they were identified as *talk turns*. Like the name declares, talk turns was a code used to transfer the other person the turn to talk. It was frequent that affirmation codes and talk turns were used at the same time through the same word. The next quotations contained in the Table 5.15, demonstrate these Np codes in different Intervals of time (Interval 1 –T1-, Interval 2-T2-, Interval 3 –T3-).

Table 5.15
Np opening, affirmation/talk turn and closing codes as conversational facilitators

Opening Code (T1)	Affirmation code and talk turn (T1-T2)	Closing code (T3)
Np: "**Okay**, come on in ladies". (T1-p.1)	Pt: "(…) and yes" (T1-p.1) Np: "**Yeah**" (T1-p.1) Pt: "And so we (…)" (T1-p.2) Pt: "So I increased that by 4 times and um, and it still hasn't happened a lot." (T2-p.10) Np: "**Okay**". (T2-p.10)	Pt: "Thank you very much" (T3-p.18) Np: "**Okay**" (T3-p.18)

A third code found was short questions or sentences. Short questions and short sentences were used by the Np as a code to smoothen a topic. *Smoothening codes (SC)and intervention attempt codes* were the names given to those types of indications. The two examples in Table 5.16 illustrate both codes.

The five codes described before (opening-closing, talk turn, affirmation, smooth and interventional attempts) were found to maintain the balance of the relationship and

facilitate conversational relationship. However, the same codes with a different tone of voice and disruptive nonverbal behaviours, in different situations, were also found to be conversational disruptors. In spite of this, disruptor codes developed by the Np were also found to maintain the balance by breaking conversational inequity. To identify a facilitator and a disruptor then, the tone of the voice and the nonverbal behavior were taken into consideration.

At the beginning of Interval 2, the Np used affirmative and intervention attempt codes as cutting codes to prevent the patient to continue talking. Cutting codes were found when the Np was trying to understand or solve a Pt struggle, explained a solution and/or calm a concern, while the Pt was continuously interrupting the process. Sometimes these were cutting codes and sometimes they were a combination between cutting and smoothing codes. The codes "Yes." (T2-p.8),"Yep." (T2-p.10), "Right" (T1-p.6) and "Correct" are some examples of the transformation between facilitator and disruptive codes. Quotations in Table 5.16 also illustrate frequent codes used by the Np and the transformation between facilitators and disruptors, to maintain conversational balance and establish conversational connections. Sometimes, after both started sharing a few codes, the Np made cutting codes and softened them, mirroring a frequent Pt code. This was also taken into consideration as a smoothing code. In the quotation *"Correct. Um"* (T3-p.12), *correct* was a cutting code and *um*, imitating the Pt code, attempted to soften the cutting code. Some other times the Np mirrored some of the disruptor Pt codes to trigger the same silenced effect of the codes used by the Pt. One example of it is the code "so" to denote a request that has no question mark tone at the end, but an affirmation demanding tone. We will see this use of disruptive mirrored codes when explaining Np3-Pt3 conversational interactions and conversational control.

Table 5.16

Np smoothing codes and intervention attempt codes as conversational facilitators

Smoothing codes (Examples 1 and 2)	Intervention attempt code (T1-p.2)
-Pt: "(…) I'm really struggling in the morning, especially I can hardly walk. Um. (pause) And I got the appointment finally (…)" (T1-p.3) -Np: "Oh good" (T1-p.3) The Pt was irritated because her knee inflammation hadn't go away. The Np was trying to find solutions and offered her a medication recommended by the last Dr who saw the Pt. -Np: "Would you be willing to try that?" (T3-p.11)	-Pt: "(…) So he did agree to do that. He gave me" After the word *me*, the Pt made what appeared to be a talk turn, and the Np tried to participate in the conversation. -Np: "Oh he did" The Pt "sounded" as if she was interrupted and continued talking, converting the Np participation, into a failed intervention. -Pt continues: ">the same (pause) he give me the same dosage as I have had (…)"
Smoothing codes and intervention attempt codes transformed into cutting codes.	
<u>Cutting -smooth question (T3-p.15)</u>	<u>Cutting intervention attempt (T3-p.12)</u>
The Np was trying to write in her computer all the actions that she needs to do individually in order to solve the Pt struggles. After a period of silence, the Pt and her partner returned to an old topic about how the Pt health problem is affecting them. The Np turns to them and asks with a cutting tone, but a smooth facial gesture: - Np: Did I answer all your questions today? Or did you have some more? The Pt´s partner responded with a cutting affirmation. Pt´s partner: Yes. Silence is reestablished while the Np was working on her computer.	The Np was trying to explain to the Pt the medication prednisone, so that the Pt could decide to take it or not. The Pt kept interrupting the Np explanation by completing her sentences as if she (the Pt) already knew everything. -Pt interruption: "Well" -Np tried to continue: "it´s it´s systemic". -Pt: "Yeah. I don´t know. Is that, is it, I know the cortisone directly inserted to the joint is recommended only, you know, two or three times in your life." Np cuts her with a -soft intervention attempt. -Np: "Correct. Um…" -Pt: "So the prednisone is that" Np interrupted her with a cutting sentence, after explaining to her and trying to calm her about taking the prednisone recommended by Dr. E. Pt: "This is systemic."

The Pt3conversational codes

The Pt had her own conversational codes (a full description of the codes used in this thesis is in Table 4.16 Chapter 4). Most of the codes used by the Pt in Interval 1, gave her the opportunity to control the conversation. "And so", "And, um", "Um, and", "And so", "And, and", "So" are 6 codes indicating *self-talk turns*. Self-talk turns were the most frequent (n=30) codes used by the Pt at Interval 1 as a way to continue talking, and to change the topic within her monologue. Self-turn talks dramatically decreased after the Np made a radical change. She imitated one the Pt´s self-talk-turns. This allowed her to start talking. This will be discussed further in before (5.18). After this event, only 13 self-turn talks were made. Most of them, did not sustain such long interventions and even the code "so" shifted into as smoothing code. The code "so", as other codes like "sort of"/"kind of", were found to have another softening meaning attached. The Pt used a type cutting code or self-interruption code to self-control, a complaint or a potential demand expressed by her. This softened controlling code is called complaint/demand hiding code. Like its name suggests, it tries to soften a claim, by hiding the demand under it.

A type of eye contact that seemed to tell that she was waiting for an Np response accompanied sometimes self-talk turn codes. In addition, short (::) or medium (:::) pauses were made, which in combination with the code and a type of eye contact, "sounded" like a talk turn to indicate the Np that she had the turn to talk. However, when the Np took the turn given by the Pt, the Pt kept talking as if she was the one being interrupted. This turn transfer simulation, likening utterances ending, was a

frequent behaviour found in the patient conversation particulates; and it was identified as *false talk turn*, and it usually leads to a false topic turn.

False talk turn were frequently (n=8) made by the Pt on Interval 1 to *control the conversation*. This suggests the patient, by controlling it, was preventing an equity of potentials in the relationship. Interventions made by the Np after a false turn and topic turn, were considered as *false interruptions*. Self-interruption cutting codes were also extremely recurrent during the whole encounter. The Pt used them to cut her own ideas. Functioning almost in an identical way to false talk and false topic turns, self-interruption cutting codes senta cutting message. In the case of false turn the interruption and control message was given to the Np. In the case of self-interruptions the cutting and control message was given from the Pt to herself (this is illustrated in Table 5.17). Self-interruptions (//) and pauses (::) were recurrently before, or following a false turn, until a hiding code preceded a demand or complaint. Self-interruptions were frequently posted several times before the Pt could actually speak out a complaint or a demand.

Silence, interruptions, self-cutting codes, self-talk turns and false turns were the means to control topics, topic turns and the whole interaction, especially during the first time Interval. They were the most important Pt unbalance disruptors; and the most important aspects contributing to a control mechanism, which generated inequity in the conversation. Conversational self-control and conversational *others-control*(Np's)were developed in a similar fashion. Self-interruption codes contributed to self-controlling her (the Pt) own conversation, in the same way that other-interruption codes controlled others attempts to intervene. This self-mechanism reflected in the relational mechanism

with others, suggests how during interaction with others, self-communication can be repeated. Looking closely at these code particulates allowed us to access deep level intrapersonal communication. From the intrapersonal level, we can "hear" a disruptive fractal of a whole communication process found in the interpersonal relationships.

The next paragraph -and the second monologue in Letter C, Appendix 2, are two of the many examples where this recurrent Pt self-interruption, self-control mechanism is expressed. Within an Np monologue, self-talk turns (↔);self-interruption cutting code (//) followed by a hidden complaint or demand (C× or Dx); false talk turns (~) followed by Pt real interruptions (>); and Np false interruptions (FI) with a false interruption repair (FIR) are presented as follows.

Table 5.17
Self-interruption, self-control mechanism (T1-p.2)

Pt: "(…)(↔)**And** then I went back to saw him in February 2nd(↔)**and** he said, basically they fixed the mechanics but there is something else going on here that they hadn't(//)**uh**, you know (//)**uh**(//) there was an issue (Cx). Arthritic likes symptoms and I needed to see a rheumatologist. (↔)**So** he's made the referral to the rheumatologist, **and**(//) but(//) in (//) he said I'd have to wait (Cx). **So** I said (//) well in the meantime(//)**um**(↔) 2004 I had similar inflammation in the knee and I had (//)at the X Clinic (name) at the time, I had taken cortisone shot which resolved things almost immediately"(~). (T1-p.2)

Np: "(FI) **Uh, huh**." Silence (FIR)(T1-p.2)

Pt: "(>) (↔) **And**(//) (↔) **and** I didn't see any problems again until 2008 when this started (Cx)" ~ (T1-p.2)

Np: "~ **Okay**." Silence (FIR)(T1-p.2)

Pt: "(>) (↔) **So** I thought, well, you know, that's what I need (//) is (//) give me another cortisone shot and I'll be fine (Dx). (↔) **So** he did agree to do that (~). He gave me (FI) " (T1-p.2)

Np: "(FI) Oh, he did?" Silence (FIR) (T1-p.2)
Pt: "(>) the same. He gave me the same dosage (…)"(T1-p.2)

Codes Np3-Pt3 interaction

Regarding Case B conversational codes, two different behaviours between Np and Pt were "heard" along the encounter.

In general, the Np made several efforts to facilitate a conversation relationship and to maintain a conversational balance. The Np efforts had an effect on the Pt behaviour; nevertheless the Pt´s constant conversational disruptors prevented the interaction to establish connections that could promote a constant constructive equitable relationship.

Typically, on the whole interaction, being more evident at Interval 1 because of the conversational lengths, the Pt made frequent disrupting codes. Among others, interruptions, self-interruptions, false talk turns and false topic turns represent those disruptive codes. In addition, though the Np developed several strategies to maintain a harmonious conversation. Affirmation and smooth codes reflecting empathy, as well as opening and closing codes indicating real talk turns were made. In addition, even though the Np false interruptions were provoked by the Pt false talk turns, the Np still made interruption repairs. The Np interruption repairs were always rooted in silent pauses. After several times, silent pauses were found to have a self-interruption cutting effect in the Np´s own speech. Despite of the fact that the Np strategies were commonly identified as positive features in a care relationship, through this conversational particulates qualitative research, sometimes they acted in the opposite way. For example, a frequent pattern of interruption repairs, if recurrent, can be transformed (as evidenced in Case B) into a mirrored self-cutting, self-control mechanism holding preventing interactions.

Accumulations of Np self-interruptions (pauses to listen the Pt) to repair false interruptions, transformed in what were small pauses, into ongoing prolonged pauses. These Np strategies, instead of constructing an equitable relationship, allowed the Pt to enlarge forced periods of conversation and enlarge periods of silence. There were no shared codes during the first part of Interval 1 either. This lack of interaction promoted a clear disparity in the conversation. The Np and Pt behaviours at this Interval of time consolidated an inequitable disruptive interaction. The more the Pt talked, and the more the Np remained in silence without sharing codes, the more a split in the relationship became evident.

However, it appears that the Np efforts present interval 1 through affirmation codes, might be a pre-construction for conversational mirroring establishment at Interval 2. A radical change triggered by the Np, happened two minutes before entering Interval 2, shifting the Np and Pt individual coding patterns into a *mirroring coding behaviour*.

Radical change: Around minute 8:50 after one of many monologues sustained by the Pt for almost one minute, she paused. The Np used the pause to intervene by using the most frequent Pt self-talk turn, and converted it into a turn to speak. The next quotation explains the shift (see Table 5.18).

Table 5.18

Radical change. Np mirroring the most frequent Pt´s self topic turn code

The Pt has already talked for about 35 seconds and continues talking.

Pt: "(…)(↔) **And** I didn't think anything of it. I've been to an athletic therapist who's **sort of** worked the joint through the various range of motions. **And** concluded that there was (//) this inflammation was more than what they would expect given (//), given what happened (Cx)" (T1-p.6)

The Pt made another pause after the word *happened*, which suggests another false turn to make a self-talk turn. Rapidly, the Np use one of the most disruptive codes used by the Pt, mirrored it, and transformed it into a tool to move the relationship in the opposite direction.

Np: "**And**…?" (T1-p.6), asks the Np, giving now the Pt the opportunity to talk. The Np used a self-talk turn and converted it into another talk turn.

Surprisingly, the Pt made a pause, and continued only after the Np gave her the talk turn. After a short intervention, the Pt remained in silence.

Pt: "**And** it's persisted for two months." (T1/2-p.6) (**Silence**)

Since this moment, the Np immediately started using the Pt codes and immediately the Pt started using the Np codes. After this shift the Np combined her codes with the pt codes (*see next line*). This was called mirroring behavior and it was used by both from this point, in a disruptive and constructive way.

Np: " **Yeah. And** I see that, **uh**, the last person who saw you put together that you (::), you did have a history of psoriasis, **um**." (T2-p.6)

The Pt answered for the first time, with one of the Np most frequent affirmative codes, and let the Np continue talking.

Pt: "**Yeah**" (T2-p.6)

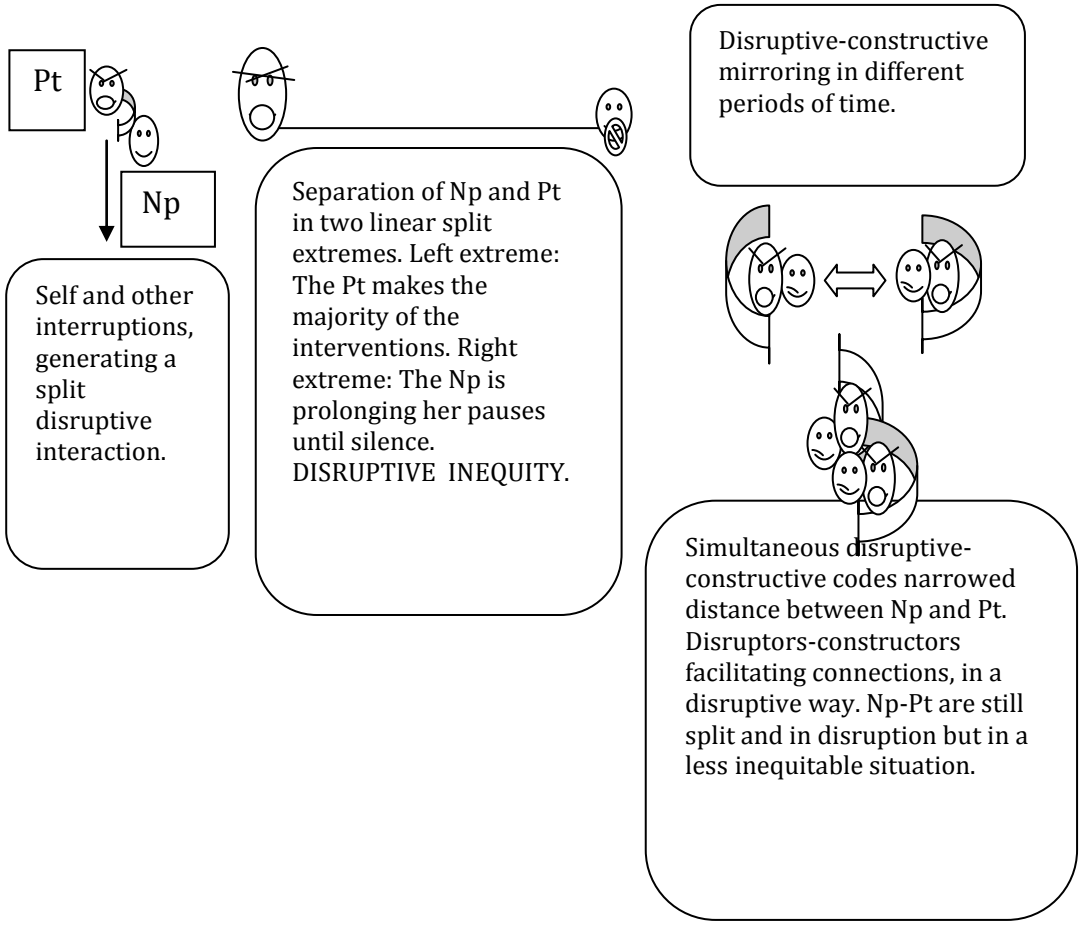
Np: "which is **kind of** autoimmune, **yeah. Yeah. So** we definitely should have that by now but I'm not seeing them there. **Um.** You know what, let me just check (…)" (p.7)

Np mirroring codes continued during Interval 2 and Interval 3. The Np made 4 "ands", 2 "Um, ands", 3 "ums", 1 combined "And, um, so", and 5 "so", under time 2 and until the middle of time 3. The Pt made 13 affirmative mirroring codes using "yeah", "okay", and "yeah, yeah". One new and immediate mirroring shared code found around minute 20, was "well". Despite of these harmonious achievements, Np constructive mirroring codes dramatically decreased arround the middle of Interval 3

and until the end of the encounter. Instead, the Np started using disruptive mirroring codes from the middle of Interval 2 and until Interval 3.

The Pt constructive mirroring codes continued until the end of the encounter, achieving 7 mirroring codes even after the decrease of the Np constructive mirroring codes. During Interval 2, the Pt interruptions (self and others) also decreased but never completely disappeared. However, the Np interruptions increased. For this reason, simultaneous interruptions were occurring, being more often during Interval 3. Although this type of interaction was disruptive, it situated the interaction into a more equitable posture. In simultaneous interruptions and disruptive-constructive mirroring periods, a more rhythmic equitable conversation was found. Both were equally inequitably participating and being interrupted in the conversation. The figure 5.1 illustrates visually what it was heard in terms of Np-Pt codes interaction along the encounter. This evolving process of Np-Pt balance reflected in codes interaction (Figure 5.1) is described below and exemplified with quotations in Table 5.19.

Figure 5.1
Codes as facilitators and disruptors to enhance disruptive-constructive equitable connections



Balance explanation (See Figure 5.1 and Table 5.19). As we saw, the Pt self and other interruption pattern generated an evolving response in the Np. Moreover, the first response at Interval 1, was to participate and then construct interruption repairs. The Np stopped talking to let the Pt talk. For a while the conversation balance was maintained, until a second response appeared as a consequence of the Pt monologues. After several repair mechanisms and various intents to reaffirm the Pt and participate on the dialogue, the Np stopped interruption repairs. At min 1.50 after of many interruption repairs, the Np chose to remain in silence, allowing the Pt's monologues to unfold without

encumbrances. This behavior was repeated during the whole interaction. Sometimes the Np complemented the silence by focusing on her computer. An example of the first two responses is provided below (See left column in Table 5.19).

When the interaction was completely broken by the Pt's multiple interventions and the lack of Np interventions, a third response shifted the interaction again. The Np decreased the interruption repairs and simultaneously increased her talking. As the patient continued with interruptions along several periods of time, sometimes both of them were found talking almost at the same time. Whenever this happened, both of them were interrupted. They did not talk exactly at the same time, but very closely. In Case B this simultaneity was disruptive because they were not able to listen to each other. However, conversational connections lost during the Pt's monologue and Np's silence periods, were recovered in **simultaneous interruption periods**. These disruptive periods engaged the Np and Pt in the same conversation. Within this type of disruptive response two outcomes were observed. Most frequently, the Pt made **cutting codes**. In fewer instances (one or two) a more **collaborative conversation** rose, which was disrupted almost immediately (See right column in Table 5.19).

Table 5.19
Evolving process of Np-Pt conversational balance

Time 1 (First and second Pt-Np action-response)	Time 3 (two cases of third Pt-Np action-response)
First action-response The Np starts the encounter with an opening *welcoming code and topic. The tone of the voice is cheerful*: - Np : "**Okay**, come on in ladies" (T1-p.1) A *prolonged silent pause* followed with *no response* from the Pt or her partner. She repeated the opening code, but this time she said the name of the patient. - Np: *"**Okay**, now (name)".* (T1-p.1) The patient prompt a *self-talk turn code*, *forcing a topic turn (knee post-surgery)*, with an *experiential request*. - Np: "**So** although I was wondering if you'd remember me and the situation I was in a year ago…" (T1-p.1) (Almost a question. Mostly an affirmation) The term "*although"* gave the impression that she did not completed the phrase, but she made a pause as if she was looking for an answer, simulating a sentence end (*false talk turn*). The Np read a talk turn without being aware it was a false talk turn, and takes it; the Np *accepted the request* and answered it *with a confirmatory question*: - Np: *"That was your leg?"*(T1-p.1)(Almost a question, mostly an affirmation) But the Pt keeps talking, with a tone and a nonverbal facial gesture that "sounded" as *if* she was *interrupted*. So the Np made an *interruption repair*, and became quiet. The Pt continued with the first explanation of the conversation about a failure of a past agreement, marked by the	***Third action-response*** An example of the frequent case is provided next (T3-p. 16) After a pattern of monologues and interruptions made by the Pt, almost about to end the appointment, the Np asked a short informational question, requesting a slight informational answer. - Np: "(…) Now you work as a…" Pt gave a simple answer. - Np: "Microbiologist" The Pt asked a second yes/no question, which the Pt took to talk more. - Pt: "**Yes.** Actually, well, it was a chance that I would be going this summer but, ***um*** // I've **kind of** said that I can't because of that (Cx). The Np used a cutting sentence combined with a cutting tone of voice. You can observe how an affirmative smooth code ("okay") was transformed into a cutting code. With it, she attempted to stop the Pt for continue talking. She didn't accomplish it. - Np: *Okay, okay, so it's held you back.* - Pt: "Yeah, and I'm not//, yeah//, where even conferences and things just//; I'm not sure about my trip in June, *um* // because I have to rely on my friends from Vancouver to drive me around, I think (Cx). Np cutting sentence and cutting tone with the opening code okay. - Np: *"Okay. Well, you know what"*

researcher as a *complaint fling (see conversational control).*

- Pt: "It was my knee and we were, um, under the assumption that it was going to be (::) a fairly simple arthroscopic surgical repair (::) on a fairly minor torn cartilage." (T1-p.1)

After the *complaint exchange* showed above, the Pt made another *false talk turn*, and the Np took it, making another question.

- Np: "And so was Dr (name A), right?" (Smoothening-defense short question) (T1-p.1)

The Pt 's code indicated that she was going to keep talking, but she made a slight pause to answer the Np question.

-Pt: "**and** (::) yes". (Cutting code)

Second followed response

- Np: "**Yeah**" reaffirms the Np simultaneously, and notices the pt has not stopped talking so she makes another *interruption repair* and becomes quiet.

The Pt made the second topic turn nested in the first one. Knee history (nested within –Post surgery)
The Pt continues.

- Pt: "**And so** we did the surgery in December. Um. And then // um // uh // that situation wasn't resolved (Cx). It continued to be inflamed despite, um // the // he gave me Celebrex post-surgery. And then I went back and saw him February 2nd(…)" (She continues talking)

At min 1.03, after only two minor interventions, the Np started writing the information coming from the Pt. Whenever the Pt gave what the Np considers important information, she wrote it and came back to make eye contact, half oriented to her, in silence and affirming with her head. When she ended the monologue, the Np only reaffirms her (Uh, huh).

Pt does not wait her turn to talk, and interrupts.

- Pt: *"Anyways"*

Np did not remained in silence. She kept talking this time, completing her short and cutting sentence. Her sentence and verbal posture was rigid, but she softened it with the tone of voice and using a "softened" *um,* mirroring the patient behavior of hidden demands and complaints.

- Np: *"Let's wait and see what we can get resolved, okay, um.*

An example of the second case is provided below (T3-p.11/p.12)

Disruption: "Simultaneous interruptions"

- Np: "Yes."

-Pt interrupts: ">So, and I know"

Np interrupts: ">and we'll see if we can (inaudible –Pt keeps talking)

-Pt: ">this inflammation from what I. Yeah, like it can damage the tissues in the joint and maybe cause problems late, even if we can (…)"

She kept talking for 15 sec. until the Np interrupted her.
-Np: ">Okay. Another thing (…)"

The Pt interrupts her.
-Pt: ">so".

The Np kept talking and then remained in silence. The quotations about to be developed show the hint of collaboration and the immediate disruption.

Collaboration started:

-Np: ">I guess Dr (name D) had recommended (…) prednisone for 5 days". (Silence)

-Pt: "Okay"

-Np: "Would you be willing to try that?

At min 1:18 after two *false talk turns* made by the Pt; the Np did not fall into the third *false turn*, and kept quiet. During the silence time, the Np affirmed with her head. The Pt kept talking for five more minutes, with five affirmation codes and 1 short sentence followed by a short question made by the Np between monologues.

At min 2:47 the Pt turned around individually oriented, watching her computer, making eventual eye contact with the Pt.

-Pt: "That's another type"

The Np interrupted her with a cutting code.

Collaboration ended. Disruption continued
Np: ">Yes."

-Pt:">of treatment." (almost a question, mostly a knowledge affirmation)

-Np: "Yeah".

-Pt: "Well"

-Np: ">it's systemic"

-Pt: "> Yeah. I don't know. Is that, is it, um, I know the cortisone directly to the joint is recommended only, you know, two or three times in your life" (Silence)

Np made a cutting code and then softened it with a mirroring code:
-Np: "Correct.Um".

-Pt: "So the prednisone, is that//"
The Pt cut herself and the Np gave a short cutting answer.

-Np: "This is systemic."

-Pt: "Yeah" (She is thinking about the Np suggestion).

-Np: "and it's not directly to the joint" (knowledge´s affirmation with cutting tone)

-Pt: "Right. It would go through the system" (knowledge demonstration with cutting tone).

-Np: "Exactly. And it's very short term, five days. (Short and cutting answer).

-Pt: "Okay".

-Np: "**So**" (Almost a question, mostly a hidden impatient demand- Np mirrored Pt code for hidden demands)

Collaboration started.

-Pt: "Well, **we could**// yea. // I'm, I'm, with

	side effects// with that or // potential issues with that are (Dx), are um (smoothing demand). -Np: "You've never taken prednisone" The Pt interrupts but she listened to the Np. -Pt: ">no." The Np completed her question: ">before? (smooth tone again) -Pt: "No. No that I'm aware." (Silence) Np: "Some people find that it makes them a little giddier". (Smoothened sentence explanation) (Silence) -Pt: "**Okay."** (Silence) -Np: "**Um,** but not necessarily. Short term really shouldn't // (Np mirroring Pt self interruption). You know, it may // it may make you // like I said, a little more awake and you may have a harder time getting to sleep at night. But other than that..." This quotation is an excellent example of a smooth intervention. The collaborative-disruptive conversation process kept going for about 1min.

Case B. Individual oriented conversation focus on demands: pronouns usage, preference organization (adjacency pairs phase 2), and topic particulates.

Pronouns usage and the request-response preference organization particulates of speech, demonstrated a conversation which at first sight appeared to be centered on the Pt, but was generally centered on struggle explanations, complaints, and demands. Shared actions from both subjects, Np3 and Pt3, were not "heard" despite Np3 efforts.

The most frequent pronoun used by the Pt was*I*. *My* and *me* were also used; both of them supporting an *I* centered conversation (n=96). Most of the Pt's *I, my, me* management was in relationship with past experiences or complaints. When the Pt addressed the pronoun *you*, it was always in relationship with herself (The *I*). The Pt's *I-you(n=5)* management had almost always demands attached to it. The few moments the Pt used the pronoun *we*, it was followed by a complaint, pointing to a shared failure (n=2), or she could not finish the sentence because of a self-interruption (n=1). As we saw, Pt self-interruptions and Pt interruptions to the Np were very frequent. Both types of interruptions were frequently accompanied by a turn talk in the conversation, followed by *I, my* or *me.*

The next quotations (Table 5.20) illustrate Pt pronouns use during different periods of time in the encounter. Letter T stands for time.

Table 5.20
Patient pronoun management

I, my, me	I-you(r) (me oriented)	We (failure complaint)	We (shared action)
Pt: "So I thought, well, you know, that's what I need is give **me** another cortisone shot and I'll be fine." (T1-p.2) Pt: "**My, my** knee, um, looking back I probably fell skating or playing tennis" (T1-p.6) Pt: "At this point **I** am ready to try, **I'm** looking for answers and if that's something that might work then." (T3 p.14)	Pt: "**I** was wondering if **you'd** remember **me** and the situation I was in the year ago" (T1 p.1) Pt: "**I'm** kind of looking for, to **you** for is some, an assessment and sort of see where I might be in at" (T1-p.4) Pt: "Yeah, **I** mean, **I** know there's lots of people. And **I** don't know, you know, **you, you**, **I** don't know how other people are compared to my situation, what you know, the risks are if I continue another five months, maybe it's not a big deal but it is certainly painful. And **your** judgment and **I** appreciate anything you can say" (Beyond T3-End of the interaction- p.17)	Pt: "(…) **we** were under the assumption that this was going to be (::) a fairly simple (::)arthroscopic surgical repair" (T1 p.1)	The affirmation below, was held under **we** as a shared action, but is on a gray area between shared action and complaint as the context of the affirmation suggest. Even though the quotation was not part of the analyzed periods of time, I decided to present it. Pt: "Even if **we** can figure out what's going on and get it fixed **I** could be left with, with, um, sort of residual issues because the joints have been inflamed for so long. It's been over a year for **my** knee" (T3-p.11)

In the same way, centered mostly on the Pt demands, the Np used the pronoun *I (n=15)* to signify current individual actions to try and solve the Pt claims. The Np never used *my* or *me*. The *I-you(r)* management was mostly used to clarify or act individually in the present or in a near future, to respond to a *you* (the patient) demand, without considering a current or future action from the patient. This kind of *I* used to refer one

Np individual solving action (n=15) is as frequent as the *I-you* usage (n=17) representing a dynamic Np and a static Pt non-action. The Np also attempted to include the Pt on shared actions, reflected on a different type of I-you (n=3) management, or we (n=2) usage.

The next quotations (see Table 5.21.) illustrate the Np pronouns use during different periods of time in the encounter.

Table 5.21
Quotation examples of Np pronouns use

I, you(r)	I-you (me oriented)	I-you (shared action)	We (shared action)
Np: "**I** will write and **I** will send them what **we** have that's that's extra. **I'll** make sure **I** have the results of the x-rays." (T2-p.10) Np: "And **I** will write him a letter and, uh, try to make a case" (T2-p.16)	Np: "Would **you** be willing to try that?" (A medication) (T3-p.11) Np: "Well, if **I** had **you** on it for, for a year" (On the medication) (T3-p.13) Np: "Did **I** answer all **your** questions today?" (T3-p.15) Np: "And **you** need a diagnosis to get on with the rest of **your** life. **You** need a diagnosis and, **you** know, uh, what to expect and" (Pt interrupts her) (Beyond T3-End of the interaction- p.17)	The next quotations are the only ones which included a shared action between **I** and **you**. Still, the Np wasthe one exercising the action and the Pt was static waiting for an action related to her. It was considered as an attempt to share an action. The first quotation was taken more as a gesture and a preventative argument and request to leave the room for so long. The second one was taken more as a material exchange (Np gave a sheet to the Pt) simulating a shared action. Np: "If you can bare with **me** for a few minutes, **I'm** just going to see if she is holding (your results) somewhere or why **we** wouldn't have received them. Okay? Be tight back."(T2-p.8) Np: "Yeah, **I'll** give **you** this" (T3-p.16)	Np: "And **we'll** see if **we** can (inaudible)" (T3, p.13) Np was talking in plural action, but she got interrupted by the Pt, so it was inaudible. Np to Pt: "Let's wait and see what **we** can get resolved, okay, um" (T3-p.16)

The next table 5.22, demonstrates the pronoun frequency along the three time Intervals (T1, T2, T3) in which the interaction was studied.

Table 5.22
Type and frequency of pronouns used during the 3 Intervals of time

	I, my, me, you(r)	I-you (me – pt- oriented)	We(failure complain)	I - you (shared action)	We (shared action)
		Time 1 (T1)			
Np	8 (Current and future Actions)	8		1	1
Pt	54 (Complains and past experiences)	3	2		
		Time 2 (T2)			
Np	5	2		1	2 (shared action with some one else that is not the pt)
Pt	14	1 (“you know”)	1		
		Time 3 (T3)			
Np	2	7 (1 “you know)		1	1
Pt	28	1			1 (couldn’t finish)

In terms of request-response preference organization, we have to say that the Pt came to the appointment with a vast history of unsatisfactory care, physical and personal struggles related to it, and “body parts fixing” interventions. She had visited other clinics and several professionals in the past. More than three health professionals were unable to go beyond fixing her knee. It appears that none of the professionals attending her were able to collaborate with her self-knowledge and her experience to detect a more general health condition struggle and resolve it. She was concerned, scared, worried and examples in the conversation that help to contextualize the findings

entrenched in the preference organization. Phrases with quotations in table 31 in the appendix 2, are some of the several examples of this type of unsatisfactory care.

In this context, several Pt conversational intentions were found on *preference organization* particulates. The most frequent conversation intentions, voiced by the Pt, were: informational explanations, demands, and rational and emotional argumentations to support the demand. Informational explanations, rational and emotional argumentation were intended to support her attention demands, or her struggle solving demands. A few experiential knowledge and experiential emotional concerns were shared by the Pt, but were always embedded in a cycle of an explanation, complaint or demand.

The way in which the Pt developed some explanations suggest a disruptive complaint rather than a simple explanation. Similarly, the way in which some invitations were made, suggest a disruptive demand rather than as a simple invitation. This is a constant pattern of patient in Case B. During the encounter we found that the Pt's response expectation was that the Np would make individual actions to solve her (Pt) struggles (requests/demands).

Supported on Conversational Analysis where the context, the nonverbal behaviour (e.g. eye contact), and the tone of what is said, highlights diverse meanings of the same word or conversation, three aspects suggest the following. The Pt turned an explanation or an argumentation into a complaint (Cx). First, the tone of the voice: Pt enunciated certain words, accentuated adjectives and made pauses; while making eye contact and a facial gesture suggesting a request attention from the Np. Second, supported by nonverbal observation, her facial gestures and her posture were disruptive. Third, she gave detailed information based on medical language, and in some occasions

she even challenged the Np's comments, recommendations or explanations. These challenges were not posted as doubts, requests or questions, but as the patient's knowledge demonstration, disruptively mirroring the Np´s knowledge explanations.

In the same way, three behaviors that turned an invitation into a demand (Dx) were found. First, the demands were frequently posted after one or several self-interruptions, and hidden into some codes like "sort of", "kind of", and "so". Second, even with self-talk turns, whereas the Pt tried to smooth a demand, it "sounded" more like hiding strategy (i.e. "and, and", "um", "And, um"). Second, supported on nonverbal observation, the type of eye contact suggest an attention demand, while her facial gesture and posture were also disruptive. The example below highlights a demand. The symbols // indicate self-interruption and (::) indicate pause.

PT DEMAND

T1-p.7 Pt Hidden demand with pre self talk turns (pauses//) and smoothened hiding code.

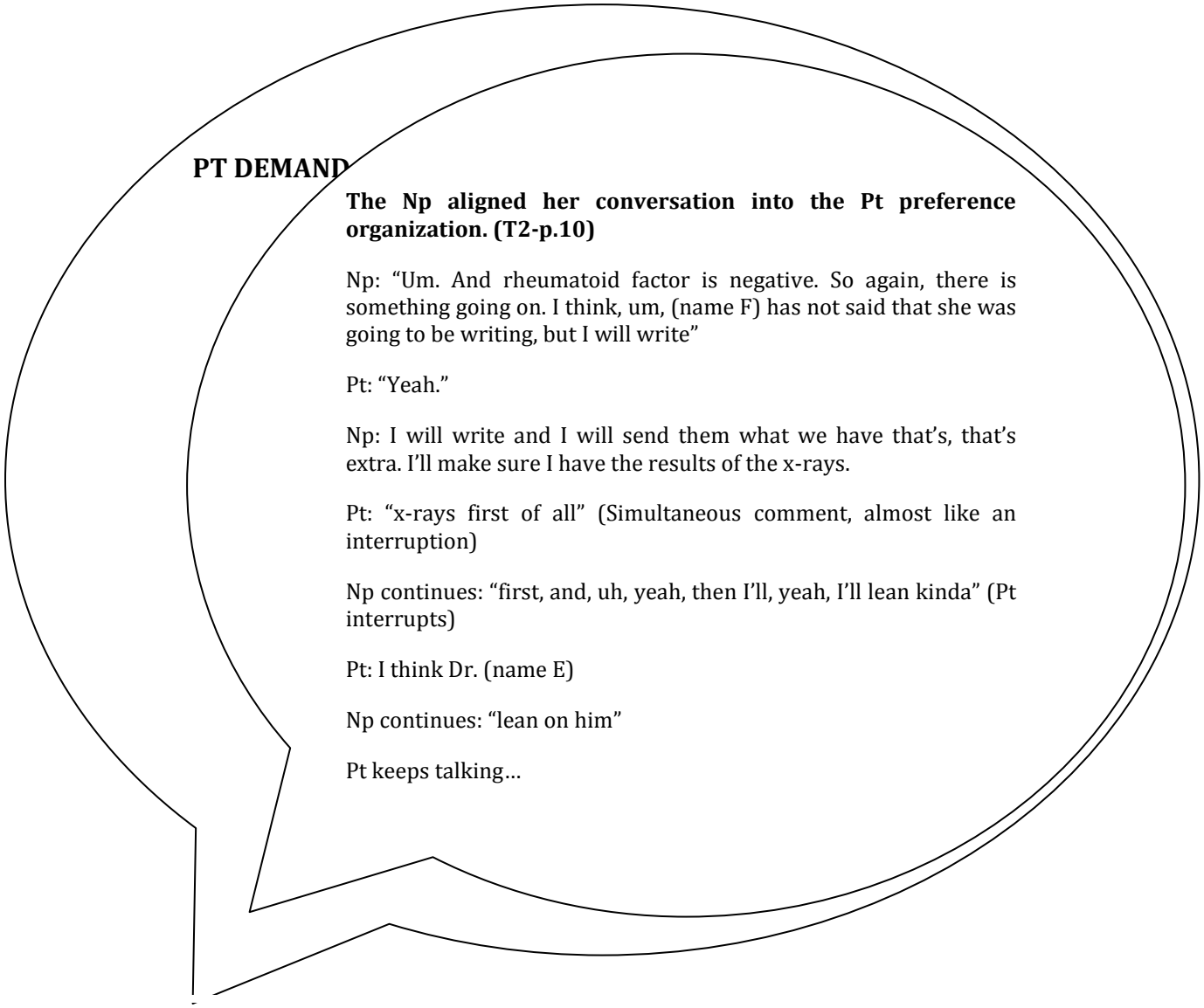
Np: "*Okay. So what did she (::) essentially she told you that she didn't think she could expedite it?*

Pt: "*Well no. She said that I could get a, uh // get a referral, like go back to see my GP and see// and, and my nurse practitioner and // um// and see, // get an assessment from you. And, um ,// if you thought that, that this would warrant an advancement of the appointment you could contact them."* The Np pauses here expecting a response, but once a response is given by an affirmation code, the Pt interrupts her with a demanding code.

Np: "Okay".

Pt: >*So (affirmative demand with a hint of question- Dx)*

At the beginning the Np interventions and even her corporal posture indicated that she was listening and trying to establish a conversational relationship with the Pt; however, apart from few affirmations and one question, the Np offered not other requests or responses during eight minutes and fifty seconds. Affirmation codes were not taken into consideration as interventions, but only as codes following the Pt's conversation. As a consequence of the Pt's long monologues the Np could not respond to the Pt requests in the short term. The Np aligned her conversation into the Pt preference organization. The most frequent conversation intentions by the Np, were: questions, frequent informational explanations as a response to the Pt demands and concerns, as well as individual action responses to individual action requests. An example of conversational alienation in the Pt´s conversation is follows.



In the next long passage found in Table 5.23, (T1-p.3, p.4), (T2-p.10 and T3-p.11), we are able to see a preference organization cyclical process repeated by the Pt during the whole interaction. This is a clear example of the transition from an experience based knowledge explanation to rational and emotional argumentations (complaints) supporting a demand. The Pt is requesting-demanding some test results and for a letter to accelerate her referral to a specialist. To delineate the explanatory comments about this process, the symbol (…)/ signifies that a comment has broken up the quotation. The symbol"*" indicates that the passage continues after the comment.

First, the Pt explained her medical history, her body sensations, and/or her experiences. Later, she converted her explanation into a rational or emotional argument. In addition, the Pt was asking for a Np response and when she obtained it, she interrupted the Np and kept talking. Then, the Np remained in silence. In these transition periods, the explanations, arguments or experiences and the complaints were undifferentiated. Next, the arguments turned into complaints to convince the Np that she (the Np) needed to generate an action to solve the Pt's struggles. Finally, the Np was able to make a request, which by its characteristics turned into a demand.

Table 5.23
Process from an explanation to a complaint to a demand (T1 p.3, p.4)

1) Pt explanation:
   - "/(…) *he gave me the same dosage as I had had in 2004. Um. But it was only effective for maybe 6 to 8 weeks.* (…)/*

1.1 Pt sharing her experience based knowledge:
- "/(…) *And, um, but then, given the situation, the knee had been inflamed for so much longer than it had in 2004. And my body's probably changed. And so um, but the cortisone was effective enough that (…)/**

*1.2*Transitioning period from explanation to complaint. She makes a slight pause and continues accentuating the word foolish and making a slight pause in the word things, with a hint of self-complaint:
- /(…) *and I was foolish enough to do some things (:), something at work that I shouldn't have. (…)/**

2) Rational argument as complaint:

/(…) *"So I, so* (…)/-(::)-Pt is thinking and continues - *and I've injured my left ankle (::) /(…)**. She elevates the tone, makes an attentive eye contact and pauses again as she waits for an Np response. The Np responds after a slight silent, after she realizes that the Pt is waiting for a response.
- Np: "Oh dear"

The Np's response makes the patient continue with her explanation-argumentation-experience. Pt continues simultaneous to the Np.

- Pt: "(…)/>*Um. And I have a problem with my left hand (…)/* * The Pt elevates the tone, make a pause, and makes sure the Np is making eye contact with her, but the Np does not respond this time

- */(…) as well (…)/** *The Pt* repeats the pause the tone and the eye contact to demand attention, but the Np did not respond this time either.

3) The Pt continues but this time the explanation-argument has turn into a complaint to a demand and the experience based knowledge has turn into another argument to support her demand. The demand is hidden under the code "sort of":

   - "/(…) *a joint in my left ankle flared up and hasn't go away, I kind of put two and two together that maybe the same things happening with my hand. So I had come in to see Dr (name) 3 or 4 weeks ago. I was here because I was concerned about the situation and I didn't' know. And at that time, I hadn't heard about my referral. And with the left ankle and my left hand there's complications that Dr. (name A) wasn't aware of. Um.(…)/**(continues under point 4.)

4) *(…)/ And wanted, and I wanted to know a second opinion or whatever. And so (name) resident saw me. And they took x-rays. So I don't know if those x-rays have come back sort of."*

A common pattern was found regarding topic structure, topic length, topic turns and intervention. Habitually, the Pt controlled the topics, making forced turns to maintain the topic control. Sixteen out of 25 topics were predominantly developed by the patient, usually with the use of forced topic turns. Nine topic turns were developed by the Np, among which 8 were forced topic turns. One topic was naturally developed by both of them.

The Pt talked more than the Np during the whole encounter, and much more so during Interval 1. The Pt, supported by a set of conversational codes, among which self-talk turns and false turns stood out, controlled the topic turns. Because the Pt controlled the topic turns, she determined topic content. With this topic control, the Pt turned what was supposed to be a conversational relationship into a one way structured conversation. Sometimes it turned to a two way structured conversation but always controlled by the Pt.

Structurally, the Np made nested topics but all related to each other. The topic never denoted shared action, but mostly demands posted by the patient. Later were solved by the Np with minimal interventions. This suggests a one way interaction where the Pt demand and expect a response back. Topic content was based then on the Pt complaints and demands, and on the Np constructive and disruptive efforts to respond the Pt to help her solve her multiple struggles.

About topic lengths, we have seen during the quotations explaining other particulates that the Pt conversation lengths were extensive. Monologue conversations also denoted a one-way exchange. The Pt fully controlled the conversation for about eight minutes and 45 seconds, and partially controlled it along the entire interaction.

Topic lengths ranged from 40 seconds to 2minutes, without interventions or with simple monosyllabic or duo-syllabic interventions from the Np. Mono or duo syllabic interventions were mostly intended to affirm the Pt conversation shape an empathetic response into an empathetic request.

Forced topic turn mechanisms were found, similar to the self-talk turn and self-and-others interruption particulates as control mechanisms. Generally, the Pt forced topic turns were founded in self-controlled conversations. This means that within her constructed topic, she makes turns, forcing herself to stop talking about one topic and started another. But these patterns led her to another closed cycle pattern, very similar and related to the *explanation-complaint-demand* pattern: When the focus of the conversation was finally on the solution of a struggle, the Pt went back to another struggle topic. Following this cycle, it appears that the Pt is always "flinging" demands for the Np to "catch" and resolved them all by herself. While one demand was being solved, another fling was thrown, and the process continued until the Np indicated a strong end. Then, the Pt started the cycle all over again. This was observed until the end of the encounter. This closed cycle of "catch and solve demand flings" interrupted an open process of collaborative struggle solving, replacing it with an individual Pt *demand fling*, and an individual Np *demand fling fixing*.

The next passage (Table 5.24) shows a solving struggle conversation, where the Np is trying to generate some individual solving actions as responses to the Pt demands; however the Pt kept returning to a topic containing a struggle, as well as a request or demand to solve it. In order to save space, minor or major conversation pieces were cut. If it is a minor cutting (---) this symbol will appear*(Conversation not posted)* marks a

longer cut. Looking closely at the next quotations we will clearly "hear" how in the middle of a struggle solving (by the Np), another cycle of complaint demands are posted, through repeated topic turns.

Table 5.24
Forced topic turns promoting a one-way or controlled a two way "demand fling, catch and solve" cycle

Context: The Pt wanted the Np to write her an referral letter to expedite consultation with an specialist. For that, the Np needed to assess the Pt. The Pt had those actions as the established agenda for the appointment, which she demanded during the encounter. During the encounter the Pt kept demanding the Np to solve several struggles. What it was "heard" in the next passage was that the Np's efforts to take care of the patient were being underminded by the Pt demands, specially the one about the referral letter. Whenever the Np made an effort to solve the previous demand, the Pt forced the topic to turn, to post another demand fling. Even though the Np agreed to write the letter at min 4:36, the Np continued justifying her complaints(why does she need the letter, the results, medication and so on).

TIME 1 (T1-p.7 min 8.20)

Topic: Referral letter nested in autoimmune disease (This was a natural topic turn)

- Pt: "(…) and, um, and see, get an assessment from you. And, um, if you though that, that this would warrant an advancement of the appointment you could contact them."
- Np: "Okay". (second time she agrees to do it)
- Pt: "So…" (***demand fling***).
-

Np came back to a previous topic of results (X-rays and blood work)

- Np: "The only thing I'm scratching my head about is that I'm not seeing, the X-rays. Did you go for them?"
- Pt: "Mm hm, that same morning."
- Np: "(…) You know what let me just make sure I don't have it in stuff that I've been putting aside because it wasn't normal (chuckle*). No, not (inaudible-Np rifling through papers). That would have been put under Dr. [D's name]"**(First effort in this piece, to take care of the Pt. 'Catch and solve')** She was looking everywhere (computer, desk, drawer).

(----------)

- Pt: "The resident consulted her."

Np made another intervention and suddenly, the Pt asked one more time for the referral. It "sounded" as if she was making the last sentence of the previous paragraph, just after the word 'so'(this happened almost one min after).

Pt Forced topic turn to referral letter

-Pt : "So I don't know whether you can (inaudible)". (***demand fling***)

Table 5.24 (continued)

Np continued in results topic (still trying to solve the results mystery)

- "And she did do antinuclear antibodies as well. And I didn't see those either. Where are all this things hiding? Let me just look again but I'm not, they didn't put them in a weird place." (**Np continued her effort about the results. *'Catch and solve'***)

The Pt, observing the movement of the Np in the middle of struggle solving 1, made another demand fling through a forced topic turn. She did not even formulate a complete question. She answered herself in advance and then flung the demand.

Pt Forced topic turn: Medication and demand.

- Pt: "And that's all um Dr. [name E] suggested I up the dosage of Naproxen, um, and take it regularly. So I've been doing that, but, and it takes the edge off. And I add, and I've been taking Tylenol when I can't take, because Naproxen you need food. So I've been kind of supplementing the Naproxen with Tylenol and I don't know whether that's OK or not; probably should be okay so that was one of my questions." (***demand fling***).

In the middle of the last individual solving, the Np generated a second effort to take care of the Pt by catching her demand and tried to solve it.

Np: "Yes. You can alternate those two safely. (T2-p.8)" (**second effort to solve a struggle in this conversation. *'Catch and solve'***)

Pt: "Okay" (T2-p.8)

Np: "We do it for children so…" (T2-p.8)
Pt: "Okay" (T2-p.8)
Np: "…not a problem (…)"

TIME 2 (T2-p.10, p.11 min. 16:20)

The next passage was in a different time of the passage above. It was actually a part of the conversation located in the double dialogue box inT2-p.10.

After 11min of explanations about why the Pt needs her results and the letter, and a 4 min Np absence, this was the new context.

Context: The Np came back with the Pt´s blood work but not the X-rays. The Np was telling her for third time that she will solve her expedites referral. Not one second had passed before the Pt was already developing another explanation-demand interrupting the Np´s struggle solving conversation. The Pt forced a topic turn to talk about another medication. She ended up coming back to the rheumatologist appointment topic.

Table 5.24 (continued)

Topic: Referal Letter/ X-ray results

Np: "I will write and I will send them what we have that´s that´s extra. I´ll make sure I have the results of the X-rays." (**Third effort**)

Pt Forced Topic turn: Medication 2 and complaint *(nested in referral letter and results)*

Pt: "> Well I think *Dr (name E) had maybe thought that I took, you know, the antibiotic or, no, the Aniprox, it was four times what I've been taking* (…)" The Pt keeps talking for about 15 sec more.
Np: "Yep".
Pt: ">So I increased that by 4 times and um and it still hasn´t help a lot (Cx)"
Np: "Okay"

Pt Forced Topic Turn. Pt came back to rheumatologist referral topic. (T2-p.11)

Pt: "> So that´s why I thought I would make the appointment today and come back and sort of, and just report back that like things still are not very easy for me. And, um, uh, I do have date now and it´s September 22nd."
Np: "Yes."
Pt: ">So , and I know"
Np: "and we´ll see if we can (inaudible)"

Pt interrupted the NP and made a topic turn with a complaint and a demand. She came back to another old topic: Inflammation. (Su-nested in medication which was nested in rheumatologist appointment, which was nested in referral letter)

Pt: ">This inflammation from what I, yeah //. Yeah, like it can damage the tissues in the joint and maybe cause problems late, even if we can figure out what´s going on and get it fixed I could be left with, with, with, um, sort of residual issues because the joints have been inflamed for so long. It´s been over a year for my knee. (Cx)

Pt: "So" (Dx)

TIME 3 (P.12, p. 13, p.15 min.20)

Np came back to solve the medication and inflammation issue (answering Pt multiple struggle posting)(T3-p.14).

The Np tried to offer the Pt prednisone, as an immediate solution to her demands and complaints. She has already told her that she will write the letter of referral and follow up her results. But the Pt continued to complain and demand conversations. Insistency was "heard" during the whole Interval and until time 3. It was also "heard" that the Np did not please the Pt even after several efforts. So, the NP offered the prednisone. The Pt, asked some questions, and then changed the topic to tell the Np about poison ivy that she had in the past. The Np responded and listened but her tone was not soft. The Np was waiting for a response and she looked a bit irritated. Finally, the Pt agreed to take prednisone, and in her answer another complaint was made. The Np interrupted her with a cutting "very good" and started typing on her computer in silence. The Pt kept talking without any pause and made a

third topic turn placing a new struggle while the Np is still trying to solve the medication. The Np kept responding and collaborating until she indicated the Pt that she needed to concentrate and keep writing on her computer.

Topic: Prednisone (4th Np effort)

Pt: "> At this point I'm ready to try. I'm looking for answers and if that's something that might // (…)/* (answer/complaint and keeps taking without taking a breath to make another demand. *See next* topic)

Np: "Very good" (cutting intervention)

Pt Forced topic turn Records Request (sub-nested in prednisone medication)

Pt: *(…)/ > work then. I asked for my files to be transferred, um, when I was here April 3rd, I got the form and submitted it"
Np: "yeah"
Pt: "> Um, from the previous clinic"
Np: "Okay"
Pt: "> But I haven't heard back anything from anybody about, there's, how to pay for that. Maybe I should follow up with the other clinic."(***Demand fling***)
Np: I would because you know what (**The Np collaborated with Pt, 5th effort. '*Catch and solve´)***
(*Continuation of the topic not posted*)

Np smooth but cutting indication to let her concentrate.
Np: "Just (*cut*) medications here…" (inaudible as she was talking to herself while writing on the computer).

They remained in silence for a while, but then the Pt starts talking again and comes back to the same topic about how much her partner and her are struggling. The partner participated this time, supporting the Pt, but the Np this time, cuts them off with a question. After that event they remained in silence for a while, until the Pt started talking again. The Np looked tense while working on her computer. The Pt tried to make social chat and the Np tried to follow her. When the Np was finished writing on her computer, she tried to end the encounter.

21:11 (Pt)FTT Partner's concern for patient welfare (nested in Records Request topic)
Pt: "> Yeah [partner's name]'s been worried, that's why and she wanted to come today. Well it's been hard for us."
Partner B: "It's been hard because I was kind of not very active for a while and she's, can barely walk, so, just to do house-cleaning and all that, those basic things."
Np: "Did I answer all your questions today? or did you have some more?" (The Np, trying to concentrate, made at this point, the most cut. But she smiles at the partner)
Partner B: "Yes." (The Pt's partner makes an affirmative cutting code and remains in silence)
(NP typing on keyboard). (Silence)

The Np turned around again and remained in silence. She was working on the computer trying to solve the Pt's struggles and demands. After a while, the Pt started a new topic.

Table 5.24 (continued)

The Np forced a topic change to ask her if she wanted a medication to her knee; the Pt also interrupted this struggle solving with a topic about a past poisoning that she had. (Not posted)
*Chukle (nervous chuckle)

As we can appreciate from the quotations in 5.24 the conversation was rooted in control. The Pt was leading the topic control. The Np was taking back the control at certain times to solve important struggles. Both of them were trapped in topic control. Forced topic changes and nested topics caught the Pt and the Np in a control mechanism where the Pt threw *demand flings* with every new topic she introduced; the Np caught them and "solved" them as best she could and then returned back to the struggle topic. "Solved" is in quotation marks because a solution implies a process, and the "solving" condition in Case B, was more like immediate demand fixing. The most radical topic turn from the Np was done by leaving the room. By leaving the room, the Np extracted herself from a difficult situation with a controlling and challenging patient. Coming back, she offered the most extensive conversation during this interval. Less radical forced topic turns by the Np, were seen along the encounter.

At Interval 1 and at the end of Interval 3 a clear association between the Np's silence and the Pt's topic initiation was found. At Interval 1 the Pt would not stop talking; the Np remained mostly in silence. At Interval 3, in periods where the Np remained in silence to concentrate on her computer (typing up notes) and forging solutions for the Pt, she (the Pt) initiated another topic, as part of her controlling closed cycles. Np overall conversational length was much shorter or limited compared to the Pt's extended topic length. Topic behavior can be appreciated in Table 5.24. A closer view to the topic pattern during the appointment can be seen in Table B1.

Case A. Prerequisites to simultaneous listening and shared action: Mirroring codes, alternating conversational leadership and opening interruption management.

Case A codes reflected sharing between the Np and Pt right from the start of their encounter. Both Np and Pt used affirmative codes (okay, Yeah, Yep., Uh-huh, Yes, Right, mm-hmm, oh yeah, oh, Sure) during the entire encounter; to let the other know, they were listening and agreed with each other. The smoothness of the codes resided in the tone of voice (paused, soft, cheerful and sometimes intertwined in a slight question). It also resided in the constructive gesture and posture, and the eye contact while affirming. Similar to Case B, the Np also used the code "okay" to open or close some sentences. The code "right" was the less smoothened code used by the Np during the first two Intervals, but it was never used as a cutting code. Though, in the middle of Interval 2 and Interval 3, the Np used few of the same type of cutting codes used in Case B; however, during Interval 1 and 2 the code "yep" was informal and smooth and it was used to reaffirm the Pt. "Yep" washer most frequent cutting code at time 3. Some codes examples are displayed in Table 5.25.

Table 5.25
Case A examples of Np codes usage

Example 1. Np use of codes (T1-p.2)	Example 2. Pt use of codes (T2-p.8)
Pt: The next morning it was a fasting thing. Np: Yep. (Cheerful and affirmative tone of voice)	Np: "Okay, so let´s talk about your blood work" Pt: "Yeah ./?" (The tone of voice, half affirmation (.), half question (?) denoted a smooth agreement). (T2-p.8)
Example 3. Less smoothened use of the code "Right". (T1-p.2)	**Example 4.Cutting usage of code "yep." (T3-p.27)**
Pt: "Or we did the, last time I was here, I went right over and get the X-ray". Np: "Right".	Pt: "All I did was go there, urinate in a bottle, and…" Np: "Yep." (She is writing on a paper)

Code mirroring was present throughout the encounter. Case A constant mirroring is in contrast with Case B's periods of mirroring, in that this behaviour facilitated conversational connections. Case A not only had mirroring codes, but also, the mirroring periods were equitable and intermittent, focusing the encounter towards shared questions, answers and actions. This means that there were no monologue periods but complementary conversational pieces. The most frequent periods were the ones where the Np led the conversation and the Pt accompanied her with short affirmative codes, questions or complementing pieces of sentences. Less frequent but still recurrent, were the occasions in which the Pt led and the Np followed with short mono or duo syllabic affirmative codes, short answers or pieces of a sentence. In the whole encounter, the leading voice alternated between both, although the Np led more often than the Pt. Moreover, an alternate leading voice was "heard" over the same piece of conversation. It was frequently found as a middle stage between the Np leading, and the Pt leading.

Two actions turned the leadership in the conversation. The first one was a question, usually posted by the Pt and usually reaffirmed by the Np. The second one was a change in the topic caused by a sudden memory about their (Np and Pt) own agenda, or a complementary recommendation. The whole leading alternate process was a broader mirrored behavior, facilitated by mirrored codes, questions, answers, and explanations.

The conversational pattern of alternating leadership was as follow. In stage 1, one person led and the other followed. In stage 2, the person in silence participated with a question, an answer, or an action. Then both of them led some parts of that

conversational piece. In stage 3, the one in silence at Stage 1, led. An equitable, open, and fluent conversation was "heard" in periods of alternate leadership. However, interruptions were made, being more frequent during the second stage where both are equitably leading. An example is displayed in Table 5.26

Table 5.26
Alternate conversational leading (T1-p.3)

Np leading the conversationT1-p.3 (Stage 1)

-Np: "So let's start with your blood work"
-Pt: "okay"
-Np: "because that's a little more simple to go through"
-Pt: "Oh, yeah"
-Np: "And I can give you a copy of your results, if you would like them"
-Pt: Eh-heh.
(----------)
-Np: "Okay? Nothing worrisome with your, with your, uh, red blood cells, white blood cells, and everything…"
-Pt: "Oh yeah"
-Np: "is good kay? Your Vitamin B12…"
-Pt: "Uh-huh"
-Np: "Is still within the normal"
-Pt: "Uh-huh"
-Np: "But it´s starting…to…like it´s it´s 132, being"
-Pt: "Yeah"
-Np: "the normal. Yours is 196. If, if I…"
-Pt: "How do I get it down?" (question)
-Np: "How do you back it up you mean?" (Question reaffirmation with correction)
-Pt: "Okay back up"

Pt posting a question generating alternate conversational leadershipT1-p.4 (Stage 2)
After a brief Np's explanation, the Pt asks some things around Vitamin B12, leading now the conversation.

-Pt: "Vitamin 12?"
-Np: "B12"
-Pt: "What is that?"
-Np: "You can buy that just over the counter…. Why is it?" (question reaffirmation)
-Pt: "Yeah"
-Np: "That it´s going down? Normal again. The gut just doesn´t absorb it"
-Pt: "Eh-heh"
-Np: "from food the way, the way…"
-Pt complements the sentence: "It should"
-Np: "Normally did"
-

Table 5.26 (continued)

Pt leading conversation (T1-p.4, p.5) (Stage 3)

Pt: "Okay, cuz I take that, ahem, it´s Kirkland, but it´s something like that Centrum A to Z thing (./?)
Np: "Yep."
Pt: "I take one of those veryday".
Np: "kay"
Pt: "And in the winter, last year, because the last two years we haven't gone south… I started that, uh, Vitamin C is it?"
Np: "Yeah. That's fine"
Pt: "That 500 thin'"
Np: "Yep"
Pt: "or somethin', so that, that was because I was, uh, not going to the south eh? So I"
Np: "Yeah"
Pt: "needed to up it."

Np making a recommendation generating alternate conversational leadershipT1-p.5 (Stage 2 again)

Np: "Yep. Vitamin D is something you also should be…"
Pt: "Vitamin D?"
Np: considering taking"

Conversation is posted in table P. You can appreciate how this stage 2, has the exact same effect that the first stage 2. This time (table P), after an equitable participation, the Np takes the lead again. As you can appreciate, Stage 3 for the patient is stage 1 for the Np and vice versa.

Alternate leading conversations were the most intense periods in regards to conversational relationship. During alternate leading conversations, interruptions were frequently made. At Intervals 1 and 3 interruptions were issued from both sides; however and different from Case B, both made immediate interruption repairs to listen to the other person. It was more likely that the one making the interruption was the one immediately making a self-interruption to maintain the silence and let the other talk. Almost simultaneously, the one being interrupted also made a self-interruption and see if she or he can continue talking or the other´s interruption was more important. This behaviour allowed the Np and the Pt to continue in a related conversation.

Self-interruptions in Case A were not part of a control mechanism, but a facilitator to enhance connections. First of all in Case A, self-interruptions worked as an *other-interruption´s-repair*, even if the interruption was not made by the person making that self-interruption. Second, self-interruptions recurrently left a conversational space open for the other to participate or for the one making the self-interruption to see if the other understood. This repetitive behavior facilitated a completely open text. In the next example (Table 5.27 several things are shown in regard to other particulates that will be explained further on. Supported by interruptions and interruption repairs, an open cycle from equitable interruptions to collaboration was possible. An example is displayed in the same Table 5.27.An open cycle is rhythmic, flexible -not blocked by one or the other-, dynamic, and alternated. The text appears open and even (more balanced) compared to the long talk periods and closed blocking interruptions in Case B. This type of open equitable and constructive communication cycles, reverse the disruptive isolating (individualized) and controlling circles based on interruptions, seen in Case B and some periods in Case A (Table45 at the end of Case A).

These opening cycles were developed through 4 stages.

1) The Np or the Pt (In the example in Table 5.27) initiated some interruptions. 2) The person interrupting made immediate self-interruptions to repair the interruption applied to the other (other-interruption). 3) The person who was interrupted also made an interruption repair, through a self-interruption. 4) An equitable simultaneous interruption was developed. A rapid and implicit simultaneous period of understanding let each one of them decide if it was more relevant what they were saying and so to continue talking, or otherwise, to remain in silence. The one in silence, never remained

is silence for more than 40sec. The one talking listened to the other after his or her participation ended. 5) A collaborative questions-answers and actions conversation was developed after stages 1 to 4. This cycle is demonstrated in table 5.27 also serves as an illustration of preference organization developed further on.

Table 5.27
Examples of interruptions and immediate equitable interruption repairs to collaborative care

Example 1. T1-p.5

1) Interruptions
-Np: "Yep. Vitamin D is something you also should be… (*/)"
-Pt interrupted: "Vitamin D?" (open question)
-Np completed her sentence: "(*/) considering taking"

2) and 3) Repairs

2) Pt talked and then made a self-interruption repair: "Well, th-the (silence)"
-Np responded to the Pt: (Yes) "A little bit of Vitamin D…."

2) Pt interrupted again: "Is that…(and then made an immediate self-interruption repair. Silence) (*/)"

3) Np continued: "not, not" (and then interrupted herself to hear the Pt question)

Stage 4 is implicit and almost simultaneous to stages 2 and 3. In this case, they decided that the Pt has an important question to ask.

Stage 5: collaborative questions-answers and actions conversation
-Pt took the gentle Np talk turn: "Is that the one for the sun?" (open question)
-Np answered to the Pt, and then continued the interrupted sentence: "Yes…not now"
-Pt shared experience based knowledge: "Yeah, that´s what we´re taking"
-Np: "Oh, that´s what you are taking already (./?)" (reinforcing question)
-Pt: "Yeah, yeah, just in the wintertime"
-Np listened the Pt's shared experience and affirmed: "uh-huh"
-Pt: We start October and we end in May"
-Np gave complementary informational knowledge suggestion: "Okay. I would recommend some Vitamin B12" (recommendation to action)
-Pt: "Yeah?" (question)
-Np answered: "Only the 500mg, that's the lower dose".

We can actually say that an adjusted period of interruptions -as conversational struggles- is needed to develop an open, rhythmic and connected conversational

relationship. It depends on the way in which the interruptions are handled. Like Case B, a disruptive inequity can be "heard" if interruptions are used for conversational control, and the one being apparently controlled remains in silence. If there are equitable interruptions from both sides without equitable repairs, a disruptive equity will follow. If equitable repairs happen, an equitable, open relation can be developed.

Case A showed a third way or a third stage in the care relationships evolutionary process. If interruptions are made and both of them share codes, repairs, experience and informational base knowledge, and the same objectives, it is more likely that what "sounded" like a disruptive equity, can be transformed into a constructive equity. In the first example in Table 5.27, and in Table 5.28, Interval 2 evolved from interruptions and interruption repair periods to complementary conversations. A subtle example of less accurate to more accurate sentence complementation at Interval 2 in Case A, is shown in Table 5.28

Table 5.28
Periods of sentence complementation

Example of non-accurate line (sentence) complementation (T2-p.10)
-Np: "And have you ever told your cholesterol was up? -Pt: "No, it´s always been 4 or 5" -Np: "4 or 5. It is 4.5, which on itself, that´s the, the…" (*Np was searching for a word*) -Pt : The edge. (*The Pt sounded confident about the word with which he complemented the sentence, but it was not the one the Np was looking for. Though, the Np made a smooth correction*). -Np: "the overall (*pause to make a smooth correction*), well, that´s the overall number of all the different kinds of, of fats in your …(*/) -Pt: "Oh yeah ./? (Smooth affirmative question tone) -Np: "(*/) in your blood, however, some of the individual ones are elevated" -Pt: "Yeah".
Example of more accurate sentence complementation. Mirroring an idea (T2-p.13, p.23,p.24)

Table 5.28 (continued)

-Np: "…talking to you about this. But I like to talk to people about it just when it´s starting to be border….(*simultaneous to Pt´s sentence complementation*)…..**line**.

-Pt: "**line**, yeah" (p.13)

-Pt: "She is over…"
-Np: "Physio?" (p.23)
-Pt: "And, and she (…)" (p.24)

The middle of Interval 2 was a combination of simultaneous intermittent leading talk, simultaneous interruptions repair, and simultaneous mirrored talking. In spite of its constructive evolution, this combination was always at risk to slip into a monologue. The risk of no one listening to the other was present all the time in the highest interactional periods in Case A. Longer periods of simultaneous interruptions can develop a more complex form of monologue, where both characters have their own monologues. Simultaneous talk was differentiated with simultaneous interrupted talk, based on the gradient of conversational relationship. If both were complementing one related conversation by counterpoint means, a simultaneous talk was "heard". If both were talking at the same time without listening to the other and the conversational line was lost, simultaneous interruption was "heard" (as in Case B). To "hear" a deeper example of a process going from simultaneous interrupted talk promoting attenuation, to simultaneous talk promoting collaboration see Table 5.35.

Case A. Shared oriented conversation focus on health: Breaking control mechanism, and facilitating a relational mechanism.

Pronouns usage and preference organization suggest an interaction based on a sum of individual actions and shared actions as well. Both particulates, pronouns and preference organization, illustrate a relationship centered on solving struggles through a two-way caring attitude.

The use of pronouns during the appointment showed the multiple Np efforts to evolve the interaction from an individual orientation to a shared orientation. It also showed how the Pt followed the Np. Although based on pronoun frequency, it seemed that the Pt had less interest to transform the interaction from an individual to a shared orientation, the Pt contributed almost at the same level as the Np, to do so.

The pronouns posted by one person, were usually in direct relationship to the other. Sometimes it was indirectly related to the other through a shared action, a previous question, or an individual action within a shared plan. One most consider context when making an individual pronoun frequency counting. Therefore, 5.29 demonstrates the pronouns frequency, and 5.30 exemplifies it through some quotations.

The Pt used the same number of first person singular *I* at Interval 1 and at Interval 3;there was a reduction of this usage at Interval 2. The Np increased the usage of this pronoun during the encounter. Though, compared to Case B, this pronoun appeared less during the whole interaction. The pronoun *you* and the use of *your*, appeared in the three Intervals, most often used by the Np.

The Pt and the Np also showed paired *I-you* conversations at Interval 1. Paired *I-you* pronouns denoted an other-oriented conversation, sometimes even showing care underpinnings. The Pt decreased this type of pronoun interaction during the three Intervals, while the Np maintained it.

In several cases, *I and you* denoted agreed individual shared actions. At Interval 1, only the Np paired *I and you* in such a way. At Interval 2, we found an equitable use of it. At Interval 3, both of them increased their *I-you individual shared actions*

conversation, being used more often by the Np, but always in agreement with the Pt. This type of interaction evolved to a *you and me* and *we* relationship.

You and me, and *we* relationship was made in periods of shared decisions and shared actions. Although the Np made the most usage of this pronoun, the Pt always agreed. This behavior suggested that even though the Np was leading the conversation, both of them agreed to construct shared decisions and shared actions. Interval 1 had fewer examples of *you andme* and *we* usage, which by Intervals 2 and 3, had greatly increased.

Table 5.29
Type and frequency of pronouns used during the 3 Intervals of time

	I, my, me, you(r)		Paired I-you (other oriented, and sometimes caring about the other)	I - you (agreed individual action or shared action)	You and me, and We (shared decision, shared action)
			Time 1 (T1)		
Np	2	you(r): 9	7	5	1
Pt	19		6		2
			Time 2 (T2)		
Np	6	you(r):20	5	1	10
Pt	16	you (r): 3	0	2	0
			Time 3 (T3)		
Np	7	you(r):3	6	12	9
Pt	19		0	5	1

Table 5.30
Pronouns example

I, my, me, you(r)	Paired I-you	I-you (agreed individual action)	We (shared decision, shared action)
Time 1			
-Np: "You know what, if **I** mided it, **I** would have said no (…)" (T1-p.1) -Pt: "or somethin', so that, that was because **I** was, uh, not going to the south eh? So **I**" (T1-p.5) -Np: "Okay? Nothing worrisome with **your**, with **your** uh red blood cells (T1-p.3)	T1-p.1 So, are **you** here because **I** asked **you** to?(see answer column at the right.) T1-p.1 (Caring I-you) -Pt: "(…) do **you** mind this? -Np: "Do **I** mind it?" Np: Do you? -Pt: No, but **I** just, **I** don´t wanna… if **you** don´t wanna -Np: Remember **I** am the one who asked you…(laugh). (p.1) -Pt: And, uh, as long as **you** don´t mind it. (p.2)	T1-p.1 -Pt: **Yeah** -Np: **You are** T1-p.3 How do **you** get it back up **you** mean? (p.3)	-Pt: "Or **we** (…) did the (…)" (T1-p.2) -Np: "Now here **we** go" (T1-p.8)
Time 2			
-Np: "Um, so, **you're your** liver is doing fine, **your** sugar is fine (…). Your thyroid level is fine" (T2-p.9) -Pt: "How do you call them?" (T2-p.22)	-Np: "And then **I'll** get to **your X**-ray" (T2-p.9) <u>Caring I-you T2</u> -Np: "**Yours** are not big problems okay? (…) But **I** like to talk to people about it just when it´s starting. (continues in example at the right column*)	(*continuation) so **you** can make the changes" (T2-p.13) -Np: "And that **you** are gonna (…) have a Ct" (T2-p.25) -Pt: "Can she (…) contact you?" (T2-p.25)	-Np: "Let´s talk about your blood work" (T2-p.8) -Np made a beautiful correction from I to we: "Um, your cholesterol is the only thing that **I** need, that **we need** to look at" (T2-p.9)

	Caring I-you T2-p.21 -Np: "**I'**ve actually brought that up on the computer here (…) You got your reading glasses?" (T2-p.21)		
	Time 3		
	Caring: -Np: "**I** can carry that out for **you** if it's easier" (T3-p.33) -Np: "Do **you** want me to get that for **you**?" (T3-p.33)	-Pt: "Did **you** wanna do that? Or do **you** wanna wait till this is over and do that?" (T3-p.27) -Np: "And did **you** do those (…) tests? Did I ask you to do those?" (T3-p.27)	-Np: "**We** are going to look into that" (T3-p.26) -Pt: "and other thing **we** talked about last time (…)" (T3-p.27)

Preference organization was based on mutual knowledge and agreements, questions and explanations to solve the Pt struggles. A constant set of open and dichotomous questions and answers was found. Moreover, the questions and answers were not controlled by anyone. No one was alienated in the preference organization of the other as in Case B. Both established a shared preference organization. Preference organization was based on sharing their diverse intentions: experienced base or informational-based knowledge, questions and actions, experiences, and care.

Tables 5.27 and 5.32 show a shared conversation oriented to the Pt's health rather than focus on demands (as was the situation in Case B). As might "hear", this orientation was possible even when complaints and struggles were present. Moreover, none of the participants were trying to demonstrate medical informational knowledge like in Case B. Both shared experiential and informational knowledge to promote

health. Additionally, questions and answers were open. These question-explanation structures suggested a preference organization based on requests and invitations, rather than in demands and demands of individual solutions. For example, the Pt posted real questions and let the Np answered them. In turn, the Np also made short but caring open questions, either to reinforce the Pt or to make sure she understood a previous request in order to answer it. The terms, *open* and *real* in this regard, means that both made questions only to be responded by the other as opposed to being previously responded by themselves (Case B i.e. Pt3 medication questions). It also means that not only short informational questions were dispatched (Case B i.e. Np: "Now, you are a…. microbiologist" p.16).

Generally, the Pt posted questions and the Np answered with an explanation based on informational knowledge. Then, the Pt complemented this information with experiential knowledge, relating that information to his own life. Subsequently, the Np invited the Pt to follow some recommendations based on the Pt's experiences.

In addition to table 5.27 and 5.32, several examples illustrate this *request-knowledge sharing-invitation* preference organization among the three Intervals of time.

In Table 5.27 Interval 1 we can see a shared experience and informational based shared knowledge. The Pt asked some questions and shared experience-based knowledge about Vitamin D, and the Np answers the questions and recommends the intake of other Vitamins based on informational knowledge. In table Table 5.34, Time 2 the Pt shares his concern about losing weight and about the harm of eating peanuts. The Np shared her knowledge about eating peanuts as a beneficial action. In the same table Table 5.34 Time 3, both are addressing their own agendas. The Pt asked about the

Colonoscopy test, and the Np answered him and asked him if they talked about blood fecal tests. In the Table 5.31 (T3) displayed further on, the Np recapitulated the actions that both of them, individually, would have to make in order to take care of the Pt. They stated an action plan developed during the appointment. Two more examples of shared care and shared experiences at T1 and T3 found in Table 5.30.

Sharing the preference organization strengthened the relationship. In turn, deeper interactions allowed a more equitable preference organization. Case A had several periods of a two-way open and caring relationship. A two-way open caring relationship, in frequent occasions followed a two-way interrupted interaction. Table V exemplifies this type of interaction (see also Table 5.35).

The first example in Table 5.30 shows how the Pt started the whole encounter with an intention completely oriented to the Np´s feelings about having a camera in the room. He is worried that the "system" is forcing her to be video recorded. The topic content was developed naturally. The Np reminded him that they both agreed to do so, and that is for a research project about what she does. The second example shows how almost at the end of the encounter, both of them, leaded by the Pt, shared some personal experiences about their holiday cottages. In this conversation, the Np shared information about her cottage, and then the Pt did the same. He also explains how he had to sell it because of his unsolved health situation; although his tone did suggests that he was complaining. In turn, the Np continued listening to his story, making brief contributors.

Table 5.30
Equitable and both sides caring preference organization with natural topic turn

Opening conversation: example of shared intentions through a two way caring attitude (T1-p.1 and p.2)

-Pt: "And another thing is, do you mind this?"
-Np: "Do I mind it?"
-Pt: "Yeah"
-Np: "No. Do you?"
-Pt: "No, but I just wanna… if you don´t wanna… (*He makes a nonverbal signal to let the Np know that they can turn the camera off if she is feeling uncomfortable with that*)
-Np: "You know what, if I minded it, I would have said no right off, right from the get go."
-Pt: "Oh. Oh. Okay"
-Np: "Remember? I´m the one who asked you… (open and cheerful laugh)
-Pt: "Yeah, I know you did but."
-Np: "Okay".
-Pt: "I wondered whether the system is forcing"
-Np: "Oh no no not at all"
-Pt: "And uh, as long as you don´t mind it"
-Np: "Now it´s to advance ah, advance research in what I do…"
-Pt: "Yeah"
-Np: "So that´s never a bad thing. (pause) Okay./?"
-Pt: "Okay."

Smooth Np topic turn to start the inquiry care interaction
-Np: "So, are you here because I asked you to come back?" (*Establishing agenda*)
-Pt: "Yeah".
-Np: "You are. Okay. Or was there a problem specifically?" (*Opening to let the Pt establish his agenda*).
-Pt: "Or, we we did the, last time I was here, I went right over and got the x-rays" (…) Now, sorta let see (…) what the results are" (*Pt establishing his agenda*)
-Np: "Okay"
-Pt: "Good or bad, or…"

Closing the encounter: example of shared intentions through a two way personal life talk (T3-p.30-31)

-Pt: "Where you going for holidays?" Curious.
-Np: "To my cottage"
-Pt: "Oh. Where's your cottage"
-Np: "Place name"
-Pt: "Oh. Isn't that nice?"
-Np: "Yeah"
(----------)
-Pt: "I had a cottage in Lake of the Woods"
-Np: "Oh, that's bit further"
-Pt: "Yeah"
-Np: "That´s farther to get to eh?
-Pt: "And, uh, I had it for 50 years. Had to sell it last year… because of these problems"
-Np: "Oh…" (Empathetic and surprised tone)
-Pt: "I can´t to the work and the wife has a new knee"
-Np: "Yeah."

Table 5. 30 (continued)

Open simultaneous related talk
-Pt: "So…"
-Np: "There comes a time…"
-Pt: "had to sell it"
-Np: "if the kids aren´t there to…"
-Pt: "Yeah"
-Np: "do all the work for you…"
-Pt: "Yeah. They were disappointed we sold it, but the one daughter helped…she paid off her mortgage like I had done it years ago. I was still working at the 80´s, I divided the thing into four, you know, four owners"

(Conversation continuation not posted)

Requests, responses and invitations were not one way or two way controlled exchanges or interactions, as was the situation in Case B, but an open and flexible two non-linear way dialogue centered in care. This shared inquiry-solving continuous process generated more and deeper connections between the Np1 and the Pt1. With such connections and small (limited) interruption mini cycles, struggles had a full solutions shared by both. A rhythmic and dynamic struggle solving relationship was heard in Case A. At the end, they shared a plan, which was reviewed and confirmed by the Np in a checklist fashion. In the plan, future individual actions for both subjects were posted by the Np and affirmed by the Pt. All the actions were oriented to solve the principal health conflicts. The plan is contained in Table 5.31.The Pt announced a doubt about a hernia operation. The Np answered him and made a smooth semi forced topic turn to condense the action plan.

Table 5.31

Shared Action Plan. Summary of the inquiry solving interaction (T3-p.28, 29,32,33, 34)

		-Np: Okay now, this is the plan (deep eye contact)
	-Pt: Okay	-Np: um, I am going to order a CT scan
✓	-Pt: Uh-huh	
		-Np: And a bone mineral density
✓	-Pt: Uh-huh	
✓	Np: Okay? (…)/ (deep eye contact)	(….)/ Cuz I want to know what your hips are doing as well (…)/
		-Np: /(…) and you go ahead and see the physio.
✓	-Pt: Yeah	
		-Np: And see the dietician
✓	-Pt: Yeah	
		-Np: And I will, I will talk to the powers to be and get an 'okay' so that you can start on something called Fosimax.
		-Pt: Fosimax? Gee everybody´s got a max on
		-Np: Yep.
		-Pt: Like I was on (Np interrupts his current experience sharing, to explain him what Fosimax is)
		-Np: "It´s a pill that you can take once a week (…) and it´s for osteo-ar- hu-porosis"
✓	-Pt: Uh-huh	
The Pt shared an experience and cut the plan. Conversation not posted to save space. Continued on the next step of the plan…		
		-Np: Okay and most of all, I am away for the next three weeks (…) but after that, I think the next appointment has to be completed physical
✓	-Pt: Yeah okay	
✓	-Np: Okay? (…)/ (deep eye contact)	/(…) so we can have a good look after everything else, okay?
		-Pt: That´s why I wanted to come now because I know you were going away.
The Pt asked friendly personal questions about why was she leaving. They both talked about their holidays, and their holiday cottages. Then, both came back to the plan. Conversation not posted. Continued on the next step of the plan. (p.32)		
		-Np: Next appointment, um, let them know when you call, for a complete physical./?
✓	-Pt: Yeah, Okay	
		-Pt: And you were going to Photostat one of those. (results)
✓	-Np: Yeah. Yep. (…)/	/(…) I´m going to do that on the way out. (…) And, um, just a bottle of Vitamin 12.
✓	-Pt: Yeah	
Pt shared another anecdote. Not posted. Continued on the final part of the plan and the closure of the whole appointment (p.34)		
		-Np: "Okay well, we´ll see if we can figure out what the problem is, and if (…) if it´s something we can fix ./?
		-Pt: Yeah. Okay. Thank you
		-Np: Okay (patient name). She put her hand on his shoulder and accompanies him on the way out.

Deeper interactions occurred during the whole encounter. Interval 1*interruption repair open cycles,* were definitely predecessors of a mechanism, which evolved from disruptive interruption periods to the development of a constructive mechanism "heard" from late Interval 1, to Intervals 2 and 3. An open, flexible and dynamic relational mechanism, where conversational connections about the same topic oriented to the same objective, was enabled in Case A. Table 5.32shows how those connections brought the Np and the Pt together in a sharing of experiential and informational knowledge to generate multiple "solutions". The term "solutions" is in quotation marks, because in Case A, the Np and the Pt were able to solve more than struggles, complaints related to the struggles, and demands. They actually, addressed multiple caring strategies and focus on the principle subject of care: the patient´s health.

In Table 5.32we can "hear" a different interaction than the one constructed in Case B, when facing some struggles. The Pt in Case A also made some complaints during the encounter in regard to other professionals and failures in the health system. Nonetheless, Pt in Case A, did not make any demands. The Np was able to calm the Pt almost immediately. As a consequence of this interaction, the struggles and complaints were not transformed into a demand, but into a shared action solving process. Table 5.32will also serve as an illustration of preference organization.

Table 5.32
Case A constructive mechanism to develop solutions (T 2 p.18 and p. 21)

Context: Np and Pt discussed the Pt's most sensible health struggle. He had a back problem that was impacting his daily life. Because of careless relationships among several professionals during a long period of time, his back had not been healed. He was to other practitioners, taken medication, and had a history of interventions. Lately some x-rays had arrived. The Np asked to get closer to revise them together, and he agreed. Both were corporeally other oriented looking at the same results, as the nonverbal results demonstrated. Np was explaining, and the Pt was listening. Constant eye contact happened.
(p.18)

-Np: "Let's talk about this X-ray (…)"
-Pt: "Okay"
-Np: "Not at all normal (disruptive presentation of results)"
-Pt: "No?" (question)
-Np: "No. A lot of things on here and I've, I've discuss it with one of my colleagues, one of the doctors I work with. (…) They didn't have any prior exams to compare it with" (p.18)

T2. p.21
-Np: "And, um, but she's recommending a CT scan for your spine."
-Pt: "Oh, another one up there" (Complaint)
-Np: "Okay. But this would be specifically for your spine" (Small and short explanation)
-Pt affirmative interruption: "Oh, yeah" (Calmed down)
-Np continues and then give a talk turn: "to see what's going on in here."
-Pt: "Oh how long's that's going to take? The last one took so long, that the problem was gone when I got up there" (from explanation to complaint, without a demand).
-Np offered a shared (we) solution with a smooth and positive tone:
"You know what? When we can attach something like this.(*/)
-Pt: "Yes(./?)" (question to make the Np continue talking)
-Np continues, simultaneously to Pt's affirmation/question:
" (*/) with it…
-Pt completes the sentence counterpointing the Np: "It helps".
-Np complemented the Pt counterpoint with another counterpoint:
"Um, they will probably expedite it"
-Pt affirmative listening code: "Yeah"
-Np: "Cuz, cuz, there's two things that we want to find out. We want to find out #1, is, is this something that shouldn't be there, like a tumor." (Pt smootheness her tone of voice and make deep eye contact).
-Pt: "Oh yeah" (He is calmed).
-Np: Ooookay? (caring question with smooth tone and deep eye contact again –*CSE*-), that's the worst case scenario. We want to know that its not that. If it's bot that, we want to know if it's something called spinal stenosis. Ooookay? (*CSE* again). And I've eventually brought that up on the computer here…let me see. You got you're reading glasses with you? (Smooth and caring invitation to look at the same results together).

The Pt dragged his chair to get closer and the Np moved the computer screen in order to share it with the Pt. The Pt was able tosee them now, and starts participating.

-Pt: "Oh well, these are…" (The Pt leaves the space open so that the Np can answer, but she only displays an affirmative code)

Table 5.32 (continued)

-Np: "Okay"
-Pt: "What do you call them?" (The Pt then makes a direct informational open question)
-Np does not demonstrates knowledge, only explained in basic terms what they are looking: "Well, I'm not gonna get too complicated about this"
The Pt gives her confidence about how she choose to expose the information:
-Pt: "No".
-Np: "But basically, it's a narrowing of one or more areas of the spine, especially in the upper or lower back (stop to check if the Pt is following).
-Pt: "Uh, huh."
-Np continued: "that presses the spinal chord…" (stop to check if Pt is following)
-Pt: "Uh, huh."
-Np continues: "Oookay? (CSE again) Where the roots of the spinal nerves come out. This pressure can lead to any problems that often occur when talking or standing" (She looks at him while pointing at the information in the screen)
-Pt: "That's what they do." (The Pt shared what he experienced in his body in relation with which the Np is explaining with an object such as a computer and the X-rays)

The next part of the conversation is displayed in Table 5.35

In terms of topics, those were also particulates contributing to Case A relational mechanism. Almost during the three Intervals, we heard equitable topic turn behaviours. An equitable and natural topic turn was more frequent than an uneven forced and controlled topic turn during the whole appointment. During Interval one, 7 out of 9 topic turns were natural and the Np forced two. The most forced topic turn happened a few moments before entering to Interval 2- the most intense stage of the interaction (see last example Table 5.35).

Interestingly enough, the most cut in Case A, was very similar to one of the most cuts in Case B. The Np made both, Case A and B cuts, right after the patients shared emotional intentions related to their health situations and the inefficiency of the health system to detect them on time and help them. What was different between both cases was the Pt´s response. Case A Pt, was disconcerted, but his recovery was almost immediate. Case B Pt reacted with an immediate "Ok" which suggested she was calm;

but afterwards, she developed another complaining monologue. Both cases are explained in Table 5.33.

Table 5.33
Case A and B examples: cut after emotional sharing

Case A Intense stage of interaction with cut after an emotional sharing
Topic- Pt Pain (nested in CT scan) (T1-p.8) -Np: "Okay" -Pt: "Then I just started with this, here up at the top of the hip here, this pain, it hurts when I walk, like sitting here, I got no pain, that´s the, that´s the frustrating part. If I do nothing I´m okay. But I like to walk and it hurts. **Np topic turn. Test-Doppler Study. (T1-p.8)** -Np: "Okay, now, you had a carotid Doppler study". -Pt: "What´s oh, yeah, (The Pt "sounded" completely disoriented, but he recovered quickly and asked a question to the Np), I went into the St. Boniface Hospital while I thought I was having a heart stroke, and they done a head ne." -Np: "Right." (looking at the results)
Cut after emotional sharing Case B comparison
-Pt: "So I don't know. **Like I'm frustrated and scared and worried that this is autoimmune and there could be something going on." (T1-p.4)** **Np topic turn** -Np:"Okay. Your rheumatoid factor was negative. Um. Now does that mean you definitely don't have arthritis, not necessarily?" (T1-p.4) -Pt: "Okay" Np continued the explanation and then asked the Pt if the antinuclear antibodies test was requested before. The Pt reacts with a monologue about how she recommended one of the physicians seeing her in the past to run antinuclear antibodies. She complained about how this physician told her that there was no need to run those tests.

Nested topics were found, but not through controlling self-talk and self-topic turn. They were found as a constant interaction of topics between the Np and the Pt.

Struggle topics had almost always a corresponded shared solving topic. Immediate repairs were seen in forced topic turns, as well. (See table 5.35)

Even though Interval 2 had the most intense balance and unbalance process as noted before, the topic turns were almost all natural and not forced. One forceful turn was found in periods not considered for the analysis; though, I used it as an example in Table 5.34. Even this forceful topic turn was smoothly and openly notified in advance to the Pt. Otherwise, only two semi-forceful topic turns were found, and were so subtle that I had no elements to say they were forced. Instead, 4 semi forceful topic turns were found in Interval 1. The conversation suggests that the Np had an agenda to go through, which by the end of the interaction was not entirely addressed. In the same way, the Pt had also an agenda, which by the middle of Interval 3 was not completely solved either. At the middle of Interval 2, after the best period of topic turns, and at the middle of Interval 3, topic turns were semi forced by the Np and the Pt with smoothness to finally address both agendas. The Pt agreed following the Np's leadership whenever she changed the topic. When the Pt led, sometimes the Np followed him, and sometimes she cut the Pt off. (see example in table Table 5.34)

Table 5.34
Shared solving process and rush to the next topic (T2-p.17, T3-p.26 and p.27)

Np example. Forced Topic turn, to address her agenda**.** Middle of Interval 2, p. 17

Topic Diet and dietician.

-Np: "Yep. Yeah, we'll see."
-Pt: "because I wanna lose weight, but cut down, and I don't think, like…I have a handful of peanuts once in a while."
-Np: "Yeah, probably not a bad thing".
-Pt: "Not a bad thing eh?"
-Np: "No"
-Pt: "okay. That's" (*Np affirms with a cutting code, which actually interrupts the Pt*).

Table 5.34 (continued)

-Np: "kay"
-Pt continues: "what"
-Np continues: "now"
-Pt continues: "(Wife's name) says, she says, 'we're gonna cut you off (*cheerful laugh*) peanuts".

Np Force topic turn notification with Pt's agreement: X ray results

-Np:"Now just because time is running…" (*open sentence to let the Pt agreed*).
-Pt: "Yeah"
-Np: "I'm gonna cut right to the chase and let's talk about this x-ray"
-Pt: "Okay"
-Np: "Not at all normal"

Pt example. Semi forceful topic turn to address his agenda (T3-p.26, p.27)

Topic. CT Scan

-Np: "And in the interim if she can get some pain relief for you that´s perfect."
-Pt: "yeah okay yeah."
-Np: "um" (*The Np was going to say something else, but the Pt suddenly remember a topic in his agenda*). (End of p.26)

Pt semi forced topic turn: Colonoscopy (T3-p.27)

-Pt: "and another thing we talked about last time was that scoping uh.."
-Np helps him: "Colonoscopy?"
-Np: "(…) Okay you know what, maybe we were looking, we were thinking of doing that because of…" (open sentence)
-Pt: "the pain" (The Pt completed)
-Np repeats and the makes a decision: "The pain. I think we´ll hold off on that"
-Pt: "okay"

Np topic turn to address another similar topic.

-Np: "And did you do those fecal occult blood tests? Did I ask you to do those?"
-Pt: "No"
-Np: "No. Okay".

The example in Table 5.35 explains a conversational balance within the pair (Np1-Pt1) and within the same conversational period. The next quotations illustrate a combination of codes, interruptions and simultaneity. They also demonstrate some of the intentions embedded in the equitable preference organization. In contrast to Case B

where complaints, demands and control of one alienate both in a closed circle, Case A presents a more open cycle by resolving interruptions. In Case A, both were working together to solve struggles. Solving struggles in equity in a continuous balance enabled Np1 and Pt1 to move form disruption to construction and connected them. Through conversational connections, disruptors were dissolved to concentrate their connections in a continuous solving struggle process.

A balance from 1) inequitable construction, 2) to equitable disruption, 3) to equitable construction is shown next. See also Figure 6.5 in Chapter 6.

Table 5.35
Conversational balance through shared codes, interruptions, interruption repair, and simultaneity

Inequitable construction (Np leads and Pt follows) (T2-p.20)
The Np is explaining the X-ray results to the Pt. Both were other oriented, making constant eye contact, and sharing the same object- results. -Np: "I know, don´t even ask me what that means. Like I said, big, big, big lumps (open and loose laugh) -Pt: (open and loose laugh) "yeah" -Np: "Ummm, okay so essentially there´s these bulky areas." -Pt: "Uh-huh." -Np: "throughout your lumbo sacral spine, down here" -Pt: "Uh-huh (T2-p.22,23)
Opening simultaneity with shared questions and responses (T2-p.22)
-Pt: "What do you call them?" -Np: "I´m not gonna get to complicated about this" -Pt: "no" -Np: "but basically, it is a narrowing of one or more areas of the spine, especially in the upper or lower back" -Pt: "Uh-huh" -Np: "that presses on the spinal chord" -Pt: Uh-huh -Np: "Okay? (medium pause to looked him in the eye) where the roots of the spinal nerves come out. (She shows the Pt with her body where they are localized). This pressure can lead to many problems that often occur when walking or standing." Pt: "That´s what they do" (complement the Pt with experience based knowledge) -Np: "Yes. Um, the most common symptoms are the pain in the buttock" (Medium pause and look him direct to the eye. She waited for the Pt to answer her)

-Pt: “Yeeeah” (prolonged yeah)
-Np: “or the leeeegs ./?” (prolonged word legs with a smooth affirmation question tone)
-Pt: No, the legs aren´t bad” (He answers to the Np insinuation of question)
-Np: “The legs aren´t bad” (The Np reaffirm the answer to be sure)
-Pt: “No”
-Np: “Um, although spinal stenosis can be caused by tumors, injuries, which we know you have had, and other disease, it most often results from degenerative changes-arthritis”
-Pt: “Uh-huh”
-Np: “Okay?” (deep eye contact)

Simultaneous mirrored talk (T2-p.23)

-Pt: “Well, to me, arthritis is continually pain, no matter where you are, like sitting or…” (Open talk)
-Np: “Not necessarily”
-Pt: “Oh! This is why I don´t think this is arthritis.”
-Np: “Yep”.
-Pt: “Nothin’”
-Np: “But, but we need to look into it”.

Simoultaneous interruption, risk of monologue (T2-p.23)

-Pt: “Okay uh…” (Np interrupts)
-Np: “Okay are you?” (None of them stop talking… Simultaneous interruption)
-Pt: “while you were”
-Np: “agreeable?”
-Pt: “were saying somethin’”

Open interruption repair (T2-p.23)

-Np: “Sorry?” (Until the Np stops talking. She couldn´t listen the Pt, so she makes an open interruption repair by directly asking the Pt to repeat so that now she can listen)

Recovery to simultaneous mirrored talk (T2-p.23) (equitable construction intent)

-Pt: Yeah, oh yeah, you were sayin, when I went to the chiropractor, not the chiropractor… I gave up on those ways a long time ago, because all they do is keep you comin´…”
-Np: “Well, well, they”
-Pt: “I went to ah”
-Np: “won´t fix something like this”
-Pt: “H (name of the physiotherapist)”
-Np: “Mm-hmm,”
-Pt: “she´s over…”
-Np: “physio?”
-Pt: “Yeah, and she said last year when this hip was killin´me, she said some vertebrae or or, some nerve was hittin´ the vein”

Risk of a second simultaneous interruption (equitable disruption)

-Np: “Well”
-Pt: “kay”

-Np: “That´s exactly what we”
-Pt: “I went about a month- I haven´t got a problem”
-Np: “Yes” (silence)

Arriving to equitable construction of shared experiences to solve a struggle in collaboration

-Pt: “Now I´m wondering, should I go back to see her about this side?”
-Np: “You know what? Yes, yes. Um, if, if it helped, I would go for it.”
-Pt: “Yeah.”
-Np. “So, no pain in the legs?”
-Pt: “No, no (…) In the small, in the back up here”
-Np: “Yeah, sooo, pain medication for for lower limb wouldn´t, wouldn´t help. Are you having anything to help you sleep at night?”

Qualitative conclusions: Case A and B

Case B patient had a chronic condition. Despite the intervention of many caregivers her situation was not resolved. The health professionals attending her in the past managed the Pt through the system for several years, so that her principle health struggle would be fixed. Based on her experience and informational knowledge she presumed the health struggle was not as simple as a knee that can be fixed with surgical repairs and medication. She thought an autoimmune condition might be the main problem. Because of a failure in the fixing procedure, the last professional who diagnosed her knee problem and made the surgical intervention, sent her to a rheumatologist. The appointment was booked several months ahead from the day she requested it. Because she was concern that leaving the problem for so long would complicate her health and her life she wanted to advance the appointment date. The rheumatologist’s secretary told her that in order to accelerate the process, she needed another assessment from her GP and Np and a referral letter. This letter needed to be based on evidence arising from the diagnosis. The Pt´s agenda for this appointment was principally to get that letter. During the encounter, she elaborated long conversations explaining the struggles that the failures in the health system were generating in her

health and every-day life. Moreover, the Pt generated dialogues with detailed medical information. Her conversation had an intention: To demand a detailed referral letter that could advance her in the line up, and fix her problem.

Summarizing Codes particulates (adjacency pairs phase 1) Case B: At Interval 1, the lack of shared codes and the frequent Pt control exercise, provoked an inequitable and disruptive conversation. Since the Np changed her own codes to start mirroring the Pt codes until the middle of Interval 3, finally some periods of shared codes were found. Yet, the Pt used most of the codes to control the conversation during the whole encounter. This action forced an overall disruptive conversation, with periods of disruptive-constructive codes. From the middle of Interval 3 and until the end of the encounter, a role change was found. The Np stopped making interruption repairs and initiated mirroring the code behaviours to start participating. Conversely, the Pt stopped making some of the disruptive codes, continued her attempt to use facilitating conversational codes and made less long monologues. However, her continuous interruptions and conversational control, did not allow a collaborative conversation.

Summarizing pronouns, conversational intentions found on preference organization (adjacency pairs phase 2) and topic particulates, Case B showed a one way or two way controlled interaction centered on the Pt´s struggles (complaints) and demands. The most frequent pronoun usages and conversation intentions suggest a conversation centered on the Pt. The preference organization showed rather than a preference, alienation into a closed circle of past struggles, and current complaints and demands. In combination, pronouns and preference organization showed an interaction centered on the Pt´s struggles, complaints and demands. The Np participation was

centered on responding to those demands. The data suggests that at Interval 1, the Pt preference organization was based on explaining, sharing experiences and complaining, to support a demand of acceleration in the health system line up. The Pt expected to be listened to and the Np occasionally emitted affirmative codes. Supported by the topic particulates, the Pt's pronouns use and preference organization denoted a one-way interaction centered on complaints and demands. Sometimes when the Np suggested another type of organization, the Pt did not let her continue, losing conversational connection with her.

The Np preference organization was subject to the Pt demands, which demonstrates an aligned organization, rather than a preference. The Np participation was alienated by the Pt monologues. During some periods at the end of Interval 1, and at Intervals 2 and 3, the Np was able to speak. Her responses were based on questions, explanations and individual actions to individually fix the Pt's demands. Whenever the Np attempted to solve a struggle the Pt let her talk decreasing the interruptions; however, almost immediately, another demand was "thrown" by the Pt and "caught" by the Np so that she could fix it. This type of conversational organization, interrupted the brief moments of an open process of collaborative struggle solving. The topic structure, topic length, topic turns and intervention suggested periods of two way interaction, controlled by the Pt with two tools constituting a control mechanism- Nested topics demonstrating self-topic control and forced topic turns demonstrating others topic control.

Case A patient also had a chronic condition. Despite the intervention of many caregivers his situation was not adequately resolved. The health professionals attending

him in the past managed the Pt through the system for several years, so that his principal health struggle would be fixed. His back and his hips had not healed; in fact, the pain was getting worse. Pain was having an impact on his health and daily life. Both, the Np and the Pt brought to the appointment their own agendas. These agendas related to each other along the conversation. To address them, he brought to the relationship experience based knowledge and questions. The Np brought information based knowledge and resources to aid the Pt to understand his problem and to make more inquiries about specificities of the Pt´s type of pain. The Np answered the Pt's questions while investigating more around the pain and leading the relationship to an action plan. Both, the Np and Pt agreed on actions to aid the Pt not only to solve his principal health struggle, but also to promote his health.

Summarizing codes particulates (adjacency pair 1) Case A. Interval 1 started with a caring conversation. Codes were shared at the beginning until the end of the appointment. The middle of Interval 2 was a combination of simultaneous intermittent leading talk, equitable and immediate interruptions repair, and simultaneous mirrored talking. Mirroring codes, mirroring interruption repairs and mirroring smoothness, even let the Np1 and Pt1 started mirroring pieces of ideas (Table 5.28). They mirrored and complemented sentences and then complemented longer conversations (Table 5.29). In addition, an open communication was possible through cycles of alternate leadership. An open conversation led the interaction to a deeper level, conforming an equitable relationship in balance. In the most intense periods of this balance, they were also at risk to dissolve the relationship, into two monologists interactions. Although the Np led more than the Pt, the beginning of a more stable relationship was "heard". Based on open questions, open answers and recommended actions founded on the Pt experience,

they were able to collaborate for solving several past struggles and focus the interaction on the Pt´s health.

In summary, pronouns, preference organization (adjacency pairs phase 2) and topic particulates Case A, showed a two-way care interaction centered in the Pt´s health. This interaction was possible by shared codes as predecessors of shared intentions. Pronouns showed an Np leading effort to move the conversation form an "I" and paired "I-you" interaction, and later to a "we" relationship, establishing shared actions.

Preference organization diverse intentions were: experienced based or informational-based knowledge, open and dichotomous questions and actions, experiences and care. The organization was not controlled by anyone. Both, the Pt1 and the Np1 covered their agendas. No one was alienated in the preference organization of the other; both established a shared preference organization. Talk turns and topic turns were clear and well respected from both characters almost during the 28:50min of interaction. This was possible because simultaneous talk dissolved the established talk turns, generating an open, rhythmic, dynamic and fluid equitable conversation. Equitable preference organization and topic turns were necessary for the Np and Pt to solve several struggles and facilitate health.

CHAPTER SIX: INTEGRATION, DISCUSSION AND CONCLUSION

Introduction

This thesis proposes a clarification of the term power by making the assertion that analyzing power is analyzing relationships. Relationships are an incessant process of struggle solving, and as well are part of a broader struggle solving process (e.g. life, education, health). Micro relationships like the ones constructed internally in a person (mind-body), are constituents of more complex relationships like the ones between people (minded bodies). Furthermore, relationships between people forms elements of a more complex relationship among people and among communities. These comprise macro relations that community is dependant on- such as the health system. In other words, you and me (mind-body potentials relationships) are we, and we (body-minded relational potentials) are the system. I -intrapersonal relationship- am power. We -interpersonal relationships- are power. All of us, -system- are power. It is in the interaction of the individuals involved in this power complex, that we can perpetuate inequity and oppression by a mechanism of control imposed on ourselves and others in a differential of potentials, or reverse the control by a relational mechanism of sharing different potentials.

The circle of domination explained by Marx, (1976) in his appreciation of *labour power*, by Foucault (1979, 1978, 1977, 1973) in his analysis of *power knowledge* in relation within the health system, and by Freire (1985, 1970) in his explanation of *oppression*, is indeed, a circle of control. In most instances, people seem to think that control is exercised by one person over another, or that control comes from an outside place. I agree with Foucault, in that power as relationship, has its genesis in the “little

places", organizing itself in terms of the "little things" before it gets to the stage of concentrated organization (Foucault, 1977).

In the health system, if micro and macro relations are based on a mechanism of differential of potentials, the following can happen: the health professional, claiming to be the "provider" is at risk of promoting permanent inequity by believing that she/he has to assume the active caring role, (as if caring were the individual action of fixing health problems). This role motivates the health professionals to perceive themselves as the ones needing to provide health (as if health were an object). This perception risks the care relationship, by bringing to the interaction the expectation of a commodity or product, rather than potentials. The patient, assuming the role of "client" expecting a product – knowledge/medication/health- or a service –care-, is at risk of bringing only expectations, and not potentials to share for a struggle-solving situation.

Although frequently, health systems, and thus nursing practice, in many parts of America and around the world have been advocating strong and diverse measures to transform ways of healing, there are still subtle (and no so subtle) practices that foster circles of domination and oppression. Similar claims can be made about the educational system as a whole, also in nursing practice.

This thesis proposes both an assumption and a challenge. It is assume that a circle of interaction based on domination provoking inequity, is not power. It is a mechanism through which power can be alienating by means of the objects offered, and a transfer of commodities. In the case of a health system based on a "banking" perspective of power balance, health is a commodity in a supply and demand economy, and care is a service through which this commodity is provided. Based on Foucault´s

(1977) explanation of permanent inequitable relationships, this management and control mechanism was identified in this thesis as a mechanism of differential of potentials and later renamed as mechanism of control based in differential of potentials.

Relationships working on the basis of this mechanism do not promote the expression of power; rather, they enhance a controlling system which can separate the parties involved into two extremes, the powerful and the powerless. The situations actually being expressed are the circle of commodities itself and the object (product or service) towards which the circle is oriented (e.g money, information, knowledge, health, care, etc). Inequity then is not about having and not having, but about a permanent and static differential of potentials embedded in controlling micro interactions. Therefore, it is the assertion of this thesis that equity is not something to be achieved through objectified individuals' transactions from the individual that has, to the individual that lacks of. Equity-inequity balance starts in the dynamic connections between and among potentials, by a relational mechanism in which sharing the **different** potentials reduces the **differential** of potentials. The challenge is that, in the "little places" (e.g health encounters, classrooms, homes) in terms of little "subjects" (i.e. intra and interpersonal relationships) supported on some resources (objects), we -as *THE SYSTEM* , continuously reverse the differentials (not the differences), in which power is silenced and inequity is permanently sustained.

In the proposition of this assumption and challenge, two mechanisms were revealed: A control mechanism identified as a mechanism of differential of potentials; and a relational mechanism related with the share of different potentials.

Integration and Discussion of the context and the fractals in the whole.

The Care Setting

Multiple failures in the Health System were found in the conversational topic contents. Both patients in Case A and B came from a history of attenuated care.

Some of the common failures at the macro relationship level (i.e. the health system) were: a) Excessive individual medical diagnoses more than collaborative caring interactions; b) Immediate fixing procedures (e.g surgical repairs, immediate effect medication, and pain killer patch) more than holistic long term healing actions; c) Loss of patients' patience, their calm and their health as a consequence of superficial care and superficial contact between them and the health professionals (exemplified by multiple referrals, over diagnosis, time constraints, and management failures); d) In the attempt to fix administrative failures, loss of health practitioners' caring empathy, and clients' timeline demands occur, prolonging problems in patients' health state. (See examples in (Tables 5.13 and 5.14 in Chapter 5; and tables B1 and B2 in Appendix B). The failures found in the conversational particulates in both cases, in the health system as a macro relationship, coincides with the circles of domination (*power-labour-commodities, power-knowledge, circle of oppression)* exposed in the theoretical framework (Foucault, 1989; Marx, 1980; Freire, 1979), where people become confused between "having" and "being". In Case B, for example, although the Pt3 needed a holistic healing process able to address and solve her problem, past professionals had focused their attention on her knee and tried to repair it; though, the Pt3 concern is that she had a systemic health struggle that could not be diagnosed by looking at the parts, and that could not be repaired will short term procedures. Her experience with health professionals had been

one of managed care where she was referred from one "expert" to another. None of these "experts", as the Pt3's conversation showed, collaborated with her to understand the problem, and start a long-term healing process. They provided medication and procedures instead of enhancing a healing through care.

In a macro relation such as the health system, individuals can be at risk of thinking that care provision can be equated to a transfer object or of an illusory "power", rather than focusing the potentials to connect, heal, and be. From this "banking perspective", equity and balance, is perceived as being fulfilled by taking or "demanding" that what is to be "offered". Patients become clients. This perception breaks what for centuries health was supposed to mean: a balance between mind, body and spirit, a balance between people, a balance among communities, and a balance within and with the environment. Healing as the ultimate purpose of a health system is enhanced by caring. However a distribution of resources is needed to support care, and management of the system by which resources distribution is possible. Hence, when individuals believe that health is a product or commodity that "clients" may "demand" demand as clients (as in Case B), and care is a service to cover those demands, they can easily confuse healing with the resources available for healing, and care with a managing activity meant to facilitate care.

At the micro relations and therefore the macro relations, self-management/self-control, and others' management or others' control mechanisms, put in danger the real caring, the healing, the beings, and the health system. This perspective rejects the vision found in the literature review thematic area *"*empowerment as a health distribution*"* (i.e. Saras Henderson, 2003; Skelton, 1994; Hokanson, 1992; and Malin and Teasdale,

1991), where empowerment means: "the interpersonal process of providing the proper tools, resources and environment to build, develop and increase the ability and effectiveness of others to set and reach goals", and occurring "between two or more people the person who empowers and the person(s) who is (are) empowered" (Hokanson, 1992 p. 609).

It also rejects the ideas in "*empowerment as a control of (the self) and health*" (i.e Aujoulat, d'Hoore & Deccache, 2006; Kettunen, Poskiparta & Gerlander, 2002; and Gibson, 1991) where empowerment is seen "as a process of personal growth and development … in which power is surrendered and conquered" (Kuokkanen and Leino-Kilpi, 2000, p.238), or as a **"**social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (Gibson, 1991, p. 339).

A management system is needed, but it should be more directed in its functions. In the current study, the nurse practitioner and the patients, should not be, by means of their demands and services, exercising management activities. Rather, they should be focusing on care. The old, but still present "banking" postures of empowerment as distribution, management or control of power, are strongly contraindicated in this thesis by: the differentiation of mind and body fractals communications *(Subunits of analysis)*, the differentiation of Cases B and Case A (*Embedded Units),* and the integration of Cases (minded-bodies) through the language of a music metaphor.

Case B-and-Case A Intermelodies

The narration in Table 6.1, contains the whole Chapter 6 in it. If you want to know how it begins and how it ends, then you have to read it. If not, then skip it and read the formal integration of results and findings.

Table 6.1
Case B-and-Case A Intermelodies: A story from control TO POWER

Do you think Case B and Case A are separated situations that we can split to oppose the characters in Case B to the characters in Case A? Well, if you are thinking that, I don't blame you, I thought so to. But in reality, these characters are not two different cases, but two fractals constituted by simpler related fractals, of a great whole. Case B and Case A situations are one related story. In this story, the principal characters are a Nurse practitioner (Np) and two different patients with similar struggles, Pt1 and Pt3. The conflict of the story is rooted in the failures of a Management system that is able to manage the clients' expectations through an offer and demand circle of health as a product or service, but unable to promote a healing process. The Np and Pt3 established a managing system, where the Pt3, in his role of client, demanded a product of care. The Np in turn, gave the Pt3 what she demanded, and individually performed the management role that she had learned to execute. Struggles in Np3 and Pt3 interaction were partially solved through a very tight circle. Their nonverbal disruptive differences were not fully solved, nor were their verbal ones. Sometimes, when the care relationship was attenuated by control, Case B was a dissonant monophonic Intermelody in half cadence. Most of the times, it was a dissonant and sometimes harmonious homophony with intention to achieve full cadency. On a few occasions, a dissonant polyphony was "heard", but not enough to be registered by the quantitative eye. Healing was displaced by immediate procedures designed to control the health problem until the next professional (for a total of 4) could see the Pt3. Sadly, fixing was preferred over healing, as was managing over caring.

However, this story does not have a "sad" ending as one might imagine imagine; from the above, because… IT DOES NOT END THERE!

It continues in the intimacy of the Np and Pt1 encounter. Case A provided to have an

Table 6.1 (continued)

Intermelody in transition between dissonance and harmony, and from repetitive half cadences to resolution in a full authentic cadence. It never sounded monophonic. It was in dynamic balance between homophony and polyphony. These characters, established a healing system able to reverse a previously managed system of care, where the co-construction of a shared health action plan dissolved management roles. "How was this possible?" one might ask. "With a macro revolution!", "Or with superhero with the strength of a God!" you can dare to propose. Well, it is simpler than that. These mortal characters, the Np1 and Pt1 collaborated with each other. Together, in collaboration, they initiated a relational mechanism able to reduce their nonverbal disruptive differences through constructive nonverbal patterns, and connect their conversations to their actions.

Yes. That simple… To solve macro struggles caused by fractures in the system, we do not need an external savior, but power. If power is intra and inter relationships, then the revolution is here, developing micro relationships not only in order to solve these fractures, but to have a continuous process and end named health!

If you are one of those, who like me, needs more evidence to be convinced because "this is too simple to be truth", please read the formal details as follows.

For the integration of results (body fractal) and findings (mind fractal), and to fulfill the purpose of this research, Case B is presented first and Case A follows. This shows a continuum in the explanation of mechanisms of power expression. The purpose was developed as follows:

First, by "listening" to the body fractals described at the beginning of each Case, the Quality (Sounds, Textures, Cadences) of each Intermelody are heard. Specific result are accompanied by numbers found in parenthesis in order to guide the reader to the detailed results in Chapter 5. Table 6.2 at the end of this explanation contains a summary of the numbers found in the parenthesis and the specific place they can be

found. The contribution of each Intramelody (by its tones) to the Intermelody is also explained. In this regard, based on the study of significant differential of potentials, qualities of sounds and textures brought by the different Intramelodies (Np and Pt) to the Intermelody (Np-Pt) were identified. In channels with significant differences, the Intrameoldy occurring with highest frequency, was considered to be the one bringing that certain behaviour to the relationship (e.g flexibility) by means of that channel (e.g. torso-neck-head), and so the one enhancing the differential (*See Case B X^2 tables in Apendix A; Tables A12-A18*). Although particular facial gestures were not considered in the analysis (because only a frequency analysis was possible) it is important to mention them now. In the same way, based on the study of significant association of potentials, we found "sounds" and "textures" in the relationship between Intramelodies, that brought the uniqueness to the Quality of the Intermelody for each Case (*See Case B Cramer´s V tables in Appendix A*). Body fractals created a means to understand Sounds and Textures of Movement as elements intertwined in the Intermelody, but provided superficial understanding of Cadences.

Second, mind fractals showed the process of the Intermelody's Quality, giving the required movement to a phenomenon (i.e power) that stands still in a static dichotomous place. The individual Cases are integrated as a whole Case by considering Case B as the first part of one story, and Case A as the continuation. They are different, and that difference will remain intact, but their comparison and intersection demonstrates the process of relationships, and as such, the process of power. Mind fractals were able to better reflect the concepts of Cadence.

Third, the Cases fractals (mind-body languages) differentiation was solved with the threads of music terminology where both of them maintained their different contributions but in a unified whole. By a hermeneutical metaphor, states and

mechanisms of power and their mobilization from low to high gradients, through a power mechanism, were explained. This was possible by moving the researcher's eye: a) from a typical dualistic and static interpretation embedded in the nursing literature (power/empowerment, conflict/non-conflict powerful/powerless, lose/gain, provide/receive), and dichotomous quantitative results (dichotomous variables, of disruptive/constructive and voice/lack of voice), to interval-averages and back to ordinal –levels variables; b) and then from quantitative linear results to a dynamic qualitative stand (and finally resolving them through the use of a non-dual metaphor).

Table 6.2
Numbers directing the reader to the specific result in Chapter 5

Case A	Case B
1: See Textures CA.H3 Cadences Krukal wallis-follow up Mann Whitney w/Bonferrioni correction.	1: See Textures CB.H3 Cadences Krukal wallis-follow up Mann Whitney w/Bonferrioni correction
2: Textures CA.H1 Level of voice analysis-Mann-Whitney U and comparison in z-test column of proportions.	2: Textures CB.H1 Average channels analysis t-test
3: Textures CA.H1 Average channels analysis t-test.	3: Textures CB.H1 Level of voice analysis-Mann-Whitney U
4: Textures CA.H1 Level of voice analysis-Mann-Whitney U and comparison in z-test column of proportion.	4a: Textures CB.H1 Level of voice analysis-Mann-Whitney U and comparison in z-test column of proportions
	4b: Textures Cadences Maximized Difference 6.
5: Textures CA.H2 channel by channel association analysis Cramer´s V.	5: Textures CB.H1 Level of voice analysis-Mann-Whitney U and comparison in z-test column of proportions
6: Textures CA.H1 Average channel analysis t-test.	6: Sounds CB.H2 channel by channel association analysis Cramer´s V)
7: Sounds CA.H1 channel by channel analysisX^2).	7: Textures CB.H1 Average channels analysis t-test)
8: Sounds CA.H1 Average channels analysis	8: Sounds CB.H1 Level of constructiveness-disruptiveness analysis Mann Whitney U
9: Sounds CB.H1 Level of constructiveness-disruptiveness analysis-Mann Whitney U).	9: Sounds CB.H2 Average associations. Kendall Tau b)
10a: Sounds CA.H3 Cadences-Kruskall Wallis.	10: Sounds CB.H2 Level association analysis, Kendall Tau b)
10b: Sounds CA.H3 Cadences-Kruskall Wallis.	
11: Sounds CA.H3 Cadences- Kruskall Wallis.	11: Sounds CB.H3 Cadences- Kruskall Wallis
12: Textures CA.H2 Average association analysis	12: Sounds CB.H3 Cadences- Kruskall Wallis
13: Textures CA.H2 Level of association analysis-Kendall Tau b	

Case B (CB) Intermelody Quality (Body-Mind Fractals)

The Case B Intermelody is mainly Homophonic with some periods of Monophony (No.1 Table 6.2 CB) in an inequitable differential of (No.2 Table 6.2 CB*)* individualized voices (No.3 Table 6.2 CB). In periods of monophony, Pt3's individual voice (74.2%) is significantly higher in frequency than the voice of the Np (49.5%) (No.4a Table 6.2 CB). It is suggested that the climax of the monophony at Interval 1 was caused by the Np3's absence from the room (No.4b Table 6.2 CB). In periods of Homophony an equitable interaction of disruptive silences between Np3 and Pt3 (No.5 Table 6.2 CB), inclining to a smoothness association (No.6 Table 6.2 CB) is found. This Intermelody presents differential of voices (No.7 Table 6.2 CB*)* and no differential in the level of disruptiveness caused by each of Np3 and Pt3. However Pt3 (n=37Op) moved toward a more constructive behavior compared to Np3 (n=41Op). (No.8 Table 6.2 CB*).* Case B's Intermelody showed highly significant associations of disruptive potentials (No.9 Table 6.2 CB), though this dissonance was moving from a level of *disruptiveness* (Np=57.7%; Pt: 56.7%) to a *process from disruptiveness to constructiveness* (Np=38.1%; Pt3 =42.3%) (No.10 Table 6.2 CB). Even though the constant and equitable (no differential) disruptiveness between Np3 and Pt3 might qualify as a harmonious homophony, by the quantitative analysis the Intermelody of Case B evidenced dissonant (No.11 Table 6.2 CB) and attenuated homophony in half cadence (No.12 Table 6.2 CB).

Np3 tones.- Np Intramelody contributed to the dissonant sound of the Intermelody with: posture rigidness (torso neck head), posture gesture rejection (Head Neck Face Posture Gesture) and disruptive gesture. The Np's Intramelody most frequent facial gestures also contributed to dissonance: removed (vs carefree); rough-loud (vs gentle and tender); faddish (vs timeless); arrogant (vs confident); somber (vs humorous); and pedantic (vs thoughtful). Np silence contributed the relationship to have a monophonic or homophonic texture (See tables Case A in Apendix A) and the Intermelody to sound dissonant.

Pt 3 tones.-Pt Intramelody brought to the Intermelody: Farness (distance); individual orientation; posture gesture closedness (arms- hands-fingers); and dynamic expressiveness (Head Face posture-gesture). These contributed to dissonance more than to harmony. The Pt's most frequent facial gestures also contributed to dissonance: dull (vs serene); worried/pedantic (vs thoughtful/understanding/aware); somber and suffering (vs humorous and cheerful); confident (vs arrogant). Pt presence (without the Np presence) and extensive talk (with the Np in the room) contributed to monophonic and homophonic textures.

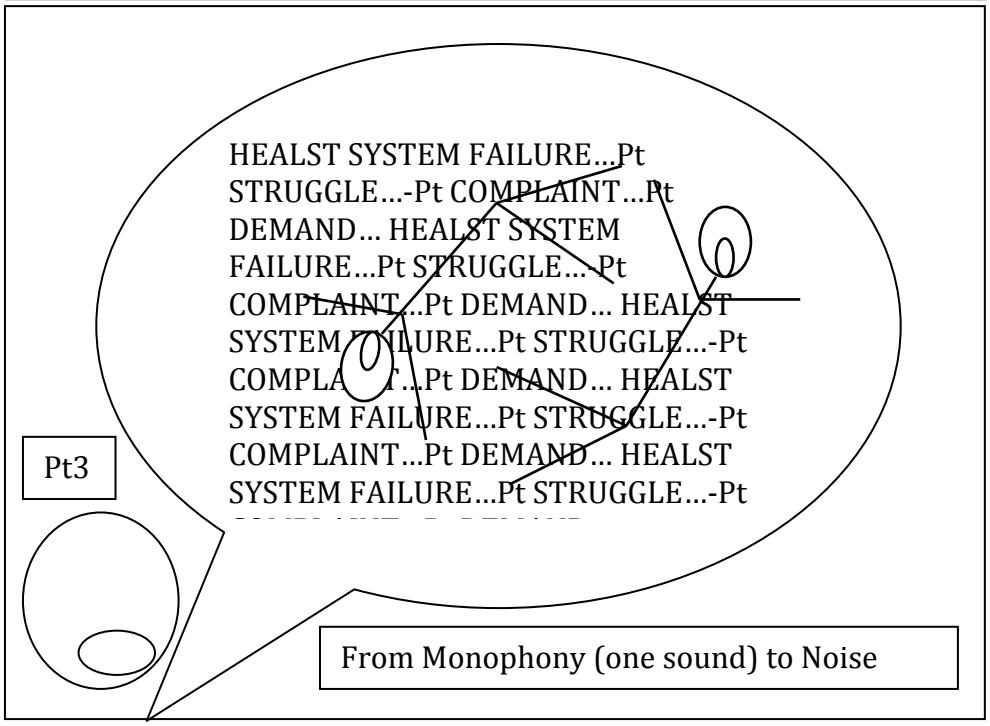
Case B Intermelody as an interaction of Intramelodies, has tones of its own (significant associations): Smoothness (Arms and hands), and dynamic expressiveness (Head Face posture-gesture) contributed to harmonious interaction. Although this was minimal, it is important because this smoothness might be an indication that the Intermelody is changing from a level of disruption to a process of construction. On the contrary, demand/complaint gesture (Arms Hands) (Np=87; Pt=84) was one of the most important nonverbal disruptors, which coincided with the qualitative findings. Continuous eye contact; and posture gesture dynamism (Head, Torso, Arms and Hands) was also observed. (*For detail See chapter 5, CaseB tables, Table 6.2 and Appendix A*).

Micro closed controlling circles Case B: We are the health system

Conversational particulates revealed three things around control: 1) Within Case B particulates, we found a Pt3 verbal *self-control pattern* using: self-interruptions, self-talk turns and self-topic turns. 2) Self control provoked a closed circle of complaints and demands, preventing her to collaborate in solving health struggles and initiate healthy actions. This repetitive cycle, paradoxically aligned her *self* to the demands and the complaints. Her participation in a healing process was stuck in this cycle. Instead of a dynamic participant, she was a static recipient of objects of care such as medications and a letter of referral. 3) Repeating the same mechanism of self-control, she incited an *other-control* mechanism. Through interruptions, false topic turns and forced topic turns she controlled the conversation. During this period, Np3 became caught in the Pt's repetitive cycles of complaints and demands. That action prevented Np3 from solving the struggles in collaboration with the Pt. Rather she attempted to fix past struggles of attenuated care by acceding to current demands.

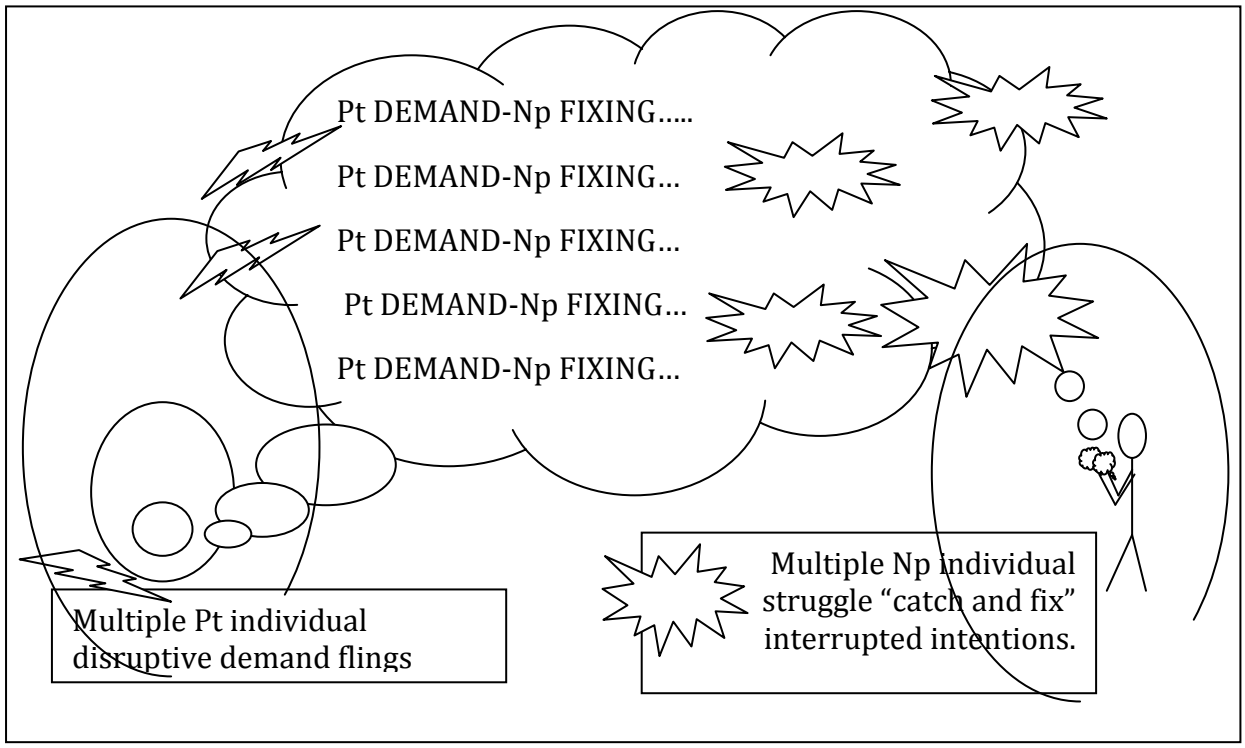
Control mechanism. Case B control mechanisms based on differential of potentials starts in self-and-other interruptions, until it upholds the relationship in a closed circle. In past interventions, the health system was unable to solve Pt3's health struggles, therefore a increased circle of explanation-complaint-demand arose. Pt3 and Np3 alienated themselves – from being subjects of care to focus on the demand of objects of care; therefore they were alienated in the failures of the health care system. Furthermore by repeating this pattern of fracture in the relationship, they perpetuate such failures. By means of a control mechanism that promoted this closed circle of oppression, a prolonged monophony was observed: Only Pt3's Intramelody sounded during those periods of dissonant explain-complaint-demand. The voice of Np3's Intramelody was attenuated by that of the Pt and, subsequently, the voice of the Pt3 was alienated as well in the circle of oppression. As Figure 6.1 shows, by the end of the interval 1, not even Monophony but only an complaint circle become an oppressive "noise" where the voices of the Np3 and the Pt3 became attenuated.

Figure 6.1
Np and Pt alienated in a conversational control circle based on demands



This circle enabled another disruptive and inequitable "catch and fix demands *flings*" closed circle (See Figure 6.2). With this pattern, the Np and the Pt, instead of generating shared actions to solve struggles, repeated management structure of care and indeed of the health system. They focused their efforts and externally available resources (i.e time, experience, results, information) to demand, give and receive two objects of care: medication and a referral letter toward a next step in the system. This type of interaction prevented the connection of potentials, a condition that was needed to achieve the vital purpose of the health system - patient's healing. Through the same control mechanism, Pt3's and Np3's voices were circling: the Pt would *fling* a demand, and the Np would repair it. In this situation, attenuating noise was interrupted by cycles of Monophony (Pt3's demand fling) evolving to a Dissonant Monophony in half cadence where: a) with the Pt3 still controlling the conversation, small open spaces were left -usually created by half questions- to let the Np fix her demand; b) Np3 interrupted the monophony and raised her voice to provide the "fix". In this process from Monophony to Dissonant Homophony the real struggle was not solved and health was not really promoted (half cadence).

Figure 6.2
Demand flings, flings flings, in a "catch and fix" struggle conversation



Disruptive mirrored equitable periods of simultaneous interruption, and Constructive-disruptive questions and answers periods, briefly created discussion, and with it, decomposing these circles into temporary cycles. Short periods of simultaneous speaking opened small spaces for collaboration (*See fig. 12 for Case A in this chapter*) However, this Intermelody stayed in Dissonant Homophony (simultaneous interruption) reverting the relationship sometimes to Monophony or noise (explanation-complaint-demand micro circles), balancing it again to dissonant homophony where the Np followed the Pt in "catch and fix demand flings" situations. (*See Case B, Table 5.24 and table B2 in Appendix 2*).

This pattern served to disconnected Pt3 from Np3 and vice versa. Conversational disconnection prevented direct caring efforts and use of resources to facilitate the Pt´s health care. Case B conversational particulates, conformed to a pattern of fractured inequitable disruptive micro interaction. This disconnection was also seen in the body particulates. Two results illustrating disconnection are: a) the significant association between Np3 and Pt3 in terms of silence; and b) the significant association found in level of disruptiveness.

Following the three things discovered around control, two more insight were developed: 4) During the less controlling and most collaborative piece of the interaction in Case B, simultaneous interruptions with hints of simultaneous collaboration were "heard". In these few periods, the rhythm of the conversation was more equitable, open and fluid. It was based on questions and answers. However those periods of rhythmic collaborative conversations were short, and equally disruptive. 5) Case B short periods of simultaneous talking, showed a way to spin a controlling demand-fixing interaction in a different direction- to a care oriented relationship. With a combination ofdisruptive and constructive mirrored behaviours, smoothened and cutting codes, radical changes and attempts to participate in the conversation, Np3 was able to start breaking this alienating circle. Two quantitative results support this qualitative finding: a) even though a significant differential of potentials was evident Case B demanding arms and hands; a significant association was also found in arms and hands smoothness. This suggests that in some periods, the controlling mechanism was replaced by a relational mechanism, in which smoothness plays a very important role. b) Even though both, Np3 and Pt3, had a significant association in disruptiveness levels, the second most frequent level of association was from disruption to construction. In spite of these 'hints' of

collaboration and control breaking, the Pt's lack of collaboration was the most important barrier to opening the circle and reorienting the focus of the interaction. During "hints" of collaboration, the Intermelody was a harmonious homophony with half cadences. (See Figure 12). In these "hints" of collaboration the Pt, in an attempt to demonstrate her concerns and express questions, ended up making medical assertions, demonstrating her own knowledge. In these small periods of collaboration, the Np also posited short questions and gave short informational answers. Most of these short interventions had the intention to calm the Pt by promising that she was going to look after her demand, explain the effects of some medications, or explain some heath system management procedures.

In a broader sense Np3-pt3's mind-body fractals contributed to macro relation based on disruption, control and management, where there was a need, and a demand for objects of care- a banking perspective of health. The particulates in this Case showed that the interaction was centered in a commodity to be demanded. Health was seen as a product and care as the service providing that product, which means that the controlling mechanism of the interaction promoted alienation. The encounter started with a complaint and a demand. It continued with immediate "fixing" actions and ended up with complaints and demands, but a Pt who was grateful for receiving what she demanded.

Case A (CA) Intermelody Quality (Body-Mind fractals)

Case A Intermelody was a Homophony that progressed to Polyohony (Interval 2). It was in movement from homophony to polyphony (No.1, Table 6.2, CA), by sharing (No.2, Table 6.2, CA*)* the same amount of different voices (No.3, Table 6.2,

CA*)* equitably (No.4, Table 6.2, CA) in dynamic association (No.5, Table 6.2, CA). This Intermelody presents no differential in voices (No.6, Table 6.2, CA), but there was a differential of constructive potentials between Np1 and Pt1 (No.7, Table 6.2, CA*)*. The differential in constructive potentials was consequence of a positive situation where both parties were brining constructive potentials to the relationship (No.8, Table 6.2, CA). The Np1 (84.4%) had higher levels of constructive participation than the patient (56.7%) (No.9, Table 6.2, CA). This construction-disruption imbalance coincided with the results showing harmonious moments, and to progress toward harmony moments (No.10a, Table 6.2, CA***).*** Case A Intermelody proceeded from dissonant attenuation to harmonious collaboration (No.10b, Table 6.2, CA). This reflects how slight imbalances in sharing constructive potentials was moving from the encounter at some point of time, in half cadence, but, in general, Np1-Pt1 Intermelody was resolved in an authentic cadence (No.11, Table 6.2, CA). This Intermelody showed a high relational association in terms of voice (No.12, Table 6.2, CA*)* and in terms of the level of relationship. Their levels of relationship were highly associated (Np=73.3%; Pt=71.1%) in polyphony (No.13, Table 6.2, CA*)*.

Case A Intermelody had tones of its own (Channels with significant associations or non significant differential of potentials): Other orientation, openness (arms, hands, fingers posture-gesture), dynamic expressiveness (head face posture gesture), a balance between requesting/explaining and demanding/complaining body gestures (arms-hands), confidence, serenity and cheerfulness. These allowed Case A Intemelody to Sound Harmonious. Continuous eye contact, presence, and body posture-facial gesture dynamism (head, torso, arms and hands), allowed the Intermelody to be in continuous flow of textures, from homophony to polyphony.

Np1 tones.- Np Intramelody brought different tones to the Intermelody Quality (14). These different tones (constructive potentials and voice) were: Closedness (orientation), posture flexibility (torso-neck-head), smooth body gesture (arms and hands), and constructive facial gesture contributed to harmony (CA. Outstanding patterns Chapter 5) Np facial gestures (table 9.1 Appendix). Np brought the following constructive -carefree (vs removed), gentle and tender (vs rough and loud), serene (vs dull), confident (vs arrogant), humorous and cheerful (vs somber and suffering), nonverbal tones.

Pt1 tones.- The Intrameoldy brought constructive potentials and voice to the Intermelody. However Pt1 brought one different tone: affirmative posture gestures (head neck face). Constructive Pt facial gestures (table 9.1 Appendix) were: understanding/aware (vs pedantic worried), confident (vs arrogant), energetic (vs agitated), serene (vs dull), and humorous/cheerful (vs humorous/suffering).

It seems that moments of silence for the Np in this Case contributed to the modulation from homophony to polyphony. In the same, way it seemed that Np moments of speaking in this Case contributed to a progression from polyphony to homophony. (For more detail See chapter 5; Case A quantitative tables in Appendix A; and Table 6.1)

Micro open relational cycles Case B and A: We are the health system

Following the five things that conversational particulates revealed around control in Case B; it was in the study of the same particulates but in a different Case (A) where one more thing about how to spin control in a different direction to promote care collaboration was revealed: 6) Case A broadly confirmed that a relational mechanism is

the way to rotate a controlling interaction towards a caring oriented relationship. Data in Case A as a continuation of Case B suggests that periods of disruption-construction balance can "sound" disruptive, but are necessary to progress towards collaboration.

Sharing codes, developing immediate and equitable interruption repairs, mirroring codes, lines and even sentences, opened up the conversation. Open conversations including alternate leadership (equitable participation) based on questions, answers, requests, and invitations to action (experience based recommendations), can form a deeper cycle of equitable inquiry and struggles solving relationship. Two quantitative results support this affirmation: a) A significant association was found between Np1 and Pt1 in terms of Hands, torso arms and/or hands dynamism, reflecting the level of activity from both; b) the voice between both had a significant association. In this type of relationship experience based knowledge of the Pt and the evidence base knowledge of the Np can work together to focus the interaction in health, and in solving the struggles with individual and shared actions. Such a discovery supported Freire´s (1977) vision of power. It also coincides with the articles based on this view (Falk-Raphael, 2001; Kettunen 2001 & 2006; McWilliam et al. 1997; Oudshoorn,2005; Patterson, 2001) which see empowerment as an active mutual participation based on awareness, dialogue and co-constructed solutions to problems.

Relational mechanism. Case A's relational mechanism based on shared different potentials, began in Np1 and Pt1 conversation by sharing the same type of codes until, in equitable solving dialogues, they ended up sharing the same action plan. On past occasions, the health system was unable to solve Pt1's health struggles. As a consequence, Pt1 hasd several unattended and serious conditions. Of interest, none of

them alienated themselves into these failures or the demand to fix the failures. Both Np1 and Pt1 worked together through periods of disruption and construction and equity and inequities in order to address both agendas, set a health action plan, and take care of what had been attenuated -his health.

On several occasions during the Case A conversations, the following relational cycle with 4 types of connection periods were found.

Period 1.- Inequitable conversation was developed. Sometimes this inequity was triggered by the Np and sometimes by the Pt. Inequity in Case A was as follows: one person was talking and the other was only participating with mono or duo-syllabic words (as in homophonic periods in Case B). One person was the leading voice, and the other was a supporting voice. For example, the Pt lead the conversation by speaking about struggles related to his health; whilen the Np1 listened. In that situation, Pt1 was temporarily separated from the Np1 in his role of posing the health struggle and the Np1 was temporarily separated in her role as listener. But both Np1 and Pt1 were relating to the same topic. Inequity allowed one person to talk while the other was listening in silence. Inequity in the conversation proved necessary. During these types of periods, Np1-Pt1 were in constructive inequity where the struggles were not solved yet. In these types of periods, the Intermelody was a harmonious homophony with half cadence. (See Figure12).

Period 2.- However, in contrast to Case B where these inequitable periods were prolonged, in Case A inequity was temporary. Inequity was frequently broken, generally triggered by a set of questions and answers related to one topic (usually agreed to by both). These periods started mobilizing and opening the conversation. Typically, the

questions were frequently posed by the person who at the time was participating less. Usually this set of questions and answers allowed turns to be taken in the conversational leadership; periods of equity based on simultaneity. Simultaneity could be constructive if both partners continued to relate to the same conversation. Simultaneity could be disruptive if constant interruptions (as we saw in Case B) disconnected individuals already in collaboration into two separated circles again. Simultaneous lines in counterpoint allowed Polyphony. If simultaneity is disruptive, the relationship can be transformed from Harmonious Homophony, to Dissonant Polyphony. These type of periods in Case B ("hints of collaboration") and the continuous presence of these periods seen in Case A, reflected a transition from harmonious homophony to dissonant polyphony in both Intermelodies. Case A Intermelody had fewer periods of interrupted simultaneity than that of Case A Intermelody.

Period 3. In Case A, immediate and equitable interruption repairs, let these periods of open simultaneous flow, maintaining the Np1 and Pt1 relationshio in the same conversational topic. These type of simultaneity constituted the climax of Case A collaboration. Case A Intermelody climax was Polyphony -as is clearly shown in the quantitative analysis in Chapter 5 (Textures CA.H3). Related simultaneity, results in a Harmonious Polyphony with full cadence where struggles were solved. These types of periods were continuous in Case A; although they presented a frequent risk. Simultaneous conversation sometimes is transformed into two different conversations, if –in the intensity of simultaneity- the Np and the Pt fault to listen to what the other is truly saying. Case A Intermelody in its most intense periods of harmonious polyphony were at risk of disintegrating dissonant polyphony into two unrelated Monophonies.

Fortunately repairs in Case were a strength. If that happened one of both, Np1 and Pt1 made equitable repairs (silence) to listen to the other.

Period 4.- After a climax of the highest relational equity (harmonious polyphony), always came a period of relational inequity (homophony). One person started leading the conversation again; and inequity was established making, further on, other turns to equity. Disruption of inequity was possible by temporary periods of relationship construction. And relationship construction was possible by temporary periods of inequity. This is a type of balance that generates connections- one in which opposites are not separated into extremes, but related to each other. In Figure 6.3, an open conversational cycle by means of a relational mechanism of different potentials is illustrated. The first type of relationship seen in Fig 6.3 is one of harmonious homophony: There is one is the leading voice and the other accompanies. Inequity makes possible that one listens while the other can talk. Then, periods of alternating leadership causes disruption (of inequity) and the Np and the Pt go through a polyphonic phase, sometimes dissonant (struggle/answer box dialogues), and sometimes harmonious (dialogue scroll box). Then, period of alternating leadership causes breaks that harmonious polyphonic equity. Inequity is re-established and then the person who has the talk turn, can lead, coming back to a harmonious homophony. However, dynamism and voice (talk) presented a highly significant association, which corroborates simultaneity and mobilization.

The average texture channels presented an association between voice and silence, finding simultaneity in 7 observational points. This mobilization between Np1 and Pt1 is entailed between apparent opposites like disruption and construction, and

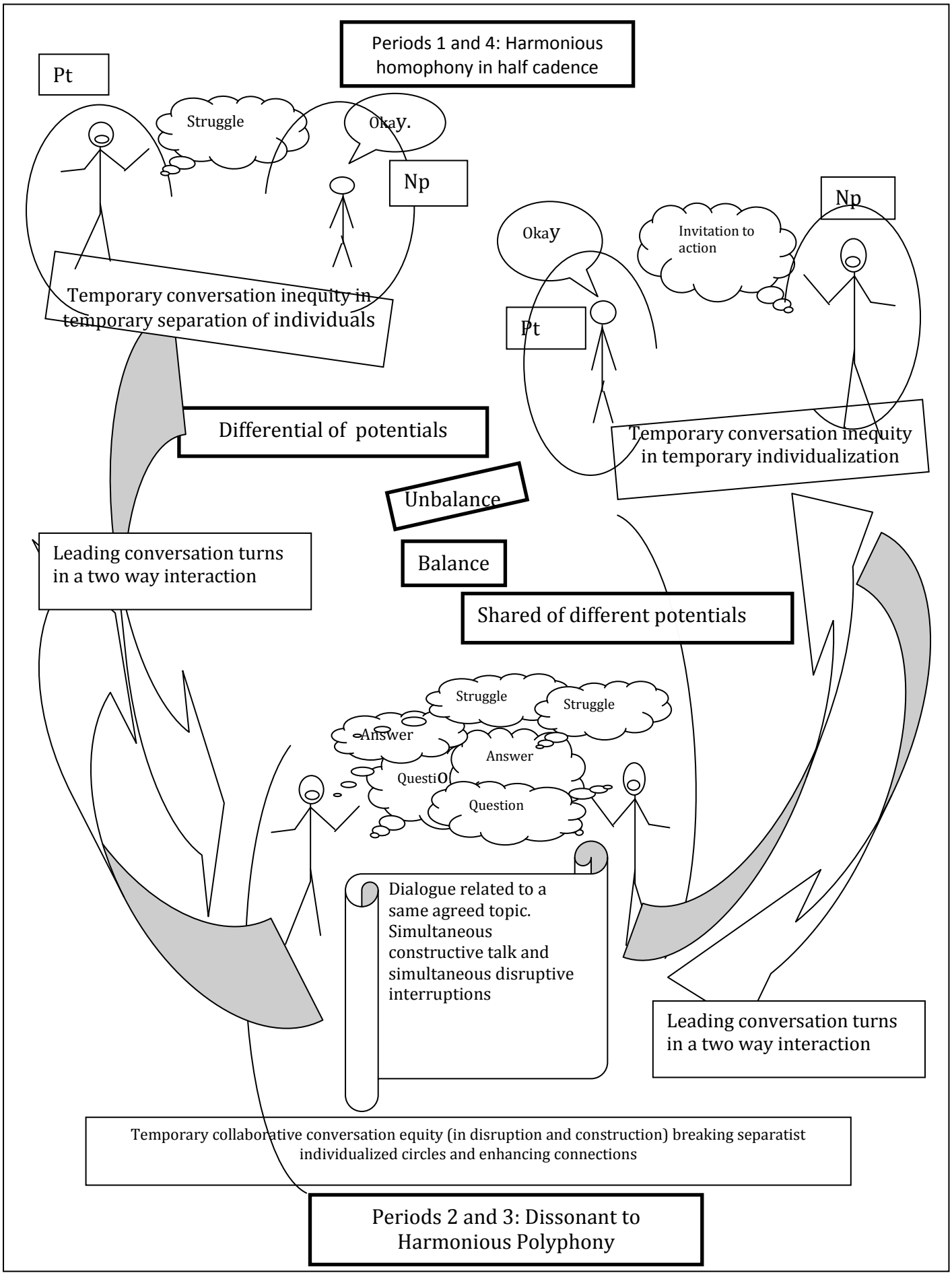
equity and inequity; opposites frequently found in *channel by channel* association results. The most frequent texture shared by the Np1 and Pt1 was Polyphony. The quantitative Cadence results coincides with the micro conversational cycles in that Np1 and Pt1 were alternating between Homophony (inequity of voices) and Polyphony (equity of voices). Verbally and nonverbally, Case A began in homophony, evolved to polyphony, and came back to homophony. The climax of the Polyphonic phase was at the middle of the interaction; in the exact same way that the climax of verbal collaboration happens in the middle of the balancing process. This subtle insight let us recognize how, the patterns in the body and mind fractals, are augmented in a larger scale in a whole encounter, and probably in a larger scale in a whole system; hence the selected names for the fractals.

This continuous equity-inequity, disruption-construction balance was clear in the nonverbal behavior. In spite of the fact that fewer differential of potentials were found between Np1 and Pt1 –which should have facilitated such association- almost all the nonverbal channels presented no significant associations between Np1 and Pt1.

During the frequent mobilization of this 4 period cycle promoted by a relational (power) mechanism, another micro cycle was revealed. After a question-answer-dialogue period, invitations to act in order to solve the struggles -from which the questions and answers are originated- were posed (see Figure 6.4). The person posting the invitation was the one leading the conversation at that point in time; the other person listened to it, and then started another related and simultaneous conversation around it, repeating the same movement as the first cycle. This mobilization, allowed both the Np and the Pt to address struggles by a related set of questions, answers and proposed

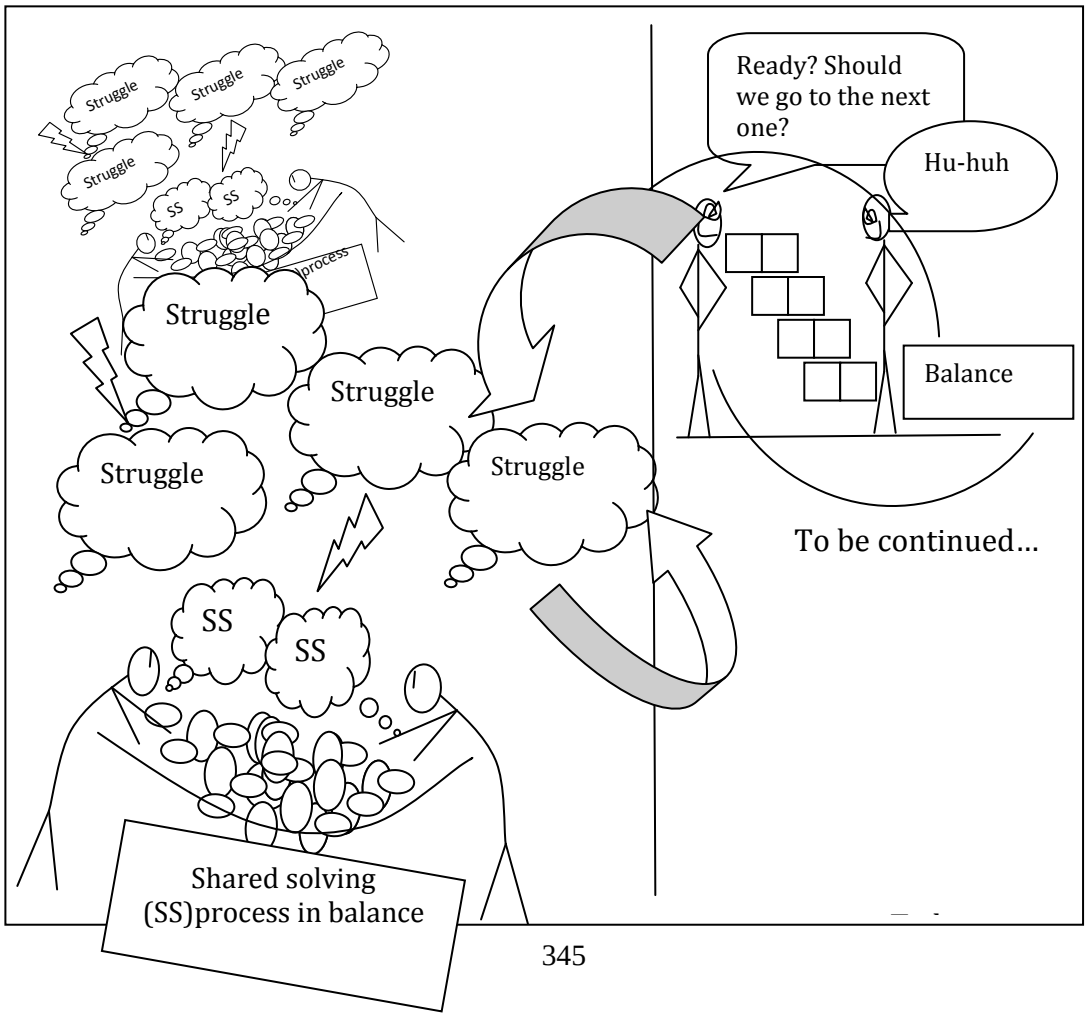
actions, maintaining them in a dynamic and open cycle, where struggles would not alienate them. Knowledge from this cycles come from both places, an external source (i.e information, evidence based on results) and an internal source (Pt´s experience and need for care and Np caring actions). Solutions also come from both places, an external resource (e.g. medication, vitamin intake, letter to expedite referral) and an internal source (Pt reflections and actions to be healthier).

Figure 6.3 *A cycle of four periods in the health struggle solving process*



These micro cycles coming from a mind fractal in relationship with another, were repeated in a larger scale. At the end of the encounter, they had a shared action plan that was actually constructed little by little during the dialogue created in the encounter. Even though half cadences occurred in the encounter, where Np or Pt changed to a new topic before solving the current struggle (As happened frequently in Case B), full cadences were also developed. A full cadence occurred when the participants solved a struggle and then changed to a new topic. This balance between half and full cadences in Case A, lead the Intermelody to solve the tensions (health and management struggles found in the topic content) in an authentic full cadence- only to start a new relational struggle solving process.

Figure 6.4
Struggle solving and healing process balance



Case A Mind-body fractals showed that the interaction was centered on the Pt´s health, which means that relational mechanism promotes health, rather than a focus on sickness or a commodity demand. Care in this encounter was about the connection establishment with the self and the other. The encounter started with a caring action: The Pt asks the Np if the system is forcing her to be videotaped, and if she is okay with it. It continues with a caring action. The Np has material prepared for his understanding and invites him to read everything with her and both make an action plan. The encounter ends with a caring action. The Np tries to help him when his cane falls down. She also opens the door and touches his back when he is leaving the room.

Based on this finding we can say that relationship is a continual balance process between equity and inequity; disruption and construction. By exploring the two cases, we can understand that it does not really matter if inequity and/or disruption are present. What really matters is the way in which these periods are faced. Although both Pts suffered from failures in a health system as an external management entity, each of them faced this situation differently. From the subtleties of conversation, the Pt3 in Case B repeated the cycle of control and management of a client demand. “Right here” in the micro relations, Pt3 from Case B is repeating the Health system cycle of failures. The Pt1 in Case A participated in his health and in the solution of the health system failures. The Pt1 and the Np1 from Case A are breaking it from within by reversing a closed circle of demand-fix, with an open cycle of dialogue based on questions-answers-actions. It the end, both Pts had a referral letter to expedite their treatments from the Np and a medication. Nevertheless, Pt3 only got what she demanded. In contrast, the Pt1 in collaboration with Np1 constructed an action plan that has the potential to initiate a continuous healing process.

Case Study integration: From control mechanism to relational mechanism

Integration of Case A and Case B quantitative-qualitative conversational findings demonstrate that care interaction, as any other human interaction, entails disruptive struggles. Disruptive periods of transition are needed to construct a collaborative disruption-construction balance. Promoting equitable connections lead to a relationship with the potential to achieve everyones agendas and solve the struggles entailed on the interaction. Getting caught in those inequitable or equitable periods of disruption for a prolonged period alienated all the participants into a never ending struggle circle. In this circle, individual split demands or actions generated a split exchange or interaction incapable of setting up and continue a healing process.

Control mechanisms promoting management as opposed to healing, do not promote care power -commonly known as empowerment-, but an illusion of care power where the client demands a product or a service and the Np needs to manage the Pt by giving him what is needed to help him/her pass through "the system". This, despite what the Pt wants or the way of asking it is self controlling or others controlling - promoting annihilation of the self and other in an oppressive circle of client demand and product provider. This is how we reject the old visions found in the articles contained in the two literature review thematic areas and their combination: "empowerment as health distribution" and "empowerment as control of (the self) health".

Micro movements in Np-Pt interactions can assuage the failures of a management health system to the opposite direction. Micro relations like Case A promote connections and potentiate efforts to solve the struggles, even if those struggles were not solved in past occasions. Case A is an exemplar of a power expression

mechanism. Np1-Pt1 demonstrated a process that reversed the control mechanism, to facilitate healing. Collaborative care promotes healing as oppose attenuating "care" which only manages and control.

The generation of a health system starts in the immediacy of corporal movements and words. A healing system starts and it is composed in the moving intimacy of connections within mind-body and within care interactions such as the one developed by a nurse practitioner and a patient. We can suggest that from deeper connections comes grater power; and from greater power arises strongest healing. This understanding coincides with the articles in the literature review thematic area, Empowerment: Returning to the source of power.

McWilliam, et al. (1997), see empowerment as the emergence of "power", not merely given by someone but co-created in the caring relationship (McWilliam et al. 1997). Falk Rafael (1998), based on the book, *Women who run with the wolves* by Estes (1992), proposed how a transformative caring practice is empowering not only for 'clients' but also for nurses. It allowed them to connect with their nursing legacy of caring. Caring, I suggest, is only possible through connections. Connections, observes Lowe (2004), "occur[s] through the dynamics of an interdependent and interrelated relationship between nurse and client" (Lowe 2002 p.4). Therefore, connectedness is a dynamic cyclical process entrenched in every corner of the nurse practitioner and patient practices. Harmony, affirms Lowe (2002), is a way of life and relationship of inner peace and contentment that is based on the cooperation and sharing, and it results from *being* in balance.

Although I agree with this view of harmony, there is one element missing in order to develop it; and that is, dissonance. Articles talking about harmony enhanced another separatist view by addressing balance related to harmony and not dissonance. In order "to avoid control and maintain harmony", says Lowe (2002, p.9) "the nurses use silence" (Lowe 2002, p.9). This thesis suggest that control cannot be avoided, and a prolonged silence – as oppose to temporary silence- can damage the relationship equally or more than control. Control cannot be avoided but it can be reversed. Care attenuation cannot be avoided but it can be reversed. Everything IS, claims the Zen (Osho, 2007); tension and concordance exist. A cyclical mechanism of relations where Intermelodies can CONTINUALLY solve the tension genreated in the differential of potentials -in concordance of different potentials- can reverse management and control mechanisms. This can happen from within (first order power) to between (second order power), and to the system (third order power), as we are the system.

Power findings through Music: Nurse practitioner-patients mind-body fractals in the whole

In the next section, the body and mind fractals, the Np1-Pt1 and Pt3-Pt3, and the Cases A and B are unified as a whole. Nine findings which in a first moment were differentiated in this thesis, integrated by the hermeneutical music metaphor, are to be listened.

First finding. Power as a balancing process of connection.- Even though the thesis was focused mostly on the maximization of differences between an equitable and an inequitable expression of power in care settings, the qualitative findings endorsed a change in the focus of the study. On one hand, the quantitative results exemplified each

case, but also presented unexpected outcomes which opened up the vision about Case A and B to be opposites for each other. Furthermore, the qualitative findings reallocated the researcher's attention; from the explanation of two extremes of power manifestation, to the process of power construction. The umbrella finding is that: Power is not a linear band with two dichotomous extremes; it is a continuous process that comes and goes among a variety of gradients that can range from a no relationship (no power) grade to a full or authentic relationship (power).

Coming from this understanding, Case A (Care collaboration) and B (Care attenuation) are not opposite mechanisms of power expression, but representations of a natural power balance process. Only one mechanism of power expression was found; the relational mechanism. The other mechanism, the control mechanism found to prevented relationships, and thusly power. For that reason it was considered as expressing control and no power. We also found that a relational mechanism can reverse the mechanisms of control. In spite of this, they were not considered static and separate opposites either, but internal (to the person) and external apparatus that in movement can reverse each other at any moment. Relationships developed with control mechanism tended to disaggregate the parties in the interaction, until there is no more relationship. If power is relationships, then control triggers power dissolution.

Conversation analysis reinforced that Case A represented a more equitable and socio-centric form of relationship enlightening an experiential problem solving care collaboration. Case B was a more inequitable egocentric interaction denoting a semi experiential problem solving care attenuation or controlling care. Regardless their

processes showed a very similar way of relationship building, and thus, of power balance.

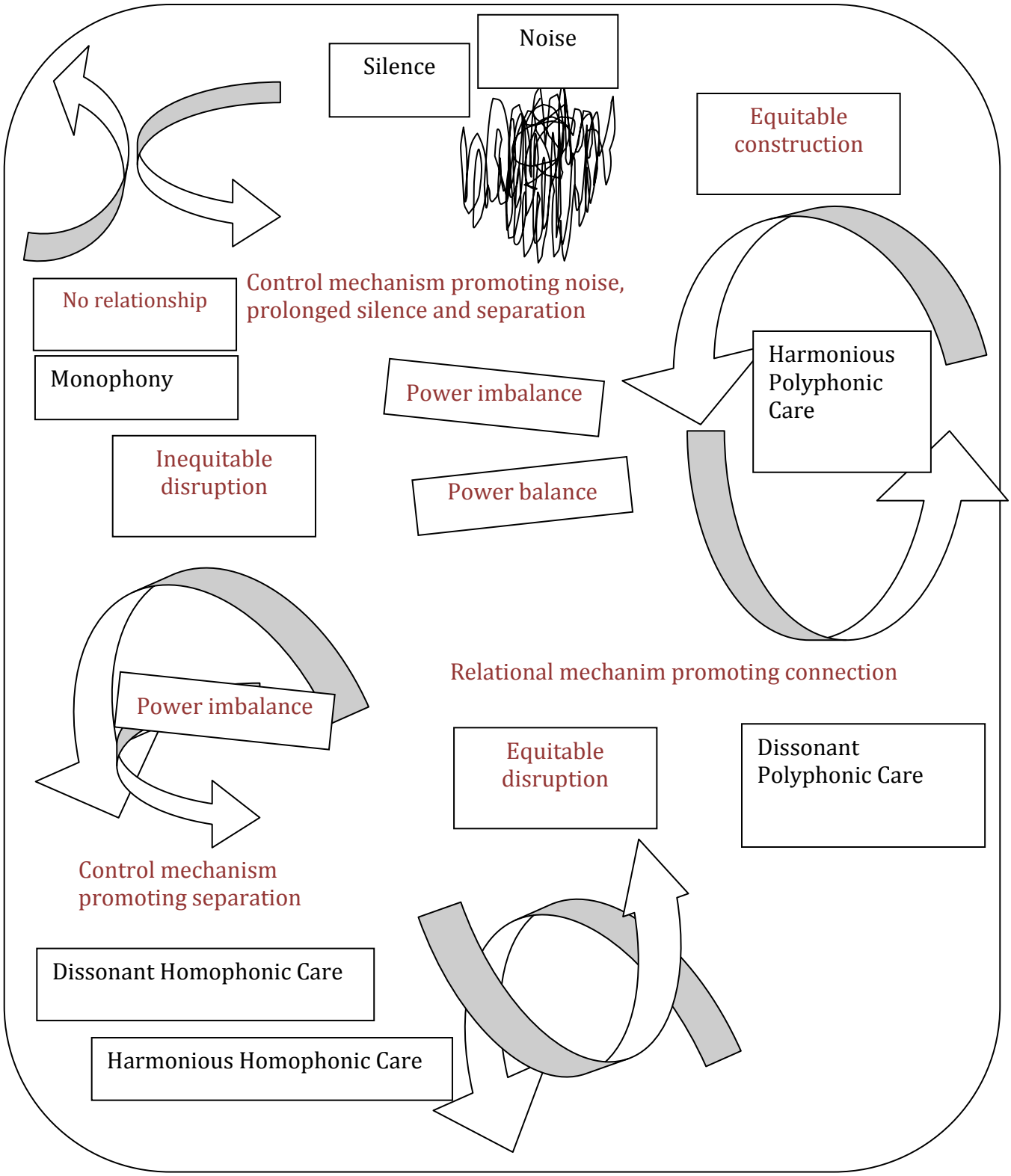
None of the cases were "extremes of power", though, they could be considered as representations of a balancing process. Even though power balance- and imbalance- is incessant, it is more evident in specific moments. In terms of conversation, imbalance happens when a relational struggle mechanism appears; but only through imbalance, can balance can be re-established. Balance occurs when both people (Np and Pt) set into motion a relational mechanism. The most important balance generator found in the cases analysis, was the establishment of connections.

The kind of balance represented in this cases coincides with the one established in the theoretical framework, where a) balance is based on connections between and among parties- (e.g. Cajete 2000; Chuckrow 1998; Hill, 2006; Horwitz, Kimmelmman, and Lui 1976; Lowe 2002; Waysun, 1995) b); connections are established through communication as a process of relational transcendence of the self and the other (Condit, 2006; Shepherd, 2006). Power balance is not a matter of gaining, loosing, giving or taking power as a transferable object between separated plate of the balance scales, like a banking perspective suggests (Freire,1985, 1970); c) Power is a continuous balancing process only possible when two opposites, in this case control/dominance/oppression and true relationships, confront each other in intra and interpersonal process of communication. Temporary periods of equitable-inequitable and constructive-disruptive communication enhanced interaction, moving the people involved in the interaction from a less relational gradient to a higher or grater relational level.

Second finding, Monophony, Homophony, Polyphony. Based on Case A and B, I conclude that a relationship in balance in a major scale can go from control/alienation (noise-and-prolonged silence) to no relationship (monophony) to inequitable disruption (dissonant homophony), to equitable disruption (dissonant polyphony) to equitable construction (harmonious polyphony). In the same way, the relationship can transit from one period to another at any point in the interaction. There is not a fixed balance process, although the descriotion in the last paragraph was the most common. This finding is illustrated in Figure 6.5

Monophony, Homophony and Polyphony, define the texture of a melody and serve to explain the three different temporary states of power developed by Np and Pts in their care encounters. Dissonance and harmony define the balancing sounds of an Intermelody (Np and Pt). Cadences, either half or authentic, serve in the understanding that power is a process of struggle solving continuum where tensions, being natural in relationships, can be solved in an authentic cadence producing concordance, or unsolved in a half cadence where tensions prevail.

Figure 6.5
Power imbalance and balance process: From noise to equitable construction by means of relational mechanism



Monophony.- Monophonic care is the lowest state of relationship, and thus, of inter-personal power. This state is fundamentally based on differential of potentials. As we listened from to the body fractal (quantitative analysis), an increase in the differences between Np and Pt´s voices and lack of voice (*See Case B. Textures channel by channel analysis and averaged TOMchs analysis*) contributes to a higher level of silence of one of the parts and an individualized voice of the other part (*See Case B. level of voice analysis*). The general conclusion is that when a differential of potentials between an Np and a Pt exists, inequity prevails.

In the qualitative analysis we listened to the *Lonely I-my-me. Lonely you* experience, described as an individually oriented autistic exchange (Wilber 2000). In this type of exchange, one of the two persons takes complete control over the talking turn and topics. The conversation, is mostly centered on I, me, or my; confining the *I* and the *you* in isolated separation. In this situation, one person hardly ever talks, and if so, makes a minimal contribution to the conversation mostly because the person controlling the interaction: a) never turns his-her body towards the other inviting to connection; b) hardly ever gives a code to change the talking turn; c) self-turns to keep talking are repeatedly made. c) She/he does not stop talking even when the other person is willing to participate in the conversation; or d) she/he signals a false turn code to fallaciously indicate the other person that he or she can talk now. In the same way mostly material information is being exchanged almost exclusively from the same person during the whole interaction. The intention ranges from a simple material exchange, to an informational/material, rational emotional or experience (action) demand fling, with no space for the other to respond. A circle of exchange as the one saw in Case B where an explanation is transformed into a complaint and then into a

demand, can perpetuate the stance of this exchange into a low level power. Monophonic state of power can be considered an autistic low level power.

No harmony or dissonance between two Intramelodies can be listened in monophonic care, by the simple fact that there is no interaction (No Intermelody). In no interaction, tensions and concordance are as well inexistent. Harmony and dissonance in this thesis can be combined only in the findings about heterophony. Heterophony is only possible in the interaction of more than one voice. Heterophony, says Wright (2008), can be divided into homophony and polyphony. In the case of this thesis Intermelody is only possible with heterophony.

Heterophony: Homophony.- Homophonic care describes the middle state of a relationship. As we listened to the body fractal, heterophonic interactions bring with them disruption and construction. This is the case of Case B in the last two intervals of time, and Case A in the first and third intervals of time. Homophonic care is still based on differential of potentials. As we listened to the body fractals expressed in both Case A and B, and although the voice starts to be equitable in periods of homophony (*Textures CA.H1 channel by channel analysis and averaged analysis*), disruptive and constructive potentials are in recurrent interplay (Sounds CA.H1 and Sounds CB.H1, *channel by channel analysis and averaged SOMchs analysis).* This contributes to a differential of potentials in the following sense. If the voices are equitable (textures), but one person is bringing more constructive potentials to the table than other, there is still a difference of potentials in which one generates more tension (disruption) to the relationship, and unbalances the concordance (construction). This can generate dissonant homophonic care.

In the qualitative analysis we listened to the *Pairing I-and-you* (or you-and-me) experience describing a narcissistic-egocentric interaction (Wilber 2000). This occurs where one of the persons involved is leading the conversation and the other one is only an accompanying voice in terms of talk turns and topics. The conversation is mostly centered on *I-me* with *you* usage with focus on the *I*. In this case, the length of the topics addressed by the leading person slightly decreases and the participation of the non-leading person slightly increases. However, the accompanying person is mostly participating with short mono or duo-syllabic interventions. In narcissistic-egocentric exchanges, interventions or the intention to participate from the one who is not controlling the interaction are made to reduce the differential of potentials, and start participating equitably. A set of verbal and nonverbal, disruptive and constructive interventions, by an active participant in the caring interactions were listened specially in Case B. These interventions were: a) verbal cutting codes and disruptive nonverbal postures and gestures; b) softening verbal codes and periods of facial gesture smoothness; c) enhancing dynamism by asking questions and moving the body posture; d) attempting to verbally answer questions or explain a requested or demanded doubt, and nonverbally enhancing body gesture (hands-arms) requesting/explaining behaviors; e) establishing eye contact and verbal mirroring codes; and e) making radical topic changes.

Prolonged silence was found to be a non-relational strategy made by the person facing control. It was found that prolonged silence prevented relational construction. Even though we might think that listening is better than talking in care relationships, based on data we established how prolonged silence is as harmful as not listening; it harmed the interaction more than it helped it, in the following sense. In Case B,

whenever the Nurse practitioner shifted into a static form of no interaction (prolonged silence, no eye contact, other orientation, rigidness, and closeness) the Np was unable to aid the patient. The patient continued to interrupt herself, continued to be trapped in an explanation-complaint-demand closed circle, and the interaction continued to be inequitable. Struggles are aggravated in periods of prolonged silence with no dialogue (verbal and nonverbal), instead of being solved. In prolonged silence with no dialogue, an interaction that was already narcissistic-egocentric can easily revert to an autistic exchange. In the attempt of avoiding disruption, prolonged silence might reinforce a dominant and oppressive circle, which at the end, says Freire (1970), will oppress them all. In oppressive circles with prolonged silence, the only voice heard is the noise of dominance. In contrast, even though we might think that disruption is "bad", based on data we listened how periods of simultaneous talk (verbal finding corroborated by a nonverbal result) and presence (even if disruptive) involved the two parties (Np and Pt) into a unified interaction. In Case B and Case A we discerned that even though simultaneity can start disruptive, it involves Np-pt voices, and might -if continuing in related simultaneity- move the relationship from a narcissistic egocentric interaction to a socio-centric relationship. In Homophony, the intention ranges from a rational and/or emotional argumentation or defense, to an unmatched request-response (informational, rational, emotional or experience). Homophonic state of power can be considered as a one way interaction narcissistic-egocentric medium level relationship.

Third finding embedded in Homophony.-. Homophony is the principal relational transistor. Homophony is the principal transition period during the whole balancing process. It is the central point in power balance. To shift from monophony to polyphony, the characters must enter into a homophonic phase. Relationships, in Case A

and B, stayed most of the time in homophony (*See Chapter 5 Textures CA.H3 and CB.H3 Cadence)*. Listening to the body fractal, we noted that Case B started in homophony, moved towards monophony at interval two, and the interaction (Np3-Pt3) recovered its homophonic state at interval 3 (See Ch5, *Textures CB.H3 Cadence*). We were also sure that it was a case of dissonant care (*See Ch5, Sounds CB.H3 Cadence)*. The mind fractal though, revealed how Case B started with a monophonic conversation that evolved to a disruptive homophonic interaction, and then remained there. Both verbal and nonverbal findings showed a dissonant homophonic care, where the Pt and the Np were attenuated by a closed demand-fix circle. Even though Case B had short periods of harmonious conversation, dissonance was always present.

However, homophony is volatile enough to trigger a change from a medium to a higher state of power: from Homophony to Polyphony. Although both cases lived homophony, they were not the same type of homophony, for one simple reason: Case B homophony centered the interaction on demands and fixing immediate strategies; Case A homophony centered the interaction in struggle solving and planning actions.

Heterophony: Polyphony.- Polyphonic care describes the highest state of relationship found between Np and Pt. It describes a state where the two of them are leading the conversation and the health action plan. Two varieties of polyphony were found on the study. The first one occurred where there were simultaneous leading voices with related topics. The second variant of polyphony occurred when one person involved in the relationship was the leading voice for almost the same number of occasions as the other; and when the other was the leading voice, he or she changed to be the accompanying voice. In this variant, the sum of equitable Np-pt homophonic

interactions in particular periods of time can be seen as an overall polyphony. Smoothening codes, natural topic endings, natural turn taking, and sporadic interventions of more than one or two words from the accompanying voice, represent a natural polyphony.

In the qualitative analysis we heard a *We, are you and me*, experience describing a sociocentric relationship (Wilber 2000) where both persons involved in the relationship are equitably participating in the conversation. The conversation is mostly centered on *you* and *me* or *we*. The pronouns usage reveals a partnership where *I* make an action, and *you* make another one; or *we* plan and intent to implement various actions together. Simultaneity appears in socio-centric relationships. Simultaneous talk -if moving from disruption to construction- needs no turns to talk, because it is based on a fluent and open dialogue of: a) requests and explanations in concordance with hands and arms explaining and requesting; and b) open and non linear questions and answers, as well as open posture gesture and posture gesture dynamic expressiveness. In related simultaneity, the conversation is open enough so that both can participate in it and construct it together.

In socio-centric relationships, they share the same topic and the length of the interventions is more equitable. Interventions of two leading persons in relation to the same topic demonstrates a highly socio-centric relationship. In sociocentric periods in the interaction, the body changes from being individually oriented to be other oriented. This brings closeness between nurse practitioners and patients. If one person invites to closeness and body connection through being other oriented, and the other does not accept the invitation, the first person may return to an individually oriented posture.

Prolonged verbal and nonverbal dialogue (related topic, disruptive and constructive simultaneity, presence and continuous eye contact) reverses prolonged silence and reduces the inequity between people and thus the differential of potentials. In Polyphony, the intention ranges from a corresponded request-response (informational, rational, emotional or experience) situation, to a sharing of concerns and experiences (actions).

Fourth finding embedded in polyphony. The first variant of polyphony is at risk of going straight to monophony. Simultaneity is probably the most pure form of polyphony –being closer to the real musical term- it is also the most volatile of all the states of power described. The two persons could be talking at the same time about the same topic understanding and complementing each other, and suddenly they stop hearing what the other is saying until the related topic and the understanding of each other are lost. Qualitative data showed that when this happens, polyphony can become two temporal monophonies. Simultaneity is when individuals co-construct the same conversation (in a related topic) at the same time. Simultaneous interrupted talk occurrs is when individuals lose connection between them, in terms of the topic. As none of the two Cases showed extensive periods of polyphony, this is an interesting opportunity for further study.

Fifth finding.- **Temporality is the most important insight found on states of power.-** Relational struggles catalyze movement from state to state and connection processes regulates the stay in a state of power.

Sixth finding embedded.-Relational challenges support temporality and catalyze movement. Relational challenges, or power struggles were found mostly in

interruptions, prolonged silences, and rejection codes. A widespread understanding of dissonance and harmony, unlocked the dichotomous view offered in the hypothetical statements of the thesis: that dissonance and harmony are only two extreme cases held in a straight line. Through verbal communication study, dissonance was mostly "heard" over unstable periods where relational struggles were being confronted.

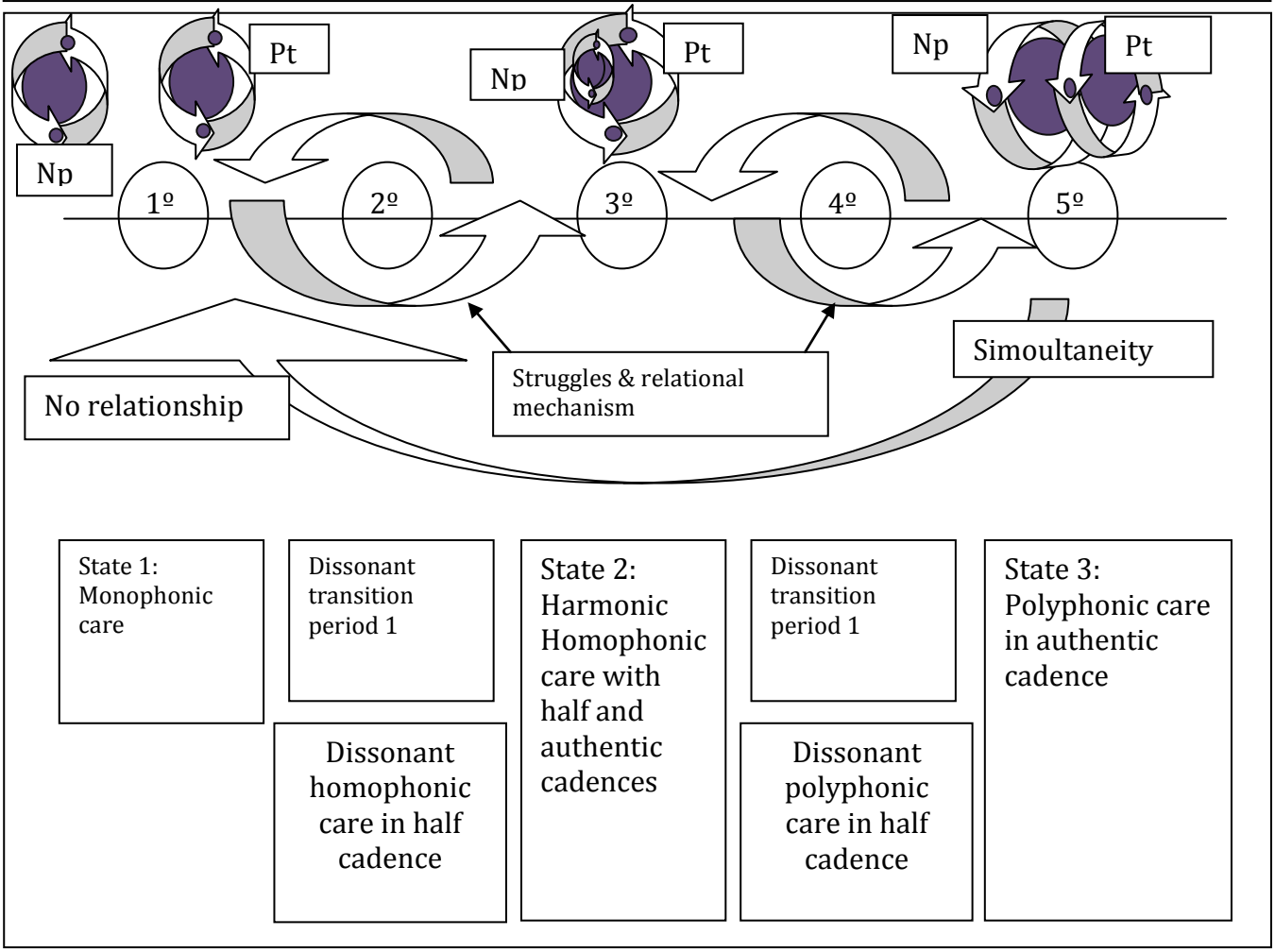
In both cases we found that relational challenges were mostly provoked when: a) either of the two characters involved in the encounter was controlling the length and the content of the topic; b) there was a frequent speaker who enforced a talk turn control through fake turns or self-turn takings; c) demands were being made instead of requests or invitations; d) the types of invitations, requests or demands being made were not addressed; e) the invitations, requests or demands were not addressed with the same level of interaction that they were made; and f) when both characters lost the shared simultaneity representing equity between speakers and simultaneity became a barrier.

Seventh finding Gradients of power .-Gradients of power are constituted by the three states of power (Monophony, Homophony, Polyphony) and their intermediate transitional periods based on Dissonance and Harmony. Struggles and the balance between constructors and disruptors of the connection processes, to solve the struggles, can either facilitate or slow down, hinder, or hold up the mobilization from a lower to a higher state of power. In this study of power, that is called an authentic cadence. In contrast, remaining struggles would trap the interaction in a transitional period, or if the disconnection is severe, it would trigger a change from a high to a low state of power. In this study of power that is called half cadence.

Imagining a linear scale (See Figure 6.6), the left hand scale would mark the 1st gradient of power in which the lowest level of relationship could be positioned, where one person controlled the conversation; this clearly manifestated attenuation of the care pair. The 1st gradient is the first state of power, Monophonic care. The next right hand position would mark the 2nd gradient of power where the first relational struggles are more evident. This is the dissonant period of transition 1. The next position marks the 3rd gradient, where a medium level of relationship is developed, between the people involved in the care interaction. The 3rd gradient is the second state of power, Homophonic care. Gradient number 4 is where the relational struggles in homophony were more evident. This is identified as dissonant period of transition 2. The 5th and last gradient of power was found in the highest level of care, where collaboration was clearly manifested between the Np and the Pt. The 5th gradient is the third state of power, Polyphonic care.

This process, though, is non-linear. In figure 6.7, a different image with the same principles can exemplify how gradients and states of power can appear at any point in the relationship, and how cyclical is the process. The arrows that come and go constituting a cycle (in both figures 6.6 and 6.7) represent how the interaction in movement is always in the possibility to change from states of power through transitioning periods or even without passing through out them.

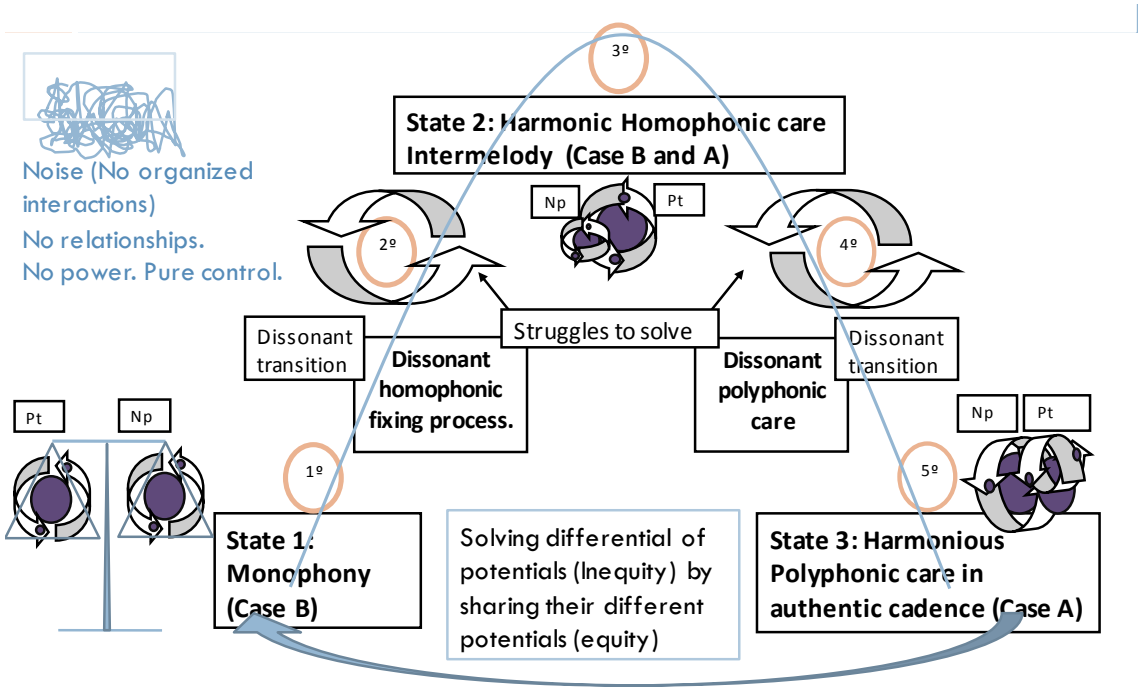
Figure 6.6
Gradients of power: From Monophonic to Harmonious Polyphonic Care



Following the Figure 6.6 we can say that before the qualitative analysis, the expectations for the cases was that they were going to represent opposites. Case A positioned in the extreme right of the line, and Case B in the extreme left. Dissonance was expected in Case B and harmony in Case A. This perspective was not considered dissonance and harmony as part of a process, but as a result; an idea that qualitative analysis was able to contradict. The enlightenment of this finding stands for a symbiotic interaction between dissonance and harmony. For harmony to be achieved, dissonance

is needed. In other words, for care collaboration to be developed, struggle periods and its confrontation and solution, are essential.

Figure 6.7
The gradients of power process



Care attenuation assigned to Case B and care collaboration assigned to Case A, as dissonance and harmony are not dichotomous. We discovered that Monophony (autistic), Homophony (narcissistic-egocentric) and Polyphony (sociocentric) are not determined states of a relationship, but temporary states that can change during the

course of time through small disruptive-constructive transitional periods; with homophony having the widest transitional period. In honor of the unexpected, Cadences, which were considered a smaller part of the analysis, were considered the theoretical and metaphorical construction able to interlace Sounds and Textures of Movements and Words. Cadences (being moments of restfulness in a continuous process of tension and concordance) reflect a process of continuous melodic balance. Cadence is not only the representation of how relationships end (first understanding), but how are they being developed, how they promote balance, and how they become paralyzed or continued moving.

In other terms, the study of power manifestations is not the study of harmonious and dissonant care cases, but the study of care cadences (process of tension-concordance relationship balance). This turn, promoted a flexible, natural, and even a more non-moral and non-dual (separatists) driven understanding of power and power balance.

Mental Model of Integration

The Mental Model of Integration (*MMI*) seen in Figure 6.8 illustrates the integration of the fractals in the "Whole": the "whole" of the movement and the "whole" of the speech; the "whole" of the Intermelody in each case; and the "whole" of the Sounds (Dissonance, Harmoniuos), Cadences (Half and Authentic), and Textures (Monophonic-Autistic, Homophonic-Narcissistic_Ego Centric, and Polyphonic-Sociocentric) in the process of the Intermelody Quality relationship. The Micro relations are constitute the Macro relations.

Through the integration path in this thesis, what was privileged in the ‘body’ movement that was not privilege in the ‘mind’ speech and vice versa, were revealed. Through the metaphor of music the maximized differences between dissonant and harmonious health care encounters between nurse practitioners (Np) and patients (Pt) were discovered. However, through verbal and nonverbal integration, the process of communication revealed that Case A and Case B were not two different extremes (Harmonious Collaboration versus Dissonant Attenuation). They were part of a balance process that can vary from: Monophonic care, to Homophonic care, and back to Monophony; or from Homophonic care to Polyphonic care and back to Homophony; or even from Homophonic Care to Polyphonic care and direct to Monophony. This study suggests that if a monophony or a dissonant homophonic care at any level of the health system is presented, there is always a way to move it so that it does not remain long periods. That is what we call power: the relations from inside (micro) to outside (macro).

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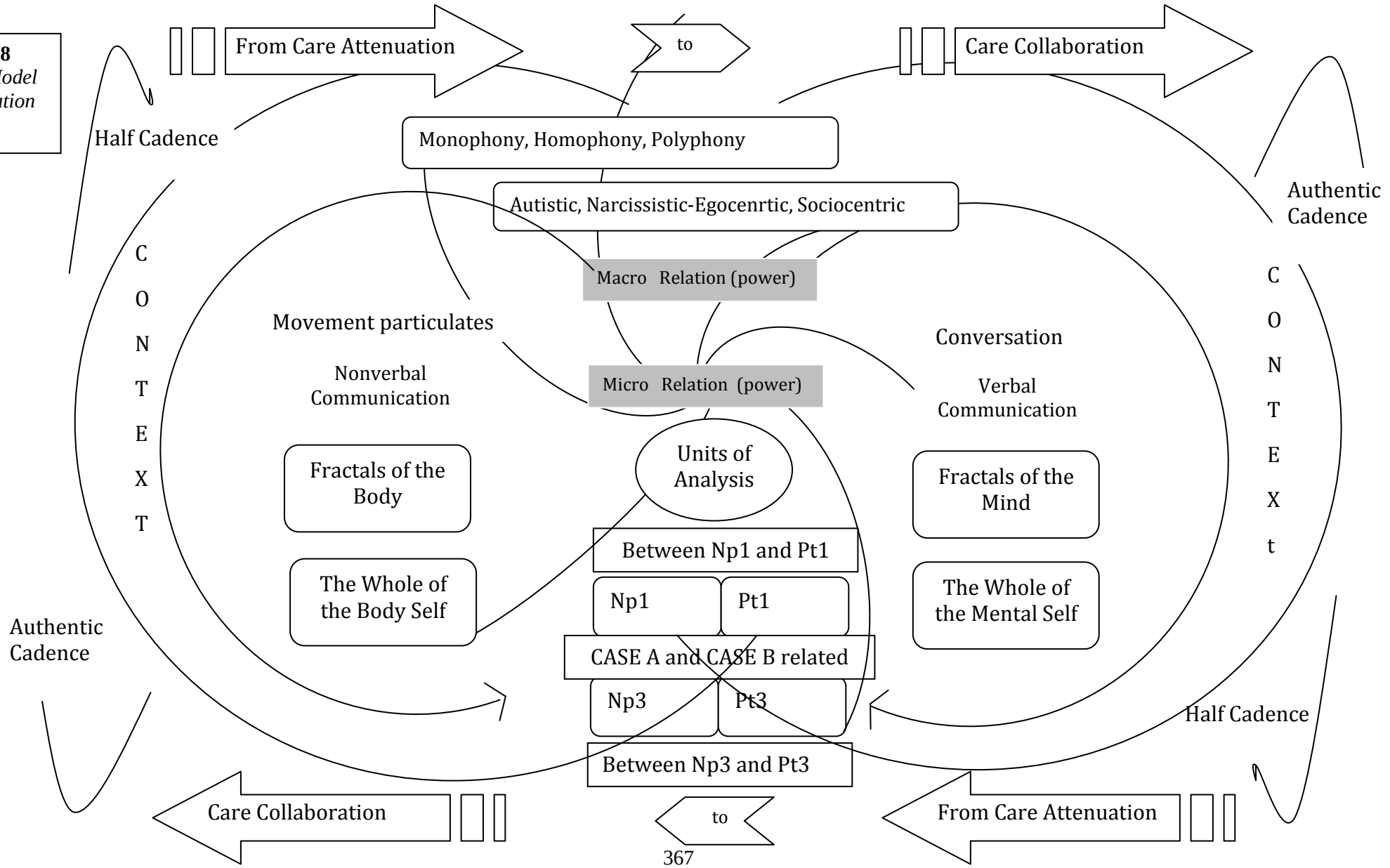
Figure 6.8
Mental Model of Integration (MMI)



Case A and B Np-Pts in a Caring Struggle Solving Continuum in tension and concordance, moving in a different type of dynamic relational balance: From Micro to Macro and from Macro to Micro POWER.

Conclusions

Equity (shared potentials) and inequity (differential of potentials) are not dichotomous, as the theoretical framework supported. A relationship like the one between the Nurse practitioner and patients is in continual ebb and flow between concordance and tension, like the music terminology helped us understand. Conflicts (tensions), both relational or health struggles, are part of life and might produce inequity. Depending on the permanency of inequity, and the mechanism used to address those tensions, is that concordance or discordance facilitated or complicated conflict resolution. Although the Cases showed us that a deeper relationship brings more tension (because in no-relationship, tensions between parts are inexistent), as soon as the individuals relate equitably to each other, balance- as a dynamic act- starts. Bringing their own voices and potentials, discordance (differentials) can be solved, enabling into periods of concordance (reduced differentials). Related simultaneous actions, mirroring, equitable disruptions and equitable immediate repairs, equitable verbal and nonverbal voice, and nonverbal harmony, are all dynamic acts forming a relational mechanism capable of solving conflict (tension) and creating concordance.

Balance starts in the subtle places of body movement and verbal conversation. The Body and Mind languages in discordance might disrupt the self and others, and body-mind concordance might construct the self and others. Control prevents concordance, and relationship provokes it. Prolonged discordance between the nurse practitioner and patient might disrupt the self and others creating more relational unsolved conflicts. This averts a deeper and long-term health struggle solution, and

supports superficial and immediate fixings which in the end costs the same time and resources than deeper and longer healing strategies but have weaker results. Nurse practitioner-patient concordance has its periods of discordance, but might more easily construct the self and others. This encourages a mirrored immediate relational conflict solving, allowing the rest of the time to be used for sharing reflections, experiences and knowledge. This sharing endorses that together, Np and Pt, plan and learn about deeper and long-term latent health inactions that might in collaboration as well, transform from latent to actual actions. Concordant interaction over time and deeper and long term actions might heal instead of fix.

In contrast to what we read in the first 4 categories of the literature review about power, where power is related to a force over the self or over others to achieve a goal, the qualitative-quantitative findings support the idea that force is an illusion of power, as well addressed by Hawkins (2000). Force enhance extreme separation, and to reestablish balance, one side needs to take what the other side has gained, and the "powerful" side needs to lose power to make the "powerless" more "powerful". Based on the term "banking education" (Freire, 1977), is the illusion that power is an object that can be given, taken, provided, lost or gained in a transaction. Supported on this perspective, people may think that equity is to have the same weight and stability of forces in two separate places. This perspective suggests that when there is a "powerful" who is not giving, then force is needed to achieve the goal of having more power, and thus establish equity. That vision of balance, supported by separation, maintains the individuals involved in apparent inequity in two static extremes (the powerful and the powerless) are

in a continuous period of transition (from imbalance to balance) or struggle. It also promotes that power is a state of "powerfulness".

This research found that fewer connections are made in separation. The less connections made, a lesser gradient of power results. Care is a way to promote connections (Leal, 2006; Lowe, 2002; Falk Raphael, 1998; McWilliam et al. 1997) and thus is a way of promoting power. Struggles in health care encounters are not states, but opportunities to engage two apparent sides –Np and Pt- in a mirrored relationship. Through a mechanism of relationship based on collaborative dialogue, Np-Pt can plan and act such that struggles are resolved in an *authentic cadence* (Wright, 2008). This socio-centric view of care is possible by a verbal and nonverbal communication in which mind-body can express their potentials in order to solve disruption and facilitate construction. The importance of struggles does not rest with struggles themselves, but about the way in which they are solved. Domination-as a struggle-, and thus inequity, occurs in closed circles of differential of potentials (Foucault, 1977) such as *labour power* (Marx, 1976), power knowledge (Foucault, 1978, 1977, 1973) and oppression (Freire, 1970, 1985). Domination is based on the illusive separation of potentials into those two extremes, the dominant and the one being dominated. In oppression, all parties are oppressed and the only thing that remains in existence is oppression itself (Freire, 1985). Struggles in health, as in many areas of our lives, are a way of oppression. Unsolved struggles provoke more oppression and oppression is domination; domination as well results in inequity.

Human beings persistently resist ppression. As oppression has no face, in a banking balance deceptive separation, the individual who does not "possess power" attaches oppression to an animate face, and that would be the one apparently possessing power and apparently dominating him/her. When there is only one self (one Monophony), then oppression can be self-attached. Resistance of the *self* or the *other*, as we clearly saw in Case B, is an act of separation; and that separation continues the cycle of domination.

In care settings situations, if this perspective continues, then the health struggles (as a form of oppression) might be at risk of not being solved, and thus health and life would also be at risk. If the "expert" or the "client" are seen as the one who has or needs power, or that must have a "position of power", it is probable that resistance within or between "expert" and "client-as-an-expert of him-herself" occurs. The "expert" avoiding or controlling resistance (from verbal patterns to acts) enhances immediate fixing actions as a way to manage conflict; a conflict that comes either from resistance or from an oppressive health situation. From verbal patterns to acts, "client-as-expert" avoiding or controlling oppression (health struggles), and which now has a face (the one of the health professional), enhances another dominant circle. This circle is based on complaints about the defective service (care) and the defective product (health), and demands about the offered product or service. As we were able to see in the qualitative data, in this circle, the Np and the Pt in Case B were all oppressed. Struggles were not being solved but repaired only by one side (verbally and in actions).

A managing system was put into place to resist and resolve the health struggles, and demand and offer a product of health. In this way neither the Np nor the Pt in Case B propose ways to start healing; they based the encounter on the exchange of two immediate fixing products - a letter and a medication- ending the encounter in a half cadence.

Contained in this conclusion is a fundamental difference that needs to be explored in power and health studies; fixing is not the same as healing. Fixing a health or a relational struggle is a false turn to connection and then a false turn to power. In a banking perspective of health, fixing requires two extremes; the one who is "broken or sick" (the powerless) and the one "capable to fix sickness" (the powerful). There are no connections there, but only the separate action of one and a static expectance of another.

However, fixing can be a dissonant period of transition to healing, as suggested by the term homophony. A mechanism reversing monophonic-to-noisy control, can reduce a differential of potentials, and promote health struggle solving and health. A relational mechanism based in sharing different potentials, as we understood in the movement from dissonant homophony to harmonious polyphony, reduces differentials in potentials by the contribution of different Intramelody qualities. The connection of Intramelody (mind-body) qualities in an Intermelody (Np-pt), allows that problems in half cadence (derived from past attenuating dissonant care situations), can be resolved in an authentic cadence. This is possible in a continuum cyclical balance relationship between the two or more individuals involved in connection. As we have seen through this thesis, one, two or more individuals in deep relationship, is power. The process between dissonant oppression

which attenuates health (health struggle or control) and harmonic liberation (health) is possible by the strength of the Np-Pt power, created in the connections of collaboration.

A moral, dual, banking perspective around power balance can temporarily disintegrate strength for healing within the natural course of health struggles (sickness). This perception breaks what for centuries health was supposed to mean: a balance between mind, body and spirit; a balance between people; a balance among communities; and a balance within and with the environment. Nursing articles around the topic, suggest that a perspective like this has not only been internalized at a systemic level but also at an individual level and therefore at the level of disciplines like Nursing. This also suggests that a perception lived in a macro level (e.g. health system) is constructed by the perception constituting that system. What would happen if the perception of those people starts changing?

Only one small movement in perception about power and caring relationship – caring power- is needed to start reversing the effects of such a management and controlling mechanism whom we (as the system) have set into motion; and which perpetuates inequity instead of mobilizing it. No one is controlling us and no one needs to liberate us from the oppression. No one needs to control or manage the self or others to fix the unhealthy or even demand and provide care to have health. Besides we do not need to resist an oppressor, but in relationship, set into motion resistance to face oppression. The revolution from managing and fixing to caring and healing is here, in the moving connected balance of our intra power (mind-body) and our inter power (nurses-healers and patients-healers).

The implications of this thesis rest in the reflection about our own perception of power as health professionals and as patients, especially in the nursing field. The way we think, move or speak can reinforce controlling mechanisms that relies on and constitutes a management system. On the other hand, the way we think, move and talk can shift the way we approach a person in a care encounter. This thesis of power revelation through body movements and conversations in nursing fields, can be use as a step in our practice as healers (nurse practitioners) taking care of other healers (the patients). Recognizing ourselves as notes with different tones to be related to other notes in the construction of a musical masterpiece, can give us another spectrum about health relationships and power. All of us are different, but of equal importance, which brings one tone or another to the melody. Moments of tension among us, or in our health will always exist, and oppress us. One following the other, dissonance and harmony will come. Different textures will bring diversity to our life. An essential act is to continue in movement from the body and the words to the rest of the people within this continuum, in order to express our power and live the conflict in authentic and empathic cadence.

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APENDIX A: QUANTITATIVE TABLES

I. Hypothesis 1 Differences

Case A (Np1-Pt1) Sounds of Movement

CASE A. Difference in the proportion between Np and Pt potentials, in terms of Sounds of Movement Channels	
Sounds of movement Channels (DV)	Person (Iv)

Table A1
Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Distance (Close vs Far)

		Np1	Pt1	Total
Distance potentials	**Disruptive**	**14**	**53**	67
	Constructive	**76**	**37**	113
	Total	90	90	**180**

X^2 (1, N=180)= 36.162, *p*= .000 (<.001)

The proportion of potentials in terms of distance (close=constructive, and far=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of distance. An unexpected significant chi-square was obtained, X^2 (1, N=180)= 36.162, *p*=< .001

Run this channel in terms of intervals of time

Table A2
Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Orientation (Other vs Individual oriented)

		Np1	Pt1	Total
Orientation potential	**Disruptive**	**34**	**40**	74
	Constructive	**56**	**50**	106
	Total	90	90	**180**

X^2 (1, N=180)= .826, *p*= .363

The proportion of potentials in terms of orientation (other oriented=constructive, and independently oriented=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of orientation. A non significant chi-square was obtained as expected, X^2 (1, N=180)= .826, *p*= .363

Table A3

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Gross Posture (Flexibility vs Rigidness)

		Np1	**Pt1**	Total
Gross posture potential	**Disruptive**	**10**	**25**	35
	Constructive	**80**	**65**	145
	Total	90	90	**180**

X^2 (1, N=180)= 7.980, *p*= .005

The proportion of potentials in terms of flexibility (flexible=constructive, and rigid=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of flexibility. An unexpected significant chi-square was obtained, X^2 (1, N=180)= 7.980, *p*= < .005

Run this channel in terms of intervals of time

Table A4

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Body Gesture –Arms and Hands- (Smoothness vs Loudness)

		Np1	**Pt1**	Total
Body Posture potential	**Disruptive**	**8**	**32**	40
	Constructive	**82**	**58**	140
	Total	90	90	**180**

X^2 (1, N=180)= 18.514, *p*= .000 (<.001)

The proportion of potentials in terms of smoothness (smooth=constructive, and loud=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of arms and hands smoothness. An unexpected significant chi-square was obtained, X^2 (1, N=180)= 18.514, *p*= <.001

Run this channel in terms of intervals of time.

Table A5

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Head Neck Face Posture Gesture (Affirmation vs Rejection)

		Np1	**Pt1**	Total
Head Neck Face Posture Gesture Potentials	**Disruptive**	**30**	**11**	41
	Constructive	**60**	**79**	139
	Total	90	90	**180**

X^2 (1, N=180)= 11.402, *p*= .001

The proportion of potentials in terms of head-neck-face posture-gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of head-neck-face posture-gesture. An unexpected significant chi-square was obtained X^2 (1, N=180)= 11.402, *p*= <.001

Run this channel in terms of intervals of time

Table A6

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Arms, hands, fingers posture-gesture (Openness vs Closeness)

		Np1	**Pt1**	Total
Arms, hands, fingers posture-gesture potential	**Disruptive**	**39**	**28**	67
	Constructive	**51**	**62**	113
	Total	90	90	**180**

X^2 (1, N=180)= 2.877, *p*= .090

The proportion of potentials in terms of arms, hands, fingers gesture (open=constructive, and close=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of arms, hands, fingers gesture. A non significant chi-square was obtained as expected, X^2 (1, N=180)= 2.877, *p*= .090

Table A7

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Head Face posture-gesture HFPG (Dynamic Expressiveness vs Static Non Expressiveness)

		Np1	**Pt1**	Total
Head Face Gesture Potentials	**Disruptive**	**0**	**1**	1
	Constructive	**90**	**89**	179
	Total	90	90	**180**

2 cells (50.05%) have expected count less than 5%. Should I do Fisher's Exact test or Yates correlation

X^2 (1, N=180)= 1.006, *p*=.316

The proportion of potentials in terms of head face posture-gesture (HFPG) (Expressivness/Dynamism=constructive, and non expressiveness/staticism=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of HFPG. A non significant chi-square was obtained as expected, X^2 (1, N=180)= 1.006, *p*=1.000

Fishers **Exact Sig** (2-sided) is 1.000

Table A8

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Arms Hands Gesture –AHG- (Requesting/Explaining or Demanding/Complaining)

		Np1	**Pt1**	Total
Arms Hands Gesture	**Disruptive**	**52**	**46**	98
	Constructive	**38**	**44**	82
	Total	90	90	**180**

X^2 (1, N=180)= .806, *p*= .369

The proportion of potentials in terms of arms, hands, gesture –AHG- (requesting/explaining=constructive, and demanding/complaining=disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of AHG A non significant chi-square was obtained as expected, X^2 (1, N=180)= .806, *p*= .369

Table A9

Nonverbal behavioural potentials proportion of people involved in Case A exemplar in terms of Facial Gesture (Disruptive vs Constructive)

		Np1	Pt1	Total
Facial Gesture potentials	**Disruptive**	**0**	**13**	13
	Constructive	**88**	**74**	162
	Total	88	87	**175**

2 missing in Np1, and 3missing in Pt1. 5 missing values

X^2 (1, N=175)= 14.205, *p*= .000 (<.001)

The proportion of potentials in terms of facial gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of facial gesture. An unexpected significant chi-square was obtained. X^2 (1, N=175)= 14.205, *p*= <.001

Table A9.1

Specific **Facial Gestures frequencies (Disruptive vs Constructive)**

		Np1		**Pt1**	
		Constructive	**Disruptive**	**Constructive**	Total
Specific facial gestures	**Frivolous/Removed vs** Carefree	**31**			31
	Rough/Loud vs Gentle/Tender	**14**			13
	Arrogant vs Confident	**4**		**11**	13
	Somber/Suffered vs Humorous/Cheerful	**3**		**8**	11
	Agitated vs Energetic		**6**	**10**	16
	Pedantic/Worried vs Understandig/Aware		**7**	**35**	42
	Dull vs Serene	**36**		**10**	44
	Fadish vs Timless				0
	Total	90	13	77	**180**

Np: 5missings

Pt: 3missing 0 not sure.

Case B (Np3-Pt3) Sounds of Movement

CASE B. Difference in the proportion between Np and Pt potentials, in terms of Sounds of Movement Channels	
Sounds of movement Channels (DV)	Person (Iv)

Table A10

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Distance (Close vs Far)

		Np3	Pt3	Total
Distance potential	**Disruptive**	**75**	**95**	170
	Constructive	**22**	**1**	23
	Total	97	96	**193**

1 missing value

X^2 (1, N=193)= 21.522, *p*= .000 (<.001)

The proportion of potentials in terms of distance (close=constructive, and far=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of distance. An expected significant chi-square was obtained, X^2 (1, N=193)= 21.522, *p*=< .001

Table A11

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Orientation (Other vs Individual oriented)

		Np3	Pt3	Total
Orientation potential	**Disruptive**	**73**	**95**	168
	Constructive	**24**	**2**	26
	Total	97	97	**194**

X^2 (2, N=194)= 25.52, *p*=< .001

The proportion of potentials in terms of orientation (other oriented=constructive, and independently oriented=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of orientation. An expected significant chi-square was obtained , X^2 (2, N=194)= 25.52, *p*=< .001

Table A12

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Gross Posture (Flexibility vs Rigidness)

		Np3	**Pt3**	Total
Gross posture potential	**Disruptive**	**81**	**47**	128
	Constructive	**16**	**49**	65
	Total	97	96	**193**

1 missing value

X^2 (1, N=193)= 25.781, *p*= .000 (<.001)

The proportion of potentials in terms of flexibility (flexible=constructive, and rigid=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of flexibility. An expected significant chi-square was obtained, X^2 (1, N=193)= 25.781, *p*= .000 (<.001)

Table A13

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Body Gesture –Arms and Hands-(Smoothness vs Loudness)

		Np3	**Pt3**	Total
Body Posture potential	**Disruptive**	**40**	**44**	84
	Constructive	**57**	**53**	110
	Total	97	97	**194**

X^2 (1, N=194)= .336, *p*= .562

The proportion of potentials in terms of smoothness (smooth=constructive, and loud=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of arms and hands smoothness. An unexpected non significant chi-square was obtained, X^2 (1, N=194)= .336, *p*= .562

Table A14

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Head Neck Face Posture Gesture (Affirmation vs Rejection)

		Np3	**Pt3**	Total
Head Neck Face Posture Gesture Potentials	**Disruptive**	**68**	**38**	106
	Constructive	**29**	**59**	88
	Total	97	97	**194**

X^2 (1, N=194)= 18.718, *p*= .000 (<.001)

The proportion of potentials in terms of head-neck-face posture-gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of head-neck-face posture-gesture. An expected significant chi-square was obtained X^2 (1, N=194)= 18.718, *p*= <.001

Table A15

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Arms, hands, fingers posture-gesture (Openness vs Closeness)

		Np3	**Pt3**	Total
Arms, hands, fingers posture-gesture potential	**Disruptive**	**58**	**78**	136
	Constructive	**39**	**19**	58
	Total	97	97	**194**

X^2 (1, N=194)=9.838, *p*= .002

The proportion of potentials in terms of arms, hands, fingers gesture (open=constructive, and close=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of arms, hands, fingers gesture. A significant chi-square was obtained as expected, X^2 (1, N=194)=9.838, *p*= .002

Table A16

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Head Face posture-gesture -HFPG- (Dynamic Expressiveness vs Static Non Expressiveness)

		Np3	**Pt3**	Total
Head Face Gesture Potentials	**Disruptive**	**23**	**1**	24
	Constructive	**74**	**96**	170
	Total	97	97	**194**

X^2 (1, N=194)= 23.014, *p*=.000 (<.001)

The proportion of potentials in terms of head face posture gesture **-HFPG-** (Expressiveness/Dynamism=constructive, and non expressiveness/staticism=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of HFPG. A significant chi-square was obtained as expected, X^2 (1, N=194)= 23.014, *p*=<.001

Table A17

Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of Arms Hands Gesture –AHG- (Requesting/Explaining or Demanding/Complaining)

		Np3	**Pt3**	Total
Arms Hands Gesture	**Disruptive**	**87**	**84**	171
	Constructive	**10**	**13**	23
	Total	97	97	**194**

X^2 (1, N=194)= .444, *p*= .505

The proportion of potentials in terms of arms hand gesture –AHG- (requesting/explaining=constructive, and demanding/complaining=disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of AHG. A non significant chi-square was obtained as unexpected, X^2 (1, N=194)= .444, *p*= .505

Table A18
Nonverbal behavioural potentials proportion of people involved in Case B exemplar in terms of

Facial Gesture (Disruptive vs Constructive)				
		Np3	**Pt3**	Total
Facial Gesture potentials	**Disruptive**	**89**	**76**	165
	Constructive	**5**	**19**	24
	Total	94	95	**189**

X^2 (1, N=189)= 9.186, *p*= .002

5 missing values. The proportion of potentials in terms of facial gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of facial gesture. An expected significant chi-square was obtained, X^2 (1, N=189)= 9.186, *p*= .002

Table A18.1
Specific **Facial Gestures frequencies (Disruptive vs Constructive)**

		Np3		**Pt3**		Total
		Disruptive	**Constructive**	**Disruptive**	**Constructive**	
Specific facial gestures	**Silence**	**24**				
	Frivolous/ Removed vs Carefree	**26**			3	
	Rough/Loud vs Gentle/Tender	**20**	**3**	0		
	Arrogant vs Confident	**6**		**2**		
	Somber/Suffered vs Humorous/Cheerful	3		**18**	**4**	
	Agitated vs Energetic					
	Pedantic/Worried vs Thoughtful/ Understandig/ Aware	**3**		**28**	**5**	
	Dull vs Serene		**2**	**28**	**7**	
	Fadish vs Timless	**7**				
	Total	89	5	76	19	**189**

Case A (Np1-Pt1) Textures of Movement

CASE A. Difference in the proportion between Np1 and Pt1 potentials, in terms of Textures of Movement Channels

Textures of movement Channels (DV) | Person (Iv)

Table A19
Potentials proportion of people involved in Case A exemplar in terms of TOUCH

		Np1	Pt1	Total
Touch potential	**Silence**	**87**	**90**	177
	Voice	**3**	**0**	3
	Total	90	90	**180**

2 cells (50%) have less than Fx(5) violating X^2 test assumptions. Is Fisher's Exact test or Yates correlation needed? How do I interpret those results?

X^2 (1, N=180)= 3.051, *p*= .081 (Fisher's .246)

The proportion of potentials in terms of touch (Touch=voice, and No touch=silence) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of touch. A non significant chi-square was obtained as expected, X^2 (1, *N*=180) = 3.051, *p*=.246

Fishers Exact Sig (2-sided) is .246

Table A20
Potentials proportion of people involved in Case A exemplar in terms of EYE CONT.

		Np1	Pt1	Total
Eye Contact potential	**Silence**	**34**	**32**	66
	Voice	**56**	**58**	114
	Total	90	90	**180**

X^2 (1, N=180)= .096, *p*= .757

The proportion of potentials in terms of eye contact (contact=voice, and No contact=silence) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of touch. A non significant chi-square was obtained as expected, X^2 (1, N=180)= .096, *p*= .757

Table A21
Potentials proportion of people involved in Case A exemplar in terms of PRESENCE

	Np1	Pt1	Total

	Silence	**0 (0%)**	**0% (0)**	0%
Presence potential	**Voice**	**90 (50%)**	**90 (50%)**	180
	Total	180	180	**180**

The proportion of potentials in terms of presence (presence=voice, and No presence=silence) as a function of type of person involved in Case A is displayed in Table X.
Check another method (I checked in my handbook Olu. It is not in the old old one)
A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of presence. No statistics were computed because presence is a constant.

. Table A22
Potentials proportion of people involved in Case A exemplar in terms of body posture-facial gesture (Head, Torso, Arms and Hands) Dynamism

		Np1	**Pt1**	Total
	Silence	**32**	**33**	65
Head, Torso, Arms and Hands Dynamism	**Voice**	**58**	**57**	115
	Total	90	90	**180**

X^2 (1, N=180)= .024, *p*= .877
The proportion of potentials in terms of Head, Torso, Arms and Hands Dynamism (Dynamic=voice, and Static =silence) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of posture-gesture dynamism. A non significant chi-square was obtained as expected, X^2 (1, N=180)= .024, *p*= .877

Table A23
Potentials proportion of people involved in Case A exemplar in terms of Talk (talking lips movement)

		Np1	**Pt1**	Total
	Silence	**46**	**30**	76
Lips talking movement	**Voice**	**44**	**60**	104
	Total	90	90	**180**

X^2 (1, N=180)= 5.830, *p*= .016
The proportion of potentials in terms of Talk-moving lips (talk=voice, and No talk=silence) as a function of type of person involved in Case A is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case A care relationship (Np1 and Pt1), have a significant difference in the contribution of potentials to the interaction, in terms of talk. The proportion of talk potential between Np1 (voice=44) and Pt1 (voice=60) , was found to be significantly different than expected, X^2 (1, N=180)= 5.830, *p*= .016

Case B (Np3-Pt3) Textures of Movement

CASE B. Difference in the proportion between Np and Pt potentials, in terms of Textures of Movement Channels

Textures of movement Channels (DV) | Person (Iv)

Table A24

Potentials proportion of people involved in Case B exemplar in terms of TOUCH

		Np3	**Pt3**	Total
Touch potential	**Silence**	**97 (50%)**	**97 (50%)**	194
	Voice	**0 (0%)**	**0 (0%)**	0
	Total	97	97	**194**

The proportion of potentials in terms of touch (Touch=voice, and No touch=silence) as a function of type of person involved in Case B is displayed in Table X.

Use another method (I search for it and didn't find it in the 1st handbook version.

A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of touch. No statistics were computed because Touch is a constant

. Table A25

Potentials proportion of people involved in Case B exemplar in terms of EYE CONT.

		Np3	**Pt3**	Total
Eye Contact potential	**Silence**	**70**	**68**	138
	Voice	**27**	**29**	56
	Total	97	97	**194**

X^2 (1, N=194)= .100, *p*= .751

The proportion of potentials in terms of eye contact (contact=voice, and No contact=silence) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of touch. An unexpected non significant chi-square was obtained, X^2 (1, N=194)= .100, *p*= .751

Table A26

Potentials proportion of people involved in Case B exemplar in terms of PRESENCE

		Np3	Pt3	Total
Presence potential	**Silence**	**22**	**0**	22
	Voice	**75**	**97**	172
	Total	97	97	**194**

X^2 (1, N=194)= 24.814, *p*= .000 (<.001)

The proportion of potentials in terms of presence (presence=voice, and No presence=silence) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of presence. An expected significant chi-square was obtained, X^2 (1, N=194)= 24.814, *p*=<.001

Table A27

Potentials proportion of people involved in Case B exemplar in terms of Head, Torso, Arms and Hands Dynamism

		Np3	Pt3	Total
Head, Torso, Arms and Hands Dynamism	**Silence**	**62**	**68**	130
	Voice	**35**	**29**	64
	Total	97	97	**194**

X^2 (1, N=194)= .839, *p*= .360

The proportion of potentials in terms of Head, Torso, Arms and Hands Dynamism (Dynamic=voice, and Static =silence) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of posture-gesture dynamism. A non significant chi-square was obtained as unexpected, X^2 (1, N=194)= .839, *p*= .360

Table A28

Potentials proportion of people involved in Case B exemplar in terms of Talk (talking lips movement)

		Np3	**Pt3**	Total
Lips talking movement	**Silence**	**73**	**54**	127
	Voice	**24**	**43**	67
	Total	97	67	**194**

X^2 (1, N=194)= 8.231, *p*= .004

The proportion of potentials in terms of Talk-moving lips (talk=voice, and No talk=silence) as a function of type of person involved in Case B is displayed in Table X. A chi-square test was conducted to evaluate whether the two individuals participating in the Case B care relationship (Np3 and Pt3), have a significant difference in the contribution of potentials to the interaction, in terms of talk. The proportion of talk potential between Np3 and Pt3, was found significantly different as expected, X^2 (1, N=194)= 8.231, *p*= .004

Case A Mann Whitney table Disruptive to Constructive

Table A29

Case A distribution of constructive potential categorizations as a function of type of person

	Np1	Pt1
Disruptive (0 to 3 shared constructive potentials)	0	5
In constructive progress (4 to 5 shared constructive potentials)	14	34
Constructive (6 to 9 shared constructive potentials)	76	51
Total	90	90

Case B Man Whitney Table Disruptive to constructive

Table A30
Case B distribution of constructive potential categorizations as a function of type of person

	Np3	Pt3
Disruptive (0 to 3 shared constructive potentials)	56	55
In constructive progress (4 to 5 shared constructive potentials)	37	41
Constructive (6 to 9 shared constructive potentials)	4	1
Total	97	97

Case A Mann Whitney Level of relationship

Table A31
Case A distribution of constructive potential categorizations as a function of type of person

	Np1	Pt1
No voice (0 potentials)	0	0
Individual voice in relationship building (1 to 2 shared potentials)	24	26
More shared voice (3 to 5 shared potentials)	66	64

Case B Mann Whitney Level of voice

Table A32
Case B distribution of constructive potential categorizations as a function of type of person

	Np3	Pt3
No voice (0 potentials)	22	0
Individual voice in relationship building (1 to 2 shared potentials)	48	72
More shared voice (3 to 5 shared potentials)	27	25
Total	97	97

II. Hypothesis 2 Association

Case A (Np1 and Pt1) Sounds of Movement

Case A. Proportions and degree of association between the movements of Np1 and Pt1, in terms of Sounds of Movement

Table A33

Proportion of Np1 distance depending on Pt1 distance and/or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**11**	**3**	14
	Constructive	**42**	**34**	76
Total		53	37	90

V= .172, *p=.103*

The proportion of **Np1 distance depending on Pt1 distance and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np1 distance (N=90) vary depending on Pt1 distance (N=90) and vice versa. An unexpected non significant constructive association was obtained, V= .172, *p=.103,* indicating that Np1 distance do not vary depending on Pt1 distance and vice versa.

Table A34

Proportion of Np1 orientation depending on Pt1 orientation and/or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**14**	**20**	34
	Constructive	**26**	**30**	56
Total		40	50	90

V= .051, *p=.627*

The proportion of **Np1 orientation depending on Pt1 orientation and/or vice versa** is shown on table 30. A Cramer's V test was conducted to evaluate whether Np1 orientation (N=90) vary depending on Pt1 orientation (N=90) and/or vice versa. An expected non significant disruptive association was obtained, V= .051, *p=.627,* indicating that Np1 orientation does not vary depending on Pt1 orientation and vice versa.

Table A35

Proportion of Np1 posture flexibility depending on Pt1 posture flexibility and/or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**1**	**9**	10
	Constructive	**24**	**56**	80
	Total	25	65	90

V= .140, *p=.183*

The proportion of **Np1 flexibility depending on Pt1 flexibility and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np1 flexibility (N=90) vary depending on Pt1 flexibility (N=90) and vice versa. An expected non significant disruptive association was obtained, V= .140, *p=.183,* indicating that Np1 orientation does not vary depending on Pt1 orientation and vice versa.

Table A36

Proportion of Np1 body gesture –arms and hands- smoothness depending on Pt1 body gesture smoothness –arms and hands- and/or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**4**	**4**	8
	Constructive	**28**	**54**	82
Total		32	58	90

V= .094, *p*=.371

The proportion of **Np1 arms and hands body gesture smoothness (AHBGS) depending on Pt1 AHBGS and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np1 AHBGS (N=90) vary depending on Pt1 AHBGS (N=90) and vice versa. An expected non significant disruptive association was obtained, V= .094, *p*=.371*,* indicating that Np1 AHBGS does not varies depending on Pt1 arms and hands AHBGS and vice versa

Table A37

Proportion of Np1 head face affirmation (HFA) depending on Pt1 HFA and/or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**4**	**26**	30
	Constructive	**7**	**53**	60
Total		11	79	90

V= .024, *p*=.820

The proportion of **Np1 HFA depending on Pt1 HFA and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 HFA (N=90) vary depending on Pt1 HFA (N=90) and vice versa. An expected non significant disruptive association was obtained, V= .024, *p*=.820*,* indicating that Np1 HFA does not vary depending on Pt1 HFA and vice versa.

Table A39

Proportion of Np1 arms, hands, fingers posture gesture Openness (PGO) depending on Pt1 PGO or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**14**	**25**	39
	Constructive	**14**	**37**	51
	Total	28	62	90

V= .090, *p=.391*

The proportion of **Np1 PGO depending on Pt1 PGO and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 PGO (N=90) vary depending on Pt1 PGO (N=90) and vice versa. An expected non significant disruptive association was obtained, V= .090, *p=.391*, indicating that Np1 PGO does not vary depending on Pt1 PGO and vice versa.

Table A39

Proportion of Np1 Head Face posture gesture Dynamic Expressiveness (DE) depending on Pt1 DE or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**			
	Constructive	**1**	**89**	90
Total		**1**	**89**	90

The proportion of **Np1 Dynamic Expressiveness (DE) depending on Pt1 PGO and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 DE (N=90) vary depending on Pt1 DE (N=90) and vice versa. No measures of association were computed, because at least in each 2-way table a measure of associations is a constant. Which test should I run then?

Table A40
Proportion of Np1 arms hands gesture (AHG) depending on Pt1 HG or vice versa.

		Pt1		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**26**	**26**	52
	Constructive	**20**	**18**	38
Total		46	44	90

V= .026, *p=.805*

The proportion of **Np1 Requesting/Explaining or Demanding/Complaining Hands Gesture –AHG-** depending on **Pt1 HG and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 AHG (N=90) vary depending on Pt1 AHG (N=90) and vice versa. A non significant association was obtained, V= .026, *p=.805,* indicating that Np1 AHG disruptive or constructive behaviours does not vary depending on Pt1 AHG and vice versa.

Table A41
Proportion of Np1 Facial Gesture Consonance (FGC) depending on Pt1 FGC or vice versa.

		Pt1	Total

		Disruptive	Constructive	
Np1	**Disruptive**			
	Constructive	**13**	**72**	85
Total		13	72	85

5missing values (5.6%)

The proportion of **Np1 FGC depending on Pt1 FGC and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 FGC (N=90) vary depending on Pt1 FGC (N=90) and vice versa. No measures of association are computed

Warnings

No measures of association are computed for the cross tabulation of Np1_HD_Bi_K_FG_Gestures_Consonance * Pt1_HD_Bi_K_FG_Gestures_Consonance. At least one variable in each 2-way table upon which measures of association are computed is a constant.

Case B (Np3 and Pt3) Sounds of Movement

Case B. Proportions and degree of association between the movements of Np3and Pt3, in terms of Sounds of Movement

Table A42
Proportion of Np3distance depending on Pt3 distance and/or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np1	**Disruptive**	**73**	**1**	74
	Constructive	**22**	**0**	22
Total		95	1	96

V= .056, *p=.584*

The proportion of **Np3distance depending on Pt3 distance and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np3distance (N=96) vary depending on Pt3 distance (N=96) and vice versa. An expected non significant constructive association was obtained, V= .056, *p=.584,* indicating that Np3distance do not vary depending on Pt3 distance and vice versa.

. Table A43

Proportion of Np3orientation depending on Pt3 orientation and/or vice versa.

		Pt3	Total

		Disruptive	Constructive	
Np3	**Disruptive**	**72**	**1**	73
	Constructive	**23**	**1**	24
Total		95	2	97

V= .085, *p=.403*

The proportion of **Np3orientation depending on Pt3 orientation and/or vice versa** is shown on table 30. A Cramer's V test was conducted to evaluate whether Np3orientation (N=97) vary depending on Pt3 orientation (N=97) and/or vice versa. An expected non significant constructive association was obtained, V= .085, *p=.403,* indicating that Np3orientation does not vary depending on Pt3 orientation and vice versa.

A Table 44

Proportion of Np3posture flexibility depending on Pt3 posture flexibility and/or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**34**	**42**	81
	Constructive	**8**	**7**	15
	Total	47	49	96

V= .038, *p=.712*

1 missing value. The proportion of **Np3flexibility depending on Pt3 flexibility and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np3flexibility (N=96) vary depending on Pt3 flexibility (N=96) and vice versa. An expected non significant constructive association was obtained, V= .038, *p=.712,* indicating that Np3 orientation does not varies depending on Pt3 orientation and vice versa.

Table A45

Proportion of Np3 arms and hands body gesture (AHBGS) smoothness depending on Pt3 AHBGS and/or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**23**	**17**	40
	Constructive	**21**	**36**	57
Total		44	53	97

V= .204, *p=.044*

The proportion of **Np3 arms and hands body gesture smoothness (AHBGS) depending on Pt3 AHBGS and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np3 AHBGS (N=97) vary depending on Pt3 AHBGS (N=97) and vice versa. An unexpetced significant constructive association was obtained, V= .204, *p=.004. Table 4 shows how Pt*3 softness varies depending on Np3 softness and vice versa.

. Table A46
Proportion of Np3head face affirmation (HFA) depending on Pt3 HFA and/or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**1**	**22**	23
	Constructive	**0**	**74**	74
Total		1	96	97

V= .183, *p=.071*

The proportion of **Np3HFA depending on Pt3 HFA and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3HFA (N=97) vary depending on Pt3 HFA (N=97) and vice versa. An unexpected non significant disruptive association was obtained, V= .183, *p=.071,* indicating that Np3HFA does not vary depending on Pt3 HFA and vice versa.

Table A47
Proportion of Np3arms, hands, fingers posture gesture Openness (PGO) depending on Pt3 PGO or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**49**	**9**	58
	Constructive	**29**	**10**	39
Total		78	19	97

V= .125, *p=.218*

The proportion of **Np3PGO depending on Pt3 PGO and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3PGO (N=97) vary depending on Pt3 PGO (N=97) and vice versa. An expected non significant constructive association was obtained, V= .125, *p=.218,* indicating that Np3PGO does not vary depending on Pt3 PGO and vice versa.

Table A48

Proportion of Np3Head Face posture gesture Dynamic Expressiveness (DE) depending on Pt3 DE or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**30**	**38**	68
	Constructive	**8**	**21**	29
Total		38	59	97

V= .155, *p=.127*

The proportion of **Np3Dynamic Expressiveness (DE) depending on Pt3 PGO and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3DE (N=97) vary depending on Pt3 DE (N=97) and vice versa. A non significant association was obtained, V= .155, *p=.127,* indicating that Np3DE disruptive or constructive behaviours does not vary depending on Pt3 DE and vice versa.

Table A49

Proportion of Np3 arms hands gesture (AHG) depending on Pt3 HG or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**76**	**11**	87
	Constructive	**8**	**2**	10
Total		84	13	97

V= .066, *p=.518*

The proportion of **Np3Requesting/Explaining or Demanding/Complaining Hands Gesture –AHG-** depending on **Pt3 AHG and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3 AHG (N=97) vary depending on Pt3 AHG (N=97) and vice versa. An expected non significant constructive association was obtained, V= .066, *p=.518,* indicating that Np3 AHG does not vary depending on Pt3 AHG and vice versa.

Table A50

Proportion of Np3Facial Gesture Consonance (FGC) depending on Pt3 FGC or vice versa.

		Pt3		Total
		Disruptive	**Constructive**	
Np3	**Disruptive**	**72**	**17**	89
	Constructive	**4**	**1**	5
Total		76	18	94

V= .005, *p=.960*

3 missing values

The proportion of **Np3FGC depending on Pt3 FGC and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3FGC (N=97) vary depending on Pt3 FGC (N=97) and vice versa. An expected non significant constructive association was obtained, V= .005, *p=.960,* indicating that Np3FGC does not vary depending on Pt3 FGC and vice versa.

Case A (Np1-Pt1) Textures of Movement

Case A.
Proportions and degree of association between the movements of Np1 and Pt1, in terms of Textures of Movement

Table A51
Proportion of Np1 Touch depending on Pt1 Touch and/or vice versa.

		Pt1		Total
		Silence (No potential)	**Voice (Potential)**	
Np1	**Silence (No potential)**	**87**	**0**	87
	Voice potential	**3**	**0**	3
Total		90	0	N=90

The proportion of **Np1 touch depending on Pt1 touch and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np1 touch (N=90) vary depending on Pt1 touch (N=90) and vice versa. No statistics were computed because Touch is a constant.

Warnings

No measures of association are computed for the crosstabulation of Np1_MHD_Bi_H_Touch * Pt1_MHD_Bi_H_Touch. At least one variable in each 2-way table upon which measures of association are computed is a constant.

Table A52
Proportion of Np1 Eye contact depending on Pt1 Eye contact and/or vice versa.

		Pt1		Total
		Silence (No potential)	**Voice (Potential)**	
Np1	**Silence (No potential)**	**14**	**19**	33
	Voice potential	**17**	**39**	56
Total		31	58	89

1 missing value
V=.122, p=.248

The proportion of **Np1 eye contact depending on Pt1 eye contact and/or vice versa** is shown on table 30. A Cramer's V test was conducted to evaluate whether Np1 eye contact (N=89) vary depending on Pt1 eye contact (N=89) and/or vice versa. A non significant disruptive association was obtained as expected, V=.122, p= .248, indicating that Np1 eye contact vary depending on Pt1 eye contact and vice versa.

Table A53
Proportion of Np1 presence depending on Pt1 presence and/or vice versa.

		Pt1		Total
		Silence (No potential)	**Voice (Potential)**	
Np1	**Silence (No potential)**	**0**	**0**	0
	Voice potential	**0**	**90**	90
Total		0	90	90

The proportion of **Np1 touch depending on Pt1 touch and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np1 touch (N=90) vary depending on Pt1 touch (N=90) and vice versa. No statistics were computed because Touch is a constant.

No measures of association are computed for the crosstabulation of Np1_MHD_Bi_K_P_Prescence * Pt1_MHD_Bi_K_P_Prescence. At least one variable in each 2-way table upon which measures of association are computed is a constant.

Table A54

Proportion of Np1 head, torso, arms, hands dynamism (HTAHD) depending on Pt1 HTAHD and/or vice versa.

		Pt1		Total
		Silence (No potential)	**Voice (Potential)**	
Np1	**Silence (No potential)**	**17**	**15**	32
	Voice potential	**16**	**42**	58
Total		33	57	90

The proportion of **Np1 HTAHD depending on Pt1 HTAHD and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 presence (N=90) vary depending on Pt1 presences (N=90) and vice versa. A significant positive association was obtained as expected, V= .254, *p=.016,* indicating that Np1 HTAHD voice vary depending on Pt1 HTAHD voice and vice versa.

Table A55

Proportion of Np1 Talking lips depending on Pt1 Talking lips or vice versa.

		Pt1		Total
		Silence (No potential)	**Voice (Potential)**	
Np1	**Silence (No potential)**	**7**	**39**	46
	Voice potential	**23**	**21**	44
Total		30	60	90

The proportion of **Np1 HTAHD depending on Pt1 HTAHD and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np1 presence (N=90) vary depending on Pt1 presences (N=90) and vice versa. A significant association was obtained, V= .393, *p=<.001,* indicating that Np1 talk vary depending on Pt1 talk and vice versa. Table 33 in the appendix show how frequently the Pt1 intent to talk (n=39) whenever Np1 is not talking, or viceversa. It also shows how frequently the Np1 talks at the Pt and he does not talk, or vice versa (n=23). A third association in this table show how frequent both of them are talking at the same time (n=21), and how almost never are in silence (n=7) Phi= -.393.

Case B (Np3 and Pt3) Textures of Movement

Case B. Proportions and degree of association between the movements of Np3 and Pt3, in terms of Textures of Movement

Table A56
Proportion of Np3 Touch depending on Pt3 Touch and/or vice versa.

		Pt3		Total
		Silence (No potential)	**Voice (Potential)**	
Np3	**Silence (No potential)**	**97**		97
	Voice potential			
Total				97

The proportion of **Np3 touch depending on Pt3 touch and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np3 touch (N=99) vary depending on Pt3 touch (N=97) and vice versa. No statistics were computed because Touch is a constant. What should I do?

Table A57

Proportion of Np3 Eye contact depending on Pt3 Eye contact and/or vice versa.

		Pt3		Total
		Silence (No potential)	**Voice (Potential)**	
Np3	**Silence (No potential)**	**55**	**15**	70
	Voice potential	**13**	**14**	27
Total		**68**	**29**	97

V= .298, *p=.003*

The proportion of **Np3 eye contact depending on Pt3 eye contact and/or vice versa** is shown on table 30. A Cramer's V test was conducted to evaluate whether Np3 eye contact (N=97) vary depending on Pt3 eye contact (N=97) and/or vice versa. A significant negative association was obtained, V= .298, *p=.003,* indicating that Np3 No eye contact vary depending on Pt3 No eye contact and vice versa. Table 55 shows how frequently there is no eye contact (n=55); how frequently while one is intending to establish eye contact the other is not making eye contact (n-28); and how less amount of time they are actually making eye contact (n=14).

Table A58

Proportion of Np3 presence depending on Pt3 presence and/or vice versa.

		Pt3		Total
		Silence (No potential)	**Voice (Potential)**	
Np3	**Silence (No potential)**	**22**	**0**	22
	Voice potential	**0**	**75**	75
Total		22	75	97

The proportion of **Np3 presence depending on Pt3 presence and/or vice versa** is shown on table 29. A Cramer's V test was conducted to evaluate whether Np3 presence (N=97) vary depending on Pt3 presence (N=97) and vice versa. No measures of association are computed for the cross tabulation because at least 1 variable in each 2-way table upon which measures of association are computed, is a constant (Pt3). What should I do?

. Table A59

Proportion of Np3 head, torso, arms, hands dynamism (HTAHD) depending on Pt3 HTAHD and/or vice versa.

		Pt3		Total
		Silence (No potential)	**Voice (Potential)**	
Np3	**Silence (No potential)**	**47**	**15**	62
	Voice potential	**21**	**14**	35
Total		**68**	**29**	97

V=.166, *p=.102*

The proportion of **Np3 HTAHD depending on Pt3 HTAHD and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3 HTAHD (N=97) vary depending on Pt3 HTAHD (N=97) and vice versa. A non significant constructive association was obtained as expected, V= .166, *p=.102,* indicating that Np3 HTAHD do not vary depending on Pt3 HTAHD and vice versa.

Table A60

Proportion of Np3 Talking lips depending on Pt3 Talking lips or vice versa.

		Pt3		Total
		Silence (No potential)	**Voice (Potential)**	
Np3	**Silence (No potential)**	**33**	**40**	73
	Voice potential	**21**	**3**	24
Total		54	43	97

V=.367, *p=.000 (<.001)*

The proportion of **Np3 talking lips depending on Pt3 talking lips and/or vice versa** is shown on table 32. A Cramer's V test was conducted to evaluate whether Np3 talk (N=97) vary depending on Pt3 talk (N=97) and vice versa. A significant association was obtained, V= .367, *p=<.001,* indicating that Np3 voice and silence vary depending on Pt3 voice and silence and vice versa. Phi= -.367

Pearson R

59, 60 Kendal tau b

Q4. Are there significant differences between Case A and Case B in terms of Sounds and Textures of Movement, and in terms of Sharing and Hoarding?

CASE A and B. Difference in the proportion between Case A (Np1-Pt1) interaction and Case B (Np3-Pt3) interaction in terms of Sounds of Movement Channels	
Sounds of movement Channels (DV)	Interaction (Iv)

Table A61
Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Distance (Close vs Far)

		Np1Pt1	**Np3Pt3**	Total
Distance potential	**Disruptive**	**56**	**97**	153
	Constructive	**34**	**0**	34
	Total	90	97	**187**

X^2 (1, N=187)= 44.788, *p*= .000 (<.001)

The proportion of potentials in terms of distance (close=constructive, and far=disruptive) as a function of type of interactions (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of distance. An expected significant chi-square was obtained, X^2 (1, N=187)= 44.788, *p*= <.001

Table A62
Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Orientation (Other vs Individual oriented)

		Np1Pt1	**Np3Pt3**	Total
Orientation potential	**Disruptive**	**60**	**96**	156
	Constructive	**30**	**1**	31
	Total	90	97	**187**

X^2 (1, N=187)= 35.224, *p*= .000 (<.001)

The proportion of potentials in terms of orientation (other oriented=constructive, and independently oriented=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of orientation. An expected significant chi-square was obtained, X^2 (1, N=187)= 35.224, *p*= .000 (<.001)

Table A63

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Gross Posture (Flexibility vs Rigidness)

		Np1Pt1	Np3Pt3	Total
Gross posture potential	**Disruptive**	**34**	**89**	123
	Constructive	**56**	**7**	63
	Total	90	96	**186**

X^2 (1, N=187)= 65.576, *p*= .000 (<.001)

The proportion of potentials in terms of flexibility (flexible=constructive, and rigid=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of flexibility. An expected significant chi-square was obtained, X^2 (1, N=187)= 65.576, *p*= .000 (<.001)

Table A64

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Body Gesture –Arms and Hands- (Smoothness vs Loudness)

		Np1Pt1	Np3Pt3	Total
Body Posture potential	**Disruptive**	**36**	**61**	97
	Constructive	**54**	**36**	90
	Total	90	97	**187**

X^2 (1, N=187)= 9.795, *p*= .002

The proportion of potentials in terms of arms and hands body gesture smoothness –AHBGS- (smooth=constructive, and loud=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of smoothness. An expected significant chi-square was obtained, X^2 (1, N=180)= 9.795, *p*= .002

In comparison to the rest, arms and hands smoothness, was the channel with less Pearson Chi-square value, and for so, with the less significative difference. In the separate tables, we can see that NP has a medium to high levels of smoothness in both encounters.

. Table A65

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Head Neck Face Posture Gesture (Affirmation vs Rejection)

		Np1Pt1	Np3Pt3	Total
Head Neck Face Posture Gesture Potentials	**Disruptive**	**37**	**76**	113
	Constructive	**53**	**21**	74
	Total	90	97	**187**

X^2 (1, N=187)= 27.074, *p*= .000 (<.001)

The proportion of potentials in terms of head-neck-face posture-gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of head-neck-face posture-gesture affirmation. An expected significant chi-square was obtained, X^2 (1, N=187)= 27.074, *p*= <.001

Table 6. Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Arms, hands, fingers posture-gesture (Openness vs Closeness)

		Np1Pt1	Np3Pt3	Total
Arms, hands, fingers posture-gesture potential	**Disruptive**	**53**	**87**	140
	Constructive	**37**	**10**	47
	Total	90	97	**187**

X^2 (1, N=187)= 23.539, *p*= .000 (<.001)

The proportion of potentials in terms of arms, hands, fingers gesture (open=constructive, and close=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of arms, hands, fingers gesture openness. An expected significant chi-square was obtained, X^2 (1, N=187)= 23.539, *p*= .000 (<.001)

Table A67

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Head Face posture-gesture HFPG (Dynamic Expressiveness vs Static Non Expressiveness)

		Np1Pt1	Np3Pt3	Total
Head Face Gesture Potentials	**Disruptive**	**1**	**23**	24
	Constructive	**89**	**74**	163
	Total	90	97	**187**

X^2 (1, N=187)= 21.315, *p*=.000 (<.001)

The proportion of potentials in terms of head face posture-gesture (HFPG) (Expressivness/Dynamism=constructive, and non expressiveness/staticism=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of head face posture-gesture (HFPG) (Expressive /Dynamism). An expected

significant chi-square was obtained, X^2 (1, N=187)= 21.315, *p*=<.001

Table A68

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Arms Hands Gesture –AHG- (Requesting/Explaining or Demanding/Complaining)

		Np1Pt1	**Np3Pt3**	Total
Arms Hands Gesture	**Disruptive**	**72**	**95**	167
	Constructive	**18**	**2**	20
	Total	90	97	**187**

X^2 (1, N=187)= 15.728, *p*= .000 (<.001)

The proportion of potentials in terms of arms, hands, gesture –AHG- (requesting/explaining=constructive, and demanding/complaining=disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of AHG (requesting/explaining=constructive, and demanding/complaining=disruptive). An expected significant chi-square was obtained, X^2 (1, N=187)= 15.728, *p*= <.001

Table A69

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Facial Gesture (Disruptive vs Constructive)

		Np1Pt1	**Np3Pt3**	Total
Facial Gesture potentials	**Disruptive**	**13**	**93**	106
	Constructive	**72**	**1**	73
	Total	85	94	**179**

X^2 (1, N=179)= 129.307, *p*= .000 (<.001)

The proportion of potentials in terms of facial gesture (Affirmation=Constructive or Rejection=Disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of Facial Gesture Affirmation. An expected significant chi-square was obtained, X^2 (1, N=179)= 129.307, *p*= <.001

Table A70

Nonverbal behavioural potentials proportion of Case A and Case B exemplars in terms of Sharing *proxemics* (orientation), *haptics* (eye contact) and *kinesics* (touch) towards a same goal –SHPHK-. (Sharing vs Hoarding)

		Np1Pt1	**Np3Pt3**	Total
Facial Gesture potentials	**Disruptive**	**13**	**93**	106
	Constructive	**72**	**1**	73
	Total	85	94	**179**

X^2 (1, N=179)= 58.902, *p*= .000 (<.001)

The proportion of potentials in terms of Sharing *proxemics* (orientation), *haptics* (eye contact) and *kinesics* (touch) towards a same goal –SHPHK- (Sharing=Constructive or Hoarding/Individualizing=Disruptive) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of SHPHK. An expected significant chi-square was obtained, X^2 (1, N=187)= 58.902, *p*=.001

CASE A and B. Difference in the proportion between Case A (Np1-Pt1) interaction and Case B (Np3-Pt3) interaction in terms of Textures of Movement Channels

Textures of movement Channels (DV)	Interaction (Iv)

Table A 71

Potentials proportion of people involved in Case A exemplar in terms of TOUCH

		Np1Pt1	**Np3Pt3**	Total
Touch potential	**Silence**	**90**	**97**	187
	Voice	**90**	**97**	187
	Total			

No statistics were computed because touch is a constant

Table A72

Potentials proportion of people involved in Case A exemplar in terms of EYE CONT.

		Np1Pt1	Np3Pt3	Total
	Silence	**50**	**84**	134
Eye Contact potential	**Voice**	**39**	**13**	52
	Total	89	97	**186**

X^2 (1, N=186)= 21.322, *p*= .000 (<.001)

1 missing value

The proportion of potentials in terms of eye contact (contact=voice, and No contact=silence) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of eye contact. An expected significant chi-square was obtained, X^2 (1, N=186)= 21.322, *p*= <.001

Table A73

Potentials proportion of people involved in Case A exemplar in terms of PRESENCE

		Np1Pt1	Np3Pt3	Total
	Silence	**0**	**22**	22
Presence potential	**Voice**	**89**	**75**	164
	Total	89	97	**186**

X^2 (1, N=186)= 22.893, *p*=000 (*p*= <.001)

1 missing value (0% cells have expected less than 5)

The proportion of potentials in terms of presence (presence=voice, and No presence=silence) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of presence. An expected significant chi-square was obtained, X^2 (1, N=186)= 22.893, *p*= <.001

Table A74

Potentials proportion of people involved in Case A exemplar in terms of Head, Torso, Arms and Hands Dynamism

		Np1Pt1	Np3Pt3	Total
Head, Torso, Arms and Hands Dynamism	**Silence**	**48**	**83**	131
	Voice	**42**	**14**	56
	Total	90	97	**187**

X^2 (1, N=187)= 23.122, *p*= .000 (*p*=<.001)

The proportion of potentials in terms of Head, Torso, Arms and Hands –HTAH-Dynamism (Dynamic=voice, and Static =silence) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of HTAH-Dynamism. An expected significant chi-square was obtained, X^2 (1, N=187)= 23.122, *p*=<.001

Table A 75

Potentials proportion of people involved in Case A exemplar in terms of Talk (talking lips movement)

		Np1Pt1	Np3Pt3	Total
Lips talking movement	**Silence**	**69**	**94**	163
	Voice	**21**	**3**	24
	Total	90	97	**187**

X^2 (1, N=187)= 17.096, *p*= .000 (*p*=<.001).

The proportion of potentials in terms of Talk-moving lips (talk=voice, and No talk=silence) as a function of type of interaction (Case A and Case B) is displayed in Table X. A chi-square test was conducted to evaluate whether there is a significant difference between the two cases of care relationships (Np1 -Pt1 and Np3-Pt3), in terms of Talk-moving lips. An expected significant chi-square was obtained, X^2 (1, N=187)= 17.096, *p*=<.001

APENDIX B: QUALITATIVE TABLES

Signals to read and relate with Macro-micro health system failures in Table B1

Bolded, are the exalted pieces indicating the Pt repeated failure claims based on the health system failures; in *italics* are the health system failures. You will see how sometimes even the parts in ***italics coincide with the bolded parts***exalting the macro failures repeated in the micro level. Highlighted are the Np changes in the different reactions over the course of time; the numbers 1,2,3,4 were placed before the highlighted reactions, indicating in which part of the reaction process exposed above was the Np at the specific quotation time. Each letter will help us recognize the topics and the nested topics discovered by R.A. Palin and R.A O'Sullivan, used in this thesis. We will also observe the topic turns. When topics have died naturally in agreement with both parties, the abbreviation (NTE) was placed at the beginning of the topic. Some comments before a quotation were made in an attempt to contextualize the conversation, and to help the reader "hear" the tone of the conversation, specifically if smooth codes or violent cuts were developed.

Table B1. An example of Macro management micro control repetition cycle, constituting the Health System (ZZ)

Excerpts Time 1(T1).

A) 00:44 Knee History (nested within post knee surgery)

Pt: "**We did the surgery in December**. Um. And then, um, uh, **that situations wasn't resolved**.**It continued to be inflamed** despite, um, the, *he gave me Celebrex* post-surgery. And ***then I went back to saw him in February 2nd***and he said, *basically they fixed the* mechanics but there is something else going on here that they hadn't , uh, you know, uh, there was an issue. Arthritic likes symptoms and *I needed to see a rheumatologist*. So *he's made the referral* to the rheumatologist, and, but, in, he said *I'd have to wait*. **So I said, well in the meantime**, um, *2004 I had similar inflammation in the knee and I had, at the X Clinic (name) at the time I had taken cortisone shot which resolved things almost immediately*". (T1-p.2)

B) Pt Topic Turn. 1:43 Cortisone shot

Pt: So **I thought**, well, you know, **that's what I need** – is- **give me another shot of cortisone and I'll be fine**. *So he did agree to do that*. He gave me" (T1-p.2)

Np: 1) "Oh he did?" (The Np's tone sounded surprise about the physician action to accomplish the Pt's demand of local cortisone.) (T1-p.2)

The Pt "sounded" as if she was interrupted, and continue talking

Pt: ">the same, *he gave me the same dosage as I had had in 2004.*Um. But *it was only effective for maybe 6 to 8 weeks.* And, um, but then, given the

situation, *the knee had been inflamed for much longer than it had in 2004*. And **my body's** probably **changed.** And so, um, **but the cortisone was effective enough that**, and **I was foolish enough** to do something, something at work that I shouldn't have. So I, so, **um, and I've injured my left ankle**." (T1-p.2)

Np: 1) "Oh dear" (Np's tone "sounded" dissonant. It was a combination between compassion, false compassion, and a *complaint about how many complaining details has the Pt been doing* for about 2min straight). (T1-p.2)

C) <u>Pt. Topic Turn. 2:25 –Two topics- Left hand injury and second opinion (nested within this topic – x-rays 1)</u>

The Pt "sounded" as if she was interrupted again, and continued talking.

Pt: ">Um. And I have **problem with my left hand** as well, **a joint in my left ankle flared up and hasn't gone away**, I kind of **put two and two together that maybe the same thing's happening with my hand**. **So I had come to see Dr (name A) 3 or 4 weeks ago**. **I was here because I was concerned about the situation and I didn't know**. And at the time *I hadn't yet heard about my referral.And with the left ankle and my left hand, **there's complications that Dr. (name) wasn't aware of**.*Um. And wanted, and **I wanted to know a second opinion** or whatever. And *so resident (name F) saw me. And they took x-rays.* So I don't know if *those x-rays have come back sort of*." (T1-p.3)

Np: 2) "Oh, okay" (T1-p.3)

Pt continues: "um and *there was blood work done about 3 or 4 weeks ago. Three weeks ago*. So, and then I, and then ***things are not getting any better*** and, um, ***I'm really struggling in the morning, especially I can hardly walk***.Um.*And I got the appointment finally from Dr. (name B*)" (T1-p.3)

Np: 2) "Oh good" (T1-p.3)

Pt repeated the information as if she was interrupted.

Np: ">Dr (name B)" (p.3)

Np: 2) "Okay" (T1-p.3)

Np,reaffirmedthe Pt, that she has listened to her.

<u># Example of Pt3 self and others controlling cutting codes</u>

Pt: >"(↔)*And it's for September 22nd*. (↔)And uh, **so I don't know whether my situation** is, is, um, **progressed to the point where I should be seen sooner or if anyone else in *that long lineup*** *between now and September 22nd* (Cx). So that's what **I'm <u>kind of</u> looking for you**,(//)**to** you for (//) is some (//), an **assessment (Dx) and <u>sort of</u> see where I might be in that. (::) (~) (↔)*And if it would warrant an advancement of that appointment (Dx)***.Um. (//) *His secretary*, when I said that there were other joints involved now, that Dr. (name A) wouldn't have been aware of when he made the referral. Um. (//) She *said, well,(//) you know (//), talk to your GP, and if, (//) and if,(//) uh, (//) he or she thinks I need to, um (//), it's progressing or there's problems, you could contact them.* (T1-p.4)

The Np "sounded" smooth, like she was trying to understand her situation and her needs calm her and help her.

Np: 3) "Yeah, no problem. So Dr. (name A) is the one who sent the initial referral?" (T1-p.4)

Pt: "Yes" (T1-p.4)

The Np madeanother question to corroborate information.

Np: 2) "Is that correct? Okay" (T1-p.4)

D) <u>Pt. Topic Turn 4:36 Fears/Autoimmune disease</u>

Pt continued:

"And I, yeah, and I asked, um, *well the resident said that I could call them and find out if I was in fact referred there*. And, um, and so, and then they said, yeah, *they were working on making appointments* and, um. And then when I, I said, **I called and talked to the receptionist, she said, I asked her what, does**

Dr. [name A] have to see me or I can I see my GP. ***And she said, no, go back to your GP***. So I don't know. **Like I'm frustrated and scared and worried that this is autoimmune and there could be something going on." (T1-p.4)**

E) <u>Np. Topic turn 5:14 Blood work (nested within Pt fears)</u>

The Np immediate response to the concerns above was a complete topic turn with a softened, informational basis calming answer.

Np:"Okay. Your rheumatoid factor was negative. Um. Now does that mean you definitely don't have arthritis, not necessarily?" (T1-p.4)

…… END of Interval 1 excerpts.……

Topic content, topic turns and topic length. Excerpts Time 2(T2).

F) <u>Pt. Topic Turn 11:09 Medication</u>

Quotations F, Kand the Pt-partner dialogue in G, arelucid examples of what the Pt has learned to do as part of the health System. First she has learnt to medicate herself as a way to fix her body in lack of a response caused by how the structure of the system provoked endless referral and time constraints. Second, although she had a body fixing question, she hadenough pain and had no more patience to wait, so she self-medicated. By looking closely in to the next conversation, you will see a fractal of the whole (a piece that repeats the total). The Pt as well, in her micro relationship, reflects the same behavior. She askeda question about her self-medication, but she wasnot patient enough – anymore- to wait for an answer; she responded herself immediately; and then she waitedfor the Np to answer. Third, she has learnt to give all the detailed medical information so that the new professional can follow her whole diagnostic and fixing process, and she realizes it. Within all that process, the Pt's patience has run off, as the particulate in G suggests.

Pt: "*And that's all um Dr (name E) suggested I up the dosage of Naproxen*, um, *and take it regularly*.***So I've been doing that***, but, and it takes the edge off. ***And I add, and I've been taking Tylenol when I can't take, because Naproxen you need food***. ***So I've been kind ofsupplementing the Naproxen with Tylenol and I don't know whether that's OK or not.*****" (T2-p.8)**

FA) Pt. Topic turn. She answers her own question.
Pt: "***Probably should be okay so that was one of my questions*****." (T2-p.8)**

Np: 3) "Yes. You can alternate those two safely. (T2-p.8)"

Pt: **"**Okay" (T2-p.8)

Np: "We do it for children so…" (T2-p.8)

Pt: "Okay" (T2-p.8)

G) <u>Np. Topic Turn 11: 45Np let the Pt know that she is leaving the room to search for the results, (First Np shift trial)</u>

Np: 3) "…not a problem. Um. If you can bear with me for a few minutes, *I'm just going to see if she's holding on them somewhere or why we wouldn't have received them*.

Okay? Be right back" (T2-p.8)

The Np left the room for 4minutes to search if Dr E has the x-rays and the blood test results.

She came back at min 15.40. Meanwhile a long silence with intermittent short talk was developed between the Pt and her partner. Moving her legs in a signal of desperation, with her arms close and rigidand a disruptive facial gesture between sarcastic, desperate and surprised "sounding" like "I can't believe this", she says:

Pt: "Well it is a saga" (T2-p.8)

Partner: "I know it's crazy" (T2-p.8)

Pt: "Too much detail?" (T2-p.8)

At one point the partner remindedher about the parking, and the patient, with the same posture but now with a disruptive facial gesture between worrisome and desperation says:

Pt: "I think we are pretty much done here. I don't know whether. (pause). Five months is crazy" (T2-p.9)

H) <u>Np. Topic turn 15:40 The Np comes back. Antinuclear Antibodies (ANA) results</u>

The Np quotation above in H, and next 4 quotations (I, J, K, L) are another lucid exampleof what the Np has learnt to do as part of a Health System focus on management, rather in healing. If you could closely see the next particulate of the conversation, you will see the management role of the Np as fractal of the whole Health System management structure.

From clinic to clinic, and from stage to stage of a long diagnosis process, the Pt had to wait because her results werelost in the system. The Np rather than focusing on the patient, wasted4minutes out and several minutes more in the room, to localize the lost results of a long diagnostic and referral system.

The Np then manages two issues. The first issue is related with the structure of the system. She <u>managedthe structural faults</u>; she localizedwhere are the Pt's lost results, for what were they asked, and what do they mean. The second issue is related to the Pt. She wasthe one dealing with her discomfort and concerns, and her long past of diagnostics, referral, procedures and failed caring relationships. The Np tried to help her but she failed, so she does what she has learnt. She <u>managedthe client</u>; she gaveher what she was demanding and expecting, and wrotea letter to accelerate the process to a next specialist which will assess her again with the hope that the rheumatologist can stop seeing and fixing a part of her body, and open his spectrum to see the whole health situation (i.e autoimmune condition).

Np: 3) "Okay. Found one. The x-rays,*she's going to have to call*. *We don't know why we wouldn't have received them*. *But somewhere they're lost* (*) *somewhere along the way or* else, uh, *Dr. (name E) has got them in her stash and she's gone to an appointment* (*) *right now so she's not available for me to ask*. Um. Anyways, ANA serum, IF. I'm not, this is not my specialties (*).*I, what it actually means I not, this is not my specialties (*). I, what it actually means I can't really tell you today. But, um, ANA speckled titer is 1 to 80 and I think that means negative titer."* (p.9 and p.10) (*nervous chuckles)

Pt: "Okay" (p.10)

I) <u>Np. Topic turn 16:26 Rheumatoid negative 2</u>

Np: 3) "Um. And rheumatoid factor is negative. So again, there is something going on." (T2-p.10)

J) <u>Np. Topic turn 16:35 Referral Letter (Second Np shift trial)</u>

Np: 4) "I think, um, *(name F) has not said that she is going to be writing, but I will write."* (T2-p.10)

Pt: "Yeah." (T2-p.10)

Np: 4) "I will write and I will send them what we have, that's, that's extra. I'll make sure I have the results of the x-rays." (T2-p.10)

K) <u>Pt. Topic turn 16:56 to 18:04, The Pt develpoed another three monologues: Medication 2, situation, and Inflammation (nested within fears).</u>

The next pieces of quotations will illustrate the topic monologues.

Pt: "Well I think *Dr (name E) had maybe thought that I took, you know, the antibiotic or, no, the Aniprox, it was four times what I've been taking* (…) **I've been taking 220miligrams** (…) *and she said to take 440 twice a day*". "***So I increased that by 4times and um it still really hasn't helped a lot***" (End of T2-p10)

Np: 1/4) "Yep (…) Okay" (T2-p.10)

……..…….…….…….…..END of Interval 2 excerpts……..…..……

Topic content, topic turns and topic length. Excerpts Time 3(T3).

Pt topic turn: "So that's why I thought I would make the appointment today and (…) report back that like things are not very easy for me" (Beginning of T3-p.11)

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Np:1/4)"Yes"(T3-p.11)

Pt: "So and I know"

The Np tried to interrupt her second monologue, but the Pt interruptedher again, developing her third monologue.

Np: 3) "and we'll see if we can" (inaudible) (T3-p.11)

Pt topic turn: "this inflammation from what I. **Yeah, like it can damage the tissues in the joint and maybe cause problems late,*even if we can figure out what's going on and get it fixed I****could be left with, with, um, sort of residual issues because the joints have been inflamed for so long. It's been over a year for my knee*" (T3-p.11)

L) <u>Np. Topic turn 16:35 Steroid prescription (Third Np shift trial with success.)</u>

From letter J and during the next passages the transition between the Np trials to assist the Np, and system failures repetition is clear. Triggered by the Pt demands, the Np agreed in <u>giving</u> the Pt what she wasasking for, during the whole intervention: A higher dose of medication, a time acceleration letter, and with it, a pass assurance to another professional diagnosis.

Np: *4) "I guess Dr (name E) had recommended is that, if this didn't help, that, uh, maybe a course of prednisone for 5 days.* (T3-p.11)

Pt: "Okay" (T3-p.11)

Np: 4) "Would you be willing to try that?" (T3-p.11)

Pt: "**That's another, that's another cortisone type of treatment**" (T3-p.11)

Np: "yes" (T3-p.11)

Np: 4) "And its, um, it's not directly in the joint" (T3-p.12)

Pt: "**Right. It would go through the system**" (T3-p.12)

Np: "*Exactly. And it's very short term, five days*." (T3-p.12)

Pt: "Okay" (T3-p.12) The Pt is thinking.

Np: "So." (T3-p.12) The Np asks with a tone of faddish demand.

Pt: "Well, we could, yeah. I'm, I'm, with side effects with that or potential issues with that are, are um?" (T3-p.12)

The Np smoothened her tone and tried to calm the Pt about the effects of the medication. Her nonverbal behaviour coincides with the smoothness change of tone.

Np: 3) "You've never taken prednisone?" (T3-p.12)

Pt: "No" (T3-p.12) the Pt interrupted

Np: "before? Um." (T3-p. 12)

Pt: "Not that I'm aware." (T3-p.12)

Np: 3) "Some people find that it makes them a little giddier. Um, but, or not necessarily. Short term really shouldn't, you know, it may, it may make you, like I said, a little more awake and you may have a harder time getting to sleep at night. But, but other than that." (T3-p.13)

Pt: "At this point I'm ready to try. I'm looking for answers and if that's something that might." (T3-p.14)

The Np interrupts the patient with a cutting reaffirmation.

Np: 1/4) "Very good" (T3-p.14)

M) <u>21:10 to 22:25 Pt's social conversation trial and personal struggles topic caused by the health problem (Nested in Np's attempt to finish the appointment).</u>

21:10 to 21:39 Np remained in silence, doing things at her computer, while the Pt wastelling her that her partner has also been worried. The partner starts talking now, but immediately the Np cuts them with a violent question. The

partner gives a short answer, and then everyone remains in silence again.

Np: 1/4) "Did I answer all your questions today? Or did you have some more?"(N3p.15)

Pt partner: "Yes". (T3-p.15)

The Pt tries to make social conversation, and even the Np respond to her, she is not even looking at her.

Pt: 21:59 "I thought the woman who was pregnant was Dr (name D) but she'e not" (T3-p.15)

At min 22:25 of interval 3, the Np is trying to finish the encounter. Then she askeda couple of yes/no questions. However, the Pt, took advantage of the Np questions to start talking again. She talks about how her health condition keeps her struggling at work.

Np: "Okay ladies" (T3-p.16)

Pt: "Thanks very much"

Np: "Now you work as a…"

Pt: "Biologist"

Pt topic turn: "Yes. Actually, well, it was a chance that I would be going this summer, but, um, I've kind of said that I can't because of that.

Np madeanother violent cut with soft voice
Np: 1/4) "Okay, okay, so it's held you back" (T3-p.16)

Pt: "Yeah, and I'm not, yeah, where even conferences and things just, I'm not sure about my tri in June, um, because I have to rely on my friends from (name of the place) to drive around I think." (T3-p.16)

Np madeanother violent cut with soft voice
Np: 1/4) Well you know what (…) Let's wait and see what can be resolved, okay? um" (T3-p. 16)

At 23:15 the Np turnedaside in a posture that suggests that although she wasstill listening, she wasabout to stand up. In a very short intervention the Pt's partner tell the Np, that she (the Pt) is also her caregiver if that could help accelerating the referral. The Np nonverbal behavior "sounded" as if she pretended to be interested on the comment, and wrote it down. Though, the Np verbal behavior (answer and tone) were soft. Within that small interaction between the Pt's partner and the Np, the Pt interruptedthem both. The Pt and her partner stand up to prepare their departure. The Np follows. The Pt takedthe opportunity to talk again.

MA) Pt topic turn: 23:48 "Yeah, I mean, I know there's lots of people. And I don't know, you know, you, you, I don't know how other people are compared to my situation, what you know, the risks are ***if I continue another five months, maybe it's not a big deal but it is certainly painful.***" (Beyond T3-End of the interaction- p.17)

Np: “Yeah” (24:04) The Np was going to say something and was interrupted by the Pt

N) 24:05 to 24:30 End of the Encounter (Pt’s appreciation, and Np’s reaffirmation)

Pt topic turn: “> And your judgment and I appreciate anything you can say.

Np Continues: “and you need a diagnosis to”

Pt interrupts: Yeah! (It sounded like “Finally” “Exactly, that is what I need”)

Np continues: “get on with the rest of your life. You need a diagnosis and, you know, uh, what to expect and” The Pt interrupts her again.

Pt: “Knowing what to prepare for”

The Np stopedtalking and started giving short answers like at the beginning of the encounter. Her nonverbal posture wasclosed. She wasstanding with her arms protecting her chest and abdomen. The Np whole posture suggestedthat she waswaiting for the Pt to stop talking, and for both to leave the room.

Np: “Yes correct”

Pt: “>that’s a big part of it”.

Np: “Yeah”

Pt: “Thanks very much”

Np: “Okay”.

They talk about the prescription while they are leaving the room.

Table QQ. Table B2.Specific control mechanism example.

Table B2. Example of conversational control mechanism (QQ)

The next conversation section, will illustrate the Pt conversational control in a process of relationship. The symbols (::) indicate a 1 sec pause, (:::) a 2 sec pause, and (::::) a 3 sec pause. The abbreviation DAEC stands for Drawing Np´s Attention Eye Contact type. This type of eye contact was detected over the course of the encounter, as a need from the Pt to be reaffirmed, an attention demand and an empathetic request. The sign (LF) spots when the pt looked forward instead of looking at the Np. The sign (MC) points out Np´s mouse scrawling and computer eye contact.

1:50- Left Ankle Injury

Pt*(Topic turn and topic control)*: “>the same, he gave me the same dosage as I had in 2004. Um // But it was only effective for maybe 6 to 8 weeks (Cx). And, um, but then, given the situation, the knee had been inflamed for much longer than it had in 2004. And my body´s probably changed. And so, um, but the cortisone was effective enough that (::) // and I was

foolish enough to do something at work that I shouldn´t have (Cx). So I // so // um // and (::) I´ve injured my left ankle. (:::)-DAEC-. (*attention demand fling exchange*)
The Np released a rigid exclamation with a false empathetic tone of voice. Adouble meaning was found on that exclamation. The Np was giving the Pt the affirmation that she was looking for, and meanwhile she "sounded" like: "I cannot believe how many complains she has done".

Np: "Oh dear!" (*Superficial interaction where the Np gives the Pt the demanded attention*)
Simoultanous to the Np empathetic response, the Pt interrupted her and kept talking (*Forced topic turn and topic control*)

2:25 Two topics- Left hand injury and second opinion (nested within this topic –x rays 1)
Pt: " >Um // And I have problem with my left hand (:::)-DAEC- as well, a joint in my left hand (::)-DAEC- which since the ankle flared up and hasn´t gone away , I kind of put two and two together that maybe the same thing´s happening with my hand. So I had come in to see Dr. [name A] wasn´t aware of. (::::) Um // And wanted, and **I wanted to know a second opinion** or whatever (Dx). And *so resident (name F) saw me. And they took x-rays.* So I don't know if *those x-rays have come back sort of*." (:::)-DAEC- (T1-p.3) (*action demand fling exchange*)
Np: "Oh, okay." (*Superficial interaction where the Np gives the Pt an affirmation*)
3:41 Pt *Forced topic change*, after another *Pt forced topic change*. Re-Assess and Expedite Specialist

Pt: "(…)>So that's what I'm **kind of** looking for // to you // for // is some assessment and **sort of** see where I might be in that, and if it would warrant an advancement of that appointment (*Action demand fling*). (…) Um //. She said, well, you know // talk to your Gp and if // and if // uh // he or she thinks I nedd to // um // it's progressing, or there are problems, you could contact them. (Silence) (*demand fling interaction*)

Np: "Yeah, no problem. So Dr (name A) is the one who sent the initial referral?" (*Smoothenedaffirmation and question; deeper interaction*)

Table B3Particulates of the conversation demonstrating ongoing unsatisfactory care, to contex findings entrenched in preference organization (Z31)

Pt: "*(…) 2004 I had similar inflammation in the knee and I had, at the X Clinic (name) at the time I had taken cortisone shot which resolved things almost immediately*" (T1-p.2) A

Pt:"And so, we did the surgery in December. Um. And then, um, that situation wasn't resolved. It continued to be inflamed despite, um, the, *he gave me Celebrex* post surgery. And *then I went back to saw him in February 2nd* and he said, *basically they fixed the* mechanics but there is something else going on here that they hadn't , uh, you know, uh, there was an issue. Arthritic likes symptoms and *I needed to see a rheumatologist*." (T1-p.2)

Pt: *"He gave me the same dosage as I had had in 2004.* Um. But *it was only effective for maybe 6 to 8 weeks". (T1-p.2) B*

F) Pt: "*And that's all um Dr (name E) suggested I up the dosage of Naproxen*, um, *and take it regularly.* (T2-p.8) F
K) Pt:"Well I think *Dr (name E) had maybe thought that I took, you know, the antibiotic or, no, the Aniprox, it was four times what I've been taking(T2-p.10) K*

Pt:*"I'm really struggling in the morning, especially I can hardly walk*. Um. *And I got the appointment finally from Dr. (name B*)" (T1-p.3) C

Pt:"So I had come to see Dr (name A) 3 or 4 weeks ago. I was here because I was concerned about the situation and I didn't know." (T1-p.3) C

Pt: "And wanted, and I wanted to know a second opinion or whatever. And *so resident (name F) saw me. And they took x-rays.* So I don't know if *those x-rays have come back sort of*." (T1-p.3) C

Pt: " I called and talked to the receptionist, she said, I asked her what, does Dr. [name A] have to see me or I can I see my GP. *And she said, no, go back to your GP*. So I don't know. **Like I'm frustrated and scared and worried that this is autoimmune and there could be something going on."**(T1-p.4) D
K)Pt: "So that's why I thought I would make the appointment today and (…) report back that like things are not very easy for me" (Beginning of T3-p.11) K