The therapeutic relationship: dead or merely impeded by technology?

Tom Foster, Jen Hawkins

Abstract
The ways in which current nurse education is delivered, combined with rapid increases in technological advances in health care, are having a major impact on the delivery of care to patients. This article focuses on one aspect of that care: the establishment, development and maintenance of the therapeutic relationship. The authors argue that the changes in education delivery and the rapid introduction of technologies are contributing to the possible demise of the contemporary nurse–patient relationship and, therefore, the loss of that essence of nursing which is essential to the patients' well-being and the nurses' professional satisfaction. The article explores the requisite knowledge and skills competences essential for the formation of the therapeutic relationship and asks whether these are being impeded by simulated educational activities and the advent of ubiquitous computing. The authors acknowledge the difficulties associated with the assessment of an effective therapeutic relationship and suggest a possible framework in which a performance of understanding of the formation of a therapeutic relationship can be established.

Key words: Interprofessional relations • Technology in health care • Nursing: care • Education: practical experience

For many years, writers have examined the impact of the therapeutic relationship and its pivotal effect, not only on the giving of care by practitioners, but also on the perceptions by the recipients of that care (Rogers, 1957; Peplau, 1952/1988; Millenson, 1995; O'Brien, 2001; Hawkins, 2003; Ramjan, 2004). The patient reacts to the practitioner from the very first contact and is a person with unique experiences and individual needs and emotions. The authors believe that recognition of this is important to the formation of an effective therapeutic relationship.

There are numerous definitions of the therapeutic relationship, from the simple to the more complex. The Registered Nurses Association of Ontario (2002) define it as being:

‘...grounded in an interpersonal process that occurs between the nurse and the patient. It is a purposeful, goal-directed relationship that is directed at advancing the best interest and outcome of the patient.’

Accepted for publication: April 2004

Mitchell and Cormack (1998) feel that practitioners must convince the patient that they care about them, must listen to the patient's story, must imaginatively put themselves in the patient's situation in order to understand what the patient feels and thereby be sensitive to the needs of patients as they change over their course of treatments. However, they suggest that, to be effective in the relationship, the practitioner must fully believe in the effectiveness of their part in influencing the impact on the patient's health.

From the definitions, it is clear to the authors that the therapeutic relationship is not merely an intellectual activity, but rather is dependent on practitioners' abilities to make and maintain personal/professional relationships with his/her patients. In turn, this is influenced by the practitioners' ability to engage in the appropriate and effective requisite competences of communication and reflection, the capacity for self-awareness, self-knowledge, accurate and appropriate empathy, trust and commitment, confidentiality and awareness of professional boundaries.

The ability to reflect on one's subjective thoughts, feelings and actions, allows the nurse to identify an attitude which could impede the therapeutic process and prevent the genuine and professional conditions required. Attitudes are shaped by many factors, such as nationality, race, culture, health, socio-economic conditions, gender, life experiences, education and information technology (Registered Nurses Association of Ontario, 2002).

More than a skill?
It is not easy to identify what the quality is which defines an effective relationship. Nevertheless, the required knowledge to inform the process and the skill competences to move it forward can be described. A useful framework for the establishment of an effective therapeutic relationship has been developed by the Registered Nurses Association of Ontario. This framework has been adapted to raise awareness of the necessary requisite knowledge and skills competences required to establish, develop and maintain effective therapeutic relationships (Figure 1).

In light of the definitions and requisite competences for the development of effective therapeutic relationships, the current trend for using skills laboratories, actors and/or simulated bodies in the education and training environment of the novice practitioner should be questioned. It will prove difficult to establish a therapeutic relationship with a dummy, albeit one that is capable of bleeding, passing urine and uttering the occasional word while being injected, catheterized, prodded and poked in the course of the learning process. There is some psycho-motor (the procedural knowledge of how to do things)
value in allowing the novice practitioner to practise in a simulated environment before they commence practice on patients. However, what may feel safe for the nurse can be emotionally destructive for the patient. The psycho-motor component of a skill should not be divorced or deferred from the affective component of that skill. Can one facilitate the necessary acquisition of appropriate attitudes, values and beliefs pertinent to the psycho-motor skill at a later date, or does one exacerbate the alienation of the affective domain and, in doing so, encourage the development of task-centred practitioners detached from both the patients and their own emotional wellbeing? Welsh (2004) believes that empathy is a skill that develops on the wards, not in the classroom, and that for nursing students to develop empathetic skills, they do so only by working alongside other empathetic nurses in the clinical environment — not by 'sitting in a classroom writing about such skills'.

The following scenario, a personal experience, will be familiar to many, and is regularly observed on busy wards up and down the country. A male orthopaedic patient is being nursed in a side-room with an intravenous drip in situ. Throughout the day a number of nurses enter the room and fail to acknowledge or engage with the patient, rather directing their attention to the drip. The drip was functioning normally, possibly needing checking, but no adjustment. Nevertheless, time and attention was given to the task of checking the drip, but at no point was communication established with the patient.

A robot performing the same task as the nurse may well have been as accurate in the undertaking of the task. However, the vital communication and emotional connection to this patient/person forming the establishment and maintenance of the therapeutic relationship would be missing.

It can be seen from this scenario that the nurse did not accept the patient as a participant in their care. Accepting the patient is perhaps the most important step for the evolution of the therapeutic relationship. Initially, by engaging and promoting patient involvement from the beginning, the nurse could have addressed the patient’s comfort, including reducing any anxiety or tension which may have arisen as a result of the actions of the nurse. The second stage of the process would involve the nurse assisting the patient to communicate their thoughts and feelings, to explore and validate their anxieties, fears and vulnerabilities. Only when the nurse and the patient have engaged at this level can the interaction be terminated; thereby building for future meaningful engagement and interaction.

It is acknowledged that in some areas of nursing, for example in mental health, the therapeutic relationship is often the primary intervention, promoting awareness and growth and empowering the patient to work through difficulties of living (Watkins, 2001). However, in other areas of nursing practice the therapeutic relationship may work hand in hand, with medical interventions serving as the intervention through which comfort, emotional support and real care can be facilitated. Regardless of setting and clinical situation, the intimate relationship developed between nurse and patient is considered to be pivotal to the patient’s wellbeing and the nurse’s professional satisfaction. The authors believe that the massive growth of information technology in health is contributing to the demise of an effective and intimate nurse-patient relationship.

**Advancing technologies**

There is no doubt that since the advent of the microchip, the almost continuous and rapid advances in technology has affected all our lives in one way or another — nowhere more so than in health care. As far back as 1996, Lock (1996) highlighted the spending of large amounts of money (£220 million) on computer technology in the NHS in pursuit of the development of information systems. This included the development of an accurate and effective electronic patient record, which enables seamless tracking throughout the patient’s journey, no matter what setting the patient may be receiving care in. Ball (2000) further explores the use on new technologies in health care, such as the use of smart cards, e-commerce, virtual reality, web technologies and mobile phone communication and wireless data networks, in pursuit of excellence in nursing care. Ball warns that the worst thing
nurses can do is to expect and wait for technological changes. Rather, they should be in a position to create it and exercise their nursing power. This may prove challenging as, anecdotally, nurses have often been accused of being technophobic and claim that time spent on the computer is time away from the patients' bedside, and is therefore viewed as detrimental to care.

Turley (2002) demonstrates the future impact of advanced technology on nursing care through ubiquitous computing. The result will be a nursing work area which will be enriched because the technological devices used for patient care will be able to communicate with each other to present information and provide data in a format most appropriate for the user. Devices like electronic clipboards, electronic kardexes and smart cards will be able to communicate with bleepers or personal information devices worn by staff to alert imminent critical incidences. Furthermore, patient medication will be automated to reduce time and effort needed to renew medication, prevent missed or improper medication and other traumatic situations. The clipboard, perhaps more than any other device, will benefit from automation and the power to communicate with other devices. For example, not only will it continuously record the patient's fluid intake and output, but it will also calculate automatic running totals, communicate these to the electronic patient record and, where balances have been exceeded, send alert messages to the electronic pagers of appropriate staff. These advances will make patient-centered care possible by using 'information on demand' as the critical focus of the delivery of care, making the delivery of care data intensive.

This article approaches these advances in technology in nursing care and their impacts on the therapeutic relationship from two very different perspectives. Firstly, the authors acknowledge that advancing technologies could impede the development of a nurse–patient relationship as technology takes over the nursing tasks which have previously been used to establish the basis of the therapeutic relationship. Time spent with the patient delivering hands-on care enables the potential for frequent communication, interaction and the development of an interpersonal relationship.

Advancing technology is not only limited to computer technology, but also includes those technological tasks which were once the responsibility of medical staff, for example the performance of endoscopies by nurses. Welsh (2004) claims that, while many nurses' technical abilities are beyond doubt, their interpersonal skills are severely deficient. Advancing technologies are improving the status of the patient; however, in doing so, these technologies may be reducing the nursing input, thereby diminishing the nursing ethic of intimate personal care for patients — the essence of the therapeutic relationship.

It is clear that nurses need to become confident and competent in the use of technology. According to Davidson (2003), many nurses lack IT skills because of the number of delays in implementing modern clinical systems. Nevertheless, there is a push in England for all staff within the NHS to undertake basic IT training in the form of the European Computer Driving Licence (Davidson, 2003). Until this happens, those nurses lacking in basic IT skills may spend a large amount of time working on computers in a less than efficient and somewhat slow and erratic manner. This will reduce both the time and opportunity to engage in one of nursing's most unique and intimate tasks — touching the patient. Time spent in the presence of the patient while engaging, not just in instrumental touch, but also in expressive touch, is a further element in the establishment of a therapeutic relationship. Nathan (1999) feels that such touching is known to facilitate self-disclosure and a positive feeling in an interpersonal transaction. Furthermore, Sayre-Adams and Wright (1995) are of the opinion that, although touching has always been an integral part of nursing and many related disciplines, it is the way that patients are touched that determines whether it will be an act of healing or a mechanistic procedural act. Smith (1992) evidences touch facilitating patient self-disclosure and leading to positive feelings for both patient and nurse. Moreover, Nathan (1999) focuses less on the amount of touch and more on the qualitative dimension of appropriate touch and its capacity to convey positive meanings, such as support, willingness to be involved and closeness. Furthermore, the patients' health status and their attitudes towards, and previous experiences of, touch also need to be considered.

When technology is sufficiently advanced and computing becomes more ubiquitous, then the potential to spend even less intimate time with the patient is increased. It is possible that nurses in the future will spend more time monitoring the collection of data than engaging with the physical and emotional care of the patient.

**Nursing as therapy**

Secondly, the counter argument is based on the removal of many nursing tasks by advancing technologies, which gives the nurse the opportunity to focus on the emotional wellbeing of the patient and to develop nursing purely as a therapeutic practice no longer obscured by physical task-orientated interventions. This change in role for nurses can already be identified from the many nurses who are enrolled on counselling courses, undertaking counselling-related modules as part of their continuing professional development, or simply attending workshops and study days offering psychological helping skills where the emphasis is clearly focused on improving the nurse–patient relationship.

Many nurses are turning to complementary therapies in their nursing practice because it allows them to maintain extended periods of physical contact with the patient (Trevelyan and Booth, 1994). This is particularly true of the therapies which involve the nurse in physical contact with the patient, such as massage, aromatherapy, and reflexology (Vickers, 1996). Historically, many of the more tactile nursing skills, such as the giving of a bed-bath, feeding and toileting of patients, have been passed on to healthcare assistants, leaving a void for nurses in establishing the relationship with the patient and also removing much of the potential for tactile nursing activities. The same is true in the current climate where nurses are taking on many of the roles that were traditionally those of the medical profession, which again takes them away from prolonged engagement with the patient and away from the traditional nursing activities involving hands-on care. Thus, the potential for the development of an effective therapeutic relationship is further diminished.

Smith (1992) makes a clear distinction between physical nursing tasks and the task of giving emotional support to patients. She claims that for nurses facilitating patients to 'unload their emotional baggage' or express their feelings through the
development of a therapeutic relationship, is demanding both physically and in terms of time. It is the authors' belief, based on many years of clinical experience, that the development of a truly effective therapeutic relationship is also mentally demanding and therefore requires appropriate clinical supervision to enable and support the nurse throughout the ongoing relationship. Nurses who receive clinical supervision and feel supported by colleagues are better able to maintain effective therapeutic relationships with their patients (Driscoll, 2000).

Longevity vs brevity
It is the authors' experience that, in the past, patients spent much longer periods of time in hospital than they do today. For example, following childbirth it was not unusual for the mother to be hospitalized for up to 10 days. Surgical patients were encouraged to rest and recuperate in hospital or a convalescent unit for some weeks before being discharged. In addition, many patients with chronic disease had extended periods of time in hospital while treatments and drug regimens were implemented and evaluated, thereby giving the nurse plenty of time to establish, develop and maintain strong therapeutic relationships with their patients based on the premise of 'knowing the patient'.

Today's and future admissions to hospital are likely to continue to be reduced to the shortest possible stay. Chronic disease is more often than not treated in the community, with only very brief stays in hospital when absolutely necessary. New mothers leave hospital within hours of giving birth, and even the most complicated surgery aims to have the patient mobile as soon as possible, hence the ever growing trend for day-case surgery. In this culture of brevity, nurses need to work rapidly to engage effectively with the patient.

Both perspectives in this discussion focus on the diminished time allowed for nurses to engage with patients, particularly where IT plays a major role in the care of that patient. This article has identified the increased importance of the establishment and development of the therapeutic relationship in light of reduced time and current technological advances. McMahon (1991), in questioning the therapeutic relationship, asks nurses to reflect on whether or not professional nursing, which holds care, nurturance and humanness as central concepts, actually does make a difference to patient care? If so, he asks, what is it about nursing care which makes that difference, and does it contribute to the healing process and help the patient attain and maintain health? Welsh (2004) advocates that a nurse's professional demeanour goes far beyond his or her ability to perform nursing tasks competently:

'...It involves a sense of caring about the tasks, about the patients and the patient's relatives and friends. It means making a conscious effort to ensure that the needs of vulnerable people are fully acknowledged.'

Psychological support and therapeutic interventions form the basis of the therapeutic relationship, which relies heavily on the active cooperation and motivation of the patient. The belief that this type of relationship is deceptively simple to establish, for example, by merely listening to the patient, is wrong. In reality, it is an extremely complex one. Salmon (2000) claims it is not just a matter of using appropriate verbal strategies and non-verbal techniques, but rather the purposes for which these techniques are employed that matters.

Listening to learn
Listening in this context ensures that patients feel that their individual problems, anxieties and fears are heard, and that the
realities of their individual symptoms and suffering are accepted by the nurse. Hawkins (2003) states that listening is an active process which requires effort, energy, commitment and attention to be fully focused on the patients, many of whom will have a history of not being heard. She claims that some patients will 'tell their story without too much prompting — it comes gushing out as they have sat on it long enough'. Others will need the sensitive probing of the nurse to establish the basis for the therapeutic relationship, a relationship based on mutual trust, with the essential qualities of respect and empathy, and the validation of the patient's concerns. The interpersonal style of the patient can affect the quality of the therapeutic relationship. Some relationships will go through phases that are non-therapeutic, more grappling and struggling, patients needing to express their anger, frustration and fears in a loud and demonstrative way. There is a danger in approaching all therapeutic relationship in hushed tones. Active listening and responding to the patient's concerns is not helped at it comes gushing out as they have sat on it long enough'.

With the introduction of information technology in health care and the possible change of emphasis of the nurses role, nurse education and training may need to move away from the objective study of physiology and treatment of disease to the more therapeutic study of the relationship process. This will focus not only on the qualities and skills required for building relationships, but also on the sequencing of the process, awareness of the possible impediments to the process and preparation and planning for the termination of the process. Clearly, the therapeutic relationship is not yet dead. But where it is being impeded and damaged by rapid technological advances and ever changing educational influences, there is an ongoing danger of it losing its crucial 'therapeutic' value for both the patient and the nurse.


Welsh I (2004) Listen Up: Empathy is a skill that develops on the wards not in the classroom. Nursing Times 100(49): 18

KEY POINTS

- The therapeutic relationship is a relationship directed at advancing the best interests of the patient, and is dependant on the practitioner's ability to make and maintain personal/professional relationships with their patients.

- The almost continuous and rapid advances in technology has affected all our lives in one way or another, nowhere more so than in health care. Ubiquitous computing will change the way in which care is delivered to patients.

- Effectively assessing values and attitudes through written assignments is almost impossible and meaningless.

- A 'performance of understanding' assessment tool designed specifically for use in the reality of clinical practice, rather than the artificiality of the classroom lends itself to the effective assessment of a therapeutic relationship.