Student Number: xxxxxxxxx

P40404: Collaborative Nursing Practice

Word Count: 1459

Introduction

The following paper is a reflection on the therapeutic relationship in the context of an interaction between myself and Joe, a patient (see box below). I will use Gibbs' Reflective Cycle (1988) as it provides a useful framework for describing, analysing, evaluating and learning from incidents. The paper will explore the key elements of the therapeutic relationship and how, and to what affect, I displayed those in my interaction with Joe. I will draw on humanistic and psychodynamic theory to think about what occurred in the interaction and how effective it was at building a therapeutic relationship. I will look specifically at the Rogerian core conditions, power in the therapeutic relationship, and at concepts of containment, projective identification and mentalisation. The paper will conclude with learning from the incident and an action plan to help develop my practice in light of the interaction with Joe.

Joe (pseudonym), a 30-year-old man, was admitted to an acute male inpatient ward a month before this encounter due to having experienced a psychotic episode and depression resulting in him feeling very suicidal. He had been sleeping rough and using illegal substances.

Joe was due to be assessed by a service offering accommodation for people with mental health problems. He had been assessed by them previously but had been rejected as he had been dishonest about his history of drug use. He appealed this decision which resulted in him being offered another assessment by a different branch of the service. Joe was feeling very anxious about the assessment and had asked for a member of staff to support him with it. I was asked by the deputy manager of the ward to attend the assessment and offer support to Joe.

On the morning of the assessment I asked Joe if he wished to meet before the assessment to think about what he wanted to get out of it, whether he had any questions for them and to think about what kinds of questions they might ask him. Joe said he would like to. I suggested that we

meet somewhere private, but Joe said he would rather sit in the dining room as it was empty at that time.

I offered Joe a hot drink which he accepted, so I made both of us a cup of coffee. We started by thinking about what Joe's strengths are and the reasons why he would be suitable for this accommodation. During this process I said to Joe, 'And what about your drug use? Do you think they might ask you about that? How do you think you are managing?' At this Joe became irritated and angry and said, 'God, I don't even know if I want to stay at this place. Why should I have to be begging for somewhere to live?' Joe explained that he felt like he was being discriminated against because of his drug history and that it was unfair that he had to continually talk about. I suddenly felt guilty and complicit in being part of a system that made vulnerable people 'beg' for basic rights such as housing. I began to question whether I was taking the right approach in this interaction. My aim was to help him feel prepared for the assessment but perhaps I was just adding to his anxiety. I also felt very conscious of the fact that we were in a public space which made me feel exposed. I worried about people overhearing the conversation, staff or other patients, and them thinking that I was an incompetent practitioner. I felt worried about losing the alliance I had built with Joe and him walking away. I imagined having to tell the deputy manager that the assessment had gone poorly because we had not prepared properly, exposing my incompetency. I responded by empathising with how unfair it must feel, and that yes, it did not seem right that he was being put under so much scrutiny for something as basic as housing. I suggested that we move the focus away from why they should accept him as a tenant and look at what he wants and needs from the service. This seemed to quell Joe's anger and we continued our discussion, but without really exploring the issue of Joe's drug use.

Critical Analysis

Peplau (1952) describes nursing as a 'significant, **therapeutic**, interpersonal process' and Bale at al. (2006) state that the therapeutic relationship is central to mental health practice. However, it is not a straightforward task to identify the defining attributes of the therapeutic relationship in nursing. Hewitt and Coffey (2005) undertook a systematic review of the research around the therapeutic relationship working specifically with people diagnosed with schizophrenia. They found that nurses' understandings of the therapeutic relationship were influenced by many different theories, including psychodynamic theory, humanism, and specific nursing models such as those by Peplau and Barker. They found that the understanding of the therapeutic relationship very often depended on the individual nurses' background, education and clinical experience. My understanding of the therapeutic relationship has been strongly influenced by humanist and psychodynamic theory as I have had some basic training in these approaches.

Humanist, or person-centred, approaches to the therapeutic relationship were developed by Carl Rogers in his seminal text, *On Becoming a Person* (1961). Rogers (1961) argues that to develop a therapeutic relationship the helper must provide empathy, unconditional positive regard and congruence. I made attempts to communicate these attitudes to Joe by actively listening to him and showing that I was genuinely interested in what he had to say. By communicating these attitudes, I was able build rapport with Joe. I also tried to communicate empathy and respect by acknowledging his boundaries and therefore not continuing the conversation around his drug use.

Rogerian approaches to the therapeutic relationship also recognise the importance of equality between the helper and the person seeking help. This has been identified as particularly important in inpatient setting where most patients are there involuntarily and the power imbalances between nurse and patient are more acutely experienced (Wilkinson and Miers 1999, Cutcliffe and Happell 2009). Research has shown a positive correlation between low levels of coercion, negative pressure

and informal inpatient admissions, and high valuation of the therapeutic relationship (Sheehan and Burns 2011, Theodoridou et al. 2012). In recognition of the inherent power imbalance between myself and Joe, I offered choice throughout our interaction. I offered time to meet with Joe but stated that it was up to him whether we met or not. We agreed a mutual time and I offered Joe choice in where we met. I also offered Joe a drink which, although a seemingly small detail, normalised the situation through mutual engagement in a cultural norm (Barker et al 1999) and communicated a sense of equality between us (Schroder et al. 2006). Towards the end of the interaction, once Joe had clearly communicated that the conversation was causing him distress, I suggested that we refocus the conversation on what Joe wished to ask at the assessment. Again, this was an attempt to communicate to Joe that he had power in the relationship.

The approach outlined above helped me to establish rapport with Joe, allowing me to start a conversation with him about the upcoming assessment. However, as Browne et al. (2012) argue, the therapeutic relationship in nursing is more than merely engaging the patient. Therapeutic relationships are those that facilitate growth and change (Browne et al. 2012). Although I was able to engage Joe in a conversation about his upcoming assessment, we were not able to have a discussion around his drug use. This was potentially a missed opportunity to explore a difficult area of Joe's life and therefore of promoting, facilitating or encouraging change.

Psychodynamic theory can help in exploring interpersonal processes and the barriers to developing a therapeutic relationship. The first concept to consider is that of containment. Bion's (1962) theory of containment explains the process by which a baby's primary care giver, "mother", receives the baby's emotional communications and fragmented impulses, thinks about them, makes sense of them and communicates them back to the baby in a way that is more integrated and tolerable. The function of containment is present in the nurse-patient relationship where the nurse acts as container for the patient's emotions. During my interaction with Joe he became distressed after I

asked him about his drug use. I did not contain Joe's feelings in this situation as I became temporarily preoccupied with my own mental state. I acted too quickly to soothe Joe's distress (and my own) by evading the feelings and changing the subject. As a result, the opportunity to think together about Joe's problematic drug use was lost.

The concept of projective identification will help to make further sense of what led to my inability to contain Joe's feelings of distress in this interaction. According to Klein (1946), projective identification is an early psychological defence whereby the baby splits off intolerable and overwhelming aspects of her experience and attributes them to the mother. The mother then becomes 'possessed by, controlled and identified with the projected parts' (Segal 1974). It is possible that me asking Joe about his drug use made him feel vulnerable, exposed and inadequate. Through the process of projective identification, I became identified with Joe's intolerable feelings, experiencing them as my own: I felt vulnerable, exposed and. By splitting off and projecting the intolerable part of himself onto me Joe succeeded in avoiding the conversation around his drug use. This would have unconsciously communicated to Joe that his feelings, which he experienced as intolerable, are not able to be thought about.

Learning and Conclusions

The concept of mentalisation has developed from psychodynamic theory and is useful to consider in relation to learning from my interaction with Joe. Mentalising refers to the ability to think about, perceive and interpret one's own mental state and the mental state of others (Bateman and Fonagy 2006). In my interaction with Joe, my ability to mentalise relates to my capacity to understand and interpret Joe's emotional response to being asked about his drug use. However, as explored above, through the process of projective identification our feelings became enmeshed. This resulted in me losing the capacity to mentalise. If I had been more able to mentalise in this situation then I might have interpreted Joe's emotional reaction as a defence against talking about a difficult. From this, I

have learnt that it is important to regulate my emotions and stress levels to improve my capacity to mentalise.

Evaluation and Action Plan

I would like to improve my capacity to mentalise by introducing mindfulness based stress reduction (MBSR) activities into my daily life as developed by Kabat-Zinn (2003). Fonagy and Adshead (2012) recognise mindfulness as a tool in improving mentalising capacity. Burton et al. (2017) conducted a literature review of MBSR techniques used by healthcare professionals. The review found that MBSR can result in an increase in affect regulation, a decrease in levels of stress and overall improvements in self-care and well-being. The MBSR website (https://mbsr.co.uk/) developed by Michael Chaskalson (2016) who is a leader in MBSR and lecturer at the Centre for Mindfulness Research and Practice, Bangor University, has a series of audio and video resources to help develop one's practice. I will use this website to learn some MBSR skills. I will know whether this is improving my practice through the process of regularly reflecting on my interactions with patients and analysing whether I am able to stay focused on my patient's state of mind and not be distracted by my own thoughts and feelings.

Conclusion

In this essay I have explored how the Rogerian core conditions and redressing power imbalances between nurse and patient can help facilitate the beginnings of a therapeutic relationship. I have argued that a therapeutic relationship is more than just engaging the patient – the relationship must be one that facilitates growth and change. However, intra and interpersonal dynamics can sometimes act as barriers to change and understanding intra and inter psychic defence mechanisms can help overcome these barriers. Finally, this essay highlights the importance of being aware of one's own and other's states of mind and how this capacity to mentalise can help facilitate the therapeutic relationship.

Student number

References

Bale, R., Catty, J., Watt, H., Greenwood, N. and Burns, T., 2006. Measures of the therapeutic relationship in severe psychotic illness: a comparison of two scales. *International Journal of Social Psychiatry*, *52*(3), pp.256-266.

Bateman, A. and Fonagy, P., 2006. *Mentalization Based Treatment – a practical guide* OUP: Oxford

Barker, P., Jackson, S. and Stevenson, C., 1999. What are psychiatric nurses needed for? Developing a theory of essential nursing practice. *Journal of Psychiatric and Mental Health Nursing*, *6*(4), pp.273-282.

Barker, P., 2001. The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of psychiatric and mental health nursing*, *8*(3), pp.233-240.

Bion, W.R., 1962. *A theory of thinking*. London, Routledge.

Burton, A., Burgess, C., Dean, S., Koutsopoulou, G.Z. and Hugh-Jones, S., 2017. How effective are mindfulness-based interventions for reducing stress among healthcare professionals? a systematic review and meta-analysis. *Stress and Health*, *33*(1), pp.3-13.

Chasklason, M, 2016, Mindfulness at Work, *https://mbsr.co.uk/,* (last accessed 02/01/2018)

Cutcliffe, J. and B. Happell., 2009. Psychiatry, mental health nurses, and invisible power: Exploring a perturbed relationship within contemporary mental health care. *Int J Ment Health Nurs, 18* (2): pp.116-25.

Fonagy, P. and Adshead, G., 2012. How mentalisation changes the mind. *Advances in psychiatric treatment*, *18*(5), pp.353-362.

Student number

Gibbs, G., 1988. *Learning by Doing: A Guide to Teaching and Learning Methods*. Oxford: Oxford Further Education Unit

Hewitt, J. and Coffey, M., 2005. Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of advanced nursing*, *52*(5), pp.561-570.

Kabat-Zinn, J., 2003. Mindfulness-based interventions in context: past, present, and future. *Clinical psychology: Science and practice, 10*(2), pp.144-156.

Klein, M., 1946. Notes on some schizoid mechanisms. *The International journal of psycho-analysis*, *27*, p.99.

Peplau, H.E., 1952. *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. Springer Publishing Company.

Rogers, C.R., 1961. *On becoming a person: A therapist's view of psychology*. *London: Constable*.

Schröder, A., Ahlström, G. and Larsson, B.W., 2006. Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of clinical nursing*, *15*(1), pp.93-102.

Segal, H., 1974. *Introduction to the Work of Melanie Klein*. New York, Basic Books.

Sheehan, K.A. and Burns, T., 2011. Perceived coercion and the therapeutic relationship: a neglected association? *Psychiatr Serv 62* (5), pp.471-6.

Theodoridou, A., Schlatter, F., Ajdacic, V., Rössler, W. and Jäger, M., 2012. Therapeutic relationship in the context of perceived coercion in a psychiatric population. *Psychiatry Research 200* (2), pp.939-944.

Wilkinson, G. and Miers, M., 1999. *Power and nursing practice*. Basingstoke: Macmillan.