Journal of the American Psychiatric Nurses Association

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Journal of the American Psychiatric Nurses Association 2009 15: 191
DOI: 10.1177/1078390309336932

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Mental Health Patients' Experiences of Being Misunderstood

Laura M. Gaillard, Mona M. Shattell, and Sandra P. Thomas

BACKGROUND: *Mental health patients describe "being understood" as an experience that evokes feelings of importance, worthiness, and empowerment. However, the experience of "being misunderstood" is more prevalent in patients' relationships with health care providers. Negative consequences such as vulnerability, dehumanization, and frustration reveal that being misunderstood has the potential to damage or destroy therapeutic relationships.* ***OBJECTIVE:*** *The purpose of this secondary analysis was to examine mental health patients' experiences of being misunderstood.* ***STUDY DESIGN:*** *Data consisted of transcripts from 20 interviews with community-dwelling adults with mental illness, which were analyzed using an existential phenomenological approach.* ***RESULTS:*** *Four figural themes expressed the experiences of being misunderstood: protection from vulnerability, an object to be fixed, treated like a child, and relentless frustration.* ***CONCLUSIONS:*** *Nurses and other caregivers can use the findings of this study to promote understanding, strengthen therapeutic relationships, and improve the quality of mental health care.* ***J Am Psychiatr Nurses Assoc, 2009; 15(3), 191-199. DOI: 10.1177/1078390309336932***

Keywords: *patient satisfaction; psychotherapy; brief; staff issues; relationships; roles*

"To be understood" is difficult to define. In a study examining mental health patients' experiences of being understood, patients described feeling important, worthy, and empowered when they were understood by the health care providers (Shattell, McAllister, Hogan, & Thomas, 2006). Within this study, patient reports revealed that experiences of being understood were scarce and hard to describe without contrasting these experiences with the abundant occurrences of being misunderstood (Shattell et al., 2006). These recurring testimonies of being misunderstood prompted a focused secondary analysis, which sought to describe the experience of being misunderstood from the mental health patients' perspective.

To clearly distinguish the concept examined in this study of the mental health patients' experience of being misunderstood, it is important to differentiate "being misunderstood" from a "misunderstanding." A "misunderstanding" results from an error in verbal or physical communication, whereas "being misunderstood" is the result of inaccurate perceptions, judgments, or failed acknowledgements of the unique individual. As defined by patient experiences, being misunderstood encompasses both health care providers' actions (or lack thereof) and the effect they have on the mental and emotional health of the patient. A misunderstanding is closely related to being misunderstood in that a misunderstanding can result in a patient feeling that they have been misunderstood. When persons with a mental illness are misunderstood as people, their essential being is affected and the negative impact is not easily rectified.

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The authors acknowledge the University of Alabama at Birmingham School of Nursing for providing partial funding for the original study. The authors would also like to acknowledge student members of the interpretive research group from the University of North Carolina at Greensboro and co-authors of the original study, Beverly Hogan and Sara McAllister. Finally, the authors would like to thank the study participants. The authors would like to note that Laura M. Gaillard was an undergraduate student at the University of North Carolina at Greensboro when she coauthored this article.

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REVIEW OF LITERATURE

Importance of Being Understood

The significance of being understood is noted in multiple studies that examined patient experiences, therapeutic relationships, and effective psychiatric/mental health care (Johansson & Eklund, 2003; Koivisto, Janhonen, & Väisänen, 2004; Schröder, Ahlström, Larsson, 2006; Shattell, Starr, & Thomas, 2007). In these studies, patients described feeling understood as vital to effective relationships with their health care providers and their personal progress in treatment. Theories surrounding the therapeutic relationship were revolutionized by Peplau's (1952) concept of the "shared experience" between patient and nurse. Peplau (1952, 1992, 1997) emphasized mutual understanding and interrelatedness in the formation of beneficial therapeutic relationships with mental health patients. In her classic writings, Joyce Travelbee (1969) described understanding as acknowledging the uniqueness of the ill person. She contended that understanding was "a force which can provide the ill person with the necessary endurance and courage to face the inevitable problems which lie before him [sic]" (Travelbee, 1969, p. 81).

The original study of the experience of being understood found that patients viewed being understood as an interpersonal connection with their health care providers that made them feel important, valued, and equal as a human being (Shattell et al., 2006). Similar concepts of connecting with or relating to the individuals and knowing them as persons were significant in a study focused on mental health patients' experience of the therapeutic relationship (Shattell et al., 2007).

In a study revealing patients' beliefs about what constitutes good psychiatric care, participants described being understood as a central theme in the helping relationship (Johansson & Eklund, 2003). One participant described the importance of being understood: "When they see me, when they seriously meet and relate to me, then I exist as a person" (Johansson & Eklund, 2003, p. 343). Koivisto et al. (2004) reported similar findings in their study examining patients' experiences of being helped in an inpatient setting. Being understood was reported as a central theme, described as an experience that protected patients from vulnerability by validating their individuality. Participants in this study reported the desire for nurses' understanding of their whole person to further their understanding of themselves. In all cases, being understood by a health care provider was a rare but highly valued experience by patients (Johansson & Eklund, 2003, Koivisto et al., 2004; Schröder et al., 2006; Shattell et al., 2006).

Being Misunderstood

Along with experiences of being understood, the experience of being misunderstood within the therapeutic relationship has been documented in the literature (Johansson & Eklund, 2003, Koivisto et al., 2004; Schröder et al., 2006; Shattell et al., 2007). Being misunderstood was the "most prominent" experience among patients who were dissatisfied with their psychiatric care in Johansson and Eklund's (2003) study. Feeling misunderstood and mistrusted, and having encounters with nurses who were not accepting were also commonly reported in the study conducted by Koivisto et al. (2004).

Research focused on the experience from the mental health patient's perspective was not found. Condon (2008) examined the concept of being misunderstood from Parse's human becoming theory. Participants reported recurring feelings of frustration, isolation, hurtfulness, and self-doubt when describing being misunderstood. One participant said that being misunderstood "makes you doubt your own choices of actions or words, making you even more frustrated" (Condon, 2008, p. 214). The findings in Condon's (2008) study are significant in that they describe the phenomenon of being misunderstood; however, the participants were not persons with mental illness, experiences were not described in relation to a therapeutic relationship, and Parse's theory was used as a guide. The author recommended research on the lived experience to further explore feeling misunderstood.

Patients' subjective experience of "misunderstanding events" within therapy sessions was examined by Rhodes, Hill, Thompson, and Elliot (1994) using first-person accounts of 19 clients. The events described in this study led patients to feel they were misunderstood by their therapists. All clients described inattentive therapists who provided disliked interventions (such as giving unwanted advice), which led to feelings of anger, resentment, and abandonment. If a client felt misunderstood within the climate of a generally good therapeutic relationship, the client confronted their health care provider and the incongruence was eventually worked through, as noted by a client who said,

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> It was just one thread in a larger tapestry. The tapestry could have been unraveled had it not been 'fixed.' But in the finished tapestry, the event was but one thread that added to the strength of the overall therapy. (Rhodes et al., 1994, p. 479)

Regrettably, 8 of 19 clients reported that altered perceptions of therapists were not confronted, and 5 left therapy. In the words of one client, "The lapse was like a crater/canyon" (Rhodes et al., 1994, p. 479). The findings of this study suggest that patient experiences of being misunderstood by their health care provider have the potential to damage or destroy the therapeutic relationship, likely resulting in the discontinuation of a treatment regimen. Dingfelder's (2005) study also found that being misunderstood can result in client nonadherence with psychotropic medications or discontinuance of other essential therapies.

The prevalence of the experience of being misunderstood and the damaging effects it can have on patients' psyches, attitudes toward treatment, and relationships with health care providers prompts further investigation into the experience itself from mental health patients' perspectives. Therefore, the purpose of the current study is to describe the mental health patients' experience of being misunderstood.

METHOD

Design

The study was a secondary analysis of qualitative interviews (Szabo & Strang, 1997) conducted with persons with mental illness in a larger study of the experience of being understood (Shattell et al., 2006). The original study was approved by the university's Institutional Review Board (IRB). Given the richness of qualitative interviews, it is not uncommon to conduct secondary analyses to discover answers to new research questions. Precedent for examining the data in this way may be found in the research of Vuckovich (2009), whose first study (Vuckovich & Artinian, 2005) involved nurses using coercion to achieve medication acceptance by psychiatric patients. Vuckovich (2009) returned to the data to focus on overcoming medication refusal without coercion.

Participants in our original study of being understood were recruited from an advertisement in a university newspaper in the southeastern United States, which sought community-dwelling individuals who self-identified as having one or more mental illnesses. Participants in the original study were asked to describe their experiences of being understood by a health care provider. Participants were not instructed to limit their descriptions to interactions with any particular health care provider groups, which elicited responses about individual relationships with providers from a variety of disciplines: nurses, physicians, counselors, therapists, social workers, and care coordinators. The research question in the original study was, "What is the experience of being understood by a health care provider?" Participants had the opportunity to freely discuss their experiences as interviewers prompted only with clarifying questions. The in-depth qualitative interviews in the original study were conducted by two of the authors (Shattell, Thomas); a third author (Gaillard) joined the secondary analysis study. The study used an existential phenomenological approach derived primarily from the philosophy of Merleau-Ponty (1945/1962), which provides an excellent framework for investigating relationships among interacting selves whose paths "intersect and engage each other like gears" (Merleau-Ponty, 1945/1962, p. xx). Particularly in his later writings, Merleau-Ponty focused on issues of intersubjectivity and reciprocity in communication. His writings about dialogue and affirmation seem particularly relevant to mental health nursing practice.

Sample

The sample included 20 English-speaking community-dwelling individuals who self-identified as having a mental illness. Participants were between 21 and 65 years of age (mean = 39.6 years); 15 were Euro-American (75%), 4 were African American (20%), and 1 was Native American (5%); 8 were male (40%), and 12 female (60%). Education varied from high school (or less) to graduate degrees. The number of previous psychiatric hospitalizations ranged from 0 to 33 (mode = 0; median = 0.5); the majority of the sample (n = 11; 55%) had never been hospitalized for mental illness. Participants reported diverse past and present psychiatric diagnoses, including depression (n = 10), anxiety (n = 3), generalized anxiety disorder (n = 1), bipolar disorder (n = 9), postpartum depression (n = 1), panic attacks (n = 1), posttraumatic stress disorder (n = 1), attention deficit hyperactivity disorder (n = 1), antisocial personality disorder (n = 1), schizoaffective disorder (n = 1), and schizophrenia (n = 1). Seven participants reported more than one psychiatric diagnosis (mode = 2). Six

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(4 women and 2 men) were homeless at the time of the interview. Interviews, which were audiotaped and transcribed verbatim, were conducted between February 2005 and April 2005. Individuals were compensated $20 to participate in the study. Names and references to places have been changed to protect the identity of participants.

Secondary Data Analysis

The IRB determined that approval for this secondary analysis study was not necessary because the data (interview transcripts) had been deidentified. Using the systematic method described by Thomas and Pollio (2002), interview transcripts were analyzed to address the question, "What is the experience of being misunderstood?" The authors analyzed each transcript in the original study for meaning units. Transcripts also were read from the part (meaning units) to the whole (entire transcript). Meaning units were eventually aggregated into themes (recurring patterns that constituted important aspects of participants' descriptions of their experiences). In phenomenology, deciding what is thematic does not rely on quantification, such as frequency of word use, but rather on the researchers' reflection about the deeper meaning of the words and the context in which they were spoken (Thomas & Pollio, 2002).

A thematic description was developed for each transcript. Fifteen transcripts were analyzed in an interpretive research group; the remaining five were analyzed individually, by the first and second authors. An overall structure of the experience was then developed and presented to a research group to enhance rigor, and interpretations from the group were considered in addition to the re-reading of all transcripts to finalize the thematic structure. This thematic structure was presented to one participant for validation. Ultimately, the validity of the data interpretation is evaluated by readers of the research report, who carefully review the supporting evidence (e.g., verbatim quotes) presented for each theme.

RESULTS

The Context: A Diagnosis of Mental Illness as a Frame of Reference

According to Merleau-Ponty (1945/1962), phenomena perceived by humans must be understood in the context of the lifeworlds in which they are embedded. The phenomenologist aims to discover what stands out as most important in people's perceptions (i.e., what is figural or thematic) while remaining mindful of their situatedness in specific cultures, communities, and relationships. Talero (2006), a Merleau-Ponty scholar, explains the figure/ground nature of interpersonal relationships:

> The perspective of others impinges on me, sometimes as an uncomfortable experiential "figure," and sometimes as an innocuous "ground" . . . the co-presence of myself and the other will always be in a certain way an inequality: my world and the world of the other are "inserted" in each other's experience, but do not completely overlap. (p. 186)

In this study, a mental illness is the ground of the experience of being misunderstood. These particular experiences of being misunderstood (figure) would not be experienced without the existence of the person's mental illness (ground).

Providers' perceptions were framed by participants' diagnoses, creating a hierarchal health care context in which there was more than the customary inequality discussed by Talero (2006). The mental illness and diagnosis were a totalizing frame of reference. Participants' mental health diagnoses overshadowed their other qualities, and their caregivers used mental illness as a label to define them. Participants recalled being referred to as "a schizophrenic" or "a bipolar" as if their mental illness were their only recognizable quality. The diagnosis reduced their identity to a single aspect of their lives. One participant explained, "People will interpret too much of what you do and say [into the framework of a mental illness]. 'Oh, Jessie doesn't look so good today. Maybe she's depressed.'" Another participant described her experience of a severe physiological illness and the effect that her mental health diagnosis had on her care. Throughout repeated visits to the emergency room, her questions and concerns were ignored while multiple physicians mistakenly related her physical symptoms to her mental illness:

> Everything about you starts being attributed either to the mental health diagnosis you have, even though it's stabilized, or the medication that you're on for the mental illness. And you know, then other things just get ignored; you're not seen as a whole person . . . the separation between the systems that happens is really detrimental because you have this whole group of medically oriented people who feel like they don't know anything about that stuff, the psychiatric stuff, that it belongs to someone else, and there you are, like sort of in a big gap in between.

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In summary, a mental illness diagnosis served as a totalizing frame of reference that created the potential for abundant misconceptions and misinterpretations.

Figural Themes in the Experience of Being Misunderstood

Theme 1: Protection from vulnerability. As previously defined, being misunderstood encompasses false perceptions of the individual and their effects on the individual psyche. Participants felt vulnerable to inaccurate perceptions and judgments, leading them to be wary of disclosing their mental illness. As one woman said, "I was frightened they would have thought I was crazy." The uncertainty of others' perceptions created a feeling of vulnerability in itself: "You don't know what to expect . . . you're just wide open to whatever anybody thinks." Participants were also vulnerable to negative consequences of being misunderstood such as stigmatization, patronization, and poor treatment. They felt compelled to protect themselves from vulnerability by censoring their words and actions and setting boundaries in relationships. One participant described the difficulty she had with constant self-censoring: "I just felt like it was a razor edge . . . having to watch every word you say in every way you phrase something so that it could not somehow be construed the wrong way." Vulnerability was perpetuated with each experience of being misunderstood, leading participants to fear future disclosure and continue to censor what they said by "choosing [their] words carefully." Another participant's frustration was apparent in her description of censoring herself:

> It's expecting a lot of a person . . . having to rise up to a level of articulateness, you know, determinedness, defensiveness around yourself, not to let *one thing go by* that's going to establish a misconception. And while I guess I'm directing a lot of this towards physicians . . . I sometimes wonder, where are the nurses?

Almost all participants who described the need to censor their words described discouragement and frustration. The inability to be themselves without having their behaviors associated with their mental illness created a strong sense of discomfort. One said, "If we can't be ourselves, that's always going to be a root of frustration in some aspect or another. And if we don't feel comfortable being ourselves, then we're doomed to discomfort." Many participants described using the personal technique of self-censoring to prevent being misunderstood and protect themselves from vulnerability, creating an abundance of negative feelings such as frustration, resentment, and discomfort.

Theme 2: An object to be fixed. Participants reported feeling as if their health care providers viewed *them* as the problem rather than focusing on a problem that was affecting the participant. They described feeling objectified by their health care providers as if they were "something broken that needed to be fixed." One participant said that health care providers "wanted to fix [her] right away . . . but there was no quick fix to it." Participants saw themselves and their lives as complex and resented being seen as a problem that had a simple solution.

Interactions between participants and their health care providers became mechanical when participants' mental health was seen as "something broken that needed to be fixed." Participants described multiple experiences with health care providers who did not make eye contact, did not give feedback, and paid more attention to the written medical records than to what participants were saying. As noted by one participant, "It seems like I'm talking through them. Like they're just up there, like they're not really interested . . . like what I'm saying goes in one ear and out the other." Participants perceived that "most psychiatrists and case managers treat you as a case or a number, just a person you gotta pass on through the system." Time was not taken to evaluate the underlying causes of symptoms. Patients found that most of the time spent with health care providers focused only on medications to treat their symptoms. For example, one said, "They don't look at the overall problem . . . the type of thing you live through." One participant described her frustration with the experience:

> It's like, they get satisfied if they can say, "OK, we eliminated this or that symptom." It's only good enough when you have worked and worked and worked enough and paid enough attention to find out what does it take to get this person back to where they were, back to what they're capable of doing. And that would be more, that's treating the life . . . I want you to treat my story. *I am a continuous being*. I don't just stop where you're able to write down the conclusion of what happened in my office visit.

Participants felt greatly misunderstood when they were seen as a problem or a case number rather

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than a whole person with individual qualities and needs.

Theme 3: Treated like a child. Participants experienced interactions with health care providers that were paternalistic or maternalistic. As a result, participants felt that they were misunderstood and "treated like child[ren]." Their diagnoses led providers to assume that they were "non-functional persons," which left patients feeling as if they were no longer in control of themselves. Paternalistic advice was given by caregivers, family, and friends, as well as health care providers. It was common for persons to hear "you should be out doing this" and to be criticized when they did not take the advice. Participants often perceived the advice as a lack of support or confidence in their own decisions.

Disappointment was common when providers gave simplistic suggestions in response to their substantive disclosures of feelings or experiences:

> One counselor I went to, after maybe listening to me for like 15 minutes . . . I just gave an overview of what happened over 12 years . . . she said "Why don't you try movies? Movies will make you feel better on a Friday night." That did not make me feel understood.

Participants felt misunderstood when they were not viewed as autonomous adults who could collaborate in planning treatment of their illness; in fact, they believed their treatment plan was out of their control. Experiences of being pressured into unwanted treatments, such as electroconvulsive therapy, and being denied requests to change medications were present. Prescribed medications were not explained or adjusted even when they made patients physically ill for prolonged periods of time. Patients also lost control in their therapy sessions and many reported feeling as if they were "directed" instead of guided and that health care providers "had their own agenda."

Situations were described in which participants' emotions or behaviors were dismissed or mistakenly seen as "overdramatic," "acting out to get attention," or as a normal stage of life. One young woman described others' reactions to her mania:

> Everybody was like, "*Oh* you're just stressed out, you're just a student, no big deal, you'll outgrow it." And I knew good and well it wasn't something I would ever outgrow . . . and just kind of patting me on my head and telling me to go home didn't work for me.

Many experiences of being misunderstood had detrimental effects on participants that were not easily forgotten. One woman described the repercussions of her actions when she unwittingly violated hospital rules by going into the nurses' station: "I was berated like a child, and really felt misunderstood and worthless rather than worthwhile. It really put me lower on my recovery level." The sadness, distress, and confusion caused by this experience were audible in the participant's voice. Her words are also a testament to the negative effects that the misunderstanding had on her treatment progress.

Multiple testimonies revealed frequent experiences of participants feeling misunderstood when they were "treated like child[ren]." Participants thought they were seen as incapable of being responsible for themselves and their treatment plans, negatively affecting their confidence and self-esteem.

Theme 4: Relentless frustration. The effects of being misunderstood were evident in the emotions that accompanied participants' experiences. Pounding on the table, tears and elevations in vocal tone expressed their frustration, anger, and emotional distress when recalling experiences of being misunderstood. For example, "I feel like I'm screaming and no one can hear me." One participant described the difficulty she had in communicating with health care providers thus:

> It's a little frustrating when you're not understood. Because you try to get a message across to somebody . . . and they just don't hear what you're saying, and so you're never sure if that's my method of communication or if it's the receiver . . . which is also really frustrating, because you're the recipient of what they're providing, and they need to understand why you're there and what you want, and what your goals are for your care. And it seems to me like they always have their own agenda.

Another participant described conflicting feelings about whether or not to disagree with doctors who made certain diagnoses; they were the doctors and she was the patient. Feelings of frustration developed when goals of communication and understanding between patient and health care provider were not met. Participants were frustrated by the repeated need to explain themselves or their behaviors to others and the lack of understanding within their relationships. Participants developed a sense of desperation when they experienced repeated encounters with health care providers who were impersonal and unhelpful. Participants longed to "actually be treated for what they need to be treated for [without] having

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to see 18 doctors to get the right medicine and the right treatment and the right care." One woman sadly stated that "90% of the time [she was] misunderstood." Frequent feelings of being misunderstood by health care providers and other people in participants' lives caused an abundance of frustration and discouragement.

DISCUSSION

The findings from this study reveal numerous negative consequences experienced by persons with a mental illness when they are misunderstood. They feel vulnerable, mistrustful, frustrated, and discouraged by repeated encounters with health care providers that result in the feeling of being misunderstood. Providers failed to listen, failed to empathize, and failed to acknowledge participants' uniqueness. Many participants reported that they felt misunderstood in the majority of their interactions with health care providers, which may suggest that interactions with helping professionals have become less therapeutic within the fragmented health care system in the United States.

Our participants were community dwelling and not acutely mentally ill, or emotionally distressed, at the time of the interviews. Some of the experiences that these participants described occurred when they were acutely ill and when some were hospitalized. Our findings therefore could encompass the full range or level of severity of mental illness.

Findings reflected detailed accounts of patient experiences that were mentioned in previous research. Patient reports of being treated like an object, interactions with health care providers who did not make eye contact or take time to listen, and encounters with detached nurses are consistent with findings in several studies (Johansson & Eklund, 2003; Kralik, Kok, & Wotton, 1997; Lilja & Hellzén, 2008). Testimonies of being treated like children and the resulting negative effects on patients' confidence and self-esteem are also congruent with the findings of Oeye, Bjelland, Skorpen, and Anderson (2009). Our study findings also support Riikonen's (1999) description of "sickening or disempowering, noninspiring interactional-linguistic practices we must move away from" (p. 149).

The experience of being misunderstood may be magnified when experienced by a person with a mental illness. These findings reveal an urgent need for mental health care providers to strive for the ability to understand their patients' perspectives, and express that understanding to their patients. Participants in this study reported that the experience of being misunderstood created a lack of trust to disclose personal information, thoughts, or feelings and habitual processes of self-censorship. Considering the importance of trust and full disclosure within therapy sessions and other psychiatric or physiological screenings, it is concerning that many participants reported difficulty in finding or developing relationships in which they felt comfortable enough to fully disclose to or trust health care providers. These findings could have broad implications for treatment and medication adherence, and utilization of health care services.

Experiences of being misunderstood are not limited to the realm of psychiatric/mental health patients. The majority of people from all walks of life will likely report one or more experiences of feeling misunderstood at some point during their lifetime. It is interesting to find that data from this study revealed parallel experiences with two separate projects that reported or described the experience of being misunderstood from people or patients without a mental illness. Kralik et al. (1997) found that a group of postoperative patients in the hospital experienced depersonalization, being treated like an object, and a lack of attention or compassion from nurses, similar to findings of this study. Condon's (2008) study also revealed similar emotions or experiences of persons who felt misunderstood. Participants of Condon's (2008) study described feelings of frustration, dissatisfaction, sadness, and incompleteness. These negative effects reported from participants who did not experience a mental illness are consistent with the findings from this study. Further research on the experience of being misunderstood is needed; more specifically, with persons without a mental illness in nonpsychiatric settings such as patients in primary care or with patients in nonpsychiatric acute care settings. Unfortunately, further research might find that these nonpsychiatric patient populations may similarly experience being misunderstood by their health care providers.

One limitation of the study was that it was a secondary analysis of existing data. The original interview questions were designed to elicit descriptions of experiences of being understood rather than of being misunderstood. Data would have been enriched if participants had been prompted to elaborate about their experiences of being misunderstood. However, this phenomenological study offers a broad overview

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of incidents of being misunderstood in the provider–patient relationship. A strength of the study is that participants were free to speak of incidents with diverse care providers in both inpatient and outpatient settings. Additionally, previous studies that reported findings of patients who felt misunderstood by their care providers did not focus specifically on describing the experience from the patients' perspective. This study gives voice to detrimental patient experiences that need to be addressed. Because nurses were seldom mentioned by these participants, it would be useful to replicate the study asking specifically about interactions with nurses.

IMPLICATIONS

Jung (1967) viewed the therapeutic relationship as a dialectical process that transforms both parties involved. In other words, it is a participative process in which each individual's existing perceptions and understanding of the other person continuously change (Phillips, 2007). In numerous narratives, patients described health care providers who were "shut off" or unwilling to alter preconceptions of certain diagnoses. They encountered health care providers who used diagnoses to define them as a person, consistent with findings by Lilja, Dahl, and Hellzén (2004). This suggests an unwillingness or inability of the care provider to alter existing rigid understandings of persons with a particular diagnosis and an inability to view the individual as a whole, unique person.

As reported in other research, the findings of this study reflect the mental health patients' desire to be respected and treated as equal human beings (Johansson & Eklund, 2003; Koivisto et al. 2004; Lilja & Hellzén, 2008; Schröder et al., 2006; Vatne & Hoem, 2007). Interestingly, Hem and Heggen (2003) found that psychiatric nurses reported difficult role conflicts when faced with the contradictory demands of being "professional" and being "human." This raises questions surrounding the concept of professional boundaries and their effects on the therapeutic relationship. Vatne and Hoem's (2007) study on acknowledging communication showed that mental health nurses who used self-disclosure of emotions or experiences and emotional listening developed closer, more effective relationships with their clients. This could challenge a cardinal rule in psychiatric/mental health nursing and nursing education: avoid self-disclosure. It is conceivable to suggest that the boundary created by this rule may contribute to the prevention of either understanding patients or allowing them to feel understood by a health care provider. Travelbee (1969) challenged nurses' lack of emotional involvement with their patients and Peplau (1997, p. 164) identified "empathic linkages" as significant in the development of the therapeutic relationship. Perhaps some modern psychiatric/mental health professionals have strayed too far from these concepts and formed a barrier to understanding that results in the prevalence of being misunderstood described by participants in this study.

Vatne and Hoem (2007, p. 695) found that the nurses in their study used the concepts of mutuality ("an inter-subjective sharing of good and bad feelings and beliefs in a respectful way"), validation, self-delimitation, and self-reflection to achieve greater understanding of themselves and their patients. They described these techniques as difficult to use in everyday practice, but their interactions with patients and their work in general became more meaningful. Further investigation is required to evaluate the effectiveness of these techniques in fostering patient feelings of being understood and to prevent patient feelings of being misunderstood.

The findings of this study reveal a pressing need to address abundant patient feelings of being misunderstood and foster greater understanding and acknowledgement of the individual. It is hoped that the findings of this study will further emphasize the importance for caregivers to strive for understanding of their patients—those with and without a mental illness—to prevent the negative consequences of being misunderstood. To understand a person within the therapeutic relationship is a continuous, dynamic exchange of ideas and alterations of preconceptions that transforms both parties. "If we are not transformed by the experience of understanding those we nurse, then we are unable to say we have truly listened" (Phillips, 2007, p. 93).

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