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The Relationship as Possibility and Future Gift in Professional Mental Health Encounters

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Abstract

This article highlights the lived experience of the relationship between the mental health nurse and the patient in institutional treatment. The premise for a relationship between persons in professional settings is the awareness of the responsibility that the relationship is a possibility rather than a tool, and that the relationship is a lived encounter additional to being a factual experience. Any relationship – personal and professional – in this understanding is an action as well as a re-action, as both parties are at mercy of each other and thus they can only partly plan and predict the process and the outcome of their relationship. We explore the relationship between nurse and patient, in terms of the tension between difference and togetherness, and suggest solicitude to be a core quality in mental health relations.

Keywords: Mental health, relationship, lived experience, care, difference, togetherness, solicitude, nurse, nursing.

Introduction

The experience of being ill - of being depressed - is connected with and may depend on relationships. Most important are relationships with family, friends, and colleagues. Next to these close relationships are the professionals within the public or private health system who interact with people with mental health issues. The most common professional on a mental health unit is the mental health nurse. Mental illness can be understood from a psychological or psychiatric perspective and from a medical perspective. These perspectives are subordinated in this study. The question we are interested in is: How is the patient's lived experience of the relationship with the mental health nurse of concern to the nurses' practice and how do mental health nurses think about their practice? We also ask: What relational qualities are particularly significant to the encounter between patient and nurse in the mental health unit? Why?

Ratcliffe (2015) claims that exploring depression experiences might sensitize professionals to relate to the patient with empathy and support. Although the nurse–patient relationship traditionally has been viewed as the essence of mental health nursing practice ever since Hildegard Peplau's book *Interpersonal Relations in Nursing* was first published in 1952, research disputes that the ideals of such a relationship occur intuitively in nursing practice (Moyle, 2003; Cameron, Kapur & Campbell, 2005; Pazargadi et. al. 2015; Hartley, et.al., 2020). Mental health nurses help with issues of suicidality, sleep deprivation, social isolation, nutrition, low self-esteem, personal hygiene and feelings of hopelessness (Moyle, 2003). According to Goethals et al. (2014) nurses, in general, are driven by the ideal of care and the aim of doing good. Nurses consider the patient's dignity, well-being, and quality of care. This means that nurses, in general, are aware of the patient's lifeworld, and thereby consider existential issues (Todres et al., 2007; Haahr et al., 2020). However, findings from a phenomenological study of persons hospitalized with a depressive illness indicates that a therapeutic relationship does not come intuitively to mental health nurses. While the patients hope for and expect a close relationship with nurses, patient experiences were that some nurses wanted a distant relationship (Moyle, 2003). How do we bridge the gap between the ideal of a close and caring professional relationship, a relationship that we believe might come intuitively to practitioners, and the lived abyss between what a patient might hope for and the therapeutic distance that some nurses may seek in the nurse-patient relationship?

Continental philosophy offers a view of human relationship as existential and inherently moral. The Continental tradition understands the human relation as the basis of all community and action (Saevi, 2015, 2021). This understanding is shared by the variety of European philosophical approaches and is expressed in different ways by classic, as well as contemporary, philosophy (see e.g., Arendt 1954, 1958; Buber 1948, 1992; Heidegger 1962; Løgstrup, 1956; Marion 2002; Nietzsche 1974, 1996; Ranciere 1999; Rosa 2019, 2020). The very idea of hermeneutics as the pre-condition of human relationality and action systematized by Gadamer (1975), in the European context, offers a frame for human existence as primordially open to understanding and interpretation.

The professional relationship is commonly about how well the nurse controls and manages the patient's medical and mental condition and healing and is able to distinguish between normal and abnormal psychological or psychiatric progress. Contemporary professional practices consider the human relation to be one of many tools available to the professional to manage a complex and efficient treatment practice (Saevi, 2015). Treatment in our Western culture is closely linked to rational progress and achievement of results and the relationship is considered a means to optimize progress, influence well-being and improve mental health. Systems (e.g., New Public Management (NPM) and Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)) set a strain on hermeneutic existential openness and also the time at hand for the nurse to discover and work on significant relational qualities (Horwitz & Wakefield, 2007; Jakobsen & Lind, 2022). In this discourse the patient as well as the nurse tend to become objects of care and progress and are evaluated to the degree that they adapt to the norms and regulations set by the system. The relation might thus become a means to detect problems *with* and *in* the patient that need to be attended to, corrected or diagnosed. Accordingly, patients are being compared to psychological standards and defined by a diagnosis, rather than

understood in their uniqueness and difference to others. Instead, they may be judged by their fit, or not, to status quo scientific knowledge.

In contrast, the relationality we highlight in this paper might be recognized in relational moments without an epistemological purpose as its first premise. We look for patient descriptions of episodes where professional relationships inhere existential qualities that are revealed directly or indirectly, or episodes where existential qualities are needed but missing. We are interested in how the patient's lived experience of the relationship with the mental health nurse is of concern to the nurses' practice and how the nurse thinks about their practice. We also ask: What relational qualities are particularly significant to the encounter between patient and nurse in the mental health unit? And why? In the first section we present the problem, expressed as the difference between a diagnostically oriented relationship and an existential relationship without a particular end. In the following sections, we reflect on the condition for adding another understanding of the relationship to mental health treatment reality in Western institutions. We present short examples offered by patients through which we hope to show that an experiential and existentially based relational practice might provide other possibilities than the epistemological premises foregrounded today.

Tensions in Nursing Practice – Naming the Problem

According to Prokofieva, Evmorfia,and Diekos (2016) mental health nurses struggle with lack of time, authority and competence in meeting patients' different needs. Hartley et al. (2020) state that the evidence base is lacking for ways to support nursing staff to develop and maintain good therapeutic relationships. Sharac et al. (2010) reviewed 13 relevant studies that measured nursing and patient activity and interactions on psychiatric inpatient wards. Most of the studies used observational methods, and found that, at best, 50% of staff's time was spent in contact with patients. Very little time, however, was spent delivering therapeutic activities (Sharac et al., 2010). More recently, and in keeping with the above, Goulter, Kavanagh & Gardner (2015) aimed to measure the activities of nurses. Through observational studies in mental health settings, they found that 32% of nurses´ time was spent on direct care; 17% on service-related activity and 51% on indirect care, where documentation scored as one of the most frequent activities. According to these findings it seems that nursing time in mental health settings at best is fragmented and only to some degree utilized for the care of the patient. Contextual realities, competing demands and deficiently defined professional identity are impeding good nursing practice, and the relationship between patient and nurse might suffer (Goulter, Kavanagh & Gardner, 2015). These findings correlate with Cameron et al. (2005) and Gamble (2006), who found available evidence within mental health practice, particularly on acute inpatient wards that a disproportionate amount of nursing time is taken up by administration, coordination, and managerial activities, with little time spent listening and talking to patients. Holm & Severinsson (2014) stress that there is also a tension in nursing practice of knowing the "right thing to do but experiencing institutional or other constraints making it difficult to pursue the desired course of action" (p. 403). Paradoxically, the development of a therapeutic relationship requires the nurse to "be with", spending time, and working collaboratively with the patient. Rooney (2009) suggests that not only is the time nurses spend with patients unique due to the quantity of

that time, but also that the quality might differ from that of other professionals. A trusting nurse-patient relationship is key, and it is a necessity to re-establish the nurses' availability, he states. Sercu (2015) calls the current situation in mental health nursing an identity crisis, related to and entangled with nurses' troublesome relationship with the contemporary acknowledged medical model of care.

The above presentation of relevant research results indicates tensions between varying ideals, ways of acting, and claims in mental health settings, and may serve as a backdrop for an exploration of how patients' lived relationality might speak to mental health practice and understanding. Yet, in this paper we ask for more than the nurse to be available and to know the right thing to do. We will argue that nothing less than a sense of togetherness and solicitude is required. Togetherness rests on a relationship that exists in the tension between the advantage and the suffering of being in the world with others. Patients and nurses alike are subject to a relationship that might offer support, relief and success, but also misapprehension, indifference, resentment, and even hostility. This sense of togetherness balances with existential difference and seems not to be possible without each party's sense of existential detachedness and freedom. Solicitude signifies a relationship of a certain uneasiness and even anxiety from the part of the professional[i]. A tension is also required here between a certain suspension or hesitation of action and the provision of care for the other. Lived relationality orients to corporal, spatial and temporal aspects of the experience of self, other and the world around us, and to what *is* rather than to what ought or ideally should be done or obtained. Phenomenological knowledge, as in this study, is existential and thus situated, embodied and sensed rather than general, theoretical and conceptual. As phenomenology is not an empirical analytic science deriving empirical knowledge inductively, the attempt is not a socio-realistic explication of professional approaches to mental health patients, or a critical analysis of how mental health patients should be treated according to juridical claims of empowerment or civil rights. Our aim is to describe and interpret phenomenologically the lived relationality between patient and nurse in mental health settings from the experienced reality of patients.

A Methodology of Examples

Methodically we explore existential core aspects of patient-nurse relationships in a hermeneutic phenomenological way by questioning the meaning of patients' expressions from qualitative interviews. The clinical data in this study were derived from interviews from a qualitative research project with 13 patients suffering from moderate depression, and 5 former patients who had been going through depression. The data were then organized into lived experience examples as a foundation for phenomenological reflection about the nurse-patient relationship, and an inquiry into the experience of togetherness. The interviews were captured as tape-recorded conversations. One of the authors (MBL) interviewed the patients at the District Psychiatric Center (DPS) where they received their treatment, using questions like: Can you tell me about your experiences of being a receiver of health care? Other questions were: Can you recall a health care situation that you perceive as having been especially good in your case? Why was this situation perceived as good?

The existential phenomenological meaning structures (van Manen, 1997, 2014) of the phenomenon of lived relationality orient to experiences of life as lived and lived through, rather than orient to, for instance, sociological labels or political welfare system terminology. Our interest is to interpret, with the help of a philosophical and quotidian language, the implicit meaning of concrete human experience provided by patients currently or recently in institutional mental health care, in a way that establishes contact between the uniqueness and the universality of the phenomenon. When we emphasize practice, and not theory, it is not to leave out theory, but to let significant theoretical aspects emerge as deeply influential of relational practices from the concrete encounter between patient and nurse. This indicates that experiencing something is not synonymous with reflective knowing. The experiential accounts from patients thus are moments of pre-reflective experience that are verbally expressed in the interviews. Even though nurses have professional knowledge about depressed patients, subjects and nursing practices, cognitive knowledge is secondary to the experience of encountering patients. Thus, also nurses' seeing and being are immediate, sensed and embodied lived experiences that are prior to reflective knowledge. In this paper we orient to patients' experience and to their descriptions of events with relational meaning. Seamon (2017) provides a helpful distinction between our two intertwined approaches: phenomenology and hermeneutics, by saying: "For phenomenology the aim is a more accurate, comprehensive knowledge of human *experience*; for hermeneutics, the aim is a more accurate, comprehensive knowledge of human *meaning* (p. 67) (emphasis added).

Human lived-through experience is our way to encounter the world and to make experiential sense of what our senses sense. Patients and former patients, like other human beings are in the world in their own way and make sense of situations and relationships they are in. Every way of being in the world is a way of knowing it and knowing the world always is primary, from my subjective perspective. The meaning we attach to events and encounters is related to how we sense and understand what we experience in cognitive as well as in non-cognitive ways. Experience and search for meaning happen continually and simultaneously and are understood by Gadamer (1975) as the human way of being in the world. Seamon continues: "What the two approaches [phenomenology and hermeneutics] have in common is, first, an emphasis on qualitative description and interpretation; and second, a recognition that knowledge of experience and meaning is inexhaustible" (2017, p. 67).

The direct and original contact with the phenomenon of interest can, as Merleau-Ponty (2002) emphasizes, be experienced only as immediate moments of lived meaning or meaningfulness as understanding or comprehension of those particular experiences. The patients describe their moments of experience and we as researchers try to understand what their accounts might mean experientially as descriptions of their subjective existence in that moment. As methodologically trained phenomenologists we employ the phenomenological reduction as our method to reveal essential aspects of meaning that belong to the phenomena of our lifeworld; e.g. the distinctive qualities of the phenomenon of lived relationship between the patient and the nurse s/he encounters. The pre-reflectivity of any moment is not fully attainable, of course, as the moment of the experience is always 'gone' before the time of reflection. The lived moment can only be incompletely regained in memory and language. The fluidity of the now is our common condition as human beings and as phenomenological and other methodology researchers.

Yet, another dilemma of research is that the researcher is not socially and culturally in the same lifeworld and lived circumstances as the participant. The experiential dilemma that all human beings are in the world in different ways, is the basic rationale of phenomenology and is the limitation we must relate to in each analysis and meaning search in the projects we do. Phenomenology though, by way of reduction, aims at regaining the experience as closely as possible to how it was in the moment of experience for the person having that experience, rather than trying to conceptualize or theorize about a situation. The concrete examples in the text are a special kind of narrative that are used as a methodical device in human science, and they aim at capturing experiences that easily elude us. We consider our patient accounts of momentary experience to have a pragmatic value as concrete connected descriptions of relational moments. The examples help our understanding of how lifeworld experience is connected to relevant theoretical and conceptual perspectives but without being interpreted through theory and conceptualization. In phenomenology the lived experience is where any research approach starts and ends. In the context of this study, the encounter between the patient and the nurse is being described, and the description is interpreted, although insufficiently and incompletely, as Seamon (2017) asserts above. Each encounter is contextually bound to a situation loaded with relational possibilities although always potential and not simply offering positive answers or results. The quality of the relational experience can be diverse and the exploration of the experience by nature is inconclusive. Van Manen asserts that "the paradoxical thing about anecdotal narrative is that it tells something particular while really addressing the general or the universal," (1997, p. 120).

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Illness, Convention and Sameness

The state of being ill comes with many problems for the person befallen. One problem is the felt distinction between being ill and being healthy, another the possibility of getting well or staying chronically ill. Still another distinction is between being physically ill and mentally ill. Common for all kinds of illness is the experience of change in the person's life when they are struck by illness. There is a fundamental difference between the patient and the nurse related to the fact that in the moment of their encounter, one is sick and the other is healthy. This difference does not only have consequences for their respective parts as professional and patient, but more importantly for their existence in the world, which is the very condition for their roles and tasks. A life with ordinary qualities such as getting up in the morning, starting the day by habitual routines like eating breakfast and going to work, are commonly seen as a footing for a good life. When being ill and hospitalized personal routines are challenged and invaded by institutional routines and perhaps also well-intentioned advice from professionals. Alfred, a man who is admitted to a mental health hospital with severe depression, describes waking up at the ward one morning feeling heavy-headed, tired and sad. He decides to skip breakfast. As he is lying in bed a nurse knocks on the door and walks in while saying:

> You should get up and get something out of the day. Take a shower, eat breakfast, go for a walk, talk with someone about what bothers you, eat some more, read the newspaper - do something.

The nurse's trained eye may see the pain the depression causes, and she relates this to why Alfred is staying in bed and appears to conclude with this advice. Sometimes advice works. But not in this case. The nurse might not really believe that her advice will change Alfred's wish to stay in bed, but still she offers it. We believe that most nurses know or have a qualified sense of relationality because of their competence, care and experience of what is best for a patient, often despite what the patient thinks is best at the time. A nurse, however, might also relate routinely to their shared presence and want to normalize by getting the patient on what is considered the track of recovery. Heidegger (1962) describes routines and habitual practices as a leveling down of practice by living under the force of habit. We expect certain and reject other behaviors from ourselves and others concretely and mentally. Commonly, mental health nurses try to help patients discover possibilities and take part in "ordinary life", like this nurse does. But in this case, an "ordinary" life does not appeal to the patient. Ordinary life, at least partly, is built on social conventions and common agreements of conduct, manners and ways of being and doing. These habitual ways over time become incarnated in our body, senses and movements and somehow come to reside outside our intentional actions. As conventions are part and parcel of our relational life, including our professional life, they are basically non-reflective and unintended. Despite most mental health nurses' initial focus on the significance of basic needs and activity, they themselves do not escape the swaddle of convention. Conventions develop for cultural and social reasons, in past and present within traditions and sub-traditions, and are part of our belonging to a particular culture, including a mental health treatment culture. Like social norms and routines, conventions smoothly protect our relationships by rendering them unheeded and easy, qualities that would have solved the problem if the patient in the situation above had followed the advice. Løgstrup (1997) offers an inherent critique of social conventions as they often cover up our ability to respond receptively, because "we are usually able to conform to these directives without even having to consider the other person, much less take care of his [or her] life" (p. 58).

An interesting and paradoxical aspect is that the domination of others – which is not necessarily due to any suppression – also frees the person from the burden of being himself. Somehow the other, or what Heidegger calls the "they" (1962, p. 164), represents the average mediocre and distant other, who on the one hand includes and unburdens the person from being solely responsible for his life, and on the other hand deprives him his possibility of the same. A routine, much in the same way as the "they," hides in the unreflective or pre-reflective twilight zone of action, and is not aware of the particular event it takes place in, because it is meant for average and distant all-purpose situations. Conventions thus are hidden to us in the very act of being performed, and at the same time they influence our being and acting regularly and profoundly.

In the situation above, we might ask how the professional listens to the moment. Is the voice of Alfred 'audible' to her? How can professionals respond to the 'call' of patients from within the conventional condition, the hubbubs and "theys" of life they (both) are unavoidably ensnared in? Authenticity in the professional relation is significant, and a

quality that Sercu (2015) and others refer to as a key part of the nursing identity. Without authentic encounters between an I and a you they fear we face a crisis in human professional practices. Existential authenticity, however, in Heideggerian terms, is a quality seriously threatened by routines and conventions, personal as well as institutional. The challenge of authenticity in human relationships is that this quality has a certain evasiveness affiliated and thus should be considered a guiding star rather than a goal in nurse-patient relations. As in most qualities of human existence, we do not master authenticity, like we do not control what Løgstrup calls "sovereign expressions of life" (Løgstrup 1997, p. 113). Expressions of life, like authenticity we believe, cannot be applied to a situation by me, but "can only be realized as I realize myself in it," (Løgstrup 2020, p. 53). A situation where a specific conventionally or "they"-oriented behavior is anticipated is a demand of sameness, conformity and the ruling order of things. Thus, in their very quality, conventions and routines are in tension with personal, diversified and authentic relational experiences.

Subject to Sameness

A call for sameness and conformity, rather than recognition of authenticity and difference, is also underlying Sartre's awareness of "the look of the other" and how this look robs us of our subjective self (2018, p. 354-366). By falling into habitual routines and conventional conditions, the nurse above, unintentionally denies Alfred the space of personal self. Rather than being protected by her trust in him he is exposed to her disapproving look. Sartre's look adds another dimension to conventional acts by personalizing them with a *you* that robs the *I* of its sense of self. When realizing that he is observed and evaluated, the patient becomes aware of himself as an object "closed in, circumscribed and constricted (…) and [he] become[s] slave for the look of the other" (p. 364-365). This object, which is myself in the eyes of the other, suddenly becomes recognizable to me. Instead of being unburdened from myself, the other's look makes me feel judged, embarrassed or ashamed for who I am. I am exposed to my negative dispositions, and where I "find myself" is sensed through the glance of the other. The other might attach little or no significance to the intervention in the other's self, but I am subject to the look and surrendered to the other's judgement, or so I feel. The comment of the nurse above may, despite being a convention or a consideration, have subjected Alfred to his incapability, and to his felt awkwardness of mental illness. Rather than being unaware of his self he, for a moment is being subjected to who he is not (a normal person) and to what he is not capable of. Sartre points to our experiential sense of self that cannot "perceive the world and at the same time apprehend a look fastened upon us" (p. 258), and we realize that the nurse's innocent comment might take away Alfred from his daily world. His personal agency is disturbed, and he becomes more aware of *what* he is than of *who* he is. The nurse disturbs the self of the patient in at least two ways: she subjects him to his mental illness, and the comment objectifies him and robs him of his own agency. How would the situation be different if Alfred's own seeing, knowing and doing were their common orientation?

Those who have Nothing in Common

Van den Berg (1972) points to a significant difference between the nurse and the patient regarding their relationship to the illness itself. While the illness is a fact to the nurse, something she is trained to encounter and encounters on a daily basis as a professional, illness, to the patient, is something unwanted, strange, perhaps even degrading, and not least, it is personal and subjectively sensed and felt. The patient *lives* the illness in addition to thinking of it. While the patient first and foremost knows illness as a life condition, typically the nurse treats illness and knows a lot about it professionally. Having theoretical or practical knowledge about something, according to Levinas (1998), is secondary to "knowing" it as a state of life. He phrases this insight as a human truth: "To understand our situation in reality is not to define it, but to be in an affective state. To understand being is to exist" (p. 3). Thus, a relevant question is whose existence provides the true understanding of illness? *Being* ill and *having* professional knowledge about this illness are two different phenomena. The nurse commonly knows the patient's condition from theory, evidence and from treatment of other patients. The patient, however, might also know his illness from theory and former treatments, but first and foremost the illness belongs to his or her body, self, experience and lifeworld, and is sensed in a lot of ways inaccessible and invisible to others, including the nurse[ii]. His suffering is a state of being that does not become a routine. What do these differences mean in terms of individuality and relationality? Do they form an insurmountable contrast that makes relationality, or even more, togetherness, just a futile ideal?

The existential difference between the patient and the nurse is the difference in how they live their worlds, a difference that cannot be overcome, but only encountered. A patient, like the well-known author Sylvia Plath in her only novel *The Bell Jar* (1963), describes mental illness as a glass-wall between herself and others. Behind the glass-wall she looks at life but is unable to take part. She is alone, the one solitarily living her illness. To her, normal life is far away. Other people, even those closest to her, are unreachable. Every serious illness represents a halt in a person's life, as life as we know it comes to an end. What comes after is uncertain, and perhaps also unimportant to the present. Another of our participants, Arnie, was asked what he thought about his future, and he reflected:

> *I suppose I am supposed to get on with my life. Strange sentence, indeed. I do live all the time, still I say I will have to get on with my life.*

What does it mean to get on with one's life while one is subject to time every moment of it? Life goes on even though I do nothing or something. Arnie's comment might be ironic of what he is supposed to feel but does not feel. He marvels at life as such and at the demand he experiences (in himself as well as from others) to get on and improve his life. Van den Berg (1972) proposes: "just because access to normal healthy life is barred, this life urges itself upon [us]" (p. 39). Illness somehow makes us feel that the present becomes the unwanted limit, and our future becomes unclear and blurred, although life as a fact, continues.

Where to Find Oneself

Bollnow (1989) points to an often disregarded, quality in human relationships that seems to be lacking in the exploration of the every-day-situation where the patient is urged to

get up and start the day. Well-intended advice from someone assumes something present in the other that somehow is oriented to change and directly or indirectly asks for relational support. The other must be ready for my advice or intended help. To get on with one's life, like the patient above assumes is the point for him, is also something one must be ready for. This readiness is rarely a conscious state for the human being or for the professional and the patient in our examples. In fact, being ready for change is less a cognitive question than a question of context and atmosphere and of hitting the right time, according to Bollnow. He writes: "Readiness […] is definitely not rooted in the intellect; rather it is founded on the deeper and therefore much more securely progressive spirit of a morning-like atmosphere" (1989, p. 21). Here Bollnow (1989) points to the experience that human change and development cannot be externally forced on another person. Rather, there is a possibility in every relationship that a sense of awakening and renewing might reverberate with the other's sense of self. The patient did not ask the nurse for advice, at least not there and then, and not in a verbal manner. The nurse put her faith in the patient's rationality, but rationality is not always the best motivation for change. Likely both patients in the accounts above are acutely aware of their lack of normal conduct and their disappointment in themselves might be strong. Could the professional have taken better care of their potential experience of self, as Heidegger suggests, by being aware of how a patient might find him or herself in the moment of their encounter? Each moment in life is a moment of what Heidegger calls "Befindlichkeit", or finding oneself somewhere (1962, p. 176). The mood or atmosphere is not something outwards of us but is immersed and even incarnated in how we sense ourselves each moment. Our body is "a nexus to living meanings, not the law for a certain number of covariant terms," Merleau-Ponty writes (2002a, p. 175). Our lived self is *first* and foremost a lived–through meaning, a coherent unit, the very link between me, others and the world, *then* encumbered with a diagnosis or a state of illness, being it physical or mental. Merleau-Ponty further indicates in his working notes at the end of his unfinished book *The visible and the invisible* (2002b), that the experience of our body, the world and our sense of self are simultaneous (p. 250). The patients as well as the nurses, and all persons, mentally ill or not, experience their selves as inseparable and instantaneous beings. This means that *being someone* is prior to having a diagnosis or an illness.

The Community of Difference

Amelie has long experience as a patient at a mental health hospital. She confides in the health care workers to help her and trusts that the setting is safe. She says:

> In treatment the setting is provided. The other is a nurse, and I am the patient. She takes care of the surroundings. I can trust that what happens is within a safe framework. It is like in school; teachers must be fond of all children not only the successful ones.

The nurse and the patient have different tasks and roles, and to Amelie this is a safe and comforting dispersion of parts, and a situation that implies difference and respect for differences. The allegory to pedagogical situations and teachers' love is striking but perhaps slightly out of place, as a child and a grown patient are not necessarily

comparable, although when it comes to general care and equity in professional settings, we see her point. The situation offers an aspect of the lived professional relationship that clearly places difference as a precondition for the relationship. This aspect is supported by Levinas' understanding of the individual person - the 'I' and the 'other' - as entities that do not correspond to each other. There is no other concept that corresponds to the 'I' as a human being. "The experience of the Other cannot be obtained by simple "variation" of oneself and the projection of one of those variants outside of oneself" (Levinas 1998, p. 26). Amelie trusts that she and her condition are encountered from a position outside of the nurse, a position that allows her a distinction from the nurse. The other is not the same as me, but "is encounterable," Heidegger says (1962, p. 88). The other inhabits his or her own being in the encounter, and should not be confused with routines, conventions or someone writing the script for both. However, if it is true that difference comes from life rather than from roles as patient and professional, the other, as Levinas asserts, is an "irreplaceable singularity" (1998, p. 27). Then if the irreplaceable *I* is replaced by assumed knowledge of that which is foreign, the otherness or difference does not remain fundamental but becomes appropriated by the other. In a situation like this the professional tends to conclude quickly about the other, and a certain hesitation in or suspension of action might not happen. Lippitz (2007, p. 84) adds another problem:

> It [the other] ceases to be something that is unknown, even its foreignness, and becomes a part of reflexive consciousness. The initial difference between the self and the other, the starting point of the self and the knowledge of the other, is effectively erased. It disappears in the sameness of reflection. The other and the foreign are figures of passage, not inseparable barriers to thought and understanding.

Lippitz asserts along with Levinas that, "A constituent part of ethics is the absolute separation between myself and the Other. Heterogeneity, not unity and reciprocity, is the characteristic of the ethical situation. In this situation I, as the only subject, am irreplaceable" (1990, p. 50). The patient must enact his or her *I* because this is the very thing that the nurse cannot do. This, however, does not tell either the patient or the nurse what to do with their respective I's or subjective selves. We cannot draw from Levinas a moral conclusion about how and what to do, initiate or respond. So, what is the practical use of heterogeneity and the irreplaceable *I*?

Lippitz says that the constitution of the intersubjective ethical relation is heterogeneous "for it assumes the radical separation of the interacting parties and thus acknowledges their respective uniqueness and otherness" (1990, p. 51). The *I* is a required distinction to the patient as well as the nurse, to establish a relation that neither provides care as routine for the many, where 'they' and their needs are known beforehand, nor erases the difference that presupposes an existential relationship. Thus, the condition of willed care for the other constitutes a situation of direct coexistence and a possible sense of togetherness between me and the other. In this situation the other remains other, unique and existentially unknown to me. Routines and taken-for-grantedness on the other hand, prevent an encounter of interest and curiosity of who the other truly is. Yet, how can a relation that demands radical separation rather than unity and reciprocity as its starting point be a relation of lived togetherness?

The Touch of Worlds

Løgstrup (2020, p. 16) suggests that in any encounter we form each other's world and future possibilities a little or a lot, by holding one another's lives in our hands. By addressing one another in encounters – such as in a conversation between two persons in a professional mental health setting – we, at the same time, although often unarticulated, trustfully ask the other to accept us. This request of acceptance is basic for the relationship although it most often is without words or conscious appeal. As Lingis claims, "We attach to someone whose words or whose movements we do not understand, whose reasons or motives we do not see" (2004, p. ix). The other might disturb our life a little or more profoundly and deprive us of our plans and future, and moments of unsettledness and unease might be the case in personal as well as professional encounters. We are left momentarily or lastingly touched by the other's condition. But the touch of worlds, what is it in fact? How does it look? How long does it last?

Van den Berg in his essay 'The conversation' (1953) shares a story about the poet Alfred Tennyson visiting the philosopher Thomas Carlyle on a winter afternoon. They sit by the fireplace the entire evening without exchanging a word. When Tennyson gets on his feet to leave, Carlyle thanks him for a great evening and asks him to come back very soon. Van den Berg reflects on how it might be that this relatively long-lasting encounter without a word uttered between them, still have something to do with a conversation. He concludes that a conversation does not first need the realization of words but "a being together" (p. 31) that allows for a conversation to happen. We know from experience that there is a "togetherness which gives our words freedom to be spoken or remain unspoken" he says, (p. 32). These encounters are where we as human beings feel recognized and understood. They are moments of possibility for contact, relationality and conversation, and might be what a sense of togetherness actually is about.

The sense of togetherness might not be long-lasting and perhaps is a rare experience to us in personal as well as professional encounters. More commonly we might feel a flash of closeness or the opposite, no contact. Perhaps more frequently in formal or directed conversations we feel the distance between us. We sense the conversation as an exercise in responding correctly (for the patient), and for the professional to check that important directives and information are understood and complied with. But despite a formal and potentially authoritative interaction trust might happen and a touch of worlds transpire. In human life we relate to each other and are bound "to surrender something of ourselves to the other person either by trusting him or her or asking for his or her trust" (Løgstrup 2020, p. 19). This is the precondition also for every encounter between patient and nurse, and although trust generally goes unrecognized, a touch of worlds might happen.

Meeting Each Other

Being concerned, according to Heidegger (1962), is to be in the world in a fascinated way. Fascination is a noun of action that indicates attention and attraction to someone or something[iii]. A mental health nurse might be fascinated by the possibilities of treatment of the intricacies of illness or of how patients recover and get back to health. But it takes

a certain closeness to the experience (one's own and the other person's) to be existentially stirred by the other and his or her lifeworld. The mode of being in the world in a concerned and attentive way is to encounter the experience as well as the person, with an attitude of "tarrying along" with the other, as Heidegger says (1962, p. 88). The mutual encounter is a being there, dwelling *with* rather than an attempt to achieve something from the other or the situation. Solicitude might seep through the action of professional camouflaged as hesitation, concern and a certain uneasiness on behalf of the other. Professional practice, like other practices, always is inherently intentional in terms of having its own understanding of, and often a particular plan for, the situation. Someone could intend to handle the other and determine the outcome of the situation, or on the contrary, wish to keep back from controlling or possessing the other. A fascinated concern for the other and his or her experience, however, demands a dwelling or tarrying along with, yet without taking away the other's possibility for an authentic being (p. 344). As both persons exist by residing and habituating their own being or *I*, the dwelling is no closer than being together. The interesting thing is that the first-person existent 'I am' means 'I reside' or 'I dwell' alongside the world, Heidegger reveals (1962, p. 80). The awareness that a certain distance is required in every suspension of action as well as in every sense of togetherness actualizes the question *how* we dwell with each other in professional relationships. One informant describes her idea of an ideal patient-nurse relationship with these words:

> *I must feel trust in her, believe in her. I must have the sense that she is present with me. Not secretly looking at the watch. And she must ask questions. Be interested in my world.*

Presence has many appearances. A dwelling presence has a certain hesitative quality that lets oneself and the other reside in time and space. If in the presence of each other one of the parties acts fast and is doing a lot, the atmosphere of haste might make *being* difficult for both. While dwelling is hesitant by nature and allows one's senses to speak, and as an act responds to the situation, being in a rush leaves little awareness and accordingly is a lack of respect for what appears. Interestingly, the term 'interest' (in the patient's account) stems from Latin *inter,* which means in the middle of, and *es*t from the verb to be[iv]. Inter-est thus indicates a condition of being in the midst of something that *is*. In other words, interest means being attentive to someone or something in such a way that one is engrossed in presence. Being interested in the other's life and condition is a relational quality of solicitude that might or might not include active action but always is concerned with the uniqueness of the other.

There are moments when something is more important to one of the parties than to the other. Perhaps the qualities of presence and interest in the moment described above are more significant to the patient than to the nurse. Moreover, sharing space with someone does not mean that one could not say or do something awkward or foolish. Perplexity, misunderstandings or reluctance happen and will always happen to human encounters. The thing though, is not to make or not make mistakes, but rather for the professional to try to feel what the shared moment is, and perhaps more important, to try to attune to what the experience of the moment is for oneself and for the other. A moment of togetherness is not a moment where the two parties (should) feel the same but where they

are aware of difference and uniqueness and acceptingly sense the fragility and givenness of the situation.

The patient cited above wishes that the nurse is interested in her world. One might wonder what "my" world means in a situation like this? My world is not necessarily my private world, which might be inaccessible to others, but could also be my experience of our common world. How I experience the world, my lifeworld, according to Heidegger (1962) is the one-and-only-way through which humans have access to our shared world. This is especially so when someone tells us things that are difficult for them to admit, and when it would be easy to rush to conclusions. There is a demand to us, in personal and professional encounters to meet *each other* rather than to meet others. What does to meet each other imply, and how does the difference between meeting each-other and meeting others look?

Relation as a Gift

The look of the other, if it is attentive and interested, might render us open and trustful. A look might indeed be a burden like Sartre suggests, but can also offer relief to the one being looked at. The look might be receptive to something in the other; joy and hope, or despair, helplessness or suffering. Receptivity is a kind of hesitation on behalf of the other, a dwelling that allows the other to be. Receptivity is passive, van Manen (2002) reminds us, and thereby receptivity is the ability of being "sensitive to pathos" (p. 250). The Greek term *pathos* means suffering, feelings, calamity, or simply that which befalls one.[v] Passivity and receptivity are not commonly valued today compared to the opposite, reflective action. Contrary to what we tend to believe, reflection does not imply refraining from immediate action, but is closely linked with action. But while activity presupposes an agent, passivity is "purely passionate" (p. 251), and the person for a moment forgets who he or she is and becomes immersed in the life of the other. The person is touched by a different world that in a profound way might alter him or her. In the following quote Helen describes the opening dialogue with a nurse when she was admitted as a patient to the same mental health hospital for the fifth time in two years. This encounter, she explains, was the first time she felt like being someone and not just a generalized patient.

> *I remember her looking at me. Not like staring, but being attentive, maybe even curious. So, she said, where were you born? She had warmth in her voice, though she didn't say much. I don't know how long we stayed there. But what I do know is that this unfamiliar meeting room, together with her, became my home for that moment of time.*

Although the world always is something I share with others, the world is lived by me and is "in each case mine," Heidegger says (1962, p. 150). The distinct otherness of the other might so easily be overlooked, in this case by the professional. The nurse described however, seems to be stepping back and listening receptively. She does not perform much activity and listens more than she speaks. By her question she seems to "exercise a certain blindness to conventional practices" (Saevi, 2021, p. 100) and somehow gently hits an existential core with Helen. She is "receptive (in contrast to intentional) and

passive (in contrast to active) toward the world" (p. 104), and by this, she allows Helen's world to be intact and inviolable. She seems touched by what she encounters and to be a subject among the other subjects of the world, rather than a professional oriented to detecting problems or illness in a patient. Somehow, the nurse opens a progressive mood, an atmosphere of hope and relief to the event. The moment allows for mutual openness and togetherness to happen. Helen uses the word curious, a term that stems from the Latin word *cura,* which means care[vi]. Curiosity thus connotes not only to a bad sense of inquisitive attitude, but also to the requirement of diligent care. Careful, eager inquiry is akin to caring for someone and to be interested in their life and the circumstances they live under. The nurse above opens a possibility for the patient to become transparent to herself and paradoxically also helps her to free herself from any suppressive treatment given. Care expresses itself in the simplicity of a few interested words that seems to create a curative atmosphere. The patient in a simple question is given room to wake up to her own experience of where she comes from and who she is.

What the professional in fact does by her receptive passivity is what Heidegger calls "leaping-ahead" (Heidegger 1962, p. 158). Leaping-ahead is a kind of worrying care that Heidegger calls "solicitude" (p. 157), which in this case is a "care" that is given back to the patient, who is not a case or project with which the professional is concerned, but a human being who is other and, in each case, his or her own. The professional leaps ahead of herself as well as of the patient by awakening them both to who they *are* rather than to their professional *roles*. Along with the patient, the nurse is in a dialogue with existence and here existence (in contrast to how we commonly think) means 'ex-istence[vii]', e.g. I am addressed by what stands in front of me; our reality and my possibilities. The nurse is addressed by the patient as Other. She is fascinated, interested, curious and thus helps to free the *I* of the patient and gives it back for her own disposal.

Existential moments might open for the unforeseen and unpredictable where everything can happen with what has already happened in the past. A patient-nurse relationship that is open to the unpredictable, situated and existential, requires a restraint of will and aim with the relationship, to make room for what may arise from the other and the relationship itself. This unreserved intention means letting go of the predominant control in the relationship, the habitual routine or, as Hannah Arendt (1963) puts it, refrain from slipping into banality. What we learn from Arendt is to try to avoid interpreting or acting according to a specific pattern, as a general action that should be considered correct in every situation. Rather, we should strive to see and act on the special characteristics and unique possibilities of the situation. By attending to the concrete situation at hand, encounters and relationality are risky and courageous. Whatever we do in a relationship to another person there is the risk that it might not be the right, the best or the most effective, and the outcome of the relationship might fail immediately, later or in the future. The existential relationship differs from conventional treatment relationships in that it may offer something that none of the parties could think of, foresee or imagine.

Concluding Concerns

Examining relationality as an everyday professional, interpersonal, and thus moral phenomenon, reveals existential meanings that may be helpful for practice. By bringing

lived experiences into the foreground, relationality appears to be a phenomenon that does not let itself be used to promote specific outcomes. Preplanned models, programs or agreements of treatment relations should be recognized as, in themselves, potentially caring, but not enough as such for the lived relationship of togetherness and solicitude to be experienced by the patient. The starting point for the article, and the phenomenological exploration it entails, was our wondering about whether and how experience of relationality and a sense of togetherness were in patients' minds and hopes. If so, some ways of encountering patients in mental health settings were crucial to influence and shape the patients' sense of lived relationality. In that case, these are of some concern to professional practice. Our study might add a dimension to the current discourse about nursing in mental health contexts and in direct care for patients. We offer a critical view on how seemingly paradoxical experiences like the patients' sense of togetherness with the professional, and the professionals' will and ability to encounter him or her as a foreigner with possibilities, as if for the first time, with interest and fascination, but also with a certain unease and worry on behalf of the other, are crucial for the sense of self of the patient. A nurse in mental health contexts can do so very much for and with the patient. The very thing that the nurse cannot do for the patient is to enact his or her subjectness, his or her *I*. Socially constructed norms and conventions, politically determined codes and arrangements and current research findings potentially result in good but are not always enough to lead to human experience of self, others and the world. Lingis (1994) writes:

> We appeal to the others to help us be at home in the desert, in the rain forest, in the tropics, in the tundra, and in the ocean. And in childhood, and in the strange nocturnal regions of the erotic, and in the shadow of death *that* advances. (p. 118)

The existential otherness of the patient might easily be overlooked by the nurse, despite obvious differences in tasks and roles, and their profound lived sense of being healthy and ill. To do well in mental health treatment is just an opportunity among many. The patient above tells nothing about a successful result. We might presume that outcome is not at the forefront, while her sense of concerned togetherness is. Lingis (1994) attributes instances such as the one described above as genuine moments of being. What is said is of less importance than the atmosphere or mood of the moment because "the rift between the saying and the said opens up" (Lingis, 1994, p. 109) and the event carries itself meaningfully. Based on our analysis, we argue that some ways of relating are more significantly human and thus supportive to the patient than others. To be attentively addressed by a nurse might hold the possibility for lived togetherness, and a more-than-care involvement, worrying care, solicitous interest or open fascination are all existential ways to encounter another human being. Existence is what we all share, mentally ill or not while our self is the one and only quality we existentially cannot share, ease or undertake for each other.

References

Arendt, H. (1954). *Between past and future*. Penguin Books.

Arendt, H. (1958). *The human condition*. The University of Chicago Press.

Arendt, H. (1963). *Eichmann in Jerusalem. A report on the banality of evil*. Viking Press.

Bollnow, O. F. (1989). The pedagogical atmosphere. *Phenomenology + Pedagogy*, Vol.7. https://doi.org/10.29173/pandp15111

Buber, M. (1948). *The way of man.* Routledge.

Buber, M. (1992). *Jeg og du*. Cappelens Forlag. First published in German in 1923.

Cameron, D., Kapur, R. & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse–patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 12(1), 64-74. https://doi.org/10.1111/j.1365-2850.2004.00796.x

Gadamer, H.-G. (1975). *Truth and Method*. Crossroad.

Gamble, C. (2006). The zoning revolution. *Mental Health Practice*, 10(4), 14-17. https://doi.org/10.7748/mhp2006.12.10.4.14.c7863

Goethals, S., Dierckx de Casterlé, B. & Gastmans, C. (2014). Nurses' ethical reasoning in cases of physical restraint in acute elderly care: a qualitative study. *Medicine, Health Care and Philosophy,* 16(4), 983-991. https://doi.org/10.1007/s11019-012-9455-z

Goulter, N., Kavanagh, D. J. & Gardner, G. (2015). What keeps nurses busy in the mental health setting? *Journal of Psychiatric and Mental Health Nursing*, 22(6), 449-456. https://doi.org/10.1111/jpm.12173

Haahr, A., Norlyk, A., Martinsen, B. & Dreyer, P. (2020). Nurses experiences of ethical dilemmas: A review. *Nursing ethics*, 27(1), 258-272. https://doi.org/10.1177/0969733019832941

Hartley, S., Raphael, J., Lovell, K. & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, 102, 103490. https://doi.org/10.1016/j.ijnurstu.2019.103490

Heidegger, M. (1962) *Being and Time.* Harper San Francisco.

Holm, A. L. & Severinsson, E. (2014). Reflections on the ethical dilemmas involved in promoting self-management. *Nursing Ethics*, 21(4), 402-413. https://doi.org/10.1177/0969733013500806

Horwitz, A. V. & Wakefield, C. J. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Jakobsen, L. M., & Lind, R. (2022). ´ You are not yourself anymore´: The place of the ethical demand in a practical home care context. *Scandinavian Journal of Caring Sciences*. https://doi.org/10.1111/scs.13076

Levinas, E. (1998). *Entre Nous. Thinking of the Other*. Columbia University Press.

Lingis, A. (1994). *The community of those who have nothing in common*. Bloomington and Indianapolis, IN: Indiana University Press.

Lingis, A. (2004). *Trust.* University of Minnesota Press.

Lippitz, W. (1990). Ethics as Limits of Pedagogical Reflection. *Phenomenology + Pedagogy*, Vol. 8/1990, 46-60. https://doi.org/10.29173/pandp15119

Lippitz, W. (2007). Foreigness and Otherness in Pedagogical Contexts. *Phenomenology & Practice*, 1(1), 76-96. https://doi.org/10.29173/pandpr19806

Løgstrup, K. E. (1997). *System og Symbol*. Gyldendal.

Løgstrup, K. E. (2020). *The ethical demand*. Oxford University Press. First published in Danish in 1956.

Marion, J-L. (2002). *Being Given. Toward a phenomenology of givenness*. Stanford University Press.

Merleau-Ponty, M. (2002a). *Phenomenology of Perception*. Routledge Classics. First published in 1945.

Merleau-Ponty, M. (2002b). *The visible and the invisible*. Northwestern University Press.

Moyle W. (2003). Nurse–patient relationship: A dichotomy of expectations. International *Journal of Mental Health Nursing* 12: 103– 9. https://doi.org/10.1046/j.1440-0979.2003.00276.x

Nietzsche, F. (1974) *Thus spoke Zarathustra*. *A book for everyone and no one*. Penguin Books. First published in German in 1883-85

Nietzsche, F.W. (1996). *Human, all too human*. Cambridge University Press. First published in German in 1878-80.

Paley, J. (2000). Heidegger and the ethics of care. *Nursing Philosophy*, *1*(1), 64-75. https://doi.org/10.1046/j.1466-769x.2000.00004.x

Pazargadi, M., Fereidooni Moghadam, M., Fallahi Khoshknab, M., Alijani Renani, H. & Molazem, Z. (2015). The therapeutic relationship in the shadow: Nurses' experiences of barriers to the nurse–patient relationship in the psychiatric ward. *Issues in Mental Health Nursing*, 36(7), 551-557. https://doi.org/10.3109/01612840.2015.1014585

Peplau, H. E. (1988). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. Bloomsbury Publishing. First published in 1952.

Prokofieva, M., Koukia, E. & Dikeos, D. (2016). Mental health nursing in Greece: nursing diagnoses and interventions in major depression. *Issues in Mental Health Nursing*, *37*(8), 556-562. https://doi.org/10.3109/01612840.2016.1169466

Ranciere, J. (1999). *Disagreement. Politics and Philosophy*. University of Minnesota Press.

Ratcliffe, M (2015). *Experiences of depression. A study in phenomenology*. Oxford University Press.

Rooney, C. (2009). The meaning of mental health nurses experience of providing one-to-one observations: a phenomenological study. *Journal of Psychiatric and Mental Health Nursing*, 16(1), 76-86. https://doi.org/10.1111/j.1365-2850.2008.01334.x

Rosa, H. (2019). *Resonance. A sociology of our relationship to the world*. Wiley.

Rosa, H. (2020). *The uncontrollability of the world*. Policy Press.

Saevi, T. (2015). Learning and the pedagogical relation. Scott, D. & Hargreaves, E. (2015). (Eds.). *Sage Handbook of Learning*. Sage, p. 342-351.

Saevi, T. (2021). Reality-testing subjectivity, naivety and freedom – or on the possibility of educational moments. P. Howard, T. Saevi, A. Foran & G. Biesta (Eds.). *Phenomenology and Educational Theory in Conversation. Back to Education Itself.* Routledge, 100-109.

Sartre, J-P. (2018). *Being and Nothingness*. Routledge. First published in 1943.

Seamon, D. (2017). A phenomenological and hermeneutic reading of Rem Koolhaas's Seattle

Central Library Buildings as lifeworlds and architectural texts. R.C. Dalton and C. Hölscher (Eds.). (2017). *Take One Building: Interdisciplinary Research Perspectives of the Seattle Central Library.* Routledge, 67–94.

Sercu, C., Ayala, R. A. & Bracke, P. (2015). How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian Psychiatric Hospitals. *International journal of Nursing Studies*, 52(1), 307-316. https://doi.org/10.1016/j.ijnurstu.2014.07.017

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A. & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: a literature review. *International Journal of Nursing Studies*, 47(7), 909-917. https://doi.org/10.1016/j.ijnurstu.2010.03.012

Todres, L., Galvin, K. & Dahlberg, K. (2007). Lifeworld-led healthcare: revisiting a humanising philosophy that integrates emerging trends. *Medicine, Health care and Philosophy*, 10(1), 53-63. https://doi.org/10.1007/s11019-006-9012-8

Van den Berg, J.H. (1953). The Conversation [Het Gesprek]. Van Manen, M.A & van Manen, M. (2021). (Eds.). *Classic Writings for a Phenomenology of Practice*. Routledge, 31-46.

Van den Berg, J. H. (1972). *A different existence: Principles of phenomenological psychopathology.* Duquesne University Press.

Van Manen, M. (1997). *Researching lived experience*. The Althouse Press.

Van Manen, M. (2002). *Writing in the Dark*. The Althouse Press.

Van Manen, M. (2014). *Phenomenology of Practice. Meaning-giving methods in phenomenological research and writing*. Left Coast Press.

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[i] Etymonline.com/solicitude

[ii] The relationship may shift if the nurse has experience with the illness or struggles with depression her/himself.

[iii] Etymonline.com/fascination

[iv] Etymonline.com/interest

[v] Etymonline.com/pathos

[vi] Etymonline.com/curious

[vii] Etymonline.com/existence