2

Peplau's Theory: Assumptions, Concepts and Propositions

Introduction

Assumptions are basic beliefs within a given theory that are accepted as true. One must accept the given assumptions of a theory in order to adopt it. The concepts are the major components or building blocks of the theory. Propositions describe the relations among concepts.

Assumptions of the Theory

In Peplau's 1952 book she identified two "guiding assumptions" that were underpinnings to her framework. These were:

1. The kind of nurse each person becomes makes a substantial difference in what each client will learn as she or he is nursed throughout her or his experience with illness (p. xi).
2. Fostering personality development in the direction of maturity is a function of nursing and nursing education; it requires the use of principles and methods that permit and guide the process of

grappling with everyday interpersonal problems or difficulties (p. xi).

Peplau (1989d; personal correspondence, December 1990) has also stated as assumptions that:

3. Nursing can take as its unique focus the reactions of clients to the circumstances of their illnesses or health problems (1989d, p. 28).

4. Since illness provides an opportunity for learning and growth, nursing can assist clients to gain intellectual and interpersonal competencies, beyond those that they have at the point of illness, by gearing nursing practices to evolving such competencies through nurse-client interactions (1989d, p. 28). Peplau references Gregg (1954) and Mereness (1966) in the development of this fourth assumption.

Additional implicit and explicit assumptions identified by Forchuk (1991c)[1] include:

5. Psychodynamic nursing crosses all specialty areas of nursing. It is not synonymous with psychiatric nursing since every nurse-client relationship is an interpersonal situation in which recurring difficulties of everyday life arise (summarized from Peplau, 1952a, introduction).

6. Difficulties in interpersonal relations recur in varying intensities throughout the life of everyone (Peplau, 1952a, p. xiv).

7. The need to harness energy that derives from tension and anxiety connected to felt needs to positive means for defining, understanding, and meeting productively the problem at hand is a universal need (Peplau, 1952a, p. 26).

8. All human behavior is purposeful and goal-seeking in terms of feelings of satisfaction and/or security (Peplau, 1952a, p. 86).

9. The interaction of nurse and client is fruitful when a method of communication that identifies and uses common meanings is at work in the situation (Peplau, 1952a, p. 284).

10. The meaning of behavior to the client is the only relevant basis on which nurses can determine needs to be met (Peplau, 1952a, p. 226).

11. Each person will behave, during any crisis, in a way that has worked in relation to crises faced in the past (Peplau, 1952a, p. 255).

Concepts of the Theory

Peplau's theory focuses on the interpersonal processes and therapeutic relationship that develops between the nurse and client. Figure 2.1 depicts the major concepts of Peplau's theory within this interpersonal perspective.

The metaparadigm, or core concepts, of nursing includes: nursing, person, environment, and health. Peplau's theory defines the concepts of the metaparadigm in the following way:

1. *Nursing* is an educative instrument, a maturing force, that aims to promote health (Peplau, 1952a).

2. *Person* is an individual, developed through interpersonal relationships, that lives in an unstable environment (Peplau, 1952a).

3. *Environment* is physiological, psychological, and social fluidity that may be illness-maintaining or health-promoting (Peplau, 1952a, p. 82; 1973c; 1987a).

4. *Health* is forward movement of personality and other on-going human processes in the direction of creative and constructive personal and community living (Peplau, 1952a).

Interpersonal Focus

The interpersonal focus of Peplau's theory requires that the nurse attend to the interpersonal processes that occur between nurse and client. This is in sharp contrast to many nursing theories that focus on the client as the unit of attention. Although individual client factors are assessed, the nurse also self-reflects. The focus is the interpersonal process and relationships, not the constituent parts (or individuals). Interpersonal processes include: the nurse-client relationship, communication, pattern integration, and the roles of the nurse.

Nurse-Client Relationship

Peplau's interpersonal theory of nursing identifies the therapeutic nurse-client relationship as the crux of nursing. The nurse-client relationship evolves through identifiable, overlapping phases. The
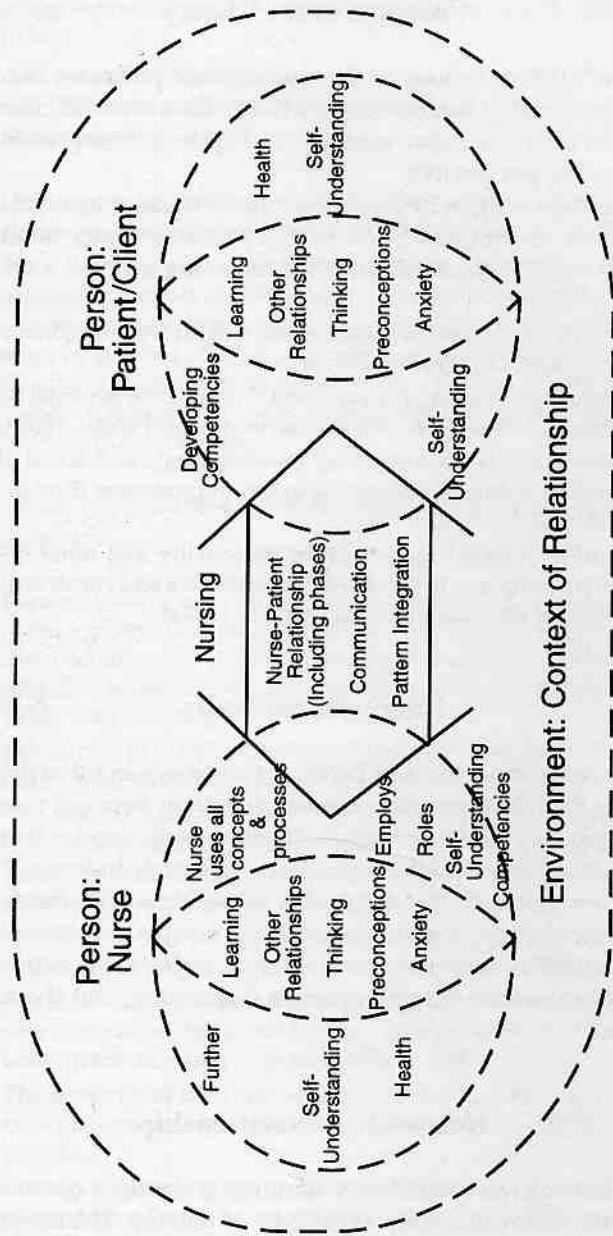
Figure 2.1. Peplau's Framework: Major Concepts and Their Interrelationships

phases include orientation, working, and resolution. The relationship form (see Figure 2.2), developed by Forchuk et al. (1986) and tested by Forchuk and Brown (1989), gives a pictorial overview of the nurse and client behaviors at each phase. The reliability and validity of the form was reported in Forchuk and Brown (1989).

The initial phase of the nurse-client relationship is the orientation phase where the nurse and client come to know each other as persons and the client begins to trust the nurse. The time in the orientation phase can vary from a few minutes of the initial meeting to months of regular sessions.

The second phase of the nurse-client relationship, the working phase, is subdivided into identification and exploitation subphases. In the identification subphase the client begins to identify problems to be worked on within the relationship. The nature of the problems identified can be as diverse as the scope of nursing practice. Examples include identifying inadequate pain management, requests for health teaching regarding breast feeding, or wanting to discuss unresolved issues related to past sexual abuse. The exploitation subphase occurs as the client makes use of the services of the nurse to work through the identified problems. Often, as initial problems are worked through, further problems are identified by the client.

The nurse does not "solve" the client's problems, but rather gives the client the opportunity to explore options and possibilities within the context of the relationship. For example, the nurse may provide information on community resources, or provide health teaching related to medication, illness, or health promotion if appropriate in the context of the relationship. However, the nurse employing Peplau's theory would resist all temptation related to "advice giving" because this would undermine the roles and responsibilities of the client.

The resolution phase of the relationship occurs between the time the actual problems are resolved and the relationship is terminated. Examples of work that may need to be done in this period include connecting the client to community resources, working through dependency issues in the relationship, learning preventative measures, strengthening social supports, and summarizing the work completed.

The nurse-client relationship does not evolve as a simple linear process. Although the relationship may be predominantly in one phase, reflections of all phases can be seen in each interaction. Every

Community Mental-Health-Promotion Program Phases of Nurse-Client Relationship

Date of Visit				
Name:				

	Orientation	Identification	Exploitation	Resolution
Orientation Phase		**Working Phase**		**Resolution Phase**
		Identification	Exploitation	

Client

Seeks assistance	Participates in identifying	Makes full use of services	Abandons old needs
Conveys educative needs	problems	Identifies new goals	Becomes independent of
Ask questions	Begins to be aware of time	Aspires to new goals	helping person
Tests parameters	Responds to help	Attempts to attain new goals	Applies new problem-solving
Shares preconceptions and	Identifies with nurse	Rapid shifts in behavior:	skills
expectations of nurse	Recognizes nurse as a	dependent	Maintains changes in style of
due to past experience	person	independent	communication and
	Explores feelings	Exploitative behavior	interaction
	Fluctuates dependence	Realistic exploitation	Positive changes in view of
	independence and	Self-directing	self
	interdependence in	Develops skills in inter-	Integrates illness
	relationship with nurse	personal relationships	Exhibits ability to stand alone
	Increases focal attention	and problem-solving	
	Changes appearance (for	Displays changes in manner	
	better or worse)	of communication (more	
	Understands continuity between	open, flexible)	
	sessions (process and		
	content)		

Nurse:

Respond to emergency	Maintain separate identity	Continue assessment	Sustain relationship as long
Give parameters of meetings	Exhibits ability to edit speech	Meet needs as they emerge	as patient feels necessary
Explain roles	or control focal attention	Understand reason for shifts	Promote family interaction
Gather data	Testing maneuvers decrease	in behavior	Assist with goal setting
Help patient identify problem	Unconditional acceptance	Initiate rehabilitative plans	Teach preventive measures
Help patient plan use of	Help express needs, feelings	Reduce anxiety	Utilize community agencies
community resources and	Assess and adjust to needs	Identify positive factors	Teach self care
services	Provide information	Help plan for total needs	Terminate nurse-client
Reduce anxiety and tension	Provide experiences that	Facilitate forward movement of	relationship
Practice nondirective	diminish feelings of	personality	
listening	helplessness	Deal with therapeutic	
Focus patient's energies	Do not allow anxiety to	impasse	
Clarify preconceptions and	overwhelm patient		
expectations of nurse	Help patient to focus on cues		
	Help patient develop		
	responses to cues		
	Use word stimuli		

*NOTE: Phases Are Overlapping

Date Completed:	Signatures:

* Peplau, H.E. Interpersonal Relations in Nursing. New York: G.P. Putnam's Sons, 1952.
* Nordall, D., Sato, A. Peplau's Model Applied to Primary Nursing in Clinical Practice, in J. Riehl and C. Roy (ed.) Conceptual Models for Nursing Practice. New York: Appleton-Century-Crofts, 1980.
* Practice. New York: Appleton-Century-Crofts, 1980.
* Peplau, H.E. audio-tape series. San Antonio, Texas. P.F.S. Productions, 1973.

Figure 2.2. Relationship Form

SOURCE: Forchuk, C., & Brown, B. (1989, p. 32). Reprinted with permission.

interaction has a beginning (orientation), middle (working), and end (resolution) that reflect the larger pattern of the ongoing nurse-client relationship.

Communication

Communication includes both verbal communication and non-verbal communication. Verbal communication is expressed through language, while nonverbal communication is expressed through empathic linkages, gestures, postures, and patterns.

Verbal communication, or language, is important as a reflection of thought processes. This is obvious on the literal content level: For example, the client gives information on pain, on current abilities, or on perceptions of problems. However, in addition to the literal content, there are symbolic meanings, patterns, and underlying assumptions that can be conveyed through the choice of words or phrases. Consider the differences among the following statements: "I have a chronic migraine headache problem and it appears to be starting to flare up," "My head is killing me," and "I'm getting a headache." Different information is conveyed regarding ownership of the headache, possible intellectualizing, and degree of distress. However, one would not make immediate assumptions but rather be attentive to emerging patterns and validate these with the client (or better yet encourage the client to note the patterns and validate these with the nurse).

Peplau considers the use of verbal communication to be an essential component of the nurse-client relationship. She states, "The general principle is that anything clients act out with nurses will most probably not be talked about, and that which is not discussed cannot be understood" (1989a, p. 197). Talking about issues and concerns gives the client an alternative to acting out these issues.

Peplau (1973d) has described patterns of word usage that may require corrective action on the part of the nurse. Common patterns include:

1. Overgeneralization — For example, the client says, "The worst things always happen to me." The nurse would attempt to help the client be more specific by asking for one incident.

2. Inappropriate use of pronouns — A paranoid client may insist "they" are out to get him, and the nurse asks, "Who are they?"

3. The suggestion of automatic knowing through repetition of the phrase "you know" — The nurse conveys the information that "I only know what you tell me about it," and drops such phrases from his or her own language.

This corrective use of language is quite similar to approaches suggested by cognitive therapists such as Aaron Beck (1976) and Albert Ellis (1962). A difference is that cognitive therapy assumes one is directly changing the thought. Peplau believes one is changing the language, but because thought and language are part of an integral whole, a change in one is reflected in the other.

Nonverbal language is more subtle than verbal language and may at times contradict the verbal message. Consider the example of the person who screams "I am not upset!" In such cases it is the nonverbal message that tends to be believed. Congruence is an important consideration for the nurse to monitor in his or her own communication. Empathy and caring can be transmitted on a nonverbal level, as can feelings such as indifference or hostility.

Most nonverbal communication is culturally influenced, so one must be cautious in transcultural interpretation and use of gestures. For example, does avoiding eye contact suggest dishonesty, shyness, or respect? It can depend on the cultural orientations of the sender and receiver of the message.

A personal example that exemplifies the need for awareness of cultural differences occurred in the author's work with a native Indian client. I had concerns about how the sessions were progressing. The client stated he felt things were going well. I could not identify what it was that was bothering me, but thought the problem might be culturally related. The client and I had one session videotaped to be viewed by a cultural anthropologist. The client and I viewed the videotape with the anthropologist and we all noticed the almost comical "dance of the eyes." He was attempting to avoid eye contact as I was attempting to maintain it. We discussed our different interpretations of eye contact (he avoided eye contact in deference to authority and out of respect, while I believed I was trying to maintain our open communication through eye contact). We agreed to not impose our rules on each other. However, the client noted that every time he went for a promotion interview, he was unsuccessful, and that the feedback I had given prior to the tape about "something not seeming quite right" was similar to the feedback he received after the interviews. He decided to use eye contact in job interview/promotion situations. Although I believe his success reflected more than a change in eye contact, that client was convinced that the two promotions he received in the next year were related to his new awareness of this difference in communication. This situation also

exemplifies how learning in the nurse-client relationship can be used in other relationships, and that both nurse and client learn and grow in the therapeutic relationship.

Similar examples of nonverbal communications that can be interpreted very differently by different people include touching, hugging, smiling, passing flatulence, hand movements, comfortable social distances, crossing legs, gestures, offering food, and gift-giving. These can have vastly different cultural meanings to different groups and individuals. Therefore the nurse needs to be aware of issues related to differences in interpretation of nonverbal communication when providing care to a client from a different cultural group. The nurse, through self-reflection and clinical supervision, also needs to be aware of his or her own personal and cultural nonverbal patterns that might, at times, interfere with the evolving nurse-client relationship.

Pattern Integration

Each individual and each system have customary patterns of interacting with others. Pattern integrations are the products of the interaction of the patterns of more than one individual or system. Peplau (1973c; 1987a) has identified four common pattern integrations: complementary, mutual, antagonistic and mixed.

A *complementary* pattern integration involves patterns that are different yet fit together like parts of a jigsaw puzzle. The "fit" assists in ensuring the continuity of the single patterns that make up the integration. An example of this integration can be found with the nurse who insists on "helping" clients by doing things they could actually do for themselves. This could range from cutting their meat at dinner to arranging an out-patient appointment. A complementary pattern occurs when this nurse works with a dependent client who prefers that others make all possible decisions. The nurse and client will form a comfortable partnership that will make it difficult for either to change. A similar integration could be perpetuated on a larger systems level if this dyad worked in the context of a hospital that emphasized the accountability of the nurse but not the accountability or involvement in decision making of the client. Similar examples of complementary pattern integrations could include anger-withdrawal, domination-submission, and belittling others-belittling self.

A *mutual* pattern integration occurs when two or more interacting individuals/systems display a similar pattern. The multiple use of a single pattern also assists in the continuity of each similar pattern. A classic example from the nursing literature is the mutual-withdrawal pattern first identified by Gwen Tudor (1952/1970) as occurring between specific clients and staff on an in-patient psychiatric unit. Unfortunately, examples of this mutual pattern can still be found across nursing specialties: consider the placement of selected, less desirable, medical or surgical patients as far away from the nursing station as possible, or the early discharge of some community clients who give the impression they are not interested in interacting with the nurse, despite their ongoing personal health problems.

Additional examples of mutual pattern integrations include: mutual anger, mutual disrespect, and mutual self-denigration. Positive examples could include mutual respect or mutual concern. It is important to consider that the nurse should employ mutual pattern integrations only with those patterns that the nurse and client would want to perpetuate.

Antagonistic pattern integrations include the combination of different individual patterns that do not fit well together. The combination, therefore, creates a discomfort or disharmony that can be used as a motivation toward change. An example given by Peplau (1973c) is that of a client with an angry pattern with a nurse who is using an investigative approach ("Tell me about what's going on") rather than responding with a complementary (e.g., withdrawal) or mutual (e.g., also responding in anger) pattern. Obviously, this is the ideal integration for patterns that require change.

The antagonistic pattern can also occur at an individual or larger systems levels. An example of an antagonistic pattern at the larger systems level could occur with a client who feels most comfortable being dependent and letting others "take care" of him or her. An antagonistic pattern would emerge if this client was in a therapeutic environment that encouraged the participation and decision making of all individuals. It would become uncomfortable for the client to maintain dependent behaviors.

An even broader systems example of an antagonistic pattern would be the introduction of a nursing care delivery system that emphasizes the accountability of each nurse (e.g., primary nursing) into a traditional paternalistic hospital system. The traditional paternalis-

tic system emphasizes centralized decision making rather than decision making and accountability at the staff level. Thus the nursing care delivery system would create an antagonistic pattern with the larger hospital system. If change is desired, it would be beneficial for the antagonistic pattern integration to occur as frequently as possible and at a variety of personal and larger systems levels.

Other examples of antagonistic pattern integrations include withdrawal-seeking out, dependance-promoting independence, and self-denigration-acceptance of self and others. It needs to be remembered that the inherent incongruence of antagonistic pattern integrations is anxiety producing. The resultant anxiety needs to be harnessed and channeled toward change. However, the anxiety also requires careful monitoring so that it does not become overwhelming. This issue is more fully discussed under the concept of anxiety.

Peplau (1987a) has also identified *mixed* or changing pattern integrations. These include a combination of the earlier identified pattern integrations. For example, a person may respond to another's anger by first getting angry himself/herself (reflecting a mutual pattern integration) and then withdrawing (reflecting a complementary pattern). Mutual-complementary combinations continue to reinforce individual patterns. Antagonistic pattern integration used in combination with a mutual or complementary integration will lose effectiveness in promoting change, since individuals are more likely to respond to patterns that reinforce familiar and comfortable personal patterns.

Roles of the Nurse

The nurse may enact several roles with the client. The roles depend on the needs of the client and the skills and creativity of the nurse. The possible roles will also be influenced by the nurse's position and agency policies. For example, a community nurse in a case management program may include a role related to cutting through red tape (the form filler role?) in order to ensure that appropriate services are in place for the client. A clinical nurse specialist may include roles that allow the nurse to transcend institutional or agency boundaries. Examples include following a client through different hospital and community settings. On the other hand, a staff nurse working a set shift may find more limitations to the type of roles he or she can offer to the client. The nurse needs to be aware of

the possibilities and constraints so that accurate information can be conveyed to the client.

Peplau's (1952a) book includes the following examples of roles: stranger, resource person, teacher, leader, surrogate for significant others, counselor, arbitrator, change-agent, researcher, and technical expert. Regardless of other roles assumed, the nurse and client always begin the relationship as strangers to each other.

In her 1964 book, Peplau emphasized the importance of the counselor role and stated that this was the primary role to be undertaken by nurses in psychiatric-mental health nursing. Traditionally, psychiatric nurses had focused on surrogate roles, particularly parent surrogate roles, and the result was custodial care that minimized the potential for growth and change. Peplau (1964) stated: "If (nurses) are unable to contribute in a truly corrective manner to the care of mental patients, the traditional nurse-patient relationship will be usurped by those who can; and nurses will be shunted into the role of glorified custodian or superclerk" (p. 7).

The counselor role must be valued as the prime vehicle for the development of the nurse-client relationship. Frequently this involves individual counseling. Other modes, such as group work, community development, and family systems nursing are also appropriate. Within these modalities, the group, community, or family would be the "client" rather than the individual constituent members. As in the example of the individual as client, the nurse-client relationship would develop in phases, and the concepts of communication, both verbal and nonverbal, pattern integrations, and roles of the nurse would also be applicable.

Intrapersonal Processes

Although the primary focus within Peplau's theory is on *interper*sonal processes, *intra*personal processes of both the client and nurse are also considered. Intrapersonal processes are processes that occur within the person, rather than between people. There is a strong interrelationship between interpersonal and intrapersonal phenomena: intrapersonal structures, processes, and changes develop through interpersonal activity. Examples of intrapersonal concepts within Peplau's theory include anxiety, learning, thinking, and competen-

cies. Although each of these is observed on an individual level, these concepts have interpersonal implications.

Anxiety

Anxiety is an energy that emerges in response to a perceived threat. The threat could range from the physical to the metaphysical. Peplau (1989a) described the sequence of steps in the development of anxiety as including: holding expectations, expectations not met, discomfort felt, relief behaviors used, and relief behaviors justified (p. 281). The expectations can include things such as beliefs, needs, goals, wishes, and feelings. The relief behaviors also cover a wide range of possibilities: aggression, withdrawal, compulsive behavior, psychosomatic complaints, hallucinations, delusions, sexual activity, risk-taking behavior, denial, intellectualizing, drug use, humor, self-reflection, discussion with others, validation, and problem solving to seek the sources of difficulty. These are only a few of the relief behaviors that can be used.

People (not just clients) generally develop patterns of relief behaviors that they tend to use over and over again. Obviously, some of these patterns are more helpful than others. Anxiety is often a basis for the client to seek assistance from the nurse. At times, problems created through these relief behaviors bring the client to seek the services of the nurse. At other times the client seeks assistance because he or she finds the relief behaviors inadequate in relieving the anxiety.

Peplau (1989a) describes how the nurse can assist the client to channel anxiety productively. First, the client needs to be aware of and be able to name the anxiety. Then, the client needs to see the connection between the anxiety and the relief behavior. Finally, the client formulates and states expectations. This final part of the process includes an understanding of the connection between held expectations and what actually happened and consideration of factors amenable to control (p. 282). Working through this process usually takes place over time and during several interactions. The author has had some experiences with chronic mental health clients where it has taken months for the client to even be aware of and to name the anxiety.

Anxiety has been described by Peplau as existing along a continuum including mild, moderate, severe, and panic. Although it is

possible to experience a state of no anxiety (euphoria), this seldom occurs. As human beings we constantly face a barrage of information and other stimuli that pose at least some minor threat to our self-views. Therefore, in most nurse-client encounters, both the nurse and client will be experiencing some anxiety.

As a person's anxiety increases, that person's focus of attention becomes increasingly narrow. At the lower end of the anxiety continuum, this may actually be useful in assisting the person to focus on important details. A common example would be writing an exam without being aware of other people or distractions in the room. However, at higher levels of anxiety, the focus of attention may become so narrow that the individual only sees small details without being able to see the larger picture. A similar example would be the student who becomes so concerned about one exam item that the total time is spent on that item and the exam is not completed. For similar reasons, problem solving may be enhanced at lower levels of anxiety but inhibited as anxiety increases. The nurse and client need to monitor anxiety levels and attempt to keep the levels at the mild to moderate levels.

Peplau (1973a) describes how the nursing approach must take into consideration the current anxiety level of the client. For example, as the client's anxiety is increased, the nurse would need to use increasingly short, concrete sentences in order to be understood. At the severe or panic levels, it would be inappropriate to use sentences with more than two or three words. It may be that even these short sentences will not be understood by the client in panic, and the nurse will need to use presence as a simple nonverbal communication. The nurse also needs to be aware of the impact of anxiety on the client's current problem-solving abilities and learning abilities and adjust accordingly. Generally at severe or panic levels of anxiety no new learning can take place.

Anxiety can be transmitted interpersonally (Peplau, 1989a). It is for this reason that the nurse needs to monitor his or her own anxiety. The anxious nurse will communicate the anxiety to the client and vice versa. A common situation where this can occur is when the client feels out of control and the nurse fears a physical threat. This situation can easily escalate to a self-fulfilling prophecy (i.e., the client loses control and becomes assaultive). Such situations can more easily be prevented by intervening with the anxiety at lower levels and not allowing one's own anxiety to escalate the situation.

Learning

Peplau has described eight stages in the learning process. These are: (a) to observe, (b) to describe, (c) to analyze, (d) to formulate, (e) to validate, (f) to test, (g) to integrate, and (h) to utilize (Peplau, 1971b). Each stage in the learning process is also a competency. Therefore, as one's learning increases so do one's competencies.

Different individuals will be at different competency levels within the stages of learning. Even within one individual a wide degree of variation is possible. For example, a person with generally high learning abilities may have a dramatic drop in such abilities when faced with a high anxiety-producing situation.

It is important that the nurse determine the current stage of learning of the client so that appropriate comments can be made to build on the current level and to assist the client to move to the next level. For example, if the client is at the very basic level of only being able to observe but unable to share the observations, the nurse would ask simple questions related to observation. Peplau (1971b) gives examples of basic questions as "What do you see?" and "What is that noise?" As the person responds to these questions, he or she begins movement to the next stage—to describe.

There is an assumption that all people will at least be able to observe on some level, even if they cannot respond. For example, even with a comatose client the nurse could use the assumption of the ability to observe. The nurse in this situation may say, "I am now going to wash your face," and recognize the client's ability for some level of observation.

Forchuk and Voorberg (1991), in a program evaluation of a community mental health program based on Peplau's theory, found that clients were able to increase their current stage of learning. For example, upon admission, 60% of the clients with chronic mental illnesses were at the first stage of learning. Only 20% remained at this level after 2 years.

Thinking: Preconceptions and Self-Understanding

Thinking is an internal cognitive process. The thoughts of another person can only be inferred through observation of language and behavior. The concept of thinking may be particularly important for the nurse working with clients experiencing difficulty with their

thinking processes. Examples include clients with thought disorders related to chronic mental illnesses such as schizophrenia, clients with developmental handicaps, and clients with organic brain disorders or brain injuries. The section on communication describes the integral relationship between thought and language as well as appropriate approaches to assist clients with their thinking through the use of language.

Specific thinking processes of both the nurse and client will impact on the evolving nurse-client relationship. These include the preconceptions the nurse and client have of each other and the self-understanding of the nurse and client.

Preconceptions are the initial impressions the nurse and client have of each other, before they know each other. The preconceptions may be formed through stereotyping, gossip, or past experiences with persons considered to be similar to the partner in the new dyad. Forchuk (1992a) found both the nurses' and clients' preconceptions of each other were highly predictive of progress in the evolving therapeutic relationship. She also found that these initial impressions were quite stable, with very little change over the first 6 months of the relationship. This study underlined the importance of consideration of both nurse and client factors. The nurse needs to be aware of preconceptions of the client, particularly negative impressions that may impede progress in the relationship. Similarly, client impressions should also be explored. If negative preconceptions cannot be worked through, a therapeutic transfer of the client to another nurse should be considered.

Self-understanding is also a specific thinking pattern that may influence the evolving relationship. However, within Peplau's theory, the concept of self-understanding has an unequal importance for the nurse and client. Self-understanding is considered to be a critical attribute of the nurse. Through self-reflection and supervision, the nurse needs to be constantly aware of how her or his own issues and behaviors are influencing the relationship. It is expected that the nurse's self-understanding will grow through therapeutic work with clients.

Clients may also experience an increase in self-understanding through the therapeutic relationship. However, an increase in interpersonal and problem-solving competencies is the client-related goal of the relationship rather than self-understanding. Self-understanding

is a helpful side effect of the process of developing these competencies.

Competencies

Competencies are skills that have evolved through practice. Peplau (1973b) states that we all have numerous interpersonal and problem-solving capacities, but in order to become competencies, these must be developed over time and through practice. The nurse-client relationship provides a venue for the development of capacities into competencies. For example, learning to share selected experiences verbally may be a capacity that the client has not developed; it may be developed during the time spent with the nurse. Other examples of competencies/capacities include sitting for 5 minutes in the presence of another person, discussing one topic for 5 minutes, learning to trust, describing one's feelings to another person, identifying personal goals, and choosing a strategy to move toward a specific goal. From these examples it can be seen that there are a wide variety of competencies and that which ones develop will vary considerably with different client situations. The specific competencies evolve through the developing relationship.

It is expected that the nurse will also develop competencies through the evolving relationship. These would also be primarily of a problem-solving or interpersonal nature. For example, the nurse may learn how a specific person copes with hallucinations, may learn to remain silent for longer periods of time to allow the client the opportunity to initiate conversation, or may develop increased empathy for a certain life situation. As the nurse's competencies grow, so does his or her ability to help other people in similar situations. However, it is the client's development of competencies, not the nurse's, that is the priority. Parallel to the nurse's development of self-understanding, the nurse's competencies develop as a beneficial side effect of the therapeutic relationship. The client's competencies develop as a goal of the therapeutic relationship.

Although the idea that the client's competencies take priority may seem obvious, it is sometimes forgotten in practice. It often appears more expedient for the nurse to complete an activity (e.g., feeding, making a bed, setting an out-patient appointment, listing alternatives, searching out community resources, summarizing progress)

rather than the client. Of course, if this occurs, the nurse develops the competency rather than the client.

Clinical Phenomena

Peplau encourages nurses to be aware of patterns with clinical phenomena. Observing patterns in the development and resolution of specific clinical issues allows learning from one clinical situation to potentially assist in others. This in no way negates the uniqueness of each situation and each client. It recognizes that each person and situation, although unique, can reveal aspects of a larger pattern.

Examples of clinical concepts that Peplau has explored are loneliness and hallucinations. Concepts are defined and operationalized with the identification of critical attributes. This would include the observable behaviors associated with the clinical phenomena. For example, observable signs that a person is having auditory hallucinations might include talking to an unobserved person and describing hearing voices in one's head. The nurse could identify a client with such behavior as having a pattern consistent with auditory hallucinations. Such behaviors may also be consistent with other patterns, for example the pattern of a peak religious experience. In this section, the clinical concepts of loneliness and hallucinations are very briefly described as examples of clinical phenomena.

Loneliness

Peplau (1989c) describes the problem of loneliness. She defines this as "an unnoticed inability to do anything while alone" (p. 256). This is contrasted with lonesomeness (a wish to be with others) and aloneness (being without company). She describes the development of loneliness through difficult early interpersonal relationships.

Peplau (1989c) describes the importance of the nurse being aware of clients' defenses of loneliness; examples include time-oriented complaints (endless days), relating to others in an overly familiar or anonymous manner, planlessness, or overplanning.

The nurse assists the client with loneliness through the establishment of a therapeutic relationship, which will include contact and limit setting. Where appropriate, the nurse and client also plan for potentially positive peer relationships.

Hallucinations

Peplau (1989a) defines hallucinations as consisting of "illusory figures, perceived *as if* they were real" (p. 312). Peplau describes the phases through which hallucinations develop in an attempt to avoid anxiety and mitigate loneliness.

The nurse needs to be aware that the experience of hallucinations seems very real to the client. The nurse will carefully use language that does not reinforce the existence of the hallucinations as being a mutually experienced reality. For example, the nurse might say, "What do the voices you are hearing say?" Peplau (1989a) states that the client needs to learn alternative ways of coping with anxiety and loneliness so that the hallucinations are not needed (pp. 319-324).

In summary, Peplau has identified a wide range of concepts that impact on the practice of the nurse and the evolving nurse-client relationship. These include interpersonal factors, intrapersonal factors, and specific clinical phenomena.

Propositions

Relations between major concepts in Peplau's theory are summarized in Table 2.1, which was originally published in Forchuk (1991a). From Table 2.1 it can be seen that the concepts are all interrelated, and that a change in one concept generally is reflected by further changes of other concepts. Most critically, the evolving nurse-client relationship moves the client through growth and therefore health.

Notes

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TABLE 1.1 Concepts and Relations

	NURSING is related to:	PERSON is related to:	HEALTH is related to:	ENVIRONMENT is related to:	INTERPERSONAL RELATIONSHIPS (I.P.R.s) are related to:
PERSON	Nursing is a process between persons (nurse and patient).				
HEALTH	Health is the goal of nursing.	Health is within the person.			
ENVIRONMENT	Environment provides the context of nursing.	The person is within the environment.	Health is within the person, who in turn is within the environment. The environment can be health promoting or illness maintaining.		
INTERPERSONAL RELATIONSHIPS (I.P.R.s)	I.P.R.s are the crux or essential processes of nursing (critical attribute).	I.P.R.s are participated in by persons.	I.P.R.s contribute to a person's health (antecedent) and a person's health will in turn influence ongoing I.P.R.s (consequence).	The environment forms the context of I.P.R.s (critical attribute).	
COMMUNICATION	Communication occurs in nursing (critical attribute).	Communication occurs between persons.	Communication facilitates health, by contributing to I.P.R.'s (intervening).	Communication occurs within the context of the environment, and is part of the environment.	Communication occurs within interpersonal relationships (critical attribute).
PATTERN INTEGRATION	Pattern integrations occur in nursing (critical attribute).	Pattern integration occurs between persons.	Pattern integrations can facilitate health, by contributing to ongoing I.P.R.s (intervening).	Pattern integrations are a part of the environment (critical attribute).	Pattern integrations occur within Interpersonal relationships (critical attribute).
ROLES	Roles are the means for conducting nursing.	Roles are used by the nurse to promote health within the patient.	Roles are used by the nurse to promote health.	Roles are used in the context of the environment.	Roles are used within Interpersonal relationships (critical attribute).
THINKING	Thinking occurs in nursing as a prerequisite and critical attribute.	Thinking occurs within persons (critical attribute).	Self-understanding can promote health. Preconceptions can impede or promote health depending on their impact on interpersonal relationships (intervening).	Thinking is a within-person phenomenon occuring in context of the person within the environment.	Self-understanding can promote I.P.R.s. Preconceptions can promote or hinder I.P.R.s and vice versa.
LEARNING	Learning occurs in nursing as a consequent.	Learning occurs within persons (critical attribute).	Learning promotes health.	Learning is a within-person phenomenon occuring in the context of the person within the environment.	Learning occurs within the context of I.P.R.s. The interactions between learning and I.P.R.s can enhance or hinder each other.
COMPETENCIES	Competencies develop as a consequence of nursing (intermediate to promoting health).	Competencies develop within persons.	The development of competencies promotes health.	Competencies are a within-person phenomenon occuring in the context of the person within the environment.	Competencies occur within the context of I.P.R.s and can assist in the development of I.P.R.s.
ANXIETY	Anxiety occurs in nursing (critical attribute).	Anxiety occurs within and between persons (critical attribute).	Anxiety impedes health at severe or panic levels.	Anxiety is a within-person phenomenon occuring in the context of the person within the environment.	Anxiety impedes the developmet of relationships at severe or panic levels.

(Continued)

TABLE 1.1 (Continued)

	COMMUNICATION is related to:	PATTERN INTEGRATION is related to:	ROLES are related to:	THINKING is related to:	LEARNING is related to:	COMPETENCIES are related to:
PERSON						
HEALTH						
ENVIRONMENT						
INTERPERSONAL RELATIONSHIPS (I.P.R.s)						
COMMUNICATION						
PATTERN INTEGRATION	Pattern Integration and communication occur together in interpersonal relationships.					
ROLES	Roles require communication (prerequisite).	Roles are used by the nurse as part of the pattern integration.				
THINKING	Thinking is mediated through symbols (language). Changes in verbal communication reflect changes in thinking and vice versa.	Thinking occurs within the person and therefore indirectly interacts with pattern integration.	Thinking is required by the nurse in the selection and maintenance of appropriate roles.			
LEARNING	Communication promotes learning, and learning can then promote future communication.	Learning occurs within the person and therefore indirectly interacts with pattern integration.	Learning occurs with successful implementation of nurse roles, particularly the counselor and teacher roles.	Thinking is a prerequisite for learning, and learning, in turn, assists thinking.		
COMPETENCIES	Communication promotes the development of competencies.	Competencies occur within the person and therefore indirectly interact with pattern integration.	Competencies are developed through successful implementation of nurse roles, particularly the couselor and teacher roles.	Competencies are both a prerequisite for thinking, and further developed through thinking.	Competencies are learned by developing skills and capacities.	
ANXIETY	Anxiety impedes communication at severe or panic levels.	Anxiety occurs in the person and therefore indirectly interacts with pattern integration.	Anxiety at severe or panic levels will limit the appropriate roles to be used.	Anxiety impedes thinking when at severe or panic levels.	Anxiety impedes thinking [*learning*] when at severe or panic levels.	Anxiety at severe or panic levels impedes the development of competencies.

SOURCE: Forchuk, C. (1991c). Peplau's theory: Concepts and their relations. *Nursing Science Quarterly* 4(2) 54-60. Reprinted with permission.