The Lived Experience of Being Comforted by a Nurse

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During my master's program in nursing at the University of Alberta my introduction to qualitative research methods sparked an interest in phenomenology and led me to spend a semester studying with Vangie Bergum, a member of the Faculty of Nursing whose research interests centered around phenomenology and its application to understanding the experience pregnancy and childbirth. We spent many enjoyable hours discussing the writings of prominent phenomenologists and the potential this research method held for understanding everyday experiences related to health and illness. I wrote and rewrote my first paper using a phenomenological approach. With Vangie's encouragement, I pursued my interest in phenomenology further by enrolling in a course led by Max van Manen in the Faculty of Education at the University of Alberta the following year. Under his patient and thoughtful guidance I learned more about the methodological practices underlying human science work and completed the paper that appears in this issue. Researching the lived experience of being comforted provided part of the foundation for my doctoral dissertation which is focused on describing the ways that nurses use touch in caring for and comforting cancer patients.

It is often the little things that count. Helen recalls a time she was at home recovering from a serious illness. A nurse came to see her and offered to fix her pillow. The nurse gently removed the pillow, efficiently fluffed it up and then carefully replaced it. Helen immediately felt more comfortable. When she asked the nurse what she had done to accomplish that, the latter dismissed it as being nothing unusual. Yet it is these seemingly simple acts, such as fixing a pillow, repositioning a patient in bed, drawing the shades, mouth care, bed-making, listening, and holding a patient's hand that bring such profound changes in comfort when one is ill. But how is this comfort experienced? What is the meaning of comfort in nursing? As nurses, when we are comforting others, what is it that we are attempting to do?

Comfort has always been an important goal of nursing care. On a day-to-day basis, nurses ask patients if they are comfortable and initiate interventions that are aimed at providing or enhancing comfort. Yet for the most part, definitions and descriptions of comfort in the nursing literature are vague and abstract. Nurses have found it much easier to describe

the experience of illness-related discomfort—the pain, chills, worry, the wrinkled sheet, the loneliness—than to describe the experience of comfort. Thus comfort is often contrasted with discomfort and viewed as a state of "physical or mental well-being" (Flaherty & Fitzpatrick, 1978) or by degrees on a discomfort-comfort continuum (Paterson & Zderad, 1988). However, these definitions tell us little about what the experience of comfort is actually like. Is comfort something that can be acquired by degrees? An injection is given to relieve pain. Is comfort only this? Is it more than this? Despite significant developments in our capacity to objectify pain, use painkillers, and manage those aspects of bodily or emotional pain accessible to us (Illich, 1976), relatively little attention has been paid to the patient's experience of comfort. The underlying assumption appears to be that if the discomfort of pain is minimized a patient must be comfortable.

There is a paradox in talking about "patient comfort." The word "patient" is derived from the Latin word *pati*, meaning to suffer. Is it, then, possible to experience comfort in the face of pain and suffering? Linberg, Hunter, and Kruszewski (1983) imply that it may not be, stating that comfort is a "feeling of consolation or relief, freedom from pain and anxiety and a satisfaction of bodily wants" (p. 527). Yet pain and suffering seem to be linked to comfort in some way. St. Thomas More (1977), who saw plight as an aspect of mankind's universal condition, begins to make this link more clear when he says:

> Comfort ... is properly taken by them that take it right, rather for the consolation of good hope, that men take in their heart, of some good growing toward them, than for the present pleasure with which the body is delighted and tickled for the while....And therefore sith I speak but of such comfort as is very comfort indeed, by which man hath hope of God's favor and remission of his sins, with minishing of his pain in purgatory or reward else in heaven, and such comfort cometh of tribulation and for tribulation well taken. (pp. 70-71)

More (1977) points to the meaning of suffering and comfort, the meaning of one with the other. Would we know comfort if we did not journey through the experience of suffering and pain? The healthy body does not question its experience, nor do we question it; rather, the body experiencing health is simply used to walk, rest, and do the things we want to do. We are at ease in the body of our daily life when we are healthy. However, injury or dis-ease changes us. We see the world differently. Olson (1986) describes the experience of an injured foot: "There is truth here, which the walking foot, resting foot could not teach us. There is pain here, the pain of brokenness" (p. 12). "Dis-ease banishes ease" (p. 56). It is through dis-ease that we come to know something of comfort. Yet it is not the mere pleasure of comfort that we are concerned with here, such as when one sits down in a favorite easy chair after a busy day; but rather, the good growing of comfort, the capacity of comfort to

enhance abilities and engender hope, the ability of comfort to bring a new kind of ease when all seems lost.

The word comfort derives from the Latin word *confortare*, meaning to strengthen (Skeat, 1910). *Con* originates from *cum*, meaning together, and *fortis*, meaning to be strong. What is the force whereby one can actually become stronger even as the body disintegrates, the force that keeps the invalid from becoming in-valid (Olson, 1986)? Together with whom is this made possible? When we are sick in bed, we call for the presence and assistance of others. The stamina that we could depend on unquestioningly yesterday seems to have ebbed away from the body. We feel weak with nausea and find it difficult to focus on anything beyond the discomfort we are experiencing. We struggle to move. Then, to our surprise, the seemingly ordinary, nontechnical, and sometimes invisible actions of some other person helps us feel better, revitalized, however temporary this may be.

A patient's way of being in the world is reflected in his or her everyday lived experiences. By paying attention to patients during periods of illness, we may come to understand the lived meaning or significance of the experience of comfort. Identifying the number of patients who are comfortable as a result of nursing care through a survey or measuring the reduction of levels of stress or anxiety by means of a questionnaire will not bring us in direct contact with living in order to capture the experiential quality of the lives of patients. In decontextualizing patients' experiences of comfort, we lose sight of the fullness of life, and therefore risk loosing the meaning we hope to capture. The complexities of human experience preclude the use of such reductionist approaches in answering questions of meaning. A question of meaning calls for a method that truly explores the lives of patients as they are comforted. By listening to patients' voices and their stories, it becomes possible to come closer to life as patients live it "rather than as we conceptualize, categorize or, reflect on it" (van Manen, 1990, p. 9); and in this way the possibility of uncovering and capturing a deeper understanding of the nature or meaning of comfort as an everyday experience is offered (van Manen, 1990).

Can Comfort be Described?

In a sense the patient already knows what comfort is when he or she says "I am comfortable." Yet the same patient would have extreme difficulty describing what that comfort exists in:

> I sort of looked forward to her coming, and I think she did [too]. Because I'd have little things, my back, and the front part of my chest—and she checked me pretty good with my heart and my lungs and everything. And I always felt real good when she left, cause she would say everything is ok. Yeah, just her being here, just her personality. We'd get to laughing and talking and you can't help but feel better. (Magilvy, Brown, & Dydyn, 1988, p. 140)

fort and there's comfort, isn't there? I mean you can be very comfortable or somewhat comfortable or not very comfortable at all. (Hamilton, 1985, p. 61)

Although Hamilton attempts to summarize patient descriptions of comfort in terms of their interaction or involvement with others (e.g., the knowledge that I am in good hands), with their illness or symptoms (e.g., being without pain), with their feelings (e.g., feeling good in yourself) and with their surroundings (e.g., having things homelike), the summary falls short of giving us an insightful understanding of the nature of comfort. On the one hand, the experience of comfort is difficult to describe because the experience itself is preverbal. On the other hand, it is hard to find the right words because we more easily speak of our pains, problems, weakness, and so forth. In this sense, many would agree that the comfort of nursing care is directed toward is the prevention, minimization, or relief of discomfort (Fleming, Scalon, & D'Agostino, 1987; Strauss, et al., 1984). Perhaps comfort always lies in the shadow of discomfort. There is a sense that the human condition is one of vulnerability and that one may never be completely comfortable. If this sense is accurate, comfort is an unachievable goal. Yet we have all been comforted when we have been ill, sometimes experiencing dramatic changes in our well-being as a result. We sense, too, that it is not only what is removed from the situation (e.g., pain) but also what is enhanced, added, or restored that contributes to our comfort. Perhaps our understanding of comfort needs to embrace more than the relief from pain or suffering but, in addition, hold the possibility for enhancing strength. Thus what is at stake is the meaning of comfort more than just describing patients' feelings or physical sensations.

It is hard to find the right words. Patients say comfort is "a quiet peacefulness," "being content," "feeling protected and safe," "an immensely gratifying release from pain or other discomforts," "being happy," or "feeling clean and refreshed." All these utterances and more may show comfort as it affirms one's choice of the positive value concealed in any situation. It depends on the situation and our approach to it that prevail (Buytendijk, 1950). To search for the invariance that occurs across the experiences of comfort in nursing care situations and in relation to various modes of existence is to search for the essence of comfort.

Being Comfortable

"I see her body lose it's tension; she smiles and thanks me, says I have made her feel better, more relaxed about everything" (Olson, 1986, p. 90). In periods of illness or pain, experiences of comfort are something pervasive and powerful. Patricia's response to the comforting she received during labor is still a vivid memory:

The most perfect spot for me was up in my own bed, nowhere ever could I have been more comfortable. It has extended beyond now—there's such a

lovely warm feeling [associated with being there] it even relaxes me now when I want to go to sleep.[1]

While comfort may be experienced as localized relief from stiff muscles or a comfortable position in bed, there is a deeper inner comfort that expresses itself as "being in comfort" in response to another's comforting. Thus comforting and comfort are closely intertwined.

Comfort is a mode of existing, a way of being and finding oneself in relation with the world. The inwardness of comfort is experienced by the feeling of being part of the real world again, integrated with the world, feeling able. It is in comfort that the possibility of forgetting or overcoming one's dis-ease, to experience an intensification of well-being presents itself: "The stream of life within us seems renewed or strengthened, rigidity gives way to an inner warmth; and we become completely under the sway of this sensation" (Buytendijk, 1961, p. 21). But how does this come about?

For John, a 75-year-old man, the recovery at home from radiation treatments and bowel surgery has been slow. A nurse visited every week to help him learn to manage his new colostomy and check on his progress. While she helped John recognize the small improvements he was making, the discomforts associated with his new colostomy and the accompanying loss of strength prevented him from carrying out most of the things he liked to do. At one level, there seemed to be no way he could escape this loss—they both knew this. He walked slowly, guarding his colostomy protectively with his hand. Each step reminded him that he could not be up long, reminded him of his despair in this life of illness. This was not living. Yet there were times, in the company of others, when the strain of suffering left his face and his voice lifted, reminding his friends of the man they had always known. He talked of the comfort this way:

I feel comfortable when I can do something interesting. My interest now is in radio. It has been for the last 50 years, but more so now that I have this situation. I am able to lie down and listen to some people talking away in code on the other end of the world. I don't have to write it down. I can sit back and listen and talk.

With the help of a nurse, his family, and his fellow radio operators, John found a way to be himself again, to be able in a situation where he was free from his bodily concerns, where he was not alone. For him, this was when he was most comfortable with himself and with the world. The body becomes "the thought or intention that it signifies to us" (Merleau-Ponty, 1962, p. 197). The experience of comfort is not simply an experience of an opposite something, as something objective outside of ourselves; like pleasure, "it fills, absorbs, and takes possession of us" (Buytendijk, 1961, p. 22).

During illness, one's body becomes foreign and unfaithful. It is not just a single part of the body that is affected or alerted, but rather the whole

body. It can no longer function in the familiar ways. We feel vulnerable and weak. Unlike the child who experiences a taken-for-granted need for help (Bollnow, 1962/1989), a patient experiences this weakness as a deficiency. The body becomes an object, a thing of investigation, vigilance, diagnosis, and treatment. During recovery, subjection of the body must again become possible in the sense that the body can be used and managed with a renewed sense of trust (Bergsma & Thomasma, 1982). We are reassured that we can become master of ourselves once again and free of a state of passive suffering, even if temporarily. Through our body we find comfort. The inwardness of comfort is experienced by the feeling of being better, feeling good, renewed vigor. Attention is no longer directed to some distrust or suspicion in the body brought on by discomfort. Liberated from self-concern, one becomes at home again with his or her body, there is room for something else. The feeling of comfort opens the person again to the world. But how does this transformation occur? What comforting facilitates this change? Was it just a radio that comforted John? Or was there something more?

The Community of Comfort

I lay in my bed and she'd talk to me and she sat on the bed with me and then she did the needle. But before she did the needle she would rub the area and warm it up and she talked about my skin to me. It was just a whole different experience. And then she said, "I imagine that was painful for you. I think you deserve a back rub for that." So she gave me a wonderful back rub. It was just so nurturing. (Ruth)

Seeing beyond the brave face, nurses can recognize a patient who needs comforting. But the responses to this need may not always be experienced as comforting:

Some nurses assume illness or sickness and they don't talk to you about who you are within that illness. They just assume you're there and this is what you need to be taken care of. It's like you don't have a history or anything. (Ruth)

For Ruth, comfort came with the nurses and friends who took time to be with *her* as a person. Finding a way to be as comfortable as possible at home following chemotherapy sessions was truly a joint endeavor. With the help of a nurse, she searched for ways she could be as comfortable as possible while she endured the side-effects of each session of chemotherapy. The nurse did not tell her how to be comfortable; rather, she offered a way for Ruth to her own discovery:

She was there and she would talk to me about it and she would make suggestions, like perhaps if we walked around or she said, "Would you like to go outside and walk around," and she suggested I try to sleep, but the anxiety was so bad that I couldn't breathe. I would tell her, I felt like I could tell her, "No I'm afraid to sleep." Because she was there for me again, she would just listen. I was allowed my experience and she reacted and comforted what I was saying rather than placation or this isn't what you're ex-

periencing or you're feeling better or everyone goes through this. She didn't have a line. (Ruth)

The knowledge or suggestions of other people often help to light the way to self-knowledge. Yet Merleau-Ponty (1962) reminds us that the situation would pass unnoticed if it did not coincide with our own inner possibilities. The suggestions or gestures of others reveal to the patient the meaning of his or her own impulses by providing them with an aim. Thus comfort is not *something* brought to the situation by a comforter, like the bandage that is provided for the child's cut or the demerol injection brought for pain. Rather, comforters through their presence provide the opportunity for possibilities to come into existence that lie within the patient, possibilities that bring comfort. The word nurse and the word nurture are both derived from the Latin word *nutrire*, meaning to nourish. The one who nourishes brings possibilities for comfort into being.

In the security of a relationship with one who cares, it was possible for Ruth to focus inward during periods of pain or discomfort to gain a better understanding of the numerous signals her body transmitted that might provide direction in finding ways to be more comfortable:

I kind of learned to watch my own body and say, "Do I really need it [medication] then?" and then wait to see what happened later. My sister was there and she would talk to me about it. (Ruth)

Bergum (1989) reminds us of the danger of losing touch with that body wisdom, the "material thing," *res extensa*, when self-hood is located with the "thinking thing," *res cognitans*, as reflected in Cartesian philosophy. One does not understand the way to comfort by some act of intellectual interpretation. Rather, knowledge of the possibilities for comfort comes from being involved with the world through our bodies: "The body has wisdom of its own which does not lie but perhaps needs time to find its own rhythm" (Bergum, 1989, p. 70). The body is the means through which the promise of comfort is sustained. How can we come to trust enough to surrender to our own bodily impulses when we are ill? Does the nurse help us do this?

Through a sense of being together with another who comforts, we feel the security of their presence and their unwavering belief in our ability to find a way to live through this despair, to find comfort. Their belief seems to lure us out of our despair, awaken unrealized resources. This belief that comfort is possible seems to hold the creative force that makes comfort possible even in the most difficult situations. By and through this trust we truly become more comfortable. Yet, importantly, the trust is reciprocal. The experiences of comfort, however short, that grow out of this relationship enhance our trust in those who care for us. Ruth's trust in her nurse as a comforter, as a person who knew her, respected her, and was capable of providing necessary assistance provided a certain relief, a

basis from which other sources and kinds of comfort could be sought. Through interactions with a nurse, Ruth came to understand the meaning of comfort. "Being listened to" did not make Ruth think of comfort; it was comfort in itself.

The Presence of Others

> I felt I was listened to through body contact and body language more so than in mutual conversation. Strange, so often the words are forgotten where as a feeling or presence remains of an experience. She was there totally just for me. (Diane)

Diane's experience of being comforted during labor are not unusual. Simply having someone be with us can significantly influence the comfort we experience. Yet it is clear that the "being with" to which we refer is more than the "with" that means "beside" or "just sitting near" as even in physical absence acts at a distance can bear the signs of a kind of presence. There is something in the "being with" that reveals the nurse's feeling with the other, regard for the other as a person, and desire for the other's well-being. Perhaps it is this attitude, as reflected in the way that nurses are "with" us, that warms and comforts us when we are under their care; after all, "being with" does not mean one is there for nothing. But how can this be?

Marcel (1969) distinguishes between physically present and being truly a presence when he says:

> There are some people who reveal themselves as "present"—that is to say, at our disposal—when we are in pain or need to confide in someone, while there are other people who do not give this feeling, however great is their good will....The most attentive and the most conscientious listener may give me the impression of not being present; he gives me nothing, he cannot make room for me in himself, whatever the material favors which he is prepared to grant me. The truth is that there is a way of listening which is a way of giving, and another way of listening which is a way of refusing....Presence is something which reveals itself immediately and unmistakably in a look, a smile, an intonation, or a handshake. (pp. 25-26)

When a nurse is *with* us, in the sense of being present, we feel the security of her protective gaze, we feel valued as a person, the focus of her attention. We know we do not need to hide behind the suffering we experience—what we say or how we look will not change this attitude. The nurse has learned to look for the indicators of disease and pain. She can *see* "shallowness around the eyes, greyness in the skin, a grimace when a painful area is touched, lethargy which can be due to the pain of movement, listlessness from the supreme effort to undergo pain" as well as recognize what is missing—"the accustomed gestures, the light in the eyes" (Olson, 1986, p. 86). But in addition, presence requires a personal response. We sense the nurse is close enough to *feel* with us, sharing the loss that accompanies the dis-ease we are experiencing in a sensitive, intimate way. Her understanding is more than an intellectual exercise.

She *understands*. When a nurse is truly present, seeing and feeling all these things, we sense a kind of hopefulness. Olsen (1986) reminds us that hope for return to well-being resides in the missing. Perhaps, as she suggests, it is the nurse's presence that is the embodiment of that hope. The presence of someone hopeful provides a moment of companionship, a moment of being *with*. For a moment, we are not alone.

The Talk of Comfort

"I'm here. I hear you. There, there. Everything is all right." These familiar words are comforting to many small children. There is a special tone and rhythm to the patter of these words. One senses that it is not the words in themselves that are important, but rather the person who is being revealed through the words. As Van den Berg (1974, p. 49) explains, "It is the tie between two people that endows the word with special power." In this case, it is the love between a mother and her child that stands behind these simple words and renders their transformative power to change the world for the child. The comforting words come before any analysis of what might be the matter. As Noddings (1984) explains, the words arise from the sharing of a feeling, a seeing and feeling with the other. In turn, "the one cared-for sees the concern in the eyes of the one-caring and feels her warmth in both verbal and body language" (p. 20).

As Anne recalls, adults, too, find comfort in the talk of others:

> The stretcher, the surgery itself—it's so metal and so bright—I remember very much, hearing the nurses, they were preparing everything, but they talked to me all the time. I remember hearing her voice as I went out, and that was very, very soothing. The humanity of that voice was so incredibly soothing.

The talk between nurses and patients occurs around kitchen tables, in hospital rooms, during the performance of routine nursing measures or painful procedures, almost anywhere where nurses are with patients. It is the gentle kind of talking, sometimes referred to as social talk and soothing talk, that occurs in these situations that is frequently associated with comfort. Having a nurse "just talk" with you makes you feel better. There may be a simple sharing of anecdotes and news about family or friends, or the nurse may speak using a technical vocabulary to explain the purpose of a procedure and what the experience will be like. Yet this talk seems to make one feel more comfortable. While the highly technical realm of health care has often devalued talking with patients, the experience of patients suggests the need to reconsider this assessment. What lies beneath the chatter of these words that we find so comforting? What do the words express?

> It was mostly a social talk. She [the nurse] would ask the appropriate medical questions and check the baby and do all the routine things they do in

the hospital, except it was done at home in a very relaxed way. We would have a cup of tea, and it would really brighten up my day. (Patricia)

Not all talk is comforting. The words of another can brighten or darken my day. The nurse is not another isolated entity, sitting beside me, pouring out empty words. Rather, she is one who is or is not together with me, a togetherness that is visible in the things we both observe. If we hear in the nurse's words a lack of regard or scorn, then "things wilt and molder around us, all color fades and light becomes a faint glimmer; our body also decays" (Van den Berg, 1974, p. 60). However, when the words of a nurse are directed to me and me alone, in a way that I can see and feel the concern in her voice, the distance between myself and the world seems to decrease. A caring person is revealed through those words. There is a sense of giving in that voice. I feel accepted and at home with the world again.

I wanted Beth to come back. She talked the whole time she was doing this [preoperative preparation]. There was a genuine sense about her, even though, you know, I wasn't anybody special to her, but somehow I felt like that and that made me feel really good. (Anne)

Perhaps, in a way, this comforting talk also reminds us of the voices of our mothers and helps us realize and accept our need and dependence on others. In this sense, the talk opens us to a way of being with another that allows us to receive the comforting and strength of the other, opens us in a way that simply telling and directing cannot do.

The Hands of Comfort

Sandy [the nurse midwife] was wonderful. I remember her touching my legs after the baby was born and after the placenta was delivered. She touched my legs and rubbed my feet a little bit. Nobody ever did that to me since I was really little and my mother rubbed my feet for me. (Patricia)

Touch is the contact of one human being with another, an immediate participating in each other (Van den Berg, 1974). Why is it that when we are ill this kind of contact with another becomes such an important source of comfort? As patients we become vividly aware of the effect of the confident hand that clasps ours as we await surgery, the gentle hand that slips beneath our bedridden bodies to help us reposition ourselves, the knowing hand that bathes us, the friendly hand that touches our shoulders, and the strong hand that supplies the supportive embrace. But what is it about a nurse's touch that we find so comforting?

Perhaps it is in the touch of a nurse's hand, the nature of the contact, the nearness of the other, that caring is revealed. Anne's experiences of being turned in bed following surgery reflect differences that had a direct impact on her comfort:

There was someone who kind of came in and was able to do that [repositioning in bed] in a way that did, in fact, make me feel much more

comfortable. There were people who weren't really listening to who I was, and you just sort of became a lump on a bed, that needs to be turned over every four hours.

Just the performance of comfort measures for another as routine interventions do not in themselves enhance patient comfort. These measures provide the possibility for comfort only in the context of a personal response to another's vulnerability. When we are ill we need to feel that these measures are being done *for us* and *with us* and not simply *to us*. The nature of the hand that performs these measures underlies the difference here.

A skillful or gnostic hand (Van den Berg, 1974; van Manen, 1990) is guided by the technical knowledge of nursing or medicine. Each movement is calculated, smoothly linking to the next, in order to intervene as effectively as possible. Thus, while there is contact between patient and nurse, a distance exists between the two. The act of the skillful hand is a depersonalized act. When the procedure is done to a patient, the patient is no longer seen in his worldly image but rather as an object, an anatomical self. The hand that offers possibilities for comfort is a knowing hand of a different kind. This hand does not touch a body of blood vessels, muscles, nerves, and bones, but rather it touches the body of a living person. This pathic or caring hand (Van den Berg, 1974; van Manen, 1990) is guided by a knowledge of a sensitive kind, a knowledge that has as its end thoughtful, caring action. Thus the caring hand that gently supports a patient as she turns to find a new position in bed does not touch the skin that encloses a body, but this hand touches the woman herself. The gentle contact of the hand and the woman's body is a direct contact between two human beings, the nurse *with* the patient. We notice that the caring hand anticipates the pain involved in moving, slips so easily under us, fitting perfectly to the curves of our back, and finding just the right place to support us. The fear of pain vanishes for a moment as we both move together to a new position with ease. From this place, the world takes on a different light. Yet there is some ambiguity here, for even a patient knows that simple procedures, like repositioning someone in bed, have a skillful element. Perhaps, when procedures are accomplished with the skillful hand alone, the patient is not comforted. Perhaps it is only the caring hand that comforts.

The Comforts of Home

I would prefer to be at home because the type of comfort I can have here cannot be anywhere, equal, or compared with in the hospital. It's entirely different. You're out of your own element, so you're on someone else's territory. So that's the bottom line, you could never be as comfortable as you are at home because it's someone else's territory. (Patricia)

When Ted came in and his sister and we turned the lights down low and watched TV and kind of sat around and talked—there was a nice warm, kind of feeling, where you don't mind being there. But then, all of a sudden

they have to go and you're back into this kind of antiseptic environment and they want to know if you want a sleeping pill, and you're back in the hospital. (Anne)

The ill person feels far from home. Whether being treated at home or in hospital, medical technology is formidable. While the properties of a patient's environment have been recognized as essential considerations for the nurse who comforts the patient (Watson, 1979), the environment in which health care is provided is often described as too inflexible and bound by tradition to meet individual comfort needs. The bright lights, the shiny metal of hospital carts and equipment, the stiff vinyl furniture, and the fact that each room is exactly like the next are constant reminders of the depersonalized features of the hospital. It is a foreign space (Bergum, 1989). Even when this technology enters the home, the environment is transformed into something strange. What does it mean to be comfortable in the technological context of health care? How does the environment affect our comfort? In response to patients' desire for a homelike atmosphere, there has been an attempt to redecorate some health care environments using a softer decor, blending the effects of color, light, bedside television, wallpaper, and piped-in music. But is this all there is to homeness?

From her bed in a two-bed ward, Anne was recovering from emergency surgery. This was her first experience of hospitalization. Despite the fact that the smells, sounds, and sights reminded her of her dislike for hospitals, some nurses were able to help her feel comfortable in this environment. She explains it this way:

Giving individual attention is much more difficult, takes much more time, but that to me is part of what makes you feel comfortable, or what makes you feel at home, in a situation which is so unhomelike.

At home, we are at ease, comfortable with ourselves, we are who we truly are. At home, our public roles fade as we exchange our work clothes for jeans and begin to relate to others as husband, mother, friend, neighbor (Bergum, 1989). Dis-ease changes this. Immediately we become dependent on others; we no longer have the same control over our activities as we did in our own home; we do not feel like ourselves. Yet, with the individual attention of a nurse, Anne could be involved in deciding what was right for her:

She [the nurse] would come by periodically and say, "Do you need something, is it painful yet?" and I'd say, "No, but I probably will in a bit." And so, she was prepared to adjust her schedule for me which I suppose, strangely enough—I mean you feel more at home somehow, with that kind of an attitude.

Patient say they feel most comfortable when they are in control. But what do they mean when they want to be in control? Complete control is never possible. As Bergum (1989) suggests, perhaps it is not control but

self-reliance that is wanted—a kind of self-reliance that does not lose the support of others. She states: "A foreign space, by the fact that it is not home, creates a problem of control, of 'whose hands it is in'" (p. 97). In hospitals, it is easy for nurses and doctors to take responsibility: it is their space. At home, although nurses are in attendance, the responsibility falls on the patient: it is their space. As patients, we feel more comfortable, more at home, when we are given the autonomy we need to feel in control. We feel comforted when we are respected for who we are. A cup of tea before bedtime? A light in the room? Another pillow? An extra blanket? The curtains drawn? A sponge bath before or after breakfast? Where would you like to sit? Where would you be most comfortable? Anne explains:

> It seemed like she [the nurse] was suggesting more things and I would be agreeing, "Well, yes, lets do that," instead of being told or directed. I felt really relaxed. She was just ready to work around whatever needs I had.

Health care environments can become a home away from home not just by changing the decor but, more importantly, by allowing the patient to be at the center, the center of each day.

Things from Home

The hospital gown, without a back, is revealing. Its shapelessness and uniformity of color and size neuter the reality of individuals who experience illness. However, when admitted to hospital, some patients bring their own pyjamas or nightgown. Wearing her own clothes helped Ruth feel comfortable:

> I would take my own clothing and not wear the hospital gowns and some of the nurses would be okay with that and some, because I would wear a jogging suit or something, were not. I would look after my own comfort needs. I learned to be assertive and do that for myself.

Clothes can express a patient's individuality, but they do more. A comfortable pair of pyjamas or clothes takes on a special significance. Worn before, often many times, they have become a part of us. Putting on *my* nightgown is not like putting on any other. Immediately I am reminded of those quiet warm nights in the familiar surroundings of my home and family, the traditional bedtime routines, the kiss goodnight, and turning out the light above my bed when my eyes cannot stay open long enough to read another page. For a moment, I am back at home again. Clothes, and the other things we bring from home, tie us to family and friends and to the support that is needed during experiences of illness, in a homelike way. For a moment, I am *with* them again.

The Time of Comfort

> There is a level of comfort that comes with familiarity and knowledge—knowing the extent of it [nausea], knowing when it would end, knowing the time it would start...kind of knowing its cycle and being able to rely on

that. If there were changes or something went wrong or whatever, then that would create discomfort. (Ruth)

Illness teaches us that there are undesired and undeserved pains that must be lived through. Yet, with time, others help us see that suffering is not strong enough to take away the peace of comfort. The pattern of discomfort that Ruth experienced after each session of chemotherapy offered her possibilities for comfort. There was comfort in knowing the nausea would pass. She waited for that time. A nurse cannot change the progression of disease or the side effects of chemotherapy, but she can help ease the experience. She can help us come to understand the patterns of discomfort and provide the light by which we can see beyond our despair. Although each session of chemotherapy, each day of dis-ease, holds the mystery of *this* time, each time of discomfort also brings its own possibilities for comfort.

Perhaps that is why our needs for comfort do not often fit with hospital schedules. Our needs for comfort change with time. We often hear of a patient having to wait for the next analgesic because it cannot be given for another half an hour, or another who is resting comfortably in bed only to be wakened to be offered a sleeping pill. When we speak of comfort, time becomes an important issue. But if comforting is a gesture in response to another's vulnerability and pain, it must be grounded in the life world of the patient. True comfort is founded on patient time rather than hospital time.

To Conclude

Disease Both Burns and Blesses Us

Dis-ease forces us to ask "What is to be done?" It is up to the doctor, he will know what to do. Yet the doctor knows only how to treat the malfunctioning organ (disease). We do not know this organ. We know the illness, the suffering, and we cry out for something more. The question "What is to be done?" is repeated in our cry for others to hear, leaving us open to other possibilities, possibilities for comfort. It is only through pain and suffering that we come to know something of comfort. Through comfort we find something good in ourselves and in the world, even if we still live with the pain. The experience of comfort offers the promise of self-knowledge, knowledge of one's limitations and capabilities, and knowledge of the importance of one's relationships with others.

Comfort Provides the Bridge to the World

Our relationship with comfort is intentional; that is, our comfort is experienced in relation to our stance in the world as patients overwhelmed by the pain of fatigue, exhaustion, illness. Through the experience of comfort we become connected to the world again. It is our bridge to life, to living.

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To Be Comforted Is to Be Comforted by Another

There is a sense of self-sufficiency in the voices of patients who have been heard to say, "I can make myself comfortable." But is this the real thing? Can one remain alienated from others entirely and still be comforted? How could one bear suffering and pain alone? From the position of vulnerability and pain in illness, we acquire a renewed sense of the value of others and are open to them. We long for others to be near, even if we do not want to admit this openly at first. But if we are to be comforted when we are no longer able to rely on our inner resources, we must reach out for their help, their strength, to keep from being drawn into despair. Our illness makes us dependent on their care. We feel comfortable when we are connected to nurses and family who stay close to our beds. When they cannot be physically near, we remain connected to them through our thoughts and memories. If we maintain an alienated, self-sufficient stance, others cannot know our weaknesses. As a consequence, they cannot care, they cannot comfort.

To Be Comforted Is to Feel Cared For

The nurse who comforts responds to the weakness and vulnerability she sees within us. We let her come close to see, we open up with the hope that she might see more. Yet if she does not care to relieve our discomfort, it is multiplied tenfold. But how does this stranger (the nurse) care? The word "care" is derived from the Anglo-Saxon *caru*, meaning sorrow or anguish. To care means to feel concern for, to love; however, the one who cares must be prepared to suffer with others in their sorrow and anguish. Only when a nurse wants to come to know and share our suffering can she be moved to offer the tender gestures that we come to know as comforting.

Note

1. Unless otherwise indicated, quotes are anecdotes related to me by patients in interviews conducted for the purpose of this paper.

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