SIXTH EDITION

# Psychiatric Mental Health Nursing

## Concepts of Care in Evidence-Based Practice

2009

**Mary C. Townsend, DSN, APRN, BC**
Clinical Specialist/Nurse Consultant
Adult Psychiatric Mental Health Nursing

Former Assistant Professor and
Coordinator, Mental Health Nursing
Kramer School of Nursing
Oklahoma City University
Oklahoma City, Oklahoma

F. A. DAVIS COMPANY • Philadelphia

CHAPTER 7

# Relationship Development

## CHAPTER OUTLINE



## KEY TERMS

attitude
belief
concrete thinking
confidentiality
countertransference
empathy
genuineness
rapport
sympathy
transference
unconditional positive regard
values

## CORE CONCEPT

therapeutic relationship

## OBJECTIVES

**After reading this chapter, the student will be able to:**

1. Describe the relevance of a therapeutic nurse–client relationship.
2. Discuss the dynamics of a therapeutic nurse–client relationship.
3. Discuss the importance of self-awareness in the nurse–client relationship.
4. Identify goals of the nurse–client relationship.
5. Identify and discuss essential conditions for a therapeutic relationship to occur.
6. Describe the phases of relationship development and the tasks associated with each phase.

The nurse–client relationship is the foundation upon which psychiatric nursing is established. It is a relationship in which both participants must recognize each other as unique and important human beings. It is also a relationship in which mutual learning occurs. Peplau (1991) states:

> Shall a nurse do things *for* a patient or can participant relationships be emphasized so that a nurse comes to do things *with* a patient as her share of an agenda of work to be accomplished in reaching a goal—health. It is likely that the nursing process is educative and therapeutic when nurse and patient can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solution of problems. (p. 9.)

This chapter examines the role of the psychiatric nurse and the use of self as the therapeutic tool in the nursing of clients with emotional illness. Phases of the therapeutic relationship are explored and conditions essential to the development of a therapeutic relationship are discussed. The importance of values clarification in the development of self-awareness is emphasized.

CORE CONCEPT

**Therapeutic Relationship**
An interaction between two people (usually a caregiver and a care receiver) in which input from both participants contributes to a climate of healing, growth promotion, and/or illness prevention.

## ROLE OF THE PSYCHIATRIC NURSE

What is a nurse? Undoubtedly, this question would elicit as many different answers as the number of people to whom it was presented. Nursing as a *concept* has probably existed since the beginning of the civilized world, with the provision of "care" to the ill or infirm by anyone in the environment who took the time to administer to those in need. However, the emergence of nursing as a *profession* only began in the late 1800s with the graduation of Linda Richards from the New England Hospital for Women and Children in Boston upon achievement of the diploma in nursing. Since that time, the nurse's role has evolved from that of custodial caregiver and physician's handmaiden to recognition as a unique, independent member of the professional healthcare team.

Peplau (1991) has identified several subroles within the role of the nurse:

1. **The Stranger.** A nurse is at first a stranger to the client. The client is also a stranger to the nurse. Peplau (1991) states:

   > Respect and positive interest accorded a stranger is at first nonpersonal and includes the same ordinary courtesies that are accorded to a new guest who has been brought into any situation. This principle implies: (1) accepting the patient as he is; (2) treating the patient as an emotionally able stranger and relating to him on this basis until evidence shows him to be otherwise. (p. 44)

2. **The Resource Person.** According to Peplau, "a resource person provides specific answers to questions usually formulated with relation to a larger problem" (p. 47). In the role of resource person, the nurse explains, in language that the client can understand, information related to the client's health care.
3. **The Teacher.** In this subrole, the nurse identifies learning needs and provides information required by the client or family to improve the health situation.
4. **The Leader.** According to Peplau, "democratic leadership in nursing situations implies that the patient will be permitted to be an active participant in designing nursing plans for him" (p. 49). Autocratic leadership promotes overvaluation of the nurse and clients' substitution of the nurse's goals for their own. Laissez-faire leaders convey a lack of personal interest in the client.
5. **The Surrogate.** Outside of their awareness, clients often perceive nurses as symbols of other individuals. They may view the nurse as a mother figure, a sibling, a former teacher, or another nurse who has provided care in the past. This occurs when a client is placed in a situation that generates feelings similar to ones he or she has experienced previously. Peplau (1991) explains that the nurse–client relationship progresses along a continuum. When a client is acutely ill, he or she may incur the role of infant or child, while the nurse is perceived as the mother surrogate. Peplau (1991) states, "Each nurse has the responsibility for exercising her professional skill in aiding the relationship to move forward on the continuum, so that person to person relations compatible with chronological age levels can develop" (p. 55).
6. **The Counselor.** The nurse uses "interpersonal techniques" to assist clients to learn to adapt to difficulties or changes in life experiences. Peplau states, "Counseling in nursing has to do with helping the patient to remember and to understand fully what is happening to him in the present situation, so that the experience can be integrated with, rather than dissociated from, other experiences in life" (p. 64).

Peplau (1962) believed that the emphasis in psychiatric nursing is on the counseling subrole. How then does this emphasis influence the role of the nurse in the psychiatric setting? Many sources define the *nurse therapist* as having graduate preparation in psychiatric/mental health nursing. He or she has developed skills through intensive supervised educational experiences to provide helpful individual, group, or family therapy.

Peplau suggests that it is essential for the *staff nurse working in psychiatry* to have a general knowledge of basic counseling techniques. A therapeutic or "helping" relationship is established through use of these interpersonal techniques and is based on a knowledge of theories of personality development and human behavior.

Sullivan (1953) believed that emotional problems stem from difficulties with interpersonal relationships. Interpersonal theorists, such as Peplau and Sullivan, emphasize the importance of relationship development in the provision of emotional care. Through establishment of a satisfactory nurse–client relationship, individuals learn to generalize the ability to achieve satisfactory interpersonal relationships to other aspects of their lives.

## DYNAMICS OF A THERAPEUTIC NURSE–CLIENT RELATIONSHIP

Travelbee (1971), who expanded on Peplau's theory of interpersonal relations in nursing, has stated that it is only when each individual in the interaction perceives the other as a unique human being that a relationship is possible. She refers not to a nurse–client relationship, but rather to a human-to-human relationship, which she describes as a "mutually significant experience." That is, both the nurse and the recipient of care have needs met when each views the other as a unique human being, not as "an illness," as "a room number," or as "all nurses" in general.

Therapeutic relationships are goal oriented. Ideally, the nurse and client decide together what the goal of the relationship will be. Most often, the goal is directed at learning and growth promotion, in an effort to bring about some type of change in the client's life. In general, the goal of a therapeutic relationship may be based on a problem-solving model.

**Example:**

**Goal**

The client will demonstrate more adaptive coping strategies for dealing with (specific life situation).

**Interventions**

1. Identify what is troubling the client at the present time.
2. Encourage the client to discuss changes he or she would like to make.
3. Discuss with the client which changes are possible and which are not possible.
4. Have the client explore feelings about aspects that cannot be changed and alternative ways of coping more adaptively.
5. Discuss alternative strategies for creating changes the client desires to make.
6. Weigh the benefits and consequences of each alternative.
7. Assist the client to select an alternative.
8. Encourage the client to implement the change.
9. Provide positive feedback for the client's attempts to create change.
10. Assist the client to evaluate outcomes of the change and make modifications as required.

### Therapeutic Use of Self

Travelbee (1971) described the instrument for delivery of the process of interpersonal nursing as the *therapeutic use of self*, which she defined as "the ability to use one's personality consciously and in full awareness in an attempt to establish relatedness and to structure nursing interventions."

Use of the self in a therapeutic manner requires that the nurse have a great deal of self-awareness and self-understanding; that he or she has arrived at a philosophical belief about life, death, and the overall human condition. The nurse must understand that the ability and extent to which one can effectively help others in time of need is strongly influenced by this internal value system—a combination of intellect and emotions.

### Gaining Self-Awareness

### Values Clarification

Knowing and understanding oneself enhances the ability to form satisfactory interpersonal relationships. Self-awareness requires that an individual recognize and accept what he or she values and learn to accept the uniqueness and differences in others. This concept is important in everyday life and in the nursing profession in general; but it is *essential* in psychiatric nursing.

An individual's value system is established very early in life and has its foundations in the value system held by the primary caregivers. It is culturally oriented; it may change many times over the course of a lifetime; and it consists of beliefs, attitudes, and values. Values clarification is one process by which an individual may gain self-awareness.

**Beliefs.** A **belief** is an idea that one holds to be true, and it can take any of several forms:

1. *Rational beliefs.* Ideas for which objective evidence exists to substantiate its truth.

**Example:**

Alcoholism is a disease.

2. *Irrational beliefs.* Ideas that an individual holds as true despite the existence of objective contradictory evidence. Delusions can be a form of irrational beliefs.

**Example:**

Once an alcoholic has been through detox and rehab, he or she can drink socially if desired.

3. *Faith (sometimes called "blind beliefs").* An ideal that an individual holds as true for which no objective evidence exists.

**Example:**

Belief in a higher power can help an alcoholic stop drinking.

4. *Stereotype.* A socially shared belief that describes a concept in an oversimplified or undifferentiated matter.

**Example:**

All alcoholics are skid-row bums.

**Attitudes.** An **attitude** is a frame of reference around which an individual organizes knowledge about his or her world. An attitude also has an emotional component. It can be a prejudgment and may be selective and biased. Attitudes fulfill the need to find meaning in life and to provide clarity and consistency for the individual. The prevailing stigma attached to mental illness is an example of a negative attitude. An associated belief might be that "all people with mental illness are dangerous."

**Values. Values** are abstract standards, positive or negative, that represent an individual's ideal mode of conduct and ideal goals. Some examples of ideal mode of conduct include seeking truth and beauty; being clean and orderly; and behaving with sincerity, justice, reason, compassion, humility, respect, honor, and loyalty. Examples of ideal goals are security, happiness, freedom, equality, ecstasy, fame, and power.

Values differ from attitudes and beliefs in that they are action oriented or action producing. One may hold many attitudes and beliefs without behaving in a way that shows they hold those attitudes and beliefs. For example, a nurse may believe that all clients have the right to be told the truth about their diagnosis; however, he or she may not always act on the belief and tell all clients the complete truth about their condition. Only when the belief is acted on does it become a value.

Attitudes and beliefs flow out of one's set of values. An individual may have thousands of beliefs and hundreds of attitudes, but his or her values probably only number in the dozens. Values may be viewed as a kind of core concept or basic standards that determine one's attitudes and beliefs, and ultimately, one's behavior. Raths, Merril, and Simon (1966) identified a seven-step process of valuing that can be used to help clarify personal values. This process is presented in Table 7–1. The process can be used by applying these seven steps to an attitude or belief that one holds. When an attitude or belief has met each of the seven criteria, it can be considered a value.

## The Johari Window

The self arises out of self-appraisal and the appraisal of others and represents each individual's unique pattern of values, attitudes, beliefs, behaviors, emotions, and needs. Self-awareness is the recognition of these aspects and understanding about their impact on the self and others. The Johari Window is a representation of the self and a tool that can be used to increase self-awareness (Luft, 1970). The Johari Window is presented in Figure 7–1 and is divided into four quadrants.

### The Open or Public Self

The upper left quadrant of the window represents the part of the self that is public; that is, aspects of the self about which both the individual and others are aware.

**TABLE 7–1 The Process of Values Clarification**

| Level of Operations | Category | Criteria | Explanation |
|---|---|---|---|
| Cognitive | Choosing | 1. Freely<br>2. From alternatives.<br>3. After careful consideration of the consequences | "This value is mine. No one forced me to choose it. I understand and accept the consequences of holding this value." |
| Emotional | Prizing | 4. Satisfied; pleased with the choice<br>5. Making public affirmation of the choice, if necessary | "I am proud that I hold this value, and I am willing to tell others about it." |
| Behavioral | Acting | 6. Taking action to demonstrate the value behaviorally<br>7. Demonstrating this pattern of behavior consistently and repeatedly | The value is reflected in the individual's behavior for as long as he or she holds it. |

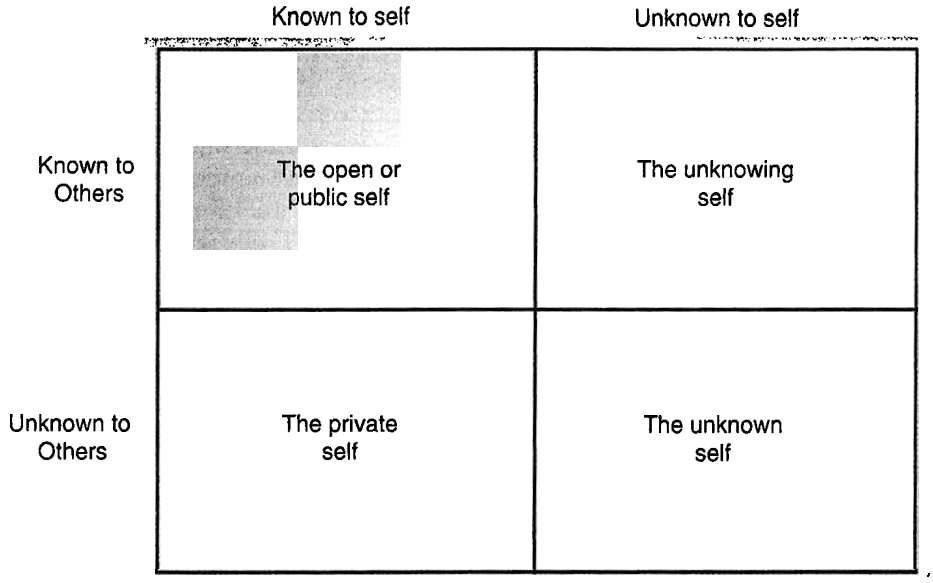


FIGURE 7–1 The Johari Window. (From Luft, J: *Group Processes: An Introduction to Group Dynamics.* National Press Books, Palo Alto, CA, 1970.)

**Example:**

Susan, a nurse who is the adult child of an alcoholic has strong feelings about helping alcoholics to achieve sobriety. She volunteers her time to be a support person on call to help recovering alcoholics. She is aware of her feelings and her desire to help others. Members of the Alcoholics Anonymous group in which she volunteers her time are also aware of Susan's feelings and they feel comfortable calling her when they need help refraining from drinking.

## The Unknowing Self

The upper right (blind) quadrant of the window represents the part of the self that is known to others but remains hidden from the awareness of the individual.

**Example:**

When Susan takes care of patients in detox, she does so without emotion, tending to the technical aspects of the task in a way that the clients perceive as cold and judgmental. She is unaware that she comes across to the clients in this way.

## The Private Self

The lower left quadrant of the window represents the part of the self that is known to the individual, but which the individual deliberately and consciously conceals from others.

**Example:**

Susan would prefer not to take care of the clients in detox because doing so provokes painful memories from her childhood. However, because she does not want the other staff members to know about these feelings, she volunteers to take care of the detox clients whenever they are assigned to her unit.

## The Unknown Self

The lower right quadrant of the window represents the part of the self that is unknown to both the individual and to others.

**Example:**

Susan felt very powerless as a child growing up with an alcoholic father. She seldom knew in what condition she would find her father or what his behavior would be. She learned over the years to find small ways to maintain control over her life situation, and left home as soon as she graduated from high school. The need to stay in control has always been very important to Susan, and she is unaware that working with recovering alcoholics helps to fulfill this need in her. The people she is helping are also unaware that Susan is satisfying an unfulfilled personal need as she provides them with assistance.

The goal of increasing self-awareness by using the Johari Window is to increase the size of the quadrant that represents the open or public self. The individual who is open to self and others has the ability to be spontaneous and to share emotions and experiences with others. This individual also has a greater understanding of personal behavior and of others' responses to him or her. Increased self-awareness allows an individual to interact with others comfortably, to accept the differences in others, and to observe each person's right to respect and dignity.

## CONDITIONS ESSENTIAL TO DEVELOPMENT OF A THERAPEUTIC RELATIONSHIP

Several characteristics that enhance the achievement of a therapeutic relationship have been identified. These concepts are highly significant to the use of self as the therapeutic tool in interpersonal relationship development.

### Rapport

Getting acquainted and establishing **rapport** is the primary task in relationship development. Rapport implies special feelings on the part of both the client and the nurse based on acceptance, warmth, friendliness, common interest, a sense of trust, and a nonjudgmental attitude. Establishing rapport may be accomplished by discussing non-health-related topics. Travelbee (1971) states:

> [To establish rapport] is to create a sense of harmony based on knowledge and appreciation of each individual's uniqueness. It is the ability to be still and experience the other as a human being—to appreciate the unfolding of each personality one to the other. The ability to truly care for and about others is the core of rapport.

### Trust

To trust another, one must feel confidence in that person's presence, reliability, integrity, veracity, and sincere desire to provide assistance when requested. As previously discussed, trust is the initial developmental task described by Erikson. When this task has not been achieved, this component of relationship development becomes more difficult. That is not to say that trust cannot be established, but only that additional time and patience may be required on the part of the nurse.

#### CLINICAL PEARL

The nurse must convey an aura of trustworthiness, which requires that he or she possess a sense of self-confidence. Confidence in the self is derived out of knowledge gained through achievement of personal and professional goals, as well as the ability to integrate these roles and to function as a unified whole.

Trust cannot be presumed; it must be earned. Trustworthiness is demonstrated through nursing interventions that convey a sense of warmth and caring to the client. These interventions are initiated simply and concretely and directed toward activities that address the client's basic needs for physiological and psychological safety and security. Many psychiatric clients experience **concrete thinking,** which focuses their thought processes on specifics rather than generalities, and immediate issues rather than eventual outcomes. Examples of nursing interventions that would promote trust in an individual who is thinking concretely include the following:

- Providing a blanket when the client is cold
- Providing food when the client is hungry
- Keeping promises
- Being honest (e.g., saying "I don't know the answer to your question, but I'll try to find out") and then following through
- Simply and clearly providing reasons for certain policies, procedures, and rules
- Providing a written, structured schedule of activities
- Attending activities with the client if he or she is reluctant to go alone
- Being consistent in adhering to unit guidelines
- Taking the client's preferences, requests, and opinions into consideration when possible in decisions concerning his or her care
- Ensuring **confidentiality**; providing reassurance that what is discussed will not be repeated outside the boundaries of the healthcare team

Trust is the basis of a therapeutic relationship. The nurse working in psychiatry must perfect the skills that foster the development of trust. Trust must be established in order for the nurse–client relationship to progress beyond the superficial level of tending to the client's immediate needs.

### Respect

To show respect is to believe in the dignity and worth of an individual regardless of his or her unacceptable behavior. Rogers (1951) called this **unconditional positive regard.** The attitude is nonjudgmental, and the respect is unconditional in that it does not depend on the behavior of the client to meet certain standards. The nurse, in fact, may not approve of the client's lifestyle or pattern of behaving. With unconditional positive regard, however, the client is accepted and respected for no other reason than that he or she is considered to be a worthwhile and unique human being.

Many psychiatric clients have very little self-respect owing to the fact that, because of their behavior, they were frequently rejected by others in the past. Recognition that they are being accepted and respected as unique individuals on an unconditional basis can serve to elevate feelings of self-worth and self-respect. The nurse can convey an attitude of respect with the following interventions:

- Calling the client by name (and title, if the client prefers)
- Spending time with the client

- Allowing for sufficient time to answer the client's questions and concerns
- Promoting an atmosphere of privacy during therapeutic interactions with the client or when the client may be undergoing physical examination or therapy
- Always being open and honest with the client, even when the truth may be difficult to discuss
- Taking the client's ideas, preferences, and opinions into considerations when planning care
- Striving to understand the motivation behind the client's behavior, regardless of how unacceptable it may seem

## Genuineness

The concept of **genuineness** refers to the nurse's ability to be open, honest, and "real" in interactions with the client. To be "real" is to be aware of what one is experiencing internally and to express this awareness in the therapeutic relationship. When one is genuine, there is *congruence* between what is felt and what is being expressed (Raskin & Rogers, 2005). The nurse who possesses the quality of genuineness responds to the client with truth and honesty, rather than with responses he or she may consider more "professional" or ones that merely reflect the "nursing role."

Genuineness may call for a degree of *self-disclosure* on the part of the nurse. This is not to say that the nurse must disclose to the client *everything* he or she is feeling or *all* personal experiences that may relate to what the client is going through. Indeed, care must be taken when using self-disclosure, to avoid reversing the roles of nurse and client.

When the nurse uses self-disclosure, a quality of "humanness" is revealed to the client, creating a role for the client to model in similar situations. The client may then feel more comfortable revealing personal information to the nurse.

Most individuals have an uncanny ability to detect other peoples' artificiality. When the nurse does not bring the quality of genuineness to the relationship, a reality base for trust cannot be established. These qualities are essential if the actualizing potential of the client is to be released and for change and growth to occur (Raskin & Rogers, 2005).

## Empathy

**Empathy** is the ability to see beyond outward behavior and to understand the situation from the client's point of view. With empathy, the nurse can accurately perceive and comprehend the meaning and relevance of the client's thoughts and feelings. The nurse must also be able to communicate this perception to the client by attempting to translate words and behaviors into feelings.

It is not uncommon for the concept of empathy to be confused with that of **sympathy**. The major difference is that with *empathy* the nurse "accurately perceives or understands" what the client is feeling and encourages the client to explore these feelings. With *sympathy* the nurse actually "shares" what the client is feeling, and experiences a need to alleviate distress. Schuster (2000) states:

> Empathy means that you remain emotionally separate from the other person, even though you can see the patient's viewpoint clearly. This is different from sympathy. Sympathy implies taking on the other's needs and problems as if they were your own and becoming emotionally involved to the point of losing your objectivity. To empathize rather then sympathize, you must show feelings but not get caught up in feelings or overly identify with the patient's and family's concerns. (p. 102)

Empathy is considered to be one of the most important characteristics of a therapeutic relationship. Accurate empathetic perceptions on the part of the nurse assist the client to identify feelings that may have been suppressed or denied. Positive emotions are generated as the client realizes that he or she is truly understood by another. As the feelings surface and are explored, the client learns aspects about self of which he or she may have been unaware. This contributes to the process of personal identification and the promotion of positive self-concept.

With empathy, while understanding the client's thoughts and feelings, the nurse is able to maintain sufficient objectivity to allow the client to achieve problem resolution with minimal assistance. With sympathy, the nurse actually feels what the client is feeling, objectivity is lost, and the nurse may become focused on relief of personal distress rather than on helping the client resolve the problem at hand. The following is an example of an empathetic and sympathetic response to the same situation.

***Situation:*** **B.J.** is a client on the psychiatric unit with a diagnosis of major depressive disorder. She is 5'5" tall and weighs 295 lbs. B.J. has been overweight all her life. She is single, has no close friends, and has never had an intimate relationship with another person. It is her first day on the unit, and she is refusing to come out of her room. When she appeared for lunch in the dining room following admission, she was embarrassed when several of the other clients laughed out loud and called her "fatso."

***Sympathetic response:*** Nurse: "I can certainly identify with what you are feeling. I've been overweight most of my life, too. I just get so angry when people act like that. They are so insensitive! It's just so typical of skinny people to act that way. You have a right to want to stay away from them. We'll just see how loud they laugh when *you* get to choose what movie is shown on the unit after dinner tonight."

***Empathetic response:*** Nurse: "You feel angry and embarrassed by what happened at lunch today." As tears fill BJ's eyes, the nurse encourages her to cry if she feels like it and to express her anger at the situation. She stays with BJ but does not dwell on her *own* feelings about what happened. Instead she focuses on BJ and what the client perceives are her most immediate needs at this time.

## PHASES OF A THERAPEUTIC NURSE–CLIENT RELATIONSHIP

Psychiatric nurses use interpersonal relationship development as the primary intervention with clients in various psychiatric/mental health settings. This is congruent with Peplau's (1962) identification of *counseling* as the major subrole of nursing in psychiatry. Sullivan (1953), from whom Peplau patterned her own interpersonal theory of nursing, strongly believed that many emotional problems were closely related to difficulties with interpersonal relationships. With this concept in mind, this role of the nurse in psychiatry becomes especially meaningful and purposeful. It becomes an integral part of the total therapeutic regimen.

The therapeutic interpersonal relationship is the means by which the nursing process is implemented. Through the relationship, problems are identified and resolution is sought. Tasks of the relationship have been categorized into four phases: the preinteraction phase, the orientation (introductory) phase, the working phase, and the termination phase. Although each phase is presented as specific and distinct from the others, there may be some overlapping of tasks, particularly when the interaction is limited. The major nursing goals during each phase of the nurse–client relationship are listed in Table 7–2.

### The Preinteraction Phase

The preinteraction phase involves preparation for the first encounter with the client. Tasks include the following:

1. Obtaining available information about the client from his or her chart, significant others, or other health team members. From this information, the initial assessment is begun. This initial information may also allow the nurse to become aware of personal responses to knowledge about the client.
2. Examining one's feelings, fears, and anxieties about working with a particular client. For example, the nurse may have been reared in an alcoholic family and have ambivalent feelings about caring for a client who is alcohol dependent. All individuals bring attitudes and feelings from prior experiences to the clinical setting. The nurse needs to be aware of how these preconceptions may affect his or her ability to care for individual clients.

### The Orientation (Introductory) Phase

During the orientation phase, the nurse and client become acquainted. Tasks include:

1. Creating an environment for the establishment of trust and rapport.
2. Establishing a contract for intervention that details the expectations and responsibilities of both nurse and client.
3. Gathering assessment information to build a strong client data base.
4. Identifying the client's strengths and limitations.
5. Formulating nursing diagnoses.
6. Setting goals that are mutually agreeable to the nurse and client.
7. Developing a plan of action that is realistic for meeting the established goals.
8. Exploring feelings of both the client and nurse in terms of the introductory phase. Introductions are often uncomfortable, and the participants may experience some anxiety until a degree of rapport has been established.

Interactions may remain on a superficial level until anxiety subsides. Several interactions may be required to fulfill the tasks associated with this phase.

### The Working Phase

The therapeutic work of the relationship is accomplished during this phase. Tasks include:

1. Maintaining the trust and rapport that was established during the orientation phase.
2. Promoting the client's insight and perception of reality.

**Phases of Relationship Development and Major Nursing Goals**

| Phase | Goals |
|---|---|
| 1. Preinteraction | Explore self-perceptions |
| 2. Orientation (introductory) | Establish trust<br>Formulate contract for intervention |
| 3. Working | Promote client change |
| 4. Termination | Evaluate goal attainment<br>Ensure therapeutic closure |

3. Problem solving using the model presented earlier in this chapter.
4. Overcoming resistance behaviors on the part of the client as the level of anxiety rises in response to discussion of painful issues.
5. Continuously evaluating progress toward goal attainment.

Transference and countertransference are common phenomena that often arise during the course of a therapeutic relationship.

### *Transference*

**Transference** occurs when the client unconsciously displaces (or "transfers") to the nurse feelings formed toward a person from the past (Sadock & Sadock, 2007). These feelings toward the nurse may be triggered by something about the nurse's appearance or personality characteristics that remind the client of the person. Transference can interfere with the therapeutic interaction when the feelings being expressed include anger and hostility. Anger toward the nurse can be manifested by uncooperativeness and resistance to the therapy.

Transference can also take the form of overwhelming affection for the nurse or excessive dependency on the nurse. The nurse is overvalued and the client forms unrealistic expectations of the nurse. When the nurse is unable to fulfill those expectations or meet the excessive dependency needs, the client becomes angry and hostile.

Hilz (2008) states,

> In cases of transference, the relationship does not usually need to be terminated, except when the transference poses a serious barrier to therapy or safety. The nurse should work with the patient in sorting out the past from the present, and assist the patient into identifying the transference and reassign a new and more appropriate meaning to the current nurse-patient relationship. The goal is to guide the patient to independence by teaching them to assume responsibility for their own behaviors, feelings, and thoughts, and to assign the correct meanings to the relationships based on present circumstances instead of the past.

### *Countertransference*

**Countertransference** refers to the nurse's behavioral and emotional response to the client. These responses may be related to unresolved feelings toward significant others from the nurse's past, or they may be generated in response to transference feelings on the part of the client. It is not easy to refrain from becoming angry when the client is consistently antagonistic, to feel flattered when showered with affection and attention by the client, or even to feel quite powerful when the client exhibits excessive dependency on the nurse. These feelings can interfere with the therapeutic relationship when they initiate the following types of behaviors:

The nurse overidentifies with the client's feelings, as they remind him or her of problems from the nurse's past or present.
The nurse and client develop a social or personal relationship.
The nurse begins to give advice or attempts to "rescue" the client.
The nurse encourages and promotes the client's dependence.
The nurse's anger engenders feelings of disgust toward the client.
The nurse feels anxious and uneasy in the presence of the client.
The nurse is bored and apathetic in sessions with the client.
The nurse has difficulty setting limits on the client's behavior.
The nurse defends the client's behavior to other staff members.

The nurse may be completely unaware or only minimally aware of the counter-transference as it is occurring (Hilz, 2008).

Hilz (2008) states:

> A relationship usually should not be terminated in the presence of countertransference. Rather, the nurse or staff member experiencing the countertransference should be supportively assisted by other staff members to identify his or her feelings and behaviors and recognize the occurrence of the phenomenon. It may be helpful to have evaluative sessions with the nurse after his or her encounter with the patient, in which both the nurse and other staff members (who are observing the interactions) discuss and compare the exhibited behaviors in the relationship.

Termination of the relationship may occur for a variety of reasons: the mutually agreed-on goals may have been reached, the client may be discharged from the hospital, or in the case of a student nurse, it may be the end of a clinical rotation. Termination can be a difficult phase for both the client and nurse. Tasks include the following:

1. Bringing a therapeutic conclusion to the relationship. This occurs when:
   a. Progress has been made toward attainment of mutually set goals.
   b. A plan for continuing care or for assistance during stressful life experiences is mutually established by the nurse and client.

c. Feelings about termination of the relationship are recognized and explored. Both the nurse and client may experience feelings of sadness and loss. The nurse should share his or her feelings with the client. Through these interactions, the client learns that it is acceptable to have these kinds of feelings at a time of separation. Through this knowledge, the client experiences growth during the process of termination.

**NOTE:** When the client feels sadness and loss, behaviors to delay termination may become evident. If the nurse experiences the same feelings, he or she may allow the client's behaviors to delay termination. For therapeutic closure, the nurse must establish the reality of the separation and resist being manipulated into repeated delays by the client.

## BOUNDARIES IN THE NURSE–CLIENT RELATIONSHIP

A boundary indicates a border or a limit. It determines the extent of acceptable limits. Many types of boundaries exist. Examples include the following:

- **Material boundaries.** These are physical property that can be seen, such as fences that border land.
- **Social boundaries.** These are established within a culture and define how individuals are expected to behave in social situations
- **Personal boundaries.** These are boundaries that individuals define for themselves. These include physical distance boundaries, or just how close individuals will allow others to invade their physical space; and emotional boundaries, or how much individuals choose to disclose of their most private and intimate selves to others.
- **Professional boundaries.** These boundaries limit and outline expectations for appropriate professional relationships with clients. They separate therapeutic behavior from any other behavior which, well intentioned or not, could lessen the benefit of care to clients (College and Association of Registered Nurses of Alberta [CARNA], 2005).

Concerns related to professional boundaries commonly refer to the following types of issues:

- **Self-disclosure.** Self-disclosure on the part of the nurse may be appropriate when it is judged that the information may therapeutically benefit the client. It should never be undertaken for the purpose of meeting the nurse's needs.
- **Gift-giving.** Individuals who are receiving care often feel indebted toward healthcare providers. And, indeed, gift giving may be part of the therapeutic process for people who receive care (CARNA, 2005). Cultural belief and values may also enter into the decision of whether to accept a gift from a client. In some cultures, failure to do so would be interpreted as an insult. Accepting financial gifts is never appropriate, but in some instances nurses may be permitted to suggest instead a donation to a charity of the client's choice. If acceptance of a small gift of gratitude is deemed appropriate, the nurse may choose to share it with other staff members who have been involved in the client's care. In all instances, nurses should exercise professional judgment when deciding whether to accept a gift from a client. Attention should be given to what the gift-giving means to the client, as well as to institutional policy, the ANA *Code of Ethics for Nurses*, and the ANA *Scope and Standards of Practice.*
- **Touch.** Nursing by its very nature involves touching clients. Touching is required to perform the many therapeutic procedures involved in the physical care of clients. Caring touch is the touching of clients when there is no physical need (Registered Nurses Association of British Columbia [RNABC], 2003). Caring touch often provides comfort or encouragement and, when it is used appropriately, it can have a therapeutic effect on the client. However, certain vulnerable clients may misinterpret the meaning of touch. Certain cultures, such as Native Americans and Asian Americans, are often uncomfortable with touch. The nurse must be sensitive to these cultural nuances and aware when touch is crossing a personal boundary. In addition, clients who are experiencing high levels of anxiety or suspicious or psychotic behaviors may interpret touch as aggressive. These are times when touch should be avoided or considered with extreme caution.
- **Friendship or romantic association.** When a nurse is acquainted with a client, the relationship must move from one of a personal nature to professional. If the nurse is unable to accomplish this separation, he or she should withdraw from the nurse–client relationship. Likewise, nurses must guard against personal relationships developing as a result of the nurse–client relationship. Romantic, sexual, or similar personal relationships are never appropriate between nurse and client.

Certain warning signs exist that indicate that professional boundaries of the nurse–client relationship may be in jeopardy. Some of these include the following (Coltrane & Pugh, 1978):

- Favoring one client's care over another's
- Keeping secrets with a client
- Changing dress style for working with a particular client
- Swapping client assignments to care for a particular client
- Giving special attention or treatment to one client over others

- Spending free time with a client
- Frequently thinking about the client when away from work
- Sharing personal information or work concerns with the client
- Receiving of gifts or continued contact/communication with the client after discharge

Boundary crossings can threaten the integrity of the nurse–client relationship. Nurses must gain self-awareness and insight to be able to recognize when professional integrity is being compromised. Peternelj-Taylor and Yonge (2003) state:

> The nursing profession needs nurses who have the ability to make decisions about boundaries based on the best interests of the clients in their care. This requires nurses to reflect on their knowledge and experiences, on how they think and how they feel, and not simply to buy blindly into a framework that says, "do this," "don't do that." (p. 65)

## SUMMARY AND KEY POINTS

- Nurses who work in the psychiatric/mental health field use special skills, or "interpersonal techniques," to assist clients in adapting to difficulties or changes in life experiences.
- Therapeutic nurse–client relationships are goal oriented, and the problem-solving model is used to try to bring about some type of change in the client's life.
- The instrument for delivery of the process of interpersonal nursing is the therapeutic use of self, which requires that the nurse possess a strong sense of self-awareness and self-understanding.
- Hildegard Peplau identified six subroles within the role of nurse: stranger, resource person, teacher, leader, surrogate, and counselor.
- Characteristics that enhance the achievement of a therapeutic relationship include rapport, trust, respect, genuineness, and empathy.
- Phases of a therapeutic nurse–client relationship include the preinteraction phase, the orientation (introductory) phase, the working phase, and the termination phase.
- Transference occurs when the client unconsciously displaces (or "transfers") to the nurse feelings formed toward a person from the past.
- Countertransference refers to the nurse's behavioral and emotional response to the client. These responses may be related to unresolved feelings toward significant others from the nurse's past, or they may be generated in response to transference feelings on the part of the client.
- Types of boundaries include material, social, personal, and professional.
- Concerns associated with professional boundaries include self-disclosure, gift-giving, touch, and developing a friendship or romantic association.
- Boundary crossings can threaten the integrity of the nurse–client relationship.

## REVIEW QUESTIONS

### Self-Examination/Learning Exercise

Test your knowledge of therapeutic nurse–client relationships by answering the following questions:

1. Name the six subroles of nursing identified by Peplau.
2. Which subrole is emphasized in psychiatric nursing?
3. Why is relationship development so important in the provision of emotional care?
4. In general, what is the goal of a therapeutic relationship? What method is recommended for intervention?
5. What is the instrument for delivery of the process of interpersonal nursing?
6. Several characteristics that enhance the achievement of a therapeutic relationship have been identified. Match the therapeutic concept with the corresponding definition.

| | |
|---|---|
| _____ 1. Rapport | a. The feeling of confidence in another person's presence, reliability, integrity, and desire to provide assistance. |
| _____ 2. Trust | b. Congruence between what is felt and what is being expressed. |
| _____ 3. Respect | c. The ability to see beyond outward behavior and to understand the situation from the client's point of view. |
| _____ 4. Genuineness | d. Special feelings between two people based on acceptance, warmth, friendliness, and shared common interest. |
| _____ 5. Empathy | e. Unconditional acceptance of an individual as a worthwhile and unique human being. |

7. Match the actions listed on the right to the appropriate phase of nurse–client relationship development on the left.

| | |
|---|---|
| _____ 1. Preinteraction Phase | a. Kim tells Nurse Jones she wants to learn more adaptive ways to handle her anger. Together, they set some goals. |
| _____ 2. Orientation (Introductory) Phase | b. The goals of therapy have been met, but Kim cries and says she has to keep coming to therapy in order to be able to handle her anger appropriately. |
| _____ 3. Working Phase | c. Nurse Jones reads Kim's previous medical records. She explores her feelings about working with a woman who has abused her child. |
| _____ 4. Termination Phase | d. Nurse Jones helps Kim practice various techniques to control her angry outbursts. She gives Kim positive feedback for attempting to improve maladaptive behaviors. |

8. Nurse Mary has been providing care for Tom during his hospital stay. On Tom's day of discharge, his wife brings a bouquet of flowers and box of chocolates to his room. He presents these gifts to Nurse Mary saying, "Thank you for taking care of me." What is a correct response by the nurse?
   a. "I don't accept gifts from patients."
   b. "Thank you so much! It is so nice to be appreciated."
   c. "Thank you. I will share these with the rest of the staff."
   d. "Hospital policy forbids me to accept gifts from patients."
9. Nancy says to the nurse, "I worked as a secretary to put my husband through college, and as soon as he graduated, he left me. I hate him! I hate all men!" Which is an empathetic response by the nurse?
   a. "You are very angry now. This is a normal response to your loss."
   b. "I know what you mean. Men can be very insensitive."

c. "I understand completely. My husband divorced me, too."
d. "You are depressed now, but you will feel better in time."

10. Which of the following behaviors suggests a possible breach of professional boundaries?
    a. The nurse repeatedly requests to be assigned to a specific client.
    b. The nurse shares the details of her divorce with the client.
    c. The nurse makes arrangements to meet the client outside of the therapeutic environment.
    d. C only.
    e. A, B, and C

## REFERENCES


College and Association of Registered Nurses of Alberta (CARNA). (2005). *Professional boundaries for registered nurses: Guidelines for the nurse–client relationship.* Edmonton, AB: CARNA.

Hilz, L.M. (2008). Transference and countertransference. *Kathi's mental health review.* Retrieved June 21, 2008 from http://www.toddlertime.com/mh/terms/countertransference-transference-3.htm

Peplau, H.E. (1991). *Interpersonal relations in nursing.* New York: Springer.

Peternelj-Taylor, C.A., & Yonge, O. (2003). Exploring boundaries in the nurse–client relationship: Professional roles and responsibilities. *Perspectives in Psychiatric Care, 39*(2), 55–66.

Raskin, N.J., & Rogers, C.R. (2005). Person-centered therapy. In R.J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (7th ed.). Belmont, CA: Wadsworth.

Registered Nurses' Association of British Columbia (RNABC). (2003). *Nurse–client Relationships.* Vancouver, BC: RNABC.

Sadock, B.J., & Sadock, V. A. (2007). *Synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia: Lippincott Williams & Wilkins.

Schuster, P.M. (2000). *Communication: The key to the therapeutic relationship.* Philadelphia: F.A. Davis.


## CLASSICAL REFERENCES


Coltrane, F., & Pugh, C. (1978). Danger signals in staff/patient relationships. *Journal of Psychiatric Nursing & Mental Health Services, 16*(6), 34–36.

Luft, J. (1970). *Group processes: An introduction to group dynamics.* Palo Alto, CA: National Press Books.

Peplau, H.E. (1962). Interpersonal techniques: The crux of psychiatric nursing. *American Journal of Nursing, 62*(6), 50–54.

Raths, L., Merril, H., & Simon, S. (1966). *Values and teaching.* Columbus, OH: Merrill.

Rogers, C.R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.

Sullivan, H.S. (1953). *The interpersonal theory of psychiatry.* New York: W.W. Norton.

Travelbee, J. (1971). *Interpersonal aspects of nursing* (2nd ed.). Philadelphia: F.A. Davis.