

Ward atmospheres of horror and healing: a comparative analysis of narrative

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ABSTRACT Aspects of a social setting profoundly influence personal experience in the setting. The purpose of our study was to further understand the phenomenon of ward atmosphere through a detailed case study. One narrator describes and contrasts two ward experiences, one where she lost her mother through death, and the other where she became a mother through birthing. Using classic storytelling forms, she develops a long narrative juxtaposing the two settings: one healing, the other horrifying. Close examination of narrative structure and aesthetics of the illness narrative shows how the narrator forges a discourse about the moral life – how healing should occur. Experiences in the two settings continue to have significance in her subjectivity. The research suggests aspects of ward atmosphere that warrant further investigation.

KEYWORDS *aesthetics; healing; horror; narrative analysis; ward atmosphere*

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Upon entering a ward setting most of us sense in a split moment the atmosphere of that setting. The dictionary concept, atmosphere, is defined as a

gas or aeriform fluid surrounding various bodies, but also as a surrounding moral element and a prevailing psychological climate, tone and mood (Simpson and Weiner, 1989). Atmosphere has social dimensions that literally surround us in the same way the atmosphere studied by natural scientists does.

Becoming sick and receiving care in health care institutions forces the patient into environments that he or she has little or no possibility to escape. The relationship between humans and the environment has been studied using terms such as social climate or atmosphere, which according to Hall and Pill (1975) are interchangeable concepts, referring to how social environments impinge upon the perception of persons. Atmosphere refers to the 'feeling tone' of a setting and is important to understand, as people tend to recollect the general image rather than particular details when referring to social settings (Hall and Pill, 1975). Perception of an atmosphere defines what one must cope with, and suggests directions for how to behave within a social setting (Moos and Houts, 1968).

The research literature on the phenomenon ward atmosphere is voluminous, part of the broad field of study on the relationship between environment and human life. In trying to understand this relationship, many studies of ward atmosphere have been conducted in psychiatric and/or mental health settings (Friis, 1986; Eklund and Hansson, 1995, 2001), several using instruments developed by Moos and colleagues (Moos and Lemke, 1984; Moos, 1988, 1989). Other studies focus on ward atmosphere from a staff perspective (Ekvall, 1990; Sarvimäki and Sandelin-Benkö, 1998a, 1998b), and on elements of the physical environment of settings (Moos and Lemke, 1980; Williams, 1988) such as color (Wijk et al., 1999), sound (Biley, 1994; Pope, 1995) and architecture (Biley, 1993; Fridell, 1998). Thus within the health sciences, research-based knowledge concerning the environment's influence on people's changes to regain health is starting to accumulate (Ulrich, 1992; Watkins, 1997).

There is need, however, to broaden the focus of inquiry in research on caring to include the entire social context where care is provided. What aspects of an environment facilitate health and healing, and how are they perceived as healing (Benoliel, 1996; Rasmussen, 1999)? Such questions invoke the wisdom of Florence Nightingale: the locus of healing is within the person and the art of caring is to provide an environment such that the patient is in the best condition for nature to act upon him/her (Nightingale, 1969).

Kerfoot and Neumann (1992) and Belanger (1996) reflect upon and discuss from clinical experiences the importance of ward atmosphere using the concept 'a healing environment'. However, no studies have been located focusing on humans' lived experiences of the phenomenon, but some studies touch upon patients' (e.g. Buckingham et al., 1976; Gates, 1991; Rasmussen et al., 2000), relatives' (e.g. Andershed and Ternstedt, 1998) and staff's (e.g. Rasmussen et al., 1997; Hellzén et al., 1999)

experiences of care, thus indirectly examining ward atmosphere and its relation to healing or fragmentation.

The purpose of our study is twofold: to further understanding of the phenomenon ward atmosphere, experienced as either supporting and/or obstructing the possibility to stay 'whole' in the midst of life-changing events, and to show how narrative analysis can be of aid. We analyze how one narrator, Linda, describes her experiences of ward atmosphere in two different hospital settings: her identity as a daughter to a dying mother is supported in one (an experience of healing), and in another her emerging identity as a mother is obstructed, when she gives birth to her first child (an experience of horror). In addition to referential content, Linda's narrative contains structural and linguistic features that aid interpretation of meaning. It can also be viewed as an aesthetic project that engages the listener and (hopefully) readers in understanding the world of illness and care.

Material and methods

The study is a part of a larger one that explores ward atmosphere as experienced by patients, relatives and staff. Linda is an adult female, 50 years old, white and a registered nurse. The interview with her was conducted by the first author (DE) in partial fulfilment of his doctoral study and training in narrative analysis. DE is male and also a registered nurse. Both Linda's and DE's native language is Swedish, but the interview was conducted in English, a language in which both are fluent. The participant, Linda, was asked to describe experiences of ward atmosphere she evaluated as positive and negative.

In what follows we use narrative methods to analyze how Linda evaluated and compared ward atmospheres during the process of becoming a mother and losing a mother, and how her identity and the possibility of staying 'whole' were supported and/or obstructed in the two settings.

As Atkinson says, narratives organize experience through the 'unfolding of events and evaluations' (1997: 340). Narrative is a form of discourse for telling others about significant experiences, and making meaning of them. Narrative analysis, a case study approach, is a methodology that identifies segments of text that take the form of narrative, and examines structural and linguistic features to analyze how they support particular interpretations of the lived experience of a research participant (Riessman, 1993, 2002a). Unlike other qualitative methods the approach does not fragment texts into thematic categories for coding purposes. The approach preserves the integrity of the narrative and expands the basis for interpretation: how experiences are talked about is as important to interpretation as what is said (e.g. content of speech).

While a variety of approaches exist in the field (for reviews see Riessman, 1993, 2002a; Mishler, 1995), many scholars treat narrative as discrete units

of discourse with identifiable beginnings and endings. A narrative typically involves the recollection and communication of past events in temporal order, in which narrators evaluate significance – the moral of the story. Distinguished by order and sequence, reported events are located temporally and spatially. Narrators often use certain linguistic devices such as intonation, emphasis, pitch and false starts in telling their tales (Labov and Waletzky, 1967; Labov, 1972; Gee, 1986, 1991, 1999; Riessman, 1993, 2002a; Mishler, 1995; Hydén, 1997). Although there are many approaches in narrative studies, the tradition we draw on focuses analytic interest in how a narrative is put together. Interpretation extends beyond the content to which language refers, and opens up language itself, the form of telling, for study (Mishler, 1986, 1999; Bell, 1988, 1999; Riessman, 1993, 2002a).

Narrative methods have been used in psychology (Bruner, 1987; Capps and Ochs, 1995), anthropology (Mattingly, 1998; Good and DeVecchio, 2002), education (Michaels, 1981; Luttrell, 2000), nursing (Sandelowski, 1991; Öhlén, 2003), sociolinguistics (Labov, 1972; Gee, 1986, 1991, 1999) and studies in the sociology of illness (Riessman, 1990, 2003; Hydén, 1997; Bell, 1999). Mishler (1999) argues that narrative is an umbrella term, which covers a large and diverse range of approaches. Labov in contrast, argues that texts must contain certain structural elements to be considered narrative (Labov and Waletzky, 1967; Labov, 1972); they are brief and told in response to a single question.

Unlike Labov's limited definition, Linda's narrative is lengthy and not clearly bounded. It is infused with evaluation, although it does not meet other criteria as he suggests: 'narratives themselves may serve only as a framework for the evaluation' (Labov, 1972: 371). We found Gee's (1986, 1991, 1999) approach better suited to represent and interpret the text. His approach to oral narratives attends to other linguistic features in addition to structure, e.g. how a narrative is spoken. Interpretation of content in terms of topics, themes and prosodic features is used to organize the narrative into hierarchically ordered units such as lines, stanzas, strophes and parts. By analyzing changes in pitch, intonation and pauses, together with characterization used in the narrative, the interpreter can examine the relationship between form and meaning (Gee, 1986, 1991, 1999; Riessman, 2002a). For analysis of Linda's narrative we draw on some insights from Labov (Labov and Waletzky, 1967; Labov, 1972), but attend primarily to linguistic features (Gee, 1986, 1991, 1999; Riessman, 2002a) and thematic elements – meaning in relation to narrative structure and identity construction.

The interview was first transcribed verbatim. By close listening to the tape-recording and attending to linguistic features, the text was re-transcribed to include false starts, hesitations, silences and pitch falls/rises, which were then sorted into a hierarchical structure: idea units (fundamental units of speech marked by a pitch glide that signals the focus of an utterance). Idea units were grouped into lines about one central idea or

topic. Lines were formed into larger units across the lengthy narrative (stanzas, a group of lines about a single topic). Stanzas often fall into related pairs (strophes), which fall into still larger units (parts, which make up the story as a whole) (Gee, 1991: 23; Riessman, 1993, 2002a).

Analysis

Linda's long narrative is composed of three parts. The first part (the healing atmosphere) stretches from stanza 1–40, the second part (the horrifying atmosphere) from stanza 41–60 and the third part (juxtaposing horror and healing) from stanza 61–7. Due to space constraints we have chosen to present only some of the stanzas in each part. In our representation, the beginning word of each stanza is in bold print, the idea units are separated by a slash, material that is 'focused' (said with prominent pitch and emphasis) is underlined>, and lines that end with a pitch rise are symbolized with <, and pitch falls are symbolized with >. The transcription technique is an adaptation of Gee (1991), and the lines and stanzas are idealized, meaning that hesitations, false starts and repetitions are omitted. An idealized transcription is problematic especially if the interactional features are a focus of the analysis (cf. Mishler, 1986: 169). It is beyond the space constraints to examine interactional features here, but we are well aware that all narratives are co-constructed between teller and listener (cf. Mishler, 1986, 1999; Riessman, 1993, 2002a, 2003; Schegloff, 1997).

Part 1: being at home

The first part of the narrative comes immediately after the first author asked Linda to describe experiences of ward atmosphere, positive and/or negative.

(As I told you earlier I am interested in the atmosphere or the climate at care units, either hospital or other units, so I would like you to narrate an experience when you have either been visiting a friend or a relative in a hospital environment or you have been yourself as a patient in the environment.)

She used the opening to describe the experience of losing her mother. The title we assigned to this part is 'being at home', and titles have also been assigned to the 11 stanzas we present here. As a whole, the first part facilitates an understanding of specifically how ward atmosphere supported Linda in being 'at home' with self, staff and others, and with the world around her.

Linda began by introducing the topic she wants to narrate about, the period when her mother was dying of cancer. She gives an orientation to time, place and the characters involved. She concludes the first stanza by saying it was 'a very special experience', providing with this statement a rationale for why the narrative is worth telling. The first stanza is similar to what Labov (Labov and Waletzky, 1967; Labov, 1972) labels an abstract, it summarizes what is to follow.

Stanza 1 Abstract/orientation

what I want to narrate about is when my mother was very sick/ she died four years ago in cancer>
it was not here in --- it was in --- which is a smaller hospital>
and I spent the last ten days and nights with her in the ward>
and this was a very special experience to me<

Linda describes when she and her mother came to the hospital. The entire first part is temporally ordered and carries events forward. Linda and her mother came to the hospital and in her mother's room the staff had placed a bed for Linda as well. The staff initiated nursing tasks and asked Linda if she wanted to be involved. She continues to describe how the staff attended to her and to her mother and she ends the temporally ordered event sequence by evaluating it as 'very special'. From this point forward, the narrative changes character: Linda evaluates the significance of specific moments in four scenes, each formed by groups of stanzas.

Scene 1: experiencing calmness Our title for the scene is derived from the focused material in the stanzas below, which indicates sound and motion are important features of calmness. Linda uses general characters (someone/no one/they) in order to indicate the pervasiveness of the experience. She describes calmness on the ward, as shown in the two stanzas below. In stanza 10, Linda repeats her evaluation: it was 'a remarkable experience', she 'never heard a loud voice' and no one was 'yelling'. In stanza 11, she continues to evaluate aspects of ward calmness. It seems here to involve sounds and the absence of physical stress among the staff. Even though the ward was crowded with people, the staff's behavior facilitated calmness in Linda.

Stanza 10 I never heard a loud voice

and then well she stayed here/until she died<
and I spent ten days and ten nights there>
and it was a remarkable experience>
because during this period I never heard/a loud voice/or someone yelling<

Stanza 11 No one was running

or no one was running in the ward<
I didn't have the feeling/that it was a calm period or anything like that<
there were patients everywhere/and they were very sick and so>
but everything was very calm>

Linda returns to the aspect of calmness in stanza 29. Even though she had the impression that there was a lot of nursing to be done, staff always had time. Linda uses metaphor to describe the experience: they 'dropped' what they were doing and attended totally to her.

Stanza 29 They always had time for you

it was a lot that had to be done they were very busy/ but not stressed<
if you went to the nurses' office/ they dropped everything on the table

'please sit down/ have a seat'<
and they never ran around<
and it was a special atmosphere<

Scene 2: being seen The next two stanzas communicate another aspect of ward atmosphere: being seen by the staff. In the material Linda recounts there is mainly the sense of being looked at and being seen. She refers to characters as 'they', seemingly to indicate that being seen is not dependent on individual persons, but rather from staff in general. Linda refers to herself as 'you', communicating a general sense that includes others (her father). Linda begins by saying in stanza 12 that she experienced the staff as 'very present', a phrase she repeats for emphasis. By sitting down they made her feel like they had time just for her. When someone entered the room, they always introduced themselves.

Stanza 12 They looked into your eyes
and everyone was very present in every moment/they were very present>
and every person who entered the room /introduced themselves/very nice and calmly>
and you know they looked into your eyes<
and they sat down<

She comes back to language in stanza 30 that she introduced in 12: staff members looked into her eyes, spoke to her and they smiled. Critical to ward atmosphere, she communicates here that she was seen as a person when she spent time on the ward or met staff outside.

Stanza 30 They saw you when you entered
if I went down to the cafeteria or when my father came/ people always looked in your eyes>
and said hello>
and smiled<
they saw you when you entered the ward<

Scene 3: being who she wants to be In the four stanzas below, Linda's evaluation of the ward atmosphere emphasizes her experience of being able to be who she wants to be. She focuses the material mainly on experiences of being respected and allowed to be a daughter. She introduces her conflicting identities, as either a daughter or a nurse, in the four stanzas. In stanza 13 she states that she was a nurse, in 15 she wanted to be a daughter and in 16 she was her mother's daughter. Thus the way she constructs characters in these stanzas supports the interpretation that Linda was able to be who she wanted to be. Linda refers to others as they, staff in general, and how they gave her an option to choose a preferred identity. Even though the staff knew she was a nurse, they did not take for granted either her knowledge or willingness to participate in the nursing care. She contrasts this experience by giving examples from other settings where she

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felt that she was expected to take an active part in the nursing on basis of the staff's knowledge of her professional role.

Stanza 13 I was allowed to be a relative

and they knew/that I was a nurse<

but this was the first time during this year my mother was very sick<

I spent time in many wards/with different people<

but this was the first time/that I was allowed to be a relative/**and not only a nurse**>

Stanza 14 They asked if I wanted to participate or not

they always asked/how I wanted to do this/ if I wanted to participate or not<

it was not as in other wards/it was in a way of course/you will take care of this>

you see the infusion will soon be ready>

so you know how to handle this>

In these poignant examples, Linda communicates how she wished to be at her mother's side as a daughter, not as a nurse, a wish she suggests her mother shared. The wish was granted by the way the staff approached the situation, they 'always asked', importance emphasized by repetition.

Stanza 15 I wanted to be a daughter

but they didn't do that/they always asked<

do you want to take care of this/or do you want us to do it>

and I wanted them to do it>

because I wanted to be there as a daughter/**and nothing else**>

Stanza 16 I could be her daughter

and this was very nice I think they respected my part in this>

and it was also very good for my mother/because she didn't want me to be there as a nurse>

she didn't because I was her daughter<

and I know it was always difficult for her/ to look upon me as a nurse>

Scene 4: recognizing self in an illness experience In the two stanzas below, Linda evaluates an important dimension of ward atmosphere: understanding what is going on and recognizing self. She continues with her conflicting identities as nurse and daughter, and it seems as if the openness of questions (focused material) from the staff (referred to as 'they') ultimately helped her resolve the conflict of identity, and to recognize herself in the illness experience. She said she could ask the staff her sometimes 'stupid' questions; all questions were allowed. She makes clear how her professional role as a nurse sometimes conflicted with her role as a relative at times with her ill mother. She said there were some questions she should not ask as a nurse, but she had to because she could not always 'think in a rational way'. The staff's attitude toward her and willingness to help her understand the situation identifies another important dimension of ward atmosphere – the ability to develop an identity as a family member, despite other identities in the 'outside' world.

Stanza 31 All questions were allowed

So it was easy to talk to them>
and you could ask/about anything I felt that all questions were allowed>
as a nurse/ there was questions that I shouldn't ask<
but I had to/ because it was my mother laying there<

Stanza 32 They will not laugh at me

I couldn't think/ in a rational way<
and I felt I could ask them>
they will not laugh at me when I leave the room>
it was very positive>

Linda concludes the first part of the narrative by saying that during the night when her mother died, the whole family gathered. She speaks of a feeling of connection to the staff, a feeling 'difficult to explain'.

Part 2: being on another planet

The second part of the long narrative offers a vivid contrast to the theme of the first part: a horrifying ward atmosphere. Linda was becoming a mother for the first time. As in the first part, she begins with an abstract, and moves quickly to orienting the listener to the past time event she will narrate.

Stanza 41 Abstract/orientation

Because I experienced quite the opposite<
when I had a baby many years ago/ >
my first child>
it was in --->

The title we assigned to this part, being on another planet, is developed in the 10 stanzas presented here. They relate how ward atmosphere can create alienation from self, others and the surrounding world. As in the first part of the narrative, Linda starts by introducing the topic she wants to describe: a birth. She gives orientation to time and place, and provides a rationale ('a total opposite experience') for telling the particular story.

Again, she starts with a number of temporally ordered stanzas describing experiences and evaluating them. Linda became a mother with the birth of her first child and the delivery was 'dramatic'. Having the flu when they came to the maternity ward, the baby was taken away from her for observation. Linda experienced the staff as neglectful and, consequently, she failed to initiate breastfeeding; the physician she reports even questioned the appropriateness (because of the flu) of her being on the ward. Comparing linguistic features of the first two parts, this second part has a more emotional tone. The lines and stanzas end strikingly, more often with a falling pitch; in several stanzas the tone of voice reaches a whisper at the end of lines. Linda uses more metaphors to express meaning in the second part of the narrative. Interpretation is supported, both by the structure of

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telling and the language Linda selects to describe the events themselves: the birth was, and is still, a traumatic experience in memory.

Scene 5: experiencing chaos Linda describes the ward atmosphere as chaotic in the two stanzas below. Sound and motion are mainly in focus when Linda talks about chaos. As in scene 1, chaos and calmness are foremost characterized by using the indefinite 'people', thus communicating both as a general perception of the atmosphere. Everything was 'very dramatic': Linda was sick, labor started too early, the birth may have been atypical (although precisely how remains unclear) and, when she arrived on the maternity ward, it was noisy (stanza 43). People were talking and 'running around'; the ward was 'crowded'. To communicate the level of noise in line 2 Linda raises her voice to a near scream.

Stanza 42 Everything was very dramatic
and the delivery/ and everything was very dramatic<
because I had the flu/ I was very sick/ and I coughed/ coughed/ and coughed<
so the delivery started too early<
and it was a very dramatic delivery>

Stanza 43 People were running and it was very noisy
Because they took me/ and the baby down to the maternity ward in the bed>
and when we came down people were talking BJEJBEBJEBJEBJE it was very noisy<
and people were running around<
and I knew that they had many mothers it was crowded in the ward>

Scene 6: not being seen In contrast to the first part, Linda relates the experience of not being seen on the maternity ward in the second part. She focuses the material in the stanzas mainly on not being looked at. Linda uses characters somewhat differently in these stanzas compared to the stanzas in scene 2 where 'they' looked at 'you'. Below she selects the more individual-centered 'she' didn't look at 'me'. By this subtle difference in characterization, Linda communicates the impact of a staff member's negligence on her as a person. In stanzas 48–51 below, she describes how a female staff member brought her baby in a brutal way, rolling the crib so it crashed into the bed, not looking at or talking to Linda.

Stanza 48 She never looked at me
So she never looked/ at me<
I don't know if she looked at the other mothers>
but I remember/ her back<
and she pulled the little bed/ with my baby<

Stanza 49 She didn't bring my baby to me
she put it / she didn't bring it to me>
she put it so it rolled by itself<
and smashed in to my bed<
and then she went out<

Stanza 50 My god what is this

and I was thinking my god what is this>

am I supposed to get up<

and I was so tired/ after spending 17 hours in the delivery room>

so I didn't dare to stand on my feet/because I was afraid/ I would faint/

and I was bleeding a lot<

Stanza 51 She didn't even look at me

So I couldn't move and there far away from me/ was my baby>

and no one gave her to me>

she didn't even look at me/ and say hello you are supposed to do this>

no she just left<

Scene 7: not being who she wants to be In evaluating the experiences, Linda suggest alienation from self – she was not who she wanted to be. She focuses the material in the following stanzas mainly on not behaving as she should. As in scene 3, Linda constructs characters of two possible selves in conflict: 'I' and 'ordinary mother'. Linda concludes stanza 59 by saying that she was not an ordinary mother; i.e. she was not able to choose her identity of 'I' and 'ordinary mother' merging together. She uses a raise in pitch – almost a scream – in stanza 52 (line 1) to convey a sense of failure when the staff accused her of not breastfeeding as she should. Linda then describes how she fell asleep, leaving her daughter unattended and unfed. Her voice diminishes continuously as she speaks the lines of stanza 53.

Stanza 52 I didn't behave like I should

and they returned/ one hour later and WHY DIDN'T YOU BREASTFEED HER<

and I don't know what I said>

but I felt sort of guilty<

because I didn't behave like I should have done>

Stanza 53 I was so tired I just fell asleep

and then when they gave her to me>

I was so tired just fell asleep>

So I don't know if she could eat or anything>

Linda sums up the ward experience in the following stanza: 'a horrifying experience'. She perceived the staff were angry with her; she felt she was not 'an ordinary mother', not behaving as an ordinary mother should.

Stanza 59 I wasn't an ordinary mother

it was a horrifying experience really>

I felt like they were angry/ with me in some way>

and I wasn't an ordinary mother<

I didn't behave as I should<

Scene 8: not recognizing her self in the experience Compared with the surgical episode (part 1), in the second part she focuses on how she could not ask anyone her questions, which left her unable to recognize herself in

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the birth experience. In stanzas 57 and 58, she vividly communicates emotion, using repetition. She had 'so many questions' but did not dare to ask anything. Nothing happened as Linda expected, and she just wanted to leave the ward 'as soon as possible'. Once again the pitch of her voice falls as she tells about these experiences; there is a continuous fall in pitch in stanza 57 ending with a whisper. Her pitch rises briefly in line 4 of stanza 57 but falls again continuously throughout stanza 58. The observation of pitch here provides support for the interpretation that the traumatic experience is still emotionally affecting the narrator, even though she is narrating events that occurred 20 years previously.

*Stanza 57 I didn't dare ask anyone anything
and they left>*

and I cried/ and I cried/ and I cried>

and I felt during the days I spent there I didn't dare ask/ anyone/ anything>

and I had so many questions because it was my first baby<

*Stanza 58 Nothing happened as I had expected it to
it was so many traumatic experiences>*

and nothing happened/ as I had expected it to do>

so I didn't dare to ask/ anyone/ about anything>

and I just wanted to go home as soon as possible>

Part 3: juxtaposing horror and healing

In the third part of the narrative, Linda explicitly contrasts her experiences in the two ward environments, she asks the listener (and reader) to interpret one in light of the other. The title we have assigned (juxtaposing horror and healing), and those assigned to the seven stanzas presented, are interpretive. Experience in the two settings is evaluated very differently.

Scene 9: being on another planet Staff provided so much on the ward where her mother died, both women were cared for, but when she needed help as a new mother, she did not dare to ask for anything. Linda again finds vivid metaphors: on the maternity ward she felt like she was 'on another planet' (stanza 61), but on the ward where she lost her mother, she felt safe (stanzas 62–3). Linda implicitly characterizes herself as an alien in a new world, on another planet, providing us with interpretative cues of how to understand the impact on identity.

Stanza 61 I was like being on another planet

So it was just a new world you know>

and I was like being on another planet>

and I didn't know anything and no one told me>

and I didn't dare to ask/ anything so>

Stanza 62 It was such a different experience

and I was thinking about that when I was sitting with my mother>

I know/ that I was of course older/ and more experienced<

and I was familiar with the milieu there as a nurse>
but how people can it was such a different experience>

Stanza 63 I didn't dare to ask anything

they allowed so much>
and when I needed it so much when I was a new mother>
and I didn't dare/ to ask anything>
so it's very different>

Scene 10: being rescued Her baby's transfer to a ward for premature infants is described as a 'rescue'. Linda's voice rises here (stanza 64). In the following one, she again makes her point with contrast and metaphor: the maternity ward was like 'closed doors', there were 'walls' between her and the staff.

Stanza 64 For me it was a rescue

for me it was a rescue/ that (_ _ _) was moved>
because she was yellow all over so we had to move her/ to this ward for premature>
and there/ I could ask my questions<
and they hugged me and they helped me/ to get the breastfeeding to work<

Stanza 65 It was like closed doors

but in the maternity ward/ I couldn't ask anything>
it was like closed doors>
or like walls between us>
it was very strange>

Scene 11: coming home The third part of the narrative ends with metaphor. On one ward there was a 'home-like feeling', similar to 'coming home'. Pitch again emphasizes significance: both stanzas end with a falling voice.

Stanza 66 A home-like feeling

and in this surgical ward where my mother was it was very familiar to get there>
it was like a home-like feeling>

Stanza 67 It's like coming home

and we went there/ a few days after my mother died>
and we bought some cakes/ and brought to the staff>
and when we went there/ my father said/ it's like coming home in a way>
it was not a very strange environment we felt like we belonged there it was very strange>

Discussion

The phenomenon ward atmosphere, as it unfolds in the long narrative of one research participant, suggests how significantly it influences the relationship between care and identity construction. Ward atmosphere in the case study, ironically, transcends the actual outcome of each

hospitalization (e.g. death versus birth). An atmosphere of healing supported the narrator during the difficult time of losing her mother. Her identity as a daughter was affirmed; she was offered choices, an atmosphere of calmness where she was seen, welcomed and greeted, and where she received help in understanding what was happening. She could construct and maintain a caring daughter identity in the setting, leaving behind her identity as a nurse. In sharp contrast, Linda's nascent identity as a new mother was obstructed by a ward atmosphere of remembered horror, 'on another planet', in a foreign world. The birthing environment was chaotic; she was deprived of the possibility of becoming who she wanted to be, an ordinary mother. Linda was unable to find a 'self' in that ward experience.

By comparing experiences of two ward atmospheres, distinguished as positive and negative, the narrator suggests four dimensions that aided and/or impeded: calmness versus chaos, being versus not being who she wanted to be, recognizing self in the experience or not and being seen versus invisibility. Derived from the concrete language of lived experiences, the four aspects are consistent with what other research traditions define as the psychosocial climate of a setting. Such a climate is typically described with abstract concepts such as, autonomy, relationship and order/organization (Moos and Houts, 1968; Moos and Lemke, 1984; Friis, 1986; Moos, 1988, 1989; Eklund and Hansson, 1995, 2001). All four aspects are shaped by staff actions, doing and being, although the chaos dimension includes the physical environment as well. An atmosphere of calmness, where there are no strange or loud sounds, where people move in a seemingly relaxed way, indicating that time exists for human interaction, can transform stressful events (cf. Williams, 1988; Biley, 1994; Pope, 1995; Rasmussen, 1999).

The huge importance of ward atmosphere surfaces in other qualitative studies of caring. Feeling confirmed, seen as a person, embraced in hospitality and having the chance to talk openly and freely about emotions and worries are essential for well-being and recovery of patients and/or family (Rieman, 1986; Lindholm and Eriksson, 1993; Halldörsdóttir and Hamrin, 1997; Fagerström et al., 1999; Rasmussen et al., 2000). In an insightful piece, Andershed and Ternstedt (1998) argue that relatives' participation in the care of a dying member often pivots on opposites that the authors refer to as involvement in the light and involvement in the dark. Involvement in the light means experiencing a trusting relationship where one is seen, listened to and respected, similar to Linda's: she can be a daughter to a dying mother, not a nurse. Involvement in the dark means being given no information, not acknowledged or seen by staff, aspects that bear a close resemblance to Linda's experiential account of becoming a mother.

Weitz (1999) describes experiences that involve the dark. Writing from multiple positions – as a medical sociologist and relative of a dying brother-in-law – she describes the devastating effects of the staff's unwillingness to involve family members in decision making. It shatters the family, adds to strain and leaves family members in limbo, unable to find meaning or

resolution in the face of the meaningless treatment of a loved one. Hellzén et al. (1999) put it bluntly, such 'care' is to face evil: violated in a relationship that is supposed to be healing, loss of control and the experience of profound loneliness. Weitz's account of a horrifying atmosphere, like Linda's, instantiates uncaring (cf. Halldörsdóttir and Hamrin, 1997). Such encounters in health settings have devastating effects on patients and relatives, and raise an important question: is uncaring an ethical issue for the health professions, a form of emotional malpractice?

We found that an adapted form of narrative analysis originally developed by Gee (1986, 1991, 1999) was a fruitful way to understand and compare one woman's experience of contrasting ward atmospheres. Looking beyond the content of speech, the approach allowed us to examine narrative structure, how she told the narrative, including subtle aspects such as tone of voice and the construction of characters in the story. As all narrators do, Linda used the pitch of her voice differently in the various parts of the long narrative. In the first part pitch rises and falls seemingly without pattern. In the second, pitch changes are striking and distinctly patterned, falling at several points to the level of a whisper. Such pitch changes signal emotionally charged memories, still affecting the narrator as she relives the emotions, even when reporting events that occurred years ago.

Although tonal changes helped us to interpret the long narrative, it is through Linda's portrayals, her enactments of key moments (becoming a mother, being a nurse and being a daughter about to lose her mother) that readers can 'see' horror. As Radley says about written accounts: 'it is in the chasm between the mundane and the terrifying that the horrors of illness experience are forged' (1999: 782). Applying his insights to spoken narratives, power lies in aesthetic actions where the teller 'shows' or performs instances of living and suffering. Throughout part 3, for example, Linda juxtaposes horror and healing, portraying the chasm between the mundane and the terrifying. By offering horror for the listener (and then reader) to witness, it can be grasped sensually, unlike explanations.

Radley's (1999) view of narrative as an aesthetic project goes beyond previous views, e.g. personal narrative is a form for representing, evaluating, even constituting the past (Riessman, 1993). Similar in some respects to a performative view (Riessman, 2002a, 2002b, 2003; Langellier and Peterson, forthcoming), attention shifts to everyday aesthetics: how a narrator like Linda enacts for and engages with a listener/reader to forge a discourse about the moral life. Looking beyond the literal content of her narrative, she opens up a critical question: How can moments in the life course – giving birth and dying – progress ethically? In Linda's account, the horror of the one is accomplished figuratively, by enactment for (and with) an audience-listener and then reader – where 'the appearance of the unthinkable [occurs] in the guise of the innocuous' (Radley, 1999: 783). The contrasting memories she chooses to perform and the aesthetics of their display symbolize, on the one hand, a woman's alienation when giving birth

– colonization of the female body by medical professions – and, on the other, the healing that can accompany a ‘good’ death. Horror is juxtaposed with the sublime.

We have shown the continuing significance of ward atmosphere on a woman’s present subjectivity through microanalysis of a narrative about past memories. Linda skilfully draws on classic narrative forms – the aesthetics of telling – to make a moral point: she juxtaposes good and bad, horror and healing, the ideal and the real (Riessman, 2002b).

Some questions remain. The interview was conducted in English, which both teller and listener spoke fluently, but not natively. There is little research on narrative telling in non-native languages. Are pitch glides used in the same way and can linguistic features be interpreted on the same grounds in interviews constructed by two non-native English speakers, as they can be in interviews in native English? The issue needs further exploration in narrative studies.

On a practical level, the results of our research underscore, once again, the important message of Nightingale (1969): the crucial significance of the social environment of care for both patients and family. Subtle aspects of the atmosphere of a ward can support and/or obstruct healing. To create a healing ward atmosphere, professionals must ask themselves if participants in the setting perceive symbols of welcome, nurture and calmness, or if the environmental message is one of chaotic activity and depersonalization (Kerfoot and Neumann, 1992; Walker, 1994; Belanger, 1996).

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