

EMPIRICAL STUDIES

The composite first person narrative: Texture, structure, and meaning in writing phenomenological descriptions

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Abstract

This paper illustrates the use of composite first person narrative interpretive methods, as described by Todres, across a range of phenomena. This methodology introduces texture into the presently understood structures of phenomena and thereby creates new understandings of the phenomenon, bringing about a form of understanding that is relationally alive that contributes to improved caring practices. The method is influenced by the work of Gendlin, Heidegger, van Manen, Gadamer, and Merleau-Ponty. The method's applicability to different research topics is demonstrated through the composite narratives of nursing students learning nursing practice in an accelerated and condensed program, obese female adolescents attempting weight control, chronically ill male parolees, and midlife women experiencing distress during menopause. Within current research, these four phenomena have been predominantly described and understood through quantified articulations that give the reader a structural understanding of the phenomena, but the more embodied or "contextual" human qualities of the phenomena are often not visible. The "what is it like" or the "unsaid" aspects of such human phenomena are not clear to the reader when proxies are used to "account for" a variety of situated conditions. This novel method is employed to re-present narrative data and findings from research through first person accounts that blend the voices of the participants with those of the researcher, emphasizing the connectedness, the "we" among all participants, researchers, and listeners. These re-presentations allow readers to develop more embodied understandings of both the texture and structure of each of the phenomena and illustrate the use of the composite account as a way for researchers to better understand and convey the wholeness of the experience of any phenomenon under inquiry.

Key words: *Composite first person narrative, phenomenology, female adolescents, obesity, accelerated nursing program, male parolees, reintegration, healthcare, distress, menopause*

(Accepted: 10 March 2011; Published: 12 April 2011)

Introduction

There exists a tension in writing phenomenological descriptions: how best to present qualitative research to convey its findings in a way that is meaningful for others that also meets scientific standards of credibility, dependability, or confirmability (Denzin & Lincoln, 2005). It is tacit that knowledge is gained and shared in order to ascribe meaning with others so that sense can be made of things and situations. Because of this human

science research is not just a personal cognitive process. According to Eugene Gendlin (1997), it is also a lived body participation, a "felt sense." It is intimate participation in life that makes knowing possible. Within this philosophy, research regarding human experience is not only logical but responsive and authenticates the experience of the phenomena. This is resonance; more than explanation, it is understanding (Risser, 1997). Sharing these understandings is the goal in publishing qualitative research.

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In order to do this, the researcher must provide the texture that brings the fullness and richness of the experience to the reader so that it is alive in Gendlin's "felt sense," allowing one to go beyond emotion or a mere feeling about the topic, and find in oneself the physicality evoked by the words (Gendlin, 2004). And yet the researcher must provide a structure that "thematizes," expressing the boundaries of the phenomenon with other experiences and contexts in generalities to reveal what it essentially appears to be (Todres, 2007). A challenge to the researcher is to find a balance of texture and structure in describing the phenomenon. Todres (2007) established a method that explicates how this might be accomplished through the blending of texture and structure in the form of a composite first person narrative. This paper will illustrate how the use of Todres' method to harmonize the texture with the presently understood structures of four different phenomena creates new understandings that are more evocative of the complex experiences of each phenomenon; understandings that carry both the "what is it like" as well as an openness to possible variations (Todres, 2008).

This paper takes its form from a panel presentation to the 29th International Human Science Research Conference. It stems from the authors' collaboration in a professional writing group that included an exploration of Todres's *Embodied Enquiry* (2007). The composite first person narrative resonated with the authors as a method by which sense was made of the difficulties each author had separately experienced in writing phenomenological research for presentation to the nursing community. The application of Todres' method is further described and exemplified in this paper through the presentation of findings of different phenomenological inquiries using composite first person narratives. The four phenomena presented are the lived experiences of student nurses (McNiesh, 2008), obese adolescent girls (Wertz, 2009), male parolees (Marlow, 2008), and menopausal women (Nosek, 2007).

Background

Interpretive phenomenology was used in the design of each of the four inquiries, which were each conducted under approval of the University of California San Francisco Committee on Human Research. There are several basic assumptions to phenomenology as a human science research method: (1) humans are social, dialogical beings; (2) humans are self-interpreting, i.e., hermeneutic activity is always already under way; (3) interpretation presupposes some shared understandings; and,

(4) interpretation requires involvement in a dialogical relationship of the interpreter and the interpreted (Dreyfus, 1999; Heidegger, 1962; Plager, 1994; Taylor, 1985). This method is especially well suited to the study of persons, events, and practices on their own terms (Benner, 1994). It is characterized by data collection using in-depth, semi-structured interviews, and field observations of participants (Benner, Tanner, & Chesla, 1996); by analysis centered on interpretation of text leading to an understanding of world, self, and other (Dreyfus, 1999; Heidegger, 1962); and by incorporating narrative analysis methodology (Gee, 1985, 1986; Labov, 1997; Riessman, 1993, 2002).

Text is defined as a hermeneutic term (Risser, 1997) and extends beyond what is written to other aspects of a phenomenon that are open to interpretation, such as oral narratives, observed practices, habits, and experiences (Benner, 1994; Dreyfus, 1999). The concept of the hermeneutic circle influences this methodology in every way. Within the Heideggerian perspective it is assumed that the self is constituted and shaped by the world it is raised within; and that the self is always already situated in the world. We understand that it is this situated-ness that makes it possible for things to show up for us at all (Merleau-Ponty, 1962) and for us to act in the manner that we do. This kind of exploration affords us a shared understanding of the close-in world of the informants and an understanding of a phenomenon as described by those that embody it (Gendlin, 1997).

Narrative is an important element in interpretive analysis, with its emphasis on the elements of language: how words are put together, what words are chosen, where pauses and emphases are inserted, and the presence of exclamatory and emotive utterances (Polkinghorne, 1988). Embedded in the language is a discovery of what matters to the narrator, the listener, and the society and culture at large (Lawler, 2002).

Method

The composite first person narrative is a reflective story. It draws a composite picture of the phenomenon emerging from the informants. The composite is not a simple re-telling. It is interpretation by the researcher in several important ways: through her knowledge of the literature regarding the phenomenon under enquiry, through listening and hearing the stories told by the informants, and through her own reflexivity during the process. As outlined by Todres (2007), the composite first person narrative is more than a definition or series of statements about a phenomenon; tells something that connects

with universal human qualities so that the reader can relate personally to the themes; is a story that readers can imagine in a personal way; attempts to contribute to new understanding about the phenomenon; and is not exhaustive, but allows the topic to be seen more clearly. It aims to illuminate, to allow the reader to have an increased sense of contact with the phenomenon without fully possessing it. Use of the personal pronoun “I” is essential to the method. It indicates the composite-informant in the first-person sense as someone who typifies the general experience within a living and situated context.

In order to write the composite narrative regarding the chosen phenomenon, each of the authors initially approached the project similarly. Each began by re-reading informant interview transcripts, re-reading memos and paradigm cases written during prior interpretive sessions, and re-visiting findings in previously written papers and dissertations. Each has dwelled with the data from the original project for at least 2 years. The process of creating the actual composite narratives took two different forms, one initially more structured and the other initially more textured. Two of the authors wrote their first drafts by outlining the structure or themes that had been previously identified (within their previous papers and dissertations) to frame the narrative. For the other two, the first drafts were evoked from within and written as texture-rich stories that required editing to draw out the structure that, as taken-for-granted, had receded into the background. The authors critically reviewed each others’ iterative written drafts in preparation for the panel presentation of the composite narratives at the International Human Science Research Conference. In preparing this manuscript the authors have incorporated feedback from conference attendees and other reviewers.

In the paragraphs that follow, the reader will find a brief description of the distinct phenomena under enquiry, followed by the respective first person composite narrative. Since three of the studies are specifically related to persons across the life span who have experienced phenomena regarding health and well-being and one of our studies addresses experiences of becoming nurses who will care for such persons, the composites are presented accordingly. First is presented the phenomenon of nursing students navigating the new foreign world of nursing and medicine, followed by the experience of adolescent girls making sense of living in large bodies; men with chronic diseases negotiating the space between imprisonment and the free world; and concludes with a study of aging women transitioning through the final stages of reproduction.

Formation in an accelerated nursing program: learning existential skills of the practice

The overall goal of McNiesh’s interpretive phenomenological study (McNiesh, 2008; McNiesh, Benner, & Chesla, 2011; McNiesh, 2010) was to articulate the lived experience of students in an accelerated master’s entry program learning the practice of nursing within a clinical setting. Nineteen students from an accelerated master’s entry program in nursing (MEPN) located within the western United States were purposively recruited for this study. Previously understood as self-motivated adult learners (Cangelosi, 2007; Meyer, Hoover, & Maposa, 2005) with a variety of life experiences (American Association of Colleges of Nursing, 2010), students in accelerated master’s entry nursing programs are thought by educators to be more favorably positioned for these intense and condensed programs. The findings of this project indicate that particular clinical learning, afforded by practicing on their own, was pivotal for these second degree MEPN learners. Themes apparent in their narratives include (1) existential skills of navigating the practice environment and (2) forming agency as part of a new identity. Agency, the ability to take a stance and influence the situation, forms and develops because situations are often ambiguous and the practitioner must choose from a number of options and actions.

The MEPN composite first person narrative. Entering the hospital as a brand-new student was like being in a foreign country. Time was different. Light was unnatural and constant and there were unfamiliar noises and beeps that I didn’t understand. There was a practical side of learning important but mundane knowledge that I didn’t know for weeks such as the operation and significance of the call light. No one had pointed that out to me. Something just magically beeped and blinked and I didn’t know where it came from—or why it existed—or how to turn it off. And then there was the medical lingo. I didn’t understand probably three-quarters of the conversations between medical professionals. It reminded me of the times I’ve traveled abroad and just ultimate culture shock; what are the right behaviors in this environment? I mean—in what country do you meet someone for the first time and ask them about their bowel movements?

During our hospital orientation we were confronted with an early reminder of the reality of death: the code blue cart. If anyone did code, we would be expected to start cardiopulmonary resuscitation (CPR). I’d never been around acutely ill people. I had no context to begin to understand. It was terrifying. I remember the first weeks being

asked to feed patients—something that you think would not be scary, but these people were at risk for aspiration. You needed to make sure they were sitting totally upright and were chewing all their food and didn't have trouble swallowing. The once benign act of feeding a patient became terrifying because I could unwittingly harm someone. But I guess that added to my sense of responsibility—I was now operating in a high stakes learning environment: the risks were real, and it was better to know them than ignore them.

At first, I felt like a guest wearing a costume. My scrubs designated me as a nurse, but I did not yet have the confidence to give directions to patients, or to expect that patients would believe in my abilities sufficiently to follow my instructions. Initially I was afraid to even walk into the room alone. But I needed to walk into the room alone. I just had to suck it up and go in. And at a certain point I perceived a change. I could do more stuff and was making more decisions, coming to conclusions about patient care, taking information that I received from the patient as to what they needed or how they were doing and turning that into action. I felt more confident and independent. Somehow there was a shift motivated by my direct connection with the patient without the middle person of the staff nurse to interpret what was needed. I was no longer a guest who was intruding on the patient or making illegitimate claims or requests. I felt entitled and responsible to coach and instruct patients, but especially, to perform uncomfortable procedures. Sometimes things like turning the patient or getting the patient out of bed were unwanted by a patient who was already in pain. Being “charged” with the care of patients, pushed me toward a more authoritative stance because I needed to take action based on what the patient needed.

This sense of being in charge of the patient's safety heightened my vigilance too. I paid more attention to equipment and to the particular details of care. I asked more questions and then I needed to think through what was wrong with the patient and what could go wrong. If I'm just observing, I may not pay attention to how many lines they have, what's running, or how many liters of oxygen they're hooked up to. But if I'm actually trying to take that patient on, I'd better look at every detail, because I actually have to be responsible. As a learning experience, it's much better to be the person who has to do it. Now the corollary of that is that it's riskier for patients. When we're actually the ones responsible, it means we can miss things: there's a level of danger in this learning. Without the gravity for me—without feeling like the patient's health is dependent on me, I just don't learn as

much. I need to feel that what I'm doing is making a difference and I just take it more seriously. It's also why I wake up in the middle of the night concerned about something that I forgot.

Much of nursing is physical, like re-positioning somebody in bed or putting in an intravenous (IV). You can watch somebody put in IVs all day, but—if you're just watching someone do it, it seems easy and seamless, and only once you actually do it yourself do you realize what can go wrong, and as a result you have the drive to perfect it. It's me in my body learning from the inside out. Physically performing the work of caring for patients required me to respond to situational demands. And that's how I learn—by doing the work. Anything that I found I had to follow-up with. It's very different than being a student who just observed but rather to be the one who took action and followed through.

Learning when and how to access other members of the health care team were existential skills that I took up to navigate the clinical environment for the sake of my patient. My care became more efficient when treatment decisions were not filtered through the nurse as go-between. At first it was a little intimidating to reach out to these different parties, but then you do it a few times and it's a lot easier. I see the network of the hospital much more clearly. Whereas [before] I felt like I was kind of floating and not really interacting with these different parties. Now I'm anchored. My sense of responsibility to provide effective care propelled me to communicate with these other folks on the health care team.

Becoming at home in the social and physical environment of the hospital entailed using equipment flexibly, navigating the physical environment, dealing with social expectations smoothly and skillfully, and developing my own care routines. All of that was part of taking on the responsibility for caring for patients, and in doing that I experienced emotions of concern and vigilance. My involvement with the patient, my sense of agency, and responsibility became motivating forces. Feeling the weight has been formative for me; I feel like the responsible nurse.

Experience of Obesity

The primary aim of Wertz's phenomenological inquiry (Wertz, 2009) was to describe how overweight adolescents experience and articulate the meaning of being overweight. Fifteen adolescent girls with a mean age of 15.8 years and mean Body Mass Index (BMI) of 40.13 kg/m² (99th percentile, termed “morbidly obese”) (American Medical Association, 2007), referred from a pediatric obesity clinic, participated in the study. Three home visits

and parent interviews were also conducted. While it has been noted that obese youth are 5.5 times more likely to report low Health Related Quality of Life than non-obese youth (Varni, Limbers, & Burwinkle, 2007), this study shows what being obese is for teenagers and its impact on daily life. In this composite first person narrative, the following themes are emphasized: (1) problematizing my body, (2) being under a gaze, (3) distinguishing good food and bad food, and (4) wanting to be like everyone else.

The obese adolescent girl composite first person narrative.

My parents brought me to this clinic and, boy, is it weird. First, I had to get up early and couldn't eat any breakfast. Then the doctor said I was fat—I mean really, that was harsh. I had been told by my regular doctor that I was putting on too much weight, but I didn't know this was so serious, that I have to see a special doctor. And this doctor says things that I don't want to hear, about how I won't live a normal life span, and I might have diabetes! This is scary stuff. I knew I was getting kinda big, but that's how the women in my family look.

I started getting bigger in about 6th grade, but lately I have gotten much bigger. It is hard to be big, in so many ways. Other people are really cruel—they're always talking about me, even saying stuff right in front of me. Kids can be so mean—they talk about everybody, if they are too skinny, too fat, too this, or too that. Mostly, I try to ignore it. But sometimes I get angry. I just get fed up with it. Just because someone is different from you is no reason to be insulting! I used to get into fights with people who teased me, but I don't do that much anymore. Even grown-ups will say stuff. I don't mean just my family, sometimes strangers make rude comments.

People are always looking at me. I notice it especially when I go out to eat. People look at me, turn around, craning their necks like they are looking at the scene of an accident. I can tell they are thinking, "I wonder what that fat person is ordering off the menu, I wonder what she's going to eat." When I go out with my skinny friends and they order a lot of food, no one says anything to them. But when I go into a fast food place, they say things like "what a fat-ass" and "oh my god, look at her." It makes it hard to just be out doing regular stuff.

Being a big person attracts attention from other people that I don't want. I have noticed that people give me a look—it makes me feel conspicuous and like I am different or not as good. I have gotten into the habit of checking out the size of other people in a new situation—like starting a new class at school, or going to a party. If there are other big people there,

then I know it will most likely be fine—but, if there aren't then I know that I will get "the look" a lot and I have to take extra care to not screw up or it will be even worse.

Another hard thing is that I feel like I am being monitored. My family does it to be helpful, I guess. Like, I baked some cupcakes the other day for my brother's birthday, and I was about to eat one and he said, "Why are you eating a cupcake, you're not supposed to." He really wants to help me out. Sometimes it does help—I will re-think eating it and maybe put it back. Other times it is annoying and I feel resentful about why I can't eat what everyone else does. Either way it bugs me that other people are paying so much attention to what I eat.

My mom tries to help me by having the right kinds of foods for me to eat, but we both get confused about this. The information we get seems to conflict. Like in school we learned the food pyramid, but the lady in the clinic said to throw out that idea. She taught us how to eat using a divided plate, and said to choose a protein first, and then fill up the plate with mostly fruits and vegetables. She gave us a shopping list. The foods on the list are too expensive, though, and not easy to find near our house. My parents mainly shop at a warehouse store where they can get more food for the same price. And, my dad and my brothers got upset when mom told them she was not going to buy soda or juice anymore. She still does buy it for them, but she gets "diet" for me. She does buy more of the good foods that I can eat now.

The rest of my family eats regular food. I asked my mom why she still buys the bad foods—like chips and cookies and other snacks. She said that since the rest of the family won't eat the healthy stuff she ends up throwing a lot of it away, and they also complain to her that there is nothing to eat in the house. They think my food is weird. My brother told me I must be turning into a rabbit because I ate so much lettuce and my cereal looks like straw. Sometimes I don't feel human anymore. With all the fuss over food our family hardly ever eats together. We all just get our own plates and go to our rooms, or we eat in front of the TV.

My favorite way to spend time is hanging out at the mall with my friends. After school or on weekends—we love to shop. I'm a "shop-a-holic" even though I can't even fit into the clothes I want. Sometimes I get mad, thinking if I was skinny I could be able to fit, but then I'm like "Dang, you can't!" So I want to lose weight, but I can't and then I am like "Dang!"—stuck in that little moment realizing I am too big and can't do anything about it. I just want something that makes me look good.

The main thing about me is that I feel like a skinny girl stuck in a big person's body. I'll just be cruising

along one minute, minding my own business, everything is fine—and the next thing I know someone is giving me that look, or saying something mean, or I can't fit into my desk or my clothes and it just reminds me all over again that I am big. That I'm not like other people. I have to go to a special doctor, eat special food, and shop in special stores. Really, I just want to be like everybody else.

Parolee's experience of community health care services

The purpose of Marlow's study (Marlow, 2008) was to understand how male parolees experience the community health care system and how their interactions with that system impact their reintegration efforts. Seventeen chronically ill male parolees 40 to 62 years of age enrolled in a residential substance abuse treatment program participated in this study. Marlow's research (Marlow & Chesla, 2009; Marlow, White, & Chesla, 2010) focuses on preventing recidivism, within a society in which 60–70% of male parolees return to prison within 3 years of release (Solomon, 2006). Her composite first person narrative emphasizes these findings: (1) participants' enmeshment in the correctional system and criminal life, (2) their frustration with and distrust of the health care system, (3) the overwhelming nature of their drug addictions, (4) their desire to change their lives co-mingled with feelings of futility and self-doubt, and (5) the influence of structural contexts of poverty and marginalization on their reintegration efforts. In creating this composite narrative, Marlow found that her desire to ensure that certain aspects of the participants' experiences were transparent to the audience played a part in the re-presentation that follows.

Male parolee composite first person narrative. Prison saved my life a lot of times. On the streets, I'm an extremist—lots of drugs and violence. When my parole agent picks me up I go back to the system and I regenerate my health. I get health care, sobriety, confinement—all things I need. It's not perfect, with how they treat you—you feel worthless. But there's lots provided for you in prison, that's not there for you on the streets. You get your old job back. You start eating again. I'm not saying I'm institutionalized but prison brainwashes you and takes way serious trains of thought on how to act out in society.

Seven years ago, I get out of prison. I am feeling good. I am doing some landscaping work for a friend, and all of the sudden I feel this ripping in my back and it hurt so much that I went to the county hospital emergency room (ER). I waited 8 hours to be seen and all they gave me was two shots of

morphine and some vicodins. I'm heroin addict! What's two little shots and some vicodins gonna do for me? They were kind a rude too. The exam was real rough and I felt like they looked down on me for being an addict.

Four weeks later, I finally get the appointment for physical therapy. It helped a little but not much. So I started using drugs again and then I got arrested. I can't say it was all the hospital's fault because I did give up and go back to prison. But I feel that if they had taken my back pain more seriously, if I could I've seen the physical therapist and the doctor more than once a month, I might have made more of an effort, but it just seemed so pointless and like they weren't really interested in me.

For now, I am in this drug treatment program and I am glad to be here, but I'm off parole in February so the State's not paying for me no more. Just pushed out the door—no good-bye, nothing to show for it. And I am remorseful for things I've done in society. I'm not a monster. I need to make this program work because if I can't get it together this time and I go back to drugs, I'll go back to prison and I don't want that, but it's so close and that's scary. But what can I do? I'm an addict with no place to live and no real job skills. I walk with a cane and can barely bend over. I can't work the jobs I used to like landscaping. I guess I could work one of those telecommunication jobs but that just seems so . . . I don't know. I've been in prison for over 20 years, in solitary confinement for most it, so I don't feel comfortable talking to people. I need my health back, so that's why I keep going back to the county hospital even though it's frustrating. They lost my medical records the last time I was there.

There was this one time, I saw this doctor and he was real good. He knew I was in real pain, and I wasn't making it up just to get drugs. He took me seriously and he listened to me, took notes, and then he gave me a full exam. I've never had an exam like that before. He figured out about my drug use and didn't judge me for it. For the first time, I felt hopeful, like I would get better, like there was someone who really cared. When I went back the next time, it was a different doctor who didn't seem to care so much.

I want something different for myself, I really do but sometimes selling drugs seems like it's the only thing I can do. Even when I've tried in the past to do something different, like one time I went to cooking school and my girlfriend at the time, she was using, and I didn't want her out hooking in the streets so I told this guy I would hold for him. I would keep the drugs in my locker at school. The director of the school found out, so I took the drugs and I left. I had to. It was \$500 and I needed the money. So I just

can't seem to get it together but I also don't want to be some big dealer either. The pressures of the criminal life are real, your life is at stake on the streets. I've been shot, stabbed. So, using drugs takes my mind off things. It hides the fact that I'm not making it, and that I might not ever make it. It gets depressing at times, like I might as well wait to get picked up, go back to prison. It's like, "Hey, see that car with the red light on top? That's my ride."

Experience of distress during menopause

The purpose of Nosek's narrative analysis study (Nosek, 2007) was to explore the experiences of distress for women during the menopausal transition. It had been noted by others that women who are distressed during menopause score high in neuroticism and trait anxiety (Bromberger & Matthews, 1996; Kuh et al., 2002). One of the specific aims of Nosek's study was to explore what constituted distress for the midlife woman. Her study included 15 heterosexual women, between the ages of 40 and 60, who were currently experiencing or had previously experienced distress self-attributed to menopause. Specific details of the method including recruitment, data collection, and analysis and findings are reported elsewhere (Nosek, Kennedy, & Gudmundsdottir, 2010). Women shared stories of frequent, unpredictable, and persistent symptoms; lived within the context of their interpersonal, professional, and social lives. They shared the process of making sense of their noted changes through interpretation of their own and other's responses to them. In addition to the intense symptom experiences, some women expressed feelings of shame regarding menopause and aging and how that caused them to withdraw in silence. Others shared fears of aging and the perception of others' insensitivity toward their experiences. The following composite first person narrative captures these themes and experiences of the phenomenon.

Women who experienced distress during the menopause transition. Some people make fun of it—the menopause. Like the time I got a brooch from a friend about being proud to have it as if it is some charming life passage. That made me so angry. Most likely she hadn't suffered like I. Or how about those who simply believe that all menopause women are crazy or neurotic? Like that bumper sticker, "Quick, give me a gun; I'm out of estrogen." I don't identify with either. I know it is a natural life occurrence, but in light of the persistent, intense, and unpredictable symptoms I have, I feel misunderstood or even worse, trivialized. This intensifies my distress. If

I could just have one person validate my experience, but they can't seem to fathom what I am going through. Thus I become silent, withdraw, and suffer privately.

I don't know why I feel embarrassed when I break into a sweat for no reason, but I do. I can't think of anything worse than to be in public and out of nowhere become all red, hot, and sweaty and then need to explain to others what is going on. For me to feel this shame, I must be deviating from some norm, like that of a perfectly composed, cool, elegant woman I suppose.

Yes, in a society that values youth and beauty, I, as an aging woman am probably viewed as aberrant. I imagine this is why I do not want to go through menopause. I fear joining the "other side" and I risk losing all of my "young woman power." Perhaps this is why other aging women don't want to talk about it, as it may outwardly expose their waning femininity. And I don't blame them. But sometimes I want to shout it out that I am flashing and that this is who I am, and that I am more powerful and wise and sure of myself than ever. It is confusing, these contrasting feelings. One moment I feel strong and self assured and the next I feel fearful, disempowered, and ashamed. Menopause and aging—it's hard to know which I am reacting to. But at times this stigma feels like the "scarlet M" or better yet, the "scarlet A."

At night, I get no rest. I fall asleep and, shortly, I awake hot, throw the covers off, then cool down, and finally drift asleep again. One hour later, I awake hot, get cool, and sleep. The cycle continues . . . over and over and over. Or some nights, I spring awake for no reason, with an electric shock rushing through my head. Then, wide awake, I am utterly unable to return to sleep. By morning I am com . . . plete . . . ly ex . . . hau . . . sted. In the day, I desperately try to relieve my symptoms, perusing pharmacies and health food stores, trying the latest natural remedies, but nothing seems to work. It's chaotic, a never ending story, just a downward spiral. I ask others . . . older women, "What did you do?" "Just take Premarin," they reply. I don't want to take hormone therapy. I've always been able to "fix" what is going on with me. This time I can't. I feel such a loss of control. This is the most distressful.

I know it would be different if I were in a different situation—like with my relationships, or my work, or if I didn't keep comparing it with how things were in the past. I'm overall very healthy. I do all the right things. I eat well. I exercise (although now I stopped going to the gym because it brings on hot flashes). Perhaps I'm just not doing enough. Perhaps I should go on hormones but I will feel defeated in a way because it would mean that I can't heal myself. But then I'll feel victorious because my symptoms will be

relieved. And what about stroke? Or breast cancer? I have heard about all those studies that have shown that hormone therapy is now bad for you.

Sex is different these days too. I used to have beautiful fantasies but now, I don't even think about it. That's fine when my man has no desire. But often he does. And if I do engage, it either triggers a hot flash when he is on top of me, heating me to 200 degrees, or he takes too long to ejaculate and I become dry and sore. But I cannot tell him. I fear losing him.

These experiences often feel so out of context with my life. The past, present, and future blend into one moment, and the linear concept of time as I know it seems so foreign. Only in relation to my calm past does this present anxiety seem so salient. And only with the potential fear of loss in the future do I truly believe I am going to lose my mind. Who am I now? My attitude scares me. It really does because it's like I'm a totally different person. All that I was familiar with, which grounded me to the reality of self, family, and work, now eludes me. It's "just a painful reminder that I am getting old."

Sometimes I withdraw out of desperation. At other times, I recoil to seek meaning in all of this. You could call it a quest in some way. This empowers me. I reassess my values and I am now grateful for the simplest of things. I have time only for the few who understand me. In review of my life, I think of things I did not accomplish, and the loss of my physicality, and I fear losing mental clarity. I think of death more now too. I think of my mother, her fading, her death. Will the same happen to me?

In a way, this menopause feels like a death, just preparing me for the ultimate. It's full of uncertainty, kind of like a snake getting a new skin, not knowing what the new one will be like.

Discussion

Utilizing Todres's method for writing phenomenological descriptions allows the researcher to reconsider qualitative interview and observation data in a new—but inherently familiar—way. The individual narratives of each study participant are unified with the reflexive understandings of the researcher in the telling of the composite narrative. This complex retelling affords the reader the ability to explore the "felt-sense" of the informants' experiences. It does this while locating those experiences in a particular structural world. It is in this space, balanced between structure and texture that the work has relevance. It is this space in which interpreters as well as readers can have a "felt sense" of each of these four different phenomena.

The resultant composite narratives are accessible to us because each reveals something that matters to us in our being-with. Heidegger described this always already in relationship with others as "when we are explicitly hearing the discourse of another, we proximally understand what is said . . . we are already with him, in advance, alongside the entity which the discourse is about" (Heidegger, 1962). For health and social care practitioners, the act of being-with is central to practicing care that is sensitive to unique persons and contexts while considering any evident patterns and what is transferable in a phenomenon. It allows for providing care that is judgment-based. Judgment-based care, as described by Polkinghorne (2004), incorporates various levels of knowledge, using evidence as well as understanding. This sort of everyday caring practice may be more appropriate for human beings, who are complex whole beings with a sense of worth, than is the more technically, rationally focused practice of evidence-based care (Todres, 2008).

For example, in writing the composite narrative of the overweight adolescent, Wertz uses the language of the teenage informants to evoke for health practitioners in the audience a sense of what it is like to be obese and treated in the usual way—it is "scary," "hard," "confusing." The evidence-based strategy of weighing, measuring, and medicating objectifies the patient in a way that interferes with the ability of the clinic staff to empathize and tailor care to a particular girl. The clinicians' ability to have a positive impact on the lives of young women depends on them using judgment-based care, coming from an understanding of the girl's world and her way of being in it. In this way an embodied understanding facilitates better care. Additionally, this composite narrative when shared with other obese teens affords them a new understanding of the complex situations they encounter. Seeing one's own experience as not so unique as previously believed may improve a teen's general sense of well-being.

With regard to male parolees, findings expressed through the composite narrative suggest a need for new ways of conceptualizing reintegration that includes health more centrally in the processes of success or failure. The results also suggest that the health care system can sustain newly released individuals in their home communities for an extended period of time (Sheu et al., 2002; Solomon, 2006; Vigilante et al., 1999). However, effective clinical practice with men on parole should incorporate assessment of, and accommodation to, the multiple and complex needs of this population. By demonstrating interest in their problems and clinical attention to parolees' complaints, clinicians

can encourage male parolees' engagement with the health care system. Conversations about the role of illicit drugs on medical conditions can provide a basis for more in-depth discussions about patients' addiction disorders and interest in changing their circumstances. Non-judgmental discussion about the negative and positive roles that addiction and criminality play in their lives and their readiness to change may enhance parolees' disclosure and clinical engagement. In order to effectively support and care for chronically ill individuals on parole, the health care system, as an institution and as individual clinicians, must begin to integrate the problems and issues of long-term involvement in criminal and prison life into its evaluation and treatment of these individuals.

Using Todres's method to interpret and write phenomenological descriptions does not address all of the possible important themes that are to be found in qualitative inquiry. Its focus is limited to commonalities. Implementation of this method is best suited to data the researcher has repeatedly reviewed and dwelled with over a long period of time. One caveat is that the researcher must resist becoming too focused on the final representation but rather always remain close to the text, as phenomenological research is about understanding phenomena not creating a product. It is through engaging with the text that the essential meaning of and the themes within the phenomena will become clear. This method's strength is that it allows researchers to constitute an embodied relational understanding of a phenomenon that is the experience of another and make it available to a wider audience.

Conclusion

Ultimately the goal of using composite first person narrative is to express the insights gleaned through qualitative research in a way that is accessible to others; in a way that will add to the knowledge of a certain phenomenon and increase empathy in health and social care providers.

As has been demonstrated, the composite first person narrative can be used to express the voices within a vast range of human experience. In these composite narratives, the authors have shown this method applied to different kinds of phenomena by re-presenting the experiences of nursing students forming skills of a new profession, adolescent girls navigating the world in their large bodies, male parolees finding respite in the "security" behind prison walls, and midlife women seeking to be heard and understood while transitioning through their changing bodies. Woven into these voices are the voices of four nursing researchers and each of their

life-worlds, simultaneously similar and different. In this exercise of weaving together structure and texture in an embodied interpretation of the study participants' narratives, the authors have aspired to evoke a "felt sense" in the reader; to elicit an embodied understanding of these phenomena in a balanced manner, with thematic structure portrayed in a texture-rich and authentic way. By re-visiting the original data, findings papers, and early drafts of the composite narratives to craft this manuscript, the authors found that this iterative interpretation continues to deepen understanding and shape their own caring practices.

Conflict of interest and funding

The authors report no conflicts of interest. The authors disclose receipt of financial support for their research: University of California Office of the President Dissertation Year Fellowship (Wertz), National Institute of Nursing Research (1 F31NR 9749-03) (Marlow), the UCSF School of Nursing Century Club Award (Wertz & Marlow), and The Betty Irene Moore Doctoral Fellowship (Nosek & McNiesh).

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