Reflection, emotion and knowledge of the self

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Abstract

The chapter positions human beings as critical entities in the dimensions of the self, the world and knowledge. It considers reflection as a necessary component of professional life where knowledge of the self is essential. The ideas expressed in this chapter have strong roots in westernised sociology and philosophy. The challenges presented reside in post-modernist thinking and are relevant to work across the professional spectrum. The post-modernist perspective questions aspects of society today that we take for granted. It analyses and challenges our relationships with the world we live in and how we interact with complex social forms that reproduce themselves or 'social institutions' like government, the family, language, higher education institutes, health services, multinational corporations or legislative systems. This exploration of reflection, emotion and knowledge of the self, considers how professionals greatly influence people in their interactions and how in turn this affects the lives of those with whom they interact. In each of our experiences in life, we begin with an interpretation of what we see and it triggers in us an emotional response. Our emotional response governs how we in turn respond, yet, as professionals, we are also affected by the world that we live in, a world that we respond to in an emotional way; in this, problems of practice become 'wicked'. Consequently, individuals' attitudes, values, beliefs and emotions contribute significantly to interactions. The chapter explores the power relationships inherent in these interactions and how knowledge of the self is crucial in understanding motivations for action. As a mental health nurse and an educator, the illustrations I use principally draw from the area of mental health nursing and are based loosely on the real experiences of nurses in clinical practice, however as illustrations of the post-modern perspective, they may bring challenges that have relevance to your domain of practice.

Keywords: emotion, clinical practice, institutional reflexivity, reflection, self-knowledge

1. Introduction

Human beings are in essence critical entities. As critical entities, Barnett (1997) identifies three overlapping dimensions in which we are critical; the domains of self, the world and knowledge. The ideas in this chapter have strong roots in westernised sociology and philosophy. It begins from a standpoint that the actions of individuals are bound by 'situatedness' or the context in which they occur. These are embedded in cultures and they are bound by time. As a reader, you are asked to consider how these perspectives bring challenges that may have relevance to your practices in whichever domain you consider them. The challenges presented reside in post-modernist thinking, and are the challenges relevant to work. The post-modernist perspective, questions aspects of society today that we take for granted. It analyses and challenges our relationships with the world we live in and how we interact with its *'social institutions'*, the *"…complex social forms that reproduce themselves such as governments, the family, human languages, universities, hospitals, business corporations, and legal systems*" (Miller, 2014).

In this exploration of reflection, emotion and knowledge of the self, I want you to consider how professionals greatly influence people in their interactions and how in turn this affects the lives of those with whom they interact. Here, professionals are individuals affected by the world that they live in, a world that they respond to in an emotional way. This chapter explores the power relationships inherent in these interactions. As a mental health nurse and an educator, the analogies I use draw from the area of mental health nursing. The examples given are loosely based on an amalgam of real experiences of nurses in clinical practice. In drawing from the sphere of mental health, there are shared understandings, as one in four of the population will experience a major mental health problem over the course of their lives. If we do not experience the problem ourselves, we will at least have close ties to a family member or friend who have. It is an important dimension, common to us all.

This aspect of professional influence and the role of the individual may at first be a little difficult to grasp. As an illustration, I would like to consider a mental health condition,

the medical diagnosis of schizophrenia. There is an increasing view that the medical diagnosis of 'schizophrenia' is not a unitary illness but rather a syndrome composed of subtypes of differing origin (Boyle, 2002). Bentall (2003) and Esterberg and Compton (2009) regard it as an experience at the extreme end of a continuum of psychosis.

For cultures based upon ideographic forms of writing, the literal translation of 'schizophrenia' to 'seshin-bunretsu-byo' or 'split mind disease' caused inherent sociological problems, as the general population came to accept the categorisation's literal translation as fact. Connotations are particularly important in this instance, as the denotations of Japanese ideographs of 'schizophrenia' evoked a state of 'catastrophic disorganisation' that generated powerful stigma in Japanese society towards those receiving the diagnosis. This caused practical problems for psychiatry in Japan as psychiatrists became reluctant to use the diagnosis. As a direct consequence, people were left to languish in institutions without receiving a diagnosis, treatment was provided without rationales or no treatment was provided at all and families did not get explanations of problems (Kim & Berrios, 2001). Japan replaced the diagnosis in 2002, with a new diagnostic category, that of "Integration Disorder", a syndrome based on a stress vulnerability framework, with a variety of causes, symptoms and outcomes (Sato, 2006).

In western culture, the diagnosis has proved equally divisive. Despite concerted campaigns to follow the route taken in Japan, the diagnosis was retained in the most recent variant of the Diagnostic and Statistical Manual for Mental Disorders - DSM-Ver. 5 (American Psychiatric Association, 2013). The divisiveness of the diagnosis has led to clinicians adopting polarised standpoints on both causation and the most appropriate treatment. This is where the role of the *'self'* and the individual's response come into play– based upon the person's knowledge, values, beliefs and attitudes. Place yourself in the role of the professional who meets a young woman referred to a mental health service experiencing behaviours often associated with the diagnosis of schizophrenia. If you believe the causation of her experiences – for example the presence of voice hearing - to be a biological imbalance in brain chemistry, a very common interpretation used to understand the diagnosis, then you will advocate a treatment regime of medication that the person will require for a lifetime. Alternatively, if your interpretation is that the person's experiences of psychosis are at the extreme end of a

stress response to trauma, another interpretation commonly held, then a completely different treatment regime may be advocated, with entirely different outcomes. It is from this point that the young woman's narrative originates and becomes constructed. The same condition is perceived in different ways, based on the values and beliefs of the person encountered. The values and beliefs of the professional fashion the outcomes of those they meet. So why do professionals act the way they do and why reflect?

1.1 Emotional response and the decisions of 'the self'

There are many definitions of reflection. Usually they identify taking a step back from situations or events and considering experiences, or trying to make sense and meaning of the events. To navigate the process of reflection and in responding to challenges, theorists have put forward models of reflection for consideration. These in the main comprise three common core elements. The first element invariably begins with the registration of an uncomfortable feeling that an individual has after the experience of an event. Every feeling triggers an emotional response. The person moves from the registration of an initial 'feeling', which is his/her response to an event as it unfolds in front of them to an action. Then, he or she 'observes', and thinks about what happened, how it affected him or her. Finally, he or she does or 'acts'. The emotional response is central to action. This emotional response becomes highly significant when people encounter conflicting values, common occurrences in working lives.

When we transfer emotion to the educational setting, our emotions indicate to us how our learning is progressing. Emotion points us towards what we need to learn (Claxton, 1999). In advocating the use of reflection, Bringle and Hatcher (1999, pp. 156-157) identify that student reflections on events can produce *"a poignant description of the personal impact of the service"*. It is this personal impact and the emotion it generates that is significant. Dewey (1934, p. 42) describes how emotion can effect perception: *"Emotion is the moving and cementing force. It selects what is congruous and dyes what it selected with its colour"*.

The two notions of '*emotion'* and '*the self'* take on great significance when faced with '*the processing of conflicting values'*. When emotions are triggered, the response of '*the self'* in what it selects and interprets, if we accept Dewey's argument, leads to selectivity of interpretation; we see what we want to see and believe what we want to

believe. Think back to my initial example of the young woman and the medical diagnosis of schizophrenia. Supposing I do not wish to see a person as having a 'broken brain' (Andreasen, 1984). Festinger, Riecken, and Schachter (1956) predict when faced with conflicts in our beliefs, we will act to find positive reinforcement for our actions and seek negative reinforcement for what we do not believe all for the sake of being comfortable in our emotional response. Accordingly, the construction of knowledge, the nature of emotion and the involvement of the 'self' in the context of the individual's values, beliefs and attitudes, have an effect on what we do and influence the outcomes for those with whom we interact. Through this, our 'emotions' serve as a trigger for reflection in intellectual work.

The question is often posed as to whether rationality alone can solve problems. Stephen Toulmin (2009) in his critique 'Return to Reason' identifies from the mid-seventeenth century in western culture, how an imbalance began to develop where the rationality of science took precedent[1]. In this regard, the use of 'narrative' was seen as less reliable and lacking scientific support. In this epoch, sometimes referred to as *The Enlightenment*, consistency and deductive reason acquired prestige and achieved a kind of certainty that other opinions could not claim. From this, the belief grew that man could progress towards some ideal state that was achievable through rationality and the methods of science.

The consequences of this debate have implications for the use of reflection. The notion that solutions derived from rationality are timeless, abstract and universal can no longer give an adequate platform on which to base assumptions. Toulmin (1992) argues that trying to handle problems using 'pure reason' needs reconsideration. He argues that the 'situatedness', the time and context of problems, discounted by science, can no longer be ignored or considered as a separate non-entity. With the recognition of the 'applied', real life context is not something peripheral to be discounted; it is a phenomenon that must be viewed as at the core of problems. It is this 'situatedness', along with the inherent complexity of problems it brings that reflection attempts to elucidate. When exploring problems all we can do is begin from where we are, when we are there. It is not possible to consider the technical separate from the moral or ethical.

[1] Around 1800 Romanticism, a Counter-Enlightenment, began to evolve that placed a new emphasis on emotion. Those associated with it argued that the Enlightenment was reductionist.

1.2 Life's 'wicked problems'

> *"Some problems are so complex that you have to be highly intelligent and well-informed just to be undecided about them."*
>
> Peter (1977)

In life, people encounter many challenges; some refer to them as problems. Whenever we introduce people into a problem, we usually increase its complexity. Adding the individuality of the person who attempts to try to solve the problem from the outside and the problem can become even more complex. It is in this increasing complexity that it is important to consider the role of the 'self'.

Given the infinite variance of individuals, these problems become harder to solve; they become *'wicked'* as Rittel and Webber (1973) and Rolfe (2014) intriguingly name them. The intriguing and challenging notion of *'tame'* and *'wicked'* problems comes into play. A wicked problem can be defined as *"... one for which each attempt to create a solution changes the understanding of the problem. Wicked problems cannot be solved in a traditional linear fashion, because the problem definition evolves as new possible solutions are considered and/or implemented"* (Walker, 2004).

The difficulty is that science is equipped to deal with *'tame'* problems; the randomised control trial, so highly regarded as the 'gold standard', seeks to atomise for the isolation of a variable which ultimately it can control. Accordingly, science struggles when presented with a *'wicked'* problem. Most problems involving people constitute *'wicked problems'*. Let us attempt to situate the problem in the 'real' world and return to the young woman given a medical diagnosis of schizophrenia and who is struggling because her 'voices' or 'hallucinations' have become more distressing. Perhaps we have responded to her problems of voices with a pharmacological intervention that lessens the impact of the presence of voice hearing has on her, but what impact will the intervention have on her unemployment status? She is an unmarried lone parent with an 18-month-old son, receiving state welfare supplements, currently homeless because her parents are unable to cope with the distress of her mental health experiences and she is fighting a custody battle with her son's father, who believes she is an unfit mother owing to her mental health problems. These secondary social problems compound the

primary mental health problem, becoming additional stressors and exacerbating her symptoms. *"Wicked problems always occur in a social context"* and *"...every wicked problem is essentially unique and novel"* (Burton, 2011, p. 242). It is often the social dimension of problems, not their technical complexity that overwhelms most attempts at problem solving. There may often be multiple solutions or no solution at all. As in the illustration given the actions, goals and outcomes may be interdependent and variable. In the example, the 'tame' problem of voice hearing becomes infinitely more complex, *wicked*, as the layers of social complexity are added to the considerations. How, as a mental health professional, do I respond to this 'wicked' problem? How do my own values effect my responses and actions? It is the capacity of reflection that allows the professional scope to consider these things. I will return to this later, when considering *'emotional labour'*.

The difficulty is that it is impossible to understand a problem until a solution is developed. In trying to solve problems, pure reason cannot be divorced from emotion; as even neuroscience demonstrates that *"... aspects of the process of emotion and feeling are indispensable for rationality",* wherein the absence of emotion and feeling can lead to a breakdown in rational decision making, rendering it nearly impossible (Damasio, 2006, p. xiii). Gadamer (1996) in *The Enigma of Health* illustrates this. He considers that once science provides a profession like medicine with universal laws, root causes and ways of action, the information required remains incomplete. The professional still needs to work out the right thing to do in each instance with each patient, and they can neither predict or know what actions will be required in advance (Rolfe, 2006). In finding the most appropriate course of action in each situation, the *'logos'* or rationality must be balanced with *'nous'* or intuitive reason and similarly the *'epistēmē'* or scientific knowledge requires *'phronēsis'* or practical wisdom in its application.

1.3 Challenges to reflecting on the involvement of emotions

Producing and engaging with reflection does not come easily to everybody, as sometimes the probing and engagement with emotion required is more than people can manage. Developing reflective capacity depends upon the individual's status on the continuum of life. Dealing with the emotional, can often be linked to dealing with difficulties in one's personal life. Ironically, people who experience problems of a

mental health nature can find engagement with reflection more meaningful. Involvement in psychotherapy can encourage people to be more emotional and allow them to discuss their vulnerabilities (Ellis, 2004). Men often find the process more difficult, as according to social convention or taboo, they find it harder to talk about their emotions and difficulties, being socialised into trying to maintain an appearance of control. The challenge for men, particularly 'younger men' is not to 'man-up' but to 'open-up' as social conditioning, around male emotions, makes it difficult for them at times not to feel like damaged goods (Ellis, 2004). Having personal experiences of managing mental health problems and working with reflective processes in education, I can identify with these sentiments.

Emotion is sociocultural construction and it is deeply rooted within cultures (Zembylas, 2004). Emotions are not encoded genetically. When people respond emotionally, they are improvising. Their response is grounded in their interpretation of what they see (Averill, 1980). Their emotional response depends on what and how they have learned to respond as is appropriate, or in accordance with social convention (Zembylas, 2004). Emotions differ across cultures, in how people talk about and construct their emotional responses (Cornelius, 1996). Accordingly, asking people to engage with their emotions through reflection can be quite challenging due to prevailing cultural attitudes. This is because our cultural norms regulate the degree to which people can be open about their feelings to others (Dardjowidjojo, 2001; Kuswandono, 2014; Minnis, 1999). We can only see emotion in how a person uses the emotion in their culture (Harré, 1988). As experienced by the subjective self, reflexivity is integral to recognising and interpreting a culture, as drawn from experiences and interactions with others (Spry, 2001). We can do this through the examination of personal thoughts and actions, on how we interact with our colleagues and the environment. It is in that we obtain a clearer picture of our own behaviour.

People make their interpretations through the process of cognitive appraisal or *'how we evaluate situations'*. Cognitive appraisal reflects how people subjectively experience environments and situations and it relates strongly to emotional responses. There are four ways that we use cognitive appraisal in situations:

1. **Relevance:** *Is this event relevant to me? Does it have direct consequences for people or groups that I associate with, or for me personally?*
2. **Implication:** *Are there consequences or significances in here that relate my well-being and my plans or goals?*
3. **Coping capacity:** *Will I be able to cope with or manage the after effects?*
4. **Normative significance:** *Will this effect who I see myself as or impinge upon social norms and conventions or values that I subscribe to?*

For many years people believed that emotions were a law unto themselves, however, N. H. Frijda (1998) considers that emotions follow general rules. He argues that whilst not all actions are under the individual's control, these laws remain constant in most situations. In 2007, he proposed twelve laws that accounted for emotional responses.
The first of these he categorised as the *Law of Situational Meaning*. In this, emotional response is seen as deriving from the situation in which the individual finds him or herself. As a rule, similar situations evoke largely similar emotional responses, for example when we lose a loved one we grieve; when we win, we feel happy and when we are threatened, we feel fear.

Frijda's 12 Laws of Emotion (2007)
1. The Law of Situational Meaning
2. The Law of Concern
3. The Law of Apparent Reality
4. The Law of Change
5. The Law of Habituation
6. The Law of Comparative Feeling
7. The Law of Hedonic Asymmetry
8. The Law of Conservation of Emotional Momentum
9. The Law of Closure
10. The Law of Care for Consequences
11. The Law of the Lightest Load
12. The Law of the Greatest Gain

Under the *Law of Concern*, Frijda sees emotions as arising from goals, motivations or concerns. If a matter arises about which the individual is unconcerned, he or she will not feel a need to act and may become ambivalent. If the event is an area that he or she cares about and has an interest in, he or she will be motivated to engage. This response can relate to the self, an object or another person.

In consideration of the *Law of Apparent Reality,* an individual responds when he or she feels the event appears real and elicits an emotional response. How the person evaluates

or constructs the event governs the emotion he or she experiences. People can have trouble in responding emotionally to aspects that are not understandable. As an illustration, the impact of the death of a loved one may not become immediately apparent, however the grief response may be triggered when they engage in an activity that the deceased was previously involved in. The fourth law Frijda (2007) proposed was the *Law of Change*. Put simply, on the journey of life, as I encounter new experiences, my life changes and in this my emotional responses to situations to which I responded to emotionally in the past, can also change.

Frijda's (2007) *Law of Habituation* translates as an individual basing emotional responses relative to the frequency that the encounter circumstances. Effectively the person gets used to the circumstances. An example of this might be the response of a nurse on the first occasion they encounter a cardiac arrest. The response may be one of fear and panic. When encountering the phenomenon on the tenth occasion, an air of calmness and rationality may have replaced the fear. The *Law of Comparative Feeling* focuses on the individual's interpretation of a situation. The person draws comparisons using a frame of reference based on their previous experiences and what he or she has grown used to. This emotional response alters proportionately around the person's reference framework. However, we can never grow accustomed to some things. In this situation, Frijda (2007) proposed the *Law of Hedonic Asymmetry*. Feelings like shame, fear or anxiety are universal and impossible to escape; they endure. This is unlike the positive experience which fades with time.

The notion that time heals all wounds is one that Frijda (2007) does not subscribe to. The *Law of Conservation of Emotional Momentum* proposes that events can have emotional power over individuals for years. Reflection on the event or a re-experiencing of a similar event can reduce the emotional burden of the event that the individual carries, otherwise unreconciled feeling such as those of anger and fear can perpetuate long after. This leads nicely to Frijda's ninth law, the *Law of Closure*. Individuals often respond emotionally in an absolute fashion causing them to embark on a course of action to bring about closure. Here they are reluctant to either accept or consider alternatives. Their own judgement and perception of the situation create a resolution of purpose as to their choice and option, until their perception of the right solution emerges or they are confronted by an alternate emotion that alters their

perception of the situation.

By the *Law of Care for Consequences* Frijda (2007) sees individuals as naturally considering the effects of their emotional responses and adapting them to correspond to the context and environment. They purposefully tailor their response to achieve the desired effect given the time and place and those around, effectively a performance for effect. Occasionally however, as the expression goes, *'their emotions may get the better of them'*.

Frijda's (2007) two final laws reflect almost two contradictory perspectives; however, both operate at times with equal validity. Under the *Law of the Lightest Load,* the emotional impact of an incident is dependent upon subjective interpretation. As a defence mechanism, an individual may selectively reinterpret an event to cushion him or herself from negative feelings perhaps establishing a barrier between them and the effect. The apparently contradictory standpoint comes in the *Law of the Greatest Gain* where the individual may, in interpreting, utilise the negative emotional response surrounding an emotional event in positive emotional terms to personal gain. As an illustration, anger can be used as a weapon in confronting an aggressor or anguish can be used to garner support and sympathy.

Although not universally agreed, Frijda's Laws of Emotion provide a point of embarkation for those working with reflection to explore the effect of individual emotions in how individuals act or modify their interpretations in situations.

2. The Role of the 'Self' in Educating

The post-modern process of deconstruction encourages the exploration of constructs to the point of exposing the contradictions in the foundational knowledge. Deconstruction offers an important point of view for us to consider in the impact of the individual on events. Values, beliefs and attitudes are highly significant in what we do and whom we work with. Take for example the influence of educators. The educators' values, beliefs and attitudes are all imparted in teaching, at times interwoven subliminally in the subtext of the lesson. In Freire's notion of transformational pedagogy, this may be all the more outwardly visible. The influence of the educator raises particular challenges in the content they teach. Educators must understand the nature of what they teach and its

capacity to create disharmony and conflict for students. Educators need to acknowledge the radicalising capabilities of the classroom. We need to remember that what we teach has a direct relationship to the outcomes of people's lives. The struggle of the post-modern world is to be ethical, all the while being aware of dissonance or inner discord. As post-modern educators, the more content that teaching contains that is contra the 'established' or 'orthodox' perspectives, the more students will struggle with conflict and dissonance in practice. The ethic of the classroom is not just in knowing the theory; it is also in the explaining of opposing positions or perspectives and challenging both sides of arguments. At this point, nothing is hidden, and the irony of inconsistencies are there for all to see. Educators need to consider how they can help students to learn how to tolerate uncertainty and cope with disharmony, if they are to survive. Reflection has a very significant role to play in this. If education fails to do this, it risks increasing conflict in practice and attrition in professions.

2.1 Reflecting on the motivations for action

Being self-aware allows a person to identify his or her strengths, weaknesses, thoughts and issues. Through this identification process, particularly as related to nursing, self-awareness has the ability to enhance the therapeutic relationship and therapeutic interventions (Jack et al. 2008). Self-awareness is fundamental to the ability to reflect. It is an ongoing process. As we discover new insights and aspects of ourselves, we need to re-evaluate. Reflective practice is a way that we can accomplish this. Rungapadiachy (1999) considers that reflection occurs at three levels:

- Superficial: awareness of basic dimension
- Selective: being aware of things we think we need to be aware of
- Deep awareness: reflected in our deepest secrets and thoughts

In the digital age, with the instant access to knowledge and data in everybody's hands, for educators it is less important to appear all knowing and detached, and to feel a need to place 'distance' between students and educator. According to Burnard (2002), it is the authenticity of the educator, in their representation of the 'self' in a 'genuine' way that is the most important. In presenting a *'genuine self'*, then knowledge of the 'self' becomes a prerequisite. It is a difficult task, when often it might be easier to ignore emotional responses and the feelings that work generates.

Identifying strengths and weaknesses and having a clear understanding of how your behaviour and emotions effect events improves your capacity for interactions with others. There are three essential elements to self-awareness: cognition, affect and behaviour, in other words thought, feeling and action. For example, an emotion like anger can reduce the ability of the individual to communicate, and the person's argument may be disregarded or dismissed. The self-aware individual has the capacity to control the response or accept responsibility for the action (Jack & Miller, 2008). Knowing more about the 'self' increases our ability to recognise boundaries, knowing where our feelings end and those of others start (Jack & Miller, 2008). Reflecting, having self-awareness, allows people to clearly understand where boundaries exist and differentiate between their problems and those of others (Jack & Miller, 2008). With growing self-awareness, comes more effective practice, individuals recognise what they know and where their limitations lie. Then people act with greater consciousness about what they do; an aspect particularly important when taking student or novice behaviour into account. Susan Sontag observes that in regarding the pain of others, while images of suffering may "haunt" us, it is "narratives" that "can make us understand."

A problem with educational programmes is that they do not always provide clear definitions and understandings for what 'ideal' people should strive. Caution is necessary in driving people when this notion of the ideal self is defined so poorly. Where it is not effectively managed, it leads to frustration, stress and burnout. In addition, the constant striving to reach ill-defined, unrealistic or vague goals is problematic and it dissuades people from exploring greater levels of self-awareness. At a student level, this leads to greater attrition in educational programmes.

Developing greater self-awareness can be a difficult and complex process due to the uncertainty of what may be revealed. The notion that there is an 'ideal' self can be counterproductive, a state that is 'elusive' and always just out of reach. The pursuit of the 'ideal self' will frequently end in the feeling that the person is just 'not good enough'; the person enduring a mortification akin to *'self-flagellation',* a pattern sometimes present to a large extent in student reflections, believing that the solution to the majority of the problems they encounter lies within them; with their 'self'. Consider the dilemmas of a young female nurse and the experience of the politics of sexuality, when working in a mental health community residence for adolescents. The event

illustrates the boundaries and challenges daily practice brings for nurses, for example where to their sexuality and life choices become sources of challenges in their interactions and the deeper need for self-awareness:

> *After tea, I was helping to clean in the kitchen and an interaction opened up between two young girls and myself. The discussion drifted on to the topic of a national referendum on same sex marriage. As we spoke one of the girls, Eve, revealed her bisexual orientation. She was fourteen. Initially, I felt a little off my guard. I had not anticipated the disclosure. I was initially uncertain as to how to respond. In considering her age and the sensitive nature of the matter, I decided to react positively by affirming her declaration. Leaving the conversation open, I thought this would allow her the opportunity to expand on the subject without forcing her to do so. I was also unsure how widely other people were aware of her orientation. I also had to consider the reaction of the other girl present. She was only thirteen; I was not sure what effect the event might have on her.*
>
> *Eve continued by recounting how she had 'come out' at home. Again, attempting to be non-judgmental I responded positively allowing her to express her feelings in relation to the response. The other girl supported her in her decision and I felt relieved that the event not only had a positive outcome, but that I had provided support to Eve and the other girl. A little uncertain afterwards, I discussed the event with a colleague who felt I had handled it well.*
>
> *The following afternoon, it was my turn to facilitate a group session with the clients; Eve and the other girl were present. The topic of sexuality was raised again. Eve, somewhat brazenly turned the topic to me and asked '…what about you, aren't you a lesbian? How do you deal with it?'*
>
> *I am. I make no secret of this. I actively campaign for gay rights. All of my colleagues are aware of my orientation and prior to this moment, it had never been a barrier in work. I felt stunned. I did not feel that Eve, or any other client had the right to ask this question of a mental health nurse. What difference would it make to the care I could give? Surely, there were boundaries?*

> *Although I did not sense any malice from Eve's question, a degree of panic struck me. What should my response be? Should I uphold the principles to which I subscribe? What was the potential for me influencing minors in an aspect of personal life? I know the research states that positive role modelling by LGBTQ clinicians can influence outcomes for young people questioning their sexuality. Yet, is it appropriate for staff to influence adolescents when they are in an mental health facility? Would I be imposing my value system on others in both revealing and discussing my own sexuality?*
>
> *Ultimately, I responded that as a professional certain boundaries exist across which it was not appropriate to discuss, in the same way that it would be inappropriate for me to discuss dimensions of her care with others outside of a clinical environment. Despite this, I was left with a hollow feeling. In defence of my professional dimension, I found myself hiding the truth of who I am.*

In the exploration of the self, reflection may create a better understanding of people's reasons for action and the influence that individuals hold. Reflection has a strong capacity to provide understanding when people experience dissonance. People create expectations of how they expect themselves to behave. In explaining patterns of behaviour, Aronson's (1968) 'Self-consistency' theory explains that people are motivated by a desire to be 'right' or 'good'. Their core values reflect how they see themselves. When they encounter situations, they label them as either good or bad, depending on the way the situation affects them and the emotions they experience. When the person has to break the expectations that they hold for themselves, the notion of *'self-concept'* or who the person sees himself or herself to be registers as dissonance. Aronson (2004) believes that this creates a discrepancy for the individual between *'...what they practice and what they preach'*. Consequently, the individual becomes confronted with the experience of *'hypocrisy'*.

2.2 The 'self' as professional

The aspect of power/knowledge is an element put forward in the work of Foucault (1980). He argues professionals are vested with power and autonomy. Professionals have discretion. Professionals by their nature have and use 'power' and 'discretion' by way of the 'autonomy' they perceive within their role.

When we are faced with dissonant dilemmas, as in role ambiguity, dealing with finite resources or managing high workloads, we are forced to make uncomfortable decisions about how resources are used and where and with whom they are used. Michael Lipsky produced a thesis in 1980 that explored this area, a theory he subsequently extended in 2010. In his theory, he described the actions of professionals whom he categorised as 'street level bureaucrats'.

Lipsky (2010) describes aspects that govern the action of the professionals, describing it as 'street-level bureaucratic' behaviour. He includes public servants like police, teachers, doctors, nurses and social care professionals in this category. Lipsky (2010) found these bureaucrats operated in face-to-face contact with people and were invested with large degrees of autonomy in these interactions. Lipsky's theory holds important considerations when thinking about how individuals function in the course of their roles. When dealing with real world situations professionals determine what they feel is the *'most appropriate'* intervention, method and outcome, based upon their *'individualised interpretations'* of the problem. When trying to manage situations, as Lipsky highlights, emotions and individual biases contribute to professionals' decisions that can result in rationing, favouritism, stereotyping and the routinizing of practices that place the needs of the bureaucrat or those of the agency before the needs of the individual. When dealing with dilemmas in real world situations professionals determine what they feel is the 'most appropriate' intervention, method and outcome, based upon their 'individualised interpretations' of the problem. Here they resort to the use of 'power' and 'discretion' afforded by the 'autonomy' they perceive within their role. In this, every extension in the level of engagement with the professional increases the influence and control that the professional has over an individual's life in the decisions they make.

2.3 The role of critical reflection

Brookfield (1995) discusses the concept of critical reflection. The concept encompassed a wider critical thinking perspective into reflection, placing emphasis on social and power dynamics, as they relate to personal experience. Brookfield (1995) argues for a need to grapple with the individual's fundamental values, beliefs and assumptions about how power functions if reflection is to be used as a source for change.

Having considered the notion of the power of the individual, it is also appropriate to reflect upon the individual's relationship with institutions in post-modernity. Post-modern perspectives are highly sceptical of 'narratives', where 'authority' holds power in determining what constitutes 'an authority' (Rolfe 2001). Increasingly, the modern world wrapped up in risk and uncertainty has started to intrude on people's lives and their interaction with others. Professional encounters become enshrined in manuals and guidelines, information sheets, pamphlets, research and academic texts. Giddens (1991) categorises all of these sources of knowledge and information within the rubric of *'institutional reflexivity'*. Institutional reflective devices have effects on every individual. Institutional devices determine how individuals should act, dictate what information should be communicated, indicate what should be assessed and dictate how people should feel.

Institutional reflexive information directs people's actions and is influential in extending the discourses they contain. They increase the perception that the information they contain is authoritative and without question. The consequence of this is that in a professional area like mental health, institutional reflective devices fashion the person's identity of 'self'. As an example, consider the influence of a guideline given to a service user or a family member designed to educate them about a diagnosis like schizophrenia.

In 2006, the National Institute of Mental Health (NIMH) in the United States produced a revision of their booklet, *'Schizophrenia',* specifically designed for this purpose. The booklet reached a wide audience and in many clinical environments across Europe and the United States, many professionals adopted and distributed the booklet to families and service users as a way of communicating information about the diagnosis. The NIMH is a part of the U.S. Department of Health and Human Services' National Institutes of Health. The Institute considered its role as fulfilling:

> *'...a vital public health mission, it must foster innovative thinking and ensure that a full array of novel scientific perspectives are used to further discovery in the evolving science of brain, behaviour, and experience. In this way, breakthroughs in science can become breakthroughs for all people with mental illnesses'.*

It is a twenty-page document that the NIMH website refered to as *'A detailed booklet that describes symptoms, causes, and treatments, with information on getting help and coping'*. Critical analysis of the booklet offers some very interesting perspectives that carry significant relevance for reflection on the role of institutional reflexivity in professions. What is immediately apparent is how the text followed a biomedical narrative closely. It presented a two-page outline on the causes of 'schizophrenia', strongly orientated to biological explanations of genetic causation, structural brain abnormality and brain chemistry malfunctioning. The aspects of the psychological, the social, the role of the environment, intrauterine viral infection, birth trauma and malnutrition received a 25-word commentary. When a professional placed a text such as this in the hands of a service user or family member it, immediately created an impression on the recipient that this is the expert's interpretation of what my problem is. It was one, which I must accept; as the professional has provided it as 'truth' and the professional knows 'best'. The content beyond reproach.

What must be noted is that much of this content was not evidenced and was contested. In the folk understanding of mental health problems, medical narratives are accepted as preeminent and aspects such as dissociation and trauma, considered as highly relevant in the diagnosis, in the reader's are relegated to the role of insignificant asides. If we reflect upon the impression given in the booklet's narrative, then it intimated certain facts. Schizophrenia was biological, it was caused by abnormal structures in your brain and brain chemistry and that it was genetic. What does this imply about treatment? To suppress the effects of genetics, brain abnormality and faulty brain chemicals you must take a pharmacological preparation to correct this. Yet, psychiatric narratives have previously proven highly inaccurate, with treatments for schizophrenia such as insulin comas, camphor-induced and pentylenetetrazol-induced brain seizures and lobotomy now widely discredited. In addition to this, sociological critique asks serious questions of psychiatry's conduct and its relationship with the pharmaceutical industry (Kirk & Kutchins, 1997; Whitaker, 2002, 2010). In one hundred years time how will we view the treatments of today?

The booklet identified 'schizophrenia' as a 'chronic, severe, and disabling brain disorder' and compares it to lifelong 'chronic' physical diseases such as diabetes and hypertension implying an underlying, but yet unproven physical cause. It dedicated

three and a half pages to the singular discussion of medication and despite emphasising that:

> *'NIMH does not endorse or recommend any commercial products, processes, or services and this publication may not be used for advertising or endorsement purposes' (p. 22)*

Yet a revision of the document, added in January 2007, included a special addendum between pages 18 and 19, in which a solitary paragraph stated:

> *'Aripiprazole (Abilify) is another atypical antipsychotic medication used to treat the symptoms of schizophrenia and manic or mixed (manic and depressive) episodes of bipolar I disorder. Aripiprazole is in tablet and liquid form. An injectable form is used in the treatment of symptoms of agitation in schizophrenia and manic or mixed episodes of bipolar I disorder.'*

How was this insertion to be interpreted and at whose behest? It detailed not only the generic name but also the trade name of the drug. Yet by comparison, the booklet's content on psychological and social interventions, cognitive behavioural therapy, illness management skills, integrated treatment for co-occurring substance abuse, rehabilitation, and family education and self-help groups comprised two pages.

Reflect upon the knowledge within the document and how it fashions the way a person given a diagnosis like schizophrenia or their family member thinks about him/herself or their loved one. Also consider the effect on the professional; it coaches the professional on how to think of him or herself as a practitioner and what information they should communicate. The consequences are that they influence both service users and service providers in the roles they are expected to play.

Our reflections and engagement emotionally also extend into our relationships with our social institutions and our relationships with state and government. The power of institutions, those of social, political, organisational and religious have asked individuals to believe in the integrity of the institution. Yet events in post-modern societies like Ireland question the fundamental integrity of institutions as they come

under pressure to account for the actions of their members. Irish society questions the trust placed in the state and religion in our treatment of state run industrial schools and orphanages where problematical and sometimes-unwanted children were housed under abusive regimes overseen by religious orders. As with many other countries, Ireland has struggled with the shame of clerical sex abuse and the church's response to the actions of its priests in covering up and failing to protect children. It has also struggled to respond to the treatment of unmarried mothers in society, removed to 'Magdalene laundries' to hide the families' shame, again under cruel and disciplined regimes. With the benefit of hindsight and as a society, we now reflect, but the question is asked "Why did the individuals entrusted with care and those who were aware of these tragedies fail to act?" Arguably, they failed to reflect or act on the relationship with the institution.

2.4 Emotions and reflections in professions

Denzin (1984, p. 1) in posing the question *"How is emotion as a form of consciousness, lived, experienced, articulated, and felt?"* fundamentally describes it as such. Engaging reflectively poses a great difficulty, especially considering the growing need to embrace the feelings associated with revisiting and analysing practices and beliefs relating to work. 'Work' is an emotional practice. In a profession like nursing, it can be easy to identify how attending to the ongoing anxieties, distress, and frustrations experienced by patients and their families takes an emotional toll on those working in the area (Mann & Cowburn, 2005). Experiences with cancer care, suicide, dementia, death and dying place a high demand on the emotions of those employed in the area (Gray, 2009; Hochschild, 1983; Staden, 1998). The following excerpt offers an illustration of a mental health interaction and the challenges of reflecting on the emotional as a young female nurse struggles with the appropriateness of an emotional response:

> *"Over the period of a month as a key nurse[2], I built a good rapport with Peter, a man in his thirties. He was admitted to our unit, an acute mental health facility, following a suicide attempt. I felt I developed a solid therapeutic relationship, so much so that he spoke to other clients and staff about how much he was benefitting from our interaction. Over the course of our individual sessions, we embarked on a journey of discovery in his recovery.*

[2] In many mental health nursing environments staff are allocated as 'key nurse' to a number of clients, in this situation they are given prime responsibility for addressing the needs of these clients both physically and psychologically.

He felt he made significant progress mentally, although his suicidal ideation had not entirely dissipated. I felt that our work together contributed positively to his progress. Other staff complemented me on what we accomplished. I felt my confidence grow in response to the recognition of the effect.

All of this was to change on one afternoon. It happened in the middle of an individual therapeutic interaction. As we traced the history of his problems, Peter chose to confide in me an aspect of his personal life that he had hidden from the mental health team on his previous admissions. It was a dimension that was unexpected and it left me transfixed. Peter disclosed his history as an abuser, that in his intimate relationships he physically and sexually abused his partners.

As a woman, a sense of revulsion shrouded me, as he disclosed his catalogue of behaviours; it greatly affected me and I felt betrayed. A raft of emotions built up, anger, disappointment and disgust and I felt I could not stay in the same room as him. I felt overwhelmed. I wished he could have been on the receiving end of his own abuse. I struggled to stay in the room until the end of the session, and could not wait to leave. I returned to the nurses' office, I sat alone waiting for the anger to subside. I spoke with a colleague about what happened and the conversation seemed to help, but by the time I finished my shift and went home, I still carried resentment towards him. I felt betrayed, how could a person to whom I had grown so close to as a therapist, almost as a friend, suddenly reveal himself in this way. I was conflicted, I could not discern whether I now felt I was his therapist or his victim. My perspective of this man had changed, irrevocably. I could not bring myself into his company. As I returned to the unit the following day, I could not bring myself to engage with him at anything resembling a therapeutic interaction. I managed to get myself to engage with him for a while, but I did not feel it was meaningful. It was a façade, I went through the motions but that bond, which had previously existed was lost. He also knew; he sensed the difference in the nature of the relationship. He asked me if there was an issue; I lied. I discussed the experience with my nurse manager and I requested a new key nurse be allocated to Peter, as I could not cope with the emotions he now evoked in me. Yet, I felt like a hypocrite, as a mental health nurse, my practice

> *is underpinned by Rogers' (1961) concept of unconditional positive regard*[3]*. I felt I did not uphold the principle. I felt fortunate that I was to start in a new unit two days later, but left deeply conflicted".*

Day to day practices such as the emotive experience of working with a sexual abuser in a mental health setting provide severe tests of ethical and moral character, as individuals grapple with the awfulness of the person's actions, whilst simultaneously trying to abide by principles like positive unconditional regard for the person. Here the nurse viewed the information she received as a negative; she could not see the positive side of the disclosure and the strength of the relationship that had developed.

The term *"emotional labour"* (Hochschild, 1983), has emerged to describe these experiences. Reflection in this area places high demands and exposes the individual to a level of 'personal risk' (Hanson, 2011 p. 301). Professions like teaching are also subject to the experience of emotional labour, as the following excerpt from the work of Isenbarger and Zembylas (2006) illustrates:

> *"Reed's reputation preceded him before he came into my classroom. He was well known in our building for having an explosive temper, being uncooperative with adults, and having difficulty getting along with classmates. Early in his school years, Reed had been labelled with a behaviour disorder but he had progressed enough while in a Behaviour Disorder classroom that he had been allowed to return to the regular education classroom. However, he was disruptive, never turned in any homework, and had a foul mouth. During his fourth grade year I had had a run-in with him while on a field trip and had found him disrespectful, even obnoxious, clearly delighting in talking back to me and flouting my directions."*

Involvement in this type of *"emotional practice"* involves social relationships and depends upon a capacity for *"emotional understanding"*. People need to be able to construct understandings in order to communicate with others (Denzin, 1984). The problem is it can be difficult to find time to address the interpersonal aspects of

[3] Morrissey and Callaghan (2011) describe the concept as 'acceptance or warm regard for a person no matter what her/his behavior, feelings or condition'. It involves non-judgmental and non-possessive regard, and an ability to demonstrate acceptance.

relationships in professional environments with high workloads, competing demands, organizational pressures, and increasing administrative burdens adding to the dilemma (Henderson, 2001). For most people, the emotional support provided by informal personal networks and employee assistance schemes tend to be more reactive rather than active and people do not consider these effective enough (Haddock, 1997). The difficulties of emotional demands can be compounded when people in the wider organization fail to recognise these problems. In this experience of emotional labour, individuals progress from feelings of disempowerment and futility, to compassion fatigue and burnout (Edward & Hercelinskyj, 2007; Gentry, Baranowsky, & Dunning, 2002).

3. Discussion

If the area of emotion in our work is not challenged then the consequences are clear. Staff experiencing emotional overload, who feel unsupported and unappreciated, become limited in their capacity to perform effectively. Performance is compromised when interactions and decisions are influenced by personal, emotional, and organizational agendas (Dawber, 2013). The results reflect not just upon the individual but have negative psychological effects and outcomes for their subjects (Bee et al., 2008). This is especially true for 'difficult' clients, the unpopular student or service user who can become the focus for negative feelings (Dawber, 2013; Dugan et al., 1996).

When people advocate for the use of reflection in practice, they need to consider the potential negative consequences of the process. The overall experience of carrying out reflective practice is off-putting for some students, it leads to negative effects on their self-perception; this can have an effect on their behaviour both academically and professionally, as it is linked to future behaviour (Philippe, Lecours, & Beaulieu‐Pelletier, 2009). Sparrow (2009, p. 568) states reflection is *'an emotional experience in itself'* as in the re-ignited emotions the person re-feels when he or she relives the event. It can affect the person's current mood state. It affects his or her emotional state and can effect cognitive processes. It can induce low mood and can reduce the person's ability to problem solve. In educational settings, it can also affect aspects like student assessment and memory, to such an extent that the person will concentrate upon and attend to things that match that mood (Philippe et al., 2009; Sparrow, 2009).

Despite the potential pitfalls of engaging in reflection, as in the opening of Pandora's Box, hope remains. Service (2012) puts forward a very interesting discursive point, namely the utility of reflection in a cycle for 'human flourishing'. As a PhD student, Service's (2012) use of reflection reveals the benefits of reflective practice in tracing her progression from research idea to establishing meaning and purpose in life. In her journey from the plan to undertake the research through to the transformative learning process, the emotions reflection brought aroused hope and ultimately provided meaning and purpose that she could transfer to learning. Reflection generates a huge amount of emotional upheaval. Do not look upon the emotional upheaval you experience as a weakness or deficit of character, it is not you; it is a part of the process.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders. (5th ed.)* Arlington, VA: American Psychiatric Publishing.

Aronson, E. (1968). Dissonance theory: Progress and problems. In R. P. Ableson (Ed.), *Theories of cognitive consistency: A sourcebook* (pp. 5-27). Chicago: Rand McNally.

Averill, J. R. (1980). A constructivist view of emotion, In R. Plutchik, and H. Kellerman (Eds.), *Theories of Emotion*, (pp. 305-339). New York: Academic Press.

Barnett, R. (1997). *Higher education: A critical business*: McGraw-Hill International.

Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies, 45*(3), 442-457.

Bentall, R. P. (2003). *Madness explained: psychosis and human nature*. London: Allen Lane.

Boyle, M. (2002). *Schizophrenia: A Scientific Delusion?* London: Routledge.

Bringle, R. G., & Hatcher, J. A. (1999). Reflection in service learning: Making meaning of experience. *Educational Horizons, 77*, 179-185.

Brookfield, S. (1995). *Becoming a critically reflective teacher*. San Fransisco: Jossey-Bass.

Burnard, P. (2002). *Learning human skills: An experiential and reflective guide for nurses and health care professionals* (4th ed.). Oxford: Butterworth-Heinemann.

Burton, T. T. (2011). *Accelerating Lean Six Sigma Results How to Achieve Improvement Excellence in the New Economy*. Fort Lauderdale, FL: J. Ross Publishing.

Cornelius, R. R. (1996). *The science of emotion: Research and tradition in the psychology of emotions*: Prentice-Hall, Inc.

Damasio, A. (2006). *Descartes' error: Emotion, reason and the human brain*. New York: Vintage.

Dardjowidjojo, S. (2001). Cultural constraints in the implementation of learner autonomy: The case in Indonesia. *Journal of Southeast Asian Education, 2*.

Dawber, C. (2013). Reflective practice groups for nurses: A consultation liaison psychiatry nursing initiative: Part 1 – the model. *International Journal of Mental Health Nursing, 22*(2), 135-144.

Denzin, N. K. (1984). *On Understanding Emotion.* . San Fransisco: Jossey-Bass.

Dewey, J. (1934). *Art as Expereince*. New York: Minton, Balch & Company

Dugan, J., Lauer, E., Bouquot, Z., Dutro, B. K., Smith, M., & Widmeyer, G. (1996). Stressful Nurses: The effect on patient outcomes. *Journal of Nursing Care Quality, 10*(3), 46-58.

Edward, K. L., & Hercelinskyj, G. (2007). Burnout in the caring nurse: learning resilient behaviour. *British Journal of Nursing, 16*(4), 240-242.

Ellis, C. (2004). *The Ethnographic I.* Wallnut Creek CA: Alta Mira.

Esterberg, M., & Compton, M. (2009). The psychosis continuum and categorical versus dimensional diagnostic approaches. *Current Psychiatry Reports, 11*(3), 179-184.

Foucault, M. (Ed.). (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. New York: Pantheon.

Frijda, N. (2007). *The laws of emotion*. Mahwah, NJ: L. Erlbaum Associates.

Frijda, N. H. (1998). The Laws of Emotion. In J. M. Jenkins, K. Oatley & N. Stein (Eds.), *Human Emotions: A Reader.* (pp. 271-287). Malden, MA: Blackwell Publishers.

Gadamer, H.-G. (1996). *The enigma of health.* Stanford, CA. Stanford University Press.

Gentry, J., Baranowsky, A., & Dunning, K. (2002). The accelerated recovery program (ARP) for compassion fatigue. In C. Figley (Ed.), *Treating compassion fatigue* (pp. 123-137). New York: Brunner-Routledge.

Giddens, A. (1991). *Modernity and self-identity*. Cambridge: Polity Press.

Gray, B. (2009). The emotional labour of nursing–Defining and managing emotions in nursing work. *Nurse Education Today, 29*(2), 168-175.

Haddock, J. (1997). Reflection in groups: contextual and theoretical considerations within nurse education and practice. *Nurse Education Today, 17*(5), 381-385.

Harré, R. (1988). *The Social Construction of Emotions*. Oxford: Basil Blackwell.

Henderson, A. (2001). Emotional labor and nursing: an under-appreciated aspect of caring work. *Nursing Inquiry, 8*(2), 130-138.

Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. Berkeley, CA: University of California Press.

Isenbarger, L., & Zembylas, M. (2006). The emotional labour of caring in teaching. *Teaching and Teacher Education, 22*(1), 120-134.

Jack, K., & Miller, E. (2008). Exploring self-awareness in mental health practice. *Mental Health Practice, 12*(3), 31-35.

Kim, Y., & Berrios, G. E. (2001). Impact of the term Schizophrenia on the culture of ideograph: The Japanese experience. *Schizophrenia Bulletin, 27*(2), 181-185.

Kirk, S., & Kutchins, H. (1997). Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Illness: New York: The Free Press.

Kuswandono, P. (2014). University mentors' views on reflective practice in microteaching: building trust and genuine feedback,. *Reflective Practice: International and Multidisciplinary Perspectives, 15*(6), 701-717.

Lipsky, M. (2010). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Sage.

Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 12*(2), 154-162.

Miller, S. (2014). Social Institutions. In E. N. Zalta (Ed.), The Stanford Encyclopedia of Philosophy (Winter 2014 ed.): Stanford University. Retrieved from http://plato.stanford.edu/archives/win2014/entries/social-institutions/.

Minnis, J. R. (1999). Is reflective practice compatible with Malay-Islamic values? Some thoughts on teacher education in Brunei Darussalam. *Australian Journal of Education, 43*, 172-185.

Morrissey, J., & Callaghan, P. (2011). *Communication skills for mental health nurses*. Maidenhead: Open University Press, McGraw-Hill Education (UK).

National Institute of Mental Health. (2009). *Schizophrenia*. Bethesda, Maryland: U.S. Department of Health and Human Services.

Peter, L. J. (1977). *Peter's Quotations: Ideas for Our Time.* New York: Morrow, 316.

Philippe, F. L., Lecours, S., & Beaulieu‐Pelletier, G. (2009). Resilience and positive emotions: Examining the role of emotional memories. *Journal of Personality, 77*(1), 139-176.

Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy Sciences, 4*(2), 155-169.

Rogers, C. (1961). *On Becoming A Person: A Therapist's View of Psychotherapy*. Boston: Houghton Mifflin Company.

Rolfe, G. (2006). Nursing praxis and the science of the unique. *Nursing Science Quarterly, 19*(1), 39-43.

Rolfe, G. (2014). Rethinking reflective education: What would Dewey have done? *Nurse Education Today*. 34,(8),1179-1183.

Rungapadiachy, D. M. (1999). *Interpersonal communication and psychology for health care professionals: Theory and practice*. Oxford: Butterworth-Heinemann.

Sato, M. (2006). Renaming schizophrenia: a Japanese perspective. *World Psychiatry, 5*(1), 53-55.

Service, B. (2012). Keeping the faith: how reflective practice can turn emotional turmoil into a positive outcome in the context of doctoral study. *Reflective Practice: International and Multidisciplinary Perspectives, 13*(2), 169-182.

Sparrow, J. (2009). Impact of emotions associated with reflecting upon the past. *Reflective Practice, 10*(5), 567-576.

Spry, T. (2001). Performing autoethnography: An embodied methodological praxis. *Qualitative Inquiry, 7*(6), 706-732.

Staden, H. (1998). Alertness to the needs of others: a study of the emotional labour of caring. *Journal of Advanced Nursing, 27*(1), 147-156.

Toulmin, S. (1992). *Cosmopolis: The hidden agenda of modernity*. Chicago: University of Chicago Press.

Toulmin, S. E. (2009). *Return to reason*: Cambridge, MA: Harvard University Press.

Walker, A. (2004). Understanding social capital within community/government policy networks. *Social Policy Journal of New Zealand* (22), 1-18.

Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Publishing.

Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Crown Publishers.

Zembylas, M. (2004). Emotion metaphors and emotional labor in science teaching. *Science Education, 88*(3), 301-324.